List of Issues Prior to Reporting in Canada: Submission to the United Nations Committee against Torture

Violations of Articles 1 and 16 of *the Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment*

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INTRODUCTION

1. In advance of the adoption of the List of Issues Prior to Reporting for Canada's periodic review under the *Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment* ("Convention"), to be held during the 72nd Session (8 November 2021 - 3 December 2021), the HIV Legal Network and the Centre on Drug Policy Evaluation (CDPE) would like to provide information to the United Nations (UN) Committee against Torture on violations of Articles 1 and 16 of the Convention with respect to people who use drugs.

2. 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 those who are in prison.

3. The Centre on Drug Policy Evaluation (CDPE) works collaboratively with governments, affected communities, and civil society to improve community health and safety by conducting research and outreach on effective and evidence-based policy responses to substance use. Founded in Vancouver, Canada in 2010 as the International Centre for Science in Drug Policy (ICSDP), the CDPE is now housed within the Li Ka Shing Knowledge Institute at St. Michael's Hospital, a site of Unity Health Toronto, in Toronto, Canada.

4. We are grateful to the UN Committee against Torture for the opportunity to make this submission focusing on torturous, cruel, and inhuman treatment of people who use drugs in Canada.

CRIMINALIZING PEOPLE WHO USE DRUGS
Violations of Article 16

5. In Canada, "controlled substances" are governed by the federal *Controlled Drugs and Substances Act* (CDSA), which applies across the country. Under section 4(1) of the CDSA, unauthorized possession of a controlled substance for personal use (or "simple drug possession") is a criminal offence. The penalty for contravening this provision depends on the substance and how it is "scheduled" and can range from a fine to a maximum 7-year sentence.[1]

6. "Trafficking" is defined to include any act of selling, administering, giving, transferring, transporting, sending, or delivering of a controlled substance — or offering to do any of these things — unless authorized by a regulation, whether for a profit or for free. The maximum penalty upon conviction for trafficking, or possession for the purpose of trafficking,

[1] *Controlled Drugs and Substances Act* (S.C. 1996, c. 19). For example, Schedule I includes opioids, cocaine and other coca derivatives, amphetamines, and various other synthetic drugs, Schedule II includes various synthetic cannabinoids, Schedule III includes stimulants, sedatives, and psychedelics, and Schedule IV includes barbiturates, benzodiazepines, steroids, and the psychedelic salvia.

is life in prison. Importing, exporting, and production of controlled substances are also criminal offences, and trafficking, importing, exporting, or production in certain circumstances are subject to a mandatory minimum prison sentence.

7. While most substance use in Canada is not problematic (and national surveillance indicates there is far higher prevalence of dependence on alcohol, for which production and sale are regulated rather than criminalized[2]), it is nonetheless an offence to possess controlled substances for personal use or to sell and share controlled substances in limited quantities. In the latter case, the burden of harsher enforcement (and its associated mandatory minimum sentences) falls most heavily on those with drug dependency, particularly those who may engage in small-scale dealing to support their own drug use.[3] From 2014-2019, 542,050 drug arrests were made in Canada, of which 372,945 (or 69%) were for simple drug possession.[4]

8. Punitive drug laws and policies have fueled deadly stigma and epidemics of preventable illness and death, contributing both to significantly higher rates of HIV and hepatitis C (HCV) among people who inject drugs in Canada than among the population as a whole[5] and to an overdose crisis that has resulted in almost 20,000 overdose deaths between January 2016 and September 2020,[6] with Indigenous Peoples particularly affected.[7] Fentanyl and fentanyl analogues continue to be major drivers of overdose, with 82% of overdose deaths involving fentanyl between January and September 2020.[8] Data from drug checking services indicate an increase in unexpected and highly potent drugs in the unregulated supply. In samples expected to be opioids, Toronto's drug checking service has increasingly found benzodiazepines and related drugs, highly potent opioids including carfentanil, isotonitazene, and etonitazene, as well as synthetic cannabinoids including AMB-FUBINACA and ACHMINACA.[9] Unexpected contents in the unregulated opioid supply have also been observed by drug checking services in British Columbia.[10]

9. Although the toxic drug supply is primarily responsible for the dire number of overdose fatalities, the unregulated market is driven by Canada's long-standing policy of criminalizing drugs and the people who use them. An immense body of evidence demonstrates that the

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[2] Statistics Canada, *Mental and substance use disorders in Canada*, 2021.
[3] See, for example, *R. v. Hassard*, 2021 ABPC 21; *R. v. Etmanskie*, 2019 NSPC 74; and *R. v. Parenteau*, 2016 BCPC 88.
[4] Statistics Canada, *Police-reported crime statistics in Canada: Police-reported crime for selected offences*, Canada, 2014 and 2015, July 20, 2016; Statistics Canada, *Police-reported crime statistics, 2016*, July 24, 2017; Statistics Canada, *Unfounded criminal incidents in Canada, 2017: Police-reported crime for selected offences, Canada, 2017*, July 23, 2018; Statistics Canada, *Police-reported crime statistics, 2018*, July 22, 2019; and Statistics Canada, *Police-reported crime statistics in Canada*, 2019, October 29, 2020.
[5] See, for example, Public Health Agency of Canada, *Estimates of HIV incidence, prevalence and Canada's progress on meeting the 90-90-90 HIV targets*, 2020 and M. Trubnikov, P. Yan, C. Archibald, "Estimated Prevalence of Hepatitis C Virus infection in Canada, 2011," *Canada Communicable Disease Report*, Volume 40-19 (2014).
[6] Special Advisory Committee on the Epidemic of Opioid Overdoses, *Opioids and Stimulant-related Harms in Canada*, Public Health Agency of Canada, March 2021.
[7] See, for example, First Nations Health Authority, *First Nations Illicit Drug Deaths Rise during COVID-19 Pandemic*, July 6, 2020 and J. Tarasuk et al., "Findings among Indigenous participants of the Tracks survey of people who inject drugs in Canada, Phase 4, 2017–2019," *CCDR* Volume 47-01, January 2021.
[8] *Opioids and Stimulant-related Harms in Canada*, supra.
[9] E. de Villa, *Toronto Overdose Action Plan: Status Report 2021*, June 3, 2021; Toronto's Drug Checking Service, 2021.
[10] V. Long et al., *A Supplemental Report on British Columbia's Unregulated Drug Supply Amidst Dual Public Health Emergencies: Results from British Columbia's Community Drug Checking Service, January 2020 – October 2020*, BC Centre on Substance Use, 2020.

continued overwhelming emphasis on drug prohibition — from policing to prosecution to prisons — fails to achieve both the stated public health and public safety goals of prohibition (including reducing drug use). It also results in costly damage to the public purse, public health, and human rights. The emergence of highly potent opioids in the drug supply can be understood by the "Iron Law of Prohibition," which dictates that as law enforcement becomes more intense, the potency of prohibited substances increases.[11] Moreover, the observed displacement/replacement effect[12] indicates that the scheduling of substances is routinely followed by the emergence of new substances often posing greater harms from consumption. Given the limited availability of safe supply[13] projects providing quality-controlled alternatives to the unregulated drug market in Canada, the vast majority of people who use drugs are left to access the increasingly toxic unregulated supply. In spite of the evidence, **drug prohibition and insufficient scale-up of safe supply projects providing regulated alternatives force many people who use drugs to rely on a poisoned unregulated market for supply, subjecting them to an increased risk of overdose, and can be considered as constituting a form of cruel, inhuman or degrading treatment (Article 16).**

10. Beyond contributing to an increasingly toxic unregulated drug supply, the criminalization of personal possession and trafficking has hampered the scale-up and operation of supervised consumption services (SCS), which are settings that provide a safe, hygienic environment where people can use drugs with sterile equipment under the supervision of trained staff or volunteers to prevent the transmission of infections and overdose-related deaths. Not only have SCS been one key measure to address Canada's ongoing overdose crisis, they can also provide a refuge from various forms of violence that women who use drugs may experience on the street. In 2017, Canada replaced some of the onerous legislative requirements to operate SCS with simpler, streamlined requirements, resulting in new SCS being implemented across the country. Yet there remains a need to facilitate the scale-up of SCS nationally and to remove restrictions (imposed by the criminalization of trafficking) on assisted injection administered by SCS staff or peers and on splitting and sharing of controlled substances — restrictions which prevent people from accessing SCS and increase their risk of overdose and criminalization.

11. Notably, the provision of other harm reduction services — including drug checking — are also hampered by the criminalization of personal possession and trafficking. Drug checking services provide people who use drugs with information on the chemical composition of their drug samples to facilitate more informed decision-making.[14] Given the extreme toxicity of the unregulated drug market and staggering loss of life due to overdose fatalities, **impediments to the implementation of harm reduction interventions like supervised consumption and drug checking services push some people to use their drugs in isolation and compromise their ability to take vital safety precautions, deter people from essential health care and social supports, subject people who use drugs to increased risk of overdose, HIV and HCV infection, and other harms, further constituting a form of cruel, inhuman or degrading treatment (Article 16).**

12. During its 2016 review of Canada, the Committee on the Elimination of Discrimination

[11] J. Clayton and S. Atkins, *Drugs and Drug Policy: The Control of Consciousness Alteration*, 2007 at pp. 308–09.
[12] UNODC, *The growing complexity of the opioid crisis. Global SMART Update, Volume 24*, September 2020.
[13] Canadian Association of People who Use Drugs, *Safe Supply Concept Document*, 2019.
[14] N. Maghsoudi et al., "The Implementation of Drug Checking Services for People Who Use Drugs: A Systematic Review," *Qeios,* 2021. doi:10.32388/TXE86U.

against Women (CEDAW Committee) expressed its concern with the "excessive use of incarceration as a drug-control measure against women" and "the significant legislative and administrative barriers women face to access supervised consumption services." To address this, the Committee recommended that Canada (i) "reduce the gap in health service delivery related to women's drug use, by scaling-up and ensuring access to culturally appropriate harm reduction services"; (ii) "establish a transparent process for exemptions permitting the operation of supervised consumption services without risk of criminal prosecution of clients or service providers"; and (iii) "repeal mandatory minimum sentences for minor, non-violent drug-related offences."[15] In 2017, concerned with the disproportionately high rates of incarceration for Indigenous and Black people in Canada, the UN Committee on the Elimination of Racial Discrimination called on Canada to re-examine its drug policies and to provide "evidence-based alternatives to incarceration for non-violent drug users."[16]

13. These recommendations are in line with those made by other UN human rights bodies. For example, the UN Special Rapporteur on the right to health has stated, "[a]t the root of many health-related problems faced by people who use drugs is criminalization itself, which only drives issues and people underground and contributes to negative public and individual health outcomes."[17] Most recently, the UN Chief Executives Board for Coordination unanimously adopted a common position on drug policy calling for increased investment in harm reduction measures, respect for the dignity and human rights of people who use drugs in all aspects of drug and social policies, alternatives to conviction and punishment, including the decriminalization of drug possession for personal use, and changes in laws, policies, and practices that threaten health and human rights.[18] Similarly, the *International Guidelines on Human Rights and Drug Policy* recommend that States "decriminalise the possession, purchase, or cultivation of controlled substances for personal consumption."[19]

14. In Canada, there is strong support for the decriminalization of simple drug possession from community organizations, harm reduction and human rights advocates,[20] as well as public health associations and authorities including the Canadian Public Health Association,[21] Canadian Mental Health Association,[22] Canadian Nurses Association,[23] Toronto Board of

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[15] Committee on the Elimination of Discrimination against Women, *Concluding observations on the combined eighth and ninth periodic reports of Canada*, CEDAW/C/CAN/CO/8-9, 18 November 2016.
[16] Committee on the Elimination of Racial Discrimination, *Concluding observations on the twenty-first to twenty-third periodic reports of Canada*, CERD/C/CAN/CO/21-23, 25 August 2017 at paras. 15-16.
[17] *Open letter by the Special Rapporteur on the right of everyone to the highest attainable standard of mental and physical health, Dainius Pūras in the context of the preparations for the UN General Assembly Special Session on the Drug Problem (UNGASS), which will take place in New York in April 2016*, to UNODC Executive Director Yury Fedotov, December 7, 2015.
[18] UN Chief Executives Board for Coordination, *Segment 2: common United Nations system position on drug policy,* UN Doc.CEB/2018/2, 18 January 2019.
[19] International Centre on Human Rights and Drug Policy, UNAIDS, UNDP, WHO, *International Guidelines on Human Rights and Drug Policy*, March 2019.
[20] Canadian HIV/AIDS Legal Network, "Canada must adopt a human-rights based approach to drug policy," Statement, November, 22, 2018. The statement was endorsed by Amnesty International Canada, Canadian Aboriginal AIDS Network, Canadian Association of People Who Use Drugs, Canadian Drug Policy Coalition Canadian Nurses Association, Canadian Public Health Association, Criminal Lawyers' Association, HIV & AIDS Legal Clinic Ontario (HALCO), Moms Stop The Harm, moms united and mandated to saving the lives of Drug Users (mumsDU) and Pivot Legal Society.
[21] Canadian Public Health Association, *Decriminalization of personal use of psychoactive substances*, October 2017.
[22] Canadian Mental Health Association, *Care not Corrections*, April 2018.
[23] Canadian HIV/AIDS Legal Network et al., "Canada must adopt a human-rights based approach to drug policy," Statement, November 22, 2018.

Health,[24] Montreal Public Health,[25] Winnipeg Regional Health Authority,[26] and Provincial Health Officer of British Columbia.[27] Support for a regulated market and safe supply is also growing.[28]

Case study:
While representing only 3.3% of the population in the province of British Columbia, Indigenous People accounted for a staggering 16% of all overdose deaths in the province in the first half of 2020 and died at 5.6 times the rate of other provincial residents.[29] Not only do Indigenous Peoples who use drugs face many barriers to health care, including systemic racism and stigma, they also face far higher rates of arrest and prosecution for drug offences. Decriminalizing people who use drugs would be in line with the Truth and Reconciliation Commission of Canada's calls to Canada to "close the gap" between Indigenous and non-Indigenous communities on health indicators including addiction, to implement community-based alternatives to imprisonment, and to eliminate the overrepresentation of Indigenous People in custody.[30]

Case study:
In 2015, Cheyenne Sharma, a young Indigenous woman and single mother, was arrested for importing cocaine into Canada. Sharma accepted the assignment, for which she was paid $20,000, because she was behind in her rent and facing eviction. Her grandmother was a residential school survivor and her mother spent time in foster care. Sharma ran away from home and was raped at 13; at 15, she began selling sex. She gave birth to her daughter at 17, after which she remained unstably housed until her arrest. In light of Sharma's particular circumstances as an intergenerational survivor of colonialism and systemic discrimination, the unique history of Indigenous Peoples in Canada and the fact that this was her first offence, the sentencing judge concluded that the mandated minimum penalty of two years' incarceration for drug importation was unconstitutional.[31] Despite this ruling, Canada has yet to repeal mandatory minimum sentences for non-violent drug offence.

DENIAL OF EQUIVALENT HEALTH SERVICES TO PEOPLE WHO USE DRUGS IN PRISON

Violations of Articles 1 and 16

15. Canada's repressive approach to drugs has resulted in a significant number of people serving a federal sentence (i.e., a prison sentence of 2+ years) in relation to a drug offence.

[24] See, for example, Toronto Board of Health, *Toronto Overdose Action Plan: Status Report 2021*, June 14, 2021.
[25] Direction régionale de santé publique de Montréal, « Décriminalisation des drogues pour usage personnel, » news release, July 27, 2018.
[26] Winnipeg Regional Health Authority, *Position statement on harm reduction,* December 2016.
[27] B.C., Office of the Provincial Health Officer, *Stopping the Harm. Decriminalization of people who use drugs in B.C.*, April 2019.
[28] C. Bains, "B.C. doctor [Medical Health Officer of Vancouver Coastal Health] calls for illicit drug regulation to save lives," *Canadian Press*, July 26, 2019; CAPUD, *Safe Supply. Concept Document,* February 2019; and BC Centre for Disease Control, *2018 BC Overdose Action Exchange*, October 2018.
[29] First Nations Health Authority, *First Nations Illicit Drug Deaths Rise during COVID-19 Pandemic*, July 6, 2020.
[30] Truth and Reconciliation Commission of Canada, *Calls to Action*, 2015.
[31] *R. v. Sharma*, 2018 ONSC 1141.

An estimated 30% of women and 14% of men in the federal system are incarcerated on drug-related charges,[32] while Indigenous and Black women are more likely than white women to be in prison for drug-related offences.[33] Moreover, 80% of men entering federal prison have a substance use issue,[34] and 80% of federally incarcerated women and 92% of federally incarcerated Indigenous women report problematic substance use prior to arrest.[35] Not surprisingly, research shows that the incarceration of people who inject drugs is a factor driving Canada's HIV and HCV epidemic.[36]

16. In a 2007 national study of federal prisoners, 14% of women admitted to injecting drugs while in prison, many of whom shared their injection equipment.[37] A lack of harm reduction and other health measures, including prison-based needle and syringe programs, has contributed to significantly higher rates of HIV and HCV in prison compared to the community as a whole.[38] A 2016 study indicated that about 30% of people in federal prisons, and 30% of women and 15% of men in provincial prisons are living with HCV, and 1-9% of women and 1-2% of men are living with HIV.[39] Federally incarcerated Indigenous women, in particular, have much higher rates of HIV and HCV than non-Indigenous prisoners, with reported rates of HIV and HCV of 11.7% and 49.1%, respectively.[40]

17. Moreover, as the Correctional Investigator of Canada (Canada's ombudsperson for federal prisons) has noted, Correctional Service Canada has failed to provide adequate drug treatment, programs, and staff at a time when Canada is experiencing an unprecedented overdose crisis.[41] In the province of Ontario, for example, 1 in 10 of all overdose deaths over a seven-year span was among a recently released prisoner.[42]

18. In particular, **Canada does not provide prisoners, who are disproportionately Indigenous and Black, with equivalent access to key harm reduction measures, violating their right not to be subjected to cruel, inhuman or degrading treatment or punishment (Article 16).** As the UN Standard Minimum Rules for the Treatment of Prisoners (Nelson Mandela Rules) recommend, prisoners must enjoy the same standards of health care that are available in the community,[43] including key interventions recommended

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[32] K. DeBeck et al., "Incarceration and drug use patterns among a cohort of injection drug users," *Addiction* 2009 Jan; 104(1): 69–76.
[33] Office of the Correctional Investigator, *Annual Report of the Office of the Correctional Investigator 2014–2015*, June 26, 2015 and Office of the Correctional Investigator, *Annual Report of the Office of the Correctional Investigator 2016–2017*, June 28, 2017.
[34] *Annual Report of the Office of the Correctional Investigator 2014–2015*, ibid.
[35] Correctional Service Canada, *Substance Use Patterns of Indigenous and Non-Indigenous Women Offenders*, No RIB-19-08, June 2019.
[36] See, for example, M.W. Tyndall et al., "Intensive injection cocaine use as the primary risk factor in the Vancouver HIV–1 epidemic," *AIDS* 17,6 (2003): pp. 887–893; H. Hagan, "The relevance of attributable risk measures to HIV prevention planning," *AIDS* 17,6 (2003): pp. 911–913.
[37] D. Zakaria et al., *Summary of emerging findings from the 2007 National Inmate Infectious Diseases and Risk-Behaviours Survey*, Research Report R-211, 2010, Correctional Service of Canada.
[38] Ibid and and F. Kouyoumdjian et al, "Health status of prisoners in Canada: Narrative review," *Canadian Family Physician* 62:3 (March 2016): 215-222.
[39] "Health status of prisoners in Canada," ibid.
[40] *Summary of emerging findings from the 2007 National Inmate Infectious Diseases and Risk-Behaviours Survey*, supra.
[41] C. Bains, "Prisons fail to provide adequate addiction treatment: ombudsman," *Canadian Press*, March 20, 2019.
[42] E. Groot et al., "Drug Toxicity Deaths after Release from Incarceration in Ontario, 2006-2013: Review of Coroner's Cases," *PLoS One* 2016; 11 (7): e0157512.
[43] Rule 24 of the *United Nations Standard Minimum Rules for the Treatment of Prisoners (Nelson Mandela Rules)*, UN Doc. A/RES/70/175, December 17, 2015.

by the UN Office on Drugs and Crime (UNODC), UNAIDS and the World Health Organization (WHO), such as condoms and other safer sex supplies, initiatives to reduce the sharing and reuse of equipment used for tattooing, piercing, and other forms of skin penetration, needle and syringe programs, and opioid agonist therapy (OAT).[44] In an updated technical brief, the UNODC and other UN agencies further recommend that "[n]aloxone should be made available to people held in prison, prison staff and other people in prisons and other closed settings who might witness an opioid overdose."[45] The UN Chief Executives Board for Coordination has unanimously adopted a common position on drug policy that calls for the provision of equivalent health care services in prison settings.[46] In some cases, state obligations to safeguard the lives and health of people in custody and to protect them from ill treatment may require states to ensure a *higher* standard of care to prisoners than they may have access to outside prison, where they are not wholly dependent upon the state for protection of their health and welfare.[47]

19. In addition, incarcerated women should have access to gender-specific health care that is at least equivalent to that available in the community.[48] In relation to women in prison, the CEDAW Committee in 2016 expressed its concern with the "high rates of HIV/AIDS among female inmates" in Canada and urged Canada to "expand care, treatment and support services to women in detention living with or vulnerable to HIV/AIDS, including by implementing prison-based needle and syringe programmes, opioid substitution therapy, condoms and other safer sex supplies."

20. Affirming this right, the UN Special Rapporteur on Torture and other Cruel, Inhuman, and Degrading Treatment or Punishment has called on States to "ensure that drug dependence treatment as well as HIV/hepatitis C prevention and treatment are accessible in all places of detention and that drug dependence treatment is not restricted on the basis of any kind of discrimination," and specifically recommended that "[n]eedle and syringe programmes in detention should be used to reduce the risk of infection with HIV/AIDS."[49] The subsequent UN Special Rapporteur on Torture has also recommended that States ensure "that all harm-reduction measures and drug-dependence treatment services" and "evidence-based measures for the prevention and treatment of HIV and hepatitis C" including OAT and needle and syringe programs are available to people who use drugs in prison, "at all stages of their detention."[50]

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[44] UNODC, ILO, UNDP, WHO and UNAIDS, *Policy brief: HIV prevention, treatment and care in prisons and other closed settings: a comprehensive package of interventions*, 2013; Office of the High Commissioner for Human Rights (OHCHR) and UNAIDS, *International Guidelines on HIV/AIDS and Human Rights*, *Consolidated Version*, U.N. Doc. HR/PUB/06/9, 2006, Guideline 4, para. 21(e).

[45] UNODC, ILO, WHO, UNFPA, UNAIDS and UNDP, *Technical Brief 2020 Update HIV prevention, testing, treatment, care and support in prisons and other closed settings: a comprehensive package of interventions*, 2020.

[46] UN Chief Executives Board for Coordination, *Segment 2: common United Nations system position on drug policy,* UN Doc.CEB/2018/2, 18 January 2019.

[47] R. Lines, "From equivalence of standards to equivalence of objectives: The entitlement of prisoners to health care standards higher than those outside prisons," *International Journal of Prisoner Health* 2(4): 269-280, December 2006.

[48] Rule 10 of *United Nations Rules for the Treatment of Women Prisoners and Non-custodial Measures for Women Offenders*, UN Doc. A/RES/65/229, March 16, 2011.

[49] UN Special Rapporteur on torture and other cruel, inhuman or degrading treatment or punishment, *Report of the Special Rapporteur on torture and other cruel, inhuman or degrading treatment or punishment, Manfred Nowak*, UN Doc. A/HRC/10/44, January 14, 2009, para 74 (c).

[50] See UN Human Rights Council, *Report of the Special Rapporteur on torture and other cruel, inhuman or degrading treatment or punishment, Juan E. Méndez*. Report on the 22nd session, agenda item 3, UN General Assembly, UN doc. A/HRC/22/53, February 1, 2013 and UN General Assembly, *interim report of the Special Rapporteur of the*

21. In spite of these recommendations, access to sterile injection equipment in prison is extraordinarily limited in Canada. While acknowledging the health benefits of needle and syringe programs in prison with the introduction by Correctional Service Canada of a "Prison Needle Exchange Program" (PNEP) in some federal prisons beginning in June 2018, details of the PNEP reveal serious deficiencies that are not in keeping with public health principles or professionally accepted standards for such programs. Most fundamentally, the PNEP violates prisoners' confidentiality at many points without reasonable justification, and participation is contingent on the approval of both prison health staff and security staff.[51] According to the Correctional Investigator of Canada, "Too much of what should be an exclusively health and harm reduction program has been shaped by security concerns," leading merely a handful of individuals to enroll in the program.[52]

22. To date, only 11 out of 43 federal prisons have a PNEP and no provincial or territorial prison system in Canada offers this program. The Correctional Investigator consequently recommended that Correctional Service Canada "revisit" the program and participation criteria with the aim of "building confidence and trust, and look to international examples in how to modify the program to enhance participation and effectiveness."[53]

    Case study:
    After more than two decades of advocacy by prison health and human rights organizations, the Correctional Service of Canada introduced a "Prison Needle Exchange Program" (PNEP) in 2018 in response to a lawsuit initiated by a former prisoner and HIV organizations.[54] While the roll-out of the PNEP was a historic development, representing the first prison-based needle and syringe program in the Americas, the model adopted prioritizes security over clinical need and breaches prisoners' confidentiality at multiple points, contrary to national and international standards of medical ethics and conduct, public health principles, and best practices as described in UN guidance and elsewhere. A March 2020 interim evaluation of the PNEP revealed extremely low rates of participation: of the nine federal prisons in which the program had been implemented, only four had any participants, and three institutions had not received a single expression of interest in the program.[55] Low uptake, vocal opposition to the program from correctional officers and Canada's Official Opposition in Parliament, as well as the indefinite suspension of the PNEP during the COVID-19 pandemic mean the program remains vulnerable to cancellation, and prisoners continue to be exposed to increased risk of HIV and HCV.

23. Moreover, despite overwhelming evidence of the health benefits of OAT, and WHO guidelines that state OAT should be available to people in prison and be equivalent to

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Human Rights Council on torture and other cruel, inhuman or degrading treatment or punishment, Juan E. Méndez, submitted in accordance with Assembly resolution 67/161, UN Doc, A/68/2959, August 9, 2013 at para. 71.
[51] Canadian HIV/AIDS Legal Network, *The Correctional Service of Canada's Prison Needle Exchange Program: Policy Brief*, 2019.
[52] Office of the Correctional Investigator, *Annual report of the Office of the Correctional Investigator, 2018-2019*, 2019.
[53] Ibid.
[54] Correctional Service Canada, "Correctional Service Canada announces a Prison Needle Exchange Program," 14 May 2018.
[55] Lynne Leonard, *Evaluation of the Prison Needle Exchange Program Interim Report*, March 2020.

community treatment options,[56] federal and provincial prisoners in Canada continue to experience barriers to OAT, including long waiting lists and inappropriate medication terminations.[57] Some opioid dependent people are forced to undergo abrupt opioid withdrawal upon incarceration (in some cases, because some provincial and territorial prisons do not offer OAT to prisoners or impose severe restrictions on access[58]) or because of inappropriate medication termination, which can contribute to an increased risk of overdose.[59] In the province of Nova Scotia, for example, jails have a blanket policy of not providing prisoners with OAT unless they are already on it when they arrive.[60] As the UN Special Rapporteur has noted, "denial of medical treatment [such as methadone] and/or absence of access to medical care in custodial situations may constitute cruel, inhuman or degrading treatment or punishment and is therefore prohibited under international human rights law."[61]

24. Forced or abrupt opioid withdrawal can cause serious mental and physical pain (including severe abdominal cramping, nausea, diarrhea, anxiety, and convulsions) and can have serious medical consequences for pregnant people and their fetuses, immunocompromised people, and people suffering from co-morbid medical conditions.[62] The trauma of imprisonment, coupled with severe opioid withdrawal, can also increase the risk of suicide in opioid dependent individuals with co-occurring conditions.[63] In Canada, there are documented cases of punitive discontinuation of OAT.[64] The Special Rapporteur on torture has recognized that withdrawal symptoms can cause severe pain and suffering and that "there is an evident potential for abuse of withdrawal symptoms, particularly in custody situations, **and that the use of withdrawal symptoms may amount to torture if used for any purposes mentioned in Article 1.**"[65]

25. Access to naloxone, a medication used to counter the effects of an opioid overdose, is also critical in the context of an overdose crisis. In 2016, Health Canada reclassified its status and made naloxone available without a prescription, facilitating free, unrestricted access to naloxone through first line responders, health centres, and pharmacies.[66] However,

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[56] World Health Organization, *Guidelines for the Psychosocially Assisted Pharmacological Treatment of Opioid Dependence*, 2009.
[57] F. Kouyoumdjian et al., "Physician prescribing of opioid agonist treatments in provincial correctional facilities in Ontario, Canada: A survey," *PLoS One* 2018; 13(2): e0192431; West Coast Prison Justice Society, *Representative human rights complaint against Correctional Service Canada (CSC) on behalf of federal prisoners with opioid use disorder*, June 4, 2018; and A. Marmel and N. Bozinoff, "Punitive discontinuation of opioid agonist therapy during incarceration," *International Journal of Prisoner Health* 16:4 (2020): pp. 337 –342.
[58] Canadian HIV/AIDS Legal Network and PASAN, *Hard Time: HIV and Hepatitis C Prevention Programming for Prisoners in Canada*, 2007.
[59] C. Bodkin, M. Bonn and S. Wildman, "Fuelling a crisis: Lack of treatment for opioid use in Canada's prisons and jails," *The Conversation*, March 4, 2020.
[60] A. MacIvor, "Lawyers, advocates question why some inmates denied medication," *CBC*, August 05, 2016.
[61] UN Special Rapporteur on torture and other cruel, inhuman or degrading treatment or punishment, *supra* note 53, para 71.
[62] K. Fiscella et al., "Management of opiate detoxification in jails," *Journal of Addictive Diseases* 2005; 24:61–71.
[63] U.S. Department of Health and Human Services. *Medication-Assisted Treatment for Opioid Addiction in Opioid Treatment Programs: Substance Abuse and Mental Health Services Administration*, 2005.
[64] See, for example, *Representative human rights complaint against Correctional Service Canada (CSC) on behalf of federal prisoners with opioid use disorder*, supra; "Punitive discontinuation of opioid agonist therapy during incarceration," supra; and R. Boudjikanian, "More Canadian federal prisoners waiting for opioid treatment," *CBC News*, August 31, 2020.
[65] UN Special Rapporteur on torture and other cruel, inhuman or degrading treatment or punishment, *supra* note 53, para 57.
[66] Health Canada Prescription Drug Status Committee, *Notice: Prescription Drug List (PDL): Naloxone*, 2016.

prisoners do not receive the same standard of care. In most cases, naloxone continues to be only accessible to prison health care staff; an increasing number of prison authorities also make naloxone accessible to correctional staff. A limited number of prisoners (e.g., those who are already taking OAT or are known to correctional authorities to have a history of opioid use or overdosing) are given take-home naloxone kits only when they are released back into the community.[67] As Health Canada itself has noted, "Naloxone is a safe drug and administering naloxone to a person that is unconscious because of a non-opioid overdose is unlikely to create more harm."[68] Correctional staff will not always be immediately available in overdose situations, yet a timely response to an opioid overdose can mean the difference between life and death. **Canada's ongoing failure to provide health care for people who use drugs in prisons, including needle and syringe programs, OAT, and naloxone, are forms of cruel, inhuman, or degrading treatment or punishment (Article 16).**

RECOMMENDED QUESTIONS TO BE INCLUDED IN THE LIST OF ISSUES:

- **Does the federal government commit to decriminalizing the possession of all drugs for personal use through a full repeal of section 4 of the *Controlled Drugs and Substances Act* (CDSA)?**
- **Will the federal government commit to decriminalizing the selling and sharing of limited quantities of controlled substances?**
- **Does the federal government commit to minimizing custodial sentences and repealing all mandatory minimum prison sentences for drug offences?**
- **Does the federal government commit to providing a safe, legal, and regulated supply of drugs to curtail the harms of the unregulated drug market?**
- **Does the federal government commit to sustaining and scaling up the number of supervised consumption services (SCS) in Canada, including by providing adequate funding for these services and removing the need for a case-by-case exemption of SCS?**
- **Does the federal government commit to exempting:**
    - **the selling and sharing of limited quantities of controlled substances in SCS; and**
    - **peer-assisted injection and SCS provider-assisted injection in SCS?**
- **Does the federal government commit to sustaining and scaling up the number of drug checking services in Canada, including by providing adequate funding for these services and removing the need for a case-by-case exemption?**

[67] S. Taylor, "Correctional Service Canada expands take-home naloxone kit program for inmates," *CBC*, July 13, 2017.
[68] Government of Canada, *Frequently Asked Questions: Access to naloxone in Canada (including NARCAN™ Nasal Spray)*, June 30, 2017.

- **Does the federal government commit to implementing, maintaining, and scaling-up the following health and harm reduction measures in all prisons in Canada in accordance with best practices in public health and professionally accepted standards and in consultation with prisoner groups and community health organizations to ensure operational success, taking into account the need for culturally appropriate and gender-specific programs:**

    - **needle and syringe programs;**
    - **opioid agonist therapy;**
    - **naloxone;**
    - **supervised consumption services;**
    - **safe supply;**
    - **drug checking;**
    - **condoms and other safer sex supplies; and**
    - **safer tattooing programs?**