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

Brief to the Toronto Board of Health regarding Supervised Injection Services in Toronto

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1. Background

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 and AIDS, in Canada and internationally, through research, legal and policy analysis, education and community mobilization. As Canada's leading organization working on the legal and human rights issues raised by HIV and AIDS, the Legal Network intervened before the Supreme Court of Canada in *Canada (Attorney General) v PHS Community Services Society* to bring its expert perspective to the Court on evidence-based policies, practices and services to reduce harms that can arise from the use of psychoactive drugs by people currently unable or unwilling to stop.

We appreciate the opportunity to comment on the Toronto Board of Health's study of supervised injection services and to draw the Board's attention to certain elements which are particularly relevant from the perspective of public health and human rights, including relevant Canadian and international law and practice.

Health and Social Benefits of Supervised Injection Services

As outlined in the recent reports of the Toronto Drug Strategy's Supervised Injection Services Working Group and the Medical Officer of Health, health programs such as supervised injection services (SISs) have numerous health and social benefits.[1] SISs have been demonstrated to be effective in reducing deaths from overdose, facilitating lower-risk, more hygienic consumption of drugs, and decreasing sharing of drug injection equipment, thus decreasing the spread of blood-borne infections such as HIV and hepatitis C virus (HCV) among people who inject drugs.[2] The latter outcome is particularly relevant in Toronto in light of data indicating that 61 percent of people who recently injected drugs in Toronto tested positive for HCV and 6 percent tested positive for HIV.[3]

More generally, SISs promote the health of some of those most marginalized by connecting people to health care services, such as counselling, drug treatment and the services of physical and mental health practitioners.[4] By providing a facility that other services cannot offer, SISs play an important role in establishing and maintaining contact with people who use drugs,[5] and particularly those who inject drugs in public, who tend to be characterized by social exclusion, poor health and homelessness, and who often lack access to health care services.[6] SISs thus stabilize and promote the health of clients.

At the community level, SISs address public order and safety concerns associated with public drug use by reducing public drug use and associated disturbances,[7] helping to prevent crime in the neighbourhoods around the facilities,[8] reducing costs to health and law enforcement systems,[9] and promoting community integration and improved quality of life for people who use drugs.

Extensive research documenting the positive public health and safety outcomes of SISs, wide agreement among health professionals that SISs should be available as part of a

comprehensive continuum of health services for people who inject drugs, and the conclusion of the *Toronto and Ottawa Supervised Consumption Assessment Study* (TOSCA) that Toronto would benefit from SISs integrated into health services already serving people who inject drugs prompted Toronto's Medical Officer of Health to recommend that the Toronto Board of Health urge the provincial government to fund the integration of SISs into existing provincially funded clinical health services in Toronto. In order to advance the implementation of SISs in Toronto, Dr. David McKeown further called on the Board of Health to formally register its opposition to Bill C- 65, which is aimed squarely at impeding such health services.

We strongly endorse Dr. McKeown's recommendations and elaborate below the legal and human rights arguments bolstering these recommendations.

2. Canadian and International Law

Ontario Public Health Standards 2008

The *Ontario Public Health Standards 2008* (Standards) are published as the guidelines for the provision of mandatory health programs and services by the Minister of Health and Long-Term Care, pursuant to Section 7 of the *Health Protection and Promotion Act*.[10] In the section of the Standards addressing blood-borne infections, the stated goal is to "prevent or reduce the burden of sexually transmitted infections and blood-borne infections."

Among the mandated "outcomes" of boards of health is that "[p]riority populations have access to harm reduction services to reduce the transmission of sexually transmitted infections and blood-borne infections."[11] This confers on those boards a responsibility to ensure access to "a variety of harm reduction program delivery models which shall include the provision of sterile needles and syringes and may include other evidence-informed harm reduction strategies in response to local surveillance."[12] [emphasis added]

In addition to the numerous evaluations of SISs that provide compelling evidence that SISs reduce risk behaviours that cause HIV and HCV infection, there is also evidence demonstrating local need and feasibility. As noted above, a majority of people who inject drugs in Toronto are infected with HCV and a disproportionate number are HIV-positive. The TOSCA study further demonstrates the feasibility of SISs in Toronto. SISs consequently reflect a health service that is wholly consistent with the obligation of the Toronto Board of Health to provide "priority populations" such as people who inject drugs with access to a critical harm reduction service.

Canadian Charter of Rights and Freedoms

Section 56 of the CDSA permits the federal Minister of Health to issue exemptions from the application of all or any of the provisions of the *Controlled Drugs and Substances Act* (CDSA) if the exemption "is necessary for a medical or scientific purpose or is otherwise in the public interest."[13] In a unanimous 2011 decision, the Supreme Court of Canada ordered the Minister to grant Insite, Vancouver's SIS, an extended exemption from the

criminal prohibition on drug possession in the CDSA, thus permitting it to continue to operate.[14] The Court held that while the CDSA provisions were applicable to Insite as valid exercises of the federal government's criminal law power, the Minister's refusal to extend Insite's CDSA exemption violated the *Canadian Charter of Rights and Freedoms* (Charter).

In its decision, the Court recognized that "Insite has saved lives and improved health. And it did those things without increasing the incidence of drug use and crime in the surrounding area."[15] While the Health Minister has discretion in deciding whether to approve any particular request for an exemption to run a SIS, that discretion must be exercised in a way that respects the Charter. With respect to Insite, the Court declared that the Health Minister had violated the Charter rights of people who need access to this health facility to reduce the risk of blood-borne infections such as HIV and HCV and the risk of dying from overdose.

The Court set out five factors and said the Minister must consider any evidence there is about those factors in making a decision. This includes any evidence about community support or opposition to the proposed health service. However, the Court did not say that these are preconditions that must all be satisfied. The Court held that, on future applications for such exemptions, the Minister must exercise such discretion within the constraints imposed by the law and the Charter. This means striking the appropriate balance between achieving public health and public safety, and considering whether denying an exemption would cause deprivations of life and security of the person that are not in accordance with the principles of fundamental justice. Further, the Court held that the Minister should generally grant an exemption where "the evidence indicates that a supervised injection site will decrease the risks of death and disease, and where there is little or no evidence of a negative impact on public safety."[16]

International law

The arbitrariness of Canada's decision effectively to outlaw Insite and similar SISs is confirmed by international law, which recognizes harm reduction as an integral part of the right to enjoy the highest attainable standard of health and thus requires access to harm reduction services.

For example, the *International Covenant on Economic, Social and Cultural Rights* (Covenant) states that the right to "enjoyment of the highest attainable standard of physical and mental health" requires Canada "to take steps…, including particularly the adoption of legislative measures" that are necessary for, *inter alia*, "the prevention, treatment and control of epidemic … diseases" and the "creation of conditions which would assure access to all medical services and medical attention in the event of sickness."[17] Both these requirements of the right to health support access to harm reduction services, given that (1) addiction is an illness of which drug use is an aspect and for which harm reduction services are a necessary form of medical services and attention, and (2) harm reduction services help prevent and control epidemic diseases such as HIV and HCV.

Indeed, there is overwhelming international consensus that full realization of the right to health demands access to harm reduction services. In 2001, 2006 and 2011, UN General Assembly members committed themselves to ensuring "a wide range of prevention programmes" for HIV/AIDS, including "harm reduction efforts related to drug use."[18] UNAIDS, the UN Development Programme, UNICEF, the UN Office on Drugs and Crime and the World Health Organization have repeatedly urged states to implement and scale up harm reduction measures to address HIV.[19]

The UN Human Rights Council's Special Rapporteur on the right to health has frequently affirmed the essential nature of harm reduction services.[20] So has the UN Committee on Economic, Social and Cultural Rights (UNCESCOR), the independent body of expert jurists that monitors states' compliance with their Covenant obligations.[21] The Office of the UN High Commissioner for Human Rights recently reminded states of the "longstanding evidence that a harm reduction approach is the most effective way of protecting rights, limiting personal suffering, and reducing the incidence of HIV." [22]

Also relevant is the UNCESCR's clarification that the Covenant includes a "strong presumption" that retrogressive measures are prohibited. This sets a very high bar for justifying Canada's attempts to erect obstacles to SISs:

> As with all other rights in the Covenant, <u>there is a strong presumption that retrogressive measures taken in relation to the right to health are not permissible</u>. If any deliberately retrogressive measures are taken, the State party has the burden of proving that they have been introduced after the most careful consideration of all alternatives and that they are duly justified by reference to the totality of the rights provided for in the Covenant in the context of the full use of the State party's maximum available resources.[23] [emphasis added]

The obligation to provide all persons in the community with the highest attainable standard of health is clearly infringed when deliberate policies thwart the establishment of a potentially life-saving, disease-preventing measure. Given the seriousness of the dangers associated with unsafe injection drug use, Canada has an obligation to ameliorate or prevent the negative health consequences of injection drug use, such as the spread of infectious disease.

Bill C-65

Flouting the Supreme Court of Canada and constitutional and international law, the federal government introduced a bill in Parliament that aims to make it even more difficult for health authorities and community agencies to offer SISs to Canadians who are among those most at risk of HIV infection and fatal overdose. Bill C-65 introduces numerous conditions that must be met before the Minister of Health will issue a Section 56 exemption under the CDSA to allow a SIS to operate.

The bill is an irresponsible initiative that ignores not only the extensive evidence that such health services are needed and effective, but also the human rights of Canadians with addictions. In essence, the bill seeks to create multiple additional hurdles that

providers of health services must overcome. The bill declares that the Health Minister should issue an exemption only in "exceptional circumstances." In addition, numerous provisions of the bill create opportunities for community opponents, local police and others to voice their opposition — even if ill-informed — to such health services, and for the federal Health Minister to then use such opposition as an excuse for denying exemptions. As the Toronto Medical Officer of Health noted in his recent report, the requirements in the bill are "extremely onerous and disproportionate to what is required for other health services," such that if the bill is passed as currently drafted, "health services seeking to implement supervised injection will have great difficulty meeting the requirements for a CDSA exemption."[24]

Bill C-65 deliberately undermines the Supreme Court of Canada ruling and is an impermissible retrogressive measure taken by the federal government in relation to the right to health. People who use drugs are entitled to needed health care services just like all other Canadians. It is unethical, unconstitutional and damaging to both public health and the public purse to block access to SISs, which save lives and prevent the spread of infections.

3. Recommendations

We urge the Toronto Board of Health to show leadership in recognizing the science that solidly supports SISs as an important health service for some of those at greatest risk of harm and by ensuring such services can operate where they are needed by:

1) endorsing SISs as an essential health service that is consistent with the mandate of the Toronto Board of Health to improve population health by tackling health inequities, pursuant to the *Ontario Public Health Standards 2008*;

2) urging the provincial government to fund SISs for people who use drugs in Toronto, in at least three sites consistent with the TOSCA recommendation — opened as soon as possible; and

3) making a submission to the federal government to register its opposition to Bill C-65, and to recommend the development of a more feasible CDSA exemption application process for SISs, in consultation with relevant provincial, public health, public safety and community stakeholders, including people who use drugs, as was recommended by Toronto's Medical Officer of Health.

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[1] Toronto Drug Strategy, *Supervised Injection Services Toolkit, Appendix A*, June 2013 and Medical Officer of Health, *Supervised Injection Services in Toronto*, June 21, 2013.

[2] See, for example, Medically Supervised Injecting Centre (MSIC) Evaluation Committee, *Final report on the evaluation of the Sydney Medically Supervised Injecting Centre*, Sydney, 2003; D. Hedrich, *European report on drug consumption rooms*, European Monitoring Centre for Drugs and Drug Addiction, February 2004, p. 50; E. Wood et al, "Safer injecting education for HIV prevention within a medically supervised

safer injecting facility," *International Journal of Drug Policy* 16(4) (2005): 281–284; T. Kerr et al, "Safer injection facility use and syringe sharing in injection drug users," *The Lancet* 366(9482) (2005): 316–318; F. Benninghoff et al, *Résultats de l'étude de la clientèle du Cactus BIEL/BIENNE 2001*, Institut universitaire de médecine sociale et préventive, 2002; F. Benninghoff et al, *Evaluation de Quai 9 'Espace d'acceuil et d'injection' à Genève: période 12/2001–12/2000*, Institut universitaire de médecine sociale et préventive, 2003; S. Poschadel et al, *Evaluation der Arbeit der Drogenkonsumräume in der Bundesrepublik Deutschland: Endbericht im Auftrag des Bundesministeriums für Gesundheit*, Das Bundesministerium für Gesundheit und Soziale Sicherung (Schriftenreihe Bd 149), Nomos-Verlags-Gesellschaft, 2003.

[3] L. Challacombe et al, *Toronto Phase 3 I-Track Report*, HIV Social, Behavioural & Epidemiological Studies Unit, Dalla Lana School of Public Health, University of Toronto, 2013.

[4] See, for example, B. Marshall et al, "Reduction in overdose mortality after the opening of North America's first medically supervised safer injecting facility: a retrospective population-based study," *The Lancet* 377(9775) (2011): 1429–1437; K. Dooling, "Vancouver's supervised injection facility challenges Canada's drug laws," *Canadian Medical Association Journal* 182(13)(2010): 1440–1444 ; M.A. Andresen & N. Boyd, "A cost-benefit and cost-effectiveness analysis of Vancouver's supervised injection facility," *International Journal of Drug Policy* 21(1)(2010): 70–76; E. Wood et al, "Summary of findings from the evaluation of a pilot medically supervised safer injecting facility," *Canadian Medical Association Journal* 175 (11)(2006): 1399–1404; E. Wood et al, "Attendance at supervised injecting facilities and use of detoxification services," *New England Journal of Medicine* 354(23) (2006): 2512–2514; BC Centre for Excellence in HIV/AIDS, *Evaluation of the Supervised Injection Site: One Year Summary*, 17 September 2004, p. 5; J. Kimber et al, "Drug consumption facilities: an update since 2000," *Drug and Alcohol Review* 22 (2003): 227–233; and *Final report on the evaluation of the Sydney Medically Supervised Injecting Centre*, supra.

[5] European Monitoring Centre for Drugs and Drug Addiction (EMCDDA), *European report on drug consumption rooms — executive summary*, Office for Official Publications of the European Communities, 2004, p. 4.

[6] H. Klee and J. Morris, "Factors that characterize street injectors," *Addiction* 90 (1995): 837–841; D. Best et al, "Overdosing on opiates: thematic review— part 1: causes," *Drug and Alcohol Findings* 4 (2000): 4–20.

[7] See, for example, E. Wood et al, "Changes in public order after the opening of a medically supervised safer injecting facility for illicit injection drug users," *Canadian Medical Association Journal* 171 (2004): 731–734; *European report on drug consumption rooms,* supra at pp. 61–64; and *Final report on the evaluation of the Sydney Medically Supervised Injecting Centre*, supra.

[8] E. Wood et al, "Impact of a medically supervised safer injecting facility on drug dealing and other drug-related crime," *Substance Abuse Treatment, Prevention, and Policy* 1 (8 May 2006): 13.

[9] See *European report on drug consumption rooms,* supra at p. 48; D. MacPherson. *A framework for action: A four-pillar approach to drug problems in Vancouver,* City of Vancouver, April 2001, pp. 20–21; and *Final report on the evaluation of the Sydney Medically Supervised Injecting Centre*, supra at pp. 192–193.

[10] R.S.O. 1990, c. H.7.

[11] See p. 35.

[12] See p. 36.

[13] *Controlled Drugs and Substances Act* (S.C. 1996, c. 19).

[14] *Canada (Attorney General) v PHS Community Services Society*, 2011 SCC 44.

[15] Ibid at para 19.

[16] Ibid at para 152.

[17] *International Covenant on Economic, Social and Cultural Rights*, General Assembly resolution 2200A (XXI) of 16 December 1966, entry into force 3 January 1976, articles 2 and 12.

[18] *Declaration of Commitment on HIV/AIDS*, GA Res S-26/2, UNGAOR, 26th Special Sess, UN Doc A/RES/S-26/2, (2001), at para. 52; *Political Declaration on HIV/AIDS,* GA Res 60/262, UNGAOR,60th Sess, UN Doc A/RES/60/262, (2006) at para. 22; and *Political Declaration on HIV and AIDS: Intensifying Our Efforts to Eliminate HIV and AIDS* GA Res 65/277, UNGAOR, 65TH Sess, UN Doc A/RES/65/277, (2011), at para. 59.

[19] See, for example, World Health Organization, *A strategy to halt and reverse the HIV epidemic among*

people who inject drugs in Asia and the Pacific: 2010–2015, (Geneva: WHO Press, 2010); UNAIDS, UNICEF and World Health Organization, *Towards Universal Access: Scaling up priority HIV/AIDS interventions in the health sector, Progress Report 2010*; and United Nations Development Programme, *HIV/AIDS in Eastern Europe and the Commonwealth of Independent States: Reversing the Epidemic, Facts and Policy Options*, (Bratislava: United Nations Development Programme, 2004).

[20] *Report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, Paul Hunt*, UNHRC, 4th Sess, UN Doc A/HRC/4/28/Add.2, (2007) and *Report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health (Report to the UN General Assembly)*, UNGAOR, 65th Sess, UN Doc A/65/255, (2010).

[21] *Concluding observations of the Committee on Economic, Social and Cultural Rights: Ukraine*, UNESCOR, 39th Sess, UN Doc E/C.12/UKR/CO/5, (2008); *Concluding observations of the Committee on Economic, Social and Cultural Rights: Tajikistan*, UNESCOR, 37th Sess, UN Doc E/C.12/TJK/CO/1, (2006); and UN Committee on Economic, Social and Cultural Rights, *Concluding observations of the Committee on Economic, Social and Cultural Rights: Mauritius*, UNESCOR, 44th Sess, UN Doc E/C.12/MUS/CO/4, (2010).

[22] UN Office of the High Commissioner for Human Rights, Press Release, "High Commissioner calls for focus on human rights and harm reduction in international drug policy" (10 March 2009).

[23] *General Comment No. 14: The right to the highest attainable standard of health*, UNESCOR, 22nd Sess, UN Doc E/C.12/2000/4, (2000), at para. 33.

[24] Medical Officer of Health, *Supervised Injection Services in Toronto*, June 21, 2013 at pp. 9 and 2.