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Consultation on the development of new regulations under the *Controlled Drugs and Substances Act* with respect to supervised consumption sites and services

The HIV Legal Network (formerly the Canadian HIV/AIDS Legal Network) promotes the human rights of people living with, at risk of, or affected by HIV or AIDS, in Canada and internationally, through research and analysis, litigation and other advocacy, public education, and community mobilization. Since the HIV Legal Network's inception, the organization has advocated for drug policies that respect, protect, and fulfill the human rights of people who use drugs, including through effective, equitable access to harm reduction services. We are pleased to make this submission in relation to the development of new regulations on supervised consumption sites and services.

(1) What are the impacts of supervised consumption sites or services on people who use drugs, the communities in which these services are located, and the provinces and territories?

Like other harm reduction services (e.g. needle and syringe programs), supervised consumption services (SCS) are a pragmatic, necessary, and compassionate response to the needs of people who use drugs. They do so by offering an environment to consume drugs in a safe and hygienic way without fear of arrest or harassment, with access to sterile equipment and support from trained volunteers and/or staff as needed, including in the event of overdose or other harm.

For the purpose of our submission, we use the term **"supervised consumption services"** (SCS) to describe a wide range of services offering supervised consumption of drugs (usually, at the current time, pre-obtained illegal drugs) by trained volunteers and/or staff in a safe and hygienic environment. Our definition of SCS is purposefully broad in order to encompass multiple forms of supervised consumption. In Canada, SCS are currently offered in both (i) "**supervised consumption sites**," which operate pursuant to an exemption issued by the federal Minister of Health for a "medical purpose" under section 56.1 of the *Controlled Drugs and Substances Act* (CDSA) as well as (ii) "**overdose prevention sites**" (OPS), which include "Urgent Public Health Need" sites (UPHNS) approved by Health Canada including in response to COVID-19.[1] OPS, including UPHNS, are meant — at least in the way they are currently treated by governments — to be temporary locations offering low-threshold services, which distinguish them from supervised consumption sites that may offer a wider range of services and are expected to be longer-lasting. OPS have been authorized unilaterally by provincial governments (e.g. British Columbia) or pursuant to a section 56 exemption granted. In some cases, OPS operate, or have operated, independently of formal provincial or federal approvals, and it should be recalled that the first supervised consumption sites to operate in Canada also did so without an

[1] Public Health Agency of Canada, *Questions and Answers - Provincial/Territorial Class Exemptions: For Supervised Consumption Site Operators*, 2020. Available at www.drugpolicy.ca/wp-content/uploads/2020/04/Qs-and-As-Class-Exemption-April-20-2020-SCS-FINAL.pdf.

exemption from the CDSA. Without an exemption from the provisions of the CDSA, users and operators of SCS are exposed to the risk of criminal prosecution for certain drug offences (e.g., possession, trafficking) under the CDSA; the practical risk in a given situation depends heavily on the local political context and stance of local law enforcement.

Impact of SCS on people who use drugs

SCS save lives by reducing health risks associated with drug use, including potentially fatal overdose. This is particularly vital in the context of a contaminated, toxic drug supply. They also help prevent the transmission of infectious diseases, including HIV and hepatitis C, that can occur through the sharing of injection or other drug consumption equipment; help prevent other harms such as injection-site abscesses that can occur from the re-use of equipment and/or use of non-sterile equipment or unhygienic conditions; and increase access to treatment and care, including treatment for drug dependence, by either connecting people to such services or also offering a wide range of health and social services on site. Importantly, SCS attract and provide protection to some of the most marginalized people who use drugs, whose social, physical and mental health–related needs are rarely met.[2] SCS can notably be a refuge for women and gender-diverse people experiencing various forms of violence on the street.[3] For example, SCS have been found to disrupt gendered, unequal power relations in certain drug scenes, enabling women and gender-diverse people to assert agency over drug use practices.[4]

Impact of SCS on communities

More broadly, SCS contribute to the safety and quality of life in local communities by reducing drug use in public places and the extent of related litter, including discarded needles or other materials.[5] Evaluations of SCS in Canada have also shown them to be cost-effective, particularly by reducing the health care costs associated with HIV and HCV infection.[6] As an integral part of a harm reduction approach to substance use, SCS can also reduce stigma against people who use drugs by affirming that the safety, health, and dignity of these members of our communities are important and worthy of protection and promotion.

(2) What are the main federal regulatory barriers faced by those who are applying to operate or are operating an SCS in Canada? Are there any aspects of either the initial or subsequent process to apply for an exemption under the CDSA that are more burdensome than others?

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[2] D. Hedrich, *European report on drug consumption rooms*, European Monitoring Centre for Drugs and Drug Addiction (EMCDDA), 2004.

[3] N. Fairbairn, "Seeking refuge from violence in street-based drug scenes: Women's experiences in North America's first supervised injection facility," *Social Science & Medicine* 67 (2008) 817–823. See also, Canadian HIV/AIDS Legal Network, *Gendering the Scene: Women, Gender-Diverse People, and Harm Reduction in Canada*, 2020. Available at www.hivlegalnetwork.ca/site/gendering-the-scene-women-gender-diverse-people-and-harm-reduction-in-canada-full-report/?lang=en.

[4] J. Boyd et al., "Gendered violence & overdose prevention sites: A rapid ethnographic study during an overdose epidemic in Vancouver, Canada," *Addiction*, (2018) 1113:12, pp. 2261-2270. DOI: 10.1111/add.14417. See also Canadian HIV/AIDS Legal Network, *Gendering the Scene: Women, Gender-Diverse People, and Harm Reduction in Canada*, ibid.

[5] C. Potier et al., "Supervised injection services: What has been demonstrated? A systematic literature review," *Drug Alcohol Depend*. 145C (2014): pp. 48-68; European Monitoring Centre for Drugs and Drug Addiction (EMCDDA), *Perspective on drugs. Drug consumption rooms: an overview of provision and evidence*, 2018.

[6] See, for example, A. Bayoumi and G. Zaric, "The cost-effectiveness of Vancouver's supervised injection facility," *CMAJ*. 2008 Nov 18; 179(11): 1143–1151**;** E. A. Enns et al., "Potential cost-effectiveness of supervised injection facilities in Toronto and Ottawa, Canada," Addiction 111, 475–489 (2016). E. Jozaghi, A. A. Reid, and M. A. Andresen, "A cost-benefit/cost-effectiveness analysis of proposed supervised injection facilities in Montreal," *Canada. Subst. Abuse Treat. Prev. Policy* 8, 25 (2013). E. Jozaghi, A. A. Reid, M. A. Andresen, and A. Juneau, "A cost-benefit/cost-effectiveness analysis of proposed supervised injection facilities in Ottawa, Canada," *Subst. Abuse Treat. Prev. Policy* 9, 31 (2014).

An exceptional legal regime

In recent years, welcome efforts have been made at the federal level to facilitate the expansion of SCS across the country, but prospective SCS operators continue to be constrained by the need to apply on a **case-by-case basis** for a section 56.1 exemption under the CDSA (issued for a "medical purpose") as the principal avenue for providing protection to SCS clients and providers from potential criminal prosecution.[7] Service providers cannot confidently and sustainably offer SCS without a *specific* federal exemption protecting staff and clients from criminal prosecution under the CDSA. Such **an exceptional regime** for an evidence-based health service constitutes a significant barrier to the rapid implementation of SCS and is a great source of vulnerability. Contrary to what community and health groups have repeatedly urged, section 56.1 does not include a specific provision delegating power so as to enable provincial, territorial and local authorities to *also* grant exemptions from the CDSA. Exemptions are still granted **at the sole discretion of the federal Minister of Health**.

This exclusive gatekeeping function is a further barrier. The history of SCS in Canada demonstrates that relying solely on the discretion of the federal Minister of Health to obtain an exemption makes SCS highly vulnerable to the political context and political priorities (even if the Supreme Court of Canada has set some parameters to guide the exercise of ministerial discretion). Between 2005 and 2016, no new supervised consumption sites opened in Canada because the federal government at the time opposed them and therefore would not grant exemptions — and in fact, after being ordered by the Supreme Court of Canada in 2011 to renew an exemption for Vancouver's Insite,[8] amended the CDSA in 2015 to create a new, SCS-specific exemption regime that was deliberately and patently intended to make it virtually impossible to secure an exemption and provide multiple grounds that the government could invoke as a "justification" for denying an exemption, including in potential future litigation. Amendments enacted by the subsequent government in 2017 significantly streamlined the legislative framework; this, combined with a political willingness to issue exemptions, led to significant progress in scaling up SCS. However, the changes did not go far enough.

A burdensome application process and unnecessary restrictions attached to exemptions

For its 2019 report *Overdue for a change: scaling-up supervised consumption services in Canada*,[9] the HIV Legal Network interviewed a number of key informants, including researchers, SCS managers, CDSA exemption applicants, policymakers, and people who use drugs, to understand regulatory and other barriers as well as facilitators to applying to operate a SCS. Even though progress had been made, respondents maintained that the **exemption application process under section 56.1 remains overly and unnecessarily burdensome**, and that many of the current legal and policy criteria and requirements are problematic or irrelevant. At the outset, preparing exemption applications creates a hurdle for organizations without the capacity to undergo this resource-intensive process, and does not allow for rapid and adaptable public health responses during a health emergency. Respondents stressed that decisions about health services should be made on the basis of need, and organizations seeking to provide supervision of drug consumption to reduce harms and save lives should not be required to overcome a series of unnecessary bureaucratic hurdles or garner public support before opening. In some cases, they also described additional, unreasonable reporting requirements that only applied to

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[7] In December 2017, Health Canada announced that it would authorize emergency "overdose prevention sites" for those provinces and territories that request them. Class exemptions for OPS were granted in "the public interest" to provinces under section 56, as opposed to the exemptions for "supervised consumption sites" under section 56.1. Characterizing these sites as OPS allowed organizations to bypass the burdensome application process required to secure an exemption for a SCS under section 56.1 of the CDSA. Similarly, in April 2020, to facilitate the response to COVID-19, Health Canada issued temporary class exemptions to all provinces and territories enabling provincial or territorial Ministers of Health to approve UPHNS applications in their jurisdictions. They are also able to further delegate UPHNS approval to municipalities. Of note, prospective UPHNS operators can apply directly to Health Canada. See CRISM, *Supporting people who use substances in shelter settings during the COVID-19 pandemic: National rapid guidance*, 2020.

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

[9] Canadian HIV/AIDS Legal Network, *Overdue for a Change: Scaling-Up Supervised Consumption Services in Canada*, February 2019. Available at www.hivlegalnetwork.ca/site/overdue-for-a-change-full-report/?lang=en.

certain specific sites. Such an approach embodies a stigmatizing and discriminatory treatment of health services that are specifically needed by people who use drugs, and in many instances, particularly those who are already socio-economically marginalized.

More specifically, respondents identified the following barriers and some partial solutions:

- *Health Canada should not demand more information from applicants than is legally required* by CDSA section 56.1[10] or impose additional hurdles for prospective and operating service providers.[11] Decisions about the implementation of health services should be based on evidence of need and the potential for benefit in addressing that need.

    - *Community consultation should not be required* to obtain an exemption. Instead, organizations should be able to determine the appropriate methods and time to engage with their local community. In some places, imposed community consultations have created an avenue for some community members and elected officials to perpetuate misinformation, fear, and stigma against people who use drugs. The purpose of such community engagement is to facilitate effective operation of the site; it is not a process on which potential criminal liability of site users or staff should depend — which is the purpose served by a CDSA exemption.

    - *Secured funding should not be a precondition* for obtaining a federal exemption. It should be feasible to secure an exemption that removes any legal uncertainty about the operation of the service before securing the funding for operations. Indeed, in some cases it will be challenging to secure funding without first having the legal certainty of an exemption. In fact, federal funds should be made available to support SCS, including and especially in provinces and municipalities where local governments are reluctant to fund these life-saving services.

- Current exemptions for new SCS are time-limited and range in length from 1 to 3 years. *Communities should not be required to repeatedly undergo a burdensome reporting and approval process.*

- Given the current criminalization of drug possession, excluding people with criminal records from working at SCS is a significant barrier to the recruitment of SCS staff, especially staff with experience of drug use,[12] which research has shown to promote accessibility and, for

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[10] For example, Health Canada's 2017 guidance suggested that applicants should include, if any, statistics related to crime and public nuisance as well as public drug consumption and inappropriately discarded equipment in their application. This is not information that is legally required under the CDSA. Rather, the law provides that applications shall include information on the impact of the site on crime rates, the local conditions indicating a need for the site, the administrative structure in place to support the site, the resources available to support the maintenance of the site, and expressions of community support or opposition, *if this information is available*. This reflects the Supreme Court of Canada's 2011 decision that, in exercising ministerial discretion to issue an exemption, the Minister must consider such information *if it is available* — but the Court's decision *does not require* such information in order for the Minister to grant (or deny) an exemption. See, Health Canada, "Application form: Section 56.1 Exemption for Medical Purposes under the Controlled Drugs and Substances Act for Activities at a Supervised Consumption Site," May 16, 2017.

[11] Recent guidance from Health Canada on how to apply for an SCS exemption demonstrates an effort to remove some hurdles for prospective service providers. For example, since November 2018, applicants are no longer required to include a letter of opinion from the provincial or territorial Minister of Health in their application for an exemption.

[12] Under Health Canada's current policy, only the "responsible person in charge" of a site should be subject to a criminal record check (see information available at www.canada.ca/en/health-canada/services/substance-use/supervised-consumption-sites/apply/before-you-start.html). However, it has been reported to us that excluding people with a criminal record from working at SCS is still a barrier.

women in particular, the feeling of safety.[13] Working with a personal history of drug use allows staff and volunteers to share knowledge, build trust, and form meaningful relationships; this is valued by clients and coworkers and helps create compassionate and non-judgmental work environments and insights that would otherwise be absent.[14] Significantly, involving people with lived expertise of drug use has resulted in increased diversity within harm reduction and drug dependence treatment interventions, with socially and economically marginalized women and Indigenous people who use(d) drugs taking a particularly prominent role in emerging programming.[15]

- Organizations should be *permitted to submit joint applications to open satellite sites or change location without having to apply for a new exemption.* This would ease the administrative burden associated with exemption applications and facilitate coordination of service implementation within municipalities.

- To better accommodate the needs of individual communities, *flexibility is needed to encourage and authorize a wide range of service models and an ability to adapt to changing contexts*. Services should be expanded where needed to accommodate not only supervised injection, oral and intranasal consumption, but also inhalation (smoking), assisted injection, drug checking, drug sharing, and interventions to address the critical issue of the unsafe drug supply leading to fatal overdoses (e.g. prescription of controlled substances or other means to provide a "safe supply").

- Service providers, especially grassroots, peer-led organizations that are well positioned to provide SCS, may not have the financial or human resources necessary to apply for an exemption or to implement SCS. For instance, community organizations may need support to undertake renovation or build consumption rooms that respond to safety requirements. Such support, including funding, should be made available.

Moving forward: generally exempting SCS from criminal prosecutions and providing funding
Our report identified a number of priorities to improve Canada's approach to SCS and facilitate the expansion of these vital, life-saving health services. A major recommendation emerging from our research is the need for Canada to move from an outdated, problematic framework requiring a specific federal exemption towards larger-scale policy shifts that would better support the expansion of these harm reduction services.

This policy shift should include decriminalizing drug possession for personal use. **Decriminalization** would effectively end SCS exceptionalism as there would be no need for an exemption from criminal prosecution to protect SCS clients and staff (from possession charges). Decriminalization would also remove a major driver of stigma against people who use drugs — stigma that impedes their access to vital health and harm reduction services including SCS.

In the interim, **new regulations under section 55 of the CDSA** offer a tremendous opportunity to rethink the current legal framework governing SCS, move away from a case-by-case approach to these urgently needed health services, and **normalize and integrate SCS seamlessly into a comprehensive set of services for people who use drugs**.

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[13] M. Thulien, T. Nathoo, J. Worrall, et al., *SisterSpace, Shared Using Rooms: Women-Only Overdose Prevention Site: Three-Month Developmental evaluation*, August 2017. Available at https://atira.bc.ca/sites/default/files/SisterSpace_Report_August2017.pdf.
[14] CRISM People with Lived Expertise of Drug Use (PWLE) National Working Group, "Having a Voice and Saving Lives: A survey by and for people who use drugs and work in harm reduction," July 2019.
[15] Ibid.

In 2017, Health Canada took helpful temporary measures under section 56 to bypass the burdensome "supervised consumption sites"-specific application process required under section 56.1 of the CDSA and facilitate the implementation of OPS, and more recently, of UPHNS. Health Canada has also made efforts to simplify the application process under section 56.1, but the Canadian government has yet to use its authority under section 55 to regulate SCS in a simple, streamlined fashion under the CDSA.

We recommend that the federal government **adopt a simple regulation under section 55 that effectively grants a class exemption permitting the easy operation of SCS** by automatically providing protection against prosecution to clients and staff of SCS for any service meeting a few key conditions defined in the regulation. Such an exemption would remove a significant administrative burden from SCS operators, who would no longer have to apply on a case-by-case basis for individual exemptions from Health Canada. This approach is particularly important in the context of a dual public health crisis (i.e. an overdose epidemic exacerbated by the ongoing COVID-19 pandemic) that requires rapid responses. It would also ease the administrative burden on some harm reduction organizations that are well positioned to provide SCS but have limited capacity for overcoming administrative hurdles.

Importantly, the class exemption must be broad enough to offer flexibility for the implementation of a continuum of SCS models across the country, from peer-run, low-threshold services (e.g. many OPS) to comprehensive health services that include the supervision of consumption within a range of other services. **The wording of the exemption should set out certain minimum conditions to protect the safety and wellbeing of clients, staff, and the surrounding community**.

It is important to underscore that these minimum conditions for SCS exemptions would define when the CDSA's criminal prohibitions do not apply to staff and users of the service; they are not the place to legislate all desirable best practices that may guide the implementation of different models of SCS of different scale.

In addition, the minimum conditions required for being exempt from criminal prosecution under the CDSA should be designed in consultation with service providers and people who use drugs, following experiences in other countries and within Canada (including with OPS), and should focus on structural aspects of services related to personnel, procedures and protocols, equipment and health and safety requirements. Minimal conditions should not be excessive or onerous, as this would maintain or recreate barriers to the scale-up of much-needed services, defeating the purpose of a streamlined framework based on a class exemption. Based on the OPS and UPHNS experiences in Canada, minimum conditions for being covered by the class exemption from CDSA prosecution might include the following:

- A reasonable minimum number of people with training in administering naloxone and CPR available at all times, as well as a "designated person" responsible for overseeing all operations of the SCS, including guaranteeing that minimum standards, procedures, and protocols are respected, and for liaising with the local community.

- Availability of appropriate equipment to ensure the immediate provision of evidence-based emergency interventions in the event of an overdose (e.g. naloxone, administration of oxygen) and to provide SCS, including harm reduction supplies such as sterile needles, syringes, and other sterile drug use equipment, as well as basic equipment for the safe disposal of used equipment (e.g. sharps containers).

- Basic health and safety protocols and procedures related to: the roles and responsibilities of staff; response in the event of an overdose; and disposal of used drug equipment and substances left behind.

- Satisfying reasonable provincial and municipal requirements of general application (e.g. meeting health and safety requirements such as fire safety regulations).

- A notification to Health Canada within five days of beginning to offer services in a given venue, which includes confirmation that the above conditions are satisfied.

Complying with these minimum criteria would mean the users and staff (and any volunteers) of the service in question are automatically exempt from prosecution under the relevant CDSA provisions, as set out in the regulation. There would be no longer a need for a site/service-specific application, with a decision then issued on a case-by-case basis, by the federal Health Minister. (Note: this regulation under CDSA s. 55 would complement, not replace, the ministerial exemption power under CDSA sections 56 and 56.1.)

In addition, the federal government should **consider issuing a class exemption for individuals or a class of individuals** (e.g. nurses working in harm reduction settings) who are well positioned to offer safe SCS within their community.[16] This is particularly important given that many people use alone, especially during the COVID-19 pandemic, and may not have access to health services, including those available in the community. The parameters of such a class exemption would need to be defined in consultation with service providers and people who use drugs.

Finally, it should be noted that while changes to the legal framework are necessary to scale up and secure SCS in Canada, they will not be sufficient to overcome all barriers to SCS. Not only does Health Canada need to relax its approach to SCS, but it must also play a **leadership role by directly supporting and encouraging provincial authorities to support the implementation of diverse SCS models**. The implementation of SCS in Canada is contingent not only on the federal government's approach to exemptions, but also on the willingness of various orders of government to support the services. In particular, **federal funds are absolutely critical** to support SCS, including and in particular in provinces, territories, and municipalities where authorities are reluctant to fund these life-saving services but the need exists. The federal government must financially support the operation of SCS. It should also work with provincial, territorial, and municipal governments to ensure they commit to facilitate the scale-up of SCS where needed, including through immediate and sustained operational funding for SCS.

(3) **What types of supervised consumption services (e.g. drug checking, peer assistance, medication-assisted treatment, and safer-supply treatment options) should be included under the proposed new regulations? What evidence exists to support the effectiveness of such services?**

Respondents who participated in our research project on SCS unanimously stressed a strong need for a continuum of SCS to be made available in Canada, from peer-run, low-threshold services to comprehensive health services offering primary care, mental health care, treatment, and/or social services. SCS should be made available in multiple forms and in multiple places to adapt to clients' needs, including in mobile sites, housing facilities, harm reduction organizations, drop-in centres, shelters, stand-alone sites, or hospitals.

In particular, informants in our study emphasized the need for greater accommodation of, and support for peer-led, non-medicalized SCS, in addition to more traditional SCS where health care workers play important roles. This is particularly important to meet the specific needs of women and gender-diverse people who use drugs.[17] Research conducted in Vancouver and evaluations of OPS in Toronto show that women appreciate the low-barrier approach and small, intimate spaces associated with OPS. Indigenous and more marginalized women in particular have expressed feeling more comfortable in a

[16] See for example, BC Centre for Disease Control, *COVID-19: Provincial Episodic Overdose Prevention Service (e-OPS) Protocol*, May 6, 2020.
[17] Canadian HIV/AIDS Legal Network, *Gendering the Scene: Women, Gender-Diverse People and Harm Reduction in Canada,* supra note 3.

non-medical environment run by people with experience of drug use.[18] Ensuring operating times or services exclusively for women and gender-diverse people is also key to fostering a safe environment for women and gender-diverse people who use drugs.[19]

At the same time, SCS providers should be allowed to offer a wide range of services depending on local needs. This should include but not be limited to allowing various forms of drug consumption (including inhalation), assistance with injection from both other people with experience of drug use (sometimes called "peer-assisted injection") and nurses ("provider-assisted injection"), drug checking, safer-supply initiatives (including but not limited to prescription of controlled substances as substitutes for drugs obtained on the illegal market), and treatment options.

Again, this is especially important to address the needs of the most marginalized communities of people who use drugs, including women, gender-diverse people, people with disabilities, and youth. For example, physical violence is common in crack-smoking environments and often driven by gender power dynamics, with particular consequences for women who smoke crack. In a study conducted among people accessing a safer smoking room run by people who use drugs in Vancouver, all participants (half of whom were women) reported that their decision to smoke crack in the safer smoking room was motivated by the need to minimize their exposure to the social violence within unregulated crack smoking settings.[20] Additionally, studies have long shown that women, along with youth and people with disabilities, are more likely than men to require help from others to inject. Women are more likely to be injected by an intimate partner and are less likely to know how to inject.[21] Studies have also reported women's experiences of theft, violence, and abuse by intimate partners in relation to assisted injection as well as on the streets.[22] To ensure people without a "peer" on whom they can depend for injection can benefit from SCS, assisted injection should also include assisted injection by nurses.

Moreover, regulations should provide sufficient flexibility to allow for limited drug sharing and splitting where necessary, which respondents in our research project stressed should be authorized at SCS. Failure to allow this on the premises can discourage clients from accessing services, thereby exposing them not only to preventable risk of harms to their health but also to the risk of arrest or police harassment. Many people purchase drugs collectively with the intention of sharing them.[23] Drugs in pill form often have to be prepared in solution before they can be divided, making it impossible to split in advance.[24] Allowing a limited degree of drug sharing between SCS users brings this activity inside, which serves to both protect vulnerable clients and achieve community goals of moving drug preparation and transfer activities off of the street.

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[18] Vancouver Coastal Health Research Institute, "Specialized overdose prevention strategies needed for women," January 13, 2019; G. Kolla, R. Penn, and C. Long, *Evaluation of the Overdose Prevention Sites at Street Health and St. Stephen's Community House, Street Health and St. Stephen's Community House*, 2019.
[19] Canadian HIV/AIDS Legal Network, *Gendering the Scene: Women, Gender-Diverse People and Harm Reduction in Canada,* supra note 3.
[20] V. Bungay et al., "Women's health and use of crack cocaine in context: Structural and 'everyday' violence," *International Journal of Drug Policy* (2010) 21(4): 321-329.
[21] R. McNeil, W. Small, H. Lampkin, et al., "'People knew they could come here to get help': an ethnographic study of assisted injection practices at a peer-run 'unsanctioned' supervised drug consumption room in a Canadian setting," *AIDS and Behaviour 2014*;18:473-85.
[22] N. Fairbairn et al., supra note 37, citing N. Wright, C. N. Tompkins, L. Sheard, "Is peer injecting a form of intimate partner abuse? A qualitative study of the experiences of women drug users," *Health & Social Care in the Community* 2007, 15:417-425; C. Tompkins et al., "Exchange, deceit, risk, harm: the consequences for women of receiving injections from other drug users" Drugs, education, prevention and policy 2006, 13:281-297. See also, K. Shannon et al., "Social and structural violence and power relations in mitigating HIV risk of drug using women in survival sex work," *Social Science & Medicine* 2008;66(4):911–21.
[23] K. Freeman, C. G. Jones, et al. "The impact of the Sydney Medically Supervised Injecting Centre (MSCI) on crime," Drug Alcohol Rev. 2005 Mar;24(2):173-84.
[24] Ontario HIV Treatment Network, "What is the effectiveness of supervised injection services?" May 2014. Available at www.ohtn.on.ca/rapid-response-83-supervised-injection/.