Provider-Assisted Injection

in Ontario's Supervised Consumption Services

FREQUENTLY ASKED QUESTIONS

HIV LEGAL NETWORK
RÉSEAU JURIDIQUE VIH

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About the HIV Legal Network

The HIV Legal Network promotes the human rights of people living with HIV or AIDS and other populations disproportionately affected by HIV, punitive laws and policies, and criminalization, in Canada and internationally. We do this through research and analysis, litigation and other advocacy, public education, and community mobilization.

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Overview

Supervised consumption services (SCS) are an effective intervention to reduce the harms associated with drug prohibition and a toxic drug supply.[1] SCS increase access to health care, promote safer consumption, and prevent overdoses and other health complications. An SCS may support multiple forms of drug consumption, including consumption by injection, inhalation (smoking), oral, and intranasal (snorting). For people who inject drugs, SCS reduce the risk of HIV and hepatitis C, soft tissue infections, venous injuries, sepsis, and overdose-related deaths.

However, a significant number of clients who inject drugs—between 14% to 49%, according to Canadian studies[2]—require more than a safe, hygienic space and access to care and services: they also require assistance with injection. This resource answers some frequently asked questions about legal liability to help SCS providers in Ontario make informed decisions about their practices related to assisted injection.

What is "assisted injection"?

In this document, "assisted injection" refers to assistance provided with the injection *itself* (i.e. puncturing the skin and/or pushing the plunger). It does not include any assistance provided with preparation, such as handling material, cleaning the injection site, applying the tourniquet, and holding the syringe—collectively referred to as "injection support." Injection support is widely practiced in SCS and is not legally contentious.[3]

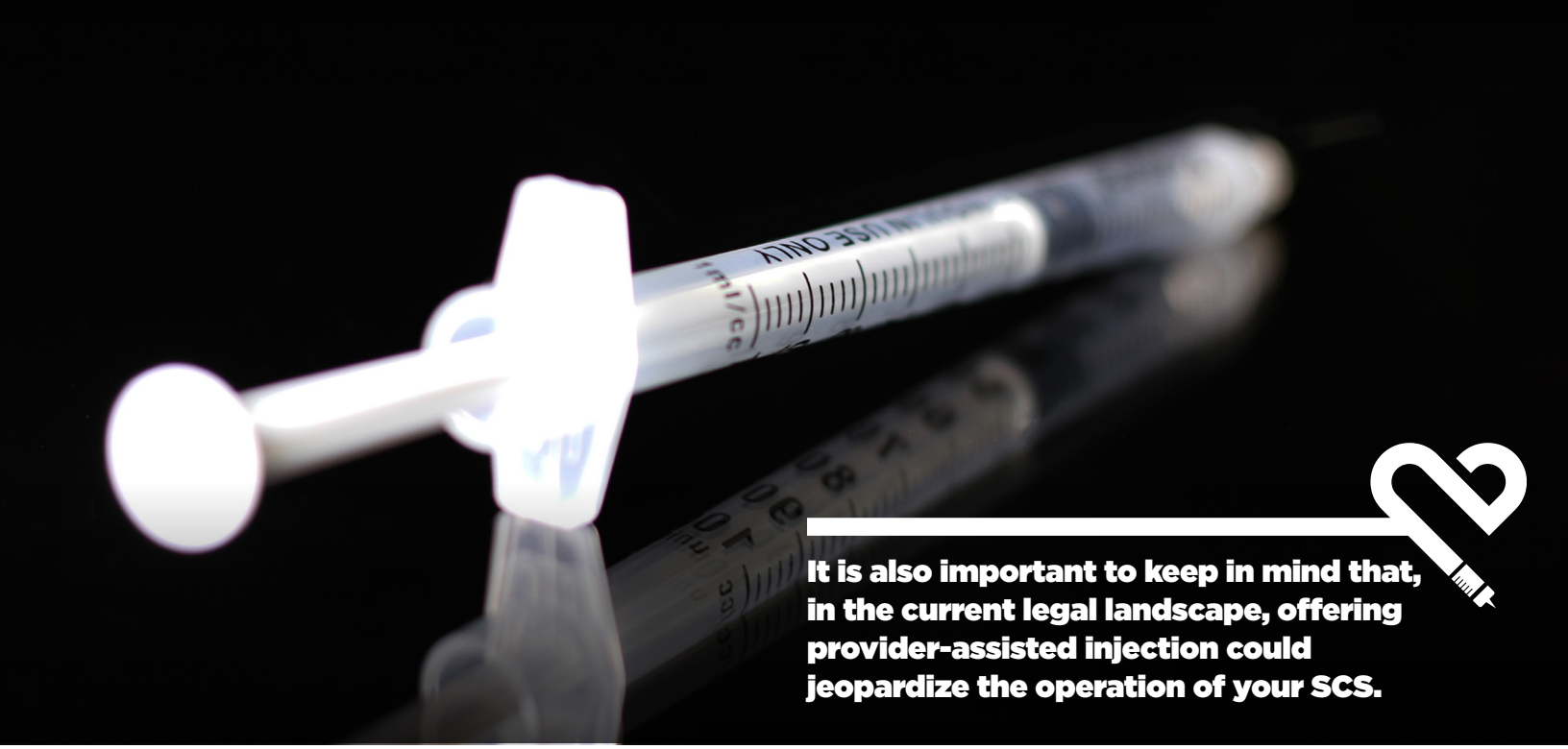
A person may require assisted injection for a number of reasons, including difficult venous access, disability, withdrawal symptoms, emotional distress, or a lack of knowledge and skills because they are usually injected by someone else (e.g. a partner, friend, or "hit doctor") or are new to injection drug use.[4] Research has shown that women, youth, people with disabilities, people experiencing homelessness, and people injecting shorter-acting substances are more likely to require injection assistance than others.[5]

Individuals who are unable to access assisted injection are less likely to use SCS and may seek assistance outside the SCS.[6] This increases the risk of equipment-sharing, injection-related injuries, HIV and HCV infection, overdose, coercion, exploitation, and street-related and gender-based violence.[7] The risk of violence and abuse is particularly high for women seeking assistance outside SCS settings, due to gendered power dynamics and other structural risks.[8]

Without access to assistance, the many benefits of SCS remain unavailable to the most vulnerable people who inject drugs, putting them at greater risk of harm.[9] This is especially concerning given the ongoing drug toxicity crisis in Ontario, and Canada, generally.

In March 2020, peer assistance became a regulated optional service within SCS in Canada, opening the door for peer-assisted injection. Health Canada defines peer assistance as "providing assistance to another in the course or preparing and consuming drugs." Peers can be "friends or other clients."[10] SCS must apply and be approved by Health Canada to offer this service. As of September 2022, peer assistance is authorized at 28 out of the 39 federally exempted SCS in Canada.[11] Research suggests that peer assistance programs within SCS are a valuable service for people who inject drugs, and can help foster empathy, compassion, trust, protectiveness, and solidarity among those accessing the program.[12]

While peer-assisted injection is now authorized within SCS, Health Canada has not done the same for provider-assisted injection.[13] In this document, "provider" refers to SCS nursing staff and SCS workers with lived experience of injection drug use, often referred to as "peer workers." Because peer workers are paid employees of the SCS, they do not fall within the definition of a "peer" for the purpose of "peer assistance" and thus would not be permitted to provide "peer assistance" at their place of work. Provider-assisted injection currently exists in a legal "grey zone":



It is also important to keep in mind that, in the current legal landscape, offering provider-assisted injection could jeopardize the operation of your SCS.

many providers do not perform assisted injection, despite frequent requests, because they are unclear about possible criminal, civil, and professional (in the case of SCS nurses) liability risks, and because they are concerned about possible pushback from management.

It is important to note that, under Ontario's *Regulated Health Professions Act*, injection of a substance is a "controlled act" that can generally only be performed by certain health professionals (e.g. nurses, physicians) in certain situations.[14] With a few exceptions,[15] non-health professionals are generally prohibited from injecting another person with a substance and can be found guilty of an offence under this act if they do not follow these limits.[16]

It is also important to keep in mind that, in the current legal landscape, offering provider-assisted injection could jeopardize the operation of your SCS. The operation of an SCS is subject to the terms approved by Health Canada. Health Canada can revoke its approval of an SCS for non-compliance with the terms of the agreement. Until Health Canada expressly permits provider-assisted injection, the provision of this service raises such concerns. As well, in Ontario, provider-assisted injection may impact a Consumption and Treatment Services' (CTS) compliance with the additional standards and protocols mandated by the provincial government.[17] It is important to consult SCS management and site policies if you are considering practicing assisted injection.

Scope: This resource was created for providers—specifically, nurses and workers with lived experience (peer workers)—to provide information about the potential criminal, civil, and professional liability risks associated with practicing assisted injection within Ontario SCS. "Nurse" includes registered nurses, nurse practitioners, and registered practical nurses. Unless otherwise specified, this document assumes that SCS staff are handling an unregulated (illicit) supply of drugs. While this resource is Ontario-specific, some of the content (particularly on criminal and civil liability) may be transferable to SCS providers in other Canadian jurisdictions.

Disclaimer: The information in this document is for **informational purposes only and does not constitute legal advice.** To our knowledge at this time, there are no publicly available decisions in criminal, civil, or professional liability cases relating to assisted injection—thus, we can only provide our best assessment of the state of the law and potential sources of legal accountability based on legislation and decided cases. **We strongly recommend that you contact a lawyer if you are considering practicing assisted injection or have further questions.**

Criminal Liability

The following section examines potential criminal liability for providers who assist with injection. In Canada, drug-related offences are set out in the *Controlled Drugs and Substances Act (CDSA)*, while non-drug-specific offences (e.g. murder, assault) are set out in the *Criminal Code*. The *CDSA* criminalizes the possession, trafficking, importation and exportation, and production of controlled substances (e.g. opioids, cocaine, methamphetamines).

In reading this section, it is important to keep in mind that, while a criminal charge may be theoretically possible, there are several practical factors that reduce (though not *eliminate*) the likelihood of criminal liability. For one, both police and prosecutors have discretion in criminal proceedings. This means that, even when there is proof of an offence, police can decide whether to lay a charge and, even when a charge is laid by police, prosecutors can still decline to prosecute. In Ontario, prosecutors can only proceed with a charge if there is a "reasonable prospect of conviction" and it is in the public interest to do so.[18] In determining if there is a "reasonable prospect of conviction," prosecutors consider the availability of appropriate evidence and witnesses, for example. Prosecutors then must decide whether proceeding is in the public interest by considering factors such as the seriousness of the incident, the views of the victim, the potential impact of the offence on the community, the accused's cooperativeness, and the accused's criminal history. In the context of assisted injection, there would likely be many public interest factors weighing against prosecution.

In addition, even if a case was prosecuted, courts would also likely weigh their decision against public interest considerations. As with other harm reduction practices within SCS, provider-assisted injection *reduces* harms associated with injection drug use, particularly in the current context of a toxic drug supply. In 2011, the Supreme Court of Canada recognized that denying access to SCS violated clients' constitutionally protected rights and endorsed the principles of harm reduction.[19] Courts *may* be alive to the principles outlined in this decision, and the reality that a conviction in these cases could have a "chilling effect" on the provision of life-saving care within SCS.

1. Why should I be concerned about criminal liability if SCS are subject to an exemption from the *CDSA* by the federal government?

A federal exemption to operate a SCS does not provide staff with blanket protection from criminal liability. SCS are permitted to operate under what's known as a "s. 56.1 exemption." Section 56.1 of the *CDSA* permits the federal government to exempt SCS providers, clients, and peers (meaning those permitted to provide "peer assistance") from certain offences in the *CDSA*, including possession (s. 4) and trafficking (s. 5), in order to enable the routine operation of an SCS.

However, these exemptions are crafted narrowly—they do not exempt clients, providers, or peers from every and all circumstance in which a charge could be laid. For instance, clients who enter the SCS are exempt from possession charges in specific circumstances, such as when possessing drugs for personal consumption, drug checking, disposal, or peer assistance. Likewise, providers are exempt from drug charges as it relates to fulfilling specific functions and duties (e.g. drug checking or disposal). Because provider-assisted injection is not currently authorized by Health Canada, providers who perform assisted injection are not exempt from the *CDSA*, unlike peers who do so at an authorized SCS.[20]

Additionally, SCS exemptions do not provide staff with protection from criminal liability for offences under the *Criminal Code* (only under the *CDSA*), which a provider may be at risk of for performing assisted injection, as discussed below.

2. Could I be charged for the mere act of providing assisted injection (i.e. even in the absence of harm)?

It is possible that providers could be criminally liable for the mere act of performing assisted injection—that is, handling and administering a syringe filled with drugs to a client—even if the client suffers no harm as a result. In this case, charges could be laid under the *CDSA*. There are two possible charges providers should be aware of: possession of drugs for personal use, or "simple drug possession" (s. 4 of the *CDSA*) and possession for the purpose of trafficking and trafficking (s. 5 of the *CDSA*).

Possession

Handling a filled syringe in order to perform assisted injection likely constitutes possession within the meaning of section 4 of the *CDSA*. As discussed above, providers are exempt from possession charges as it relates to specific functions within a SCS (e.g. disposal and drug checking); they are not protected from possession charges in the context of providing assisted injection, since Health Canada has not authorized this service. In addition, it is possible that possession charges—specifically, charges for "joint possession"[21] —could be brought against other providers who did not actually assist, but who knew that their colleague was in possession of a drug on the SCS's premises for the purposes of assisted injection and who were in a position to authorize this practice (e.g. management-level staff).

As a result of a 2020 prosecutorial policy (which applies in Ontario and across most of Canada), prosecutions for simple drug possession are only being pursued in the "most serious cases raising public safety concerns."[22] It is unclear whether provider-assisted injection would fall within this category, although one can argue that provider-assisted injection improves public safety and decreases health risks by lowering barriers to accessing SCS.

It is important to note that the federal government has decriminalized simple drug possession in British Colombia for a three-year period beginning in January 2023. During this time, people 18 and older in B.C. will not be charged for possessing up to a cumulative amount of 2.5 grams of certain drugs for personal use.[23] However, criminal charges are still possible in cases where someone possesses substances for purposes other than personal use, which would be the case where a provider assists with injection. Overall, this development does not modify the law as it applies to SCS providers, but it may further reduce the political appetite to pursue simple drug possession charges against SCS providers.

Trafficking

It is possible that providers who perform or who offer to perform assisted injection could be charged with trafficking or possession for the purposes of trafficking under section 5 of the *CDSA*. Under the *CDSA*, the definition of trafficking includes to "administer" a substance to another person, or to offer to do so.[24] More specifically, courts have interpreted trafficking to include the act of injecting another person with drugs (even when done with that person's consent),[25] as well as the act of supplying another person with a syringe containing drugs with the knowledge and intention that person will use it to self-inject.[26] It is important to note that the accused persons in these cases were facing manslaughter charges for the death of the individuals they supplied with drugs in a non-SCS context and were not facing standalone trafficking charges as is contemplated here for SCS providers who merely assist with injection without any ensuing harm to the client.

3. Could I be charged if a client experiences harm as a result of assisted injection (e.g. non-fatal overdose, infection, tissue or vein injury)?

The chances of being charged in this situation likely depend on the seriousness of the harm experienced by the client as a result of assisted injection, and whether the harm goes beyond the typical harms associated with injecting an illicit (and toxic) supply (including from self-injection). There are at least three offences providers should be aware of:

Criminal negligence causing bodily harm: If a provider shows "wanton or reckless" disregard for the life and safety of a client they assisted injecting, and as a result, that client experiences bodily harm, then it is possible the provider could be guilty of criminal negligence causing bodily harm.[27] The *Criminal Code* defines bodily harm as "any hurt or injury to a person that interferes with the health or comfort of the person and that is more than merely transient or trifling in nature."[28] Given this broad definition, injection of an illicit drug likely rises to the level of "bodily harm."

To establish whether a provider acted with "wanton or reckless" disregard, a court would likely judge the accused's conduct against that of a reasonably prudent SCS nurse or peer worker in similar circumstances.[29] Nursing staff should be aware that their conduct would likely be judged to a higher standard than peer workers based, in part, on professional nursing standards and their prior training, experience, and qualifications.[30] To reduce the risk of a charge, SCS providers should ensure their practices align with established standards on injection and any relevant organizational policies and procedures in place at the SCS.[31] Nursing staff should align their assisted injection practices with professional standards around injection to the best of their ability, or with any other relevant standards in other provinces or territories if none exist in their own jurisdiction.[32]

Administering a noxious thing: Providers should also be aware of the offence of "administering a noxious thing."[33] A court would likely consider illicit drugs to be a "noxious thing."[34] The prosecution would need to prove that a provider administered an injection with the intent of endangering the life, causing bodily harm, or annoying or aggrieving the client. Under the criminal law, someone can be said to have "intent" when they knew that a consequence was certain or substantially certain to result from their conduct, even if they did not desire that consequence.[35] In other words, a provider could be convicted of administering a noxious thing if they knew that injecting a client with an illicit substance was highly certain to cause them bodily harm, even if they did not want such an outcome. It is likely that injection of an illicit drug could be said to amount to "bodily harm" (as discussed above) and possibly to "endangering the life" of a client. However, providers may be able to argue that the availability of overdose-prevention tools and training within SCS means that foreseeability of these consequences is less certain, and that prosecution is not in the public interest.

Assault: It's possible assisted injection could be considered an assault. There are three types of assault that are relevant here: simple assault, assault causing bodily harm, and aggravated assault. In legal terms, a simple assault occurs when someone intentionally applies force to another person (e.g. injects them) without that person's consent.[36] Where this assault causes bodily harm to the person, the charge becomes elevated to assault causing bodily harm (i.e. an injury to a person's health or comfort that is not merely fleeting or trivial).[37] Similarly, an assault that "wounds, maims, disfigures or endangers the life" of someone transforms into an aggravated assault.[38] In the context of assisted injection, the charge would depend on the type of harm experienced by the client.

One important caveat in assault law is the notion of consent. Typically, there can be no offence of assault if the victim consents to the application of force by the perpetrator. While the Supreme Court has said that a victim generally cannot consent to force that could cause them serious hurt or non-trivial bodily harm, such as in the case of two people consenting to a fist fight,[39] the Court also said that this rule does not apply to someone who is consenting to "medical treatment or appropriate surgical interventions."[40] It is not clear whether assisted injection could be considered a "medical" or "surgical" treatment since the courts have never looked at this issue.

4. If a client dies following provider-assisted injection, could I be charged with murder?

First, it is important to acknowledge that there has never been a death in a Canadian SCS, and that provider-assisted injection is yet another intervention that is meant to reduce the risk of overdose-related death. In the unlikely situation that a client died following provider-assisted injection, the chances of a provider being charged with murder are very slim. To convict someone of murder, the Crown prosecutors would need to prove that the provider performed

assisted injection intending to cause the client's death or intending to cause bodily harm that they knew was likely to cause the client's death.[41] In the case of murder, a person has "intent" if they have "subjective foresight of death,"[42] meaning they knew death was likely following assisted injection. It is unlikely that a provider would ever have this level of certainty of the risk of death when assisting with injection.

5. If a client dies following provider-assisted injection, could I be charged with manslaughter or criminal negligence causing death?

It is possible in this case that a provider could face a charge of manslaughter, specifically what is called "unlawful act" manslaughter.[43] Under this type of manslaughter, a prosecutor would need to prove that the provider committed an unlawful act that caused someone's death and that the provider could have reasonably foreseen that this act risked causing non-trivial bodily harm.[44] In the context of provider-assisted injection, the underlying unlawful act would likely be trafficking, assault, or a regulatory offence under a provincial health act.[45] Courts have established that trafficking drugs by injecting a controlled substance into another person is a sufficiently dangerous underlying act to meet the requirements for unlawful act manslaughter.[46] However, these cases involved drug use among people who use drugs in non-SCS settings, and this question has never been considered in the context of injection within an SCS.

It could be argued that a provider could not have reasonably foreseen the risks of non-trivial bodily harm because, as the Supreme Court has recognized, the "risk to injection drug users of death and disease is reduced when they inject under the supervision of a health professional."[47] Additionally, the risks of prosecution could be lowered by taking several precautionary measures before injecting the client (e.g. ensuring you are properly trained to inject, advising the client on safer injection practices, and making sure you are capable of responding in the event of an overdose).[48] Nonetheless, prosecutors may argue that the risk of non-trivial bodily harm is a reasonably foreseeable outcome of administering an injection of illicit substances, particularly given the current context of a toxic supply, and this is why precautions are taken in the first place.

A charge of criminal negligence causing death can also be brought against an individual when they cause the death of another person by acting in a way that shows "wanton or reckless disregard for the lives or safety of other persons."[49] The prosecutors would need to prove a "marked and substantial" departure from the conduct of a reasonable person in the accused's circumstances (in this case, a reasonable SCS nurse or peer worker).[50] Please refer to the discussion of "criminal negligence causing bodily harm" in Question 3 for more information on potential measures to reduce the risks of conduct not being found reasonable.

6. Could I be charged for helping my colleague practice assisted injection?

Yes, it is possible. A person can be found guilty of an offence if they "aided" or "abetted" someone else in the commission of that offence.[51] A person aids or abets when they do something (or fail to do something) with the intent to assist or encourage the perpetrator to commit an offence.[52] The criminal law does not distinguish between people who actually commit an offence, and those who aid or abet a person committing an offence: both parties will be equally liable under the *Criminal Code* or the *CDSA*. This means that a provider who helps or encourages a colleague in providing assisted injection could face the same potential charges as their colleague.

7. Are the risks of criminal liability reduced if I am handling a safe supply?

Likely yes. Many of the *Criminal Code* offences relevant to provider-assisted injection require an actual harm or injury to have occurred, or the presence of a foreseeable risk of harm or injury arising from the act of injection. The risks of harm associated with safe supply are substantially lower than for an illicit supply, since its production is regulated, and its contents and dose are clearly defined. Thus, the probability that an actual harm will occur is lower, as is the foreseeability of a risk of harm, meaning that a provider who administers a safe supply likely faces a reduced chance of criminal liability.

Civil Liability

Civil liability refers to disputes between two private parties (where one party sues another party for alleged wrongdoing). In theory, there is a risk that a client (or someone on the client's behalf) could sue a provider in "torts" for harms arising from assisted injection, depending on the circumstances. A tort is an act or omission that causes harm to another person and gives rise to civil liability. The remedy often sought in these types of claims is monetary compensation. Many of these civil liability risks are not unique to provider-assisted injection and exist for most services provided within an SCS. It is important to keep in mind that these claims are usually only initiated when a party feels wronged. To date, there have been no known civil lawsuits in Canada related to assisted injection.

1. Could a client sue me if they experience a harm as a result of assisted injection?

Theoretically, it is possible that a client could sue a provider and/or the SCS for harm experienced as a result of assisted injection. There are two possible civil suits that could be brought, depending on the circumstances: (1) battery or (2) negligence.

Battery: Under the tort of battery, a provider could be liable for harm if they carried out assisted injection without a patient's full and informed consent (except in the case of an emergency).[53] However, this is unlikely given that provider-assisted injection would generally only be carried out where it was requested by the client, who would be aware of the risks of such a procedure. A provider would likely only be liable for battery where they made no attempt to obtain consent from the client before injecting, lied to the client about the risks, or injected the client in a manner that went well beyond the boundaries of their consent (e.g. injecting in a vein that the client explicitly asked not to use).

Negligence: A provider could also be civilly liable—whether for the act of injecting itself, or for any harm flowing from injection—under the tort of negligence. A provider could be found negligent where, in performing assisted injection, they acted in a way that fell below what a "reasonable and prudent" SCS provider of the same experience would have done in the circumstances.[54] It is important to note that what is considered "reasonable and prudent" will likely differ depending on the qualifications of the provider—that is, SCS nursing staff are likely to be held to a higher standard than peer workers with lived experience, given their professional qualifications and education. Nevertheless, healthcare providers are not expected to be perfect and are not responsible for every bad outcome experienced by a client.[55]

It's not clear whether the sole act of performing an injection could be considered negligent: current cases have been limited to improperly injected substances and not proper administration of illicit substances.[56] It's more likely that a provider would be found negligent where their assistance fell far below standard practices, causing the client significant additional and unnecessary harm than typically experienced.

2. Are there any ways to reduce the risk of civil liability?

To reduce the risks of civil liability, SCS providers should ensure they obtain clients' informed consent to assisted injection. To do so, providers should clearly and fully outline the risks of assisted injection to each client (such as the risks of the injection, the challenges of locating good veins, the unknown concentration and active ingredients of the substance, etc.). Clients must give consent freely, with a full understanding of the procedure and its risks, and their consent should be specific as to what the SCS provider may do (e.g. venipuncture only, venipuncture and administration). Assistance should be provided in continuous conversation with the client to ensure verbal approval is obtained at each step of assistance.

In addition, the law provides for a defence known as "voluntary assumption of risk." Since a client would need to procure their own drugs, bring them to an SCS, and then request assistance with injection of a self-determined quantity of drugs, it is likely that clients would be held to have taken on the risks associated with assisted injection. SCS could also implement client waivers that discharge the client of the right to sue the person assisting them, the SCS, or its staff if harm befalls the client as a result of the substance itself.[57] However, an improperly performed injection could still leave the staff member open to liability, regardless of whether a waiver was signed.

Finally, SCS providers should do their best to align their assisted injection practices with established standards. Ideally, these standards would be set out in practice policies set by the SCS, or in professional standards articulated by regulatory bodies in the case of SCS nurses. Practice policies drafted by the SCS could include training requirements and procedures for providing assisted injection. However, professional standards or procedures set by regulatory bodies do not currently exist in Ontario. Instead, an SCS provider could look to other jurisdictions in Canada where clearer professional guidance exists. At the very least, it would be helpful to align your practice with administration standards and protocols for regulated substances and with common best practices followed by the injection drug use community.

3. Do Good Samaritan laws reduce the chances of civil liability?

Likely not. Most provinces in Canada have enacted Good Samaritan legislation, which generally precludes individuals from civil liability for injury or death for providing emergency assistance in certain circumstances. For example, Ontario's *Good Samaritan Act, 2001* protects individuals from civil liability when they provide "emergency first aid assistance to a person who is ill, injured or unconscious as a result of an accident or other emergency" at the scene of the emergency, provided their conduct is not grossly negligent.[58] However, even assuming that assisted injection falls into this situation—which it likely would not—this protection only applies to people who are acting without any expectation of compensation. SCS staff could not be classified as such since they are employed by the SCS. Additionally, this law does not protect "health care professionals" who are within health care facilities at the time of the emergency, a classification that could apply to an SCS.

4. Is there a risk of civil liability to my employer if I practice assisted injection?

Yes. Organizations can be held vicariously liable for the torts of their employees when these people are acting in the course of their duties. Thus, an SCS could be civilly liable if one of its staff members performed their duties negligently and caused harm (including, but not limited to, assisted injection).

5. Would the costs associated with a civil lawsuit be covered by insurance?

Likely not. Regulated health professionals (e.g. nurses and physicians) working within an SCS are required to possess professional liability insurance as a condition of licensing. In addition, the SCS itself likely also possesses general liability insurance. These policies are designed to protect the insured organization or individual from having to pay out-of-pocket for being sued. However, these policies often state that, if liability arises as a result of illegal activity, the insurance coverage is void. As discussed above, there are several potential criminal liability implications associated with assisted injection, which would likely void coverage. The best practice would be to consult your insurer.

6. Could I be sued for declining to provide assisted injection?

Likely not. The law of negligence sometimes imposes a "positive duty of care," meaning a person has an obligation to act in order to avoid being negligent. This duty is only applied to certain people in certain situations where there exists some measure of control, such as a parent in relation to their child. There also exists a positive duty for people that "exercise a public function…that includes implied responsibilities to the public at large."[59] While SCS providers may fall within this group, they do not create or control the risks associated with injection drug use. There are numerous criminal and civil considerations that SCS providers need to weigh before assisting with client injection, and it would be unreasonable to expect all SCS providers to act despite these risks.

Professional Liability

The following section discusses the potential professional liability considerations for SCS nurses licensed to practice by the College of Nurses of Ontario (CNO), including Registered Nurses (RNs), Nurse Practitioners (NPs, categorized as a sub-class of RNs and also referred to as "Extended Class" nurses in Ontario), and Registered Practical Nurses (RPNs).[60]

1. What am I permitted to do under my scope of practice related to injection generally?

Within the nursing scope of practice,[61] nurses are authorized by the *Nursing Act* to perform certain "controlled acts." This includes the controlled act of "administering a substance by injection."[62] However, with a few exceptions, RNs and RPNs are generally only permitted to administer an injection after they obtain an order from someone with prescribing authority (physician, dentist, chiropodist, midwife, or NP).[63] An order is a prescription for a procedure, treatment, drug, or intervention.[64] Medication orders can be direct orders (apply to one client), or directives (apply to more than one client)—but orders for the administration of controlled substances must be direct orders.[65]

NPs have a broader scope of practice. Unlike RNs and RPNs, NPs can initiate certain controlled acts on their own, without an order. In the case of the controlled act of administration, NPs are authorized to initiate or order an injection so long as there is a nurse–patient relationship and the injection is for "therapeutic purposes."[66] For these reasons, many of the concerns expressed in this section relating to obtaining appropriate authority for injection are more applicable to RNs and RPNs.

It is important to note that having the proper authority to perform an injection does not automatically mean it is appropriate to do so—nurses must ensure they are also adhering to the CNO's practice standards when performing any procedure within their scope of practice.[67] Importantly, before administering an injection, nurses must ensure they: have the proper knowledge, skill, and judgment to safely perform the injection; assess environmental supports; and assess client factors, including consent.[68] For instance, nurses must assess the appropriateness of medication by considering the client, the medication itself, and the environment in which it is to be administered, and must take appropriate action to minimize the risk of harm in case of an adverse reaction.[69] It is considered professional misconduct to perform a controlled act without the proper authorization,[70] or to act in contravention with a practice standard.[71] For more details, please refer to the CNO's *Medication* practice standard.[72]

2. Is assisted injection currently permitted under my scope of practice as a nurse in Ontario?

Under a strict reading of the relevant practice standards and legislation, nurses are not permitted to practice assisted injection in Ontario. RNs and RPNs can generally only perform the controlled act of administering a substance upon receiving an order from someone with prescribing authority (unless, as discussed in Question 3 below, the situation falls within an exception).[73] Without a direct order from a physician or NP, for example, SCS nurses would not be authorized to inject someone with a controlled substance. However, since a prescription could not be written for a drug obtained on the unregulated market, provider-assisted injection would not be permitted under the regulatory framework governing nurses.

In addition to lacking the proper authority, assisted injection of unregulated controlled substances would likely fail to meet the CNO's practice standards, particularly the medication standard.[74] While experienced SCS nurses may have the skill and judgment to perform assisted injection, without a very clear understanding of the composition and strength of the substance they are injecting, it's unlikely nurses would be considered as having the "knowledge" required to ensure injection could be done safely.

3. Could it be argued that assisted injection is a routine activity of living, and thus does not require an order?

Possibly, but this has not been tested before. The *Regulated Health Professions Act* provides several exceptions in which a person (nurse or not) is able to perform a controlled act without proper authorization. Nurses (and non-regulated individuals, such as peer workers) are permitted to administer a substance via injection without an order when assisting a person with their "routine activities of living."[75] Procedures are considered to be routine activities of living when "the need for, response to, and outcome of the procedure have been established over time and are predictable."[76] For instance, administering insulin injections to someone with well-controlled diabetes over an extended period of time is considered to be a routine activity of living, so long as the dosage and type of insulin do not require frequent adjustment.[77] SCS nurses could argue that injecting an individual who routinely uses drugs via injection with the same dosage and type of drugs is a routine activity of living. This line of argument is strongest for nurses administering a safe supply, where there is consistency in terms of dosage and type of drug. However, it is unlikely this would apply to assisted injection involving unregulated drugs.

In addition to routine activities of living, nurses can also administer an injection without an order when rendering "temporary assistance in an emergency."[78] It's not clear whether assisted injection could be considered as such. If a nurse routinely performs assisted injection for a client, it is unlikely to be classified as "temporary assistance." As well, unless the situation rose to level of imminent danger to the client, the circumstances in which the need for assisted injection arose would not likely be considered an "emergency."

4. As an RN, I can insert an IV without an order. Could assisted injection fall under this authorization, too?

RNs (but *not* RPNs) can independently initiate venipuncture in the narrow circumstances of establishing peripheral intravenous access and maintaining patency using a 0.9% saline solution, and only when the client requires medical attention and delaying venipuncture is likely to be harmful.[79] However, this likely cannot be interpreted broadly to include assisted injection. This exception permits an RN to establish intravenous access in *anticipation* of treatment being prescribed imminently—not to actually administer a treatment (e.g. a controlled substance). The authorized procedure is "establishing the access, not using the solution as a form of treatment."[80] RNs under this exception are still not able to determine the solution and rate of solution.[81] As a result, it is unlikely that this provision allows RNs to administer a substance, even a regulated one, without an order

5. Could the CNO's *Code of Conduct* be interpreted as offering support for assisted injection?

A liberal interpretation of the CNO's *Code of Conduct* could potentially be read as offering support (but not permission) for assisted injection: nurses are to "listen and collaborate with patients," "advocate for patients and help them access appropriate health care," and understand and work to address the gaps between patient care and health outcomes in certain communities.[82] Although there is no explicit mention of harm reduction, nurses could interpret these principles as being loosely supportive of assisted injection; the provision of assisted injection is responsive to the needs of clients and can help improve access to SCS by limiting the gap between health offerings and outcomes, especially for the most marginalized SCS users. Yet, it is important to note that the *Code of Conduct* does not offer explicit condonement of the practice of assisted injection.

6. Are the risks of professional liability lowered if I am assisting injection of a safe supply?

Yes, likely. Generally, RNs and RPNs may only administer a controlled substance if they have obtained an order to do so from a prescribing authority in accordance with their scope of practice.[83] Thus, a direct order to administer a prescribed safe supply intravenously would likely give an RN or RPN sufficient authority to perform assisted injection, similar to any other situation involving a medication administration order. However, in the situation where a client arrives at the SCS with a prescribed safe supply that is not intended for injection (e.g. oral safe supply), the risk of professional liability would remain since this would be acting without proper authorization.[84]

In any case, administering a safe supply would also be more conducive to ensuring one's practice is aligned with the required professional standards, including competency and safety requirements, since the substance type and dose would be more easily identified.

7. If I perform assisted injection, what are the risks of professional discipline by the CNO?

It is not clear. Nurses may be subject to professional discipline when they contravene or fail to meet a standard of practice of the profession or a provision of the *Nursing Act*, the *Regulated Health Professions Act*, or regulations under either of those acts.[85] Assisted injection would likely be considered a contravention of the *Nursing Act* and its regulation[86] and/or of relevant practice standards, specifically the medication standard. It is also an act of professional misconduct to be convicted of a criminal offence[87] which, as discussed above, is a possible outcome of providing assisted injection. Thus, a nurse who performs assisted injection *could* be subject to professional discipline on several grounds.[88]

There have been no reported discipline decisions related to assisted injection, so it is difficult to assess the risk of professional discipline by the CNO. However, there have been several cases in which nurses in non-SCS settings have been found to have committed professional misconduct for administering a (non-illicit) substance without an order or other authorization.[89] In one case, a nurse was found to be in breach of the standards of practice, specifically the medication standard, for administering a fentanyl patch on one occasion and Haloperidol injections on four occasions, without an order, and for failing to document these incidents.[90] The disciplinary panel found that the nurse's conduct could be regarded as "disgraceful, dishonourable or unprofessional," and that her actions were "deliberate" and showed "clear disregard for the limits on her scope of practice bestowed on her." Further, they stated that:

> "...the Member's persistent and ongoing disregard for the practice standards with regard to medications and documentation, as well as her cavalier attitude towards administering psychotropic medications, is a matter of grave concern. The fact that this misconduct occurred repeatedly and in increasingly casual circumstances brings into question the Member's governability. By practi[s]ing outside her scope of practice, the Member put a number of clients at risk of serious harm or death."

In another decision involving a nurse who performed injections of Xeomin without proper authorization, the disciplinary panel stated that "engaging in controlled acts without proper authorization ... will not be tolerated."[91]

Despite these cases, it is not clear what the CNO's appetite would be for pursuing professional misconduct allegations against SCS nurses who perform assisted injection. While SCS nurses who practice assisted injection would be "deliberately" and "repeatedly" performing unauthorized injection, they would be doing so to reduce the risks of harms or death and not in a "cavalier" fashion. For that reason, it seems unlikely that a panel would find a nurse's conduct in these circumstances to be "disgraceful, dishonourable or unprofessional," especially given the ongoing drug toxicity and overdose crisis.

It's likely that the risks of professional discipline would decrease if Health Canada was to authorize provider-assisted injection within SCS—but until this happens, nurses should be aware that there are likely several grounds on which the CNO could allege professional misconduct.

8. If I am reprimanded by the College for performing assisted injection, what are the potential repercussions?

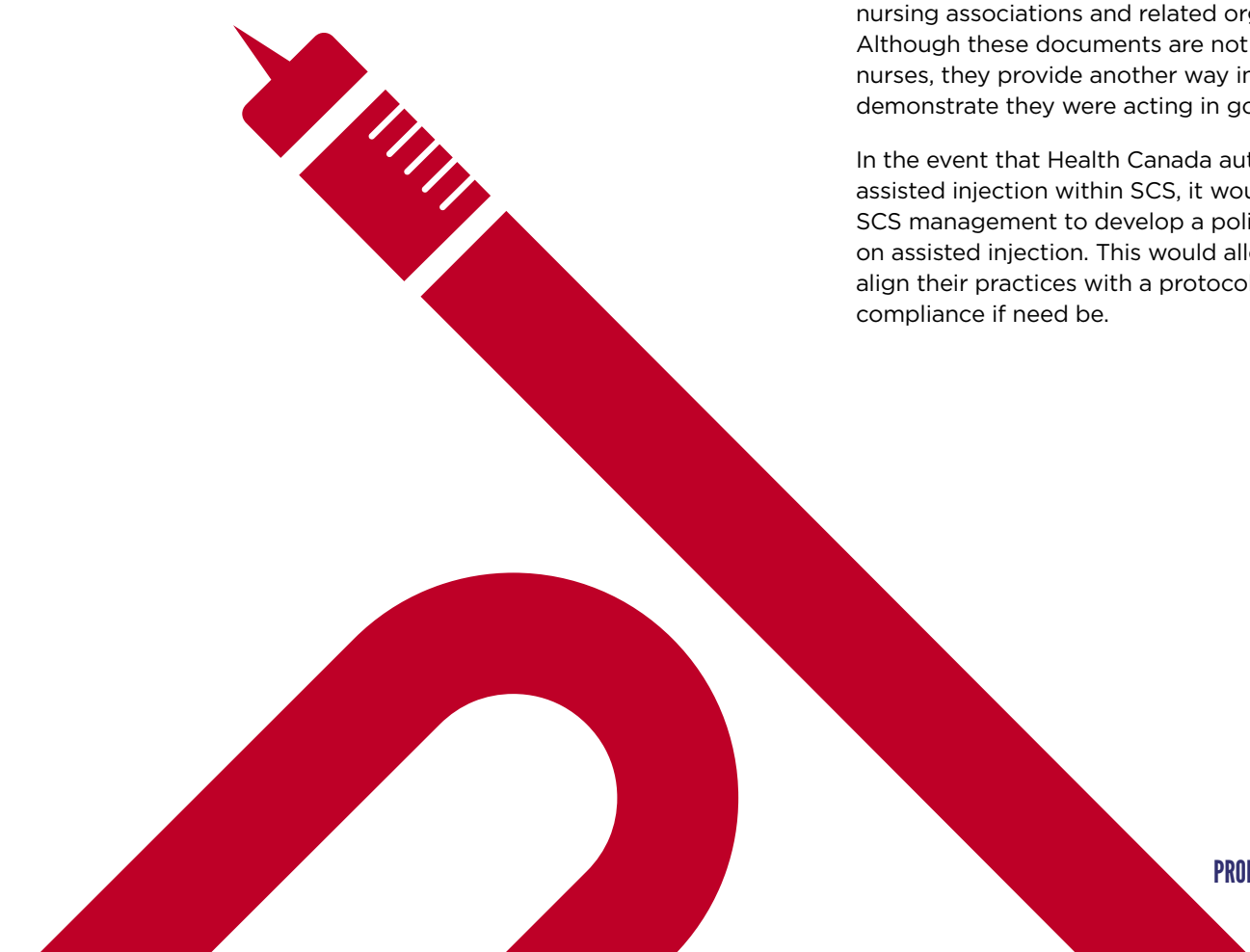
Since there have been no reported cases in this area, it is unclear what disciplinary action the CNO would take. However, in previous cases where nurses administered substances without an order (in non-SCS settings), penalties have included: a suspension for three to four months, an oral reprimand, imposition of terms and conditions on the nurses' licence, requirements to undergo a number of educational or mentorship requirements, a 12- to 24-month period in which the nurse was required to notify employers of the disciplinary decision against them, and revocation of the nurse's licence in the most serious of cases.[92] Based on a scan of disciplinary committee decisions where physicians, nurses, nurse practitioners, and pharmacists performed actions without appropriate authority, the penalty often depends on a number of factors and circumstances, such as the individual's participation and cooperation in the investigation and hearing, admission of wrongdoing and desire to do better, whether the error was negligent, intentional, or a mistake, and whether the breach was for the individual's personal gain.[93]

9. If I decide to perform assisted injection, what are the ways I can reduce the risk of professional discipline?

To reduce the risks of professional liability (or at least to reduce the severity of disciplinary action), nurses who decide to practice assisted injection could take steps to ensure they comply with the CNO's practice standards, particularly the medication standard, as much as possible. For example, aligning one's practice with the competency standards could mean ensuring an evidence-informed approach to assisted injection, assessing the appropriateness of assisted injection for each client, and declining assistance when outside your competence. As with any procedure, it is critical that nurses do not act outside of their knowledge and skill level. To comply with safety standards, nurses could seek information from clients about their drug use, continue to provide clients with education about safe injection, and collaborate with clients to make decisions about the provision of assisted injection, in addition to upholding existing SCS safety measures. Performing drug checking before providing assistance may be an additional way of aligning your practice with the competence and safety standards.

It would also likely benefit nurses to align their practices with relevant harm reduction guidelines and best practice recommendations published by nursing associations and related organizations.[94] Although these documents are not legally binding on nurses, they provide another way in which nurses can demonstrate they were acting in good faith.

In the event that Health Canada authorizes provider-assisted injection within SCS, it would be advisable for SCS management to develop a policy or procedure on assisted injection. This would allow nursing staff to align their practices with a protocol and demonstrate compliance if need be.



References

[1] In this document, "SCS" includes Consumption and Treatment Services (CTS). In Ontario, federally exempted SCS are referred to as CTS if that they comply with standards, protocols, and other requirements set by the provincial government, and receive provincial funding to operate.

[2] M.C. Kennedy et al., "Assisted injection within supervised injection services: Uptake and client characteristics among people who require help injecting in a Canadian setting," *The International Journal of Drug Policy* 86 (2020): 102967-102967.

[3] M. Gagnon et al., "Nurse-Assisted Injection: A Path to Equity in Supervised Consumption Services," (2022).

[4] R. McNeil 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 Behavior*, 18(3) (2014): 473–485.

[5] *Ibid;* M.C. Kennedy et al., supra note 2.

[6] A. Mitra et al., "Requiring help injecting among people who inject drugs in Toronto, Canada: Characterizing the need to address socio-demographic disparities and substance-use specific patterns," *Drug and Alcohol Review* (2022); E. Pijl et al., "Peer-assisted injection as a harm reduction measure in a supervised consumption service: A qualitative study of client experiences," *Harm Reduction Journal* 18(1) (2021); R. McNeil et al., supra note 4; W. Small et al., "Injection drug users' access to a supervised injection facility in Vancouver, Canada: the influence of operating policies and local drug culture," *Qualitative Health Research* 21(2011):743–56.

[7] In one study from Vancouver, people who could not self-inject often turned to hit doctors for assistance in street and off-street settings, leading to violence, exploitation, and increased vulnerability to infectious diseases (R. McNeil et al., supra note 4). See also: Small et al., supra note 6; M.C. Kennedy et al., supra note 2.

[8] R. McNeil et al., supra note 4.

[9] M. Gagnon, "It's time to allow assisted injection in supervised injection sites." *CMAJ : Canadian Medical Association journal = journal de l'Association medicale canadienne* 89,34 (2017): E1083-E1084.

[10] Health Canada, "Supervised consumption sites: Status of applications," updated 11 August 2022.

[11] *Ibid*, filtered by sites that offer Peer Assistance, as of 14 September 2022.

[12] E. Pijl et al., supra note 6.

[13] Health Canada's definition of "peer assistance" states that "employees of a supervised consumption site do not directly administer the drugs."(Health Canada, supra note 10). Additionally, in SCS approval agreements we reviewed as part of our research, only "peers" (friends or other clients) are specifically exempted from drug charges for assisting with injection within SCS, and not staff.

[14] SO 1991, c 18, s. 27(2).5.

[15] For example, a person can administer a substance by injection if they are giving first aid or temporary assistance in an emergency, treating a member of their household, or assisting someone their routine activities of living (*Regulated Health Professions Act*, s. 29(1)).

[16] *Regulated Health Professions Act*, s. 40(1).

[17] A compliance analysis of assisted injection under the rules governing CTS is not within the scope of this FAQ. For more information: Ontario Ministry of Health, "Consumption and Treatment Services Compliance and Enforcement Protocol, 2021," June 2021.

[18] Ministry of the Attorney General of Ontario, *Crown Prosecution Manual: Charge Screening*, 14 November 2017.

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

[20] One exemption we reviewed explicitly stated that "only peers may administer an illegal substance for the purposes of peer assistance" and that failure to obey the terms of the exemption may "constitute an offence under the *CDSA*."

[21] *Criminal Code,* RSC 1985, c C-46, s. 4(3)(b).

[22] Public Prosecution Service of Canada, *Public Prosecution Service of Canada Deskbook*, "5.13 Prosecution of Possession of Controlled Substances Contrary to s. 4(1) of the *Controlled Drugs and Substances Act*, " 17 August 2020. The "most serious" cases justifying criminal prosecution include conduct that: poses a risk to the safety or well-being of children or young people; puts the health and safety of others at risk (e.g. operating a vehicle or operating machinery while impaired); poses a risk to a community's efforts to address consumption of drugs, particularly in isolated or remote communities; is associated with another *CDSA* or *Criminal Code* offence; is in breach of rules in regulated setting like a custodial facility, jail, or penitentiary; or is committed by a peace officer or public officer if relevant to the discharge of their duties.

[23] Health Canada, "Exemption from Controlled Drugs and Substances Act: Personal possession of small amounts of certain illegal drugs in British Columbia (January 31, 2023 to January 31, 2026)," 31 May 2022. Under the terms of the agreement, opioids, cocaine, methamphetamine, and MDMA are exempted from criminal charges for personal possession.

[24] *CDSA*, SC 1996, c 19, s. 2(1).

[25] *R. v. Creighton*, [1993] 3 S.C.R. 3. In this case, the accused injected cocaine into the forearm of a companion, with her consent. She subsequently began to convulse and stopped breathing. The accused tried unsuccessfully to resuscitate her, and refused to call for emergency assistance. The act of injecting the victim with cocaine was considered "trafficking." and the accused was found guilty of manslaughter as her death was a direct consequence of this trafficking.

[26] *R. v. Worrall*, 2004 CanLII 66306 (ONSC). In this case, the accused was found guilty of manslaughter on the basis that he trafficked heroin by preparing a syringe of heroin for his stepbrother, and either injected him with it or provided it to him for the purposes of self-injection (the evidence at trial was unclear). His stepbrother was later found dead with heroin in his system. The accused had helped inject his stepbrother, who was described as an "inexperienced user," with heroin on earlier occasions.

[27] *Criminal Code*, ss. 219(1), 221.

[28] *Criminal Code*, s. 2.

[29] See e.g. *R. v. Javanmardi*, 2019 SCC 54 at para 38, where a naturopathic doctor's conduct was judged based on that of a "reasonably prudent naturopath in the circumstances."

[30] *Ibid,* at paras 39–41.

[31] SCS management could help reduce the risks of liability by establishing clear guidelines on assisted injection, so that providers can align their practices with these standards and demonstrate compliance if need be.

[32] *R. v. Javanmardi*,, at para 41. The Supreme Court held that Ms. Javanmardi's conduct was reasonable based, in part, on the fact that she followed naturopathic standards from other provinces, since none were available in Quebec where naturopathic medicine is unregulated.

[33] *Criminal Code*, s. 245(1)(a), 245(1)(b).

[34] *R. v. Burkholder*, [1977] 2 AR 119 at paras 22–25: A noxious thing is defined as something capable of endangering life, causing bodily harm, or aggrieving or annoying a person.

[35] *R. v. Buzzanga and Durocher*, [1979] OJ No 4345 (QL).

[36] *Criminal Code*, s. 265(a).

[37] *Criminal Code*, ss. 2, 267(b).

[38] *Criminal Code*, s. 268(1).

[39] *R. v. Jobidon*, [1991] 2 SCR 714.

[40] *Ibid*, at 767.

[41] *Criminal Code*, ss. 229(a)(i), 229(a)(ii).

[42] *R. v. Martineau*, [1990] 2 SCR 633.

[43] *Criminal Code*, s. 222(5)(a).

[44] *Ibid*; *R. v. Creighton*, supra note 25, at 42–43.

[45] In *R. v. Javanmardi*, supra note 29, the Supreme Court agreed that, for the purposes of manslaughter, a naturopath committed an unlawful act by administering an intravenous injection when she did not have authority to do so under Quebec's *Medical Act*. As discussed in the Overview section, it is likely that provider-assisted injection would be an offence under Ontario's *Regulated Health Professions Act*, and thus could serve as the "unlawful act" in a manslaughter case.

[46] *R. v Creighton*, supra note 25; *R. v. Worrall,* supra note 26.

[47] *Canada (Attorney General) v. PHS Community Services* Society, supra note 19, at para 131.

[48] *R. v. Javanmardi*, supra note 29.

[49] *Criminal Code*, ss. 219(1), 220. It is also possible that a provider could be charged with criminal negligence manslaughter, which is "indistinguishable" from the offence of criminal negligence causing death (*R. v. Plein*, 2018 ONCA 748, at para 26).

[50] *R. v. Javanmardi*, supra note 29, at paras 21–23.

[51] *Criminal Code*, s. 21.

[52] *R. v. Briscoe*, 2010 SCC 13, at para 14.

[53] *Hopp v. Lepp*, [1980] 2 SCR 192; *Reibl v. Hughes*, [1980] 2 SCR 880.

[54] *Levac v. James*, 2016 ONSC 7727 (CanLII).

[55] *Ibid*, at para 150.

[56] See e.g. *Wilcox v. Cavan*, [1975] 2 SCR 663 (dealing with a nurse who purportedly negligently injected a medication into the plaintiff, but the plaintiff's claim failed); *Sisters of St. Joseph v. Villeneuve*, [1975] 1 SCR 285 (finding a doctor negligent for his decision to inject sodium pentothal into a moving child, the nurses not being found liable).

[57] *Kelliher v. Smith*, [1931] S.C.R. 672; *Dyck v. Manitoba Snowmobile Association*, [1985] 1 S.C.R. 589; *Dube v. Labar*, [1986] 1 S.C.R. 549; *Crocker v. Sundance Northwest Resorts Ltd*., [1988] 1 S.C.R. 1186.

[58] *Good Samaritan Act*, 2001, S.O. 2001, c 2.

[59] *Childs v. Desormeaux*, 2006 SCC 18 at para 37.

[60] While some of the analysis in this section may be transferable to other Canadian jurisdictions, this section is specific to the regulatory framework in Ontario and may not be applicable in your province or territory.

[61] The *Nursing Act* defines the nursing scope of practice as "the promotion of health and the assessment of, the provision of care for and the treatment of health conditions by supportive, preventive, therapeutic, palliative and rehabilitative means in order to attain or maintain optimal function." (*Nursing Act*, 1991, SO 1991, c 32, s 3.)

[62] *Nursing Act*, *1991*, S.O. 1991, c. 32, s. 4.

[63] See *Ibid*, s 5(1); see also College of Nurses of Ontario, *Medication,* Practice Standard, 2019.

[64] Colleges of Nurses of Ontario, *Authorizing Mechanisms*, Practice Guideline, 2022, p. 5.

[65] College of Nurses of Ontario, *Medication*, supra note 63, p. 3.

[66] *Nursing Act,* s. 5.1(1); *General*, O Reg 275/94, s. 20.

[67] Colleges of Nurses of Ontario, *Decisions about Procedures and Authority,* Practice Standard, Appendix A, 2020.

[68] College of Nurses of Ontario, *Medication*, supra note 63, at pp. 3, 5.

[69] *Ibid*.

[70] *Nursing Act*, s. 5(2)

[71] College of Nurses of Ontario, *Decisions about Procedures and Authority*, supra note 67, p. 3.

[72] Though note that illicit drugs would not be considered "medication" since they are unregulated and cannot be prescribed.

[73] See *Nursing Act*, s. 5; see also College of Nurses of Ontario, *Medication*, supra note 63.

[74] *Ibid*.

[75] *Regulated Health Professions Act, 1991,* SO 1991, c 18, s. 29(1)(e).

[76] Colleges of Nurses of Ontario, *Authorizing Mechanisms*, supra note 64, p. 8.

[77] *Ibid*.

[78] *Regulated Health Professions Act*, s. 29(1)(a).

[79] *General*, O Reg 275/94, s. 15(4).

[80] College of Nurses of Ontario, *Legislation and Regulation: RHPA: Scope of Practice, Controlled Acts Model*, Reference Document, 2020, p. 6.

[81] *Ibid.*

[82] College of Nurses of Ontario, *Code of Conduct*, Practice Standard, 2019, Principles 1.4, 2.6, and 2.7, respectively.

[83] See Colleges of Nurses of Ontario, *Authorizing Mechanisms*, supra note 64, p. 5.

[84] Though, as contemplated in Question 3 of this section, it may be arguable that injecting a safe supply falls under the "routine activities of living" exception, and thus does not require an order.

[85] *Professional Misconduct,* O Reg 799/93, s. 1(1); College of Nurses of Ontario, *Professional Misconduct*, Reference Document, 2019, p. 3.

[86] Specifically, ss. 4.1, 5(1) of the *Nursing Act*.

[87] Health Professions Procedural Code in Schedule 2 of the *Regulated Health Professions Act*, clause 51(1)(a); *Professional Misconduct,* O Reg 799/93, s. 1(1); College of Nurses of Ontario, *Professional Misconduct*, supra note 85, p. 15.

[88] See *Nursing Act*, s. 5(2); *College of Nurses of Ontario v. Lim*, 2012 CanLII 100002 (ON CNO).

[89] E.g.: *College of Nurses of Ontario v. Lim* (for administering fentanyl and Haloperidol without an order); *College of Nurses of Ontario v. Russon,* 2018 CanLII 139525 (ON CNO) (in the context of Botox injections); *College Of Nurses Of Ontario v. Zorn*, 2017 CanLII 49763 (ON CNO)(in the context of Botox injections*); College of Nurses of Ontario v. Cecilioni*, 2013 CanLII 91850 (ON CNO) (in the context of Botox injections); *College of Nurses of Ontario v. Ozueh,* 2017 CanLII 84900 (ON CNO)(in the context of Botox injections and dermal fillers).

[90] *College of Nurses of Ontario v. Lim*.

[91] *College of Nurses of Ontario v. Russon.*

[92] *College of Nurses of Ontario v. Lim*; *College of Nurses of Ontario v. Russon*; *College of Nurses of Ontario v. Zorn*; *College of Nurses of Ontario v. Cecilioni*; *College of Nurses of Ontario v. Ozueh*.

[93] See e.g. *Ontario (College of Massage Therapists of Ontario) v. Rabbani-Rassouli*, 2019 ONCMTO 23 (CanLII); *College of Optometrists of Ontario v. SHS Optical Ltd.*, 2003 CanLII 39086 (ON SC); *College of Nurses of Ontario v. Russon*; *College Of Nurses Of Ontario v. Zorn*; *College of Nurses of Ontario v. Mast*, 2014 CanLII 98904 (ON CNO); *College of Nurses of Ontario v. Lim*; *Ontario (College of Physicians and Surgeons of Ontario) v. Sweet*, 2002 ONCPSD 42 (CanLII).

[94] For example, Registered Nurses' Association or Ontario, "Implementing Supervised Injection Services", (February 2018); M. Gagnon et al., "International Consensus Statement on the Role of Nurses in Supervised Consumption Sites," *Journal of Mental Health and Addiction Nursing* 3,1 (2019): e22 – e31.

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