



Establishing Safe Injection Facilities in Canada: Legal and Ethical Issues

prepared by
Richard Elliott, Ian Malkin, and Jennifer Gold



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Executive Summary

[D]rug users are citizens: they include our sons, daughters, brothers and sisters and, increasingly, our parents. They deserve humane responses; let us not wage war on them.¹

Why a Paper on Safe Injection Facilities?

Injection drug use presents a growing health crisis for Canada. People who inject drugs face serious potential health risks, including fatal and non-fatal overdoses and bloodborne diseases such as HIV/AIDS and hepatitis C. Canada has moral and legal obligations that require it to respond courageously and pragmatically to their plight, with the goal of reducing the potential harm to them.

One partial solution that has been suggested is the establishment – initially by way of a trial – of “safe injection facilities” (also known as “safe injection sites” or “supervised injection facilities”). This strategy has been used successfully in Switzerland, Germany, and the Netherlands and, most recently, at a trial facility in Australia.

Safe injection facilities are places in which drug users are able to inject using clean equipment under the supervision of medically trained personnel. The drugs are not provided by anyone at the facility, but are brought there by the drug users. The professional staff do not help to administer the drugs, but assist users in avoiding the consequences of overdose, bloodborne diseases or other negative health effects (such as abscesses) that may otherwise result from using unclean equipment and participating in unsafe injecting practices.

Safe injection facilities also help direct drug users to treatment and rehabilitation programs, and can operate as a primary health-care unit. Facilities provide free sterile equipment, including syringes, alcohol, dry swabs, water, spoons/cookers, and tourniquets. The facilities are intended to reduce incidents of unsafe use of injection drugs and to prevent the negative consequences that too often result from unsafe injection. They are not “shooting galleries,” which are not legally or officially sanctioned and are often unsafe because they do not offer hygienic conditions, access to sterile injection equipment, supervision and immediate access to health-care personnel, or connections to other health and support services.²

Safe injection facilities are places in which drug users are able to inject using clean equipment under the supervision of medically trained personnel.

What Is the Goal of this Paper?

Promoting the well-being of both drug users and communities requires changes to drug laws and policies, including the introduction of safe injection facilities.

The paper demonstrates that promoting the well-being of both drug users and communities requires changes to drug laws and policies, including the introduction of safe injection facilities. Such changes can and must be initiated, with a view to reducing the harms associated with drug use and the harms caused by drug policies themselves.³

This paper follows the 1999 publication of the Canadian HIV/AIDS Legal Network's Final Report on *Injection Drug Use and HIV/AIDS: Legal and Ethical Issues*, which addressed a variety of issues but did not specifically analyze the legal and ethical questions related to safe injection facilities. It also follows numerous reports in Canada that have specifically addressed the issue of safe injection facilities and have called for the implementation or at least a trial of such facilities as one important part of Canada's overall strategy in responding to the use of injection drugs and related harms.⁴ The goal of the paper is to contribute to the informed development of Canadian law and policy that supports harm-reduction measures such as safe injection facilities.

What Does the Paper Contain?

The first chapter ("Facing Up to an Epidemic") describes the extent and severity of Canada's injection drug use problem, with a particular focus on the city of Vancouver, which faces an ongoing health crisis among drug users in the Downtown Eastside. It then briefly describes the kinds of approaches adopted in response to drug use, ranging from those that are prohibitionist in nature to those that are multi-faceted and incorporate harm-reduction initiatives.

Including safe injection facilities as one harm-reduction component of a broader policy response to injection drug use is likely to produce significant benefits for both drug users and the general community.

The second chapter ("Safe Injection Facilities as a Harm-Reduction Measure: The Debate") outlines the nature of the calls for reform and addresses the arguments commonly made for and against the introduction of safe injection facilities. It concludes that many of the arguments against are ill-conceived or overstated, and are outweighed by the likely benefits of safe injection facilities. It concludes there is also an ethical imperative to at least trial such facilities, given the unacceptable harms currently experienced by drug users and the general community, and the potential of safe injection facilities to eliminate or reduce at least some of these harms.

The third chapter ("Learning from Other Countries' Experience") canvasses the successful implementation of safe injection facilities in several European jurisdictions, with brief descriptions of those schemes. Also discussed is an account of recent initiatives in certain Australian jurisdictions. The available evidence suggests that including safe injection facilities as one harm-reduction component of a broader policy response to injection drug use is likely to produce significant benefits for both drug users and the general community, and that at the very least such initiatives must be tried.

The fourth and fifth chapters ("The Legal Issues: International Law" and "Domestic Legal Issues") address legal issues related to establishing safe injection facilities. First, a brief discussion of international human rights law demonstrates that the refusal to introduce safe injection facilities may be a violation of Canada's human rights obligations under international law. Second, the paper examines the drug control treaties signed by Canada and concludes that they do not preclude the establishment of safe injection facilities, and in fact make

allowances for such programs. Third, the paper examines questions of criminal and civil liability raised by the operation of safe injection facilities, and concludes that these concerns can be addressed. It also briefly discusses the argument that, by failing to implement or at least experiment with safe injection facilities, governments might be held liable for negligence or for failing to discharge their constitutional obligations. Finally, the legal mechanisms available or necessary to permit a trial of safe injection facilities are discussed; without our delving too deeply into operational issues, some specific recommendations are presented regarding key elements of a legal framework to govern the operation of safe injection facilities in Canada.

The sixth chapter (“Conclusion: Responsible Reforms Needed”) concludes the paper with a reminder that Canada’s drug strategy is supposedly premised on preventing harm. While safe injection facilities are but one important component of a comprehensive harm-reduction strategy, Canada cannot sit by, refusing to implement reasonable measures demonstrated to have been effective in other countries, while HIV, hepatitis C, and other preventable harms continue to befall drug users. Government policymakers have a legal and moral obligation to at least allow and support trials of safe injection facilities as measures that are permissible under drug control treaties, further our human rights obligations, and are required out of logic, compassion, and basic decency.

The last chapter (“Recommendations”) presents six recommendations, based on the analysis in the paper, aimed at ensuring the introduction of safe injection facilities (at least on a trial basis) in Canada within a supportive legal environment.

Canada cannot sit by, refusing to implement reasonable measures demonstrated to have been effective in other countries.

What Are the Recommendations in the Paper?

The paper presents six recommendations for immediate action by government(s) in Canada regarding safe injection facilities.

1. The federal government should update Canada’s Drug Strategy to expressly support trials of safe injection facilities as harm-reduction measures that are an important component of the overall policy response to the harms associated with injection drug use.
2. The federal government should create a regulatory framework under the *Controlled Drugs and Substances Act* (CDSA) to govern safe injection facilities that would eliminate the risk of criminal liability for staff and clients and reduce the risk of civil liability for operating such facilities.
3. That regulatory framework should address such issues as the conditions of access to the facility, the activities and services permitted on the premises, and minimum administrative requirements aimed at ensuring the facilities’ safe and effective operation. In particular, the regulatory framework devised under the CDSA that would exempt approved facilities from the CDSA:
 - should not restrict access to safe injection facilities to adults only, but should allow access to drug-using youth;
 - should not deny access to pregnant women;
 - should not deny access to drug users accompanied by children;
 - should not automatically deny access to drug users simply because they are intoxicated;
 - should prohibit the sharing of injection equipment between clients of safe injection facilities;

- should prohibit the sharing or selling of drugs on the premises;
- should only allow clients to self-inject, prohibiting staff from assisting with injection;
- should require that security considerations be taken into account in the physical set-up of safe injection facilities and that security personnel be on site during all hours of operation; and
- should require that some staff be medically qualified nurses or physicians and that all staff be trained in basic first aid, responding to drug overdose, crisis management, and all facility policies and procedures covering matters such as security, confidentiality of client information, referrals to other services, etc.

Health Canada should fund the operation and evaluation of a multi-site scientific research trial of safe injection sites.

4. In the interim, before such a regulatory framework is in place, the federal Minister of Health should grant ministerial exemptions from the application of the provisions of the *Controlled Drugs and Substances Act* that make it an offence to possess a controlled substance in designated safe injection facilities (and needle exchange programs), and would apply to their staff and clients, so that such facilities can operate on a trial basis.
5. Health Canada should fund the operation and evaluation of a multi-site scientific research trial of safe injection facilities, including research studies assessing the impact of safe injection facilities on the health and well-being of drug users, the public health generally, and the communities affected.
6. Federal, provincial/territorial, and municipal officials with responsibilities in the areas of health, social services, and law enforcement should collaborate to ensure that trials of safe injection facilities can occur as soon as possible.

Next Steps

The paper will be sent to a broad range of individuals and organizations working in areas related to drug use, harm reduction, and/or HIV/AIDS. It will also be sent to appropriate government policymakers such as ministers of health and justice, to organizations of health-care professionals, to police officials and associations, researchers, and advocates. Those who receive the paper will be asked for their comments, and their views on how best to ensure action on the recommendations.

In addition, the Legal Network's series of info sheets on injection drug use and HIV/AIDS has been updated, and a new info sheet that provides a summary of the issues and recommendations in this paper has been prepared. These easy-to-read info sheets will make the contents of the paper more accessible to a wider audience and provide useful tools for education and discussion of these issues.

For Further Information...

Contact Thomas Haig at the Canadian HIV/AIDS Legal Network at info@aidslaw.ca or 514 397-6828 ext 224.

Further copies of this paper and the info sheets can be retrieved at the website of the Canadian HIV/AIDS Legal Network at www.aidslaw.ca/Maincontent/issues/druglaws.htm, or ordered through the Canadian HIV/AIDS Clearinghouse. Tel: 613 725-3434; fax: 613 725-1205; email: aids/sida@cpha.ca.



Facing Up to an Epidemic

The Problem

Canada is facing a public health crisis with respect to injection drug use and among people who inject drugs.⁵ Rates of bloodborne infections among injection drug users increased during the 1990s at an alarming rate. By 1996, almost half of all new HIV diagnoses were in people who inject drugs.⁶ Since 1997, the proportion of new HIV infections annually that are attributable to people who inject drugs has decreased slightly; by 1999, the number had dropped to 26 percent.⁷ However, HIV and AIDS infection remain a major problem. Overall, the number of adult AIDS cases related to injection drug use has increased to 21.7 percent of all new reported AIDS diagnoses in 2001, up from 8.3 percent of new AIDS cases in 1995.⁸ As noted by Health Canada, the “absolute number of infections in this group is still unacceptably high.”⁹

Rates of bloodborne infections among injection drug users increased during the 1990s at an alarming rate.

Rates of infection with hepatitis C (HCV) are also high. Among Montréal street youth, 35 percent of injection drug users have the virus,¹⁰ while 88 percent of participants in the Vancouver Injection Drug User Study (VIDUS) are infected.¹¹ More recent data found that rates of HCV infection among injection drug users reach 85 percent in Vancouver and 70 percent in Montréal, with annual incidence rates of 26 percent and 27 percent respectively.¹²

The prevalence of HIV in injection drug users is on the rise in larger Canadian cities.¹³ In Montréal, HIV prevalence among people who inject drugs was 19.5 percent in 1997, nearly four times what it was in 1988.¹⁴ In Toronto, HIV prevalence among injection drug users was 8.6 percent in 1997/98, up from 4.8 percent in 1992/93.¹⁵ Similar trends have been observed in Québec City, Winnipeg, and Ottawa.^{16,17} The available (limited) data also show that the HIV epidemic among injecting drug users is increasingly being seen outside major urban areas.¹⁸ The mobility of people who inject drugs and their interactions with people who do not use suggest that the problem is not limited to cities or to injection drug users, but affect all of Canadian society. Further, the problem of drug use in Aboriginal communities has been the subject of increasing concern.¹⁹

There have been more than 2000 overdose deaths in British Columbia since 1992.

The problems are most apparent in Vancouver. The city's Downtown Eastside is Canada's poorest neighbourhood.²⁰ Street-based drug use is rampant in this area, and HIV prevalence among injection drug users was estimated to be between 23 to 30 percent in 2000.²¹ The prevalence of HCV was even higher, at approximately 88 percent in the same year.²² While fatal overdoses and other health concerns related to drug use have been observed in the area since the 1970s,²³ they have increased dramatically.

There have been more than 2000 overdose deaths in British Columbia since 1992, and it has been the leading cause of death among people aged 30 to 49 for five years in a row.²⁴ Among those participating in the Vancouver Injection Drug User Study, overdose is the leading cause of death, regardless of HIV status.²⁵

There are many reasons for the escalating problem of drug use and overdose in Canada. They include a rise in the number, variety, and potency of drugs produced, sold, and used on streets, a decline in the street cost of drugs, and the fact that people using drugs are beginning to do so at a younger age.²⁶ Users who inject quickly in order to reduce the risk of being detected and arrested are also more likely to inject in an unsafe fashion. The shift from heroin to cocaine use also contributes to the escalation, as cocaine users may inject as many as 20 times a day.²⁷ Greater frequency of injection, and the incentive to inject quickly, increases the likelihood that individuals will share needles and other equipment, putting themselves at risk for HIV and HCV infection. Studies with people who use drugs across Canada have indicated that approximately 40 percent had shared needles within the past six months.²⁸

It has also become clear that injection drug use affects the whole community, not just drug users. Injecting in public spaces results in large amounts of litter that is [sic] unsightly and costly to collect. Such litter, particularly discarded syringes, pose a health risk of accidental needle sticks and the transmission of blood-borne pathogens, especially to municipal workers and custodians who collect such litter, and trash haulers and sorters who separate and process it... But in addition to the problem of drug-related litter, congregations of injectors are widely regarded by the public-at-large as a nuisance and a threat. Moreover, some inner-city areas have been de facto expropriated by injectors, including whole sections of municipal parks, street-corners, vacant lots, sidewalks and alleys. SIFs [safe injection facilities] are seen as offering an innovative way to reduce significantly such expropriations of public spaces, and the nuisance and fear of public drug use, by giving injectors a sanctioned, alternative space that accommodates the needs and sensibilities of both injectors and the larger community. As the Australian Drug Foundation reported, "Overseas experience suggests that communities find a well run [SIF] more acceptable in their neighbourhood than the intense street-using situations that preceded them."²⁹

Drug Policy and Strategy in Canada: From Prohibition to Harm Reduction?

Criminal laws to control illegal drugs and their use have been in place in Canada since the early 1900s.³⁰ The current statute, the *Controlled Drugs and Substances Act* (CDSA),³¹

enacted in 1996 and brought into force in 1997, consolidated several preceding statutes.

The CDSA prohibits the import or export of illegal drugs, as well as drug possession and trafficking. Trafficking of drugs is defined to include providing, administering, transferring, and selling illegal substances.³² The CDSA also prohibits the *unauthorized* possession of equipment intended for ingesting drugs into the human body, or meant for the production of such substances, if it contains traces of a prohibited drug; therefore, possessing used injection equipment is itself a crime.³³

The current legal status of syringes distributed to drug users is also somewhat uncertain. Needles are produced and sold for medical purposes and therefore technically qualify as “devices” under the *Food and Drugs Act* (FDA).³⁴ However, the *Criminal Code* prohibits the promotion or sale (which includes free distribution) of “instruments for illicit drug use,” which are defined as including anything “intended under the circumstances” for ingesting illegal substances.³⁵

There are several negative consequences that flow from pursuing strictly prohibitionist policies.³⁶ They encourage users to inject quickly, out of fear of police apprehension.³⁷ Zero tolerance also produces an underground market for drugs, with associated crime and corruption.³⁸ Further, drug users are often compelled to use unclean equipment or to inject in unsafe or unhygienic circumstances (particularly in the case of street-based injecting), increasing the risk of contracting infections.³⁹ Riley notes that a zero-tolerance model creates a culture of marginalized and stigmatized people who are difficult to reach with educational messages about safe practices or treatment. This is the product of a “drug war” mentality, abstinence-based morality, and the fact that “AIDS and other drug-related harms are sometimes viewed as just deserts”⁴⁰ for drug users. The prohibitionist mindset undermines community caring by fostering “public attitudes that are vehemently anti-drug, and the view that drugusers do not care about their own lives.”⁴¹

Put simply, prohibition alone, as a public health strategy, is not a success. Wodak and Owens note that “[p]rohibition is increasingly regarded as flawed in principle and a resounding failure in practice.”⁴² They conclude that

Put simply, prohibition alone, as a public health strategy, is not a success.

increasing the health, social, legal and economic costs of drug use in order to minimise the number of people who use drugs, the very basis of prohibition, produces more net harm to individuals and society than accepting the inevitability of some drug use.... Authorities around the world are increasingly recognising that most problems associated with illegal drugs are caused by prohibition rather than being the inevitable result of their pharmacological properties.⁴³

Many policy-makers and community members recognise that strictly prohibitionist policies are ineffectual in stopping drug use, and can have damaging consequences, as outlined above.⁴⁴ A policy of “harm minimisation” or “harm reduction” has been recommended by many. The philosophy underlying harm reduction is the desire to reduce the negative consequences associated with drug use. It tolerates (but does not condone) drug use, and accepts that abstinence from drugs is not realistic for some users. Drug use is acknowledged as a fact of life, and effort is directed to diminishing the harmful consequences of drug use on the user and the community.⁴⁵

The criminal law should be employed to deal only with that conduct for which other means of social control are inadequate or inappropriate.

Following a harm-reduction approach, drug addiction and the risk of the spread of disease are understood as public health issues. The Joint United Nations Programme on HIV/AIDS (UNAIDS) observes that if comprehensive, wide-ranging harm-reduction programs are implemented to combat the spread of HIV among injecting drug users – including education, promotion of condom use, drug treatment, and needle exchanges – infections can be contained at a low level.⁴⁶ It emphasizes that this is particularly the case “in the many countries where drug injection is a major driving force for the spread of HIV.”⁴⁷

As indicated by Riley, “[o]ne of the main barriers to the adoption of non-prohibitionist policies is idealism. Adopting harm reduction means accepting that some harm is inevitable.”⁴⁸ It is an admission that a zero-tolerance approach based on abstinence has failed. A harm-reduction approach acknowledges that the police cannot eliminate illegal drug use and, in particular, the problems associated with street-based injecting.

The federal government’s stated position for two decades has been that “[t]he criminal law should be employed to deal only with that conduct for which other means of social control are inadequate or inappropriate, and which interfere with individual rights and freedoms only to the extent necessary for the attainment of its purpose.”⁴⁹ Such a position lends support to proposals for a drug policy based on harm-reduction principles.

There is evidence that the Canadian drug strategy is shifting, if slowly and not always consistently,⁵⁰ toward a harm-reduction philosophy, with an emphasis on initiatives such as needle exchange and methadone programs. Canada’s Drug Strategy, adopted in 1998 by the federal government, states that its long-term goal is to reduce the harm associated with drugs to individuals, families, and communities.⁵¹ The Strategy also states that because “substance abuse is primarily a health issue rather than an enforcement issue, harm reduction is considered to be a realistic, pragmatic, and humane approach as opposed to attempting solely to reduce the use of drugs.”⁵²

In April 2000, a Special Senate Committee on Illegal Drugs was established with a goal to “develop a national harm reduction policy in order to lessen the negative impact of illegal drugs in Canada [and to] study harm reduction models adopted by other countries and determine if there is a need to implement them wholly or partially in Canada.”⁵³ As well, Health Canada has indicated that programs aimed at HCV prevention should adopt a harm-reduction approach.⁵⁴

“Changes are needed to existing legal and policy frameworks – both national and international – in order to effectively address IDU as a health issue.”

– Health Canada, 2001

In September 2001, Canada’s federal, provincial, and territorial ministers of health “acknowledged” a report jointly prepared by several intergovernmental advisory committees that set out a harm-reduction approach and a framework for action.⁵⁵ The ministers tasked a working group of the committee with examining the feasibility of establishing a safe injection facility as a scientific, medical research project.

Also welcome is the indication of Allan Rock, then federal Minister of Health, that more steps would be taken in the direction of harm reduction in the future. In Health Canada’s public response to the Final Report of the Canadian HIV/AIDS Legal Network on *Injection Drug Use and HIV/AIDS: Legal and Ethical Issues*, the Minister acknowledged that “a comprehensive response to IDU requires a partnership approach involving other disciplines and jurisdictions.”⁵⁶ The Minister pledged his commitment to “support efforts to reduce injection drug use–related harm in correctional settings.”⁵⁷

According to Health Canada's response, while Health Canada recognizes that "changes are needed to existing legal and policy frameworks – both national and international – in order to effectively address IDU as a health issue, the required changes are complex and must be developed collaboratively over time."⁵⁸ However, in the interim Health Canada advocates a harm-reduction approach within the current frameworks. For example, the response refers to needle exchange programs as an important harm-reduction measure as well as an example of "strong co-operation between the health and law enforcement sectors" (although the federal or provincial governments have yet to implement needle exchange programs in correctional facilities in Canada). Minister Rock subsequently publicly stated his support, in principle, for the establishment of safe injection facilities,⁵⁹ as has the Québec Minister Responsible for Health and Social Services, Agnès Maltais.⁶⁰

A Multi-faceted Response: Vancouver and the "Four-Pillar Approach"

In November 2000, the City of Vancouver released the draft discussion paper *A Framework for Action: A Four-Pillar Approach to Drug Problems in Vancouver*.⁶¹ The paper establishes a framework for action to "appropriately and effectively deal with city-wide substance misuse and associated crime." The approach is based on the "four pillars" of prevention, treatment, enforcement, and harm reduction:

- *Prevention* focuses on education regarding substances, as well as on building awareness about the reasons behind drug abuse and what can be done to avoid addiction.
- *Treatment* involves numerous interventions and support programs, including detoxification, counselling, social programs, and medical care.
- *Enforcement* consists of a "redeployment of officers" in the Downtown Eastside to combat organized crime and drug dealing, and to strengthen ties with health services and similar agencies.
- *Harm reduction* is a "pragmatic approach that focuses on decreasing the negative consequences of drug use for communities and individuals." The paper draws upon successful harm-reduction initiatives undertaken in other parts of the world.

One of the recommendations in the paper is that the federal government establish a task force to examine the feasibility of a safe injection facility trial. As already noted, this task force has been struck.

Following the document's release, the public was consulted on the various aspects of the proposal. In general, the public was supportive of the framework, including harm-reduction measures and safe injection facilities. The revised framework, released in early 2001, indicates that the question of injection facilities deserves "careful consideration," and suggests "stringently controlled trial site or sites" as one method of evaluating such an initiative.

Harm-Reduction Strategies: An Ethical Imperative

The criminal approach to drug use was ostensibly designed to decrease the various health and social problems that result from the use of and addiction to various substances. This approach, however, has simply failed to achieve its objectives. Rather than solving problems, the model both exacerbates existing dilemmas and creates new ones. The criminal approach has been characterized as failing to achieve the goals for which it is designed and promoted; excluding those who inject drugs from the community; misusing limited resources; "stimulating the rise to power of socially destructive and violent empires;" and fuelling the "decline of humanity that is essential to civilized societies."⁶²

Adopting an ethic of harm reduction acknowledges that prohibitionist approaches to drug use do not work. A harm-reduction approach does not identify abstinence as the necessary goal of any intervention. It is deemed unethical to demand from someone something of which they are physically or mentally incapable. That said, proponents of harm-reduction

The criminal approach to drug use was ostensibly designed to decrease the various health and social problems that result from the use of and addiction to various substances. This approach, however, has simply failed to achieve its objectives.

measures would certainly recognize abstinence as being a worthwhile goal for some people. “While harm reduction approaches do not preclude abstinence as a worthwhile goal, they question the long established notion that abstinence is the only acceptable drug policy or program outcome.”⁶³

The harm-reduction ethic emphasizes pragmatism in dealing with the problems associated with drug use: for instance, the utilization of methadone treatment programs to combat heroin addiction, or the establishment of needle exchange facilities to reduce the sharing of needles and associated spread of disease. The emphasis is on keeping those who choose to use drugs alive and disease-free, with rehabilitation open as a possibility.

Moralizing about the intrinsic evils of drugs and drug use is avoided, and recognizes that many of the ills associated with drug use result from the approach we as a society use to deal with these individuals.



Safe Injection Facilities As a Harm-Reduction Measure: The Debate

Calls for Reform: The Need to Trial Safe Injection Facilities

The main objective of safe injection facilities is to allow drug users to inject in a safe, hygienic, controlled environment rather than in unsafe, unhygienic, and often public or quasi-public settings. They can save lives by enabling immediate responses to overdoses and by decreasing the level of bloodborne disease transmission through access to sterile injecting equipment and education about safe injection practices. They can facilitate necessary health care, and give clients information and advice about referrals and counselling. They can reduce public nuisances often associated with public drug injection scenes.

For these reasons, it has been recommended that safe injection facilities be trialled in Canada.⁶⁴ The Harm Reduction Action Society based in Vancouver has been particularly vocal in its advocacy, urging the implementation of an 18-month pilot study of safe injection facilities in Vancouver, based on the European model.⁶⁵

The proposed facility would consist of several rooms: an open waiting area; medical and counselling consult rooms; needle exchange; washrooms; staff and equipment room; and, finally, an injection room. Services provided by the facility would include: provision of nutritious snacks; primary health care; needle exchange; information about safe injection practices; supervision of injections; resuscitation in the event of overdose; peer support; and counselling. Staff would include registered nurses, counsellors, and social services workers, with five staff on shift at all times. The site would accommodate 35 people at any one time, and would be limited to those 18 years of age and over (at least during the pilot period). Finally, the site would be open a minimum of eight hours a day, seven days a week. On the day welfare cheques are issued – referred to as “welfare Wednesday” – and the day following, the site would remain open 24 hours, as it has been observed that a large percentage of overdoses occur within this time frame.⁶⁶

Many health-care professionals and street workers, and some municipal councillors, have supported safe injection facilities. In August 2001, the *Canadian Medical Association Journal* argued strongly that:

Harm reduction is not a retreat from the high ground. It is the *only* ground on which to meet drug users in the here and now – a here and now that may include, in addition to the consuming fire of a chemical addiction, poverty, limited education, unemployment, a history of abuse and family dysfunction. Until now, in Canada, that meeting ground has taken the form of outreach and education, methadone maintenance and needle exchange.... It will take a certain *sang-froid* to see this idea [safer injection facilities] through. It will require that we face up to the severity of the drug problem that Canadian communities are experiencing. There is no quick fix, either for addiction or its risk factors and effects. But we can make the lives of people with drug addictions a little better and neighbourhoods a little safer. Supervised injection rooms are a logical next step, one that combines the merits of realism and compassion.⁶⁷

Harm reduction is not a retreat from the high ground. It is the *only* ground on which to meet drug users in the here and now.

In Toronto, a city councillor has suggested his downtown ward as a home for a safe injection facility.⁶⁸ A proponent of such facilities since he visited Frankfurt in 1993, the councillor believes they would remove the nuisance of an open drug scene from the public eye.

Law enforcement officials also appear to be increasingly supportive of the idea. Chief Superintendent Robert Lesser, the officer in charge of the drug enforcement branch of the Royal Canadian Mounted Police (RCMP), indicated that police are aware of the urgent need to stop the spread of bloodborne infections such as HIV and hepatitis and publicly stated that establishing safe injection facilities is “something we need to need look at.”⁶⁹ Toronto’s police chief also acknowledged that there is a problem (albeit in a fashion that continues to stigmatize drug users): “Our jails are already filled with druggies. Fighting drugs is like digging a hole in the Sahara desert.”⁷⁰

The safety of police officers and others such as paramedics, firefighters, and other emergency response personnel would also be enhanced by a harm-reduction approach that includes safe injection facilities.

Moreover, it should be noted that the safety of police officers and others such as paramedics, firefighters, and other emergency response personnel would also be enhanced by a harm-reduction approach that includes safe injection facilities. It would reduce the policing of individual drug users carrying possibly contaminated injection equipment, meaning fewer opportunities for altercations in which an officer could be stuck with a needle. Furthermore, in the broader picture, safe injection facilities would reduce the spread of HIV and HCV among drug users, meaning fewer users that police, firefighters, and paramedics encounter are likely to be infected.

With respect to general public opinion on the matter, 71 percent of Vancouver residents polled supported the creation of safe injection facilities in the Downtown Eastside.⁷¹ The provincial medical health officer for British Columbia shares this opinion. In an article in the *Canadian Medical Association Journal*, Dr Perry Kendall was quoted as saying that “the evidence from other countries is very, very convincing and more robust than the evidence we had when we started putting in needle exchanges.”⁷²

Further, in addition to the successful uptake of safe injection facilities by drug users in various European cities (described in more detail below), survey evidence from both Canada and Australia demonstrates that injecting drug users “overwhelmingly support the establishment of safe injecting rooms.”⁷³ In Melbourne, 96 percent of 215 users surveyed favoured establishing facilities near where they bought and used their heroin; 89 percent said they would use the facilities rather than inject in the street.⁷⁴ In Montréal, 94.4 percent of 195 drug users participating in a survey indicated they thought a safe injection facility was a good idea, and identified safety, health issues, and the services that could be available at the facility as major reasons for supporting them.⁷⁵

There are, of course, those who object to the establishment of safe injection facilities. In Montréal’s Plateau Mont-Royal neighbourhood, the suggestion to establish safe injection facilities was met with considerable opposition from the Mont-Royal Avenue Merchants’ Association.⁷⁶ The street worker who proposed the idea was described as an “alarmist.”⁷⁷ Also opposed to the idea are various neighbourhood groups. In Vancouver, the Community Alliance accuses the Harm Reduction Action Society of putting the safety of drug users ahead of the safety of the community at large.⁷⁸

At the municipal level, the trend is to proceed guardedly. As mentioned, in November 2000 Vancouver mayor Philip Owen proposed a comprehensive four-pillar approach to the city’s drug-use problem: prevention, treatment, enforcement, and harm reduction.⁷⁹ The last component has been the subject of considerable controversy, as the plan considers establishing safe injecting facilities and heroin prescription trials.⁸⁰ The mayor, however, takes a cautious stance: “Eventually we’ll have them,” he says of the safe injection facilities.⁸¹ First, though, he believes that informed public support is necessary. Criticizing the activist approach of the Harm Reduction Action Society, Owen said the group should be working with the city process: “They should allow us to engage the public. The one-off starts have never been effective.”⁸²

“The evidence from other countries is very, very convincing and more robust than the evidence we had when we started putting in needle exchanges.”

– Dr P Kendall, 2001

The Nature of the Debate

Sending out the “wrong message”?

Some have suggested that establishing safe injection facilities sends “the wrong message” to the community – namely, that injection drug use is acceptable and has official support. It is argued that this will contribute to increased use.⁸³ This claim is not borne out by the evidence, and in any event is based on the premise that an abstinence approach has in fact eliminated (or contained) drug use, and that a relaxation of prohibition – in any way – would yield unacceptable results, such as more widespread use.⁸⁴ As an example of this kind of thinking, the Vatican decreed that no Catholic organization anywhere in the world should take part in trials, as doing so – despite good intentions – would amount to “cooperation in the grave evil of drug abuse.”⁸⁵

This approach is naive and unrealistic. Strict prohibition does not meet its objective. As concluded by the Honourable Justice Wood, heading up the Royal Commission into the New South Wales Police Service, “it is fanciful to think that drug addicts can be prevented from obtaining and using prohibited drugs.”⁸⁶ In fact, the feared increase in drug use is “unfounded and contrary to existing evidence” – there is evidence that in cities with safe injection facilities the total number of drug users has decreased.⁸⁷

Recommending the introduction of safe injection facilities should not be interpreted as saying that drug use is desirable. Rather, it is a limited, self-contained, responsible harm-reduction policy that realistically responds to immediate health risks and dangers that can, at least in some circumstances, be minimized. Furthermore, the trial of a safe injection site need

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not be characterized as sending a negative message. If facilities are established discreetly and sensitively, “adverse messages can be avoided and the message itself can be positive and constructive.”⁸⁸ For example, the genuine advantages to health care of establishing safe injection facilities can be highlighted.

Lessons from needle exchanges: extending the health-care message

Needle exchange programs are harm-reduction measures that represent tangible, sensitive, successful responses to serious public health risks. They are particularly relevant to the discussion of safe injection facilities, as they underscore society’s tolerance for policies other than prohibition. They provide concrete evidence

refuting the claim that harm-reduction policies convey the “wrong message.”

Needle and syringe exchange programs provide injecting drug users with free sterile injecting equipment (often in conjunction with education measures) to reduce their risk of contracting bloodborne diseases such as HCV and HBV.⁸⁹ Exchange programs are “to many people, the epitome of the harm reduction approach.”⁹⁰ Even though they were initially controversial, they have been widely accepted as a significant means of containing the spread of serious diseases.

The effectiveness of needle and syringe exchanges is generally accepted: HIV prevalence among injecting drug users is far lower in cities with exchanges than in cities without them.⁹¹ Aside from their direct impact in reducing harm to drug users by providing sterile equipment, exchanges facilitate users’ access to counselling and relevant referrals.⁹² With exposure to drug education – more readily attainable after the establishment of needle exchanges – injecting drug users are likely to adopt less risky behaviour.⁹³

The effectiveness of needle and syringe exchanges is generally accepted.

Exchanges are but one of many strategies that should be implemented to respond to complex drug-use issues. One other such strategy – related but significantly different – is the trial of safe injection facilities. Facilities are a natural, small step beyond what has already been implemented – and accepted – with the introduction of syringe and needle exchanges. The existence of exchanges is an acknowledgement of the fact of illegal drug use. Warren O’Brian of AIDS Vancouver suggests that the process of establishing safe injection facilities would probably work in much the same way as needle exchange programs did when they were first implemented ten years ago.⁹⁴ Needle exchanges were also started by non-profit organizations with government funding. Moreover, O’Brian notes that those involved had to deal with similar, complex legal quandaries: for example, a used needle may contain traces of illegal substances, meaning needle exchange staff could, technically, be charged with possession.⁹⁵

While safe injection facilities and needle exchanges may sometimes serve broadly similar harm-minimization objectives, this is not necessarily the case. They *are* different, and *both* are necessary – as complementary measures – to address different types of harm experienced by specific target population groups. Needle exchanges are primarily concerned with reducing the possibility of contracting HIV, HBV, HCV, and other bloodborne diseases (with

opportunities to refer clients to treatment, health-care, and educational services). In contrast, injection facilities not only provide users with sterile equipment but also give them the opportunity to avoid fatal overdoses and non-fatal overdoses, because the injecting is supervised.⁹⁶ Importantly, “in contrast to needle exchange outlets where clients generally visit briefly, safe injection facilities allow for a more prolonged interaction between health-care staff and clients.”⁹⁷ In this sense, safe injection facilities are enhanced needle exchanges.

Put simply, with needle exchanges it is known that the person who comes to the exchange is going to inject. That person is thus given a way of doing so that minimizes the risk of contracting and/or spreading bloodborne diseases. In a sense, they are told, “go ahead – society knows what you are doing – but *go away* and do it.” And this is done with the full knowledge that in other respects that person may be acting unsafely (eg, sharing needles; or injecting alone in an unsupervised setting with no assistance in the event of overdose; or at risk of violence) and perhaps creating risks or nuisances for others in the neighbourhood.

With safe injecting facilities, the community goes beyond the half-hearted approach of needle exchange, recognizing the need for a more comprehensive effort to protect and promote health. The community is willing to (i) provide needles to the specific population group targeted by the scheme, and (ii) ensure that they inject their drugs hygienically and avoid overdose. What seems to be most objectionable to some is the “official involvement” in the actual use of the drug – the supervision or oversight. The measure gets characterized as one that sanctions illegal behaviour in a more intimate or active manner than is the case with needle exchanges.

With safe injecting facilities, the community goes beyond the half-hearted approach of needle exchange, recognizing the need for a more comprehensive effort to protect and promote health.

But in reality this is not substantially different from providing the needle to do what we know the person will in fact be doing – injecting an illegal substance. The significant positive difference between the measures is the fact that safe injection facilities provide a *relatively* safe place to inject. Safety is not guaranteed, but it is heightened, at least for some users, compared with street-based injection and/or injecting alone with no access to health services if needed. There is no doubt that it is safer. There is no doubt that it reduces risk. Yet *it* is the measure considered by some to be dangerous. It seems odd to have gone so far as to establish exchanges, but to stop short of providing this additional potentially effective harm-reduction strategy. The “anomalous nature” of this situation is noted in the Wood Report in Australia, written prior to the trial of an injection site in New South Wales:

At present, publicly funded programs operate to provide syringes and needles to injecting drug users with the clear understanding they will be used to administer prohibited drugs. *In these circumstances, to shrink from the provision of safe, sanitary premises where users can safely inject is somewhat short-sighted.*⁹⁸

Dr Van Beek, medical director of the facility in New South Wales, states:

In one sense what we do (at the moment) is quite immoral because we give drug addicts needles to inject, then they go off and do it... Sure, they won't die of AIDS one day in the future. But they might die of a drug overdose, right here and now. Surely we should try to save some of them.⁹⁹

Some time ago, the establishment of needle exchanges necessitated a shift in attitude from abstention to harm minimization. That shift has happened at least to the degree that needle exchanges have become a reality. Safe injection facilities could sit comfortably alongside

what already exists – needle exchanges – as another means of addressing a specific, self-contained, targeted problem: they are simply one more important strategy designed to combat some of the harmful effects of injection drug use. Any differences between these measures are neither meaningful nor significant enough to deny the trial of this initiative, when the ultimate, positive public health effects are likely to be substantial. For the sake of preventing serious disease or death, we as a community should acknowledge the inevitability of some drug use and seek to reduce the negative effects on individuals and the community, which means we should be willing to tolerate (but not promote) otherwise illicit behaviour. That is the relevant message communicated by establishing a trial safe injection site.

An effective public health measure

There are three main ways in which safe injection facilities can be effective at improving public health: (1) preventing fatal overdoses, (2) preventing the spread of bloodborne diseases¹⁰⁰ and other injuries caused by unsafe injecting, and (3) acting as a gateway to education, treatment, and rehabilitation. Those

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resisting safe injection facilities assert there is little clear evidence from jurisdictions where they have been introduced that demonstrate their success: in essence, they claim such facilities are ineffective or even harmful.

However, the available evidence suggests otherwise. There is “evidence from the European experience that ... sites reduce both health risks and risks to the community of substance misuse.”¹⁰¹ In fact, no overdose deaths have been recorded in European facilities, and the numbers of overdose deaths in communities with facilities have declined.¹⁰² One of the foremost reasons supporting the introduction of facilities lies in the simple but significant fact that trained staff are in a position in which they can prevent overdoses.¹⁰³

Even if there were a deficiency of hard empirical evidence specifically demonstrating the effectiveness of facilities in preventing overdoses, logic dictates and experience suggests that there will be *some* drug users who would take advantage of the existence of facilities, and who would thereby be in a position to receive assistance from professional staff should the need arise – unlike someone injecting on the street and/or alone with no access to health services. It is difficult to determine the degree of success in preventing harm with absolute precision, since this involves proving what might have happened had circumstances been different. Nevertheless, there is little doubt that at least some lives could be saved.

Available evidence suggests that safe injection facilities could help prevent injuries and infection related to unsafe injecting practices. Street-based injection drug users are often rushed, injecting quickly because of their fear of police detection¹⁰⁴ and subsequent arrest, or because of anxieties associated with other users’ behaviour. Not surprisingly, there is a heightened risk that appropriate safe injection procedures will not be followed: for example, needles or equipment will be shared, drugs will not first be tested, clean water will not be used, and shared equipment will not be repeatedly bleached or otherwise cleaned between uses.

Therefore, one of the primary benefits associated with facilities is that some individuals will use safe injection sites for the immediate purpose of using the clean equipment provided by the staff in a relaxed, safe, and non-threatening environment. These rooms provide drug users with the ability to inject in an atmosphere that is free from the threat of prosecution; in turn, this would allow injecting in a more relaxed manner that would reduce the risk of avoidable harm.¹⁰⁵ As one drug user put it: “It wouldn’t be in anyone’s face.... You

wouldn't get stood over by someone threatening to bash you for your hit, and it would help save lives."¹⁰⁶ Evidence from Europe and Australia indicates that clients using safe injection facilities also access other health care such as treatment of abscesses, skin conditions, etc.¹⁰⁷

The third benefit is that the clients will have made contact with professional staff who can, at a minimum, direct them to appropriate health and welfare agencies, as dictated by the needs of each particular case.¹⁰⁸ With the introduction of facilities, health, welfare, and rehabilitation services can be provided to at-risk individuals who otherwise would not have access to them. The German experience shows that hundreds of clients can be referred directly from facilities to drug treatment, detoxification and abstinence-based programs, and methadone schemes.¹⁰⁹ Swiss studies indicate similar results, in which the facilities' users are directed to health services and programs, including those where methadone and drug treatment are available.¹¹⁰ Safe injection facilities are not intended to stand alone as an isolated measure, but are meant to be one component of an overarching strategy, with links to wide-ranging health-care services.

Creating a magnet for trouble, or reducing public nuisance?

One of the most frequently cited objections to the introduction of facilities is that they will attract drug users and traffickers from outside the area – referred to disparagingly by some opponents as the “honey pot” hypothesis.¹¹¹ Businesses, primarily, use this reason to justify their opposition to the establishment of facilities in their neighbourhoods. For example, as described above, the Mont-Royal Avenue Merchants' Association in Montréal has opposed the establishment of safe injection facilities: it believes that creating such safe houses would only exacerbate the problem, attracting even more drugs, crime, and prostitution.

Those who advocate the introduction of such facilities contend that these fears are unfounded, as the facilities would have the opposite effect: they are intended to respond to the street-based injection-drug-using cohort that *already* “frequents the local street drug market.”¹¹² The location chosen for setting up a facility is usually a well-known, highly concentrated injection drug use and trafficking area. There is evidence to support the view that this population is not particularly mobile. Street-based injecting drug users do not generally travel from one part of the city to another to inject: “addicts will travel only a short distance between the point of purchase and the use of drugs.”¹¹³

The Harm Reduction Action Society doubts safe injection facilities would attract more drug users to Vancouver, pointing to the Frankfurt experience as an example. Frankfurt has not had an influx of drug users, despite operating safe injection facilities for eight years. The recent Australian initiative in New South Wales provides further evidence that fears of attracting more problems to the area are largely unwarranted. According to the medical director of the project, so far police have reported no additional drug activity in the area and the safe injection facility there has not attracted drug users from other areas.¹¹⁴

Anxieties regarding potential consequences can be addressed by registering drug users who are permitted to enter the facility, so that it can only be used by established local users. Further, the police presence in the area would be maintained to discourage traffickers. It is likely that this would serve to dissuade individuals from outside the area flocking to it, as feared. It is also said that the facility should be established discreetly, and its presence not widely publicized. However, a word of caution is required. Some of these suggestions, presumably intended to make the presence of safe injection facilities more acceptable to the local community, may impede or defeat their objectives by imposing barriers to some local users who would otherwise be desirable clients benefiting from the facility's services.

One concern is that the introduction of safe injection facilities would increase the concentration of drug users in the area, thereby affecting the quality of life in the neighbourhood. If safe injection facilities are to be implemented successfully, local communities and businesses must be convinced their presence may in fact improve the quality of life in the area: diverting at least some drug use into legitimate premises would diminish many of the nuisances associated with street-based injection drug use.

Safe injection facilities are expected to reduce nuisance and visibility problems: crime, violence, loitering, drug dealing, and property damage could be diminished, and many needles would be disposed of safely rather than discarded on the streets. European studies support this contention, with Frankfurt police reporting declines in street robbery, car break-ins,

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and heroin trafficking and related offences after the introduction of injection facilities, and it has been noted that in Swiss cities with supervised injection facilities, there are fewer discarded syringes.¹¹⁵ Eventually, members of the public will likely come to appreciate and recognize the advantages associated with establishing facilities, compared with their current experiences. As Clover Moore, a Member of the Legislative Assembly of New South Wales states: “My constituents despair at the rising levels of drug-related street crime, dealing, overdosing and contaminated syringe disposal in their streets, on their doorsteps and in their children’s playgrounds.”¹¹⁶ Safe injection facilities have the potential to alleviate these problems.

Preventing “shooting galleries”

In the absence of government-sanctioned premises, some injection drug use moves off the street, into so-called “shooting galleries” – a dangerous, unhygienic alternative that promotes risky behaviour, with serious health-care consequences. Facilities need to be “officially regulated ... in circumstances where it is inevitable that one will be set up anyway, but illegally and officially unmonitored.”¹¹⁷ Drug users should be able to inject in a stress-free, hygienic environment with low-risk conditions, as opposed to illegal, profit-based shooting galleries, which are not concerned with users’ health and safety. The fact of being legally approved is critical to the ability of safe injection facilities to provide health-care benefits and enhance harm reduction.

In the course of debating the introduction of a trial in New South Wales, members of the Opposition (and the International Narcotics Control Board) disparagingly referred to injecting facilities as “shooting galleries.” Special Minister of State John Della Bosca refuted this misrepresentation: [In “shooting galleries”] drugs are illegally injected, ... no safeguards are in place, ... no treatment is offered and ... no care is shown for the welfare of users.¹¹⁸

A cost-effective measure

The cost-effectiveness of implementing safe injection facilities might motivate decision-makers to introduce them.¹¹⁹ Aside from the obvious human toll and tragedy and cost, there is an economic aspect to the harm that can be prevented or minimized – as is the case with containing the spread of HIV by introducing needle exchanges. It is less costly to provide needle exchange facilities (or clean equipment at a safe injecting facility) than to treat someone with a long-term preventable disease. A 1998 study estimated that the direct and indirect costs of HIV/AIDS attributed to injection drug use in Canada would amount to \$8.7 billion over a six-year period if current trends continue.¹²⁰ Substantial health-care savings would be

realized if fewer individuals needed treatment for chronic illnesses such as HIV or septicemia or endocarditis. With the establishment of safe injection facilities, fewer funds would be spent on emergency services (in cases of fatal or non-fatal overdose). Law-enforcement costs also could be reduced, with resources diverted to prevention and health-care treatment services.

The moral imperative to trial safe injection facilities

If cost-effectiveness remains unconvincing as a rationale for introducing facilities, perhaps it is more persuasive to view this measure in moral terms. Admittedly, this is a difficult issue – “morality” is an abstract, philosophical concept about which different people will have different views. Nevertheless, it cannot be ignored in any discussion of harm-reduction measures of this nature, because moral values have an inescapable and inevitable effect on any attempt at “rational” analysis. Differing, conflicting moral values arise. During the debate surrounding the New South Wales trial, the Joint Select Committee of NSW noted that societal values and personal experiences – which construct individual attitudes – were often fundamental to arguments about the pros and cons associated with the establishment of safe injection facilities: “It is important to recognise that values and value systems inevitably enter the debate and bear on our personal choices of favoured solutions.”¹²¹

Denying access to harm-reduction measures, when there is considerable evidence available from other countries affirming their efficacy, is immoral.

On the one hand is the view that any drug use is necessarily, inherently wrong and immoral. Others argue that drug use per se is not so undesirable that continued attempts to criminalize and punish that use – in every conceivable context – should be pursued regardless of the cost of doing so:

Drug use is not inherently evil.... Prohibitions on controlled substances must be justified on some grounds other than the mere whim of authority; some objectively sound and acceptable evidence is required that convincingly demonstrates the validity of criminalizing activities relating to certain drugs but not others [such as alcohol or tobacco].¹²²

Of fundamental concern are those ideals that relate to the value associated with the preservation of human life, with attention given to the immediate need to improve public health – preventing overdoses, containing the spread of disease, and encouraging treatment. Denying access to harm-reduction measures, when there is considerable evidence available from other countries affirming their efficacy, is immoral:

It is *ethically* wrong to continue criminalizing approaches to the control of drug use when these strategies: fail to achieve the goals for which they were designed; create evils equal to or greater than those they purport to prevent; intensify the marginalization of vulnerable people; and stimulate the rise to power of socially destructive and violent empires.

It is *ethically* wrong to continue to tolerate complacently the tragic gap that exists between what can and should be done in terms of comprehensive care for drug users and what is actually being done to meet these persons’ basic needs.

It is *ethically* wrong to continue policies and programs that so unilaterally and utopically insist on abstinence from drug use that they ignore the more

immediately commanding urgency of reducing the suffering of drug users and assuring their survival, their health, and their growth into liberty and dignity... It is *imperative* that persons who use drugs be recognized as possessing the same dignity, with all the ethical consequences of this ethical fact, as of all other human beings.¹²³

While personal values doubtless play an important role in determining individual responses to the problem of street-based injection drug use, moralizing about the “evils of drug use” should not be permitted to derail the debate when determining an appropriate community response. Rather, the findings of experts in the field – doctors, scientists, researchers, social workers – and the experience of other jurisdictions must be given due consideration, as must fundamental health-care objectives¹²⁴ and the invaluable input to be gained from those whose lives and health are at stake.

Overriding ethical incentives – and the available (albeit limited) evidence – compel the implementation of this particular harm-minimization measure, in a manner whereby we can

An ethical response grounded in caring and social contract is required, one that does not blame users and is not premised on fault.

responsibly care for those in our community who face serious health risks. Failed policies of abstention have produced dismal results. An ethical response grounded in caring and social contract is required, one that does not blame users and is not premised on fault. What is needed is a recognition that the reasons for and problems associated with drug use are complex, as are the required responses. What is required is an acknowledgment that, in moral terms, keeping drug users alive outweighs the supposed

“moral evil” of drug use. It is imperative that policymakers take a realistic approach to the problem, implementing what might be perceived as a radically pragmatic vision.



Learning from Other Countries' Experiences

Injecting facilities *can* be established. This is demonstrated by their successful implementation as pragmatic, practical, and effective harm-reduction strategies in one Australian and several Swiss, German, and Dutch cities.¹²⁵ As Dolan et al note, they have been instituted in places where high-level public drug scenes existed with typically associated harmful consequences, such as deteriorating health conditions and increasing public nuisance.¹²⁶ Safe injection facilities now appear to be accepted in those jurisdictions, despite some initial opposition. This section describes the experience of four countries with safe injection facilities, and draws some lessons from the recent experience of Australia's first experiment with such a facility.

Switzerland

Government-authorized injecting facilities have been operating in Switzerland on a relatively widespread basis since the mid-1980s, with funding provided by the government and non-governmental organizations.¹²⁷ The advent of the HIV crisis as a result of unsafe injection drug use was instrumental in creating the momentum and motivation necessary for establishing a number of facilities in Berne, Basel, and Zurich.

The process leading to the introduction of government-sanctioned centres was evolutionary, taking place over many years, from a period when there was a degree of tolerance for an open drug scene to one in which the government responded to pressures to close down that scene.¹²⁸ This approach failed, and government-sanctioned facilities were established. The objectives are similar to those advocated in other developed states, such as Australia and Canada: combating fatal and non-fatal overdoses, the spread of bloodborne diseases, and public nuisance.

Generally, a facility includes a café, counselling room, medical care clinic, and injecting rooms.¹²⁹ The injecting rooms are small, and contain stainless steel tables where clients

Government-authorized injecting facilities have been operating in Switzerland on a relatively widespread basis since the mid-1980s.

prepare and inject their own drugs using materials provided by the facility (such as needles, candles, sterile water, spoons, towels, cotton pads, bandages, and bins). Anne Marxer, manager of the Low Threshold Agency in Berne, emphasizes what is not provided or permitted:

Not the drugs of course, they have to bring their own drugs. We don't distribute drugs here. Also we have very strict rules in here; they can stay for half an hour and they are not allowed to sell or to buy dope in here, not even to make a present to someone. So if they do this, we sanction them, they're not allowed to enter this room for another two days.¹³⁰

Staff cannot help drug users with their injections. A staff member must be present in the injecting room at all times; doctors work a few hours each week, and the facilities are open seven hours a day, five to six days a week.¹³¹ All staff members

“We accept the people how they are.”

are trained to resuscitate clients, and all can make referrals to drug treatment centres and counselling. Marxer explains:

For us, we accept the people how they are. We don't tell them to become clean, but when they want to become clean we help them to the next station. But first of all we accept them the way they are, and also they have to be ... older than 16 years of age. And the first injection is not allowed here. This is important ... it's really forbidden.¹³²

There are some data that indicate the success of the Swiss measures in reducing harms associated with drug use. For example, approximately a hundred clients visit each centre each day in Zurich and Basel.¹³³ In three centres in Zurich, there were approximately 68,000 injections in one year; 3000 abscesses were treated, 22 individuals were resuscitated, and 10 telephone calls to ambulance services were made.¹³⁴ Dolan notes that “[t]here have been no deaths in any injecting rooms in Switzerland to date [and that] some workers believe that the number of deaths due to overdose in the community has decreased as a result.”¹³⁵

The facilities are described “as a normal feature of the Berne cityscape.”¹³⁶ An investigating committee relates its experiences in locating a Swiss facility:

Arriving at Berne railway station we enquired of the Tourist Information Centre about the location of the safe injecting facility. In a very matter of fact manner the assistant pointed us in the right direction. On locating the street we then asked a passing elderly nun which was the building. Without batting an eyelid she directed us to a nearby door. The premises were a cross between a no frills coffee bar and a medical clinic.¹³⁷

Swiss safe injection facilities have had a positive impact beyond immediately improving the health of drug users and the community: they also have decreased public nuisance by reducing the number of syringes on the streets.¹³⁸

Germany

Germany has 13 safe injection facilities and intends to introduce additional facilities. They are funded at least partially by local authorities and are operated by non-governmental organizations with regard given to police and community interests. The facilities evolved from initially being informal in nature to receiving official government approval, despite opposition from some quarters:

Operating under semi-legal status since 1994, the city-funded rooms were fully legitimized by the German parliament in February [2000]. That move has appalled German conservatives and prompted an outcry from the United Nations, which contends that policy behind the rooms clashes with international treaties on combating the drug trade.¹³⁹

The process leading to their establishment was one in which the failure of prohibitionist policies was acknowledged, health risks were escalating, and public nuisance was increasing; they were eventually established after consultation with police, residents, local government, and businesses.¹⁴⁰ In Frankfurt, the community called for the introduction of facilities, following a process of education and discussion; even banks donated money in order to support this initiative.¹⁴¹ Dolan et al write:

Similar to Switzerland, the establishment of these facilities has been a pragmatic attempt to minimize the impact of large open drug scenes in which public injecting, homelessness and a high prevalence of blood-borne viral infections were evident. They also represent to many a logical extension of acceptance-oriented drug services and humane drug policy.¹⁴²

In Frankfurt, the community called for the introduction of safe injection facilities. Even banks donated money in order to support them.

By law, facilities must meet certain standards:¹⁴³ providing counselling; providing mechanisms to evaluate their effectiveness; a client identification system; and measures to prevent criminal offences, particularly drug trafficking. Several of these requirements are intended to guarantee Germany's compliance with its international obligations by casting the initiatives as medical or scientific trials.

Dolan et al highlight some of the most significant features of the German facilities.¹⁴⁴ The clients are over 18 years of age, are not first-time users, are not receiving substitution therapy, do not demonstrate violent tendencies, do not deal or share drugs while at the facilities, do not inject others, and may attend for a maximum of 30 minutes. Registration is not required, although identification is checked. The staff includes social workers, nurses, medical officers and, in some instances, former injecting drug users. One staff member supervises the facility at all times, and no member of staff can assist with injecting. Dolan et al describe the facilities as hygienic, stress-free, humane environments, with private areas reserved for certain practices: "Service delivery is based on harm reduction, acceptance, and anonymity."¹⁴⁵

There are four injection rooms in Frankfurt. According to city drugs official Juergen Weimer, as a result of establishing safe injection facilities in Frankfurt, the number of individuals injecting on the streets has been reduced to nearly zero. In contrast, 10 years ago, 1000 addicts would "hang out in a park," "littering the area with needles and trash, dealing heroin, selling their bodies for money."¹⁴⁶ Moreover, they are "an effective way to contact some of the most marginalized drug-users and reduce the harm of their drug use on individual and community health and public order."¹⁴⁷ According to Weimer, Frankfurt's drug policy, including the establishment of safe injection facilities, "saves human lives." In Frankfurt, drug deaths dropped from 147 in 1992 to 26 in 1999, whereas in Germany as a whole, drug deaths increased by eight percent in 1999.¹⁴⁸ Rates of HIV infection among injecting drug users also appear to have declined. In part, this has been attributed to the presence of safe injection facilities:

As a result of establishing safe injection facilities in Frankfurt, the number of individuals injecting on the streets has been reduced to nearly zero.

According to autopsy results, HIV among drug users declined from 63–65 percent in 1985 to 12–15 percent in 1994. These results are attributed to Frankfurt’s integrated harm reduction strategy, which includes [supervised injecting rooms] and a variety of other low-threshold drug services.¹⁴⁹

The Netherlands

Although Dutch safe injection facilities have existed for many years, they have only recently received government support, reflecting a change in approach to drug policy.¹⁵⁰ As of 2000, there were 16 official facilities in nine Dutch cities, with three other cities planning to establish facilities “in the near future.”¹⁵¹ Dolan et al note that they are founded on principles of drug tolerance rather than abstinence and were developed to meet the needs of youth with “psychosocial problems.”¹⁵² Like those that have existed in other jurisdictions, the nature of the services offered has evolved over time. And, as is the case elsewhere, the motivation for establishing centres was the need to reduce public nuisance and the health dangers usually associated with street-based injecting.¹⁵³

One facility in Rotterdam “provides a supervised injecting place as well as a cafeteria, an activity centre and classes in handicrafts, painting and drawing, and Bible studies.”¹⁵⁴ A survey of this facility’s clients revealed that 60 percent used it for reasons other than it being a safe place to inject.¹⁵⁵ Forty percent of clients are homeless (many of them sleep at the facility), 80 percent are male, and 84 percent are at least 30 years of age.¹⁵⁶

Although the impact of safe injection sites in the Netherlands has not been subject to thorough research, an evaluation of the facility in Arnhem showed that there had been a reduction in the use of drugs on the streets and a consequent decrease in hazardous behaviour among users.¹⁵⁷

Australia

Three Australian state and territory governments (New South Wales, Victoria, and the Australian Capital Territory) have attempted to begin trials of safe injection facilities with varying degrees of success. These initiatives have been the subject of considerable controversy and debate, and have been met with some resistance.

Most commentators concur that the most effective way of ensuring the success of safe injection facilities is to amend the criminal law (rather than rely on administrative or regulatory actions), so as to protect staff and users from criminal prosecution.¹⁵⁸ The three Australian proposals have followed this route, aiming to ensure that facilities can be operated and used with greater confidence.

New South Wales

An unsanctioned but supervised room was operational for a few weeks in 1998 in the Wayside Chapel – a Uniting Church facility.

In New South Wales, as part of its inquiry into the NSW Police Service in 1997, the Wood Royal Commission recommended a trial of safe injecting facilities. Noting that the NSW Government funds needle and syringe exchange schemes to reduce the spread of bloodborne diseases, Commissioner Wood asserted that it is short-sighted to not go further, to provide the sanitary facilities in which the drugs could be injected.¹⁵⁹ In response to Justice

Wood’s suggestion, the Parliament of New South Wales set up a Joint Committee in 1997, which, in an extensive report, recommended that safe injecting facilities not be trialed for several reasons.¹⁶⁰ These included safety concerns associated with administering and oper-

ating injecting rooms, increased crime risks associated with injecting rooms, questions concerning the impact on attitudes toward drug use, and questions of resource allocation. However, the Joint Committee also set out mandatory requirements to be adhered to if such centres were to be established. In the interim, an unsanctioned but supervised room was operational for a few weeks in 1998 in the Wayside Chapel – a Uniting Church facility in Kings Cross. The police subsequently closed it, although charges against the Reverend were later dropped.¹⁶¹

In 1999, the New South Wales Government sponsored a Drug Summit to devise a multi-faceted response to that state's increasingly severe drug-use problems. As a result of the Summit, which made over 170 recommendations, the Government announced its support for an 18-month trial of a medically safe injecting facility, established at one locale, that "will provide a gateway to treatment and aim to lessen the impact of drugs on the community":¹⁶²

The Government should not veto proposals from non-government organisations for a tightly controlled trial of medically supervised injecting rooms in defined areas where there is a high prevalence of street dealing in illicit drugs, where those proposals incorporate options for primary health care, counselling and referral for treatment, providing there is support for this at the community and local government level.¹⁶³

Finding a body willing and able to manage the facility proved to be difficult. For example, while the Sisters of Charity (operators of a public hospital near Kings Cross) were prepared to operate a facility, the Vatican vetoed that possibility.¹⁶⁴ This hurdle was overcome when the Uniting Church received an operating licence. The site chosen for the facility was formerly a pinball parlour, which was completely remodeled.¹⁶⁵

"[T]he English-speaking world's first injecting centre"¹⁶⁶ was created by Schedule 1 of the Drug Summit Legislative Response Act 1999 (NSW), which amended the Drug Misuse and Trafficking Act 1985 (NSW). It allowed the Director-General of the NSW Department of Health and the NSW Commissioner of Police to issue one licence in respect of one site for an 18-month trial period.

A licence was to be issued only if the internal management protocols were of a satisfactory standard and only if there was sufficient acceptance at the local government and community level of the facility's proposed site.¹⁶⁷ When selecting the facility's location, attention had to be given to public health and safety, visibility from the street, and proximity to schools.¹⁶⁸

Regulations were to detail the centre's standards, internal management protocols, rules of conduct to be followed by those using the centre, and the functions and qualifications of the centre's employees.¹⁶⁹ All staff supervising the injecting activities must be qualified health professionals. At least one member of staff, available at all times, must have satisfactory experience or qualifications in youth support or child protection.¹⁷⁰ Further, the facility must contain or have satisfactory access to the following services: alcohol and drug counselling, detoxification and rehabilitation, health education, methadone provision, testing for sexually transmissible and bloodborne diseases, and needle and syringe exchange.

A review of the trial is prescribed by the Act, with a report of the outcome of the review to be tabled in Parliament.¹⁷¹

Australian Capital Territory

The Legislative Assembly of the Australian Capital Territory (ACT) enacted legislation in December 1999 permitting the introduction of a safe injection facility, as well as the establishment of a large consultative committee on the matter.¹⁷² The object of the Supervised

Injecting Place Trial Act is to temporarily operate a safe injection facility for the purpose of conducting a scientific trial of the public health benefits and risks of such a place. Under the Act, the facility is to be evaluated by an advisory committee every six months, and before the Act expires the committee is to arrange an assessment of the scientific trial. However, political strife and budgetary difficulties led to a withdrawal of funding, and the trial commencement date has been postponed.¹⁷³ The recently elected Labor Party has committed to evaluating the New South Wales trial results with a view to deciding whether or not the introduction of a facility is desirable in the ACT.

Victoria

The state of Victoria was the site of considerable debate over safe injection facilities during 1999 and 2000. The government proposed the implementation of safe injection facilities in five Melbourne communities with the greatest prevalence of street-based drug use.¹⁷⁴ The proposed scheme was a time-limited trial with a start-up period of six months followed by an 18-month operation period. Goals of the proposal included the reduction of bloodborne infections, as well as the provision of counselling and primary health care. The site was to be staffed by trained medical professionals. In contrast with the New South Wales model, the Victorian multi-site approach had the distinct advantage of providing the opportunity to compare different types of facilities. The government's attempt to enact the proposal, however, was fraught with difficulty, and was blocked by the opposition parties controlling the Victorian Legislative Council.¹⁷⁵

Lessons Learned

Because the initiatives in Victoria and the ACT have been delayed, to date only the New South Wales trial has actually begun to operate. Not surprisingly, the establishment of the facility in Kings Cross, Sydney, has already been the subject of litigation. In 2001, the Kings Cross Chamber of Commerce and Tourism Inc argued in the New South Wales Supreme Court that the Uniting Church in Australia Property Trust was not legally entitled to hold a licence to operate the facility and that the way in which the site was chosen was illegal.¹⁷⁶ Justice Sully decided that the facility could open legally, that the Trust could legitimately lease the Kings Cross building, that the Commissioner of Police and Director-General of the Department of Health had "acted reasonably and within the statutory criteria," and that the challenge failed.¹⁷⁷

After successfully repudiating the challenge, the next practical hurdle faced by the facility operators involved settling upon its commencement date. They hoped to avoid overly zealous media coverage by not disclosing the actual day of opening.¹⁷⁸ In fact, the intense media scrutiny deterred many users from attending, with only eight individuals using the facility on its first day of operation, and only four attending the following day.¹⁷⁹ The facility has the capacity to tend to 16 people at a time, and is expected to handle between 150 to 200 injections over two four-hour operating shifts each day.¹⁸⁰ During the first five to six days, over a hundred people used the facility.¹⁸¹ No arrests were made during its initial commencement period.¹⁸²

A Service Manual appended to the application to operate the facility made the following observations concerning its "target population":

While a range of studies have indicated that most injecting use occurs in private it is estimated that in Kings Cross 44% of injecting drug use takes place in public places (such as streets, parks and public toilets) or in "shooting galleries" (Darke 1999). In August 1999 a survey was conducted of attendees of the K2 Needle Syringe Program (located in the epicentre of the street-based sex work and drug

scene in Kings Cross) regarding their injecting practices. Among the 198 respondents, 52 (29%) last injected in a public place and 77 (44%) last injected alone. Eighty-three percent of those who injected in public indicated that they would have preferred to use a Medically Supervised Injecting Facility.

The primary target population of an injecting room is the population of public injectors and those who inject alone. Members of this group are typically very marginalised, have multiple health and social problems including, in some case [sic], psychiatric conditions and homelessness.¹⁸³

One week after its opening, Australia's first safe injection site was proclaimed a success.

To date, the facility appears to be reaching its target. One week after its opening, it was proclaimed a success, with staff having "saved the life of a man who overdosed on heroin during a visit...."

If the centre didn't exist, it's claimed the man may well have died without supervision."¹⁸⁴ Reverend Herbert of the Uniting Church notes that staff responded immediately and "adequately" to the overdose by providing oxygen, "[a]nd that's good, because it shows that we are dealing with the very issue we were intended to deal with."¹⁸⁵ Further, even though only a handful of individuals attended the facility on its second day of operation, "one of them was a return visitor, a young man, seeking a referral for rehabilitation."¹⁸⁶

Importantly, health-risk messages are communicated to visitors, as are "simple hygiene messages."¹⁸⁷ By the three-month mark, it was reported that there "has been no violence at the centre and no incidents of people trying to sell drugs. Dr van Beek said the Kings Cross police had not reported any changes in the patterns of drug-dealing in the area."¹⁸⁸

Wayne Stuart, an injection drug user living in Kings Cross, notes that those who use heroin include the wealthy and impoverished, employed professionals, and the homeless; but he also highlights the fact that those with money and jobs have the ability, in relative terms, to care for themselves.¹⁸⁹ Commenting on the trial's great potential to provide care, he says that "[t]he big beneficiary [of the injecting centre] is the street user, who's really up against it. There's a lot of people around here who don't have anywhere to live, anywhere to go."¹⁹⁰ Another user, Pauline, 31 years old and homeless, concurs. She has frequently injected on the street during her 13 years of using drugs, as she cannot afford to hire a room in one of the area's illegal "shooting galleries" to inject privately.¹⁹¹

A report released in January 2002 reported that in the first six months of operation:

- 1503 registered individuals used the facility's services over a total of 11,237 visits that lasted an average of 30 minutes;
- approximately two-thirds of clients were men and one-third were women;
- cocaine and heroin were the drugs most frequently used at the facility;
- on roughly one-third of visits, clients received a health-care service (about 50 percent of which were injecting and vein-care advice);
- roughly one in 18 visits resulted in a referral for further assistance (42 percent of which were for drug-dependence treatment, 33 percent were to primary health care, and 25 percent were to social welfare services); and
- 87 drug-related clinical incidents occurred that required medical intervention, including 50 heroin overdoses (42 of which were managed by administering oxygen) and 28 cases of cocaine-related toxicity.¹⁹²

The facility's longer-term effectiveness will be monitored by an evaluation committee, which will assess its effect on reducing overdoses in the community of Kings Cross, its ability to act as a referral service and gateway to treatment and rehabilitation programs, and its effect on criminal activity in the area.¹⁹³



The Legal Issues: International Law

There are legal and ethical obligations to try the establishment of safe injection facilities in Canada.

Based on scientific research and evidence, it is clear that (i) a serious problem of unsafe injection drug use exists, and that (ii) it can potentially be prevented in certain circumstances. Something *can* be done. Moreover, there are legal and ethical obligations to try the establishment of safe injection facilities in Canada. This chapter examines relevant aspects of international law. It argues that international law demands that trials of safe injection facilities be undertaken as part of the international legal obligation to provide Canadians with the highest standard of health possible. Furthermore, it explains that international drug conventions do not prevent the trial of safe injection facilities. In fact, those treaties relevant to drugs expressly permit scientific and medical experimentation. It also outlines the criticism of safe injection facilities by the International Narcotics Control Board but concludes that the Board's view is unnecessarily rigid and need not prevent countries from introducing these measures.

The next chapter will examine domestic legal issues.

Human Rights Obligations

Canada is party to a number of human rights treaties imposing obligations that arguably require the provision of safe injection facilities. The refusal to introduce these facilities may amount to an infringement of our obligations under these treaties.

The Charter of the United Nations, which is legally binding on all countries belonging to the UN, considers social rights, rights of a humanitarian character, and human rights. Article 55 of the Charter specifically states that

the United Nations shall promote: ... solutions of international economic, social, health, and related problems; and universal respect for, and observance of, human rights and fundamental freedoms for all.¹⁹⁴

Furthermore, by virtue of Article 56 of the Charter, all UN member countries have pledged “to take joint and separate action in co-operation with” the UN to achieve these purposes.¹⁹⁵ Finally, Article 103 expressly states that in the event of a conflict between countries’ obligations under the Charter and “their obligations under any other international agreement, their obligations under the present Charter shall prevail.”¹⁹⁶ This would obviously include the international drug control treaties (discussed below).

The body of international human rights law elaborates on countries’ obligations to respect, promote, and fulfill human rights. The Universal Declaration on Human Rights, now recognized as having achieved the status of customary international law and is therefore binding on all countries, states that “everyone has the right to a standard of living adequate for health and well-being, including medical care and necessary social services.”¹⁹⁷

As Chapman, a leading expert in the field, notes: “Health issues are central to human well-being and dignity and, thus, are central to human rights.”¹⁹⁸ Jamar agrees:

Because ... [the right to health] is a human *right*, and not just a moral claim, a state is legally bound to do more than nothing to bring it to fruition; this obligation inheres in the term “right” and is found in the general approach of requiring State Parties to the various conventions to “take steps” to effectuate the right.¹⁹⁹

Two international treaties further define the basic parameters of international human rights law: the International Covenant on Civil and Political Rights (ICCPR)²⁰⁰ and the International Covenant on Economic, Social and Cultural Rights (ICESCR).²⁰¹ The Preamble of the ICESCR speaks of the “inherent dignity ... of the human person” and the duty to promote each person’s economic, social and cultural rights. Article 12 of the ICESCR imposes positive obligations on States that are parties to the Covenant:

(1) The States Parties to the present Covenant recognize the right of everyone to the enjoyment of the highest attainable standard of physical and mental health.

(2) The steps to be taken by the States Parties to the present Covenant to achieve the full realization of this right shall include those necessary for: ... (c) the prevention, treatment and control of epidemic, endemic ... and other diseases; (d) the creation of conditions which would assure to all medical services and medical attention in the event of sickness.²⁰²

All persons have the right to the enjoyment of the highest attainable standard of health – dependent, of course, on the state’s particular economic circumstances.²⁰³ The notion of what is “attainable,” coupled with the obligation on states to “progressively realize” the right to health, suggests that what the ICESCR requires is neither an unachievable ideal nor a bare minimum, but a realistic standard, suited to a particular nation’s state of economic development and capacity, and a good-faith attempt to improve that standard.²⁰⁴ Clearly, regard must be had to the state’s available resources in deciding whether or not it is meeting the legal obligation it has assumed under the treaty.

Not surprisingly, given its generality, the ICESCR does not discuss the particular public health concerns associated with drug use, such as dependence, overdose, and HIV and other bloodborne diseases. While Article 12(1) defines the right to health, Article 12(2) “enumerates illustrative, non-exhaustive examples of States parties’ obligations.”²⁰⁵ General Comment No 14 of the UN Committee on Economic, Social and Cultural Rights notes that

Canada is party to a number of human rights treaties imposing obligations that arguably require the provision of safe injection facilities.

“the right to health must be understood as a right to the enjoyment of a variety of facilities, goods, services and conditions necessary for the realization of the highest attainable standard of health.”²⁰⁶ This at least partially addresses some of the concerns that health – as a right – is ambiguous, reflecting “cultural, social and economic circumstances, as well as individual and medical perceptions of what is normal, habitual, and attainable.”²⁰⁷

The General Comment notes that states cannot provide protection against every possible cause of human ill health, including unhealthy or risky lifestyles.²⁰⁸ But it does state that Article 12(2)(c) of the ICESCR requires “the establishment of prevention and education programmes for behaviour-related health concerns such as sexually transmitted diseases, in particular HIV/AIDS ... and the promotion of social determinants of good health, such as ... education.”²⁰⁹

Violations of the obligation to protect include “the failure to discourage production, marketing and consumption of tobacco, narcotics and other harmful substances.”²¹⁰ While some would argue that the introduction of safe injection facilities is contrary to this obligation, it must be emphasized that these facilities are not intended to encourage drug use. In fact, they are only accessible to those who already use drugs, and provide a means of connecting drug users to drug treatment programs and other services that can reduce or eliminate drug dependence. They are meant to reduce health risks in situations where drug use would in any event take place, under dangerous conditions. Furthermore, they are intended to help give effect to other core responsibilities associated with the right to health: “adopting measures to ... control, treat, and prevent the transmission of major epidemic and endemic diseases, including ... AIDS.”²¹¹

Clearly, it cannot be claimed that the state is in breach of its human rights obligations by not controlling all drug-use behaviour. Rather, the right to health in international law is centred on the state’s obligation to take proactive measures – bearing in mind its resources – to

The right to health should be viewed as “an inclusive right extending not only to timely and appropriate health care but also to the underlying determinants of health ... and access to health-related education and information.”

ameliorate or prevent some of the serious health consequences of injection drug use, such as the spread of disease. Moreover, with the changing nature of the health problems facing the international community, and, in particular with the spread of HIV, there is an increasing need to recognize that the right to health should be viewed as “an inclusive right extending not only to timely and appropriate health care but also to the underlying determinants of health ... and access to health-related education and information.”²¹²

As several commentators have argued, and as experience from other countries has shown, one critical way of reaching some street-based injecting drug users, in order to not only care for their immediate health-care needs but also to provide them with education and information about treatment programs, is by introducing safe injection facilities. The provision of facilities therefore falls squarely within the article’s terms.

That said, it should be noted that a state has a margin with respect to its determination of those measures that best meet its needs. It could be argued that Canada, which has a serious problem of HIV/AIDS, hepatitis C, and drug overdoses among injection drug users, should be measured against similarly situated, relatively wealthy jurisdictions (such as Switzerland, the Netherlands, Germany, and Australia) that have endeavoured to tackle the problem by means of introducing novel harm-minimization measures, including safe injection facilities. Provision of clean injecting equipment in a hygienic environment, with trained health personnel to prevent the adverse effects of overdose or unsafe injection practices, is a clear

example of the sort of measure required, because it reduces the spread of preventable diseases and the high incidence of drug overdose. This initiative has the capacity to direct users to treatment and similar programs. Ultimately, if a wealthy, developed state like Canada does not implement *all plausible measures* that could conceivably reduce harm, it is in violation of these obligations under the ICESCR.

The same could be said with respect to Article 6 of the ICCPR, which states: “Every human being has the inherent right to life. This right shall be protected by law. No one shall arbitrarily be deprived of his life.” International human rights treaties protect the right to life, liberty, and security of the person. This norm of international law should be given a liberal rather than a restrictive interpretation, because of the fundamental nature of the subject matter. According to the United Nations Human Rights Committee, the right “should not be interpreted narrowly,” and states must adopt positive, proactive measures to protect human life, including those that can help reduce the spread of epidemics.²¹³ The ways in which this right can be protected and promoted in this context, whereby potentially fatal diseases and overdoses can be prevented, are clear: instituting any and all affordable harm-reduction measures.

Writing in the HIV/AIDS context with respect to states’ responsibilities under human rights treaties to promote health and prevent disease wherever possible, Gruskin notes that “the right to the highest attainable standard of physical and mental health appears in one form or another in almost all of them ... [and] nearly every article of every document can be understood to have clear implications for health.”²¹⁴ She comments that, while HIV and the rights of persons living with HIV are not specifically cited in the instruments, “all the international human rights mechanisms responsible for monitoring government action have expressed their commitment to exploring the implications of HIV/AIDS for governmental obligations.”²¹⁵ Gruskin also observes a “tremendous gap between rhetoric and practice.”²¹⁶ With respect to the care of persons infected with HIV, others argue that these treaties can be interpreted as requiring parties “to ensure access to appropriate medical care unless they can justify otherwise.”²¹⁷

By analogy, the same could be said with respect to the provision of safe injection facilities in the face of the problems related to street-based injection drug use. The conventions can be read as embracing health-care issues related to drug use. The obligation to provide all persons in the community with the *highest attainable standard* of health is clearly infringed when deliberate policies thwart the establishment of these potentially life-saving, disease-preventing measures. Focusing on the seriousness of the dangers associated with unsafe injection drug use – that is, the immediacy and urgency of the problem – it can be argued that the obligation to establish injection facilities meets even the most core, fundamental description of the right to health: “the right to health imposes a duty on a state to intervene or act, to the extent of its available resources, to reduce or address serious threats to the health of individuals or the population.”²¹⁸

Drug-Control Obligations

Do international drug conventions prevent Canada from introducing safe injection facilities?

There are three relevant treaties to which Canada is a party:

- the 1961 Single Convention on Narcotic Drugs (as amended by the 1972 Protocol Amending the Single Convention on Narcotic Drugs);

All the international human rights mechanisms responsible for monitoring government action have expressed their commitment to exploring the implications of HIV/AIDS for governmental obligations.

- the 1971 Convention on Psychotropic Substances; and
- the 1988 United Nations Convention Against Illicit Traffic in Narcotic Drugs and Psychotropic Substances.²¹⁹

It is often incorrectly assumed that these treaties require signatory countries to adhere strictly to a criminal prohibitionist approach to drug use. In reality, they incorporate provisions

Do international drug conventions prevent Canada from introducing safe injection facilities?

permitting various health-based approaches, including harm-reduction measures. Indeed, a 1972 UN conference led to the adoption of a Protocol Amending the [1961] Single Convention that “highlights the need for treatment and rehabilitation of drug addicts.”²²⁰

It has been suggested that safe injection facilities are anti-rehabilitative in nature, because they will maintain users’ dependence.

However, there is no evidence that this is so. As noted earlier, experience elsewhere suggests that drugs that would otherwise be used unsafely on the streets are used hygienically in safe injection facilities, with a lessened fear of overdose and disease. Significantly, they provide an opportunity for health workers to reach out to an otherwise inaccessible population of users, with a view to directing at least some of them to treatment. In any event, the question of whether or not the presence of facilities fosters rehabilitation is not in itself a legal one: it is factual, best determined by the experts in the field – social workers, doctors, scientists, and researchers.²²¹

Several articles in the international drug control treaties can be interpreted as permitting or even supporting harm-reduction efforts that require states to implement particular policies not concerned with criminal penalty. Importantly, Article 38(1) of the 1961 Single Convention, entitled “Measures Against the Abuse of Drugs,” states:

The Parties shall give special attention to and take all practicable measures for the prevention of abuse of drugs and for the early identification, treatment, education, after-care, rehabilitation and social reintegration of the persons involved and shall co-ordinate their efforts to these ends.

Interestingly, the conventions do not spell out how this treatment and rehabilitation is to be accomplished and do not indicate what measures ought to be taken to effectively meet these objectives. States have discretion as to how they give effect to these obligations, which are cast in flexible and vague terms.²²² For example, the provisions do not precisely define “practicable measures” that states may take as alternatives or to the prosecution and punishment of addicted people who commit criminal offences.²²³

Several articles in the international drug control treaties can be interpreted as permitting or even supporting harm-reduction efforts.

Moreover, it should be noted that none of the Conventions specifically refer to safe injection facilities, just as they do not refer to other specific types of harm-reduction measures such as methadone maintenance programs, syringe exchanges, or pre-

scription heroin trials. Therefore, the basic characteristics of safe injection facilities, their objectives, and how they operate must be borne in mind, in order to determine whether they are covered by the international instruments – as either prohibited or in fact permitted within the terms of those documents.²²⁴ In the context of safe injection facilities, the only relevant and plausible potential infringements of these conventions involve the consumption or use of drugs or the possession of drugs for personal use. Articles concerning cultivation, manufacture, sale, and trafficking are irrelevant, as these are not tolerated at safe injection facilities.²²⁵

Further, the vagueness of the conventions permits parties to look to state practice to help determine how to interpret the provisions.²²⁶ In global terms, state practice is undeniably inconsistent. On the one hand, Switzerland, Germany, and the Netherlands (and, most recently, Luxembourg, Spain, and Australia) have established safe injection facilities, whereas countries such as the United States have not. This lends support to the argument that responses to harms associated with injection drug use should be left to the discretion of states, which can, on their own terms, assess the best way of serving their communities. The conventions themselves concede a degree of latitude to a state's "prevailing conditions," "constitutional limitations" and "legal system and domestic law."²²⁷ In fact, these important provisions arguably allow for the continuation of trials, should they prove successful, as permanent strategies – with eventual treatment and rehabilitation opportunities the optimal outcome.

The 1961 Single Convention on Narcotic Drugs

Aside from the positive obligations to assist drug users with treatment, the conventions also require states to criminalize many aspects of drug use. However, concessions nevertheless exist that would arguably encompass trials of safe injection facilities.

The 1961 Single Convention states in Article 4(c): "The parties shall take such legislative and administrative measures as may be necessary ... subject to the provisions of this Convention, to limit exclusively to medical and scientific purposes the ... use and possession of drugs."²²⁸ There are no additional provisions that more fully define "medical and scientific purposes."²²⁹ Indeed, this definition has not been interpreted conclusively. It can reasonably be argued that trials of safe injection facilities fall within the scope of the term: they are trials, intended to be a gateway to rehabilitation; they incorporate record-keeping measures; and are to be evaluated after a period of time.²³⁰ These elements indicate that injecting facilities do not infringe Canada's international treaty obligations.

There is further additional support for the claim that safe injection facilities are permissible under the Convention. Although it says countries shall limit the use and possession of drugs "exclusively to medical and scientific purposes," it also states in the same sentence that this obligation to take such limiting measures is "subject to the provisions of this Convention."²³¹ Other provisions in the Convention, including the very requirement to criminalize drugs, state that a country's obligations under the Convention are "subject to its constitutional limitations."²³² Those constitutional limitations could include measures to protect the life and security of the person against government abuse and to ensure the equal benefit of the law to all, as is the case in Canada.

Furthermore, the Convention requires the state to "give special attention to and take all practicable measures to provide treatment, education, aftercare, rehabilitation and social reintegration of drug users,"²³³ and that notwithstanding the requirement to criminalize possession contrary to the Convention, countries may provide these measures "either as an alternative to conviction or punishment or in addition to conviction or punishment."²³⁴ Finally, referring again to UN Charter Article 103, a state's obligations under the Charter (which include solving health problems and securing universal respect for human rights) must take precedence over any conflicting obligations under any other international agreement.

The 1961 Convention does state that "the Parties shall not permit the possession of drugs except under legal authority."²³⁵ It can be argued that, as long as laws relevant to possession are enacted, there is leeway with respect to what those laws can provide. "Legal authority" could, in fact, allow for possession in certain circumstances – as long as doing so is still in compliance with the other Convention obligations (including those obligations, as

mentioned, that exist under a country's constitution or under the Convention itself to provide care, treatment, and social reintegration of drug users). As the Swiss Institute of Comparative Law notes: "We are thus left with the question of whether legalisation of the simple possession of drugs for the purpose of personal consumption in an environment of socio-medical care would contradict the object and purpose of the Convention."²³⁶ The provision of heroin in Switzerland is said to be part of a "controlled availability trial" to reduce harm where it serves a medical or scientific purpose. There is certainly a credible legal position that pilot heroin-maintenance projects would not violate the 1961 Convention (or the 1971 Convention discussed below).²³⁷ A similar characterization may be made with respect to safe injection facilities, with their potential role as a gateway to education and rehabilitation – thereby rebutting allegations of treaty violations.

The 1971 Convention on Psychotropic Substances

Under the 1971 Convention on Psychotropic Substances, Schedule I drugs (eg, LSD, MDMA/ecstasy, mescaline, some cannabinoids) are treated differently from Schedules II, III, and IV drugs (eg, amphetamines, barbiturates) in the context of personal use.²³⁸

States are obliged "to prohibit all use [of Schedule I drugs] except for scientific and very limited medical purposes by duly authorized persons, in medical or scientific establishments which are directly under the control of their Governments or specifically approved by them."²³⁹ Once again, there must be a factual determination as to whether or not safe injection facilities meet this description. If so, countries are free to decriminalize drug possession on the premises of such facilities. Safe injection facilities could reasonably be characterized as serving "very limited medical purposes."

The standards relevant to Schedules II, III, and IV drugs are less onerous than those applied to Schedule I drugs: parties have the discretion to take such measures as they consider appropriate to restrict possession and use of Schedule II, III, and IV drugs for scientific and medical purposes.²⁴⁰

The 1971 Convention (Article 20) contains the same obligation as the 1961 Convention (Article 38) for states to "give special attention to and take all practicable measures" to provide care, treatment, and social reintegration of drug users. This again provides a legal foundation in an international drug control treaty for governments to implement such measures as safer injection facilities.

The 1988 Convention against Illicit Traffic in Narcotic Drugs and Psychotropic Substances

The 1988 Convention against Illicit Traffic in Narcotic Drugs and Psychotropic Substances²⁴¹ establishes a comprehensive regime to criminalize, prosecute, and punish behaviour associated with trafficking in drugs,²⁴² with an obligation that penalties be severe and that officials' discretionary powers relating to prosecution for drug offences "are exercised to maximize the effectiveness of law enforcement measures ... and with due regard to the need to deter the commission of such offences."²⁴³ Possession for personal consumption is treated distinctly from more serious offences, such as the manufacture, sale, and trafficking of drugs. States' obligations with respect to the different types of more serious offences are far stricter than those relevant to the less serious conduct of possession for consumption: the latter obligations give parties a much greater degree of discretion in determining how they may respond.

By requiring states to criminalize the possession of controlled drugs for personal consumption, this article does arguably pose a hurdle (which can be circumvented) to those advocating the introduction of facilities. Yet, like the 1961 Convention, the 1988 Convention

does stipulate that states may individually decide how this should be addressed. Most importantly, perhaps, while the Convention does provide that states shall adopt such measures “as may be necessary” to make it a crime, under domestic law, to possess a narcotic drug or psychotropic substance, this requirement is qualified in two ways.

First, the obligation to impose criminal sanctions goes no farther than the equivalent obligations in earlier conventions, and stipulates that states may individually decide how this behaviour should be addressed. The requirement is to criminalize possession for personal consumption “contrary to the provisions” of the previous conventions. As has been noted, these conventions include a number of provisions that could provide a home for the legal operation of safe injection facilities, in which case the state would not be obliged under the 1988 Convention to criminalize possession across the board.

Second, the obligation of a state to criminalize possession is “subject to its constitutional principles and the basic concepts of its legal system.”²⁴⁴ Therefore, uniform measures and responses are not required with respect to punishing, prosecuting, and criminalizing the possession of narcotics (or psychotropic substances) for personal use, because states have the discretion to determine the policies they wish to adopt (although they must address this issue somehow).²⁴⁵

This provision provides a further basis for concluding that the trial of safe injection facilities can be accommodated under the 1988 Convention. Canada’s legal system incorporates the principle *de minimis non curat lex*, a long-standing common law concept that means, roughly, “the law does not concern itself with the trivial.” In this context, the simple possession of drugs in a personal-use facility is of minimal significance when compared to the kinds of conduct of fundamental concern, such as trafficking. The overriding spirit of the mischief addressed in the treaty must be borne in mind when it is interpreted and applied. This is especially so when a country such as Canada is facing a public health crisis and makes efforts to divert drug users from drug use to rehabilitation through measures such as safe injection facilities that provide the opportunity to be exposed to diversion messages, programs, and support services. Furthermore, in technical terms, the actual possession of drugs in the facility is for a very short period of time, until the drugs are used. Outside the facility, possession becomes a criminal offence, which can still be enforced by local law-enforcement agencies.

Finally, it is worth reiterating the fact that the 1961 and 1988 conventions are essentially directed at “trafficking,” as neither of them requires that possession for personal consumption per se be criminalized, and they do not require conviction and punishment for possession: “The conventions do not take an exclusively prohibitionist approach to illegal drugs, but contain provisions allowing signatories to adopt harm-reduction measures.”²⁴⁶

In international law there is leeway that permits the legitimate introduction of safe injection facilities. Possession for the purposes of consumption in injecting facilities – where, for example, trafficking, sale, and distribution are prohibited – may be tolerated. The initiatives in countries such as Australia, Switzerland, the Netherlands, and Germany fall within the relevant international instruments’ margins of appreciation – as scientific or medical tests, or as means by which social reintegration, rehabilitation, or treatment might (eventually) take place.²⁴⁷ The Swiss Institute of Comparative Law concludes:

The ... conventions do not provide any guidance on the essential question of whether or not public injection rooms are in fact conducive to the rehabilitation and social reintegration of drug addicts in the short term and to the reduction of human suffering and the elimination of financial incentives for illicit traffic in the long term. The actual practice of States ... could provide some guidance, if it is

substantially uniform. If not, it must be concluded that States Parties ... retain the freedom to make their own policy choices.... States ... are not obliged ... to prosecute and punish the possession and consumption of drugs (other than those psychotropic substances which are listed in Schedule I to the 1971 Convention) by addicts in [facilities]. This conclusion is subject only to the caveat that activities which counteract the object and purpose of the conventions must not be tolerated, but that is simply to restate the question of the underlying socio-medical utility of public injection rooms.²⁴⁸

International Narcotics Control Board: criticism of safe injection facilities

The International Narcotics Control Board (INCB) assesses compliance with the treaties. The Board is “the independent and quasi-judicial control organ for the implementation of the United Nations drug control conventions ... [and] is independent of Governments as well as the United Nations.”²⁴⁹ Established by the 1961 Single Convention, the Board’s responsibilities include assisting states in their attempts to adhere to the Conventions’ requirements.²⁵⁰ It does not have the power to interpret or adjudicate the Conventions in any binding way, as that is a matter of state practice. Rather, it can only make recommendations, “[s]o when they make their statements it is their opinion and unenforceable at international and national law.”²⁵¹

The Board comments on ways in which states have complied with their obligations and have applied the treaties as effectively as possible, and “identifies where weaknesses in the national and international control systems exist and contribute to correcting the situation.”²⁵² It can recommend changes to drug-control regimes²⁵³ and maintain ongoing discussions with governments in attempts to further the treaties’ objectives.²⁵⁴ In fact, if the Board determines that the treaties’ aims are seriously jeopardized within a particular state, it has the right to propose that consultations be opened with the government concerned, calling for explanations from that government concerning the situation.²⁵⁵ The Board can also call upon the government concerned to adopt remedial measures. If in the Board’s view the situation continues to be serious, without likely resolution or remedy, the matter can ultimately be brought to the attention of the United Nations General Assembly (after the Economic and Social Council and Commission on Narcotic Drugs have had an opportunity to resolve the problem).²⁵⁶

The INCB is well known for its views opposing the establishment of safer injection facilities.²⁵⁷ In its annual report in 1999, submitted to the United Nations Economic and Social Council, the Board “tries to identify and predict dangerous trends and suggests necessary measures to be taken.”²⁵⁸ It states that any government that sets up supervised injecting rooms “to facilitate the abuse of drugs ... also facilitates illicit drug trafficking.”²⁵⁹ It notes states’ obligations to combat trafficking and criminalize possession and purchase for personal consumption – albeit subject to the basic concepts of their legal systems and constitutional principles.²⁶⁰

While maintaining that the establishment of safe injection sites is a breach of these treaty requirements, the INCB acknowledges the seriousness of the problems associated with drug use – such as the spread of bloodborne diseases – and “encourages Governments to provide a wide range of facilities for the treatment of drug abuse.”²⁶¹ Notwithstanding its recognition of the problem, in its 1999 Report the INCB still “urges the Government of Australia not to permit the establishment and operation of drug injection rooms, or so-called ‘shooting galleries.’”²⁶² The report notes that “[t]he international drug control treaties were established many decades ago precisely to eliminate places, such as opium dens, where drugs could be abused with impunity.”²⁶³

But comparing supervised injecting facilities with dangerous, illegal opium dens and shooting galleries undermines any serious attempts by the Board to convince states to desist from introducing carefully considered, publicly debated reform measures advocated by bodies as diverse as those represented by scientists and law-enforcement officials. Those states introducing safe injection facilities (or considering doing so) are well aware of both the political sensitivity of the issue and the true nature of the continuing public health risk they face if facilities are not trialed. They are unlikely to be convinced to do otherwise by the use of hyperbole and inappropriate, misguided analogies.

Australian proposals to trial supervised injecting facilities have been controversial, resulting in highly charged political debate.²⁶⁴ One specific point of contention between the Prime Minister and the three State and Territory leaders supporting the introduction of such sites concerned the legality at international law of such sites. Not surprisingly, the Commonwealth Government seized upon the Board's opinion in its 1999 Report to criticize the States' and Territory's initiatives.

The treaties and the INCB's views also have been the subject of debate in State and Territory Parliaments. During second reading of the Drug Summit Legislative Response Bill 1999 (NSW), the NSW Special Minister of State asserted that the 1961 Single Convention permitted the possession and use of illicit drugs, including controlled clinical trials, for medical and scientific purposes.²⁶⁵

He further noted that the treaty provides leeway in which signatories may depart from blanket prohibitions where it is appropriate to do so, in the interests of protecting public health and welfare and having regard to the prevailing conditions in the relevant country.²⁶⁶ The Minister emphasized that the NSW Bill fit precisely within this framework, as it proposed a limited, scientifically evaluated trial in which medical supervision is present, and whose ultimate aim is to assist individuals in overcoming their addictions – the model adopted is a “gateway to treatment.”²⁶⁷ The NSW Government asserted that in its view the treaties permit “scope for reform and for harm minimisation measures.”²⁶⁸ The Bill's proponents stated that “[t]here is no doubt that the establishment of medically supervised injecting rooms should be accompanied by rigorous, systematic monitoring and evaluation” and that “such an approach is embedded in the Drug Summit communiqué”²⁶⁹ issued by the NSW Government in 1999. Noting the “prevailing conditions” discretion available to states to give effect to the conventions, the NSW Government argued that facilities are permissible where evaluation and monitoring demonstrate that they are beneficial to public health and welfare; it drew an analogy with needle exchange programs, which were also argued to comply with international law commitments.²⁷⁰

In contrast, Opposition members in the NSW Parliament cited Athol Moffitt's criticism of the proposed trial. Moffitt, former President of the NSW Court of Appeal, noted that the Bill's provisions clearly breached international obligations.²⁷¹ The INCB's comments were also used to refute the validity of the trial at international law.²⁷² Yet one Government member stated that the treaty issues are “arguable from either point of view, but I would think that it is clear enough that these treaties are not inflexible; they contain a range of possibilities in relation to public health and harm minimisation measures.”²⁷³

As in New South Wales, the Victorian scheme (which has yet to proceed) also appears to have been drafted with a view to recognizing Australia's treaty obligations and ensuring

“These treaties are not inflexible; they contain a range of possibilities in relation to public health and harm minimisation measures.”

– J Shaw

compliance with these international responsibilities.²⁷⁴ For example, it detailed the ways in which the trial would be independently evaluated, including publication of records of the number of visits to the facility, the regularity of the visits, incidence of overdose, and prevalence of bloodborne diseases.²⁷⁵ In accordance with international requirements, facility staff members were to provide information and counselling about the risks of injecting, and provide links to other service and treatment providers. Furthermore, the Minister of Health was to conduct the trial in conjunction with the Department of Human Services, with the Department appointing a senior clinician to medically supervise it.²⁷⁶

Prime Minister Howard invited representatives of the INCB to visit Australia to provide advice on the proposals. The Board sent a mission in April 2000.²⁷⁷ In its meeting with the

When the International Narcotics Control Board criticizes safe injection sites because they will not help reduce “drug abuse and trafficking,” it ignores the sites’ objectives: to help save the lives of those who inject in public places.

INCB, “NSW, Victoria and the ACT all argued that the medically supervised injecting room projects fell within the sections of the conventions that permit strictly controlled ‘medical or clinical trials’ of new drug treatments or reforms.”²⁷⁸ Nevertheless, in another report issued in February 2001, the Board continued its criticism. It noted that those Australian jurisdictions wishing to trial safe injection facilities “unfortunately challenge the policy of the federal Government and choose to support policies that run counter to the treaty obligations limiting the use of drugs to medical and scientific purposes only, by establishing heroin injection rooms where illicitly obtained drugs can be injected under supervision.”²⁷⁹ Bill Stronach, Chief Executive of the Australian Drug Offensive, notes that when the INCB criticizes safe injection sites

because they will not help reduce “drug abuse and trafficking,” it ignores the sites’ objectives: to help save the lives of those who inject in public places and to provide them with access to treatment and support services, as well as provide the community with a safer environment and a reduction in risks associated with used needles.²⁸⁰

It is apparent from the INCB’s Reports that the Board’s objection to safe injection facilities is part and parcel of a larger criticism. The Board rejects harm reduction as a “goal in itself” and asserts that “such a strategy should not be adopted at the expense of a strong commitment to reduce both the supply of and demand for illicit drugs.”²⁸¹ This hostility to harm-reduction measures may, in part, arise from political pressures brought to bear on the INCB. At the NSW Joint Select Committee, Dr Manderson noted the reality of interpreting the Conventions with a view to initiating supervised injecting facilities, saying that

there is certainly pressure from some sources, particularly the United States, for them to be interpreted in a certain way, but interpretation is a question of State parties and the practices of State parties.... [T]he kind of limited harm reduction measures that we are talking about ... fall within the acceptable boundaries of State discretion within the terms of those conventions.... [T]hat has been even more the case over the last ten years, where the movement towards some of these ... principles has been taking place in a number of countries ... including Australia. I think there is a pretty good State practice as to a broad interpretation of what those requirements are, although there may be some countries in the world that think they have ownership of the meaning of those conventions, they do not.²⁸²

It is worth noting that in theory, a state could denounce its treaty obligations. It might want to do so if it believes that the treaties constrain it to such a degree that it could not pursue

harm-reduction policies seen to be in the best interests of its population – perhaps as a result of a negative appraisal by the INCB. That is, if these provisions are deemed to be inordinately restrictive on the state’s policymakers and are therefore deemed undesirable, the state could refute these obligations, as permitted by the conventions themselves as well as the Vienna Convention on the Law of Treaties.²⁸³ Of course, the political ramifications of such a move – for example, the response of the United States, in trade terms – could be devastating, and should not be understated, as is the case with the following assertion:

A fairly common device [used by anti-prohibitionists] is to blame the United States for imposing the conventions on the world and then to assert that the United States cannot dictate what is best for Australia. This does not negate the obligation. Australia, as a mature and independent-minded nation, signed the Conventions involving international co-operation and – after delays, consideration and consulting the states – ratified them.²⁸⁴

This seems to be a rather naive non-assessment of the realpolitik at play in ratifying these treaties. It does not engage with inequality of bargaining power issues and the degree to which state sovereignty is often present merely in form rather than substance (the substantive equality among states being rather illusory). Further, the authors quoted downplay the overwhelming significance of health issues, highlighted in the present context by the urgent need to trial safe injection facilities.

In any event, it should again be emphasized that going so far as to denounce the drug control conventions is not necessary for countries to move forward with implementing harm-reduction measures such as safe injection facilities. As has been argued above, the conventions themselves permit the establishment of such facilities as a step toward fulfilling our international human rights obligations.



Domestic Legal Issues

This chapter provides a general examination of criminal and civil liability under Canadian law regarding the operation of safe injection facilities. It concludes that the concerns about criminal and civil liability, often exaggerated, are not insurmountable obstacles to implementing such facilities. The chapter then provides a brief overview of the question of government liability for failing to take such measures in the interests of protecting and promoting the health of drug users and the public. Finally, it examines some key questions that should be addressed by a regulatory framework governing safe injection facilities developed by the federal government.

Criminal Liability of Staff and Operators of Safe Injection Facilities

Possession of used syringes as a “controlled substance”

The *Controlled Drugs and Substances Act* (CDSA) was enacted in May 1997, consolidating several previous drug policy statutes. Under the CDSA, the unauthorized possession, manufacture, cultivation, trafficking, export and import of specified substances is expressly forbidden. These laws extend to anything containing an illegal drug as well, if it is intended for use in producing the drug or introducing it into the human body – for example, a used needle that has traces of heroin or cocaine on it. This means that staff members of safe injection facilities who are in possession of used syringes or other equipment could, technically, face prosecution for possession of a controlled substance.

Needle exchange employees must rely on law enforcement or prosecutorial discretion to evade criminal charges.

As with needle exchange facilities, there is no special exemption or protection in the Act for health-care workers involved with injection drug users who are knowingly in possession of used equipment. As stated by Bruckner, needle exchange employees must rely on “law enforcement or prosecutorial discretion to evade criminal charges.”²⁸⁵ Operators and employees of a safe injection site would be in a similar legal position, principally relying on police and prosecutorial discretion to avoid criminal charges.

Given that needle exchange or distribution programs have operated with official sanction for several years in many Canadian municipalities, it seems that this provision in the *Criminal Code* should be no barrier to safe injection facilities providing clean needles to drug users. Nonetheless, clarification of this legal uncertainty is warranted so as to remove any threat of criminal liability for staff and operators of both needle exchange programs and safe injection facilities.

Promotion or distribution of “drug paraphernalia”

As noted above, it is also conceivable (although unlikely) that the “drug paraphernalia” provisions of the *Criminal Code* could give rise to criminal liability on the part of staff at a safe injection facility, as they do for needle exchange staff. The *Criminal Code* makes it an offence for anyone to knowingly promote or sell “instruments or literature for illicit drug use.”²⁸⁶ Selling is defined as including free distribution. The definition of an “instrument for illicit drug use” includes anything that is “designed primarily or intended under the circumstances” for consuming or facilitating consumption of illicit drugs.²⁸⁷ However, the definition expressly excludes things that are “devices” under the *Food and Drugs Act*, which includes articles and instruments that are made, sold, or represented for use in “treatment, mitigation or prevention of a disease.”²⁸⁸

In all likelihood, this includes at least needles and syringes. It might be less certain that it includes other materials provided at a safe injection site (eg, cookers, spoons, etc). Under the circumstances, these items would be intended to facilitate the consumption of an illegal drug, although in a fashion that would lower the risk of injury such as HIV infection, abscesses, etc. They might therefore fall afoul of the law against distributing drug paraphernalia. That said, at a safe injection facility, these articles promoted and distributed to drug users are “represented for use” in the “mitigation or prevention” of disease. Therefore, they should also be considered “devices” under the *Food and Drugs Act* rather than “instruments for illicit drug use” under the *Criminal Code*.

The same *Criminal Code* provision also prohibits knowingly distributing “literature for illicit drug use.” However, again there is a strong argument to be made that this should not prohibit the distribution of literature at safe injection facilities that provides information and advice about how to inject drugs as safely as possible. The literature that is prohibited is any written or video material that describes or depicts, *and* is “designed primarily or intended under the circumstances to promote, encourage or advocate” the production, preparation, or consumption of illicit drugs.²⁸⁹ In a safe injection facility, material on safer injection practices should not be considered to meet this definition, since it is not aimed at promoting or encouraging the use of illegal drugs, but rather to promote the health of people who use drugs by avoiding unsafe practices.

In the absence of any clear legal situation on this point, staff of safe injection facilities would be relying principally on the exercise by police and prosecutors of their discretion not to pursue charges. It would certainly be preferable to have it clear, in the law, that staff members providing such material at safe injection facilities face no chance of criminal prosecution. But overall this is a relatively remote risk, particularly in the case of injection facilities that have been opened after obtaining government support.

Liability for aiding or abetting possession of illegal drugs

Another unlikely possibility is that staff could face charges of aiding or abetting an offence. After all, as noted above, the International Narcotics Control Board takes the view that any government that permits the establishment of such facilities “could be considered in

contravention of the international drug control conventions by facilitating, aiding and/or abetting the commission of possession and use crimes, as well as other criminal offences including drug trafficking.²⁹⁰ But this extreme, rigid interpretation need not govern the conduct of Canadian lawmakers, law enforcement personnel, or judges.

According to the *Criminal Code*, “aiding” is the provision of assistance in the commission of the crime, while “abetting” is being present at, and encouraging the commission of, the crime.²⁹¹ While the Supreme Court has ruled that a person “is not guilty of aiding or abetting merely because they are present at the scene of the crime,” an individual may be found guilty if he or she has “facilitated” the commission of the crime in any way.²⁹² Theoretically, a prosecutor might argue that the provision of safe needles or the supervision of injection drug use “facilitates” criminal possession of drugs, and that therefore the staff of a safe injection facility could be convicted of aiding or abetting a drug offence.

However, this seems unlikely. Safe injection facilities do not furnish drugs or help users buy drugs. They merely offer a site at which those drugs can be used with lessened risk of injury. Furthermore, staff at needle exchange programs could also theoretically be charged with aiding or abetting the criminal possession of illegal drugs, but there appears to be no reported case of such a prosecution in Canada. As noted above, clarifying that staff of needle exchanges and safe injection facilities are not open to this kind of secondary liability under the criminal law would be a positive signal of government support for such projects.

Criminal negligence charges

Finally, it is possible that safe injection facilities operated by health-care facilities could face charges of criminal negligence if prosecutors could prove that facilitating the use of drugs led to the harm of some individual (user, staff, visitor, etc). For a conviction of criminal negligence causing bodily harm or death, it must be proved by the prosecution beyond a reasonable doubt that in doing something (or in failing to do something there was a legal duty to do), a person showed “wanton or reckless disregard for the lives or safety of other persons.”²⁹³ Canadian courts have decided that this means the person’s conduct must represent a “marked departure from the standard of behaviour expected of a reasonably prudent person in the circumstances.”²⁹⁴

As any other health-care facility (eg, a hospital), a safe injection facility would have a legal duty to take reasonable care to protect all clients and staff from harm. Whether or not staff at

As any other health-care facility (eg, a hospital), a safe injection site would have a legal duty to take reasonable care to protect all clients and staff from harm.

a safe injection facility departed “markedly” from the acceptable standard of a reasonable health-care provider in similar circumstances would be for a court to decide on the facts of a particular case. But there is nothing unique about a safe injection facility that makes it particularly susceptible to this kind of criminal liability for staff. For example, health-care providers in many facilities (eg, hospitals) regularly deal with situations such as drug overdoses, and with patients whose condition or use of a drug (legally prescribed or illegal) may cause them to be at risk of harming themselves or others.

In this respect, safe injection facilities do not differ from other health-care facilities already in operation. The only difference is that safe injection facilities, by their very nature, would tolerate the use of illegal drugs on their premises. But this fact should not in and of itself be sufficient to establish a “marked departure” from the care required of a “reasonably prudent person in the circumstances.” Rather, in the circumstances, the very purpose of the facility would be to assist the willing client in preventing harm that might otherwise happen and is very easily foreseeable. This is the very antithesis of negligence that causes harm.

Options for eliminating concerns regarding criminal liability

As the previous discussion should illustrate, the risks of criminal liability for staff/operators of a safe injection facility are relatively small. Nonetheless, it would be a positive step for policymakers to expressly preclude this possibility, sending an important signal to staff, drug users, and the community at large that such measures are seen as legitimate and important harm-reduction elements of a broader policy response to injection drug use and related harms. There are several legal avenues that could be pursued to facilitate the effective operation of safe injection facilities without concern for criminal liability on the part of site operators, staff, and/or clients.

Administrative agreements

One option would rely on an “administrative agreement” between the various relevant authorities: health authorities, local government, public prosecutors, and law enforcement officials.²⁹⁵ Under such an agreement, there is a tacit understanding that police will not enter facilities except in “extreme circumstances.” This model has worked effectively in other countries with respect to needle exchange programs (Britain) and drug offences (the Netherlands). Public prosecutors could also agree to abstain from prosecuting drug offences that occur within the facility – at least possession offences, although trafficking might still be criminally prohibited.

However, while such agreements would be welcome, reliance on the benevolent discretion of the police or prosecutors – or judges if a matter were to go so far as to produce a charge – to circumvent what might otherwise be seen to be violations of the criminal law, would be inadequate. Dependence on “lenient” interpretations of particular provisions would be too tenuous a basis on which reforms could be founded and criminal sanctions avoided. Furthermore, it leaves clients and staff of safe injection facilities dependent upon the goodwill and political temperament of local authorities, regardless of the need that may exist in a given area for such harm-reduction measures. Rather, express amendments, or legally definite exceptions, to all relevant statutes that might otherwise make the provision and operation of injecting facilities – as well as their use – illegal must be implemented.

Ministerial or regulatory exemptions from criminal liability

One option would be the use of existing statutory provisions to protect staff and users of safe injection facilities from criminal liability. Facilities could seek exemption from the Minister of Health under the CDSA. Section 56 allows the Minister to exempt any person or class of persons from the application of all or any of the provisions of the Act or the regulations if, in the Minister’s opinion, “the exemption is necessary for a medical or scientific purpose or is otherwise in the public interest.”²⁹⁶ This section could be used by the Minister to designate staff and users at safe injection facilities as exempt from criminal liability for offences under the CDSA such as possession of a controlled substance (ie, used injection equipment containing drug residue). All three grounds mentioned in the section (medical, scientific, or public interest) would provide a basis for exempting safe injection facilities.

Alternatively, the federal Cabinet has the power to enact regulations that would have the same effect.²⁹⁷ Furthermore, the Cabinet may, on the recommendation of the Solicitor General of Canada, make regulations “that pertain to investigations and other law enforcement activities conducted under this Act by a

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The Minister of Health could designate staff and users at safe injection facilities as exempt from criminal liability for offences under the CDSA such as possession of a controlled substance.

member of a police force.”²⁹⁸ This power could be used to enact regulations directing police forces that enforce the CDSA to not lay charges against the operators and staff of safe injection facilities, and could also be used to direct police to not lay charges against drug users for possession of drugs or used injection equipment on the premises of a safe injection site.

Since the exemption is only an exemption to the sections of the CDSA, this would not authorize ministerial or cabinet exemptions from the drug paraphernalia provisions found in the *Criminal Code*. However, there could be an indirect way for the federal Cabinet (but not the Minister) to use its regulatory authority under the CDSA to eliminate not only the exposure to possession charges under the Act but also the small risk of drug paraphernalia charges under the *Criminal Code*.

In prohibiting the distribution of “instruments for illicit drug use,” the *Criminal Code* defines “illicit drug use” as the possession of an illegal drug “contrary to the *Controlled Drugs and Substances Act* or a regulation made under that Act.”²⁹⁹ This indicates that changing what is prohibited under the CDSA also controls the definition of “illicit drug use” for the purposes of the drug paraphernalia provisions in the *Criminal Code*. Therefore, by Cabinet regulation, the government could clarify that it is not illegal under the CDSA to possess otherwise illegal drugs on the premises of a safe injection facility. Because possessing and using the drugs at the facility would not be illegal, providing instruments for their use would not be illegal either. This would indirectly protect staff at a safe injection facility from charges of promoting or distributing “instruments for illicit drug use.”

Amendments to drug laws

Finally, going a step further than regulatory or ministerial exemption would be the Australian model of statutory changes to the criminal law. Under the New South Wales Drug Summit Legislative Response Act 1999, individuals using small quantities of drugs at the supervised facilities are exempt from criminal liability. Further, those responsible for the operation and management of the trial facility are also granted exemption.³⁰⁰

As has just been noted, a similar state of affairs could be brought about in Canada, at least with respect to the CDSA, either through the exercise of ministerial discretion by the federal Minister of Health or through federal Cabinet regulations. A less convoluted and more forthright approach (although one that would likely be more politically sensitive) would be for the federal government to explicitly amend both the *Criminal Code* and the CDSA to reassure those who use or work at safe injection facilities (or needle exchange facilities and similar operations) that they will not be found liable for criminal activity.

More generally, amendments to the CDSA could include: permitting drug use in health facilities (which could be defined to include safe injection facilities); removing syringes and other articles that contain drug traces from the definition of a controlled substance under the CDSA; and clarifying that operators and staff of needle exchanges and safe injection facilities are exempt from prosecution on charges of promoting or distributing drug paraphernalia under the *Criminal Code*.

Conclusion regarding criminal liability concerns

The issue of criminal liability does not present an insurmountable barrier to the operation of safe injection facilities. The question of liability for negligent conduct by staff is not appreciably different than for any other health facility. Since staff at safe injection facilities do not purchase or provide drugs, and do not encourage their possession and use, charges of aiding or abetting drug possession would be difficult for prosecutors to sustain. The risk of charges for possession of used injection equipment, or for providing “drug paraphernalia,” is

also relatively minor and, as has been explained, a number of options are open to the federal government to remove this as a concern for facility operators.

Civil Liability of Safe Injection Facility Staff and Operators

Liability for negligence only

There is a possibility that, in spite of all safeguards put in place, a client using a safe injection facility may be injured, fall ill, or overdose as a result of their own conduct and/or staff action (or inaction). Similarly, it is also possible that a client could injure another client or a staff member, or a client or staff member could be injured by a contaminated syringe. These circumstances do not automatically give rise to civil liability. Liability would only arise if the facility has been negligently operated, or if a staff member has acted negligently, in which case the entity operating the facility could be held “vicariously liable” for their employee’s negligence. It is only in negligently providing care or operating a safe injection facility that there is a question of civil liability. In such a case, the site operator could be liable in negligence if it had not exercised reasonable care in implementing adequate protective measures.

It should, of course, be remembered that patients in other health-care facilities sometimes come to injury because of their own conduct and/or that of health-care providers. Indeed, facilities that deal with people in distress of one sort or another will often be dealing with situations of injury or responding to injury: it is the nature of the work. In such circumstances, sometimes care is provided negligently to those in need, and sometimes staff are injured (eg, through a needle stick). Not all injuries necessarily mean there has been negligence on the part of the facility or its staff. Furthermore, medical personnel are often present at other sites where people participate in risky activities, such as sporting or entertainment events, precisely because there is a foreseeable possibility of injury.

There is nothing unique about safe injection facilities in this regard: facilities supervised by health-care staff are inevitably sites where drug users are at risk of injury as a result of injecting drugs (the goal being to reduce those risks) and where it is possible for staff to be injured. While proper care should obviously be exercised in the operation of a site, the possible liability of site operators for injury to either clients or staff is not a concern that should be exaggerated, as such facilities are no different from other health-care facilities.

The possible liability of site operators for injury to either clients or staff is not a concern that should be exaggerated, as such facilities are no different from other health-care facilities.

Ethical obligations regarding precautions and insurance

What is ethically required is that reasonable care be taken to guard against such risks, and that insurance be in place so that those who may be injured in the course of operating the facility may be compensated. If, under the laws of the province/territory, employees injured in the course of their work at a safe injection facility are not eligible for workers’ compensation, then private liability insurance to cover injuries to employees should be purchased. Similarly, there should be in place, among other workplace health and safety policies, a protocol for ensuring access to testing for HIV, HCV, HBV, and other bloodborne diseases, and access to post-exposure prophylaxis in the event of a possible exposure (as it is reasonably foreseeable that this particular kind of injury could occur in such a workplace).

In the case of injury to a client through negligent conduct on the part of facility staff, liability insurance such as covers health-care professionals in other settings should be established. Some health-care professionals will already be personally covered as a result of

professional liability insurance plans they are legally required to maintain. As with other health facilities such as hospitals, the operators of a site would likely require liability insurance covering the operation of the site beyond the insurance covering the conduct of some professional health-care staff. To date not a single lawsuit has been brought against the employees or operators of safe injection facilities in the several European countries that have been operating them for many years.³⁰¹ Nonetheless, some private insurers may be unwilling to provide this liability coverage at a reasonable price because of an exaggerated assessment of the risk of liability. Therefore, there may be a need for provincial/territorial governments to insure such facilities, at least initially.

Conclusion regarding civil liability concerns

As Jones points out:

The important message here is that civil liability issues are not in any way a serious bar to the operation of a safe injection facility. Indeed, in my view the greatest threat of lawsuits comes from citizens in the neighbourhood of such a site, who may believe that it is a public nuisance. In such a case, though, the harm and inconvenience caused by such a facility is weighed against the benefits; surely the balance of utility tips in favour of the facility, and ultimately such challenges would be unsuccessful.³⁰²

As is the case with international drug control treaties or concerns regarding criminal liability, concerns about civil liability of site staff or operators should not be seen as preventing the operation of safe injection facilities. While liability concerns need to be addressed as a matter

of ethical practice, they are not particularly complex or unique, and do not provide an excuse for inaction.

Commentators have asked whether governments could be held civilly liable for failing to implement (or at least trial) safe injection facilities.

Liability of Government for Inaction

Commentators have asked whether governments could be held civilly liable for failing to implement (or at least trial) safe injection facilities, or whether they could be compelled to do so as a matter of satisfying their constitutional obligations.

These issues warrant, and have received, closer examination.³⁰³ As the focus of this paper is on the legal issues more directly related to the operation of a safe injection facility, they are not addressed in great detail here. Rather, only the outlines of the legal analysis are sketched here.

Civil liability: claiming government negligence

A civil lawsuit alleging government negligence could conceivably be brought by the family of someone who died as a result of not having access to a safe injection site, or a number of

A civil lawsuit alleging government negligence could conceivably be brought by the family of someone who died as a result of not having access to a safe injection site.

individuals via a class action suit claiming harm as a result of the government's decision not to provide safe injection facilities. Examples of such groups are people with HIV/AIDS or HCV who inject drugs and become infected through the use of unsafe injection practices in the absence of adequate access to safe injection options.

There are some significant obstacles to successfully arguing that the government has been negligent in not implementing safe injection facilities. Nonetheless, such a claim might be stronger in some jurisdictions than others, given variations in legislation.

Perhaps most significantly, the initial hurdle would be to establish that the government's inaction represents an "operational" matter (for which government can be sued for negligence), rather than a "policy" decision (for which the government cannot be sued in negligence). If this hurdle could be overcome, then on basic principles of the law of negligence, a plaintiff would need to establish three things to establish a claim in negligence against government:

- (1) the government owed them a "duty of care" that it can be held liable for breaching;
- (2) the government breached that duty by failing to meet a "reasonable standard of care" in the circumstances; and
- (3) as a result of that failure, the government's conduct "materially contributed" to the harm suffered by the plaintiff.

If these three things could be proven, the plaintiff would then need to address any affirmative defences made out by the government, such as the claim that drug users had voluntarily assumed the risk of the harm they suffered (*volenti non fit injuria*), or that their own negligence contributed to the harm they suffered ("contributory negligence"). A government defendant might also argue that a person cannot bring a legal action for harm suffered as a result of their own illegal or immoral action (the legal doctrine *ex turpi causa non oritur actio*).

Does government have a constitutional obligation to act?

It could also be argued that governments' constitutional obligations under the *Canadian Charter of Rights and Freedoms*³⁰⁴ extend so far as to require them to implement safe injection facilities. One possibility might be to invoke the right to life, liberty and security of the person guaranteed by section 7 of the Charter. This provision is most often applied in the context of criminal charges against an individual, but the Supreme Court of Canada has adopted a broad definition of the term "security of the person"³⁰⁵ and has accepted that it can be applied outside the criminal context.³⁰⁶ However, the most significant difficulty with this case would be establishing, to the court's satisfaction, that the (in)action of government has a direct causal link to the harm to a person's constitutionally protected security of the person.³⁰⁷

Another possibility might be an argument, based on the equality rights provisions in section 15 of the Charter, that the failure of government(s) to implement safe injection facilities amounts to unconstitutional discrimination based on disability in that it denies equal access to health care to drug users.

Courts and other tribunals have concluded that drug addiction amounts to a disability, thereby bringing at least those drug users who are addicted within the protection of the Charter's equality provisions.³⁰⁸ Furthermore, assessing claims of disability discrimination under the Charter requires that the focus be on the government's response to a person's disability or impairment, not on the disability itself. Does the state's (in)action stigmatize the disability or fail to take into account that the purpose of constitutional equality rights is to remedy disadvantage?³⁰⁹ The Supreme Court has ruled that failing to make "reasonable accommodation" for a disability represents unconstitutional discrimination,³¹⁰ and that the Constitution's equality rights provisions may require positive action on the part of government to avoid discrimination. In the leading case, it ruled that the British Columbia government's failure to fund sign language interpreters for deaf patients in hospitals was unconstitutional.³¹¹

It could therefore be at least argued that the government's failure to implement safe injection facilities represents a dereliction of its constitutional duty to ensure equal access to

the health-care system. Positive measures that can reasonably be expected to address at least some of the ill-health experienced by drug addicts are constitutionally required.³¹² At the very least, it could be argued, the Charter's equality rights provisions require government to eliminate any legal barriers to the safe and competent operation of safe injection facilities, even if the courts might not go so far as to require governments to fund such initiatives.

Developing a Regulatory Framework for Safe Injection Facilities

Although there is a risk of criminal prosecution as described above, this risk appear small and nothing in Canadian law per se prohibits the operation of safe injection facilities. That said, the chance of charges being pursued might be higher if such facilities are operated in

It is advisable to establish a clear framework for the legal operation of safe injection facilities.

the face of opposition from local law enforcement or political decision-makers. A facility will likely operate more effectively if it does so with the support, or at least tolerance, of government authorities, particularly if it is clear under the law that those operating it are not exposed to criminal charges. Furthermore, while the staff/operators of a safe injection facility face relatively little risk of criminal liability, in the absence of legal reform, clients of such a facility would

remain very much exposed to criminal charges of possession of illegal drugs. This could hinder significantly the successful operation of a safe injection facility. It is, therefore, advisable to establish a clear framework for the legal operation of safe injection facilities.

Some jurisdictional questions may arise regarding the regulation of safe injection facilities, but a federal regulatory scheme is still important and necessary. There are numerous operational issues to be considered in designing and implementing a safe injection facility that will operate effectively. The following discussion focuses on those with a legal dimension that could and should be addressed by the federal government in designing a regulatory framework.

Jurisdictional issues

Some jurisdictional considerations should be flagged at the outset. Precisely because the use of drugs continues to be treated as a criminal matter, in addition to increasingly being recognized as a health issue, safe injection facilities would operate at the intersection of two areas of law-making: criminal law and health.

Under Canada's division of powers between federal and provincial/territorial governments, the federal government has the authority to legislate in the area of criminal law (although both the federal and provincial/territorial governments are responsible for the administration of the criminal law).³¹³ But both levels of government share authority to legislate in the area of health,³¹⁴ while the provinces have exclusive jurisdiction over the supply of health goods and services (including the governance of health facilities) and these cannot be regulated directly by the federal government.³¹⁵

The federal government cannot alter provincial laws or municipal by-laws, meaning there may be other legal dimensions that will need to be addressed with provincial and municipal governments and police. For example, a province or territory might seek to exercise regulatory authority over safe injection facilities as health-care facilities – although depending on the legislation in the province or territory, its claim to regulate them could depend on whether the province or territory covers the services they provide under its public health insurance plan. Alternatively, the province or territory might seek to exercise regulatory control over

the health-care professionals staffing a safe injection facility. Or it might use its power over the approval of plans by municipal or regional health boards to fund safe injection facilities as part of their local health services. A municipality might seek to use zoning by-laws to govern the location and operation of a safe injection facility.

Because of the division of powers between different levels of government in Canada, developing further understandings with provincial/territorial or municipal governments may, depending on their political temperament, still be necessary in addition to law reform or the development of regulations at the federal level. Nonetheless, a regulatory framework adopted under federal law could certainly assist in successfully establishing a safe injection facility by removing any taint of criminality. Furthermore, by setting out requirements regarding the operation of a facility that must be met in order to qualify for an exemption from criminal liability, the federal government could go some considerable distance in addressing concerns about safety or public nuisance that provincial/territorial or municipal governments might raise.

Federal regulatory powers

As noted previously, both the federal Cabinet and the federal Minister of Health have powers under the CDSA that could be exercised so as to relieve against the possibility of criminal liability problems with the operation of safe injection facilities. Relevant excerpts from the statute are found in Appendix A. This step would be of both symbolic and practical importance to the effective operation of safe injection facilities.

Ministerial exemptions

The power of the Minister of Health (section 56) is limited to exempting an individual or group, or a controlled substance or class of substances, from the application of the CDSA if the Minister is of the opinion that this is necessary for a medical or scientific purpose or is otherwise in the public interest. This mechanism could be used very easily, without the need for any statutory amendments or the elaboration of regulations, to protect both staff and clients of a safe injection facility from the risk of criminal liability.

For example, the Minister could issue an official document listing certain designated safe injection facilities (and needle exchange programs) and granting a generic exemption stating that:

Any person employed by or providing services at a designated facility, and any person receiving services at a designated facility, is, while on the premises of that facility, exempt from the application of the provisions of the CDSA that make it an offence to possess a controlled substance.

Such a ministerial exemption would ensure that drug users accessing the facility, which would of course be known to police, would not risk criminal prosecution for possession of drugs they have brought to the site. It would also preclude any possible criminal charge of “constructive” or “joint” possession for staff who are, obviously, knowingly tolerating the use of illegal drugs on the premises, and who will be in possession of used injection equipment (which is technically prohibited as a “controlled substance” under the CDSA). As noted above, authorizing, under the CDSA, the possession of illegal drugs on the premises of the facility, would indirectly protect against prosecution of staff under the *Criminal Code* for distributing “literature or instruments for illicit drug use.” Because use of

“Any person employed by or providing services at a designated facility, and any person receiving services at a designated facility, is, while on the premises of that facility, exempt from the application of the provisions of the CDSA that make it an offence to possess a controlled substance.”

the drugs would not be illicit at the facility, thanks to the CDSA exemption, distributing sterile injection equipment or “safer injection” information could not be considered to encourage or facilitate “illicit drug use.”

However, this mechanism is limited. The power to make regulations granted to the federal Cabinet is more extensive than the Minister’s power to grant exemptions, and offers an opportunity for a more comprehensive approach. Ministerial exemptions could be used as an initial, temporary measure to allow the immediate establishment of safe injection facilities on a trial basis while the development of a more thorough regulatory framework proceeds.

Regulations made by Cabinet

The federal Cabinet enjoys extensive powers that could be used to create a more comprehensive legal authorization for safe injection facilities. The Cabinet has open-ended authority under the CDSA to

make regulations for carrying out the purposes and provisions of this Act, including the regulation of the medical, scientific and industrial applications and distribution of controlled substances ... and the enforcement of this Act... and, without restricting the generality of the foregoing, may make regulations

(a) governing ... the ... provision, administration, possession ... or other dealing in any controlled substances ... or any class thereof; [...]

(z) exempting, on such terms and conditions as may be specified in the regulations, any person or class of persons or any controlled substance or precursor or any class thereof from the application of this Act or the regulations.³¹⁶

The federal Cabinet therefore has the authority to enact comprehensive regulations specifying that parts of the Act (such as the prohibition on possession of controlled substances) do not apply in certain circumstances. Defining those circumstances could be the basis for the federal government to introduce a regulatory scheme governing the establishment and operation of safe injection facilities.

Questions to be addressed in developing regulations

The following discussion does not claim to comprehensively address all questions that could arise in the process of drafting regulations to govern safe injection facilities, but addresses

There are at least three particular areas that could be addressed by regulations: the conditions of access to safe injection facilities; the activities and services permitted at such facilities; and the administrative requirements of facilities.

several of the more pressing issues. There are at least three particular areas that could be addressed by regulations, discussed in more detail below: the conditions of access to safe injection facilities; the activities and services permitted at such facilities; and the administrative requirements of facilities.

Conditions of access

Determining who can access the services provided at safe injection facilities raises a number of legal and ethical questions. The following questions are discussed briefly, leading to recommendations:

Should access be restricted to adults only? Should access be denied to pregnant women? Should access be denied to clients accompanied by children? Should access be denied to clients who are intoxicated?

Should access be restricted to adults only?

Many European facilities refuse to admit those under the age of 18,³¹⁷ and this is also the case with the site proposed by the Vancouver Harm Reduction Action Society (at least during the pilot period).³¹⁸ However, this categorical exclusion is unwarranted and to impose such a requirement by regulation would amount to at least a prima facie case of discrimination based on age.

The drug user who is under 18 is just as much (and possibly more) at risk of harm from overdose, bloodborne disease, or other harm associated with drug use as the adult user. There is no principled basis for concluding that only drug users over the age of 18 can, or are entitled, to the health protection and promotion benefits of safe injection facilities.

Clients of safe injection facilities would not obtain their drugs on site, so a concern about providing a “gateway” to drug use for youth is unfounded. Clients of whatever age would only be permitted to use drugs they have already obtained. If there is concern that there are other risks to which youth would be exposed by sharing a facility with adults (eg, possible exploitation), it does not follow that denying youth access to the facility and its services is the acceptable solution. Rather, operators of a facility would be ethically obliged to make reasonable efforts to address those risks in the manner in which the facility is operated, and operators and policymakers should ensure that youth have access to these health services in a setting where such risks are not present. It should be remembered that youth continue to be vulnerable to exploitation outside the premises of the safe injection facility, including possibly from those with whom they associate in the course of obtaining drugs. So the concern that a safe injection facility would increase the chance of such exploitation seems exaggerated.

Restricting access to adult users would be to the detriment of youth who use drugs. It would deny them the opportunity to avoid or minimize their risk of harm by injecting in a safer, hygienic environment with access to sterile injection equipment, medical care when needed, and a “gateway” to addiction treatment programs and referrals to other social services. Canadian law recognizes, both by statute (varying across provinces/territories) and in the common law, that minors under the age of 18 can be competent to make their own medical decisions.³¹⁹ It would therefore be strange to decide that drug users under the age of 18 cannot decide to access the health and other services of a safe injection site in the interests of preventing avoidable harm.

The issue of youth accessing harm-reduction services related to their drug use has been considered in the context of youth accessing needle exchange programs. In response to a request from the Québec Centre for AIDS Coordination (Ministry of Health and Social Services), Dr David Roy of the Centre for Bioethics in Montréal provided an ethical analysis of distributing sterile needles to youth under the age of 18. He concluded:

In an ideal world, one would not give syringes to young people to help them to engage in IV drug use. One would rather rapidly institute a comprehensive programme of psychological, social and familial rehabilitation to protect these young people against both drug addiction and the transmission of HIV. But... we do not live in an ideal world. We have to act, as we try to protect these young

There is no principled basis for concluding that only drug users over the age of 18 can, or are entitled, to the health protection and promotion benefits of safe injection facilities.

Restricting access to adult users would be to the detriment of youth who use drugs.

people, within constraints that simply do not allow us to achieve the ideal immediately and in a comprehensive fashion....

If a young person is ready and open for comprehensive rehabilitation and can be persuaded to avoid IV drug use altogether, that is the goal that should be pursued. To such a young person, one would not distribute syringes....

It is not the age of a young person, but that young person's danger of being inducted into IV drug use with needle sharing, and that young person's danger of becoming HIV-infected via needle sharing, that should govern the kind of protective intervention that we do or not adopt.

It is not the age of a young person, but that young person's danger of being inducted into IV drug use with needle sharing, and that young person's danger of becoming HIV-infected via needle sharing, that should govern the kind of protective intervention that we do or not adopt....

We must never lose sight of the most immediate objective of our protective intervention with these highly vulnerable young people whose lives are maximally disorganized. The most immediate goal is to protect them against lethal HIV infection. That biological goal should be paramount and predominate. This goal may well require furnishing these young people, whatever their age may be, with sterile, clean needles....

These ... considerations are based upon the ethical principle of first avoiding the greatest of evils when not all evils can be avoided at the same time. It is more important that we protect these vulnerable, socially disorganized youth from HIV infection and eventual death; more important that we have surviving youth for eventual rehabilitation – than that we immediately insist on ideal ways of living that these youth cannot now understand, adopt or achieve. This is, in other words, the principle of harm reduction.³²⁰

Safe injection facilities are enhanced needle exchange programs. In addition to providing injection equipment, they provide a safer location to inject and on-site access to other health and social services. Dr Roy's analysis applies equally well in the context of accessing safe injection facilities. It would certainly be ethical and wise to make additional efforts at safe injection facilities to assist youth obtain voluntary treatment for drug addiction. But to deny those under 18 access to sterile injection equipment and the use of the injection room would be unethical and possibly illegal discrimination.

Should access be denied to pregnant women?

Similarly, it would be unethical and illegal to deny pregnant women access to a safe injection facility. Discrimination based on pregnancy is a form of sex discrimination that unjustifiably violates the equality guarantees of the Charter.³²¹ In addition, denying pregnant women access to safe injection sites would do more harm than good.

We must be concerned for the well-being of both the woman and her fetus. But denying a pregnant woman access to a safe injection facility advances neither her well-being nor that of her fetus. All clients accessing a safe injection facility will have already obtained their drugs and have come to the facility because they intend to inject them. As with any other client, the pregnant woman's health and well-being are certainly at less risk if she can access sterile equipment to inject in a safe, hygienic location with access to immediate medical attention in the event of overdose and to other health-care services as needed.

Similarly, while the health of her baby is damaged by her drug use during pregnancy, that harm is already done or about to be done whether or not she can access the safe injection facility. But the well-being of her baby is certainly even more compromised if she is turned away and ends up contracting HIV or HCV from sharing needles, or overdosing in an alley or rooming house. Furthermore, denying her access to the safe injection facility means denying her one possible gateway to health and support services (eg, drug treatment) that would benefit both her and her baby.

Denying a pregnant woman access to a safe injection facility advances neither her well-being nor that of her fetus.

The Supreme Court of Canada has ruled that current Canadian law does not permit the state to infringe the liberty of a pregnant woman against her will in order to protect her unborn child from her conduct that may harm the child. In the case of *Winnipeg Child and Family Services (Northwest Area) v DFG*,³²² it ruled that the state could not detain a pregnant woman addicted to glue sniffing who had previously given birth to two children injured in utero in this way. The Court concluded that this kind of coercive approach would likely be counterproductive for the health of both women and their children, because it “may tend to drive the problems underground,” driving women (and particularly those most in need) away from prenatal care. As with the underage user, it would be ethical to make additional efforts to assist pregnant clients at a safe injection facility access services such as drug treatment, prenatal and other health care, social services, etc. But denying access to the facility and clean injection equipment would be unjustified.

Should access be denied to clients accompanied by children?

Clients who come to a safe injection facility accompanied by their children present a somewhat different scenario. But again, denying access to the facility’s services is unwarranted. As with the underage or pregnant client, it is best if such clients are helped to access health and social services (including, as appropriate, for their children). But denying the client intent on using their pre-purchased drugs access to clean injection equipment and a safe location will only be to their detriment and that of their children. It would be wise to insist that children remain in the secure waiting area of the facility, under staff supervision, while the parent uses the injecting room.

But it is much preferable that a parent or person having charge of a child be able to inject their drugs using clean equipment in a safe, hygienic location with immediate access to medical care in the event it is necessary, while their child is safely supervised by others, than to shoot up in an alley in the child’s presence and to then be impaired while responsible for that child. The child’s interests are better served by allowing the parent’s access to the facility.

This does not preclude the application of standard child protection legislation in force in the province/territory. If staff at a facility have reasonable grounds to believe, in a given case, that the child is “in need of protection,” they would be legally required to bring this matter to the attention of child protection authorities. This would be the case at other health facilities and is, at least in some jurisdictions, a legal duty imposed on all people.

Should access be denied to clients who are intoxicated?

It is very likely that some clients may arrive at a safe injection facility under the influence of alcohol or other drugs. As in the other scenarios, denying a person access to the facility simply on this basis would be unwarranted. It would send a strange signal to the target client community of drug users, whom a safe injection facility is intended to benefit, if the facility refuses to allow access to someone intoxicated by drugs. Furthermore, the intoxicated

person intent on injecting drugs is likely at even higher risk than usual of sharing needles, fatally overdosing, being assaulted, or otherwise unsafely injecting if they are denied access to sterile equipment and a safe location with on-site medical supervision.

Facility operators (and regulators) should, quite rightly, be concerned about the heightened risk of opioid overdose or cocaine toxicity upon further injection. But refusing entry to the facility is no solution. Rather, it would be prudent to require staff to assess, based on the information available to them, the risk of these harms. If, in their opinion, there is a significant risk of overdose or toxicity if more drugs are consumed, then they should have the authority to refuse the use of the injection room (although the client should, of course, have access to other services at the facility). In the case where the potential harm of overdose is reasonably foreseeable, given the state of the client upon arrival, a facility could be held civilly liable in negligence if it allowed the client to use the facility to ingest more drugs.

Finally, there is legitimate concern over the possibly heightened potential for violence from a client that is intoxicated. Other health-care facilities routinely face such situations. But it would be inaccurate and unwarranted to assume that every client who came to a safe injection facility discernibly intoxicated poses any such threat to staff or other clients. Some clients will, many will not. Again, this decision can only be made on the basis of a case-by-case assessment. Regulations governing such facilities should give staff clear authority to refuse entry to the facility if they have reasonable grounds to believe the person poses a threat to the health and safety of others – whether it be because of intoxicated belligerence, the carrying of weapons, etc.

Activities and services permitted

Regulations could set out conditions regarding the conduct of clients and staff at a safe injection facility that must be met in order for it to be exempt from the application of the CDSA provisions. These conditions would arise out of the very objectives of such facilities, but would also address some of the concerns about civil or criminal liability.

1. Given that one key objective of such a facility is to avoid the harms associated with sharing injection equipment, regulations could and should require facilities to prohibit the sharing of injection equipment between clients.
2. To prevent safe injection facilities from becoming sites for drug trafficking, clients should be prohibited from sharing or selling drugs on the premises. This would reinforce that safe injection facilities are providing health services, not illegal drugs, and would help allay possible community concerns about safe injection facilities becoming a “magnet for drug dealers.” This would also protect staff/operators from possible criminal charges of aiding or abetting trafficking and possession. In addition, it would not prevent medical personnel from prescribing controlled substances on site if such authorization were granted – in the context of a prescription heroin trial, for example.
3. Only self-injecting should be permitted. Staff cannot assist clients with injection, as this would open the door to civil or criminal liability if the user were injured through overdose or toxicity, vein damage, or infection.

Clients should be prohibited from sharing or selling drugs on the premises.

Administrative requirements

Finally, while it would be unnecessary and unwise to attempt to micro-manage safe injection facilities by way of federal regulation, certain basic requirements regarding the administration and management of facilities could be spelled out as conditions of being CDSA-exempt.

These could include:

- security considerations must be taken into account in the physical set-up of the facility (eg, adequate monitoring of injection room and other areas, locked doors controlled by staff, etc);
- security personnel should be on site during all hours of operation;
- some staff should be medically qualified nurses or physicians; and
- all staff should be trained in basic first aid and in responding to drug overdose, as well as crisis management and the facility's policies and procedures regarding security, referrals to other services, confidentiality of client information, etc.



Conclusion: Responsible Reforms Needed

Canada has an ethical obligation, and arguably has a legal obligation (at least under international law) to implement a trial of safe injection facilities as a measure that will protect and promote the health of Canadians. It is past time for government action to prevent further needless illness and death as a result of unsafe drug use. The response thus far has been inadequate and undermines the harm reduction objectives that supposedly underlie Canada's Drug Strategy.

Federal, provincial, and municipal governments cannot continue to ignore the health risks associated with injection drug use and with the prevailing criminal law approach to combating drug use. Switzerland, the Netherlands, and Germany have demonstrated that the provision of safe injection facilities is possible and effective. Australia has recognized the need and is experimenting. To date, Canada is lagging behind these significant and progressive developments elsewhere, failing even to experiment with approaches that have been shown to work.

Resisting the introduction of safe injection facilities is not only unethical, but also amounts to a breach of Canada's international human rights obligations – for example, to fulfil attainable health-care standards. Such initiatives are permissible under international drug treaties as scientific experiments in preventing ill-health and enhancing treatment and rehabilitation. Moreover, assuming that injecting facilities are successful as trials (already demonstrated in Australia, Switzerland, Germany, and the Netherlands), they may well become permanent features of multi-faceted harm-reduction strategies. Once again, their continuation would help fulfil international obligations. Moreover, the drug-related treaties to which Canada is a party permit the permanent establishment of facilities, as part of each state's right to assess what measures may be taken in accordance with its "prevailing conditions" and domestic requirements. Finally, Canadian law does not necessarily stand in the way of safe injection facilities, and in fact could accommodate them relatively easily.

Establishing safe injection facilities is but one of many strategies proposed to combat some of the harms associated with injection drug use. This measure is intended to respond to a discrete problem, adding a missing dimension to an existing array of measures – some of which seek to reduce drug addiction, others of which seek principally to reduce the harms associated with drug use and to temper the unproductive harshness of punitive approaches. Safe injection facilities have deliberately limited aims and objectives, their primary focus being to reduce the risks associated with injecting drugs, while providing an additional opportunity to bring drug users into contact with other health and support services (including treatment for addictions) and reduce the negative effects on the community of an open drug scene.

After noting the billions of dollars spent on law enforcement, the thousands of persons sent to prison for breaches of drug laws, and the fact that prison does not cure drug addiction, Peter Cleeland of the Australian Drug Law Reform Foundation observes:

Injecting rooms for users of illegal drugs will not reduce the sale of illegal drugs. They will not reduce the uptake of new users, they will not stop the crime associated with the trade. No one who understands the illegal drug market ever believed they would. But we who support them know that the homeless, the mentally ill, the physically sick and those who are looking for help will go to these facilities where they will not be treated as criminals, where they will receive counselling, and where they will not die on our streets like unwanted human garbage. That is better than a continuation of a failed system of prohibition.³²³

The proposal of experimenting with safe injection facilities is deliberately modest in terms of what it claims to be capable of achieving. Indeed, it is misguided to view injecting facilities as a panacea or even a standalone measure, as doing so could divert attention from other worthy, complementary options and necessary reforms. But they are measures worth trying. In the words of two experts:

It is time we gave up making war on drugs and drug users, and instead made peace with people who use drugs. We should try where we can to limit the damage that drugs do to people, and endeavour to keep drug users alive and well. Sooner or later, most will give up drugs when they are ready. Drug policy will develop by evolution, not revolution. We must abandon the search for perfect solutions. There are none.³²⁴

It is misguided to view injecting facilities as a panacea or even a standalone measure, as doing so could divert attention from other worthy, complementary options and necessary reforms. But they are measures worth trying.



Recommendations

1. The federal government should update Canada's Drug Strategy to expressly support trials of safe injection facilities as harm-reduction measures that are an important component of the overall policy response to the harms associated with injection drug use.
2. The federal government should create a regulatory framework under the *Controlled Drugs and Substances Act* (CDSA) to govern safe injection facilities that would eliminate the risk of criminal liability for staff and clients and reduce the risk of civil liability for operating such facilities.
3. The regulatory framework should address such issues as the conditions of access to the facility, the activities and services permitted on the premises, and minimum administrative requirements aimed at ensuring facilities' safe and effective operation. In particular, the regulatory framework devised under the CDSA that would exempt approved facilities from the Act:
 - should not restrict access to safe injection facilities to adults only, but should allow access to drug-using youth;
 - should not deny access to pregnant women;
 - should not deny access to drug users accompanied by children;
 - should not automatically deny access to drug users simply because they are intoxicated;
 - should prohibit the sharing of injection equipment between clients of safe injection facilities;
 - should prohibit the sharing or selling of drugs on the premises of the facility;
 - should only allow clients to self-inject, prohibiting staff from assisting with injection;
 - should require that security considerations be taken into account in the physical set-up of safe injection facilities and that security personnel be on site during all hours of operation; and
 - should require that some staff be medically qualified nurses or physicians and that all staff be trained in basic first aid, responding to drug overdose, crisis management, and

all facility policies and procedures covering matters such as security, confidentiality of client information, referrals to other services, etc.

4. In the interim, before such a regulatory framework is in place, the federal Minister of Health should grant ministerial exemptions from the application of the provisions of the *Controlled Drugs and Substances Act* that make it an offence to possess a controlled substance to designated safe injection facilities (and needle exchange programs), and to their staff and clients, so that such facilities can operate on a trial basis.
5. Health Canada should fund the operation and evaluation of a multi-site scientific research trial of safe injection facilities, including research studies assessing the impact of safe injection sites on the health and well-being of drug users, the public health generally, and the communities affected.
6. Federal, provincial/territorial, and municipal officials with responsibilities in the areas of health, social services, and law enforcement should collaborate to ensure that trials of safe injections facilities can occur as soon as possible.



Appendix: Excerpts from the Controlled Drugs and Substances Act, SC 1996, c 19

Section 55

- (1) The Governor in Council may make regulations for carrying out the purposes and provisions of this Act, including the regulation of the medical, scientific and industrial applications and distribution of controlled substances and precursors and the enforcement of this Act and, without restricting the generality of the foregoing, may make regulations
 - (a) governing, controlling, limiting, authorizing the importation into Canada, exportation from Canada, production, packaging, sending, transportation, delivery, sale, provision, administration, possession or obtaining of or other dealing in any controlled substances or precursor or any class thereof;
 - (b) respecting the circumstances in which, the conditions subject to which and the persons or classes of persons by whom any controlled substances or precursor or any class thereof may be ... delivered, sold, provided, administered, possessed, obtained or otherwise dealt in, as well as the means by which and the persons or class of persons by whom such activities may be authorized; [...]
 - (h) respecting the qualifications of persons who are engaged in the ... selling, providing or otherwise dealing in any controlled substance or precursor of any class thereof and who do so under the supervision of a person licensed under the regulations to do any such thing; [...]
 - (s) respecting the communication of any information obtained under this Act or the regulations from or relating to any person or class of persons who is or may

be authorized to ... send, transport, deliver, sell, provide, administer, possess, obtain or otherwise deal in any controlled substance or precursor or any class thereof (i) to any provincial professional licensing authority, or (ii) to any person or class of persons where, in the opinion of the Governor in Council, it is necessary to communicate that information for the proper administration or enforcement of this Act or the regulations; [...]

(w) establishing classes or groups of controlled substances or precursors; [...]

(z) exempting, on such terms and conditions as may be specified in the regulations, any person or class of persons or any controlled substance or precursor or any class thereof from the application of this Act or the regulations; [...]

(2) The Governor in Council, on the recommendation of the Solicitor General of Canada, may make regulations that pertain to investigations and other law enforcement activities conducted under this Act by a member of a police force and other persons acting under the direction and control of a member [...]

Section 56

The Minister may, on such terms and conditions as the Minister deems necessary, exempt any person or class of persons or any controlled substance or precursor or any class thereof from the application of all or any of the provisions of this Act or the regulations if, in the opinion of the Minister, the exemption is necessary for a medical or scientific purpose or is otherwise in the public interest.



Endnotes

¹ Margaret Hamilton, Transcript of Proceedings, NSW Drug Summit 1999, 17 May 1999, available at <http://drugsummit.socialchange.net.au>.

² This description is derived from Drugs and Crime Prevention Committee (DCPC), Parliament of Victoria, "Safe Injecting Facilities – Their Justification and Viability in the Victorian Setting", Occasional Paper No 2 (1999), at 1-2 (available at www.parliament.vic.gov.au/dcpc).

³ The paper is a Canadian adaptation of an article by Malkin on the need for safe injection facilities in Australia: I Malkin. Establishing supervised injecting facilities: A responsible way to help minimise harm. *Melbourne University Law Review* 2001; 25(3): 680.

⁴ See, for example: T Kerr. *Safe Injection Facilities: Proposal for a Vancouver Pilot Project*. Prepared for the Harm Reduction Action Society. Vancouver, 2000; JV Cain. Report of the British Columbia Task Force into Illicit Narcotic Overdoses [hereinafter Cain Report]. Victoria, BC: British Columbia Ministry of Health, 1994; E Whynt. Health impact of injection drug use and HIV in Vancouver. Vancouver: Vancouver Health Board, 1996; Provincial Task Force on Addictions. "Weaving the Threads." Report commissioned by the Premier of British Columbia, 2001; Reducing the Harm Associated with Injection Drug Use in Canada. Report of the Federal/Provincial/Territorial Advisory Committee on Population Health, 2001.

⁵ Canadian HIV/AIDS Legal Network. *Injection Drug Use and HIV/AIDS: Legal and Ethical Issues*. Montréal: The Network, 1999, at 1.

⁶ Health Canada (Division of HIV/AIDS Epidemiology and Surveillance, Bureau of HIV/AIDS, STD and TB, Centre for Infectious Disease Prevention and Control). HIV/AIDS Among Injecting Drug Users in Canada. HIV/AIDS Epi Update, May 2001. Ottawa: Health Canada, 2001 (available via www.hc-sc.gc.ca/hpb/lcdc/bah).

⁷ Ibid.

⁸ Health Canada (Division of HIV/AIDS Epidemiology and Surveillance, Bureau of HIV/AIDS, STD and TB, Centre for Infectious Disease Prevention and Control). *HIV and AIDS in Canada: Surveillance Report to December 31, 2000*. Ottawa: Health Canada, 2001 (available via www.hc-sc.gc.ca/hpb/lcdc/bah) at 31.

⁹ HIV/AIDS Among Injecting Drug Users in Canada, *supra*, note 6.

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¹¹ SA Strathdee et al. Needle exchange is not enough: lessons from the Vancouver injecting drug use study. *AIDS* 1997; 11: F59-65.

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¹³ HIV/AIDS Among Injecting Drug Users in Canada, *supra*, note 6.

¹⁴ C Hankins, T Tran, D Desmarais et al. Moving from Surveillance to the Measurement of Programme Impact: CACTUS – Montreal Needle Exchange Programs. *Canadian Journal of Infectious Diseases* 1997; 8 (Suppl A): 28A (abstract 223).

¹⁵ P Millson, T Myers, L Calzavara et al. *Prevalence of HIV and Other Blood-Borne Viruses and Associated Behaviors in Ontario IDUs*. Proceedings of the 7th Annual HIV Epidemiology Meeting Organized by the Division of HIV Epidemiology, Bureau of HIV/AIDS and TB, Laboratory Centre for Disease Control, Health Canada, 12-14 November 1998; M Millson. *WHO Multi-City Study on Drug Injecting & Rise of HIV Infection*. Toronto: National Health Research & Development Program (Health Canada), 1996.

- ¹⁶ M Alary, C Hankins, R Parent et al. Updated Results from the SurVI DU Surveillance Network. Proceedings of the 7th Annual HIV Epidemiology Meeting organized by the Division of HIV Epidemiology, Bureau of HIV/AIDS, STD and TB, LCDC, Health Canada. *Inventory of HIV Incidence/Prevalence Studies in Canada*. Ottawa: Health Canada, May 1999.
- ¹⁷ J Blanchard, L Elliott. Winnipeg Injection Drug Epidemiology Study: Interim results, April 1999, cited in *Injection Drug Use and HIV/AIDS: Legal and Ethical Issues*, supra, note 5.
- ¹⁸ HIV/AIDS Among Injecting Drug Users in Canada, supra, note 6.
- ¹⁹ *Injection Drug Use and HIV/AIDS: Legal and Ethical Issues*, supra, note 5; Canadian Aboriginal AIDS Network. *Joining the Circle: An Aboriginal Harm Reduction Model* (undated); Health Canada (Division of HIV/AIDS Epidemiology and Surveillance, Bureau of HIV/AIDS, STD and TB, Centre for Infectious Disease Prevention and Control). HIV/AIDS Among Aboriginal Persons in Canada Remains a Pressing Issue. *HIV/AIDS Epi Update*, May 2001. Ottawa: Health Canada, 2001 (available via www.hc-sc.gc.ca/hpb/lcdc/bah).
- ²⁰ Statistics Canada. *Population Census of Canada*, 1996.
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- ²² Strathdee et al, supra, note 11; M McLean. Vancouver drug epidemiology and drug crime statistics 2000. Canadian Community Epidemiology Network on Drug Use (draft dated 21 June 2000), cited by Kerr; supra, note 4 at 11.
- ²³ MV O'Shaughnessy et al. Deadly public policy. *International Conference on AIDS* 1998; 12: 982 (abstract no. 44233).
- ²⁴ See City of Vancouver website, available at www.city.vancouver.bc.ca/greaterdot/gv2000/episode9.htm#link7, citing BC Coroners' Service and BC Provincial Health Officer (2000).
- ²⁵ M Tyndall et al. HIV incidence and mortality among injection drug users in Vancouver – 1996-2000. *Canadian Journal of Infectious Diseases* 2001; 12: 69B.
- ²⁶ *Injection Drug Use and HIV/AIDS: Legal and Ethical Issues*, supra, note 5 at 9-11.
- ²⁷ Canadian HIV/AIDS Legal Network. *Injection Drug Use and HIV/AIDS: The Facts* [Info Sheet #1: Injection Drug Use and HIV/AIDS]. Montréal: The Network, 2002 (2nd revised edition) (available via www.aidslaw.ca).
- ²⁸ Health Canada (Division of HIV/AIDS Epidemiology and Surveillance, Bureau of HIV/AIDS, STD and TB, Centre for Infectious Disease Prevention and Control). Risk Behaviours Among Injection Drug Users in Canada. *HIV/AIDS Epi Update*, May 2001. Ottawa: Health Canada, 2001 (available via www.hc-sc.gc.ca/hpb/lcdc/bah).
- ²⁹ R Broadhead et al. Safer injection rooms in public policy and health initiatives. *Journal of Drug Issues* (in press).
- ³⁰ For a discussion of the recent history surrounding the adoption of the *Controlled Drugs and Substances Act*, see B Fischer. The Battle for a New Canadian Drug Law: A Legal Basis for Harm Reduction or a New Rhetoric for Prohibition? A Chronology. In: *Harm Reduction: A New Direction for Drug Policies and Programs*. P Erickson et al (eds). Toronto: University of Toronto Press, 1997.
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- ³² CDSA, s 2(1).
- ³³ CDSA, s 2(2)(b)(ii). The CDSA uses the definition of possession found in the *Criminal Code*, RSC 1985, c C-46, s 4(3).
- ³⁴ RSC 1985, c F-27, s 2 [hereinafter FDA].
- ³⁵ *Criminal Code*, s 462.1.
- ³⁶ For a general review of these negative consequences, see: D Riley. Injection Drug Use and HIV/AIDS: Policy Issues. In: Canadian HIV/AIDS Legal Network. *Injection Drug Use and HIV/AIDS: Legal and Ethical Issues – Background Papers*. Montréal: Legal Network, 1999, at C3-C6; D Riley, E Oscapella. Canada's new drug law: implications for HIV/AIDS. *The International Journal of Drug Policy* 1996; 7(3): 180-182.
- ³⁷ *Injection Drug Use and HIV/AIDS: Legal and Ethical Issues*, supra, note 5 at 26, referencing American Bar Association. *AIDS: The Legal Issues*. Discussion draft of the ABA AIDS Coordinating Committee. Washington, DC, 1998, at 233.
- ³⁸ Kerr; supra, note 4 at 24.
- ³⁹ Riley, supra, note 36, C3-C4.
- ⁴⁰ *Ibid* at C10. See also: E Oscapella, R Elliott. Injection Drug Use and HIV/AIDS: A Legal Analysis of Priority Issues. In: Canadian HIV/AIDS Legal Network. *Injection Drug Use and HIV/AIDS: Legal and Ethical Issues – Background Papers*, supra, note 36, at A8 (available via www.aidslaw.ca).
- ⁴¹ Riley, supra, note 36 at C4.
- ⁴² A Wodak, R Owens. *Drug Prohibition: A Call for Change*. Sydney: University of New South Wales Press, 1996, at 4.
- ⁴³ *Ibid* at 7-8.
- ⁴⁴ National Action Plan Task Force. *HIV, AIDS and Injection Drug Use: A National Action Plan*. Ottawa: Canadian Centre on Substance Abuse and Canadian Public Health Association, May 1997; J Millar. HIV, hepatitis, and injection drug use in British Columbia: pay now or pay later. Report from the Office of the Provincial Health Officer. Victoria: British Columbia Ministry of Health, 1998; Cain Report, supra, note 4; DEYAS. Something to eat, a place to sleep and someone who gives a damn – HIV/AIDS and Injection Drug use in the DTES. Vancouver: Downtown Eastside Youth Activities Society, September 1997; R Jürgens. *HIV/AIDS in Prisons: Final Report*. Montréal: Canadian HIV/AIDS Legal Network and Canadian AIDS Society, 1996; Y Dandurand, V Chin. Towards a Lower Mainland Crime and Drug Misuse Prevention Strategy. British Columbia: Lower Mainland Municipal Association, September 2000; British Columbia Aboriginal AIDS Task Force. *The Red Road – Pathways to Wholeness: An Aboriginal Strategy for HIV and AIDS in BC*. Victoria, 1999 (available at

www.hth.gov.bc.ca/cpa/publications/index.html#R).

⁴⁵ Riley, *supra*, note 36 at C3-4.

⁴⁶ UNAIDS, *Report on the Global HIV/AIDS Epidemic* (June 2000) at 76 (available via www.unaids.org).

⁴⁷ *Ibid* at 77.

⁴⁸ Riley, *supra*, note 36 at C10.

⁴⁹ Government of Canada. *The Criminal Law in Canadian Society* (August 1982) at 52-53. Note that this statement of policy is cited in O'Scapella & Elliott, *supra*, note 40 at A9, and in G Gilmour, *The International Covenants "Prohibiting" Drug Activities*. Paper submitted to Canada's Senate Standing Committee on Legal and Constitutional Affairs, 14 December 1995, at 11 (available via www.cfdp.ca/gilmour.html), which is also cited by Kerr; *supra*, note 15 at 21, in his proposal for a safe injection site in Vancouver. The Law Reform Commission of Canada has also concluded that "criminal law is a blunt and costly instrument.... It must be an instrument of last resort. It must be used as little as possible." In: Law Reform Commission of Canada. *Our Criminal Law*. Ottawa: Minister of Supply and Services Canada, 1976, at 27-28, cited in O'Scapella & Elliott, *supra*, note 40 at A9.

⁵⁰ See the commentary by Fischer; *supra*, note 30.

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⁵⁴ *Canada's Drug Strategy*, *supra*, note 51.

⁵⁵ Reducing the Harm Associated with Injection Drug Use in Canada, *supra*, note 4. The document was prepared in conjunction with: the F/P/T Committee on Alcohol and Other Drug Issues; the F/P/T Advisory Committee on AIDS; the F/P/T Heads of Corrections Working Group on HIV/AIDS; and a multi-disciplinary committee of senior Justice and Health officials.

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⁵⁷ *Ibid*.

⁵⁸ *Ibid* at 3.

⁵⁹ F Bula. Safe-injection site a go if BC wants it: Health minister praises Vancouver mayor for his courage to develop drug policy. *Vancouver Sun*, 15 November 2001.

⁶⁰ M Dufour. Une approche révolutionnaire. *Le journal de Québec*, 20 novembre 2001: 3.

⁶¹ D MacPherson. *A Framework for Action: A Four-Pillar Approach to Drug Problems in Vancouver (Revised)*. 24 April 2001.

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⁶³ Kerr; *supra*, note 4 at 7.

⁶⁴ *Ibid*.

⁶⁵ *Ibid*.

⁶⁶ *Ibid*.

⁶⁷ Editorial. Harm reduction: closing the distance. *Canadian Medical Association Journal* 2001; 165(4): 389.

⁶⁸ V Smith. Shooting Up Safely. *Eye Magazine* (Toronto), 24 May 2001.

⁶⁹ Top Drug Cop Calls For Safe-Injection Sites. *The Province* (CNBC), 6 May 2001.

⁷⁰ Smith, *supra*, note 68.

⁷¹ H Kent. Is Australia's safe injection site experiment bound for Vancouver? *Canadian Medical Association Journal* 2001; 164 (9): 1332.

⁷² *Ibid*.

⁷³ Hugh Martin. Most Addicts Favour Room Idea: Study. *The Age* (Melbourne), 20 April 2000: 5.

⁷⁴ *Ibid*. See also DCPC, *supra*, note 2 at 5: the authors cite a 1998 survey of 400 Melbourne injecting drug users, which showed that 77 percent would use a supervised injection facility.

⁷⁵ T Craig Green. My Place, Your Place, or a Safe Place: the Intention to Use a Supervised Injection Facility (SIF) in Montreal Injecting Drug Users. Data presented at Les sites d'injection supervises: Journée scientifique de L'Unité Maladies infectieuses, Direction de la santé publique de Montréal-Centre, 23 November 2001.

⁷⁶ C Fidelman. Merchants decry shooting-gallery plan. *Montreal Gazette*, 4 July 2001.

⁷⁷ *Ibid*.

⁷⁸ R Walker. Vancouver mulls safe drug sites. *Christian Science Monitor*, 28 December 2000.

⁷⁹ MacPherson, *supra*, note 61.

⁸⁰ F Bula. "This is an international crisis": Mayor Philip Owen unveils his sweeping plan for city's drug crisis. *Vancouver Sun*, 21 November 2000.

- ⁸¹ Walker, *supra*, note 78.
- ⁸² F Bula, Activists, drug users seek funds for safe injection rooms. *Vancouver Sun*, 24 November 2000.
- ⁸³ DCPC, *supra*, note 2 at 9.
- ⁸⁴ Submission to City of Port Philip [Australia]. Report to the Drug Policy Expert Committee on Community Consultation Regarding the Provision of Injecting Facilities within the City of Port Philip (2000) at 17.
- ⁸⁵ P Totaro, Vatican decrees all heroin off limits. *The Age* (Melbourne), 23 September 2000: 5. This edict also implies strong opposition to already existing harm minimization measures, such as needle exchanges. This directive was issued one year after the Vatican had ordered Sydney's Sisters of Charity to abandon their commitment to assisting the NSW Government in the operation and management of Australia's first proposed supervised injecting facility trial. See S Powell, Addiction in a safer vein. *The Australian*, 6 April 2001: 14.
- ⁸⁶ Hon. Justice Wood, Royal Commission into the New South Wales Police Service, *Final Report*. Sydney: Government of the State of New South Wales, May 1997, at 221.
- ⁸⁷ Kerr, *supra*, note 4 at 4. See also Royal Australasian College of Physicians, *From Hope to Science: Illicit Drugs Policy in Australia* (2001) at 13.
- ⁸⁸ DCPC, *supra*, note 2 at 9: "The message here is a dual one: that injecting use in these contexts is a harmful activity, and that the state is responsible and compassionate in the face of these harms."
- ⁸⁹ Premier's Drug Advisory Council [hereinafter PDAC], *Drugs and Our Community* (1996) (Australia). See also Wodak & Owens, *supra*, note 42, chapter 3 at 6: with respect to restricting the spread of HIV, hepatitis B and hepatitis C, "Prohibition made it more difficult to control these infections among injecting drug users. Control was only achieved by ignoring or contradicting prohibition."
- ⁹⁰ *Harm Reduction: Concepts and Practice – A Policy Discussion Paper*. Ottawa: Canadian Centre on Substance Abuse, 1996 (available at www.ccsa.ca/docs/wgharm.htm).
- ⁹¹ Alcohol and Other Drugs Council of Australia (ADCA), *Drug Policy 2000: A New Agenda for Harm Reduction* (2000) (available at www.adca.org.au/_private/DP2000/ADCADrugPolicy2000.pdf) at 185: "They have been shown to reduce HIV/AIDS and hepatitis C transmission and they are cost effective.... 3000 cases of HIV/AIDS were avoided in Australia in 1991 through [their] operation. Riley comments on the minimal cost of providing an exchange compared with caring for someone with HIV." This is, of course, aside from the obvious human toll if someone were to be infected with the virus when it could have been avoided: Riley, *supra*, note 36 at C53. See also Deirdre Grusovin, Member of the NSW Legislative Assembly, Transcript of Proceedings, NSW Drug Summit on 20 May 1999 (available via drugsummit.socialchange.net.au), and PDAC, *supra*, note 89 at 53.
- ⁹² *Injection Drug Use and HIV/AIDS: Legal and Ethical Issues*, *supra*, note 5 at 81, with reference to: DC Des Jarlais et al. Regulating syringe exchange programs: A cautionary note [letter to editor], *Journal of the American Medical Association* 1994; 272: 431; A Goldstein. *Addiction: From Biology to Drug Policy*. New York: WH Freeman & Co, 1994: at 234. See also Health Canada, Risk Behaviours Among Injection Drug Users in Canada, *supra*, note 28.
- ⁹³ However, it should be remembered that syringe exchanges are not a panacea. "In some cities, such as Vancouver and Montréal, the level of HIV infection is high despite the presence of syringes [sic] exchanges.... It is now widely agreed that syringe exchanges should be but one element of larger, comprehensive, and innovative programs"; Riley, *supra*, note 36 at C59.
- ⁹⁴ Bula, *supra*, note 82.
- ⁹⁵ *Ibid.*
- ⁹⁶ Grusovin, *supra*, note 91.
- ⁹⁷ *Ibid.*
- ⁹⁸ Wood, *supra*, note 86 at 222 (emphasis added). Health benefits outweigh policy considerations (ie, purportedly condoning otherwise unlawful behaviour), therefore the Commission favours introducing facilities for supervised injecting purposes.
- ⁹⁹ Quoted in Caroline Overington, Chasing an answer. *The Age* (Melbourne), 21 March 2001: 15.
- ¹⁰⁰ DCPC, *supra*, note 2 at 12-13.
- ¹⁰¹ MacPherson, *supra*, note 61.
- ¹⁰² Based on the experience in other jurisdictions, it has been suggested that supervised injecting facilities could prevent one overdose death every five days: NSW Joint Select Committee into Safe Injecting Rooms. *Report on the Establishment of or Trial of Safe Injecting Rooms* (1998) at 79; DCPC, *supra*, note 2 at 6. See also K Dolan et al, *infra*, note 126; Kerr, *supra*, note 4 at 33. Kerr reviews data from Germany and Switzerland indicating "substantial reductions in overdose deaths following the establishment of safe injection facilities."
- ¹⁰³ Wood, *supra*, note 86 at 222.
- ¹⁰⁴ Kerr, *supra*, note 4 at 32, reports that 66 percent of the clients attending Frankfurt's facilities used the premises because of their fear of police, citing: U Kemmesies. The open drug scene and the safe injection room offers in Frankfurt am Main 1995: Final report, 20 July 2000 (available at www.indro-online.de/research.htm).
- ¹⁰⁵ Wood, *supra*, note 86 at 221.
- ¹⁰⁶ Ross, a 30-year-old Australian who has used heroin for 14 years, quoted in: S Finlay, Writing on the wall for injecting rooms. *The Age* (Melbourne), 27 April 2000: 4.
- ¹⁰⁷ K Dolan, A Wodak. Final report on injecting rooms in Switzerland (1996). The Lindsmith Centre – Drug Policy Foundation (unpublished), available at www.lindsmith.org/library/dolan2.html; J Kaldor; H Lapsley, RP Mattick & D Weatherburn. Six month process report on the medically supervised injecting centre [Kings Cross, NSW], 2 January 2002 [unpublished, on file].

- ¹⁰⁸ Wood, *supra*, note 86 at 222. See also ADCA, *supra*, note 91 at 189-190.
- ¹⁰⁹ Kerr; *supra*, note 4 at 4.
- ¹¹⁰ *Ibid.*
- ¹¹¹ DCPC, *supra*, note 2 at 15-16. For example, see Queensland Premier Beattie, quoted in A Pavey, Beattie opposes injecting rooms. *The Age* (Melbourne), 24 July 2000 (available at www.theage.com.au/news/20000724/A25310-2000jul23.html). The comparison of drug users to insects reflects the dehumanization and disrespect shown to people who use drugs.
- ¹¹² Victoria Drug Policy Expert Committee. *Drugs: Responding to the Issues, Engaging the Community – Stage One Report* (2000) at 43 [hereinafter VDPEC].
- ¹¹³ MacPherson, *supra*, note 61.
- ¹¹⁴ M Fyfe, Addicts revived in drug room. *The Age* (Australia), 22 June 2001.
- ¹¹⁵ Kerr; *supra*, note 4 at 35-36; R Haemmig, Speech on Swiss Experiences with Heroin Dispensation, Fixer Rooms and Harm Reduction in Prison. Conference Overlastenverlichting, Trimbos Institute, 21 November 1996, cited by DCPC, *supra*, note 2.
- ¹¹⁶ C Moore, Transcript of Proceedings, NSW Drug Summit 1999, on 18 May 1999 (available via drugsummit.socialchange.net.au).
- ¹¹⁷ DCPC, *supra*, note 2 at 7.
- ¹¹⁸ J Della Bosca, NSW, *Parliamentary Debates*, Legislative Council, 4 April 2000, at 3971.
- ¹¹⁹ The cost of operating a Swiss facility is said to be about A\$300,000 per year: Micallef, *infra*, note 127. See also MacPherson, *supra*, note 61 at 56. The Kings Cross facility has been said to cost A\$25,000 to A\$33,000 a week to operate (or A\$1.8 million to \$2.4 million per year); see C Overington. The Cross at the crossroads. *The Age* (Melbourne), 12 May 2001: 16. But elsewhere (*supra*, note 99) Overington reports that it would cost only A\$500,000 a year to operate a facility. With respect to the cost associated with drug use generally, see, eg, Eric Single. The Economic Implications of Injection Drug Use. Paper Presented at the Conference on Injection Drug Use, Montreal, Canada, March 1999. Single discusses how the harms arising from injection drug use result in large-scale costs to public health care and lost productivity. He also comments on the connection to crime and consequent law enforcement costs. See also Kerr; *supra*, note 4 at 3; injection drug use is said to cost British Columbia more than CDN\$207 million annually; the cost of providing medical care for an injection drug-user with HIV is approximately CDN\$139,000. See also NSW Joint Select Committee, *supra*, note 102 at 110.
- ¹²⁰ T Albert, G Williams. The Economic Burden of HIV/AIDS in Canada. Ottawa: Canadian Policy Research Network, 1998 (available via www.cprn.org).
- ¹²¹ NSW Joint Select Committee, *supra*, note 102 at 187.
- ¹²² Oscapella & Elliott, *supra*, note 40 at A8-A9.
- ¹²³ Roy, *supra*, note 62 at B54 (emphasis in original).
- ¹²⁴ Royal Australasian College of Physicians, *supra*, note 87 at 14.
- ¹²⁵ Kerr; *supra*, note 4 at 68-74.
- ¹²⁶ K Dolan et al. Drug consumption facilities in Europe and the establishment of supervised injecting centres in Australia. *Drug and Alcohol Review* 2001; 19: 337-346 (available at www.lindesmith.org/library/pdf_files/harm_reduction_digest_injecting_centres.pdf).
- ¹²⁷ E Micallef. "Safe Injection Facilities: Should Victoria Have a SIF Pilot-Trial?" (Discussion Paper). The Lindesmith Center; 1998 (available at www.lindesmith.org/library/micallef.html).
- ¹²⁸ VDPEC, *Drugs: Responding to the Issues*, *supra*, note 112 at 15.
- ¹²⁹ Dolan et al, *supra*, note 126 at 339.
- ¹³⁰ A Marxer; interviewed on *The Health Report*, ABC Radio National, 3 August 1998 (available at www.abc.net.au/rn/talks/8.30/helthrpt/stories/s11569.htm).
- ¹³¹ *Ibid.*
- ¹³² *Ibid.*
- ¹³³ Dolan et al, *supra*, note 126 at 339.
- ¹³⁴ *Ibid.* See also ABC Radio National, *supra*, note 130.
- ¹³⁵ Dolan et al, *supra*, note 126, cited in Micallef, *supra*, note 127.
- ¹³⁶ DCPC, *supra*, note 2 at 9.
- ¹³⁷ *Ibid.*
- ¹³⁸ C Ward. HIV/AIDS and legal issues in Australia. *Canadian HIV/AIDS and Law Newsletter* 2000; 5(2/3): 70 at 74, citing W de Jong, U Weber. The professional acceptance of drug use: a closer look at drug consumption in the Netherlands, Germany, and Switzerland. *International Journal of Drug Policy* 1999; 10: 99 at 100.
- ¹³⁹ M Frank. BYO heroin. *Mother Jones*, 5 May 2000 (available at www.motherjones.com/news_wire/byo_heroin.html). It should be noted that the criticism of Germany's injection rooms has come not from the United Nations as a whole, but from the UN-affiliated International Narcotics Control Board which assesses signatory countries' compliance with UN drug control conventions and has consistently opposed many harm-reduction measures. See also: Bundesministerium für Gesundheit. Press release #26: 1999, Drug and Addiction Report submitted by the Federal Government's Drug Commissioner (available via www.bmggesund.de), cited in Dolan et al, *supra*, note 126.

- ¹⁴⁰ Dolan et al, *supra*, note 126 at 340.
- ¹⁴¹ Riley, *supra*, note 36 at C12.
- ¹⁴² Dolan et al, *supra*, note 126 at 339-40.
- ¹⁴³ VDPEC, *supra*, note 112 at 13.
- ¹⁴⁴ Dolan et al, *supra*, note 126 at 340.
- ¹⁴⁵ *Ibid.* Dolan et al note that some women, for example, inject in the groin, which they are able to do in private.
- ¹⁴⁶ Frank, *supra*, note 139, citing Weimer:
- ¹⁴⁷ P Coffin. Research Summary: Safe Injection Rooms. Prepared for the Lindesmith Centre (undated), available via www.lindesmith.org.
- ¹⁴⁸ Frank, *supra*, note 139, citing Weimer:
- ¹⁴⁹ Coffin, *supra*, note 147. Dolan et al, *supra*, note 126 at 341 state that "[w]hile there is no direct epidemiological evidence to show reduced incidence of blood-borne virus (BBV) transmission among clients, observed reductions in needle sharing and increased condom use reported by clients indicate a reduction in BBV risk behaviours."
- ¹⁵⁰ VDPEC, *supra*, note 112 at 17.
- ¹⁵¹ Dolan et al, *supra*, note 126 at 338.
- ¹⁵² *Ibid.*, citing H de Ler, I van der Zande. *Alternatieve hulpverlening. Teksten en kritiek*. Amsterdam: SUA, 1978.
- ¹⁵³ *Ibid.* at 338-339.
- ¹⁵⁴ ADCA, *supra*, note 91 at 188.
- ¹⁵⁵ *Ibid.*
- ¹⁵⁶ *Ibid.* at 188-9.
- ¹⁵⁷ VDPEC, *supra*, note 112 at 17.
- ¹⁵⁸ DCPC, *supra*, note 2 at 11. See also VDPEC, *supra*, note 112 at 40.
- ¹⁵⁹ Wood, *supra*, note 86 at 222.
- ¹⁶⁰ NSW Joint Select Committee, *supra*, note 102 at 87. See also Dolan et al, *supra*, note 126 at 342.
- ¹⁶¹ Dolan et al, *supra*, note 126 at 342.
- ¹⁶² *Government Response to the Drug Summit – July 1999*, NSW Drug Summit 1999 (available at <http://drugsummit.socialchange.net.au>). See also ADCA, *supra*, note 91.
- ¹⁶³ NSW Drug Summit 1999 Communique, May 21 1999 (available at <http://drugsummit.socialchange.net.au>).
- ¹⁶⁴ Dolan et al, *supra*, note 126 at 342.
- ¹⁶⁵ Powell, *supra*, note 85. See also Dolan et al, *supra*, note 126 at 342.
- ¹⁶⁶ S Powell. First addicts shoot up in centre. *The Australian* (Sydney), 8 May 2001: 5.
- ¹⁶⁷ *Drug Summit Legislative Response Act 1999* (NSW), sch 1, ss 36A, 36B.
- ¹⁶⁸ *Ibid.* at s 36F.
- ¹⁶⁹ *Ibid.* at s 36S.
- ¹⁷⁰ *Ibid.* at s 36L.
- ¹⁷¹ *Ibid.* at ss 36A, 36B.
- ¹⁷² ADCA, *supra*, note 91 at 189.
- ¹⁷³ Dolan et al, *supra*, note 126 at 343.
- ¹⁷⁴ The five communities are Greater Dandenong, Maribymong, Melbourne, Port Phillip, and Yarra: J Silvester. Police plan blitz on rural heroin. *The Age* (Melbourne), 10 July 2000: 1-2.
- ¹⁷⁵ Editorial. Injecting room fears and reality. *The Age* (Melbourne), 16 June 2000: 14.
- ¹⁷⁶ *Kings Cross Chamber of Commerce and Tourism Inc v The Uniting Church of Australia Property Trust (NSW)* [2001] NSWSC 245 (5 April 2001) (available at www.austlii.edu.au/au/cases/nsw/supreme_ct/2001/245.html) (hereinafter *Kings Cross*). See also R Morris. PM blocks heroin law for gallery. *The Daily Telegraph*, 6 April 2001, at 5: the Chamber objected to the facility's location; Chamber members supporting the failed court action included sex shops and hotels.
- ¹⁷⁷ *Kings Cross*, *supra*, note 176 at para 91. See also media reports of decision in: S Powell. Heroin injecting room can open doors today. *The Australian*, 6 April 2001: 1-2; M Fyfe. Injecting room to go ahead. *The Age* (Melbourne), 6 April 2001: 2; Morris Blocks, *supra*, note 176. The Court commented, at para 2, on its limited role in adjudicating the dispute:

It needs no extended emphasis that the very proposal that there should be a legalised facility gives rise to large questions of public policy, of public morality, of social philosophy, of social policy, and of social welfare. It is, on that account, important to establish at the outset of this judgment that it is not the function and duty of this Court to pronounce, in the context of the present proceedings, upon any of those stated types of concern. The sole function and duty of the Court is to examine and construe the terms of the licence as issued; and the procedures by means of which the application for the licence was assessed and granted; and then to come to a reasoned answer to the question whether the licence has been properly issued according to law.

The Chamber of Commerce later announced that it was abandoning its appeal against this decision for lack of funds: AIDS Law International Notes (Australia needle exchange programs), *Lesbian/Gay Law Notes*, September 2001: 183.

¹⁷⁸ M Fyfe. Drug injecting centre faces siege by media. *The Age* (Melbourne), 1 May 2001 (available at www.theage.com.au/news/2001/05/01/FFX90B906MC.html).

¹⁷⁹ A Stavrinou. Addicts keeping away from the spotlight. *The Age* (Melbourne), 8 May 2001, at 2: A hundred individuals who had shown an interest in using the facility stated they were deterred from doing so because of media intrusiveness.

¹⁸⁰ *Ibid.* See Powell, *supra*, note 166 at 5; Fyfe, *supra*, note 178. The centre initially opened each day for one four-hour session, to be followed by an evening session after one month's operation.

¹⁸¹ ABC News Online. Injecting room success. *AM*, 12 May 2001 (available at www.abc.net.au/am/s295295.htm). As explained by Powell, *supra*, note 85, for the purposes of a trial, the facility is arguably placed in an ideal location:

In a 12-month period in 1999-2000, there were 677 call-outs to drug overdoses in Kings Cross – and there were the cases in which Narcan was used, the medication that reverses a heroin overdose. Ninety per cent of these call-outs, or 621, were within 300m of the injecting centre. Fifty-four per cent, or 335, were to drug users who overdosed on the footpath of Darlinghurst Road or in the buildings on the street. Death stalks the streets of Kings Cross. It is this terrible toll that the Uniting Church is hoping to reduce with the ... trial....

¹⁸² Fyfe, *supra*, note 178.

¹⁸³ Cited in *Kings Cross*, *supra*, note 176 at para 64.

¹⁸⁴ ABC News Online, *supra*, note 181.

¹⁸⁵ *Ibid.*

¹⁸⁶ Powell, *supra*, note 166. Dr Van Beek comments: "There was communication with drug users at a level never seen before and this had assisted in achieving success with one patient": Heroin injecting room opens for business. *The Australian* (Sydney), 7 May 2001 (available at www.news.com.au/common/story_page/0,4057,1972130%255E421,00.html).

¹⁸⁷ S Powell. Injecting centre throws 831 users a safety line. *The Australian* (Sydney), 15 August 2001: 2.

¹⁸⁸ *Ibid.*

¹⁸⁹ Powell, *supra*, note 85.

¹⁹⁰ *Ibid.*

¹⁹¹ *Ibid.*

¹⁹² Kaldor et al, *supra*, note 107.

¹⁹³ Fyfe, *supra*, note 178; Operators relieved as injecting room opens for business. ABC News Online, 7 May 2001 (available at www.abc.net.au/news/2001/05/item20010507091711_1.htm).

¹⁹⁴ Charter of the United Nations, Article 55.

¹⁹⁵ *Ibid.*, Article 56.

¹⁹⁶ *Ibid.*, Article 103.

¹⁹⁷ Universal Declaration of Human Rights, GA Res 217A, UN GAOR, 3rd sess, 183rd plen mtg, 71, UN Doc A/810 (1948), Article 25.

¹⁹⁸ A Chapman. Conceptualizing the right to health: a violations approach. *Tennessee Law Review* 1998; 65: 389 at 392. With respect to the content of the right to health, see S Jamar. The international human right to health. *Southern University Law Review* 1994; 22: 1; P Alston, G Quinn. The nature and scope of states parties' obligations under the International Covenant on Economic, Social and Cultural Rights. *Human Rights Quarterly* 1987; 9: 156.

¹⁹⁹ Jamar; *supra*, note 198 at 34.

²⁰⁰ (1976), 999 UNTS 171, [1976] Can TS 47 [hereinafter ICCPR].

²⁰¹ (1976), 993 UNTS 3, [1976] Can TS 46 [hereinafter ICESCR].

²⁰² ICESCR, Article 12.

²⁰³ For example, see the comments of Weeramantry J (in dissent, but not on this general proposition) in *Legality of the Use by a State of Nuclear Weapons in Armed Conflict*, Advisory Opinion, [1996] ICJ Rep 66 at 143-4; this has gone "beyond the field of good intentions into the realm of binding international law."

²⁰⁴ Jamar; *supra*, note 198 at 25.

²⁰⁵ Committee on Economic, Social and Cultural Rights. Substantive Issues Arising in the Implementation of the International Covenant on Economic, Social and Cultural Rights: General Comment No 14, UN Doc E/C.12/2000/4 (2000) at para 7 [hereinafter CESCR General Comment 14].

²⁰⁶ *Ibid.* at para 9.

²⁰⁷ Chapman, *supra*, note 198 at 391.

²⁰⁸ General Comment 14, *supra*, note 205 at para [9].

²⁰⁹ *Ibid.* at para 16.

²¹⁰ *Ibid.* at para 51.

- ²¹¹ Chapman, *supra*, note 198 at 411.
- ²¹² General Comment 14, *supra*, note 205 at para [11].
- ²¹³ *The Right to Life (Art 6): 30/07/82 – CCPR General Comment 6*, UN Doc HRI/GEN/1/Rev.1, 6 (1982) at paras 1, 5 [hereinafter General Comment 6].
- ²¹⁴ S Gruskin. Human rights and public health: an overview. *Canadian HIV/AIDS Policy and Law Newsletter* 1999; 4(2/3): 78, 79.
- ²¹⁵ *Ibid.*
- ²¹⁶ *Ibid.*
- ²¹⁷ Oscapella & Elliott, *supra*, note 40 at A32-A33.
- ²¹⁸ Jamar, *supra*, note 198 at 61.
- ²¹⁹ The full text of the Conventions can be found via the website of the International Narcotics Control Board at www.incb.org.
- ²²⁰ UN International Narcotics Control Board (INCB). The International Drug Control Treaties. Background Note No 1 (23 February 2000) (available via www.incb.org).
- ²²¹ *Ibid.*
- ²²² Swiss Institute of Comparative Law. Use of Narcotic Drugs in Public Injection Rooms under Public International Law. Prepared by Bertil Cottier Martin Synchold, Deputy Director Staff Legal Advisor: AVIS 99-121c, 7 January 2000.
- ²²³ *Ibid.*
- ²²⁴ *Ibid.*
- ²²⁵ *Ibid.*
- ²²⁶ Vienna Convention on the Law of Treaties, 23 May 1969, 1155 UNTS 331, Article 31(3)(b) (entered into force 27 January 1980).
- ²²⁷ Gilmour, *supra*, note 49. See also C Gatto (ed Allen St Pierre). *European Drug Policy: Analysis and Case Studies*. NORML Foundation, 1999 (available at www.norml.org/legal/european_policy.shtml).
- ²²⁸ Single Convention on Narcotic Drugs, 30 March 1961, 520 UNTS 204 (entered into force 13 December 1964), Article 36(1)(a) [hereinafter 1961 Single Convention].
- ²²⁹ *Ibid.*
- ²³⁰ J Norberry. Legal Issues. In: *Feasibility Study into the Controlled Availability of Opioids*, Vol 2: Background Papers (1991) at 87, 90. See also Gilmour, *supra*, note 227.
- ²³¹ 1961 Single Convention, Article 4(c).
- ²³² *Ibid.*, Article 36(1).
- ²³³ *Ibid.*, Article 38.
- ²³⁴ *Ibid.*, Article 36(2).
- ²³⁵ *Ibid.*, Article 33.
- ²³⁶ Swiss Institute of Comparative Law, *supra*, note 222 at para 10.
- ²³⁷ Gilmour, *supra*, note 49 at 7.
- ²³⁸ It should be noted that the 1971 Convention makes no reference to heroin (and other opiates) or cocaine, as its purpose was to control drugs (chiefly pharmaceutical products) not covered by previous treaties such as the 1961 Convention dealing with narcotic drugs: see INCB, Background Note No 1, *supra*, note 220 at 1. Therefore, permitting the legal possession and use of drugs such as heroin or cocaine at a safe injection site would not in any way contravene the 1971 Convention, although legally permitting the possession of other, listed drugs could.
- ²³⁹ Convention on Psychotropic Substances, 21 February 1971, 1019 UNTS 175 (entered into force 16 August 1976), Article 7(a) [hereinafter 1971 Convention].
- ²⁴⁰ Swiss Institute of Comparative Law, *supra*, note 222.
- ²⁴¹ Convention against Illicit Traffic in Narcotic Drugs and Psychotropic Substances, 20 December 1988, UN Doc E/Conf.82/15 (entered into force 11 November 1990) [hereinafter 1988 Convention].
- ²⁴² *Ibid.* Article 3(1) states as follows:
- Paragraph 1: Each party shall adopt such measures as may be necessary to establish as criminal offences ... when committed intentionally: (a)(i): The production, manufacture, preparation, offering, offering for sale, distribution, sale, delivery on any terms whatsoever; brokerage ... of any narcotic drug or any psychotropic substance contrary to the provisions of the 1961 Convention, the 1961 Convention as amended or the 1971 Convention; [...] (ii) The possession or purchase of any narcotic drug or psychotropic substance for the purpose of any of the activities enumerated in (i) above.
- ²⁴³ *Ibid.*, at Article 3(6). A careful reading of this clause should reveal that it need not be interpreted as requiring an automatic bias toward prosecution and harsh sentences for all drug offences and offenders: the objectives are to maximize “effectiveness” of law enforcement measures (by which standard is not specified) and to have “due regard” for deterrence. This leaves plenty of room in domestic law for measures other than strict prosecution and sentencing approaches. Regard should also be had for Article 14, which states: “The Parties shall adopt appropriate measures aimed at eliminating or reducing illicit demand ...”

- ²⁴⁴ 1988 Convention, Article 3(2).
- ²⁴⁵ Swiss Institute of Comparative Law, *supra*, note 222.
- ²⁴⁶ Ward, *supra*, note 138 at 73-74. The INCB also notes that the 1988 Convention “is designed to prevent the laundering of money obtained from illicit trafficking, and to provide concrete instruments for international law enforcement cooperation.” See INCB, Background Note No 1, *supra*, note 220 at 1.
- ²⁴⁷ Swiss Institute of Comparative Law, *supra*, note 222.
- ²⁴⁸ *Ibid.*
- ²⁴⁹ INCB, Role of INCB (undated document available at www.incb.org/e/role/menu.htm). The 13 members of the INCB are elected by the Economic and Social Council of the United Nations, 10 elected from a list of Government nominees, three from a list of World Health Organization nominees.
- ²⁵⁰ *Ibid.*
- ²⁵¹ Australian Capital Territory, *Parliamentary Debates*, Legislative Assembly, 1 March 2000, 422-423 (K Tucker).
- ²⁵² Role of INCB, *supra*, note 249.
- ²⁵³ *Ibid.*
- ²⁵⁴ *Ibid.*
- ²⁵⁵ 1961 Single Convention, Article 14; 1971 Convention, Article 19; 1988 Convention, Article 22.
- ²⁵⁶ See, eg, 1961 Single Convention, Art 14.
- ²⁵⁷ Ward, *supra*, note 138.
- ²⁵⁸ Role of INCB, *supra*, note 249.
- ²⁵⁹ Report of the International Narcotics Control Board for 1999. E/INCB/1999/1. Vienna: INCB, 2000, at 26, para 176 (available via www.incb.org) [hereinafter INCB Report 1999].
- ²⁶⁰ *Ibid.*
- ²⁶¹ *Ibid.* at 27, para 177.
- ²⁶² *Ibid.* at 62, para 500.
- ²⁶³ *Ibid.* at 27, para 177.
- ²⁶⁴ Ward, *supra*, note 138 at 73.
- ²⁶⁵ NSW, *Parliamentary Debates*, Legislative Council, 21 October 1999, 1773 (J Della Bosca).
- ²⁶⁶ *Ibid.*
- ²⁶⁷ *Ibid.* See also NSW Joint Select Committee, *supra*, note 102 at 146, where Professor Carney notes that if the trial is characterized (as he believes it can be) as serving the objectives of “treatment, education, after care, rehabilitation or social re-integration ... it being a controlled and evaluated trial, [then it] would in my view unquestionably be consistent with the international treaties.”
- ²⁶⁸ NSW, *Parliamentary Debates*, Legislative Council, 9 September 1999 at 193 (J Shaw, Attorney-General).
- ²⁶⁹ *Ibid.* See also the comments of Stanhope in Australian Capital Territory, *Parliamentary Debates*, Legislative Assembly, 7 December 1999 at 3800–3803.
- ²⁷⁰ New South Wales, *Parliamentary Debates*, Legislative Council, 9 September 1999, 193-194 (J Shaw).
- ²⁷¹ NSW, *Parliamentary Debates*, Legislative Council, 18 November 1999 at 3270 (M Kerr); 9 September 1999 at 193-194 (F Nile). See A Moffitt, Malouf & Thompson. *Drug Precipice* (1998) at 131-141.
- ²⁷² NSW, *Parliamentary Debates*, Legislative Council, 18 November 1999 at 3270 (M Kerr).
- ²⁷³ NSW, *Parliamentary Debates*, Legislative Council, 9 September 1999, 194 (J Shaw).
- ²⁷⁴ Injecting Facilities Trial Framework for Service Agreements, reproduced in Victoria, *Parliamentary Debates*, Legislative Assembly, 1 June 2000 at 2151.
- ²⁷⁵ *Ibid.*, at 2153. The impact of the facilities on the community (amount of litter and extent of trafficking) also were to be documented.
- ²⁷⁶ *Ibid.* at 2153–2154.
- ²⁷⁷ Report of the International Narcotics Control Board for 2000. E/INCB/2000/1. Vienna: INCB, 2001, at 68 (para 522) (available via www.incb.org) [hereinafter INCB Report 2000].
- ²⁷⁸ P Totaro, K Taylor: UN fails to veto needle rooms. *The Age* (Melbourne), 11 July 2000: 5. J Della Bosca comments on discussions he had with members of the INCB: “They made it clear that they were very impressed with the overall response of the New South Wales and Commonwealth governments in regard to drugs. The best I can say is that they understood the position that the medically supervised injecting room trial had within a comprehensive drug response framework.” See NSW, *Parliamentary Debates*, Legislative Council, 2 May 2000 at 4913.
- ²⁷⁹ INCB Report 2000, *supra*, note 277 at 69, para 525.
- ²⁸⁰ B Stronach. World drug body ignores injecting objectives. *The Australian* (Sydney), 13 July 2000: 10.

- ²⁸¹ B Foley, MA Toy, UN hits heroin room attempts. *The Age* (Melbourne), 21 February 2001: 2, citing INCB Report 2000, supra, note 277 at 65, para 513.
- ²⁸² See NSW Joint Select Committee, supra, note 102 at 146.
- ²⁸³ Vienna Convention, supra, note 226.
- ²⁸⁴ Moffitt, supra, note 271 at 136.
- ²⁸⁵ T Bruckner. *The Practical Guide to the Controlled Drugs and Substances Act*. Toronto: Thomson Canada Limited, 1997, at 20. For a longer discussion of the issue of criminal laws technically applicable to syringe exchange programs, see Oscapella & Elliott, supra, note 40 at A52-A57.
- ²⁸⁶ *Criminal Code*, s 462.2.
- ²⁸⁷ *Ibid*, s 462.1.
- ²⁸⁸ FDA, s 2.
- ²⁸⁹ *Criminal Code*, s 462.1.
- ²⁹⁰ 1999 INCB Report, supra, note 259 at 27.
- ²⁹¹ *Criminal Code*, s 21.
- ²⁹² *Dunlop v R* [1979] 2 SCR 881, 47 CCC (2d) 93.
- ²⁹³ *Criminal Code*, s 219.
- ²⁹⁴ *R v Anderson* (1990), 53 CCC (3d) 481 (SCC); *R v Waite* (1989), 48 CCC (3d) 1 (SCC) (per McIntyre and L'Heureux-Dubé JJ); *R v Canhoto* (1999), 140 CCC (3d) 321 (Ont CA).
- ²⁹⁵ Kerr, supra, note 4.
- ²⁹⁶ CDSA, s 56.
- ²⁹⁷ *Ibid* at s 55.
- ²⁹⁸ *Ibid* at s 55(2).
- ²⁹⁹ *Criminal Code*, s 462.1.
- ³⁰⁰ Drug Summit Legislative Response Act 1999 (NSW) sch 1, ss 36N-36O.
- ³⁰¹ C Jones, Barrister & Solicitor; Bull, Housser & Tupper. Civil Liability and Safe Injection Sites: Symposium address given at: Safe Injection Facilities – Opening the Legal Doors. Vancouver, 18 June 2001.
- ³⁰² *Ibid*.
- ³⁰³ C Jones. Fixing to sue: Is there a legal duty to establish safe injection facilities in British Columbia? *University of British Columbia Law Review* 2001; 35(2) (forthcoming).
- ³⁰⁴ Part I of the *Constitution Act, 1982*, being Schedule B to the Canada Act 1982 (UK), 1982, c. 11 [hereinafter Charter].
- ³⁰⁵ Eg, *R v Morgentaler*, [1988] 1 SCR 30; *Rodriguez v British Columbia*, [1993] 3 SCR 519 (constitutionality of criminal prohibition on assisted suicide); *New Brunswick (Minister of Health and Community Services) v G(J)*, [1999] 3 SCR 36.
- ³⁰⁶ Eg, *Blencoe v British Columbia (Human Rights Commission)*, [2000] 2 SCR 307 (delay in human rights proceeding); *Winnipeg Child and Family Services (Central Area) v W (KL)* (2000), 191 DLR (4th) 1 (SCC) (apprehension of child from parent by child protection authorities); *B(R) v Children's Aid Society of Metropolitan Toronto*, [1995] 1 SCR 315 (overriding parental objections to blood transfusion for child); *Singh v Minister of Employment and Immigration*, [1985] 1 SCR 177 (administrative unfairness in determination of claims to refugee status).
- ³⁰⁷ *Operation Dismantle v The Queen*, [1985] 1 SCR 441; *Blencoe*, supra, note 306; *Rodriguez*, supra, note 305; *Morgentaler*, supra, note 305.
- ³⁰⁸ *Entrop v Imperial Oil Ltd.*, (1995), 23 CHRR 196 (Ont Bd of Inquiry), [2000] OJ No. 2689 (CA); *Toronto Dominion Bank v Human Rights Commission* (1998), 163 DLR (4th) 193 (FCA); *R v Nguyen* (1995) 56 BCCA 290 citing *R v Ping Li* (unreported, 19 November 1993), Vancouver Registry No. CC930521 (BCSC, per Oliver J); *Cominco Ltd. v USWA Local 9705*, [2000] BCCA No. 62; *Canadian Union of Distillery Workers v Hiram Walker & Sons Ltd*, 77 CLLC 16087 (BCLRB).
- ³⁰⁹ *Granovsky v Canada (Minister of Employment and Immigration)*, 2000 SCC 28.
- ³¹⁰ *Eaton v Brant County Board of Education*, [1997] 1 SCR 241.
- ³¹¹ *Eldridge v British Columbia*, [1997] 3 SCR 624. See also *Auton (Guardian ad litem of) v British Columbia (Minister of Health)*, 2000 BCSC 1142.
- ³¹² For a fuller discussion of the constitutional arguments that might be advanced, see Jones, supra, note 303.
- ³¹³ *Constitution Act, 1867* (UK), 30 & 31 Vict c 3, reprinted in RSC 1985, App II, No 5, ss 91 & 92.
- ³¹⁴ *R v Schneider*, [1982] 2 SCR 112.
- ³¹⁵ *Reference Re Employment and Social Insurance Act*, [1936] SCR 427.
- ³¹⁶ CDSA, s 55(1) (emphasis added).
- ³¹⁷ For a summary of such details, see *Lieux d'injection supervisés: aperçu et expériences internationales*. Ottawa: Bureau de la Stratégie canadienne antidrogue (Santé Canada), May 2001 (rev).

³¹⁸ Kerr; *supra*, note 4 at 39.

³¹⁹ For a discussion, see J Gilmour. Minors. In: *Canadian Health Law and Policy*. J Downie, T Caulfield (eds). Toronto: Butterworths, 1999.

³²⁰ D Roy. Access to sterile needles for young people under the age of 14: an ethical analysis. *Canadian HIV/AIDS Policy & Law Newsletter* 1996; 2(3): 4.

³²¹ *Brooks v Canada Safeway Ltd*, [1989] 1 SCR 1219.

³²² [1997] 3 SCR 925.

³²³ P Cleeland. There is no solution. Injecting rooms can help. *The Age* (Melbourne), 8 June 2000: 18.

³²⁴ Wodak & Owens, *supra*, note 42, at 58-59.