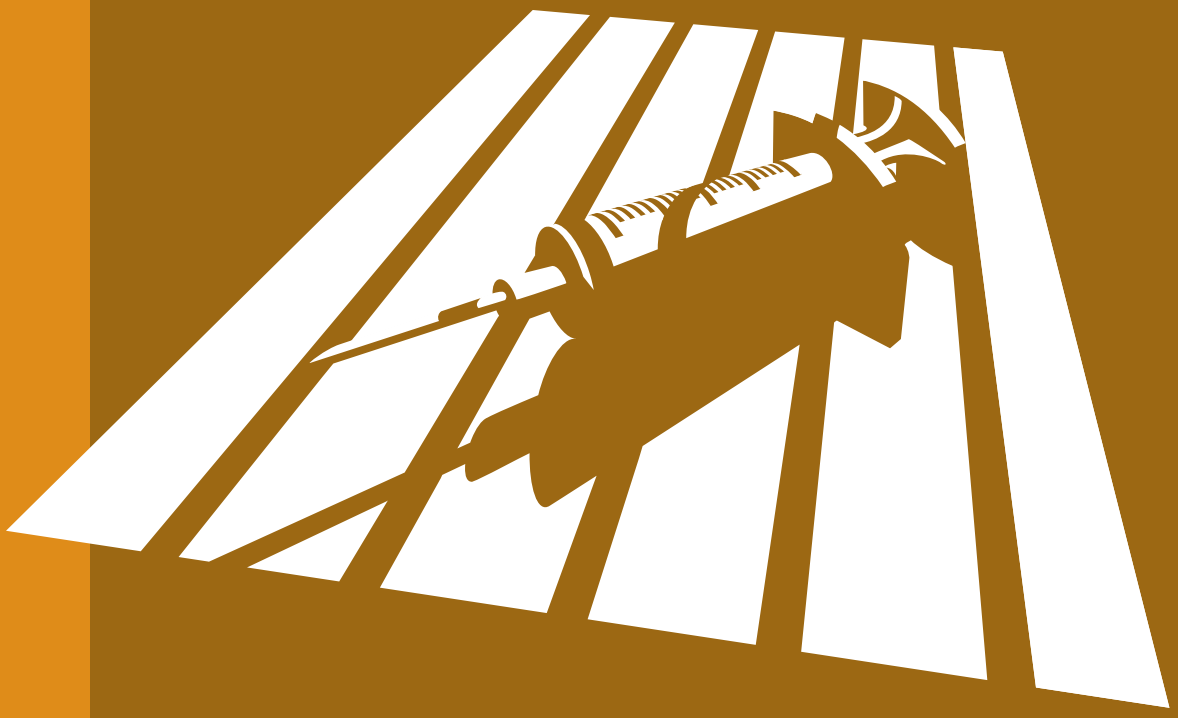

Clean Switch:

The Case for Prison Needle and Syringe Programs in Canada

Canadian HIV/AIDS Legal Network | Réseau juridique canadien VIH/sida

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About the Canadian HIV/AIDS Legal Network

The Canadian HIV/AIDS Legal Network (www.aidslaw.ca) promotes the human rights of people living with and vulnerable to HIV/AIDS, in Canada and internationally, through research, legal and policy analysis, education, and community mobilization. The Legal Network is Canada's leading advocacy organization working on the legal and human rights issues raised by HIV/AIDS.

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Executive Summary

In Canada and many other countries, the prevalence of HIV and hepatitis C virus (HCV) in prison populations is much higher than in the population as a whole. Estimates of HIV prevalence in Canadian federal and provincial prisons range from two to eight percent, or at least ten times the reported prevalence in the population as a whole.[1] Estimates of HCV prevalence in the Canadian prison population range from 19.2 to 39.8 percent,[2] or at least 20 times the estimated HCV prevalence in Canada[3] — and prevalence rates have been reported to be significantly higher for individuals who inject drugs.[4] Research over many years and from many jurisdictions has demonstrated not only the higher prevalence of both HIV and HCV infections among prisoners, but also the close relation between such infections and injection drug use, a result of the prevalence of HIV and HCV infections among people who inject drugs in the wider community, the widespread incarceration of people who use drugs, and high-risk activities within prisons.[5]

Harm reduction measures aimed at preventing HIV and HCV transmission in prisons are neither new nor groundbreaking in Canada. Prison systems have implemented, to varying degrees, forms of harm reduction such as condoms, bleach and methadone maintenance treatment. However, as of September 2008, no Canadian jurisdiction had established a prison-based needle and syringe program (PNSP)[6], despite significant evidence that PNSPs reduce risk behaviours associated with HIV and HCV transmission, result in other health benefits for prisoners, do not pose health and safety risks to prisoners or prison staff, and do not increase drug use. This paper outlines the available *evidence* and the *legal rationale*, under federal Canadian and international human rights law, for Canada to implement PNSPs without delay. The analysis focuses on the federal prison system and its governing legislation, but the evidence and the basic principles are equally applicable to provincial prison systems in Canada.

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[1] R. Lines et al., *Prison Needle Exchange: Lessons from a Comprehensive Review of International Evidence and Experience, Second edition*, Canadian HIV/AIDS Legal Network, 2006 at 6; *HIV and hepatitis C in prisons: the facts*, Canadian HIV/AIDS Legal Network, 2008. Available via www.aidslaw.ca/prisons.

[2] S. Skoretz, G. Zaniewski and N.J. Goedhuis, "Hepatitis C virus transmission in the prison/inmate population," *Canada Communicable Disease Report* 30(16) (2004): 141–148 at 142.

[3] R. Remis et al., *Estimating the number of blood transfusion recipients infected by hepatitis C virus in Canada, 1960–85 and 1990–92*, Report to Health Canada, June 1998.

[4] Correctional Service of Canada, *Springhill Project Report*, 1999 at 12.

[5] R. Elliott, "Deadly disregard: government refusal to implement evidence-based measures to prevent HIV and hepatitis C virus infections in prisons," *Canadian Medical Association Journal* 177(3) (2007): 262–264, citing: R. Lines et al., *supra* note 1; Correctional Service Canada, *Infectious diseases prevention and control in Canadian federal penitentiaries 2000–01: a report of the Correctional Service of Canada's Infectious Diseases Surveillance System*, 2003; and S. Skoretz, G. Zaniewski and N.J. Goedhuis, *supra* note 2.

[6] The term "prison needle and syringe program" is used to refer to any program that provides sterile injection equipment to prisoners who inject drugs, whether in a one-for-one exchange of a used needle for a sterile needle or in a less restrictive manner. Unless otherwise indicated explicitly or by context, the terms "needle" and "syringe" mean a device used to inject fluids into the body, and are used interchangeably throughout this paper.

Prison Needle and Syringe Programs: An Overview of the Evidence

In 2004, it was estimated that 4.1 million Canadians aged 15 and over had injected drugs at some point in their lives.[7] Of this figure, 269 000 Canadians reported injecting drugs that year.[8] Despite their illegality, the penalties for their use, and the significant resources spent by prison systems to control their availability in prisons, illegal drugs do get into prisons and prisoners use them. The federal government department responsible for Canada's federal prisons has acknowledged that "drugs in prisons are an unfortunate fact around the world."[9] A 1995 survey by Correctional Service of Canada (CSC), the federal prison system comprising 52 institutions, revealed that 11 percent of federal prisoners reported having injected an illegal drug since arriving at their current institution.[10] A 2003 study of federally incarcerated women found that 19 percent reported injecting drugs while in prison.[11] Numerous international studies have also confirmed the prevalence of injection drug use in prisons worldwide.[12] From 1998 to 2007, CSC spent significantly more time and money than it had in previous years on efforts to prevent drugs from entering prisons, yet drug use declined less than one percent during that period.[13] As the Correctional Investigator of Canada, who is mandated to review and make recommendations on CSC's policies and procedures, has concluded, "[d]rug interdiction can only go so far in reducing the rate of infection among the offender population."[14] Many prisoners, whether in pre-trial detention, awaiting sentencing following trial, or serving a sentence of incarceration, have a history of drug use or are actively using drugs at the time of imprisonment. In addition to those people entering prison with a history of, or active drug use, some prisoners start using drugs while in prison as a means to release tension and to cope with living in an overcrowded and often violent environment.[15]

Conflict with the law and incarceration are often a result of offences arising out of the criminalization of certain drugs, offences related to financing drug use or offences related to behaviours brought about by drug use.[16] Not surprisingly, the 1995 CSC survey found that prisoners in federal institutions are 30 times more likely than other Canadians to have injected illegal drugs.[17] A recent study in Ontario remand facilities found that 30 percent of those interviewed had injected drugs at some stage.[18] In a study of seven Quebec provincial prisons, 28 percent of men and 43 percent of women in prison had injected drugs outside prison.[19] According to recent figures from the Public Health Agency of Canada (PHAC), approximately 67 percent of federal prisoners have

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[7] Canadian Centre on Substance Abuse, *Canadian Addiction Survey: a national survey of Canadians' use of alcohol and other drugs*, March 2005 at 86.

[8] Ibid.

[9] Public Safety and Emergency Preparedness Canada, *Corrections Fast Facts No. 2: Drugs in Prisons*, undated, Available at www.publicsafety.gc.ca/prg/cor/acc/_fl/ff7-en.pdf.

[10] Correctional Service of Canada, *1995 National Inmate Survey: Final Report*, 1996. Available via www.csc-scc.gc.ca.

[11] A. DiCenso et al., *Unlocking Our Futures: A National Study on Women, Prisons, HIV and Hepatitis C,* Prisoners' HIV/AIDS Support Action Network, 2003. Available via www.pasan.org.

[12] See for example the studies cited in R. Lines et al., *supra* note 1 at 10–11.

[13] Correctional Investigator Canada, *Annual Report of the Office of the Correctional Investigator 2006-2007*, Minister of Public Works and Government Services Canada, 2007 at 12. Available at www.oci-bec.gc.ca/reports/AR200607_e.asp.

[14] Ibid., p. 12.

[15] See for example A. Taylor et al., "Outbreak of HIV Infection in a Scottish Prison," *British Medical Journal* 310 (1995): 289–292.

[16] R. Lines et al., *supra* note 1 at 9.

[17] Correctional Service of Canada, *supra* note 10.

[18] L. Calzavara et al., "Prevalence of HIV and hepatitis C virus infections among inmates of Ontario remand facilities," *Canadian Medical Association Journal* 177(3) (2007): 257–261.

[19] C. Poulin et al., "Prevalence of HIV and hepatitis C virus infections among inmates of Quebec provincial prisons," *Canadian Medical Association Journal* 177(3) (2007): 252–256.

substance use problems, of which 20 percent require treatment.[20] A 1995 World Health Organization (WHO) study among people who inject drugs in twelve cities found that 60 to 90 percent had been in prison since starting injection drug use, most of them experiencing incarceration on multiple occasions.[21]

Although people who inject drugs may inject less frequently in prisons, the scarcity of sterile syringes and the punitive consequences of drug use mean prisoners resort to using non-sterile injecting equipment.[22] A needle may circulate among large numbers of prisoners who inject drugs, thereby increasing the risk of transmission of HIV and HCV because of the presence of blood in needles after injection,[23] a risk further increased by the higher prevalence of both HIV and HCV among prisoners. In the Quebec study mentioned above, 63 percent of men and 50 percent of women who reported injecting in prison also reported having shared equipment.[24] In an Ontario study, 32 percent of those who reported injecting while incarcerated reported injecting with used needles.[25] A study in Vancouver estimated that incarceration more than doubled the risk of HIV infection for people who use illegal drugs, and estimated that 21 percent of all HIV infections among people in Vancouver who inject drugs may have been acquired in prison.[26] Furthermore, a number of outbreaks of HIV and HCV infection in prison have been attributed to the sharing of injection equipment. Outbreaks have been documented in Australia,[27] Lithuania,[28] the Russian Federation[29] and Scotland.[30] In the first documented outbreak in 1993, thirteen cases of HIV transmission were attributed to syringe-sharing between prisoners who injected drugs in Glenochil prison in Scotland.[31] In Lithuania, almost 300 new cases of HIV were identified

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[20] Public Health Agency of Canada, *HIV/AIDS: Populations at Risk*, 2006. Available at www.phac-aspc.gc.ca/aids-sida/populations_e.html#fpf.

[21] A. Ball et al., *Multi-centre study on drug injecting and risk of HIV infection: a report prepared on behalf of the international collaborative group for the World Health Organization Programme on Substance Abuse*, World Health Organization, 1995.

[22] See for example M.-J. Milloy et al., "Incarceration experiences in a cohort of active injection drug users," *Drug and Alcohol Review* (2008): 1–7; C. Poulin et al., *supra* note 19; European Monitoring Centre for Drugs and Drug Addiction, *Annual report on the state of the drugs problem in the European Union and Norway*, 2002 at 47; E. Wood et al., "Recent incarceration independently associated with syringe sharing by injection drug users," *Public Health Reports* 120 (2005): 150–156; W. Small et al., "Incarceration, Addiction and Harm Reduction: Inmates Experience Injecting Drugs in Prison," *Substance Use and Misuse* 40 (2005): 831–843; and K. Dolan, *The Epidemiology of Hepatitis C Infection in Prison Populations*, University of South Wales, National Drug and Alcohol Research Centre, 1999 at 6.

[23] See for example S. Shah et al., "Detection of HIV-1 DNA in needle/syringes, paraphernalia, and washes from shooting galleries in Miami: a preliminary laboratory report," *Journal of Acquired Immune Deficiency Syndrome and Human Retrovirology* 11(3) (1996): 301–306; P. Shapshak et al., "HIV-1 RNA load in needles/syringes from shooting galleries in Miami: a preliminary laboratory report," *Journal of Drug and Alcohol Dependency* 58 (1–2) (2000): 153–157; R. Needle et al., "HIV risk behaviors associated with the injection process: multiperson use of drug injection equipment and paraphernalia in injection drug user networks," *Substance Use and Misuse* 33(12) (1998): 2403–2423; and B. Jose et al., "Syringe-mediated drug-sharing (backloading): a new risk factor for HIV among injecting drug users," *AIDS* 7(12) (1993):1653–1660, erratum in *AIDS* 8(1) (1994).

[24] C. Poulin et al., *supra* note 19.

[25] L. Calzavara et al., "Prior opiate injection and incarceration history predict injection drug use among inmates," *Addiction* 98(9) (2003): 1257–1265.

[26] H. Hagan, "The relevance of attributable risk measures to HIV prevention planning," *AIDS* 17(6) (2003): 911–913 at 912.

[27] K. Dolan and A. Wodak, "HIV transmission in a prison system in an Australian State," *Medical Journal of Australia* 171(1) (1999): 14–17.

[28] M. MacDonald, *A Study of Health Care Provision, Existing Drug Services and Strategies Operating in Prisons in Ten Countries from Central and Eastern Europe*, The European Institute for Crime Prevention and Control, 2005.

[29] A. Bobrik et al., "Prison health in Russia: the larger picture," *Journal of Public Health Policy* 26 (2005): 30–59.

[30] A. Taylor et al., *supra* note 15.

[31] Ibid. See also A. Taylor and D. Goldberg. "Outbreak of HIV infection in a Scottish prison: why did it happen?" *Canadian HIV/AIDS Policy & Law Newsletter* 2(3) (1996): 13–14. Available via www.aidslaw.ca/review.

in a correctional facility in 2002, an outbreak believed to be due to the sharing of drug injection equipment.[32] A similar outbreak was documented in a correctional colony in Tatarstan, Russian Federation, where 260 prisoners contracted HIV in 2001.[33]

In addition to the risks posed by injection drug use, HIV and HCV may be transmitted through tattooing. In prison, tattooing is common and the reuse of needles creates the risk of transmitting blood-borne viruses such as HIV and HCV. In the 1995 CSC survey, 45 percent of federal prisoners in Canada reported having had a tattoo done in prison.[34] In September 2005, CSC started a pilot project for safer prison tattooing, and tattoo shops were established in six federal prisons, including a women's prison. The shops were run by prisoners and supervised by staff. Prisoners working in the shops received training in infection prevention and control practices, and were taught to be peer health educators. Prisoners paid to receive tattoos. Although the initial evaluations conducted by CSC indicated that the program may have reduced the risk of transmission of HIV and HCV and resulted in cost savings in the long run,[35] the project was terminated by the Minister of Public Safety in late 2006.[36] At the time of publication, the final evaluation report had yet to be released publicly.

Despite their illegality, the penalties for their use, and the significant resources spent by prison systems to control their availability in prisons, illegal drugs do get into prisons and prisoners use them.

Despite the closure of safer tattoo rooms in federal prisons, a number of prison systems in Canada have responded to the problem of HIV and HCV transmission in prison by making bleach available to prisoners.[37] While bleach is an important second-line strategy in the absence of access to sterile needles and syringes, it is not an adequate substitute for the provision of PNSPs.[38] Cleaning syringes with disinfectant such as bleach is not fully effective in reducing HCV transmission,[39] a finding recently confirmed by a study examining the

[32] M. MacDonald, *supra* note 28.

[33] A. Bobrik et al., *supra* note 29 at 46.

[34] Correctional Service of Canada, *supra* note 10.

[35] Correctional Service of Canada, *Draft evaluation report: Correctional Service Canada's Safer Tattooing Practices Pilot Initiative* [obtained by the Canadian HIV/AIDS Legal Network through an access-to-information request].

[36] W. Kondro, "Prison tattoo program wasn't given enough time," *Canadian Medical Association Journal* 176 (2007): 307–308.

[37] In Canada, all federal and most provincial prisons have a policy of making bleach available to prisoners. See for example Correctional Service of Canada, *Commissioner's Directive, 821–2 Bleach Distribution*, 4 November 2004 and B.C. Corrections Branch, Adult Custody Division, *Health Care Service Manual, Chapter 14 Blood and Body Fluid Borne Pathogens*, August 2002.

[38] See WHO, *Effectiveness of Sterile Needle and Syringe Programming in Reducing HIV/AIDS Among Injecting Drug Users*, Evidence for Action Technical Papers, 2004 at 28; Ontario Medical Association, *Improving our Health: Why is Canada Lagging Behind in Establishing Needle Exchange Programs in Prisons? A Position Paper by the Ontario Medical Association*, October 2004 at 8 available at www.oma.org/phealth/omanep.pdf; W. Small et al., *supra* note 22; N. Abdala et al., "Can HIV-1-contaminated syringes be disinfected? Implications for transmission among injection drug users," *Journal of Acquired Immune Deficiency Syndromes* 28(5) (2001): 487–494; and R. Carlson et al., "A preliminary evaluation of a modified needle-cleaning intervention using bleach among injection drug users," *AIDS Education and Prevention* 10(6) (1998): 523–532.

[39] H. Hagan and H. Thiede, "Does bleach disinfection of syringes help prevent hepatitis C virus transmission?" *Epidemiology* 14(5) (2003): 628–629.

incidence of HCV among Scottish prisoners (to whom disinfecting tables have been available since 1993).[40] In addition, while research has demonstrated that thorough, repeated applications of bleach may eliminate HIV in syringes,[41] field studies also indicate that many people who inject drugs have trouble following the correct procedure to properly disinfect syringes of HIV using bleach[42] and have concluded that disinfection with bleach appeared to offer no, or at best little, protection against HIV infection.[43] In numerous studies, half or more of people injecting drugs did not know or did not practise the proper method of using bleach effectively for disinfecting needles.[44]

Furthermore, evidence from Australia indicates that a substantial proportion of prisoners do not use bleach even when it is made available.[45] The probability of effective decontamination of needles using bleach is further decreased in prison because cleaning is a time-consuming procedure and some prisoners are reticent to engage in any activity that increases the risk of alerting prison staff to their illicit drug use, given the penal consequences that follow.[46] In a comprehensive review of the available evidence as of 2004, the WHO has also concluded that "[b]leach and other forms of disinfection are not supported by good evidence of effectiveness for reducing HIV infection."[47]

In the community, needle and syringe programs (NSPs) have been studied in great detail for over 20 years and have been proven to be an important mechanism for reducing the risk of infection from the use of non-sterile injecting equipment.[48] Health Canada reported that in 2001 there were over 200 NSPs in the country, with more in development,[49] and NSPs have enjoyed the support of federal,[50] provincial and territorial,[51] and

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[40] J. Champion et al., "Incidence of Hepatitis C Virus Infection and Associated Risk Factors among Scottish Prison Inmates: A Cohort Study," *American Journal of Epidemiology* 159 (2004): 514–519.

[41] N. Abdala et al., *supra* note 38.

[42] See W. Small et al., *supra* note 22 and C. McCoy et al., "Compliance to bleach disinfection protocols among injecting drug users in Miami," *Journal of Acquired Immune Deficiency Syndromes* 7(7) (1994): 773–776.

[43] S. Titus et al., "Bleach use and HIV seroconversion among New York City injection drug users," *Journal of Acquired Immune Deficiency Syndromes* 7(7) (1994): 700–704; D. Vlahov et al., "Field effectiveness of needle disinfection among injecting drug users," *Journal of Acquired Immune Deficiency Syndromes* 7(7) (1994): 760–766; C. McCoy et al., *supra* note 42; and W. Small et al., *supra* note 22.

[44] C. McCoy et al., *supra* note 42; A. Gleghorn et al., "Inadequate bleach contact times during syringe cleaning among injection drug users," *Journal of Acquired Immune Deficiency Syndromes* 7(7) (1994): 767–772; and R. Carlson et al., *supra* note 38.

[45] K. Dolan et al., "A bleach program for inmates in NSW: an HIV prevention strategy," *Australian and New Zealand Journal of Public Health* 22(7) (1998): 838–840.

[46] WHO Europe, *Status Paper on Prisons, Drugs and Harm Reduction*, 2005 at 12, noting "[s]erious problems are related to the use of bleach in prisons. For example, prisoners are highly to unlikely to spend 45 minutes shaking the syringes to clean them while waiting to inject in some hidden corner of the prison. Bleach can therefore create a false sense of security between prisoners sharing paraphernalia."

[47] WHO, *supra* note 38 at 28.

[48] Ibid.

[49] A. Klein, *Sticking Points: Barriers to Access to Needle and Syringe Programmes in Canada*, Canadian HIV/AIDS Legal Network, 2007 at 9, citing Health Canada, *Harm reduction and injection drug use: an international comparative study of factors influencing the development and implementation of relevant policies and programs,* September 2001 at 13.

[50] See Government of Canada, *Federal Initiative to Address HIV/AIDS in Canada: Strengthening Federal Action in the Canadian Response to HIV/AIDS,* 2004; Government of Canada, *Canada's Drug Strategy: Working Together to Reduce the Harmful Use of Substances*, 2005; F/P/T Advisory Committee on Population Health, F/P/T Committee on Alcohol and Other Drug Issues, F/P/T Advisory Committee on AIDS and F/P/T Heads of Corrections Working Group on HIV/AIDS, *Reducing the Harm Associated with Injection Drug Use in Canada*, 2001 at 11. Available at http://www.hc-sc.gc.ca/hl-vs/alt_formats/hecs-sesc/pdf/pubs/adp-apd/injection/injectiondrug-eng.pdf. According to the Public Health Agency of Canada, between 1989 and 1993, the federal government shared with provinces the cost of pilot outreach syringe exchange programs in four provinces: www.phac-aspc.gc.ca/hepc/pubs/hridu-rmudi/canada_e.html.

[51] See for example Alberta Alcohol and Drug Abuse Commission, *Stronger Together: a provincial framework for action*

municipal governments.[52] By 2007, 60 countries had implemented legal and/or government-sponsored NSPs in community settings.[53] Numerous evaluations of community NSPs have demonstrated that they reduce the risk of HIV and HCV,[54] are cost effective,[55] and facilitate access to care, treatment and support services.[56] For example, the WHO in 2004 undertook a comprehensive study of the effectiveness of sterile needle distribution in reducing HIV infection among persons who inject drugs, and found that "there is compelling evidence that increasing the availability and utilization of sterile injecting equipment" among persons who inject drugs "reduces HIV infection substantially."[57] The study also concluded that "there is no convincing evidence of any major, unintended negative consequences" from such programmes, including "no persuasive evidence that needle syringe programmes increase the initiation, duration or frequency of illicit drug use or drug injecting."[58]

As of 2007, PNSPs had been introduced in over 60 prisons of varying sizes and security levels in Switzerland, Germany, Spain, Moldova, Kyrgyzstan, Belarus, Armenia, Luxembourg, Romania, Portugal and Iran.[59] In Kyrgyzstan and Spain, PNSPs have been rapidly scaled up and operate in a large number of prisons. In addition, PNSPs are being considered in jurisdictions such as Azerbaijan, Ukraine, Belgium and Scotland. In every case, PNSPs have been a response to evidence of the risk of HIV and HCV transmission within prisons through the sharing of syringes to inject illicit drugs. While these PNSPs have been implemented in diverse environments and under differing circumstances, the results of the programmes have been remarkably consistent.

The evidence and experience from the aforementioned countries has demonstrated that PNSPs:

1. reduce the use of non-sterile injecting equipment and of resulting blood-borne infections;
2. do not lead to increased drug use or injecting;
3. reduce drug overdoses;
4. lead to a decrease in abscesses and other injection-related infections;
5. facilitate referral of users to drug addiction treatment programmes;

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on alcohol and other drug use, 2005; Ministry of Health and Social Services, Government of Quebec, *Plan d'action interministérielle en toxicomanie 2006–2011*, 2006; and Government of Saskatchewan, *Premier's Project Hope: Saskatchewan's action plan for substance abuse*, August 2005.

[52] See for example Toronto Drug Strategy Advisory Committee, *The Toronto Drug Strategy: a comprehensive approach to alcohol and drugs*, December 2005 at 31–32 and City of Vancouver, *A Framework for Action: A Four-Pillar Approach to Drug Problems in Vancouver*, 2001.

[53] R. Jürgens, *Interventions to Address HIV/AIDS in Prisons: Needle and Syringe Programmes and Decontamination Strategies,* WHO, UNODC and UNAIDS, 2007 at 12.

[54] Ibid.; M. Macdonald et al., "Effectiveness of needle and syringe programmes for preventing HIV transmission," *International Journal of Drug Policy* 14 (2003): 353–357; R. Bluthenthal et al., "The effect of syringe exchange use on high-risk injection drug users: a cohort study," *AIDS* 14(5) (2000): 605–611; D. Gibson et al., "Effectiveness of syringe exchange programs in reducing HIV risk behaviour and HIV seroconversion among injecting drug users," *AIDS* 15(11) (2001): 1329–1341; K. Ksobiech, "A meta-analysis of needle sharing, lending and borrowing behaviours of needle exchange program attenders," *AIDS Education and Prevention* 15(3) (2003): 257–268; and A. Wodak and A. Cooney, "Effectiveness of sterile needle and syringe programmes," *International Journal of Drug Policy* 16S (2005): S31–S344.

[55] M. Gold et al., "Needle exchange programs: an economic evaluation of local experience," *Canadian Medical Association Journal* 157(3) (1997): 255–262 and F. Laufer, "Cost effectiveness of syringe exchange as an HIV prevention study," *Journal of Acquired Immune Deficiency Syndrome* 28(3) (2001): 273–278.

[56] R. Heimer, "Can syringe exchange serve as a conduit to substance abuse treatment?" *Journal of Substance Abuse Treatment* 15(3) (1998): 183–191 and H. Hagan et al., "Reduced injection frequency and increased entry and retention in drug treatment associated with needle-exchange participation in Seattle drug injectors," *Journal of Substance Abuse Treatment* 19(3) (2000): 247–252.

[57] WHO, *supra* note 38 at 28.

[58] Ibid., p. 28.

[59] R. Jürgens, *supra* note 53 at 25.

6. have not resulted in needles or syringes being used as weapons against other prisoners or staff;
7. have been effective in a wide range of institutions; and
8. have effectively employed different methods of needle distribution, such as peer distribution by prisoners, hand-to-hand distribution by prison health-care staff or outside agencies, and automatic dispensing machines.[60]

In Canada, as early as 1994, the Expert Committee on AIDS and Prisons (ECAP), a body established by CSC to assist the federal government in preventing the transmission of HIV and other infections in federal correctional institutions, concluded that making sterile injection equipment available in prisons "will be inevitable," since only this strategy would make it possible for prisoners in federal correctional facilities to avoid sharing their makeshift drug injection equipment.[61] In his 2003–2004 Annual Report, the Correctional Investigator of Canada called for the introduction of PNSPs, finding that "the prohibition of drug injection, and the resulting clandestine use of scarce injection tools, have resulted in great harm" to federal prisoners.[62] The Correctional Investigator has since made repeated recommendations for the introduction of PNSPs.[63]

In 2004, the Canadian HIV/AIDS Legal Network undertook a comprehensive study of detailed evidence and experience of PNSPs in Switzerland, Germany, Spain, Moldova, Kyrgyzstan and Belarus which confirmed many of the findings of previous evaluations of PNSPs. Notably, the study revealed that PNSPs do not endanger staff or prisoner safety, do not increase drug consumption or injecting among prisoners and reduce risk behaviour and disease (including HIV and HCV transmission).[64] More recently, in 2006 PHAC prepared for CSC an exhaustive report to provide scientific, medical and technical advice on the effectiveness — and adverse outcomes if any — of PNSPs from a public-health perspective, and to provide a comprehensive

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[60] K. Stark et al., "A syringe exchange programme in prison as prevention strategy against HIV infection and hepatitis B and C in Berlin, Germany," *Epidemiology and Infection* 13(4) (2006): 814–819; H. Stöver and J. Nelles, "10 years of experience with needle and syringe exchange programmes in European prisons: A review of different evaluation studies," *International Journal of Drug Policy* 14 (2003): 437–444; S. Rutter et al., *Prison-Based Syringe Exchange Programs: A Review of International Research and Program Developments, NDARC Technical Report No. 112*, National Drug and Alcohol Research Centre, University of New South Wales, 2001; J. Nelles et al., "Provision of syringes: the cutting edge of harm reduction in prison?" *British Medical Journal* 317(7153) (1998): 270–273; K. Dolan et al., "Prison-based syringe exchange programmes: a review of international research and development," *Addiction* 98 (2003): 153–158; J. Nelles et al., *Prevention of drug use and infectious diseases in the Realta Cantonal Men's Prison: Summary of the Evaluation* (Berne: University Psychiatric Services, 1999); J. Nelles et al., "Provision of syringes and prescription of heroin in prison: The Swiss experience in the prisons of Hindelbank and Oberschöngrün," in J. Nelles and A. Fuhrer (eds.) *Harm Reduction in Prison* (Berne: Peter Lang, 1997), 239–262 at 239; H. Stöver, "Evaluation of needle exchange pilot projects show positive results," *Canadian HIV/AIDS Policy & Law Newsletter* 5(2/3) (2000): 60–64; C. Menoyo et al., "Needle exchange programs in prisons in Spain," *Canadian HIV/AIDS Policy & Law Review* 5(4)(2000): 20–21; Ministerio Del Interior/Ministerio De Sanidad y Consumo, *Needle Exchange in Prison: Framework Program*, 2002; J. Sanz Sanz et al., "Syringe-exchange programmes in Spanish prisons," *Connections: The Newsletter of the European Network Drug Services in Prison & Central and Eastern European Network of Drug Services in Prison* 13 (2003): 9–12; N. Bodrug, "A pilot project breaks down resistance," *Harm Reduction News* 3(2)(2002): 11.

[61] Correctional Service of Canada, *HIV/AIDS in prisons: final report of the Expert Committee on AIDS and Prisons*, Minister of Supply and Services Canada, 1994.

[62] Correctional Investigator of Canada, *Annual Report of the Correctional Investigator 2003–2004,* June 2004. Available at www.oci-bec.gc.ca/reports/AR200304_e.asp#19.

[63] For example, in his 2005–2006 Annual Report, the Correctional Investigator recommended that "the Correctional Service immediately implement a prison-based needle exchange to ensure that inmates and society at large are best protected from the spread of infectious diseases." See Correctional Investigator of Canada, *Annual Report of the Office of the Correctional Investigator of Canada 2005–2006,* September 2006. Available at www.oci-bec.gc.ca/reports/AR200506_e.asp. In his 2006–2007 Annual Report, the Correctional Investigator recommended that CSC "move beyond existing harm reduction initiatives of education, methadone treatment, condoms and bleach. It must implement a broader range of initiatives that have reduced transmission of infectious diseases in other jurisdictions without compromising the safety of staff and offenders." See Correctional Investigator of Canada, *Annual Report of the Office of the Correctional Investigator 2006–2007, supra* note 13 at 12.

[64] R. Lines et al., *supra* note 1 at xi.

scientific analysis of available published and unpublished information on PNSPs.[65] As part of the research, over 200 documents were reviewed, a team visited PNSPs in Germany and Spain, and a two-day expert consultation was convened. The PHAC report concluded that evidence from numerous jurisdictions showed that PNSPs:

1. decreased needle-sharing practices among prisoners;
2. increased referrals of prisoners to drug addiction treatment programmes;
3. decreased the need for health-care interventions related to injection-site abscesses; and
4. decreased the number of overdose-related health-care interventions and deaths.

With respect to institutional security and safety, the PHAC report concluded that the current body of evidence indicates that PNSPs do not result in:

1. PNSP syringes being used as weapons;
2. increased institutional violence;
3. any increase in needle-stick injuries;
4. increased seizures of illegal drugs or drug paraphenalia;
5. increased drug use; or
6. increased initiation by prisoners of injecting drug use.

Moreover, the PHAC report concluded that prison staff in institutions with PNSPs see such programmes as an important and necessary addition to a range of harm reducation services and health and safety interventions.

Further reinforcing the public-health imperative for PNSPs in Canada, a number of organizations, including the Canadian Medical Association[66] and the Ontario Medical Association[67] have recommended that CSC develop, implement and evaluate pilot NSPs in prisons under its jurisdiction and in 2005, the Canadian Centre on Substance Abuse concluded that there was ample justification for the government to implement pilot studies to assess the effectiveness and feasibility of PNSPs.[68]

PNSPs: International Health and Human Rights Standards

The Canadian government has a heightened obligation to protect the health of prisoners given that, as a result of incarceration, their integrity and well-being is dependent upon the actions of prison authorities. Two principles are particularly relevant to prisoners' rights in the context of PNSPs.

First, the international community has generally accepted the "principle of retaining all rights", which means that prisoners retain all human rights that are not taken away expressly or by necessary implication as a result of the loss of liberty flowing from imprisonment.[69] Under international law, the *right to the highest attainable standard of health*, which is recognized in Article 12 of the *International Covenant on Economic,*

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[65] Public Health Agency of Canada, *Prison needle exchange: Review of the evidence*, report prepared for Correctional Service of Canada, April 2006.

[66] Canadian Medical Association, Resolution 26 of 17 August 2005. Available at www.cma.ca/index.cfm/ci_id/45252/l.htm.

[67] Ontario Medical Association, *supra* note 38.

[68] G. Thomas, *Assessing the need for prison-based needle exchange programs in Canada: a situational analysis*, Canadian Centre for Substance Abuse, 2005. Available at www.ccsa.ca/NR/rdonlyres/62CB53B4-F416-455E-8069-9561275C1931/0/ccsa0113242005.pdf. See also F/P/T Advisory Committee on Population Health, F/P/T Committee on Alcohol and Other Drug Issues, F/P/T Advisory Committee on AIDS and F/P/T Heads of Corrections Working Group on HIV/AIDS, *supra* note 50 which recommends the "consideration of pilot projects in correctional facilities."

[69] *Basic Principles for the Treatment of Prisoners*, UNGAOR, 45th Sess., Supp. N 49A, UN Doc. A/45/49 (1990), Principle 5.

Social and Cultural Rights (ICESCR) is explicitly retained by people in detention.[70] According to the UN Committee on Economic, Social and Cultural Rights, the body of independent experts that monitors states' progress in implementing the ICESCR, "[s]tates are under the obligation to *respect* the right to health by, *inter alia*, refraining from denying or limiting equal access for all persons, including prisoners or detainees…to preventive, curative and palliative health services."[71] Given that HIV and HCV are potentially fatal diseases, the *right to life* is also relevant in considering states' obligation to take effective measures to prevent the transmission of blood-borne viruses in prisons by the provision of sterile syringes. The UN Human Rights Committee, the body of independent experts that monitors states' compliance with the *International Covenant on Civil and Political Rights*, has clarified that under Article 6 of the Covenant, states are obligated to take "positive measures" in order to "increase life expectancy" and "eliminate…epidemics."[72] Furthermore, the Committee has stressed that "the State party by arresting and detaining individuals takes the responsibility to care for their life."[73] According to the Committee, it is therefore "incumbent on States to ensure the right of life of detainees, and not incumbent on the latter to request protection."[74]

Under international law, the right to the highest attainable standard of health . . . is explicitly retained by people in detention.

Second, the "principle of equivalence" entitles persons in detention to have access to a standard of health care equivalent to that available outside of prisons, and includes preventive measures comparable to those available in the general community. The principle of equivalence requires standards that achieve equivalent health *objectives*, and in some cases could require that the scope and accessibility of prison health services be higher than that outside of prison.[75] Prisoners' right of access to health care equivalent to that available in the community is reflected in international declarations and guidelines from the United Nations General Assembly,[76] the WHO in its 1993 *Guidelines on HIV Infection and AIDS in Prisons*,[77] the United Nations Office on Drugs and Crime (UNODC)[78] and the Joint Nations Programme on HIV/AIDS (UNAIDS).[79]

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[70] See Article 2(2) of the *International Covenant on Economic, Social and Cultural Rights*, UN Doc. A/6316 (1966).

[71] UN Committee on Economic, Social and Cultural Rights, *General Comment 14: The right to the highest attainable standard of health*, 22nd Sess., (2000) UN Doc E/C.12/2000/4 at para. 34 [emphasis in original].

[72] UN Human Rights Committee, *General Comment No. 6: The right to life (Article 6)*, 16th Sess., (1982) UN Doc. HRI\GEN\1\ Rev.1 at 6 at para. 5.

[73] *Lantsova* v. *Russian Federation*, CHR Comm. 763/1997, UNCHR 74th Sess. (2002), UN Doc. CCPR/C/74/763/1997 at para. 9.2.

[74] Ibid.

[75] R. Lines, "From equivalence of standards to equivalence of objectives: The entitlement of prisoners to health standards higher than those outside prisons," *International Journal of Prisoner Health* 2 (2006): 269–280.

[76] *Basic Principles for the Treatment of Prisoners*, *supra* note 69 at para 9.

[77] WHO, WHO Guidelines on HIV Infection and AIDS in Prisons, 1993.

[78] UNODC, WHO and UNAIDS, HIV/AIDS Prevention, Care, Treatment and Support in Prison Settings: A Framework for an Effective National Response, 2006 at 10.

[79] UNAIDS, "Statement on HIV/AIDS in Prisons to the United Nations Commission on Human Rights at its Fifty-second session, April 1996," in *Prison and AIDS: UNAIDS Point of View* (Geneva: UNAIDS, 1997) at 3.

Numerous international health and human rights bodies support the position that, as a corollary to the right of people in prison to preventive health services, the state has an obligation to prevent the spread of contagious diseases in places of detention. Prison health standards and declarations from the WHO[80] and the World Medical Association,[81] for example, are clear that prisoners must be provided with measures to prevent the transmission of disease The UN *Rules for the Protection of Juveniles Deprived of their Liberty* specifies that all juvenile detainees shall receive preventive health care,[82] and in line with their general comments, both the UN Human Rights Committee and the UN Committee on Economic, Social and Cultural Rights have expressed concern about the spread of contagious diseases in prisons, calling upon the states in question to take steps to combat disease transmission among persons in detention.[83]

The specific issue of providing sterile syringes to prisoners as a means of preventing the spread of blood-borne viruses has also been considered and supported by numerous international organizations, as a matter of both sound public-health policy and human rights. For example, in the *International Guidelines on HIV/AIDS and Human Rights*, UNAIDS and the Office of the UN High Commissioner on Human Rights (OHCHR) call on prison authorities to, among other things, "provide prisoners (and prison staff, as appropriate), with access to HIV-related prevention information, education, voluntary counselling, means of protection (condoms, bleach and clean injection equipment)...."[84] The WHO in its *Guidelines on HIV Infection and AIDS in Prisons* affirms the principle of equivalence by recommending that in "countries where clean syringes and needles are made available to injecting drug users in the community, consideration should be given to providing clean injecting equipment during detention and on release to prisoners who request it."[85] Similarly, in *HIV/AIDS Prevention, Care, Treatment, and Support in Prison Settings: A Framework for an Effective National Response*, the UNODC, WHO and UNAIDS recommend that prison systems "ensure the measures available outside of prisons to prevent transmission of HIV through the exchange of bodily fluids are also available to prisoners," and specifically recommend that sterile needles and syringes and sterile tattooing equipment be accessible to prisoners in a confidential and non-discriminatory manner.[86] This recommendation is in keeping with one of eleven general principles identified in the report — namely, the requirement that prison health care be equivalent to that available in the outside community, including preventive measures. Most recently, WHO has reiterated that "people in prisons and other closed settings…are entitled to the same standard of health care as all other members of society," and that the range of services required for people in prisons and similar settings includes "clean needle and syringe provision."[87]

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[80] WHO, *supra* note 77.

[81] World Medical Association, *Declaration of Edinburgh on Prison Conditions and the Spread of Tuberculosis and Other Communicable Diseases*, 2000. Available at www.wma.net/e/policy/p28.htm.

[82] United Nations Rules for the Protection of Juveniles Deprived of their Liberty, UNGAOR 45th Sess., Supp. No. 49A, UN Doc.A/45/49 (1990) at para. 49.

[83] See for example *Concluding Observations of the Human Rights Committee: Republic of Moldova*, UNCHROR, 75th Sess., UN Doc CCPR/CO/75/MDA(2002) at para. 84(9); *Conclusions and Recommendations of the Committee on Economic, Social and Cultural Rights, Russian Federation*, UNCESCROR, 1997, UN Doc. E/1998/22 at para. 112; *Conclusions and Recommendations of the Committee on Economic, Social and Cultural Rights, Russian Federation*, UNCESCROR, 2003, UN Doc. E/2004/22 at paras. 33, 61; and *Conclusions and Recommendations of the Committee on Economic, Social and Cultural Rights, Republic of Moldova*, UNCESCROR, 2003, UN Doc. E/C.12/1/Add.91 at paras. 25 and 47.

[84] OHCHR and UNAIDS, *International Guidelines on HIV/AIDS and Human Rights*, *Consolidated Version*, UN Doc. HR/PUB/06/9, 2006, Guideline 4 at para. 21(e).

[85] WHO, *supra* note 77, Guideline 24.

[86] UNODC, WHO and UNAIDS, *supra* note 78, Recommendation no. 60.

[87] WHO, *Priority Interventions: HIV/AIDS prevention, treatment and care in the health sector*, August 2008 at 25. Available at http://www.who.int/hiv/pub/priority_interventions_web.pdf.

Canadian Correctional Law and Prisoners' Health

In Canada, the federal government has a statutory obligation to provide prisoners with essential health care equivalent to that available in the community. The CSC is responsible for the administration of all federal prisons[88] and is governed by the *Correctional and Conditional Release Act (*CCRA) and its accompanying regulations.[89] The CCRA obligates the federal correctional system to contribute to the maintenance of a just, peaceful and safe society by "carrying out sentences imposed by courts through the safe and humane custody and supervision of offenders,"[90] and also requires the CSC to "take all reasonable steps to ensure that penitentiaries, the penitentiary environment, the living and working conditions of inmates and the working conditions of staff members are safe, healthful and free of practices that undermine a person's sense of personal dignity."[91]

The CCRA reflects the legal principle of retaining all rights by stipulating that "offenders retain the rights and privileges of all members of society, except those rights and privileges that are necessarily removed or restricted as a consequence of the sentence."[92] The CCRA further mandates that the CSC must provide every prisoner with "essential health care" that will contribute to his or her rehabilitation and reintegration into the community.[93] (It is worth noting that in May 2008, in *PHS Community Services Society* v. *Attorney General of Canada*, Justice Pitfield of the B.C. Supreme Court held that Insite, a supervised injection site where injection drug users are provided with clean injection equipment and are able to inject their drugs under the supervision of health-care professionals, is a "health care undertaking".[94] Justice Pitfield further held that while "users do not use Insite to directly treat their addiction…they avoid the risk of being infected or of infecting others by injection."[95] In his view, "this is health care", logic which obviously applies equally to NSPs — and of course, is consistent with the fact that both Insite and other NSPs in Canada are, not surprisingly, often operated or funded by health departments, ministries or agencies at various levels of government.)

Further, the CCRA stipulates that medical care for prisoners "shall conform to professionally accepted standards," thereby implying a right to comparable health care as offered in the community at large. This is confirmed by CSC *Commissioner's Directive 800* on "Health Services" stipulating that prisoners "have

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[88] Under the sentencing provisions of the *Criminal Code*, people who receive a sentence of incarceration of at least two years are incarcerated in a federal institution; those who receive sentences of less than two years are incarcerated in a provincial institution.

[89] *Corrections and Conditional Release Act* (CCRA), S.C. 1992, c 20; SOR/92-620 and *Corrections and Conditional Release Regulations* (CCRR), SOR/92-620.

[90] CCRA, s. 3.

[91] CCRA, s. 70. In *Gates* v. *Canada (Attorney General)*, 2007 FC 1058 , the Federal Court (Trial Division) held at para. 13 that "the duty to provide a safe and healthy living environment includes providing adequate heat." In *Maljkovich* v. *Canada,* [2005] F.C.J. No. 1679 (QL), the same court held that CSC's failure to ensure the applicant was not exposed to second-hand smoke violated s. 70 of the CCRA, given his allergy to tobacco smoke. In *Curry* v. *Canada*, [2006] F.C.J. No. 87 (Federal Court, Trial Division), the court held that CSC's failure to obtain a prisoner's consent prior to performing x-rays and a body cavity search on her was contrary to s. 70 of the CCRA.

[92] CCRA, s. 4(e).

[93] CCRA, ss. 85–88. While s. 85 the CCRA defines "health care" as "medical care, dental care and mental health care," s. 87 of the CCRA requires CSC to "take into consideration an offender's state of health and health care needs." These provisions on health care are correctly interpreted as including access to health services that prevent the harms flowing from drug dependence, including possible blood-borne infection such as HIV and HCV. In *Lavoie* v. *Canada*, 2002 FCT 220 (Federal Court, Trial Division), the Court interpreted s. 86 to include access to a specialist in gastroenterology where the applicant suffered from cirrhosis of the liver. In *Canada (Attorney General)* v. *Canada (Canadian Human Rights Commission)*, [2003] F.C.J. No. 117 (Federal Court, Trial Division)(QL), the Court held that the Canadian Human Rights Tribunal was not unreasonable when it concluded that sex reassignment surgery was "essential health care" pursuant to s. 86 of the CCRA.

[94] *PHS Community Services Society* v. *Attorney General of Canada* 2008 BCSC 661 (B.C. Supreme Court) at para. 117.

[95] Ibid. at para. 136.

reasonable access to other health services…which may be provided in keeping with community practice."[96] While the principle of equivalence is not directly stated in the CCRA, the broad definition given to "health care" and the proviso to provide health services "in keeping with community practice" are correctly interpreted as meaning that prisoners are entitled to equivalence of essential health services, including HIV prevention services, particularly in light of the CCRA's explicit statement that prisoners retain all rights except those necessarily limited by the fact of incarceration.[97] This interpretation is further bolstered by the affirmation of the principle of equivalence in *Milton Cardinal* v. *The Director of the Edmonton Remand Centre and the Director of the Fort Saskatchewan Correctional Centre*, in which the Alberta Court of Queen's Bench ordered that prisoners who received methadone maintenance treatment prior to incarceration also be provided with it during their period of incarceration.[98]

In Canada, the federal government has a statutory obligation to provide prisoners with essential health care equivalent to that available in the community.

Pursuant to *Commissioner's Directive 821*, harm reduction is described as a "policy, a program or a measure aimed at reducing the negative health, social and economic consequences of harmful behaviours such as injection drug use and unsafe sex," and CSC "shall be guided by public health principles in managing infectious diseases in the penitentiary environment."[99] Accordingly, bleach is available in all federal correctional facilities, in order to "promote public health and a safe and healthy environment…as a harm reduction measure against the transmission of HIV and other infectious diseases."[100] Bleach kits are issued to prisoners at reception, which must include "instructions on the proper cleaning of syringes and needles."[101] However, as noted above, the evidence indicates access to bleach alone is insufficient as a means of protecting against the risk of transmission of HIV and HCV via shared injection equipment. Despite these affirmations of harm reduction measures in prisons, and an implicit acknowledgement in this Commissioner's Directive of the urgency of eliminating blood-borne viruses in needles and syringes (as well as the explicit acknowledgment by the federal government that drugs are available in prisons), the CCRA does not authorize the possession of sterile needles and syringes in prison, which are by implication prohibited.[102] In view of the availability of

[96] Correctional Service of Canada, *Commissioner's Directive 800: Health Services*, 2004.

[97] As mentioned above, s. 85 of the CCRA defines "health care" as "medical care, dental care and mental health care, provided by registered health care professionals." Under s. 86(1), CSC "shall provide every inmate with essential health care and reasonable access to non-essential mental health care that will contribute to the inmate's rehabilitation and successful reintegration into the community." Moreover, under s. 86(2), the provision of health care "shall conform to professionally accepted standards."

[98] *Milton Cardinal* v. *The Director of the Edmonton Remand Centre and the Director of the Fort Saskatchewan Correctional Centre* (Action No. 021531397P1) (Alberta Court of Queen's Bench). See also N. Whitling, "New policy on methadone maintenance treatment in prisons established in Alberta," *Canadian HIV/AIDS Policy & Law Review* 8(3)(2003): 45–47. Alberta's *Corrections Act*, R.S.A. 2000, c. C-29 does not explicitly feature provisions on health care, thus implying a generally accepted principle of equivalence in correctional health care.

[99] Correctional Service of Canada, *Commissioner's Directive 821: Management of Infectious Diseases*, 2004, s. 5.

[100] Correctional Service of Canada, *Commissioner's Directive 821; Guidelines 821-2: Bleach Distribution*, 2004, s. 1.

[101] Ibid., s. 7.

[102] Section 40 of the CCRA includes among its disciplinary offences the possession of, or dealing in, contraband; the possession of, or dealing in, without prior authorization, "an item that is not authorized by a Commissioner's Directive or by a written order of the institutional head"; and the taking of an "intoxicant". Section 2 of the CCRA defines an "intoxicant" as "a substance that,

NSPs in the community, the significant number of individuals who inject drugs in prison, the high prevalence of HIV and HCV in prisons, and the endorsement in the CCRA of the principle of retaining all rights and the principle of equivalence, CSC's failure to provide PNSPs contravenes both international health and human rights standards and Canadian correctional law. The next section considers whether it also violates Canadian constitutional law.

Canadian Constitutional Law

I. The rights to life, liberty and to security of the person: Charter, section 7

Section 7 of the *Canadian Charter of Rights and Freedoms* (Charter) protects everyone's right to "life, liberty and security of the person and the right not to be deprived thereof except in accordance with the principles of fundamental justice."[103] By virtue of their incarceration, prisoners' life, liberty and security of the person are entirely dependent upon prison authorities. Therefore, CSC has a responsibility to mitigate the additional risk of HIV and HCV transmission that incarceration poses to injection drug users in prison.

To establish an infringement of section 7, one must demonstrate:

a) an interest protected by the right to "life, liberty and security of the person";
b) a "deprivation" by the State with respect to that interest; and
c) that the deprivation is contrary to the principles of fundamental justice.[104]

In addition, in applying the Charter's protection of life, liberty and security of the person, courts must ensure that prisoners benefit equally from the protection which section 7 affords to the population as a whole, in a manner consistent with the equality rights guaranteed by section 15.[105]

Life

The right to life is concerned with state activity which can cause death to a person. Because HIV and HCV are potentially fatal diseases, the right to life is relevant in considering CSC's obligation to take effective measures to prevent the transmission of blood-borne viruses in prisons by, *inter alia*, the provision of sterile

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if taken into the body, has the potential to impair or alter judgment, behaviour or the capacity to recognize reality or meet the ordinary demands of life, but does not include caffeine, nicotine or any authorized medication used in accordance with directions given by a staff member or a registered health care professional." "Contraband" is defined in the CCRA as "an intoxicant" or "a weapon or a component thereof…and anything that is designed to kill, injure or disable a person or that is altered so as to be capable of killing, injuring or disabling a person, when possessed without prior authorization." Given that needles and syringes have not been authorized by a Commissioner's Directive, and could also be construed as contraband, the possession of needles or syringes (sterile or not), could lead to a disciplinary offence. It should be noted that, as of this writing, CSC had not explicitly stated this position; however, the fact remains that prisoners in Canada's federal (and provincial) prison systems do not have access to NSPs.

[103] *Canadian Charter of Rights and Freedoms*, Part I of the Constitution Act, 1982, being Schedule B to the Canada Act 1982 (U.K), 1982, c. 11 (Charter).

[104] *Gosselin* v. *Quebec (Attorney General),* [2002] 4 S.C.R. 429 (Supreme Court of Canada) at para. 75.

[105] For example, in a concurring judgment in *New Brunswick (Minister of Health and Community Services)* v. *G. (J.)*, Madame Justice L' Heureux-Dubé of the Supreme Court of Canada held that: "All Charter rights strengthen and support each other… and s. 15 plays a particularly important role in that process. The interpretive lens of the equality guarantee should therefore influence the interpretation of other constitutional rights where applicable, and in my opinion, principles of equality, guaranteed by both s. 15 and s. 28, are a significant influence on interpreting the scope of protection offered by s. 7." She added: "Thus, in considering the s. 7 rights, and the principles of fundamental justice that apply in this situation, it is important to ensure that the analysis takes into account the principles and purposes of the equality in promoting the equal benefit of the law and ensuring that the law responds to the needs of those disadvantaged individuals and groups whose protection is at the heart of s. 15." See *New Brunswick (Minister of Health and Community Services)* v. *G. (J.)*, [1999] 3 S.C.R. 46 (Supreme Court of Canada) at paras. 112 and 115.

syringes. The Supreme Court of Canada has held that excessive waiting times for treatment in the public health-care system of Quebec increased the risk of death, and were therefore a violation of the right to life (as well as security of the person).[106] In *PHS Community Services Society* v. *Attorney General of Canada*, the B.C. Supreme Court held that allowing the criminal prohibition on drug possession to extend to the premises of a supervised injection site would engage the right to life because "it prevents healthier and safer injection where the risk of mortality resulting from overdose can be managed, and forces the user who is ill from addiction to resort to unhealthy and unsafe injection in an environment where there is a significant and measurable risk of morbidity or death."[107] (The Court therefore maintained, as a matter of constitutional entitlement, the exemption for Vancouver's Insite from Canada's criminal law prohibiting drug possession, ruling that access to this health service had to take priority over an inflexible application of the criminal law.) Similarly, CSC's failure to provide PNSPs prevents "healthier and safer injection" by prisoners, which could lead to HIV and HCV infection and potentially death. While the Canadian government in *PHS Community Services Society* argued that the threat to life in that case resulted from an individual's choice to inject a harmful and dangerous narcotic, the Court held that:

> …the subject with which those actions are concerned has moved beyond the question of choice to consume in the first instance...the original personal decision to inject narcotics arose from a variety of circumstances, some of which commend themselves to choice, while others do not. However unfortunate, damaging, inexplicable and personal the original choice may have been, the result is an illness called addiction. The failure to manage the addiction in all of its aspects may lead to death, whether from overdose or other illnesses resulting from unsafe injection practices. If the root cause of death derives from the illness of addiction, then a law that prevents access to health care services that can prevent death clearly engages the right to life.[108]

Canadian courts may also turn to international law for interpretive guidance.[109] Under international law, the UN Human Rights Committee has clarified that under Article 6 ("right to life") of the ICCPR, States are obligated to take "positive measures" in order to "increase life expectancy" and "eliminate… epidemics."[110] Furthermore, the Committee has stressed that "the State party by arresting and detaining individuals takes the responsibility to care for their life."[111] Although HIV and HCV are potentially fatal viruses, there are means to control their spread; among injection drug users, the provision of sterile needles and syringes is a proven, effective means to enable CSC to fulfill its obligation to respect, protect and fulfill the right to life pursuant to section 7 of the Charter and under international law.

Liberty

In *Blencoe* v. *British Columbia*, Justice Bastarache, for the majority of the Supreme Court of Canada, affirmed that liberty in section 7 is not "restricted to mere freedom from physical restraint"; it applies whenever the law prevents a person from making "fundamental personal choices."[112] Liberty is afforded individuals in respect of matters that "can be properly characterized as fundamentally or inherently personal such that, by their very nature, they implicate basic choices going to the core of what it means to enjoy individual dignity and

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[106] *Chaoulli* v. *Quebec (Attorney General)*, [2005] 1 S.C.R. 791 (Supreme Court of Canada) at para 123.

[107] *PHS Community Services Society*, *supra* note 94 at para. 140.

[108] *PHS Community Services Society*, *supra* note 94 at para. 142.

[109] See for example *Suresh* v. *Canada (Minister of Citizenship and Immigration),* [2002] 1 S.C.R. 3 (Supreme Court of Canada) at para. 60: "in seeking the meaning of the Canadian Constitution, the courts may be informed by international law. Our concern is not with Canada's international obligations *qua* obligations; rather, our concern is with the principles of fundamental justice. We look to international law as evidence of these principles and not as controlling in itself."

[110] UN Human Rights Committee, *General Comment No. 6: The right to life (Article 6)*, 16th Sess., (1982) UN Doc. HRI\GEN\1\ Rev.1 at 6, para 5.

[111] *Lantsova* v. *Russian Federation*, *supra* note 73 at para. 9.2.

[112] *Blencoe* v. *British Columbia*, [2002] 2 S.C.R. 307 (Supreme Court of Canada).

independence."[113] Accordingly, section 7 has been applied to invalidate conditions imposed by the criminal justice system that interfere with a person's access to health-care services. For example, in *R.* v. *Parker*, a criminal prohibition against the use of marijuana to alleviate severe pain was considered a violation of the individual's liberty to choose a medically suitable course of treatment.[114] In *R.* v. *Reid*, the B.C. Provincial Court found that the blanket imposition of a "red zone" as a condition of probation for all people convicted of drug offences violated the section 7 rights to liberty and life because it was arbitrary and did not take into account the circumstances of the particular offender and the facts of the case, such as the accused's need to access the NSP located within the "red zone" part of the city, which the order prohibited him from entering. In Justice Gove's view,

> an order to not enter the "red zone" has the effect of banishing a person from the heart of the entire region. To impose such a condition without demonstrating that it is necessary and justified for a particular individual would, in my opinion, violate rights that any citizen has, even one convicted of a serious crime. Such an arbitrary imposition of a sanction would be an unreasonable interference with the citizen's liberty.[115]

Significantly, Justice Gove added that "many people who are subject to a 'red zone' condition have their lives put at risk because they are effectively forbidden from accessing necessary health and other social services…. [I]t is apparent that a lot of people who need The Needle Exchange's services are either not getting them or are violating the 'red zone' condition to do so."[116] Moreover, Justice Gove weighed any perceived benefit of the red zone prohibition with the harms it causes. He observed that imposing "the 'red zone' condition as a means to stop the activity of street drug trafficking has not been demonstrated as being successful. To the limited extent that it may have some value, the effect on individual rights is greatly disproportionate to any perceived social gain."[117] In the context of PNSPs, denying prisoners access to sterile needles and syringes which are available to persons outside of prison has a potentially grave impact on their health, with little or no impact on the use of drugs inside prisons.[118] The disproportionate effect of this deprivation lends further support to the argument that the infringement of prisoners' liberty interest, through restrictions on their access to health services, is unjustified.

Security of the person

The right to "security of the person" protects individuals' physical *and* psychological integrity,[119] and is infringed by state action which has the likely effect of seriously impairing a person's health.[120] In the context of prisons, the right of prisoners to security of the person is affirmed by the CCRA, which obligates the CSC to provide "essential health care" as well as "reasonable access to non-essential health care that will contribute to the inmate's rehabilitation and successful reintegration into the community for prisoners."[121] In *Chaoulli* v. *Quebec (Attorney General)*, the majority of the Supreme Court of Canada clarified that only "serious" health issues rise to the level of adverse impact on a person's security. In *Chaoulli*, patients who were denied

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[113] See *R.* v. *Malmo-Levine; R.* v. *Caine*, [2003] 3 S.C.R. 571 (Supreme Court of Canada) at para. 85, citing *Godbout* v. *Longueuil (City),* [1997] 3 S.C.R. 844 (Supreme Court of Canada) at para. 66.

[114] *R.* v. *Parker* (2000), 49 O.R. (3d) 481 (Ontario Court of Appeal).

[115] *R.* v. *Reid*, [1999] B.C.J. No. 1603 (B.C. Provincial Court)(QL) at para. 78.

[116] Ibid. at para. 80.

[117] Ibid. at para. 61.

[118] As mentioned above, from 1998 to 2007, CSC spent significantly more time and money than it had in previous years on efforts to prevent drugs from entering prisons, yet drug use declined less than one percent during that period. See Correctional Investigator Canada, *supra* note 13 at 12.

[119] *Rodriguez* v. *British Columbia (Attorney General)*, [1993] 3 S.C.R. 519 (Supreme Court of Canada).

[120] R. v. Morgentaler, [1988] 1 S.C.R. 30 (Supreme Court of Canada).

[121] CCRA, s. 86.

"timely health care for a condition that is clinically significant to their current and future health" experienced a violation which was sufficient to meet the threshold of seriousness.[122] Previously, in *R.* v. *Morgentaler*, another majority of the Supreme Court of Canada held that though the overall complications for women who experienced a delay in obtaining medically necessitated abortions was relatively low, delays which materially increased their exposure to serious health risks nevertheless breached women's right to security of the person.[123] In the prison context, the B.C. Supreme Court held in *McCann* v. *Fraser Regional Correctional Centre* that prisoners could "well be in danger as a result of aggressive behaviour of other inmates because they are suffering from [nicotine] withdrawals." The short notice provided for a smoking ban was therefore deemed to be a "risk to the security of the inmates" and "a breach of s. 7."[124] In *PHS Community Services Society* v. *Attorney General of Canada*, the B.C. Supreme Court rejected the argument that the right to security of the person is not engaged because those who use Insite do so "merely to satisfy the craving for an illegal drug" and held that denying an addict access to a health-care facility "where the risk of morbidity associated with infectious disease is diminished, if not eliminated" also threatened security of the person.[125]

Not only are actual impairments of life, liberty or security of the person violations of section 7 but so too are risks of impairment. In *Singh* v. *Minister of Employment*,[126] the majority of the Supreme Court of Canada held that section 7 encompasses freedom from physical punishment or suffering as well as the threat of punishment, and cited with approval *Collin* v. *Lussier*, in which the Court held that the security of a person is infringed not only by an actual impairment of health but also when state action increases an individual's "anxiety as to his state of health" and "is likely to make his illness worse…by depriving him of access to adequate medical care."[127] As Justice Wilson held:

> It is noteworthy that the applicant [in *Collin* v. *Lussier*] had not demonstrated that his health had been impaired; he merely showed that it was likely that his health would be impaired. This was held to be sufficient to constitute a deprivation of the right to security of the person under the circumstances.[128]

In *Morgentaler*, the Supreme Court held that state interference with bodily integrity offends the right to security of the person, and this extended to state-imposed limitations upon the ability of persons to obtain beneficial medical treatment where those limitations do not adequately take into account the needs, priorities and aspirations of those persons.[129] Therefore, the mere creation of a *risk* of complications and mortality resulting from delay due to mandatory procedures imposed was sufficient to constitute a section 7 violation.[130] In *Chaoulli*, the Court held that limitations imposed by the Government of Quebec on access to private health insurance violated section 7 because the consequent lack of patient access to timely health care had the potential to cause serious psychological and physical suffering in patients, and in some cases, even death.[131] In

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[122] *Chaoulli*, *supra* note 106 at para 123.

[123] *Morgentaler*, *supra* note 120 at para 29.

[124] *McCann* v. *Fraser Regional Correctional Centre*, [2000] B.C.J. No. 559 (B.C. Supreme Court)(QL) at para. 15.

[125] *PHS Community Services Society*, *supra* note 94 at paras. 144–145.

[126] *Singh* v. *Minister of Employment*, [1985] 1 S.C.R. 177 (Supreme Court of Canada).

[127] *Collin* v. *Lussier*, [1983] 1 F.C. 218 (Federal Court Trial Division) at 239.

[128] *Singh*, *supra* note 126 at para. 48.

[129] *R.* v. *Morgentaler*, *supra* note 120.

[130] In *United States of Mexico* v. *Hurley*, the Ontario Court of Appeal considered *Singh* v. *Minister of Employment* and held that a "likely" risk to health is "at a minimum, equivalent to one based on a balance of probabilities." The Court further held that this is "the standard commonly adopted in Charter cases." See *United States of Mexico* v. *Hurley*, [1997] O.J. No. 2487 (Ontario Court of Appeal)(QL) at paras. 57–58.

[131] *Chaoulli, supra* note 106 at para 123. Conversely, the Court in *Flora* v. *Ontario Health Insurance Plan*, which concerned an appellant who attempted to recover monies spent on surgery which the Ontario Health Insurance Fund refused to support, held that the state action did not deprive the appellant of his right to life or security of the person because the regulation was not

the context of PNSPs, an "imminent deprivation" of life, liberty or security of the person (i.e. one that has not yet occurred) is sufficient to establish a violation of section 7. Because HIV and HCV transmission among persons in prison has been amply documented in numerous studies,[132] prisoners should not need to prove actual HIV or HCV infection in order to prove a violation of section 7. Demonstrating a risk of infection is sufficient, and this risk has been recognized by numerous organizations, both within Canada (including CSC) and worldwide, as well as supported by several studies of confirmed outbreaks of HIV in prison.[133]

Denying prisoners access to sterile needles and syringes which are available to persons outside of prison has a potentially grave impact on their health, with little or no impact on the use of drugs inside prisons.

Given the severe health consequences of HIV and HCV infection, the risk of harm posed by banning PNSPs qualifies as sufficiently "serious" to ground a violation of security of the person under section 7. Notably, in *Chaoulli* the Court found that "the system left the individual facing a lack of critical care with no choice but to travel outside the country to obtain the required medical care at her own expense."[134] Yet persons who inject drugs in prison face no alternative options for accessing health care and must rely solely on services provided directly by CSC. Given the standard articulated by the Supreme Court of Canada, in the prison environment, where the state exercises exclusive control over prisoners' access to health services, a denial of access to sterile needles even more clearly violates prisoners' security of the person by significantly increasing their likelihood of HIV and HCV infection.

Deprivation of these rights by the state

The violation of the right to life, liberty or security of the person must be the direct causal result of a state action. In *Operation Dismantle* v. *R*, the plaintiffs claimed that the testing of a cruise missile in Canada posed a threat to the life, liberty and security of Canadians by increasing the risk of nuclear conflict and sought declaratory relief, an injunction and damages. The alleged violation of section 7 turned upon an actual increase in the risk of nuclear war resulting from the federal cabinet's decision to permit the testing, a nexus which the Supreme Court found the appellants could not prove, since there must was no direct "impingement by government upon the life, liberty and personal security of individual citizens."[135] At the same time, courts have stipulated that the government is not permitted to shield itself from constitutional review by hiding behind its "private delegates or the algorithms that determine its policies on the basis of what private actors do."[136] For

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prohibitive and did not completely obstruct the patient's ability to secure out-of-country treatment. In contrast, a ban on PNSPs completely or almost completely obstructs the ability of prisoners to obtain sterile needles, which in turn heightens prisoners' risk of HIV and HCV infection. See *Flora* v. *Ontario Health Insurance Plan,* [2007] O.J. No. 91 (Ontario Superior Court of Justice, Divisional Court) (QL) at para. 184.

[132] See for example P. Ford et al., "HIV and hep C seroprevalence and associated risk behaviours in a Canadian prison," *Canadian HIV/AIDS Policy & Law Newsletter* 4(2/3) (1999): 52–54; K. Dolan, "Evidence about HIV transmission in prisons," *Canadian HIV/AIDS Policy & Law Newsletter* 3(4)/4(1) (1997/98): 32–35; A. Taylor et al., *supra* note 15; A. Taylor and D. Goldberg, *supra* note 31; and M. MacDonald, *supra* note 28.

[133] *Supra* notes 27–33.

[134] *Chaoulli, supra* note 106 at para. 121.

[135] *Operation Dismantle* v. *R*., [1985] 1 S.C.R. 441 (Supreme Court of Canada) at para. 102.

[136] *Flora*, *supra* note 131 at para. 166.

example, in *Flora* v. *Ontario Health Insurance Plan*, a case in which the appellant attempted to recover monies spent on surgery which the Ontario Health Insurance Fund (OHIP) refused to cover, the court held that even if it could be said that the core of the appellant's problem was not OHIP's decision, but the physicians', "there is still an element of state action that attracts *Charter* scrutiny….Because accepted medical practice is adopted as government policy for this purpose, the Regulation is permitted to track medical policy only within the bounds of the Constitution."[137]

The prison environment is one in which exclusive state control could not be more apparent. Although prisoners retain the "rights and privileges of all members of society" except those that are necessarily removed as a consequence of incarceration, prison systems in Canada have so far refused to implement PNSPs.[138] As the Ontario Court of Appeal held in *R.* v. *Parker*, "preventing access to a treatment by threat of criminal sanction" constitutes a deprivation of security of the person.[139] Similarly, the Federal Court (Trial Division) in *Covarrubias* v. *Canada (Minister of Citizenship and Immigration)* held that the state controlled "the quality of the medical services that would be available to [the inmate] in the maximum security unit. The risk to the inmate's security interests, if established, would have been entirely caused by 'the state's conduct in the course of enforcing and securing compliance with the law'…"[140] In *PHS Community Services Society* v. *Attorney General of Canada,* the government argued that the threat to life associated with drug injection resulted from an individual's choice to inject rather than state action. The B.C. Supreme Court rejected that argument and held that "the subject with which those actions are concerned has moved beyond the question of choice to consume in the first instance.... However unfortunate, damaging, inexplicable and personal the original choice may have been, the result is an illness called addiction."[141] Therefore, the Court held that a law that prevented access to health-care services that could prevent death engaged the right to life.[142]

Because prisoners are under the jurisdiction of CSC and are entirely dependent upon it for their health care, the nexus between CSC's refusal to implement PNSPs and prisoners' risk of HIV and HCV infection is clear. The absence of sterile needles and syringes has been proven in numerous studies to increase prisoners' risk of HIV and HCV infection and evidence of actual outbreaks also directly link CSC's failure to implement PNSPs with increased risk of harm to prisoners' life and security of the person.[143] For persons in prison, particularly those who inject drugs, this state action constitutes an "imminent deprivation" of their security by the state.

Principles of fundamental justice

Depriving someone or a class of people of any of the rights to life, liberty or security of the person is a breach of section 7 of the Charter only if the deprivation is "not in accordance with the principles of fundamental justice." The earliest definition of the principles of fundamental justice was offered by the Supreme Court of Canada in *Re B.C. Motor Vehicle Act*, which held that these principles are to be found "in the basic tenets of our legal system."[144] In *Rodriguez* v. *British Columbia (Attorney General)*, the court held that the principles of fundamental justice must be "capable of being identified with some precision and applied to situations in a manner which yields an understandable result. They must also…be legal principles."[145] Furthermore, the

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[137] Ibid. at para. 166.

[138] CCRA, s. 4(e).

[139] *Parker*, *supra* note 114 at para. 97.

[140] *Covarrubias* v. *Canada (Minister of Citizenship and Immigration)*, [2005] F.C.J. No. 1470 (Federal Court, Trial Division) at para. 86.

[141] *PHS Community Services Society, supra* note 94 at para. 142.

[142] Ibid.

[143] See *supra* notes 27 to 33.

[144] *Re B.C. Motor Vehicle Act*, [1985] 2 S.C.R. 486 (Supreme Court of Canada) at para. 31.

[145] *Rodriguez*, *supra* note 119 at para. 141.

principles of fundamental justice must be "'fundamental' in the sense that they would have general acceptance among reasonable people.[146] In *Rodriguez*, the Court found the criminal prohibition on euthanasia did not violate the principles of fundamental justice because there was no such consensus on the issue. Similarly, in *R.* v. *Malmo-Levine*, the court held that a principle of fundamental justice is a legal principle generally accepted among "reasonable people" for which "there is significant societal consensus that it is fundamental to the way in which the legal system ought fairly to operate, and it must be identified with sufficient precision to yield a manageable standard against which to measure deprivations of life, liberty or security of the person."[147] Nevertheless, the Supreme Court has taken a broad and loosely defined approach to fundamental justice, and subsequent cases have demonstrated that there is no clear consensus as to what qualifies according to this criterion.

For example, subsequent section 7 cases have demonstrated that there is not an absolute requirement of social consensus on an issue before the courts can find a breach of fundamental justice. In *Chaoulli,* for example, the Supreme Court said, in reference to the privatization of health care, that "[t]he fact that the matter is complex, contentious or laden with social values does not mean that the courts can abdicate the responsibility vested in them by our Constitution to review legislation for *Charter* compliance."[148] In contrast to *Rodriguez*, the absence of a clear social consensus on the issue of private health insurance was not decisive in determining whether a violation was in accordance with the principles of fundamental justice.[149] This is significant with respect to PNSPs because their presence in prisons is controversial, despite the extensive evidence of their benefits and the increasing number of organizations in Canada and worldwide that have publicly recommended their implementation. As in *Chaoulli*, this does not preclude Charter evaluation of the detrimental effects flowing from a failure to implement PNSPs. Moreover, in reaching its conclusion in *Rodriguez*, the Court did not restrict itself to Canada, but also considered laws and policies from other jurisdictions to determine whether social consensus existed on the issue of euthanasia.[150] The fact that PNSPs have been introduced in over 60 prisons of varying sizes and security levels worldwide — and are recommended by a wide range of national and international organizations with expertise in HIV, health and human rights — is indicative of an increasing recognition of the human rights and public-health imperative of implementing NSPs in prison.[151]

To comport with the principles of fundamental justice, *Rodriguez* also established that a law or state action must not be so arbitrary "as to be no more than vague generalizations about what our society considers to be moral or ethical."[152] Building upon the principles set out in *Rodriguez*, the court in *Chaoulli* provided that a law is arbitrary where "it bears no relation to, or is inconsistent with, the objective that lies behind [it]."[153] In *Chaoulli*, the Court held that that the government's prohibition on private health insurance was arbitrary based on a review of experiences in other jurisdictions.[154] According to the Court in *Chaoulli*, its task "is to evaluate the issue in the light, not just of common sense or theory, but of the evidence," and that "interference with life, liberty and security of the person is impermissibly arbitrary if the interference lacks a *real connection on the facts* to the purpose the interference is said to serve."[155] Laws are not arbitrary if the restriction on life, liberty or security of the person has both a theoretical connection to the legislative objective as well as

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[146] Ibid at para. 173.

[147] *Malmo-Levine*, *supra* note 113 at para. 113.

[148] *Chaoulli, supra* note 106 at para. 107.

[149] Notably, the dissent pointed to the absence of societal consensus as to what is a "reasonable" wait time. It is not clear how decisive this particular point was for the dissent in finding against a s. 7 violation.

[150] *Rodriguez*, *supra* note 119 at paras. 163–174.

[151] Jürgens, *supra* note 53 at 25.

[152] *Rodriguez*, *supra* note 119 at para. 141.

[153] *Chaoulli, supra* note 106 at para 130.

[154] Ibid. at paras. 77–84.

[155] *Chaoulli*, *supra* note 106 at paras. 150 and 134 [emphasis added].

a real factual link.[156] The Supreme Court has consistently ruled that where depriving a person or class of persons of any of the rights to life, liberty or security of the person does not enhance the state's interest, then a breach of fundamental justice will be made out, since the individual's interest has been deprived for no valid purpose.[157] In *R.* v. *Parker*, the court held that a blanket prohibition on marijuana use would be in breach of the principles of fundamental justice if it is unrelated to the state's interest in enacting the prohibition, and if it lacks a foundation in the legal tradition and societal beliefs that are said to be represented by the prohibition.[158] Correspondingly, in *PHS Community Services Society* v. *Attorney General of Canada*, the B.C. Supreme Court held that section 4(1) of the *Controlled Drugs and Substances Act*, which applies to possession for "every purpose without discrimination or differentiation in its effect, is arbitrary…. Instead of being rationally connected to a reasonable apprehension of harm, the blanket prohibition contributes to the very harm it seeks to prevent. It is inconsistent with the state's interest in fostering individual and community health, and preventing death and disease."[159]

In the absence of any clear statement from the government as to why PNSPs have not been instituted, especially given its acknowledgement of both drug injection and the need for harm reduction measures in prisons (including through the provision of bleach for the sterilization of needles and syringes), it is difficult to know for certain what objectives CSC seeks to pursue by continuing to prohibit PNSPs. This in turn makes it difficult to subject the prohibition to proper constitutional analysis. Since CSC has never publicly articulated its specific reasons for failing to broadly implement harm reduction strategies in prisons through the provision of clean needles, completing a section 7 analysis must presume that CSC's objections reflect those commonly raised by governments, which include the claims that PNSPs would:

1. undermine abstinence-based messages and programs by condoning drug use;
2. lead to increased violence and the use of needles as weapons against prisoners or staff;
3. lead to an increased consumption of drugs, and/or an increased use of injection drugs among those who were previously not injecting; and
4. not necessarily work in Canada because other jurisdictions with successful PNSPs reflect specific and unique institutional environments.[160]

The first claim, that PNSPs condone drug use, is inconsistent in light of the availability of NSPs in the community. Despite the criminalization of illicit drug use in Canada, NSPs operate legally in the community, are recognized as a valuable harm reduction measure that reduces the risk of HIV and HCV transmission among injection drug users, and have the support of various orders of government. Community NSPs are not viewed by the federal government as undermining abstinence or condoning drug use. As confirmed recently by the review done by PHAC,[161] studies have also refuted the assumption that PNSPs lead to increased violence and/or the use of needles as weapons against prisoners or staff,[162] or lead to increased drug use and/or an increased use of injection drugs among those who were previously not injecting.[163] Finally, PNSP studies worldwide have demonstrated that they work in a variety of different institutions, including men's and women's prisons, prisons of different security levels and prison populations, open and closed environments,

[156] Ibid. at para. 131.

[157] See for example *Rodriguez*, *supra* note 119 and *R.* v. *Ruzic,* [2001] 1 S.C.R. 687 (Supreme Court of Canada). See also the Ontario Court of Appeal decision in *Parker*, *supra* note 114 at para. 117.

[158] *Parker*, *supra* note 114 at para. 117.

[159] *PHS Community Services Society*, *supra* note 94 at para. 152.

[160] Lines et al., *supra* note 1 at 44–52.

[161] Public Health Agency of Canada, *supra* note 65.

[162] WHO, *supra* note 38.

[163] Ibid.

and barracks and cells.[164] Given the breadth of institutions in which PNSPs have been successfully implemented, there is no support for the argument that PNSPs would not work in Canada, especially if a pilot program has yet to be implemented. The positive public-health benefits of PNSPs observed from numerous evaluations, and the evidence disproving CSC's presumed concerns, confirms that the prohibition of PNSPs is arbitrary and does not enhance the "state's interest". As the Court in *Chaoulli* held, "rules that endanger health arbitrarily do not comply with the principles of fundamental justice."[165] Where state action puts individuals' lives at stake, there must be a clear connection between that measure and its underlying legislative goals. In the case of PNSPs, there is no such connection.

In *Cunningham* v. *Canada*, the Supreme Court held that, in determining whether an individual's life, liberty or security of the person has been deprived in accordance with the principles of fundamental justice, the interest of the individual must be balanced against those of society as a whole.[166] The question, according to the Court, is whether, "from a substantive point of view, the change in the law strikes the right balance between the accused's interests and the interests of society."[167] In light of the evidence garnered from PNSPs worldwide, there is no legitimate societal interest in depriving prisoners of access to PNSPs.[168] As the Correctional Investigator of Canada has observed, almost 10 years of significant CSC expenditure on drug interdiction as well as the prohibition of PNSPs has led to a decline of less than one percent in drug use in prisons during that period.[169] There is, therefore, little substance to the claim that withholding NSPs from prisoners is necessary — or effective — in reducing drug use in prisons.

In *Cunningham*, the deprivation of a prisoner's liberty was in accordance with the principles of fundamental justice because his continued incarceration was "directly related to the public interest in protecting society from persons who may commit serious harm if released on mandatory supervision."[170] In contrast, there is a common interest on the part of persons in prisons and society as a whole in reducing HIV and HCV prevalence inside prisons. Evaluations of PNSPs worldwide have shown they reduce the risk of HIV and HCV transmission within prisons, a result which has broader positive public-health outcomes, since most prisoners return to the community upon release. While prison management is legitimately within the scope of CSC's expertise, the decision to prohibit PNSPs is arguably not. A decision not to provide PNSPs can be distinguished from other correctional policies, such as night-time bed checks or pat-downs which may warrant deference to prison officials, since the failure to provide PNSPs affects the health of the prison population, and further affects the health of the wider population when prisoners eventually reintegrate into society. Given the overwhelming evidence supporting PNSPs as a public-health measure and the lack of correlation between banning PNSPs and CSC's presumed objectives, the breach of prisoners' rights to life, liberty and security of the person is arbitrary and not in accordance with the principles of fundamental justice.

II. The right to equality: Charter, section 15

Section 15(1) of the Charter guarantees equality to all Canadians:

> 15.(1) Every individual is equal before and under the law and has the right to the equal protection and equal benefit of the law without discrimination and, in particular, without discrimination based on race, national or ethnic origin, colour, religion, sex, age or mental or physical disability.

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[164] Ibid.

[165] *Chaoulli, supra* note 106 at para 133. See also *Morgentaler*, *supra* note 120 at para 57.

[166] *Cunningham* v. *Canada*, [1993] S.C.R. 143 (Supreme Court of Canada) at 152. See also *Rodriguez*, *supra* note 119.

[167] *Cunningham*, ibid. at 152.

[168] See for example Public Health Agency of Canada, *supra* note 65 and studies cited *supra* note 38.

[169] Correctional Investigator Canada, *supra* note 13 at 12.

[170] *Cunningham*, *supra* note 166 at 152.

The purposes of section 15 are to prevent discrimination, promote equality and remedy disadvantage.[171] As Justice Sopinka observed in *Brant County Board of Education* v. *Eaton*, section 15 is intended to "ameliorate the position of groups within Canadian society who have suffered disadvantage by exclusion from mainstream society."[172] A law or other state action can be struck down for violating section 15 based on a discriminatory distinction written into its text, or based on the impact of the law or state action on a member of an already disadvantaged group. A law or state action that does not make a distinction based on a prohibited ground for discrimination may nevertheless violate section 15 if it results in differential treatment on the basis of such personal characteristics.[173] At its core, the equality guarantee in section 15 of the Charter protects against differentiations by the state that reflect, perpetuate, exacerbate or fail to remedy historical patterns of oppression of particular groups and individual members of these groups.[174] Therefore, the focus of the analysis must be on the impact of the impugned law or policy, regardless of whether there is an intention to discriminate.[175]

CSC's denial of PNSPs to prisoners in federal correctional facilities constitutes unequal treatment between injection drug users in prison and injection drug users outside.

The Supreme Court of Canada has repeatedly outlined the importance of taking a purposive and contextual approach to the evaluation of section 15 claims, using the analytical framework set out in *Law* v. *Canada (Minister of Employment and Immigration)* as a guideline.[176] It has ruled that a mechanistic and formalistic approach fails to recognize a commitment to substantive equality and to the remedial purpose of section 15 by prioritizing the accurate application of legal tests over a thorough investigation of whether a law fails to recognize an individual or group "as members of Canadian society…equally deserving of concern, respect, and consideration."[177] A mechanistic approach should be rejected for its inability to properly identify and address "the true social, political and legal context underlying each and every equality claim."[178] Courts are instructed to look at "the reality of the situation and assess whether there has been discriminatory treatment having regard to the purpose of s. 15(1), which is to prevent the perpetuation of pre-existing disadvantage through unequal treatment."[179]

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[171] See *Andrews* v. *Law Society of British Columbia*, [1989] 1 S.C.R. 143 (Supreme Court of Canada) at 164–177 and *Law* v. *Canada (Minister of Employment and Immigration*), [1999] 1 S.C.R. 497 (Supreme Court of Canada) at paras. 51, 52 and 88.

[172] *Brant County Board of Education* v. *Eaton*, [1997] 1 S.C.R. 241 (Supreme Court of Canada) at para. 66.

[173] *Eldridge v. British Columbia (Attorney General)*, [1997] 3 S.C.R. 624 at para. 61.

[174] See for example *Law*, *supra* note 171 at paras. 42 and 51.

[175] *Law*, *supra* note 171 at paras. 25 and 80; *Andrews*, *supra* note 171 at 165 and 173–174.

[176] See *Andrews*, *supra* note 171 at 168–169; *Law*, *supra* note 171 at paras. 25, 38, 68, 70, 75, 81, 88 and 110; *Lavoie* v. *Canada*, [2002] 1 S.C.R. 769 (Supreme Court of Canada) at para. 46.

[177] *Law*, *supra* note 171 at para. 51.

[178] Ibid. at para. 110.

[179] *Auton (Guardian ad litem of)* v. *British Columbia (Attorney General)*, [2004] 3 S.C.R. 657 (Supreme Court of Canada) at para. 25. See also *Andrews*, *supra* note 171 at 169–175; Law, supra note 171 at paras. 25, 38, 81 and 110.

The framework for analysis set out in the *Law* judgment dictates that, in order to find a violation of the Charter's equality rights clause, there must be:

1. differential treatment or failure to take into account prior disadvantage;
2. this must be based on a ground that is either enumerated explicitly in s. 15 of the Charter or is analogous to the listed grounds; and
3. this must constitute discrimination.[180]

The existence of differential treatment or failure to take into account prior disadvantage

The Supreme Court of Canada in *Auton (Guardian ad litem of)* v. *British Columbia (Attorney General)* held that in order to make a claim under section 15(1), the claimant must show unequal treatment under the law, the denial of a benefit or the imposition of a burden.[181] In 2001, Health Canada reported that there were over 200 NSPs in the country, with more in development.[182] Evaluations of PNSPs undertaken by Canadian and international organizations have demonstrated their efficacy in reducing risk behaviour and HIV and HCV transmission, an obvious benefit for persons in prison, particularly those who inject drugs. Correlatively, failure to provide PNSPs in federal correctional facilities has imposed a burden on persons who inject drugs in prison, who resort to using non-sterile injection equipment. Persons who inject drugs outside of prison and have access to NSPs are not subjected to the same burden. Thus, CSC's denial of PNSPs to prisoners in federal correctional facilities constitutes unequal treatment between injection drug users in prison and injection drug users outside.

CSC is one of four entities which have been mandated by the Government of Canada to carry out the *Federal Initiative to Address HIV/AIDS in Canada*[183] — "a key element of the Government of Canada's comprehensive approach to HIV/AIDS" and which "defines the federal government's commitment and contribution to the national framework for HIV/AIDS, embodied in *Leading Together: Canada Takes Action on HIV/AIDS (2005–2010)*."[184] In *Leading Together*, described as the "blueprint for Canada's response to HIV/AIDS to 2010," a number of targets and actions are set out with respect to NSPs in the community and in prisons. Desired targets include significantly increasing "access to…harm reduction measures such as needle exchange programs,"[185] ensuring that "[p]risoners in prison systems have access to the same prevention measures available to people in the general population,"[186] and the provision of "clean needles and syringes" to prisoners to reduce the risk of HIV transmission.[187] The document also observes that Canadian prison systems "lag behind some other countries that have implemented comprehensive harm reduction programs, including needle-and-syringe-distribution programs."[188] As noted earlier, while NSPs have enjoyed the support of governments at all levels, targets for implementing PNSPs have obviously not been met.

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[180] *Law*, *supra* note 171 at paras. 84 and 88.

[181] *Auton, supra* note 179.

[182] A. Klein, *supra* note 49 at 9, citing Health Canada, Harm reduction and injection drug use: an international comparative study of factors influencing the development and implementation of relevant policies and programs, September 2001 at 13.

[183] According to the Public Health Agency of Canada, "[t]hrough the Federal Initiative, the Public Health Agency of Canada, Health Canada, the Canadian Institutes of Health Research and Correctional Service Canada will collaborate with other federal government departments, provincial and territorial governments, non-governmental organizations, researchers, health care professionals and people living with and vulnerable to HIV/AIDS": "Federal Initiative to Address HIV/AIDS in Canada," on-line at www.phac-aspc.gc.ca/aids-sida/fi-if/index-eng.php.

[184] Ibid.

[185] Canadian Public Health Association, *Leading Together: Canada Takes Action on HIV/AIDS (2005–2010)*, 2005 at 37.

[186] Ibid., p. 37.

[187] Ibid., p. 38.

[188] Ibid., p. 34.

The Supreme Court of Canada has repeatedly held that "once the state does provide a benefit, it is obliged to do so in a non-discriminatory manner."[189] The exclusion of prisoners from the full range of health benefits available to persons in the general community fails to take into account the actual health needs, social position and context of persons who inject drugs in prison,[190] and flouts the principle of equivalence. Tacit or explicit approval of this continued exclusion by CSC creates an environment in which it is acceptable to treat persons who inject drugs in prison as second-class citizens and to subject them to risks of irreparable harm. The provision of clean syringes in prison is not simply a matter of internal management for the CSC, but an expression of government policy. As Justice La Forest stated for the majority in *Eldridge*, "while hospitals may be autonomous in their day-to-day operations, they act as agents for the government in providing the specific medical services set out in the [Hospital Insurance] Act."[191] Similarly, the CSC acts as an agent for the government in providing services to prisoners which are set out in the CCRA and its accompanying regulations. In so far as the government provides, or allows access to, a service such as NSPs, it must provide it equally.

According to the Court in *Auton*, "it is not open to Parliament or a legislature to enact a law whose policy objectives and provisions single out a disadvantaged group for inferior treatment."[192] When this happens, governments must "take positive action, for example, by extending the scope of a benefit to a previously excluded class of persons."[193] The availability of NSPs in the community is a health service which injection drug users are able to access to reduce their risk of HIV and HCV transmission. Because the government has implemented a scheme to provide, or facilitate the provision of, health-care services to persons who inject drugs, it must comply with the Charter. The direct burden of the exclusion from access to clean syringes means a corresponding inequality of result for people who inject drugs in prison.

Differential treatment on the basis of an enumerated or analogous ground

At this stage of the test, differential treatment must be demonstrated between injection drug users in the community and injection drug users in prison, based on a ground either enumerated in section 15 of the Charter (such as sex, race or disability) or an analogous ground. While there is no formal "test" to establish an analogous ground, a number of "indicators" have been identified by the courts. In *Corbiere* v. *Canada (Minister of Indian and Northern Affairs),* the Supreme Court of Canada described an analogous ground as involving personal characteristics that are "immutable or changeable only at unacceptable cost to personal identity."[194] Contextual factors that may be relevant to finding an analogous ground include whether the matter is important to the person's "identity, personhood or belonging," whether people defined by the characteristic "are lacking in political power, disadvantaged, or vulnerable to becoming disadvantaged or having their interests overlooked," and whether the ground is protected under federal or provincial human rights legislation.[195] In *Law*, the contextual indicia suggested by the Supreme Court included:

- pre-existing disadvantage, stereotyping, prejudice or vulnerability experienced by the individual or group at issue;

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[189] E.g., see *Eldridge*, *supra* note 173 at para. 73, and *Halpern* v. *Canada (Attorney General)* (2003), 65 O.R. (3d) 161 (Ontario Court of Appeal).

[190] See *Law*, *supra* note 171 at para. 70.

[191] *Eldridge*, *supra* note 173 at para. 51.

[192] *Auton, supra* note 179 at para. 41.

[193] *Eldridge*, *supra* note 173 at para.73.

[194] *Corbiere* v. *Canada (Minister of Indian and Northern Affairs),* [1999] 2 S.C.R. 203 (Supreme Court of Canada) at para 13. It is obviously the case that, whatever the underlying factors and actions that have led to incarceration, the status of being a prisoner is immutable (by the prisoner) during the period of his or incarceration; indeed, this is the essence of being a prisoner.

[195] Ibid. at para. 60.

- the correspondence, or lack thereof, between the ground or grounds on which the claim is based and the actual needs, capacity or circumstances of the claimant or others;
- the ameliorative purpose or effects of the impugned law upon a more disadvantaged person or group in society; and
- the nature and scope of the interest affected by the impugned law.[196]

The *Law* framework has been reaffirmed by the Supreme Court as the guiding approach for section 15 cases in a number of decisions.[197]

Previously, in *Sauvé* v. *Canada (Chief Electoral Officer),* a minority of the Supreme Court of Canada took the position that "the status of being a prisoner does not constitute an analogous ground" under s. 15 of the Charter.[198] (The specific s. 15 issue was not addressed by the majority, which decided the case on other grounds; the minority was in dissent on those grounds.) On a number of occasions, the Federal Court of Canada and Tax Court of Canada have both taken a similar view.[199] This position, however, has not been endorsed by a majority of the Supreme Court of Canada or by provincial appellate courts — these judgments are not binding on those courts, and the position they espouse should be reconsidered and rejected, for at least two reasons.

First, the overly simplistic reasoning underlying this conclusion leads logically to results at odds with the basic principles underlying the Charter (including the equality rights provision in s. 15) and internationally accepted human rights principles. In the dissenting opinion in *Sauvé*, Justice Gonthier held that "prisoners do not constitute a group analogous to those enumerated in s. 15(1) because the fact of being incarcerated cannot be said to have arisen because of a stereotypical application of a presumed group characteristic."[200] Rather, Justice Gonthier took the view that the unifying characteristic of the group is "past criminal behaviour,"[201] and as such, different treatment under the law is justifiable. In essence, under this analysis, past criminal behaviour disentitles prisoners as a class to any protection of rights under the equality rights provision of the Charter. By this logic, the state could single out prisoners, as opposed to those not incarcerated, for any number of arbitrary measures, including those that demean basic human dignity, and would be immune from scrutiny under s. 15. This runs directly counter to two well-established principles already noted above. International and Canadian law affirm the principle that prisoners retain all rights except those necessarily limited by the fact of incarceration — how is a wholesale denial of the full complement of s. 15 equality rights (equality before and under the law, and equal protection and equal benefit of the law) a necessary consequence of incarceration? Furthermore, the principle of equivalence in health services clearly reflects a basic recognition that prisoners retain at least some elements of the right to equality, and that to deny such equivalence in health services on the basis of prisoner status is unjustified discrimination against a class. As previously noted, both of these principles are already reflected, explicitly or implicity, in the CCRA (as well as international human rights law), further evidence that Justice Gonthier's categorical dismissal of equality rights attaching to prisoners overreaches. Such principles have been articulated in law specifically because prisoners have historically been subject to abuse and the denial of rights — or "lacking in political power" and

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[196] *Law*, *supra* note 171 at paras. 62 to 88.

[197] E.g., see *Newfoundland (Treasury Board)* v. *N.A.P.E.*, [2004] 3 S.C.R. 381 (Supreme Court of Canada) and *Auton*, *supra* note 179 at para. 22.

[198] *Sauvé* v. *Canada (Chief Electoral Officer),* [2002] 3 S.C.R. 519 (Supreme Court of Canada) at paras 189-206. See also *Alcorn* v. *Canada (Commissioner of Corrections)*, [2002] F.C.J. No. 620 (Federal Court of Appeal) (QL) in which the Court held at para. 7 that "prisoners *per se* do not constitute an analogous group under section 15."

[199] See cases cited in the dissenting opinion written by Justice Gonthier in *Sauvé,* ibid. at para. 193.

[200] Ibid., para. 195.

[201] Ibid.

vulnerable to "having their interests overlooked", to put it in terms used by the Supreme Court in *Corbiere*.[202] In *Law*, the Supreme Court was clear that a mechanistic approach to s. 15 cannot be allowed to obscure the fundamental question of whether a law fails to recognize an individual or group "as members of Canadian society…equally deserving of concern, respect, and consideration."[203] Given the principles articulated in international and Canadian law, including those found in the CCRA itself that affirm the state's legal obligation of consideration for the welfare of those it incarcerates (as noted above), the approach articulated by the dissenting minority in *Sauvé* is at odds with the basic approach to the interpretation of s. 15 of the Charter that has been repeatedly affirmed by the Supreme Court.

Second, the categorical denial of protection under s. 15 to prisoners as a group ignores the context of prisons and prisoners, including multiple intersecting grounds of disadvantage that are clearly of concern under s. 15. In *Law*, the Supreme Court was clear in its disapproval of a mechanistic and formalistic approach to s. 15 that fails to address "the true social, political and legal context underlying each and every equality claim."[204] To a great extent, prisons are home to people who have been socially marginalized. As PHAC has acknowledged, "inmates in Canada experience higher rates of infectious diseases than the general public because many belong to vulnerable populations."[205] This is confirmed by estimates of HIV and HCV prevalence in federal and provincial prisons, which are respectively on the order of ten and twenty times higher than the reported prevalence in the population as a whole. According to the Canadian Centre for Justice Statistics, the majority of prisoners come from disadvantaged backgrounds characterized by poverty, substance abuse, low levels of education and high levels of depression and attempted suicide.[206] While persons who inject drugs in prison and those who inject outside share numerous characteristics, as a class the "pre-existing disadvantages" of persons who inject drugs in prison are arguably more severe, and their vulnerability is ostensibly compounded by incarceration. The Supreme Court of Canada has recognized that grounds on which people have experienced discrimination can intersect. In *Law*, it outlined that:

> [I]t is open to a claimant to articulate a discrimination claim under more than one of the enumerated and analogous grounds…. If the court determines that recognition of a ground or confluence of grounds as analogous would serve to advance the fundamental purpose of s. 15(1), the ground or grounds will then be so recognized. There is no reason in principle, therefore, why a discrimination claim positing an intersection of grounds cannot be understood as analogous to, or as a synthesis of, the grounds listed in s. 15(1).[207]

In the minority dissenting judgment in *Sauvé*, Justice Gonthier did address the issue of the *disproportionate representation of Aboriginal people* among those incarcerated in Canada, but did not agree that, because denying voting rights to prisoners had the effect of disproportionately adversely affecting Aboriginal people, the courts should therefore recognize prisoner status as an analogous ground. However, the broader range of grounds of discrimination that many prisoners embody was not considered — some of which are particularly relevant to considering the denial of access to health services such as sterile injecting equipment to prisoners. Persons in prison disproportionately embody multiple immutable characteristics recognized as traditional

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[202] *Corbiere*, *supra* note 194 at para. 60.

[203] *Law*, *supra* note 171 at para. 51.

[204] *Law*, *supra* note 171 at para. 110.

[205] Public Health Agency of Canada, *supra* note 20. See also commentary by James Fyfe, Crown Counsel in the Constitutional Law Branch at the Saskatchewan Department of Justice, who described prisoners as "social outcasts whose interests are commonly dismissed due to social stigma" and maintained that Parliament's very attempt to deny prisoners the right to vote is evidence of the disadvantage they face. J. Fyfe, "Dignity as Theory: Competing Conceptions of Human Dignity at the Supreme Court of Canada," (2007) 70 *Sask. L. Rev*. 1–26 at para. 47–48.

[206] D. Robinson et al., *A One-Day Snapshot of Inmates in Canada's Adult Correctional Facilities*, Canadian Centre for Justice Statistics, 1998 at 5.

[207] *Law*, *supra* note 171 at paras. 93–94.

grounds on which discrimination is prohibited.[208]

In 2006–2007, Aboriginal people represented approximately 17 percent of people incarcerated in federal prisons but less than 3 percent of the adult population in Canada,[209] a ratio that is even more disproportionate for Aboriginal women in federal prisons.[210] Aboriginal people serve a higher proportion of their sentences before being released on parole,[211] and Aboriginal persons who are in correctional facilities in Canada are also more likely to use drugs by injection than non-Aboriginal prisoners.[212] The Supreme Court of Canada has held that the overrepresentation of Aboriginal people in Canadian prisons reflects "a crisis in the Canadian criminal justice system,"[213] and in *Sauvé*, Justice McLachlin, writing for the majority in that case, noted that the negative effects of the impugned provision prohibiting prisoners from voting in federal elections had "a disproportionate impact on Canada's already disadvantaged Aboriginal population."[214] Similarly, denying prisoners access to sterile needles and syringes would have a disproportionate impact on Aboriginal Canadians, who already disproportionately represent injection drug users and persons living with HIV/AIDS in the population as a whole. For example, the 2005 national HIV estimates indicate that 53 percent of all new HIV infections among Aboriginal people in 2005 were attributable to injection drug use, a proportion considerably higher than the 14 percent of overall new HIV infections in this category.[215] If the majority in *Sauvé* was concerned, among other things, that denying prisoners the right to vote would disproportionately affect Aboriginal people, then presumably that concern would extend to denying prisoners access to health services available outside prison that provide the means to protect against infection with diseases such as HIV or HCV.

The majority of prisoners come from disadvantaged backgrounds characterized by poverty, substance abuse, low levels of education and high levels of depression and attempted suicide.

People with mental illnesses are also overrepresented among people in prison. In 2001, an internal prevalence study by CSC found that, in the Pacific region, 84 percent of prisoners at entry had at least one lifetime diagnosis of a mental disorder, including substance abuse, according to the handbook of "Diagnostic and

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[208] S. Galea and D. Vlahov, "Social Determinants and the Health of Drug Users: Socioeconomic Status, Homelessness and Incarceration," *Public Health Reports* 117 (Supp.1) (2002): 135–145; A. Palepu, et al., "The social determinants of emergency department and hospital use by injection drug users in Canada," *Journal of Urban Health* 76(4) (1999): 409–18; R. Room, "Stigma, social inequality and alcohol and drug use," *Drug and Alcohol Review* 2 (2005): 143–155; and Canadian Association of Social Workers, *The Declining Health and Well-Being of Low Income Women in Canada,* 2006.

[209] Public Safety Canada Portfolio Corrections Statistics Committee, *Corrections and Conditional Release Statistical Overview 2007*, December 2007 at 57.

[210] According to CSC, Aboriginal women comprise 28 percent of female prisoners and Aboriginal men comprise 18 percent of male prisoners in federal prisons: CSC, *Basic Facts about the Correctional Service of Canada,* 2005.

[211] Public Safety Canada Portfolio Corrections Statistics Committee, *supra* note 209 at 84.

[212] For example, a survey reported that Aboriginal young offenders aged 12 to 15 were five times more likely to have injected drugs than non-Aboriginal young offenders. D. Rothon et al., "Determinants of HIV-Related High Risk Behaviours Among Young Offenders: A Window of Opportunity," *Canadian Journal of Public Health* 88(1) (1997): 14–17.

[213] *R.* v. *Gladue*, [1999] 1 S.C.R. 688 (Supreme Court of Canada) at para. 64.

[214] *Sauvé, supra* note 198 at para. 60.

[215] Public Health Agency of Canada, *HIV/AIDS Epi Updates*, November 2007 at 74.

Statistical Manual of Mental Disorders" (DSM) published by the American Psychiatric Association.[216] If DSM-identified "substance abuse disorders" are removed, 43 percent of prisoners still met the criteria for at least one lifetime mental health diagnosis. More broadly, the CSC recently reported that 12 percent of men and 26 percent of women in federal prisoners had been identified with "very serious mental health problems,"[217] 15 percent of men and 29 percent of women in federal prisons had previously been hospitalized for "psychiatric reasons,"[218] and the percentage of federal prisoners prescribed medication for "psychiatric concerns" at admission had more than doubled from 10 percent in 1997–1998 to 21 percent in 2006–2007.[219]

The *widespread incarceration of people who use drugs* is also well documented, with over 20 percent of people admitted to federal prisons having at least one drug-related conviction.[220] The Federal/Provincial/Territorial Advisory Committee on Population Health and others have observed that "injection drug use is an issue for all Canadians, but particularly among the vulnerable and marginalized. The relative risk of harms from drug use is highest for Canadians with a history of victimization, poverty, family dysfunction, including alcohol and other drug problems among family members, low educational attainment and unemployment, and those who lack accessibility to appropriate and effective services."[221] Substance abuse is identified as a contributing factor to the criminal behaviour of 70 percent of the people admitted to federal institutions.[222] A significant number of prisoners who inject drugs are also addicted to drugs. According to PHAC, approximately 67 percent of federal prisoners have substance abuse problems, of which 20 percent require treatment,[223] indicating that many people who use drugs in prison suffer from addiction. People with addictions have been recognized by Canadian tribunals and courts as worthy of protection against discrimination on the basis of the disability of drug dependence. Under the *Canadian Human Rights Act*, for example, disability is defined as including previous or existing dependence on alcohol or a drug.[224] As a group, people with drug dependence suffer from social, political and legal disadvantage, often as a result of the discrimination and stigmatization they face.[225] In particular, the criminalization of people with drug dependence exacerbates their stigmatization and marginalization, and can result in their inability to seek help from the police or emergency services for fear they will wind up under arrest, and the break-up of injecting networks that may also serve as social support networks.[226] There is significant jurisprudence from labour arbitrators, human rights commissions and courts

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[216] This was based on the categorization of mental disorders featured in the DSM-IV which was published in 1994. M. Daigle, "Mental Health and Suicide Prevention Services for Canadian Prisoners*," International Journal of Prisoner Health* 3(2) (2007): 163–171.

[217] CSC, Changing Offender Population: Quick Facts, April 2007.

[218] Public Safety Canada Portfolio Corrections Statistics Committee, *supra* note 209 at 55.

[219] Ibid.

[220] Public Health Agency of Canada, *Atlantic Region: Environmental Scan of Injection Related Drug Use, Related Infectious Diseases, High Risk Behaviours, and Relevant Programming in Atlantic Canada*, March 2006 at 39.

[221] F/P/T Advisory Committee on Population Health, F/P/T Committee on Alcohol and Other Drug Issues, F/P/T Advisory Committee on AIDS and F/P/T Heads of Corrections Working Group on HIV/AIDS, *supra* note 50 at 4–5.

[222] Public Health Agency of Canada, *Atlantic Region: Environmental Scan*, *supra* note 220 at 38–39.

[223] Public Health Agency of Canada, *supra* note 20. A subsequent report by the CSC Review Panel states that "[a]bout 4 out of 5 offenders arrive with a serious substance abuse problem, with 1 out of 2 having committed their crime while under the influence." See *A Roadmap to Strengthening Public Safety*, Report of the Correctional Service of Canada Review Panel, October 2007 at v.

[224] *Canadian Human Rights Act* (CHRA), R.S.C. 1985, c. H-6, s. 25. See also *Employment Equity Act*, S.C. 1995, c. 44 in conjunction with Human Resources Development Canada, *Defining Disability: A Complex Issue*, 2003 at 16; *Human Rights Act* (Nova Scotia), R.S.N.S. 1989, c. 214, s. 3(l)(vii); *Human Rights Act* (Nunavut), S.Nu. 2003, c. 12, s. 1.

[225] F/P/T Advisory Committee on Population Health, F/P/T Committee on Alcohol and Other Drug Issues, F/P/T Advisory Committee on AIDS and F/P/T Heads of Corrections Working Group on HIV/AIDS, *supra* note 50 at 2; B. Link et al., "On stigma and its consequences: evidence from a longitudinal study of men with dual diagnoses of mental illness and substance abuse," *Journal of Health and Social Behaviour* 38 (1997): 177–190; S. Murphy and J. Irwin, "Living with the dirty secret: problems of disclosure for methadone maintenance clients," *Journal of Psychoactive Drugs* 24 (1992): 257–264.

[226] J. Csete, *Do Not Cross: Policing and HIV Risk Faced by People Who Use Drugs*, Canadian HIV/AIDS Legal Network,

recognizing drug dependence as a disability requiring, among other things, a duty to accommodate, and awarding damages for discrimination.[227] Most recently, the B.C. Supreme Court in *PHS Community Services Society* held that "drug addiction is an illness."[228] While persons who inject drugs both inside and outside prison may share the experience of disability, as a group persons who inject drugs in prison arguably suffer from a more severe dependency, as conflict with the law and incarceration are often a result of offences related to the financing of drug use or offences related to behaviours brought about by drug use.[229] In the absence of effective harm reduction measures, incarceration represents differential treatment, which directly leads to an additional risk of HIV and HCV infection for persons who inject drugs.

Denying access to sterile injection equipment also has a *disproportionate impact on women*. While women constitute a small minority of incarcerated persons in Canada, a significant percentage of women in Canadian prisons were incarcerated for offences related to drug use, often linked to underlying factors such as experiences of sexual or physical abuse or violence.[230] Moreover, a 2003 study of federally incarcerated women found that 19 percent reported injecting drugs while in prison[231] and a previous history of injection drug use is consistently found more frequently among female than male prisoners in federal and provincial prisons in Canada.[232] In a number of studies, HIV and/or HCV prevalence has also been shown to be higher among incarcerated women than among incarcerated men in Canada.[233]

The fact that prisoners disproportionately embody multiple and intersecting grounds of discrimination is reflected in the CCRA requirement that "correctional policies, programs and practices respect gender, ethnic, cultural and linguistic differences and be responsive to the special needs of women and [A]boriginal peoples, as well as to the needs of other groups of offenders with special requirements."[234] Denying access in prison to proven health services such as NSPs must be understood as existing under the following conditions of inequality in Canadian society: "higher rates of poverty and institutionalized alienation from mainstream society" among Canada's Aboriginal population;[235] a significant proportion of persons in prison suffering

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March 2007 at 11; K. Blankenship and S. Koester, "Criminal law, policing policy, and HIV risk in female street sex workers and injection drug users," *Journal of Law, Medicine and Ethics* 30(4) (2002): 548–559 at 553.

[227] See for example *Gates Canada* v. *United Steelworkers of America, Local 9193* (Employee A Grievance), [2006] O.L.A.A. No. 683 (Reilly) (Ontario Labour Arbitration Case); *Pacific Blue Cross* v. *Canadian Union of Public Employees, Local 1816* (College Grievance) (2005), 138 L.A.C. (4th) 27 (McPhillips) (B.C. Labour Board Case); *William Osler Health Centre* v. *Ontario Nurses' Assn*. (Ward Grievance), [2006] O.L.A.A. No. 115 (Ontario Labour Board Case); *Toronto Dominion Bank* v. *Human Rights Commission* (1998), 163 D.L.R. (4th) 193 (Federal Court of Appeal) (found testing for illegal narcotics discriminatory under s. 25 of the CHRA against dependent users); *Entrop* v. *Imperial Oil Ltd*., [2000] O.J. No. 2689 (Ontario Court of Appeal) (QL) (recognized people with drug addictions as persons with a disability for the purposes of provincial anti-discrimination law); and C. Jones, "Fixing to Sue: Is There a Legal Duty to Establish Safe Injection Facilities in British Columbia?" (2002) 35 U.B.C. L. Rev. 393–454.

[228] *PHS Community Services Society*, *supra* note 94 at para. 57.

[229] Lines et al., *supra* note 1 at 9.

[230] J. Csete, *supra* note 226 at 36–37; S. Boyd and K. Faith, "Women, illegal drugs and prison: views from Canada," *International Journal of Drug Policy* 10 (1999): 195–207 at 199.

[231] A. DiCenso et al., *supra* note 11.

[232] Public Health Agency of Canada, *Final report: estimating the number of persons co-infected with hepatitis C virus and human immunodeficiency virus in Canada*, 2001. Available at http://www.phac-aspc.gc.ca/hepc/pubs/hivhcv-vhcvih/results2-eng.php.

[233] L. Calzavara et al., *supra* note 18; C. Poulin et al., *supra* note 19; CSC, *supra* note 10; CSC, *Infectious disease prevention and control in Canadian federal penitentiaries 2002–01*, 2003.

[234] CCRA, s. 4(h). See also ss. 76–77 of the CCRA obligating CSC to provide a range of programs to address the needs of prisoners, including programs designed particularly to address the needs of women in prison.

[235] See *Sauvé*, *supra* note 198 at para. 60; Minister of Supply and Services Canada, *Report of the Royal Commission on Aboriginal Peoples*, 1996.

from, and receiving inadequate treatment for, mental illness;[236] a significant number of women in prison who struggle with addiction;[237] the routine experience of people who use drugs of negative stereotyping, social stigmatization and marginalization from members of society, social service agencies and health-care providers;[238] and the historical inadequacy of health services for persons who use drugs and for prisoners.[239] People who inject drugs are already identified with numerous negative stereotypes including the view that drug users are of lesser moral value, and are therefore less worthy of health care, a perception that is exacerbated by incarceration. People who use drugs in prison are stigmatized, lacking in political power, experience extreme vulnerability and have their interests routinely overlooked.[240] These attitudes and misconceptions have resulted in a variety of harms, including public apathy, undiagnosed mental illness and inaccessible treatment and rehabilitation programs.[241] For many, abstaining from injection drug use in prison is not an option.

Recognition of such conditions of inequality is a first step toward a full appreciation of the impact of the government's prohibition of PNSPs on the lives of people who inject drugs in prison. Considered from the broader social and historical context required by the Supreme Court of Canada,[242] denying prisoners access to NSPs disproportionately affects people who represent an intersection of the enumerated grounds such as race, sex and disability, both as a result of their addiction and given the extent to which many persons who inject drugs in prison suffer from other serious illnesses. As Justice Sopinka explained in his decision in *Brant County Board of Education* v. *Eaton*, "the purpose of s. 15 of the Charter is not only to prevent discrimination by the attribution of stereotypical characteristics to individuals, but also to ameliorate the position of groups within Canadian society who have suffered disadvantage from mainstream society."[243] The fullest equality analysis would be provided if courts were to recognize prisoner status as an analogous ground for which unjustifiable discrimination by the state is prohibited.

Differential treatment constitutes discrimination

The third part of the *Law* framework asks whether the law discriminates

> …by imposing a burden upon or withholding a benefit from the claimant in a manner which reflects the stereotypical application of a presumed group of personal characteristics, or which otherwise has the effect of perpetuating or promoting the view that the individual is less capable or worthy of recognition or value as a human being or as a member of Canadian society, equally deserving of concern, respect, and consideration.[244]

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[236] See for example Correctional Investigator Canada, *supra* note 13 (regarding the need to build mental health-care capacity in federal prisons).

[237] J. Csete, *"Vectors, Vessels and Victims": HIV/AIDS and Women's Human Rights in Canada*, Canadian HIV/AIDS Legal Network, 2005 at 36; Public Health Agency of Canada, *supra* note 232.

[238] K. Blankenship and S. Koester, *supra* note 226; Public Health Agency of Canada*, Resource Library: Hepatitis C Information for Health Professionals*, undated, available at http://www.phac-aspc.gc.ca/hepc/pubs/ihp-ips/index.html#ref; R. Room, *supra* note 208.

[239] E. Ritson, "Alcohol, Drugs and Stigma," *International Journal of Clinical Practice* 53(7) (1999): 549–551; P. Ford and W. Wobeser, "Health care problems in prisons," *Canadian Medical Association Journal* 162(5) (2000): 664–665; P. Ford et al., "HIV, hepatitis C and risk behaviour in a Canadian medium-security penitentiary," *QJM: An International Journal of Medicine* 93 (2000): 113–119.

[240] S. Hartwell, "Triple Stigma: Persons With Mental Illness and Substance Abuse Problems in the Criminal Justice System," *Criminal Justice Policy Review* 15(1)(2004): 84–99. See also Prisoners' HIV/AIDS Support Action Network (PASAN), accessible via www.pasan.org and Vancouver Area Network of Drug Users (VANDU), accessible via www.vandu.org.

[241] F/P/T Advisory Committees, *supra* note 50 at 2.

[242] See for example *R.* v. *Turpin*, [1989] 1 S.C.R. 1296 (Supreme Court of Canada) at 1331–1332; *Miron* v. *Trudel*, [1995] 2 S.C.R. 418 (Supreme Court of Canada) at 488.

[243] *Brant County Board of Education*, *supra* note 172 at para. 66.

[244] *Law*, *supra* note 171 at para. 88.

Indicia of discrimination are to be investigated mindful that treating "likes alike" does not necessarily constitute substantive equality and that differential treatment does not always imply discrimination.[245] To assist with the analysis, it is helpful to consider whether the law undermines a person's human dignity, "in light of the historical, social, political, and legal context of the claim."[246] The dignity analysis is to be undertaken from the perspective of the claimant and is to be evaluated using the standard of the "reasonable person," so subjective and objective information is considered. While human dignity is an "essential value underlying the s. 15 equality guarantee," the Supreme Court of Canada in *R*. v. *Kapp* recently confirmed that it is not an additional burden on equality claimants.[247]

The treatment of persons who inject drugs in prison bears all the hallmarks of discrimination. Prisoners are disproportionately Aboriginal, disproportionately experience mental illness and addiction and a significant number of women are imprisoned for offences related to drug use or addiction. As a group, prisoners are further disadvantaged by heightened vulnerability to disease and infection, and subject to pernicious prejudice and stigmatization.[248] CSC's prohibition of PNSPs fails to take into account conditions of systemic inequality, imposes a serious health burden and promotes the view that prisoners are less worthy of recognition and value as human beings and as members of Canadian society.

The claim that prisoners are discriminated against in the context of PNSPs is buttressed when the distinction in treatment causes harm to their human dignity. As stated by the Supreme Court, "[h]uman dignity within the meaning of the equality guarantee does not relate to the status or position of the individual in society *per se*, but rather concerns the manner in which a person legitimately feels when confronted with a particular law…. Human dignity is harmed when individuals and groups are marginalized, ignored, or devalued, and is enhanced when laws recognize the full place of all individuals and groups within Canadian society."[249] For persons who inject drugs in prison, human dignity involves freedom from the detrimental effects of stereotypes of prisoners who inject drugs as worthless, incompetent, violent and out of control. Persons who inject drugs in prison have an interest in being treated as members of Canadian society, who are as deserving of fair treatment, dignity and health as persons in the community. This encompasses being provided with needed health services, including proven mechanisms to protect themselves from infectious diseases, such as sterile needles and syringes. The denial of this benefit to prisoners is discriminatory, reinforces their marginalization and is an unjustifiable infringement of their right to equal protection and equal benefit of the law.

III. The right not to be subjected to cruel and unusual treatment or punishment: Charter, section 12

Section 12 of the Charter provides that all individuals have a right "not to be subjected to any cruel and unusual treatment or punishment."[250] In order to come within the protection of section 12, an applicant must first demonstrate that he or she has been subject to "treatment" or "punishment" at the hands of the state. The Supreme Court of Canada in *Rodriguez* v. *British Columbia (Attorney General)* accepted a distinction in purpose between punishments such as imprisonment or lashings, which involve "the convicted person paying his debt to society for the wrong he has committed," and treatment which is "arguably primarily concerned with

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[245] *Law*, *supra* note 171 at paras. 60, 61, 75 and 80; *Andrews*, supra note 171 at 165–170.

[246] *Law*, *supra* note 171 at para. 83.

[247] *R*. v. *Kapp,* 2008 SCC 41 (Supreme Court of Canada) at paras. 21–22.

[248] E.g., N. La Vigne et al., *Voices of Experience: Focus Group Findings on Prisoner Reentry in the State of Rhode Island*, Urban Institute Justice Policy Center, November 2004, pp. 13, 18, 33, 39, 48, 51, available at http://www.nga.org/cda/files/REENTRYRIREPORT.PDF; D. Pager, "The Mark of a Criminal Record," *American Journal of Sociology* 108(5) (2003): 937-975; R. Small, *The importance of employment to offender re-integration*, FORUM on Corrections Research, Correctional Service of Canada, undated, available at http://www.csc-scc.gc.ca/text/pblct/forum/Vol17No1/v17n1j-eng.shtml.

[249] *Law*, *supra* note 171 at para. 53.

[250] S. 12 of the *Charter* specifically provides: "Everyone has the right not to be subjected to any cruel and unusual treatment or punishment."

protecting society from the offender."[251] "Punishment" has therefore been interpreted in a number of cases to include mandatory minimum sentences and courts have focused on what range of sentences would be considered appropriate to punish, rehabilitate or deter a particular offender.[252]

In *Rodriguez*, "treatment" within the meaning of section 12 included that which is imposed by the state in contexts other than that of a penal or quasi-penal nature — though a mere prohibition by the state on certain action could not constitute "treatment" under section 12, unless there was some "more active state process in operation, involving an exercise of state control over the individual…whether it be positive action, inaction or prohibition."[253] In rejecting Rodriguez's claim that the prohibition on assisted suicide had the effect of imposing upon her cruel and unusual treatment, the court in *Rodriguez* held that the prohibition did not constitute "treatment" as she was not within the special administrative control of the state. By contrast, prisoners *are* evidently in the control, administrative and physical, of the state.

"Human dignity is harmed when individuals and groups are marginalized, ignored, or devalued, and is enhanced when laws recognize the full place of all individuals and groups within Canadian society."

Affirming *Rodriguez*, the Federal Court (Trial Division) in *Lord* v. *Canada* held that a visual inspection policy that required visitors and prisoners to make contact with institutional staff four times a day "might be considered to be a treatment when considering that the policy is imposed by the state in the context of enforcing a state administrative structure, i.e. the correctional system and its body of regulation."[254] Numerous other courts have referred to conditions of incarceration as "treatment" contrary to section 12, ranging from the lobotomization of certain dangerous offenders and the castration of sexual offenders,[255] to the manner of dealing with persons in pre-trial detention (including limitations on visitation and access to open-air exercise, manners of searching prisoners and the manner in which prisoners are processed upon return to the institution),[256] to indeterminate sentences,[257] to prison smoking bans.[258] In *R.* v. *Downey*, the Ontario District Court

[251] *Rodriguez*, *supra* note 119 at para. 178.

[252] E.g., see *R.* v. *Smith*, [1987] 1 S.C.R. 1045 (Supreme Court of Canada); *R.* v. *Luxton*, [1990] 2 S.C.R. 711 (Supreme Court of Canada); *R.* v. *Goltz* [1991] 3 S.C.R. 485 (Supreme Court of Canada); *R.* v. *Morrisey*, [2000] 2 S.C.R. 90 (Supreme Court of Canada); *R*. v. *Ferguson*, [2008] S.C.J. No. 6 (Supreme Court of Canada) (QL).

[253] *Rodriguez*, *supra* note 119 at para. 182.

[254] *Lord* v. *Canada* (2001), 203 F.T.R. 1 (Federal Court Trial Division) at para. 56.

[255] *Smith*, *supra* note 252.

[256] *Soenen* v. *Director of Edmonton Remand Centre*, [1983] 35 C.R. (3d) 206 (Alberta Court of Queen's Bench).

[257] *Re Mitchell and the Queen* (1983), 42 O.R. (2d) 481 (Ontario Supreme Court).

[258] See for example *Vaughn* v. *Minister of Health* (2003), 115 C.R.R. (2d) 36 (Ontario Superior Court of Justice), *Regina Correctional Centre* v. *Saskatchewan (Department of Justice*), 30 C.R.R. (2d) 371 (Saskatchewan Court of Queen's Bench) and *Carlston* v. *New Brunswick (Solicitor General)*, [1989] 43 C.R.R. 105 (New Brunswick Court of Queen's Bench). In *Carlston*, the Court held that "had the total-ban policy…remained in operation and had it been adequately established that the applicant was in fact a smoking addict, I would have had little hesitation in finding that the application of that policy constituted cruel and unusual treatment insofar as the applicant was concerned and that as such it would amount to an infringement of that right to which he is entitled by reasons of s. 12 of the Charter. But, the policy was in fact changed as was, more importantly, the practice in respect of smoking in the gaol concerned." See also *McCann* v. *Fraser Regional Correctional Centre*, *supra* note 124 where

ruled that the state's failure to provide facilities which made adequate medical care available for detained people with HIV constituted cruel and unusual treatment, and the accused was ordered released on his own recognizance.[259] In view of the significant number of cases supporting a definition of "treatment" that comprises conditions of incarceration and the Supreme Court's ruling in *Rodriguez* that "treatment" may constitute "inaction or prohibition," CSC's failure to provide PNSPs falls within the ambit of "treatment" covered under section 12. Whether CSC's inaction with respect to PNSPs constitutes "cruel and unusual" treatment depends on several conditions which have been articulated over a number of section 12 cases.

Over the years, courts have adopted a flexible approach and interpreted "cruel and unusual" as interacting expressions to be read together as a "compendious expression of a norm."[260] In *Lord* v. *Canada*, the Federal Court (Trial Division) said that treatment could be said to be cruel and unusual if it were found to "be a grossly disproportionate punishment or treatment in regard of society's standards." [261] In *R.* v. *Wiles*, the Supreme Court of Canada held that "[t]reatment or punishment which is disproportionate or 'merely excessive' is not 'cruel and unusual'…. The court must be satisfied that 'the punishment imposed is *grossly* disproportionate for the offender, such that Canadians would find the punishment abhorrent or intolerable'…."[262] Correspondingly, courts have held that the treatment or punishment must be "so excessive as to outrage standards of decency."[263] Significantly, in determining whether a treatment or punishment is cruel and unusual, relevant contextual factors are to be taken into account, including the particular personal characteristics of the offender, the gravity and particular circumstances of the offence, the actual effect of the treatment on the individual and the existence of valid alternatives to the treatment imposed.[264]

Therefore, in order to demonstrate a breach of the right not to be subjected to cruel and unusual treatment, the jurisprudence suggests the state's failure or refusal to implement PNSPs needs to be shown to be:

1. "grossly disproportionate" for the offender;
2. so excessive as to "outrage standards of decency"; and
3. having regard to all contextual factors.

Whether the treatment is excessively or grossly disproportionate

The term "grossly" was understood by the Supreme Court in *R.* v. *Lyons* to "reflect the Court's concern not to hold Parliament to a standard so exacting, at least in the context of s. 12, as to require punishment to be perfectly suited to accommodate the moral nuances of every crime and every offender." [265] In *R.* v. *Smith*, Justice Wilson provided that she understood "grossly disproportionate" to mean that "[punishments] are cruel and unusual in their disproportionality in that no one, not the offender and not the public, could possibly have thought that that particular accused's offence would attract such a penalty. It was unanticipated in its severity

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the Court held at para. 16 that it was "cruel and unusual punishment to impose a total smoking ban" on 5 days' notice.

[259] *R.* v. *Downey*, (1989) 42 C.R.R. 286 (Ontario District Court). See also *R*. v. *Rathburn*, [2004] Y.J. No. 26 (Yukon Territorial Court)(QL) in which the Yukon Territorial Court held that the incarceration of a mentally ill prisoner in a segregation area constituted a violation of section 12 because it would contribute to the deterioration of his mental health and exacerbate his medical condition.

[260] See for example Justice Lamer's ruling for the majority in *Smith*, *supra* note 252.

[261] *Lord*, *supra* note 254 at para. 77.

[262] *R.* v. *Wiles,* [2005] 3 S.C.R. 895 (Supreme Court of Canada) at para. 4.

[263] *Smith*, *supra* note 252 at para. 54; *Goltz*, *supra* note 252 at 499; *Luxton*, *supra* note 252 at 724; *Charkaoui* v. *Canada (C.I.),* [2007] 1 S.C.R. 350 (Supreme Court of Canada) at para. 95; *Wiles*, ibid. at para. 4; *Morrisey*, *supra* note 252 at para. 26; *R.* v. *Aziga*, [2008] O.J. No. 3052 (Ontario Superior Court of Justice) (QL).

[264] *Goltz, supra* note 252. See also *Morrisey*, *supra* note 252 at paras. 27–28 and *Wiles, supra* note 262 at para. 5.

[265] *R.* v. *Lyons*, [1987] 2 S.C.R. 309 (Supreme Court of Canada) at para. 56.

either by him or them. It shocked the communal conscience. It was unusual because of its extreme nature."[266] In *Smith*, the offence of importing contained in the *Narcotic Control Act* covered numerous substances of varying degrees of danger, and disregarded the quantity of the drug imported, the purpose of a given importation and the existence or absence of previous convictions for offences of a similar nature or gravity. In the Supreme Court's view, the offence was such that it was inevitable that, in some cases, a verdict of guilt would lead to the imposition of a term of imprisonment, which would be grossly disproportionate.[267]

Ostensibly, denying access to health services is not a legitimate objective of incarceration. The *Criminal Code* stipulates that sentencing must have one or more of the following objectives:

a) to denounce unlawful conduct;
b) to deter the offender and other persons from committing offences;
c) to separate offenders from society, where necessary;
d) to assist in rehabilitating offenders;
e) to provide reparations for harm done to victims or to the community; and
f) to promote a sense of responsibility in offenders, and acknowledgment of the harm done to victims and to the community.[268]

Correspondingly, the CCRA describes CSC's purpose as contributing to the maintenance of a "just, peaceful and safe society" by "carrying out sentences imposed by courts through the safe and humane custody and supervision of offenders" and "assisting the rehabilitation of offenders and their reintegration into the community as law-abiding citizens through the provision of programs in penitentiaries and in the community."[269] Neither the *Criminal Code* nor the CCRA reflect a view of incarceration that denies health care to prisoners, and the principle of equivalence, affirmed by the CCRA and international health and human rights standards, is clearly opposed to jeopardizing individuals' health by virtue of their incarceration. The effect of CSC's inaction is prisoners' heightened risk of HIV and HCV infection, an outcome that is grossly disproportionate to any rationale for their incarceration. Not only persons who inject drugs in prisons, but other prisoners, prison staff and the community as a whole face greater risk of grave illness when persons in prisons become increasingly infected with blood-borne viruses. Given the magnitude of this public-health risk, CSC's prohibition of PNSPs is grossly disproportionate to any of its purported aims.

Whether the treatment is in accordance with public standards of decency

In *United States of America* v. *Burns*, the Supreme Court addressed the question of defining "public standards of decency," clarifying that alleged section 12 violations should not to be taken out of context or equated with opinion polls.[270] In that case, the Court cited President Arthur Chaskalson of the Constitutional Court of South Africa, who observed that

> [p]ublic opinion may have some relevance to the enquiry, but, in itself, it is no substitute for the duty vested in the Courts to interpret the Constitution…. The very reason for establishing the new legal order, and for vesting the power of judicial review of all legislation in the courts, was to protect the rights of minorities and others who cannot protect their rights adequately through the democratic process. Those who are entitled to claim this protection include the social outcasts and marginalised people of our society.[271]

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[266] *Smith*, *supra* note 252 at para. 112.

[267] Ibid.

[268] S. 718 of *Criminal Code* (R.S., 1985, c. C-46).

[269] CCRA, s. 3.

[270] *United States of America* v. *Burns*, [2001] 1 S.C.R. 283 (Supreme Court of Canada) at para. 67.

[271] Ibid. at para. 67.

CSC's "treatment" of prisoners who use drugs cannot be considered without also considering the effects of such treatment. In the case of PNSPs, the impact of using non-sterile injection equipment, namely, an increased risk of infection with HIV and HCV, could be said to outrage a collective standard of decency. This is especially true if, as affirmed by the Supreme Court of Canada in *R.*v. *Goltz* and *R.* v. *Morrisey*, the specific characteristics of the population most affected are considered. As the Court stated in *Burns*, "the social outcasts and marginalised people of our society" are entitled to claim the protection of section 12, even if opinion polls indicate otherwise. Undoubtedly, prisoners who inject drugs are among the most marginalized of society, for whom sterile needles and syringes are crucial if they are to remain free of HIV or HCV infection. Further reinforcing their marginalization by subjecting them to unnecessary health risks (that are not imposed on the population as a whole) cannot be in accordance with public standards of decency.

Furthermore, people in prison retain all their rights and are entitled to access an equivalent standard of health care, principles which have been accepted and endorsed by numerous international health and human rights organizations.[272] These internationally accepted principles should inform "public standards of decency" with respect to prisoners' health. In an environment where community NSPs enjoy widespread support domestically and internationally, and there is significant evidence of the efficacy of PNSPs in reducing the use of non-sterile injection equipment, denying people in prison, particularly those who are addicted to drugs, the right to protect themselves against HIV and HCV infection constitutes treatment that is contrary to minimum standards of decency and human rights, especially in light of the numerous recognized health and human rights reasons for PNSPs.

A counter-argument to address is the notion that section 12 is said to be triggered by a conscious decision by the state and not the result of a decision by an individual. For example, in *Chiarelli* v. *Canada*, the Supreme Court of Canada found that the deportation of a permanent resident who had deliberately violated an essential condition of residence in Canada could not be said to outrage standards of decency.[273] Rather, those standards would be outraged if individuals granted conditional entry into Canada were permitted to violate those conditions deliberately and without consequence. In light of this decision, an argument may be raised that prisoners who deliberately disregard prison rules in relation to the prohibition of drugs in prison cannot be said to suffer from cruel and unusual punishment.[274] This argument, however, ignores the fact that many persons who inject drugs suffer addiction and are unable to abstain, especially where other treatment options are not suitable or available, a distinction the B.C. Supreme Court recognized in *PHS Community Services Society* v. *Attorney General of Canada*.[275] Moreover, despite the general prohibition of illegal drugs, NSPs operate outside prisons, with government support, as effective harm reduction measures premised on the reality of drug use and the public-health imperative of reducing HIV and HCV transmission. In addressing the issue of "choice" in the context of drug injection, it is also worth noting that in the restricted context of prison, the freedom to "choose" whether or not to share needles may not be realistic, or possible.

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[272] *Basic Principles for the Treatment of Prisoners*, *supra* note 69, Principle 5; WHO, *supra* note 77; UNODC, WHO and UNAIDS, *supra* note 78 at 10; UNAIDS, *supra* note 79 at 3.

[273] *Chiarelli* v. *Canada,* [1992] S.C.R. 711 (Supreme Court of Canada).

[274] A noteworthy case in this respect is the New York Supreme Court Appellate Division case of *Domenech* v. *Goord* 20 A.D. 3d 416. There, prison officials directed a prisoner who was infected with HCV to participate in an intensive six-month drug treatment program in order to receive treatment for hepatitis. The prisoner dropped out of the program after two weeks stating that he had not used drugs for 30 years, the program contained no useful information about his medical condition and it disrupted his educational classes and work schedule. As a result, prison officials refused to provide the prisoner medication. The Court held that prison officials' denial of medical treatment amounted to "cruel and unusual punishment in violation of the Eighth Amendment."

[275] *PHS Community Services Society*, *supra* note 94 at para. 142.

Contextual factors

A determination of whether treatment is "cruel and unusual" must not merely assess the government's refusal or failure to implement PNSPs, but the effects of such action, considering the particular needs of prisoners, the actual effect of the treatment on them and the availability of adequate alternatives.[276] Therefore, the vulnerability and needs of prisoners who inject drugs should inform the interpretation of section 12. As noted earlier, the majority of prisoners come from disadvantaged backgrounds characterized by poverty, substance abuse, low levels of education and high levels of depression and attempted suicide.[277] Moreover, a significant number of prisoners have substance abuse problems requiring substantial treatment.[278] For those prisoners, the actual effect of failing to provide PNSPs poses severe health risks, especially in view of the astounding HIV and HCV prevalence in prisons. For many prisoners with substance addictions, the effect of prohibiting PNSPs is an even greater risk of HIV and/or HCV infection, a potentially fatal health outcome that is neither "decent" nor "proportionate" to the reasons for their incarceration. The "treatment" is senseless especially in light of the alternative of providing PNSPs, a move that would fulfill CSC's obligations under the CCRA and be in accordance with international health and human rights standards.

IV. Charter, section 1

If violations under sections 7, 15 or 12 have been established, it is theoretically still possible that the violation or violations could be justified under section 1 of the Charter,[279] though any law or state action that offends the principles of fundamental justice will not ordinarily be saved by section 1.[280] According to section 1, the Charter "guarantees the rights and freedoms set out in it subject only to such reasonable limits prescribed by law as can be demonstrably justified in a free and democratic society." The test to determine what can be accepted as "demonstrably justified" under this section has been outlined by the Supreme Court in *R.* v. *Oakes* and subsequent cases.[281] To justify the infringement of a Charter right by a law or government policy or action, the government must demonstrate that:

1. the objective of the government measure is of sufficient importance to warrant overriding a constitutional right, meaning that, at a minimum, it must relate to concerns which are pressing and substantial;
2. the government measure is rationally connected to achieving this objective, meaning it is not arbitrary, unfair or based on irrational considerations;
3. the government measure impairs as little as possible the constitutional right(s) in question; and
4. the harm done by limiting the right does not outweigh either the importance of the measure's objectives or the benefits of the measure.

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[276] *Goltz, supra* note 252. See also *Morrisey*, *supra* note 252 at paras. 27-28 and *Wiles, supra* note 262 at para. 5.

[277] D. Robinson et al., *supra* note 206 at 5.

[278] Public Health Agency of Canada, *supra* note 20.

[279] While it may be slightly artificial to group the section 1 arguments and analyses for violations of section 7, 15 and 12 together, many of the arguments under each rights violation overlap. Section 1 justifications of section 7 violations may have a higher threshold, in part because much of the section 1 analysis occurs during a consideration of section 7. The Supreme Court has observed that "a violation of section 7 will be saved by section 1 only in cases arising out of exceptional conditions, such as natural disasters, the outbreak of war, epidemics and the like." See *Suresh* v. *Canada*, *supra* note 109 at para. 78, citing *Reference Re Motor Vehicle Act (B.C.),* [1985] 2 S.C.R. 486 (Supreme Court of Canada) at 518.

[280] *New Brunswick (Minister of Health and Community Services),* [1999] 3 S.C.R. 46 (Supreme Court of Canada) at para. 99, and *PHS Community Services Society*, *supra* note 94 at para. 157.

[281] *R.* v. *Oakes*, [1986] 1 S.C.R. 103 (Supreme Court of Canada). See also *R.* v. *Edward Books and Art*, [1986] 2 S.C.R. 713 (Supreme Court of Canada); *Dagenais* v. *CBC*, [1994] 3 S.C.R. 835 (Supreme Court of Canada); *Thompson Newspaper Co.* v. *Canada (Attorney General),* [1998] 1 S.C.R. 877 (Supreme Court of Canada).

Pressing and substantial purpose to justify limiting Charter rights

It is difficult to subject CSC's failure or refusal to implement PNSPs to full constitutional scrutiny in the absence of any clear statement from CSC that attempts to justify the absence of such programs. As noted earlier, principal objections raised by governments in response to PNSPs have included the notion that PNSPs condone drug use and lead to an increased consumption of drugs, and/or an increased use of injection drugs among those who were previously not injecting, that PNSPs lead to increased violence and to the use of syringes as weapons against prisoners and staff, and that PNSPs may not work in Canada because other jurisdictions with successful PNSPs reflect specific and unique institutional environments.[282] Admittedly, concerns about drug use in prison and prison safety may be "pressing and substantial." However, the notion that PNSPs may not work in Canadian prisons is no justification for delaying their implementation, especially in view of the evidence worldwide demonstrating their efficacy in a range of institutions and the possibility of piloting PNSPs in select institutions. Furthermore, even if any of CSC's purported concerns are deemed "pressing and substantial," there is no nexus between those concerns and the prohibition of PNSPs. If anything is "pressing and substantial," it is the need to prevent the harms associated with unsafe drug injecting in prisons, including HIV and HCV infection.

Rational connection between government objective and limit on Charter rights

Significantly, the government's objective or objectives in failing or refusing to implement PNSPs must be rationally connected to the means undertaken to achieve them. In this respect, the prohibition of PNSPs fails section 1 scrutiny. The lack of access to sterile needles and syringes in prison undermines CSC's interest in mitigating the harms caused by injection drug use, an interest actually reflected in CSC's statutory obligation to protect the health and well-being of prisoners in its custody. In spite of the federal government's "zero tolerance" drug policy and interdiction efforts, there is undeniable evidence that drugs are being smuggled into prisons and used by prisoners, a fact that the government's own research demonstrates and that it acknowledges.[283] Numerous studies have indicated that, despite the absence of sterile injection equipment, prisoners inject drugs;[284] non-sterile injection equipment is merely used more frequently because of the shortage of injecting equipment.[285]

While CSC may not wish to be seen to condone drug use, it already acknowledges injection drug use within prisons by making bleach available, with "instructions on the proper cleaning of syringes and needles."[286] Correspondingly, community NSPs operate within a legal environment where drug use is criminalized, yet NSPs are not accused, including by the federal government, of condoning drug use. Studies of PNSPs worldwide have indicated that drug consumption and the use of injection drugs among those who were previously injecting do not increase when PNSPs have been introduced.[287] Many studies have also concluded that PNSPs do not lead to increased violence and that PNSP syringes have not been used as weapons against staff or other prisoners.[288] Finally, as the Spanish experience with PNSPs has demonstrated, PNSPs can be

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[282] Lines et al., *supra* note 1 at 44–52.

[283] E.g., see Public Safety and Emergency Preparedness Canada, *Corrections Fast Facts 2: Drugs in Prisons*, undated, available at http://www.publicsafety.gc.ca/prg/cor/acc/_fl/ff7-en.pdf.

[284] See for example Correctional Service of Canada, *supra* note 10; A. DiCenso et al., *supra* note 11; and Correctional Investigator Canada, *supra* note 13 at 12.

[285] See for example C. Poulin et al., *supra* note 19.

[286] Correctional Service of Canada, *Commissioner's Directive 821-2: Bleach Distribution,* 2004, s.7.

[287] J. Nelles et al., "Provision of syringes: the cutting edge of harm reduction in prison?" *supra* note 60; J. Nelles et al., "How does syringe distribution in prison affect consumption of illegal drugs by prisoners?" *supra* note 60; H. Stöver, "Evaluation of needle exchange pilot projects show positive results," *supra* note 60; Ministerio Del Interior/Ministerio De Sanidad y Consumo, *supra* note 60 at 4; J. Sanz Sanz et al., *supra* note 60; and H. Stöver and J. Nelles, *supra* note 60.

[288] J. Nelles et al., "Provision of syringes: the cutting edge of harm reduction in prison?" *supra* note 60; J. Nelles et al., *Prevention*

introduced in prisons of different sizes, regions and security levels.[289] In Western European prisons, programs have proven effective in prisons where prisoners are housed in ranges of individual cells, similar to the Canadian situation.[290] PNSPs have also been successfully implemented in jurisdictions that are relatively well-resourced and well-financed (i.e. Switzerland, Germany, Spain), as well as in countries in economic transition that operate with significantly less funding and infrastructural support (i.e. Moldova, Kyrgyzstan, Belarus).[291]

Given the reality of injection drug use in prisons and the evidence invalidating the purported harms of PNSPs worldwide, a blanket prohibition on PNSPs does little or nothing to advance the state's interest in protecting prisoners, prison staff, or other members of the public. There is therefore no rational connection between the objective of the prohibition and the violation of prisoners' constitutional rights.

Minimal impairment of Charter rights

Under section 1 of the Charter, if rights are to be infringed, the level of infringement must not exceed the minimum required to fulfil the desired purpose. The requirement for minimal impairment is also reflected in the CCRA, which obligates CSC to "use the least restrictive measures consistent with the protection of the public, staff members and offenders."[292] Since there is no rational connection between the purported objectives of prohibiting PNSPs and the actual evidence garnered from evaluations of PNSPs worldwide, the deprivation of prisoners' section 7, 15 and 12 rights have not been minimally impaired, especially given the dire consequences of the impairment. Denying prisoners access to a form of health care poses a significant risk of HIV and HCV infection and contravenes the principle of retaining all rights and the principle of equivalence. Such impairment is far from "minimal", even if the prohibition of PNSPs can be said to be rationally connected to CSC objectives. When there is no rational connection between the denial of sterile needles and syringes to prisoners and CSC's aims, the violation of prisoners' Charter rights is patent and unjustifiable.

Proportionality between harms and benefits of the measure

Finally, under section 1 of the Charter, the harm done by the government in limiting constitutional rights must not outweigh either the importance of the legitimate government objective or the benefits achieved by the government's measure. Evidence confirms that denying prisoners' access to sterile needles and syringes is not simply ineffective, but excessively harmful. In light of the extent of injection drug use in prisons, PNSPs are crucial to reducing the risks associated with non-sterile injection equipment. As the Supreme Court has held, an individual's physical security is immediately implicated when state actions interfere with physical integrity.[293] Prohibiting sterile needles and syringes in prisons subjects prisoners who inject drugs to a significant risk of HIV and HCV infection, a harm that outweighs the purported "benefits" of the prohibition — benefits which are not supported by evidence from evaluations of PNSPs worldwide. In contrast, the health benefits of providing sterile needles and syringes actually advance the state's interest in reducing the harm to prisoners and to society of the use of harmful drugs.

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of drug use and infectious diseases in the Realta Cantonal Men's Prison: Summary of the Evaluation, *supra* note 60; J. Nelles et al., "Provision of syringes and prescription of heroin in prison: the Swiss experience in the prisons of Hindelbank and Oberschöngrün," *supra* note 60; H. Stöver, *supra* note 60; C. Menoyo et al., *supra* note 60; J. Sanz Sanz et al., *supra* note 60.

[289] J. Sanz Sanz et al., *supra* note 60; Ministerio Del Interior/Ministerio De Sanidad y Consumo, *supra* note 60.

[290] Lines et al., *supra* note 1 at 50.

[291] Ibid., p. 51.

[292] CCRA, s. 4(d).

[293] *Morgentaler*, *supra* note 120 at para 22; *Chaoulli*, *supra* note 106 at para 119.

Conclusion

The Charter must be interpreted as a "living tree" that is "capable of growth and development over time to meet new social, political and historical realities often unimagined by its framers."[294] Worldwide, PNSPs have been implemented in numerous jurisdictions and professional health experts and organizations are increasingly endorsing their establishment. Viewed in light of (i) the reality of HIV, HCV and injection drug use in prisons, (ii) the well-established legal principles of retaining all human rights and of equivalence in health care standards, (iii) the availability and general acceptance of NSPs in the community as a vital harm reduction measure, and (iv) CSC's obligations to take effective measures to prevent the spread of infectious diseases among prisoners, the government's failure to provide PNSPs in Canadian prisons does not meet Canada's commitments to international health and human rights standards, its mandate under Canadian correctional legislation, or its obligations under the *Canadian Charter of Rights and Freedoms*.

Policies on prisoners' health must be guided by scientific evidence and human rights principles, not determined by tenuous dogma. Prisoners, who already experience marginalization, disproportionate illness and addiction, have borne the brunt of such misguided policies, and their health has deteriorated further as a result. In the face of the shocking prevalence of HIV and HCV among prisoners in Canada, the health and human rights imperative for PNSPs has never been more apparent.

[294] *Hunter* v. *Southam Inc.,* [1984] 2 S.C.R. 145 (Supreme Court of Canada) at para. 16.