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Injection Drug Use, HIV/AIDS, and HCV: Brief to the House of Commons Special Committee on Non-Medical Use of Drugs

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Injection Drug Use, HIV/AIDS, and HCV:
Brief to the House of Commons Special Committee on Non-Medical Use of Drugs

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Introduction

The Canadian HIV/AIDS Legal Network welcomes and appreciates the opportunity to make a submission to the House of Commons Special Committee on Non-Medical Use of Drugs. We hope that our contribution will help the Committee in its study of "the factors underlying or relating to the non-medical use of drugs in Canada" and to bring forward recommendations aimed at reducing "the dimensions of the problem involved in such use."

In its terms of reference, the Special Committee seeks input on a broad range of issues, including:

- Canada's Drug Strategy;
- the necessity of having reliable data on which to base the myriad policy decisions necessary for developing and administering a cohesive and viable drug strategy in Canada ("expanding the knowledge base");
- questions related to harm reduction (including: How much does criminalization contribute to the harm associated with drug use? Is treatment for drug addiction or dependence readily available in all jurisdictions? What kind of educational programs are aimed at preventing or reducing the consumption of illicit drugs in Canada?); and
- questions concerning injection drug use in Canada.

The focus of the Legal Network's submission will be on questions relating to harm reduction and on questions concerning injection drug use in Canada, specifically as they relate to HIV/AIDS and hepatitis C (HCV)..

Since the early 1990s, Canada has been in the midst of a public health crisis concerning HIV/AIDS, HCV, and injection drug use. The spread of HIV (and other infections such as HCV) among injection drug users in Canada merits serious and immediate attention.[1]

- The number of HIV infections attributable to injection drug use has been unacceptably high. In 1999, *34.1 percent of the estimated 4,190 new HIV infections were among injection drug users*. Over 60 percent of new HCV infections are related to injection drug use.
- There have been several studies documenting a rise in the prevalence and incidence of HIV among injection drug users in the larger cities of Canada, but *a rise in the number of*

[1] The following data are taken from: (1) Health Canada. *HIV/AIDS Epi Update: HIV/AIDS Among Injection Drug Users in Canada*. Ottawa: May 2001. Available at http://www.hc-sc.gc.ca/hpb/lcdc/bah/; (2) Health Canada. *HIV/AIDS Epi Update: Risk Behaviours Among Injection Drug Users in Canada*. Ottawa: May 2001. Available at http://www.hc-sc.gc.ca/hpb/lcdc/bah/; (3) HIV/AIDS in Prisons – Info Sheet 2: High-Risk Behaviours behind Bars. Montréal: Canadian HIV/AIDS Legal Network, 2nd edition, 2001. Available at www.aidslaw.ca/Maincontent/issues/prisons.htm; (4) Health Canada. *Hepatitis C & Injection Drug Use*. Ottawa: 2001. Available at www.hc-sc.gc.ca/hppb/hepatitis_c/aboutfacts.html.

injection drug users with HIV infection has also been observed outside major urban areas.

- Given the geographic mobility of injection drug users and their social and sexual interaction with non-users, the dual problem of injection drug use and HIV infection is one that *ultimately affects all of Canadian society*.

Studies undertaken in different parts of Canada illustrate the urgency of the problem:

- HIV prevalence among injection drug users in *Montréal* increased from approximately five percent prior to 1988 to 19.5 percent in 1997;
- in *Vancouver*, HIV prevalence among injection drug users increased from four percent in 1992-93 to 23 percent in 1996-97; in Victoria, from six percent in the early 1990s to 21 percent in 1999;
- HIV prevalence among injection drug users in *Toronto* increased from 4.8 percent in 1992-93 to 8.6 percent in 1997-98;
- in *Ottawa*, a 1992-93 study found an HIV prevalence of 10.3 percent among persons who attended needle exchange programs; a 1996-97 study showed that prevalence had increased to 20 percent;
- data from needle exchange programs in *Québec City* and smaller cities in Québec indicate that HIV prevalence among injection drug users is 9 percent in Québec City and as high as 9.6 percent in some semi-urban areas;
- in *Winnipeg*, HIV prevalence among injection drug users increased from 2.3 percent in 1986-90 to 12.6 percent in 1998.

The problem of injection drug use and HIV and HCV infection affects all of Canadian society. However, some populations are particularly affected.

Women injection drug users in Canada are at high risk of HIV infection. For women, the proportion of AIDS cases attributed to injection drug use increased from 0.5 percent during the period before 1989 to 45 percent in 1998. Since then, there has been a slight decrease to 34.6 percent in 2000. For men, the increase has also been pronounced, but less dramatic: from 0.8 percent before 1989 to 19.8 percent in 2000.

Injection drug use is a severe problem among *street youth*: for example, one-third of a sample of Montréal street youth had injected drugs in the previous six months.

Injection drug use is also a problem among *prisoners*. Estimates of HIV prevalence among prisoners vary from one to four percent in men and from one to ten percent in women, and in both groups infection is strongly associated with a history of injection drug use. Once in prison, many continue injecting. For example:

- In a federal prison in British Columbia, 67 percent of inmates responding to one survey reported injection drug use either in prison or outside, with 17 percent reporting drug use *only in prison*.

- In a 1995 inmate survey conducted by the Correctional Service of Canada, 11 percent of 4285 federal inmates self-reported having injected since arriving in their current institution.

Finally, *Aboriginal people* are overrepresented in groups most vulnerable to HIV, such as sex-trade worker and prisoners. In particular, they are overrepresented among inner-city injection drug use communities, including among clientele using needle exchange programs and counselling/referral sites.

Canada's response to the crisis of HIV/AIDS and HCV among injection drug users has been far from being concerted and effective. Much more can and must be done to prevent the further spread of HIV and other infections among injection drug users, and to provide care, treatment, and support to those already living with HIV or AIDS. Indeed, much more must be done, because current approaches do not withstand ethical scrutiny.

For these reasons, the Canadian HIV/AIDS Legal Network takes great interest in providing input into the study of the Special Committee on Non-Medical Use of Drugs.

The second chapter of this brief describes the Canadian HIV/AIDS Legal Network's activities ("About the Canadian HIV/AIDS Legal Network").

The third chapter ("Analysis") addresses the questions the Committee is considering. We first discuss the extent to which Canada's drug laws and policies contribute to the harms associated with drug use, in particular in the context of HIV/AIDS and HCV. We then discuss existing educational programs aimed at preventing or reducing the consumption of illicit drugs in Canada, suggesting that much of the education provided is inaccurate and ineffective. We continue by discussing proposals to (1) enhance needle exchange programs; (2) increase access to treatment options including methadone maintenance; (3) undertake clinical trials of prescribed heroin; and (4) undertake a pilot or project involving a supervised injection site. Finally, we address the issues raised by injection drug use and HIV/AIDS and HCV in prisons.

We conclude that much more can and must be done to reduce the harms from injection drug use in Canada, particularly as they relate to HIV/AIDS and HCV.

About the Canadian HIV/AIDS Legal Network

The Canadian HIV/AIDS Legal Network is a national organization engaged in education, legal and ethical analysis, and policy development. We have 250 members across Canada, about half of whom are community-based organizations with an interest in HIV/AIDS issues.

We promote responses to HIV/AIDS that:

- implement the International Guidelines on HIV/AIDS and Human Rights;
- respect the rights of people with HIV/AIDS and of those affected by the disease;
- facilitate HIV prevention efforts;
- facilitate care, treatment, and support of people with HIV/AIDS;
- minimize the adverse impact of HIV/AIDS on individuals and communities;
- address the social and economic factors that increase vulnerability to HIV/AIDS and to human rights abuses.

We produce, and facilitate access to, accurate and up-to-date information and analysis on legal, ethical, and policy issues related to HIV/AIDS in Canada and internationally.

Work on injection drug use and HIV/AIDS, as well as work on HIV/AIDS and drug use in prisons have been central to the Network's activities since the early 1990s. In particular, in the area of HIV/AIDS and drug use and prisons, we:[2]

- published a series of 13 info sheets on HIV/AIDS in prisons (second, revised and updated edition, 2001);
- published over 100 articles on HIV/AIDS and drug use in prisons in the *Canadian HIV/AIDS Policy and Law Review*;
- published a section on HIV testing of prisoners in "*HIV Testing and Confidentiality: Final Report*" (1998);
- published *HIV/AIDS in Prisons: Final Report* (September 1996) - a comprehensive analysis of issues related to HIV/AIDS in prisons; and
- gave presentations at numerous conferences, including the 1998 World HIV/AIDS Conference, Geneva.

In the area of injection drug use and HIV/AIDS, we have undertaken an in-depth examination of the legal and ethical issues surrounding HIV/AIDS and injection drug use, and continue to follow up on these issues. In particular, we:[3]

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[2] The following documents are all available at http://www.aidslaw.ca/Maincontent/issues/prisons.htm.

[3] The following documents are all available at http://www.aidslaw.ca/Maincontent/issues/druglaws.htm.

- have undertaken an in-depth examination of the legal and ethical issues related to the establishment of safe injection sites in Canada (a report, entitled *Establishing Safe Injection Facilities in Canada: Legal and Ethical Issues*, will be released in March 2002); and
- produced *Injection Drug Use and HIV/AIDS: Legal and Ethical Issues*, a 116-page report with 66 recommendations, accompanied by a volume of background materials with papers on legal, ethical, and policy issues raised by injection drug use and HIV/AIDS, and a series of info sheets on injection drug use and HIV/AIDS, with shorter, accessible information on legal, ethical, and policy issues raised by injection drug use and HIV/AIDS.

On 31 August 2001, Health Canada responded to the Legal Network's report. On the same day, the Network reacted to Health Canada's Response.

In addition, the Network

- in April 2001, commented on "Reducing the Harm Associated with Injection Drug Use in Canada," the working document for consultation prepared by five government committees;
- in April 1996, presented to the Senate Committee on Constitutional Affairs about the impact of Canada's drug laws on the spread of HIV; and
- regularly publishes a wide variety of articles on legal, ethical, and policy issues related to HIV/AIDS, HCV, and injection drug use in the *Canadian HIV/AIDS Policy & Law Review*.

The Network's work has received national and international recognition. Among other things, the United Nations Programme on HIV/AIDS included our activities in its collection of "best practices."

Analysis

In this section, we will address the questions the Committee is considering. As mentioned above, our focus will be on questions relating to harm reduction and on questions concerning injection drug use in Canada.

Defining and Enhancing Harm Reduction

How much does criminalization contribute to the harm associated with drug use? Are Canada's drug laws and policies in need of review and reform?

Several major reports released since1997 have concluded that the legal status of drugs in Canada hinders efforts to prevent the spread of HIV among injection drug users, and efforts to provide care, treatment, and support to HIV-positive injection drug users.

Care, Treatment and Support for Injection Drug Users Living with HIV/AIDS: A Consultation Report[4] stated that the pharmacological effects of the illegal drugs used by injection drug users are not in themselves necessarily harmful. The report pointed out that much of the harm is secondary, caused either by the legal status of the drugs themselves, or by things such as dangerous injecting practices, criminal behaviour, and uncertain drug strength or purity that result from the legal status of drugs. The report further pointed out that the legal status of drugs is a barrier to utilization by injection drug users of much of the addiction and medical services system; and that treatment approaches, admission protocols, and staff and public attitudes are more reflective of the legal status of drugs than of the treatment needs of injection drug users.

The *National Action Plan* prepared by the Task Force on HIV, AIDS and Injection Drug Use[5] also observed that the legal status of drugs in Canada contributes to the difficulties encountered in addressing HIV among injection drug users.

Many others have pointed out that the criminal approach to drug use may increase rather than decrease harms from drug use:[6]

- Because drugs can only be purchased on the underground market, they are of unknown strength and composition, which may result in overdoses or other harm to the drug user.

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[4] McAmmond D. *Care, Treatment and Support for Injection Drug Users Living with HIV/AIDS: A Consultation Report*. Ottawa: Health Canada, March 1997.

[5] *HIV, AIDS, and Injection Drug Use: A National Action Plan*. Ottawa: Canadian Public Health Association & Canadian Centre on Substance Abuse, 1997. Available at www.ccsa.ca.

[6] For a detailed discussion, with many references, see: Canadian HIV/AIDS Legal Network. *Injection Drug Use and HIV/AIDS: Legal and Ethical Issues*. Montréal: The Network, 1999, at 26-27.

- Fear of criminal penalties and the high price of drugs cause users to consume drugs in more efficient ways, such as by injection, that contribute to the transmission of HIV and HCV.
- Because sterile injection equipment is not always available, drug users may have to share needles and equipment.
- Significant resources are spent on law enforcement, money that could instead be spent on prevention and the expansion of treatment facilities for drug users.

The most pronounced effect is to push drug users to the margins of society. This makes it difficult to reach them with educational messages; makes users afraid to go to health or social services; may make service providers shy away from providing education on safer use of drugs, for fear of being seen as condoning use; and fosters anti-drug attitudes toward the user.

In the context of drug use, is it appropriate then to use the criminal law rather than other means of social intervention? In a Government of Canada report entitled *The Criminal Law in Canadian Society*,[7] it was stated that "[t]he criminal law should be employed only to deal with conduct for which other means of social control are inadequate or inappropriate, and in a manner which interferes with individuals rights and freedoms only to the extent necessary for the attainment of its purpose." This would seem to preclude the use of the criminal law in dealing with at least some activities relating to drugs. Other, less harmful means are available to respond to the use of drugs in a fashion that still maintains (and in fact, may encourage) social order and protection of the public.

Alternatives to the current approach to drug use and drug users are possible. Alternatives *within the current prohibitionist policy* that would not require any changes to the current legal framework could include the de facto decriminalization of cannabis possession for personal use, medical prescription of heroin, explicit educational programs, etc. Alternatives *to the current prohibitionist approach* may require that Canada denounce several international drug-control conventions.

Importantly, in 2001, Health Canada, in its response to the Legal Network' 1999 report on HIV/AIDS and injection drug use (hereafter called the "Legal Network's 1999 report"), acknowledged that "[f]undamental changes are needed to existing legal and policy frameworks in order to effectively address IDU as a health issue."[8]

From an ethical perspective, considering alternatives to the current approach is not just possible, but required. Some aspects of current drug policy must be reversed because of their intolerable social consequences. Ethical principles demand a more coherent and integrated drug policy that

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[7] Government of Canada. *The Criminal Law in Canadian Society*. Ottawa: August 1982.

[8] Health Canada. Injection Drug Use and HIV/AIDS. Health Canada's Response to the Report of the Canadian HIV/AIDS Legal Network. Ottawa: 2001. Available at www.aidslaw.ca/Maincontent/issues/druglaws.htm.

can withstand rational inquiry and scrutiny, is responsive to the complexity of the current situation, and allows for public and critical discussion.

Therefore, two overarching directions for future action were identified in the Legal Network's 1999 report:

- Canada must reverse the negative impacts of the current legal status of drugs on drug users and on those who provide services to them.
- Canada must move to adopt alternatives to the current approach to reducing drug use, and the harms of drug use, among Canadians.

Recommendations

1. In the long term, federal and provincial governments should establish a more constructive alternative to the current legal framework, and provide the research, educational, and social programming required to reduce the harms of drug use. Governments, and all Canadians, must:

- ***acknowledge the extent of drug use and the diversity of drug users in Canada;***
- ***acknowledge that Canada's current drug laws have a disproportionate impact on the most vulnerable in Canadian society, including Aboriginal people, racial minorities, and women;***
- ***acknowledge that current laws increase rather than decrease the harms from drug use and, in particular, marginalize drug users;***
- ***recognize the human rights of drug users, and recognize the ways in which current laws and treaties violate the human rights of drug users in Canada; and***
- ***if necessary, denounce international drug-control conventions if these present insurmountable barriers to implementing more constructive drug- control policies and laws in Canada that are based on a harm-reduction model.***

2. In the short term, under the existing legal framework, the federal and provincial governments should fund research on the differential impact of current drug legislation, policies, and practices according to race, class, gender, and other socioeconomic factors.

3. In consultation with drug users and community-based agencies providing services to drug users, the federal and provincial governments should assess the positive outcomes of initiatives such as diversion policies, alternative measures, and the pilot projects implementing such alternatives. If assessed favourably, such initiatives should be further expanded to temper the punitive approach currently reflected in Canadian drug laws and policies.

4. The federal government should make use of its regulatory and exemption powers under current legislation to expressly exclude injection equipment

***containing traces of illegal drugs from the definition of "controlled substance" in the* Controlled Drugs and Substances Act.**

5. The federal government should take the necessary steps to clarify that those operating needle exchange or distribution programs are not liable to criminal prosecution under the drug paraphernalia provisions of the Criminal Code for the "sale" of "instruments or literature for illicit drug use."

6. The federal government should use its regulatory and exemption power under the* Controlled Drugs and Substances Act *to decriminalize the possession of small amounts of currently illegal drugs for personal use, at least when medically prescribed by a qualified and authorized health-care professional.

7. The federal government should ensure that there is a fair and timely process by which Canadians and their health-care professionals can apply for medical access to currently illegal drugs.

What kinds of educational programs are aimed at preventing or reducing the consumption of illicit drugs in Canada? Is there realistic and honest drug education focused on health and well-being?

The Legal Network's 1999 report concluded that there is not enough provision of accurate and complete information on illegal drugs to health-care providers, drug users, and the general public, and that this lack of (accurate) information has a negative impact on provision of care, treatment, and support, as well as on prevention efforts.[9]

Educational programs based on abstinence
Many existing educational programs, particularly those for youth, are based on a zero tolerance philosophy. Abstinence from drug use is the primary objective. Youth are often told that any drug use beyond one-time experimentation with an illegal drug constitutes drug abuse, that alcohol and cigarettes are "stepping stones" to the consumption of drugs, and that use of drugs such as marijuana will lead to consumption of narcotics such as heroin and cocaine. Policy analysts see such a "Just Say No" curriculum as inherently dangerous:

> When kids are told that illegal drugs, including marijuana, are extremely dangerous and addictive, and then learn through experimentation that this is false, the rest of the message is discredited. Honest drug education is one key to

[9] *Injection Drug Use and HIV/AIDS: Legal and Ethical Issues*, supra, note 6, at 73-79.

> ensuring that individuals know how to make informed decisions. But such an approach is inconsistent with the "Just Say No" campaign.[10]

To be effective, they argue, drug education should be based on realistic assumptions about drug use: "Programs must address the needs of individuals within their social context and be as flexible, open, and creative as the young people they must educate."[11]

Harm-Reduction Education Programs

Harm-reduction educational programs take a non-judgmental approach to the use of drugs. They try to provide accurate information on the composition and effects of different substances and recommend sources of assistance to persons who use drugs. Programs geared to adolescents attempt to provide young persons with skills in assessment, communication, assertiveness, conflict resolution, and decision making.

Educational programs based on harm-reduction objectives try to: reduce the prevalence of unsafe frequencies and methods of ingesting drugs; decrease the rate of heavy or dependent consumption; reduce experimentation with drugs most likely to cause medical problems; and improve the ability of users and others to respond to drug-related problems.

Some government ministries and agencies in Canada have published information for the public based on harm-reduction principles. However, the amount of drug education and publications distributed to youth, drug users, and the public that are based upon these principles remains small.

Nor do health-care providers such as physicians, pharmacists, and nurses generally receive an adequate education on drug addiction, illegal drugs, and treatments for drug-dependent persons. For example, a study conducted in British Columbia involving medical students and residents concluded that more time should be devoted in the curriculum to drugs other than alcohol.[12]

Ethical principles

According to ethical principles, individuals in society should have accurate and comprehensive information on all matters that require decision, choice, and action. It is ethically wrong to tailor or suppress the information about illegal drugs that individual users, professionals, and citizens generally need to know to act responsibly.

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[10] Rosenbaum M. Just Say What? An Alternative View on Solving America's Drug Problem. San Francisco: National Council on Crime and Delinquency, 1990.

[11] Ibid, at 17.

[12] Towle A, Faculty of Medicine, University of British Columbia. Addiction Medicine and Intercollegial Responsibility (AMIR): Evaluation Report, 1996.

Drug users, in the name of personal autonomy, have a responsibility to seek out the most reliable and comprehensive information available to guide them in the choices and decisions that will advance or frustrate their own life plans, and perhaps the life plans of the person with whom they interact or to whom they are bound.

Health-care professionals have the responsibility to assure that they master the drug-use information and knowledge they need to care for those whose needs fall within their professional mandate. They also have a responsibility to signal to the health-care community, to the research community, and to society where, in their experience, there is a dearth of needed information and knowledge.

The responsibility of the general public (that is, of *citizens* and their *government representatives*) to become adequately informed about drug use and the effects of such use derives from their central role and power in the formulation, passage, and implementation of public policy regarding all aspects of drug use, including: the criminalization of drug use; prevention and education programs; harm-reduction programs; and care, treatment, and support of drug users.

The Legal Network's 1999 report made a number of recommendations that, if implemented, would go a long way toward ensuring the provision of accurate and complete information on illegal drugs to health-care providers, drug users, and the general public. This, in turn, would have a beneficial impact on the provision of care, treatment, and support of drug users, as well as on prevention efforts.

Recommendations

8. Federal, provincial, and territorial health officials should provide funding for the development and wide distribution of accurate, unbiased, and nonjudgmental information on illegal drugs for health-care providers, drug users, and members of the public.

9. Provincial and territorial governments, government agencies, and community-based organizations should develop education programs based on harm-reduction principles.

10. Provincial and territorial ministries of education and health should undertake an evaluation of school programs on illegal drugs.

11. Universities and colleges should ensure that the curricula of health-care professionals include accurate, unbiased, and nonjudgmental materials, presentations, and discussions about drugs, drug use, and harm-reduction approaches to drug use.

Addressing Injection Drug Use

As stated in its terms of reference, the Committee would like to hear submissions on recommendations in the Federal/Provincial/Territorial Advisory Committee Report entitled *Reducing the Harm Associated with Injection Drug Use in Canada* to

- enhance needle exchange programs;
- increase access to treatment options including methadone maintenance;
- undertake clinical trials of prescribed heroin; and
- consider a pilot or project involving a supervised injection site.

The Legal Network fully supports these recommendations which are consistent with the recommendations in the Network's 1999 report.

Needle Exchange Programs

The Purposes of needle exchange programs

Needle exchange programs (NEPs) are an important strategy in a harm-reduction approach to injection drug use. A fundamental rationale for their establishment is that injection drug users typically share needles and syringes, a frequent mode of transmission of HIV and HCV. The philosophy underlying NEPs is that if injection drug users are provided with sterile syringes and needles, this will reduce the sharing of drug equipment and thus decrease the transmission of bloodborne diseases such as HIV and HCV.

In addition to distributing sterile injection equipment, NEPs are a useful way of getting in touch with injection drug users in order to provide education and counseling, and to connect them to health-care services and drug treatment programs.

Do They Work?

Studies have concluded that NEPs

- are effective in reducing the spread of HIV;
- do not increase the number of injection drug users or lower the age of first injection; and
- do not increase the number of needles discarded in a community, or change the locations where needles are disposed.[13]

A research brief on "syringe access," last updated in March 2001, states that "every established medical, scientific, and legal body to study the issue has concluded that improved access to sterile syringes is an effective method to reduce the spread of infectious diseases."[14]

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[13] See, eg: Health Canada. *HIV/AIDS Epi Update: Risk Behaviours Among Injection Drug Users in Canada*. Ottawa: May 2001 (contains references to the studies that have shown that NEPs work). Available at http://www.hc-sc.gc.ca/hpb/lcdc/bah/. See also the articles on "Needle Exchange/Syringe Availability & HIV/AIDS" on the Drug Policy Alliance website at www.lindesmith.org/library/syringe_index.html

Needle Exchange Programs in Canada

The first NEP in Canada was established in 1989 in Vancouver. Within a few months NEPs were established in Montréal and Toronto. This was soon followed in other major Canadian cities. Currently, it is estimated that there are well over 100 NEPs. Nevertheless, only a small proportion of injection drug users have access to NEPs. Many problems remain:[15]

- In some NEPs there is a limit on the number of syringes distributed to injection drug users at each visit. Individual quotas may be imposed, and/or new syringes may only be exchanged for used syringes. Such limitations may be well-intentioned but have restricted access to sterile injection equipment. Generally, the number of needles distributed in Canada is significantly lower than the number required by injection drug users.
- The number of NEPs in Canada remains insufficient, and NEPs are generally located in large cities. Persons who live in rural areas or in small towns have little access to such programs. Moreover, NEPs have often been centralized within large cities, limiting access even within them.
- Although injection drug use is prevalent in prisons, there are no NEPs in federal and provincial prisons.
- The hours of operation of NEPs are often very restricted. In rural areas, sterile needles provided in community clinics or hospital emergency departments may be available for only two hours each week.
- In many places, pharmacists continue to be reluctant to provide syringes to injection drug users. Many are concerned about the potential negative effects on business revenue if they provide them. This is a problem, as pharmacies, particularly in rural areas, may be one of the few places in which sterile syringes may be obtained.
- Not all NEPs offer health care, counselling and support services.

Legal Issues

It is legal in Canada to give or sell sterile syringes to injection drug users. However, NEP staff and drug users may be criminally charged under the *Controlled Drugs and Substances Act* for possessing traces of illegal drugs contained in used syringes.

Ethical Issues

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[14] Drug Policy Alliance. Focal Point: Needle Exchange/Syringe Availability. At www.lindesmith.org/library/lib.html

[15] See, eg: Hankins C. Syringe exchange in Canada: good but not enough to stem the HIV tide. *Substance Use and Misuse* 1998; 33: 1129 (discusses the history and current deficiencies of needle exchange programs in Canada); *Injection Drug Use and HIV/AIDS: Legal and Ethical Issues*, supra, note 6, at 80-91.

> The governing purpose or end of NEPs programs is the reduction or elimination of a constellation of harms that accompany addiction to drugs and injection drug use. The NEPs ... are means to achieve that end.
>
> However, these programs do not work as effective means when they are operative in ways that impose restrictions that condemn the programs to fall far short of the needs of the persons for whom they were designed.[16]

Because of all the limitations mentioned above, the ethical principles of autonomy and dignity, beneficence and non-maleficence, justice and fairness and utilitarianism are not followed in some NEPs in Canada. Beneficence and non-maleficence is the maximimization of good and the minimization of harm to the drug user. Autonomy and dignity involves the right of the drug user to self-determination, namely the right to make informed decisions regarding the course of action to be taken. Justice and fairness means that sufficient resources must be provided to address the problems of drug users. Finally, the principle of utilitarianism means that measures must be taken to ensure the maximization of good to society.

Recommendations

The Legal Network's 1999 report made a number of recommendations that, if implemented, would go a long way toward ensuring that NEPs in Canada better fulfill their goals:

12. The federal, provincial, territorial, and municipal governments should ensure that needle exchange programs are easily accessible to injection drug users in all parts of Canada.

13. The federal government should repeal criminal laws that subject drug users and needle exchange staff to criminal liability for having in their possession drug paraphernalia containing residue of illegal substances.

14. Pharmacists' associations as well as licensing bodies should encourage pharmacists to distribute sterile syringes.

(A recommendation concerning access to sterile injection equipment in prisons is made below).

Methadone Maintenance Treatment

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[16] Roy D. Injection drug use and HIV/AIDS: an ethics commentary on priority issues. In: *Injection Drug Use and HIV/AIDS: Legal and Ethical Issues - Background Papers*. Montréal: Canadian HIV/AIDS Legal Network, 1999, at B48.

In Canada, methadone remains the only opioid approved for long-term treatment of opiate dependence.

The safety and effectiveness of methadone maintenance treatment (MMT) has been documented in scientific and medical publications.[17] MMT programs have been credited with decreasing opioid use, reducing criminality, and improving the general health of the drug user. Moreover, MMT reduces individual mortality and morbidity. Another important benefit of MMT is that it helps decrease the spread of HIV, as methadone is typically administered orally rather than by syringe. MMT has thus become a "critical resource in the struggle against injection drug use and AIDS." Methadone clinics are also potentially excellent sites for disease prevention and education. Patients can be offered screening and counselling for transmissible diseases; and can be provided information on safe sex, on the dangers of sharing needles, and on methods for cleaning syringes.

Barriers to effective programs

Restrictions imposed in methadone treatment programs have occurred for several reasons. They include philosophical opposition to methadone treatment, and reliance on such treatment to achieve abstinence from drugs. In many ways, MMT provides a clear example of how regulations "can reduce the public health effectiveness of a controversial program for unpopular people." The US Institute of Medicine concluded that current policies place "too much emphasis on protecting society from methadone and not enough on protecting society from the epidemics of addiction, violence, and infectious diseases that methadone can help reduce."[18] The same observation has been made in Canada, where it has been stated that the rules and regulations of methadone programs are often barriers to effective care of injection drug users. In January 1999, an Ontario physician wrote:

> Tremendous controversy exists about the severe restrictions applied to patients taking methadone - restrictions which do not apply in any fashion to the prescribing of other equally or more dangerous narcotics. It would take a treatise to explain the political and philosophic history underlying the severity of standards which must be met by Ontario methadone patients.[19]

Programs have been criticized for the array of rules and regulations to which patients are subjected. They include rigorous assessment procedures, mandatory daily visits, abstinence as a condition of treatment, and random urine sampling. Other issues include:

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[17] See, *Injection Drug Use and HIV/AIDS: Legal and Ethical Issues*, supra, note 6, at 85, with many references.

[18] [US]Institute of Medicine. *Federal Regulation of Methadone Treatment.* Washington DC: National Academy Press, 1995.

[19] Letter dated 7 January 1999 from Dr P Berger, cited in *Injection Drug Use and HIV/AIDS: Legal and Ethical Issues,* supra, note 6, at 86.

- The number of heroin-dependent persons in many parts of Canada who have been treated with methadone, although it has increased in recent years, remains low.
- Funding of methadone programs in Canada is inadequate, and in many provinces too few physicians and pharmacists participate in providing MMT.
- Access to MMT in prisons remains limited. In the federal and in many (but not all) provincial systems, inmates who were already on MMT outside can continue such treatment in prison. However, MMT should be available also to opiate-dependent prisoners who were not receiving it prior to incarceration.

Recommendations

The Network's 1999 report made a number of recommendations that, if implemented, would go a long way toward ensuring that MMT programs in Canada better fulfill their goals:

15. Federal, provincial, and territorial governments should take measures to ensure that methadone maintenance programs are more accessible to opiate-dependent persons in all provinces and territories.

16. Government health officials and Colleges of Physicians and Surgeons should ensure that comprehensive services are available to persons who participate in methadone programs, including primary health care, counselling, education, and support services.

(A recommendation concerning access to MMT in correctional institutions is made below).

Clinical Trials of Heroin Prescription

As mentioned above, currently methadone is the only opioid approved for the long-term treatment of drug-dependent persons in Canada. Although MMT has many advantages, there are some limitations. Methadone is effective for heroin addiction, but it is not a treatment for dependence on cocaine, amphetamine, and other non-opiate drugs. In addition, methadone is not indicated for multiple addictions. Finally, methadone is addictive. In fact, the withdrawal symptoms from methadone may be worse and more difficult to manage than the withdrawal symptoms from heroin. Thus, MMT it is not a sufficient solution to many of the problems associated with drug dependency, and it is necessary to explore other methods of addressing it.

In particular, members of the scientific and medical community in Canada, as well as drug users, have advocated that drugs other than methadone ought to be provided to drug-dependent individuals. They say that Canada has fallen far behind other countries such as Britain, where physicians are permitted to prescribe heroin, cocaine, morphine, amphetamine, as well as other

drugs; or Switzerland, where in 1994 the government began a multi-year, multi-city scientific trial to provide drugs to long-term dependent users in order to assess the effects on their health, social integration, and behaviour. In 1997, the heroin maintenance experiment was declared a success: crime dropped by 60 percent, unemployment by 50 percent, and significant public funds were saved due to a reduction in the costs of criminal procedures, imprisonment, and disease treatment.[20]

A heroin trial in Canada?

Because of the limitations of MMT, in recent years many have taken the position that heroin substitution and heroin maintenance are reasonable alternatives that have a place in an overall public health approach to injection drug use in Canada.[21] Canadian and US researchers have developed a protocol (North American Opiate Medications Initiative) aimed at assessing the effectiveness of heroin prescription with respect to attracting and retaining those resistant to conventional treatments. This randomized clinical study will include a control group receiving oral methadone, while the experimental group will receive an injectable opiate with or without oral methadone. The study will last two years and the experimental treatment one year. The protocol is awaiting approval.[22]

Ethical issues

Ethical consideration of whether to prescribe opiates or controlled stimulants to drug users must be based on an adequate understanding of addiction and of effective treatment for addiction. Research and practice indicates that addiction is a chronic condition (not sociopathic behaviour best managed by imprisonment, and not merely an acute condition to be treated or cured by detoxification) and that treatment for addiction requires a comprehensive program of ongoing services, including medical, psychological, and social services.[23] This assessment has implications for clinical, research, and social ethics.

Understanding drug-dependency as a chronic condition and drug treatment as a complex program of ongoing services has implications for *clinical ethics*. Improved health and social integration, not abstinence, should be the prime objective of the treatment. Roy states:

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[20] See, *Injection Drug Use and HIV/AIDS: Legal and Ethical Issues*, supra, note 6, at 59, with references.

[21] See, eg, Fischer B. The case for a heroin substitution treatment trial in Canada. *Canadian Journal of Public Health* 1997; 88: 367. See also the website of the Drug Policy Alliance (formerly the Lindesmith Center), which contains many articles and reports on heroin maintenance: www.drugpolicy.org/.

[22] For more details, see Brissette S. Medical prescription of heroin – a review. *Canadian HIV/AIDS Policy & Law Review* 2001; 6(1/2): 1, 92-98. Available at www.aidslaw.ca/Maincontent/otherdocs/Newsletter/vol6nos1-22001/heroin.htm.

[23] Roy, supra, note 16, at B22, with reference to O'Brien CP, AT McLellan. Myths about the treatment of addiction. *Lancet* 1996; 347:240; and others.

> [T]he clinical ethics of using methadone-assisted, or, where necessary, heroin-assisted treatment cannot, given the chronic nature of the addiction condition, be governed by the goal of achieving total and permanent abstinence.
>
> [T]he clinical goal governing the clinical ethics of prescribing methadone or heroin within a treatment plan encompassing comprehensive medical and psychosocial services is to improve the addicted person's physical and psychological health and to help these persons to achieve their maximum of social integration and productive satisfying living.[24]

Roy concludes that it would be clinically unethical not to use methadone-assisted and heroin-assisted treatments for persons who consent to them and who stand to benefit from them:

> Not to offer these treatments to persons who need them, who want them, and who can benefit from them is inhumane. It is the refusal to offer these treatments, not the use of these treatments, that needs to be ethically justified. That refusal cannot be justified so long as evidence for the safety and efficacy of methadone-assisted or heroin-assisted treatments is available.

As regards *research ethics*, it is imperative to conduct research that would provide the basis for sound clinical decisions, including research into prescribing opiates or controlled stimulants. "Methodologically sound research and clinical trials are an integral part of the fundamental ethical imperative that doctors and other professionals should *know* what they are doing when they intervene in the bodies, minds, and lives of sick people." Those who oppose the establishment of methodologically sound clinical trials of opiate-assisted treatment programs are promoting therapeutic abandonment of those who cannot benefit from existing treatments.

As regards social ethics, the number of comprehensive treatment programs in Canada for drug-dependent persons are inadequate and an insufficient number of physicians in Canada are trained in drug addiction. As Roy states, "[t]he complexity of care is not in keeping with the complexity of the disease." Such clinical inadequacies invoke the ethical imperatives of social justice and humanity.

The width of the gap between what should be done and what is in fact being done for drug-dependent persons in need of treatment is a measure of the injustice that is present in society. That injustice is based upon a counter-position that harbors moral and scientific incoherence. This counter-position must be reversed, according to Roy, because "it betrays the ethic of a civilized society and leads to the kind of humanization provoked by the logic of exclusion."

In conclusion, from an ethical perspective, it may be imperative to conduct a clinical trial of heroin prescription in Canada. Indeed, methodologically sound research and clinical trials are an integral part of the fundamental ethical imperative that doctors and other professionals should

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[24] Ibid, at B25-B26. All the following quotes in this section are from Roy, at B25 to B27.

know what they are doing when they intervene in the bodies, minds, and lives of persons dependent on drugs. It can be argued that those who oppose methodologically sound clinical trials of opiate-assisted treatment programs are promoting the therapeutic abandonment of those who cannot benefit from existing treatments.

Recommendations
The Legal Network's 1999 report recommended measures that would improve drug users' access to more comprehensive drug treatment options, including:

17. In the longer term, Health Canada should develop plans to permit physicians to prescribe opiates and controlled stimulants.

18. In the shorter term, trials involving the prescription of heroin should be authorized, funded, and initiated in Canada.

Supervised Injection Facilities

Another partial solution to the crisis of injection drug use, HIV/AIDS, and HCV (as well as overdoses) that has been suggested is the establishment - initially by way of a trial - of supervised injection facilities (also known as "safe injection facilities" (or "sites").

The Legal Network has just completed a comprehensive study of the legal and ethical issues raised by the establishment of safe injection facilities in Canada.[25] The study concludes:

> 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 policy-makers have a legal and moral obligation to at least allow and support trials of safe injection facilities as measures which are permissible under drug control treaties, further our human rights obligations, and are required out of logic, compassion and basic decency.[26]

What are safe injection facilities?
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

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[25] Elliott R, Malkin I, Gold J. *Establishing Safe Injection Facilities in Canada: Legal and Ethical Issues*. Montréal: Canadian HIV/AIDS Legal Network, 2002 (forthcoming).

[26] Ibid, at iii.

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, blood borne 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.[27]

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 blood borne diseases[28] and other injuries caused by unsafe injecting, and (3) acting as a gateway to education, treatment and rehabilitation. Those resisting safe injection facilities assert there is little clear evidence from jurisdictions where they have been introduced which 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."[29] In fact, no overdose deaths have been recorded in European facilities, and the numbers of overdose deaths in communities with facilities have declined.[30] One of the foremost

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[27] 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).

[28] Ibid, at 12–13.

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

[30] 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 27 at 6. See also 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; T Kerr. *Safe Injection Facilities: Proposal for a Vancouver Pilot Project*. Prepared for the Harm Reduction Action Society. Vancouver, 2000, at 33. Kerr reviews data from Germany and Switzerland indicating "substantial reductions in overdose deaths following the establishment of safe injection facilites."

reasons supporting the introduction of facilities lies in the simple but significant fact that the trained staff is in a position in which they can prevent overdoses.[31]

The debate

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.[32] 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.[33]

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.[34]

Another 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, 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.[35] Eventually, members of the public will likely come to appreciate and recognise the advantages associated with establishing facilities, when compared with their current experiences. As Clover Moore, a Member of the Legislative Assembly of New South Wales states, "[m]y constituents despair at the rising levels of drug-related street crime, dealing, overdosing and contaminated syringe

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[31] 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.

[32] 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 9.

[33] 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.

[34] Kerr, *supra* note 30 at 4. See also Royal Australasian College of Physicians, *From Hope to Science: Illicit Drugs Policy in Australia* (2001) at 13.

[35] Kerr, *supra* note 30 at 35-36; R Haemmig. Speech on Swiss Experiences with Heroin Dispension, Fixer Rooms and Harm Reduction in Prison. Conference Overlastenverlichting. Trimbos Institute, 21 November 1996, cited cited by DCPC, *supra* note 27.

disposal in their streets, on their doorsteps and in their children's playgrounds."[36] Safe injection facilities have the potential to alleviate these problems.

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.[37] 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 nuisances.[38] Safe injection facilities now appear to be accepted in those jurisdictions, despite some initial opposition.

Legal issues
The Legal Network's study also examined relevant aspects of Canadian and international law. It concludes 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, 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.

With regard to domestic legal issues, the Network's study 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 examines some key questions that should be addressed by a regulatory framework governing safe injection facilities developed by the federal government.

Recommendations
The Network's paper on safe injection facilities presents six recommendations for immediate action by government(s) in Canada regarding safe injection facilities:

19. The federal government should update Canada's Drug Strategy to expressly support trials of safe injection sites as harm reduction measures that are an important component of the overall policy response to the harms associated with injection drug use.

C Moore, Transcript of Proceedings, NSW Drug Summit 1999, on 18 May 1999 (available at: http://drugsummit.socialchange.net.au).

37 Kerr, supra, note 30, at 68-74.

38 Dolan et al, supra, note 30 (available at: www.lindesmith.org/library/pdf_files/harm_reduction_digest_injecting_centres.pdf).

20. 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.

21. 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 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 of 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.***

22. 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 CDSA making 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.

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

24. 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 sites can occur as soon as possible.

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 minimised.

In many ways, it seems odd to have gone so far as to establish needle 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.* [39]

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. [40]

Some time ago, the establishment of needle exchanges necessitated a shift in attitude from abstention to harm minimisation. 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.

Correctional Facilities

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[39] Hon. Justice Wood, supra note 31at 222 (emphasis added): health benefits outweigh policy considerations (ie, purportedly condoning otherwise unlawful behaviour); therefore, *the Commission favours introducing facilities for supervised injecting purposes.*

[40] Quoted in Caroline Overington. Chasing an Answer. *The Age* (Melbourne), 21 March 2001: 15.

As stated in the Committee's terms of reference,

> [t]he rate of injection drug use among incarcerated individuals is known to be significant. Are there prevention and treatment programs that could be better adapated to correctional facilities? Are there innovations in other jurisdictions that have proven successful within the prison environment?

As mentioned above, HIV/AIDS, HCV, and injection drug use are a serious problem among *prisoners*. Estimates of HIV prevalence among prisoners vary from one to four percent in men and from one to ten percent in women, and in both groups infection is strongly associated with a history of injection drug use. Once in prison, many continue injecting. For example:

- In a federal prison in British Columbia, 67 percent of inmates responding to one survey reported injection drug use either in prison or outside, with 17 percent reporting drug use *only in prison*.
- In a 1995 inmate survey conducted by the Correctional Service of Canada, 11 percent of 4285 federal inmates self-reported having injected since arriving in their current institution.[41]

In Canada, issues related to injection drug use and HIV/AIDS and HCV have been studied in detail by the Expert Committee on AIDS and Prisons, which released *HIV/AIDS in Prisons: Final Report of the Expert Committee on AIDS and Prisons* in 1994; and by the Legal Network, which released a follow-up report in 1996.[42] Both reports recommended, among other things, increased access to MMT and pilot needle-exchange programs. Both emphasized the need to reduce the number of drug users who are incarcerated. These recommendations are consistent with the recommendations of the World Health Organization[43] and the Joint United Nations Programme on AIDS.[44] They need to be implemented urgently.

Methadone Maintenance Treatment in Prisons

Why methadone maintenance treatment?

Many have recommended the introduction or expansion of MMT in prisons as an AIDS-prevention strategy that provides people dependent on drugs with an additional option for getting

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41 See*, HIV/AIDS in Prisons: Final Report*. Montréal: Canadian HIV/AIDS Legal Network, 1996 (available at http://www.aidslaw.ca/Maincontent/issues/prisons.htm), with many references.

42 Ibid.

43 World Health Organization. WHO Guidelines on HIV Infection and AIDS in Prisons. Geneva: WHO, 1993 (WHO/GPA/DIR/93.3). Available at www.aidslaw.ca/Maincontent/issues/prisons.htm.

44 Joint United Nations Programme on AIDS. Prisons and AIDS: UNAIDS Technical Update. Geneva: UNAIDS, 1997; and Prisons and AIDS: UNAIDS Point of View.Geneva: UNAIDS, 1997. Available at www.unaids.org.

away from needle use and sharing. *The main aim of MMT is to help people get off injecting, not off drugs*. Methadone dose reduction – with the ultimate goal of helping the client to get off drugs – is a longer-term objective.

Community MMT programs have rapidly expanded in recent years. As mentioned above, there are ample data supporting their effectiveness in reducing high-risk injecting behaviour and in reducing the risk of contracting HIV. There is also evidence that MMT is the most effective treatment available for heroin-dependent injection drug users in terms of reducing mortality, heroin consumption, and criminality. Further, MMT attracts and retains more heroin injectors than any other form of treatment. Finally, there is evidence that people who are on MMT and who are forced to withdraw from methadone because they are incarcerated often "return to narcotic use, often within the prison system, and often via injection." It has therefore been widely recommended that prisoners who were on MMT outside prison be allowed to continue it in prison.[45]

Further, with the advent of HIV/AIDS, the arguments for offering MMT to those who were not following such a treatment outside are compelling: prisoners who are injection drug users are likely to continue injecting in prison and are more likely to share injection equipment, creating a high risk of HIV transmission. As in the community, MMT, if made available to prisoners, has the potential of reducing injecting and syringe sharing in prisons.

Where Is It Being Offered?
Worldwide, an increasing number of prison systems are offering MMT to inmates.

In Canada, methadone was rarely prescribed to anyone in prison until quite recently. However, this is changing, partly because of the recommendations urging prisons systems to provide MMT, partly because of legal action. One such case was in British Columbia: an HIV-positive woman undertook action against the provincial prison system for failing to provide her with methadone. The woman had been refused continuation of MMT in prison. She argued that, under the circumstances she found herself in, her detention was illegal. In response, the prison system arranged for a doctor to examine the woman, and he prescribed methadone for her. After this, she withdrew her petition. In another case, a man with a longstanding, "serious heroin problem" was sentenced to two years less one day in prison – and thus to imprisonment in a provincial prison in Québec – because that prison had agreed to provide him with methadone treatment. The defence had submitted that it was necessary to deal with the root causes of the man's crimes, namely his heroin addiction, and that treatment with methadone was essential to overcoming that addiction.

In September 1996 the British Columbia Corrections Branch adopted a policy of continuing methadone for incarcerated adults who were already on MMT in the community, becoming the first correctional system in Canada to make MMT available in a uniform way. On 1 December 1997 the federal prison system followed suit. Today, in the federal and in many – but not all –

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45 *HIV/AIDS in Prisons: Final Report*, supra, note 41, at 67-73, with many references.

provincial systems, inmates who were already on MMT outside can continue such treatment in prison. However, only in the British Columbia provincial system and under "exceptional circumstances" in the federal system can inmates access MMT even if they were not on such treatment on the outside. In 2001, access to MMT initiation was supposed to be increased in the federal system. However, a Treasury Board submission requesting funding to allow for an extension of the program was not successful.

Are there other alternatives?
Some prison systems are still reluctant to make MMT available, or to extend availability to those prisoners who were not receiving it prior to incarceration. Some consider methadone as just another mood-altering drug, the provision of which delays the necessary personal growth required to move beyond a drug-centred existence. Some also object to MMT on moral grounds, arguing that it merely replaces one drug of dependence with another. If there were reliably effective alternative methods of achieving enduring abstinence, this would be a meagre achievement. However, as Dolan and Wodak have explained, there are no such alternatives:

> [T]he majority of heroin-dependent patients relapse to heroin use after detoxification; and few are attracted into, and retained in drug-free treatment long enough to achieve abstinence. Any treatment [such as MMT] which retains half of those who enrol in treatment, substantially reduces their illicit opioid use and involvement in criminal activity, and improves their health and well-being is accomplishing more than "merely" substituting one drug of dependence for another.[46]

Other treatment options
Offering other treatment options to help break dependence on drugs is also important. Providing MMT *and* other treatment options is crucial, and respects the rights of prisoners to the kind of care and concern that is available on the outside, rather than simply denying that drug injecting takes place inside.

Recommendation

25. Correctional systems should ensure that prisoners who were in a methadone maintenance program prior to incarceration are able to continue methadone maintenance treatment while incarcerated, and that prisoners are able to start such treatment in prison whenever they would be eligible for it outside.

In addition, opiate-dependent prisoners should have other treatment options, including methadone detoxification programs with reduction-based prescribing,

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46 K Dolan K, A Wodak. An international review of methadone provision in prisons. *Addiction Research* 1996; 4(1): 85-97.

which should be routinely offered to all opiate-dependent prisoners on admission.

Needle Exchange Programs in Prisons

Particularly because of the questionable efficacy of bleach in destroying HIV and other viruses,[47] providing sterile needles to inmates has been widely recommended. In its 1994 report, the Expert Committee on AIDS and Prisons (ECAP) observed that the scarcity of injection equipment in prisons almost guarantees that inmates who persist in drug-injecting behaviour will share their equipment:

> Some injection drug users have stated that the only time they ever shared needles was during imprisonment and that they would not otherwise have done so. Access to clean drug-injection equipment would ensure that inmates would not have to share their equipment.[48]

The Committee concluded that making injection equipment available in prisons would be "inevitable."[49]

International developments
Over the last 10 years, an increasing number of prisons has established needle exchange or distribution programs.[50]

In Switzerland, distribution of sterile injection equipment has been a reality in some prisons since the early 1990s. Sterile injection equipment first became available to inmates in 1992, at Oberschöngrün prison for men. Dr Probst, a part-time medical officer working at Oberschöngrün, was faced with the ethical dilemma of as many as 15 of 70 inmates regularly injecting drugs, with no adequate preventive measures. Probst began distributing sterile injection material without informing the warden. When the warden discovered this, instead of firing Probst he listened to Probst's arguments and sought approval to sanction the distribution of needles and syringes. Ten years later, distribution is ongoing, has never resulted in any negative

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47 US Department of Health & Human Services, Public Health Service, Centers for Disease Control and Prevention. *HIV/AIDS Prevention Bulletin*, 19 April 1993.

48 Expert Committee on AIDS and Prisons. *HIV/AIDS in Prisons: Final Report of the Expert Committee on AIDS and Prisons*. Ottawa: Minister of Supply and Services Canada, 1994, at 77.

49 Id.

50 H Stöver. *Study on Assistance to Drug Users in Prisons*. Lisbon, European Monitoring Centre for Drugs and Drug Addiction, 2001 (EMCDDA/2001). The most up-to-date overview of needle exchange programs in prison. For copies: info@emcdda.org.

consequences, and is supported by prisoners, staff, and the prison administration. Initial scepticism by staff has been replaced by their full support:

> Staff have realized that distribution of sterile injection equipment is in their own interest. They feel safer now than before the distribution started. Three years ago, they were always afraid of sticking themselves with a hidden needle during cell searches. Now, inmates are allowed to keep needles, but only in a glass in their medical cabinet over their sink. No staff has suffered needle-stick injuries since 1993.[51]

In June 1994 another Swiss prison – Hindelbank institution for women – started a one-year pilot AIDS prevention program including needle distribution. Hindelbank's program has been evaluated by external experts, with very positive results: the health status of prisoners improved; no new cases of infection with HIV or hepatitis occurred; a significant decrease in needle sharing was observed; there was no increase in drug consumption; needles were not used as weapons; and only about 20 percent of staff did not agree with the installation of the needle-distribution machines.[52] Following the first evaluation, a decision was taken to continue the program.

Other Swiss prisons have since started their own programs.

In Germany, green light to the development and implementation of the first two pilot schemes was given in 1995, and the first pilot project started on 15 April 1996. At the end of 2000, needle exchange schemes had been successfully introduced in seven prisons, and more were discussing to implement them. In Spain, the first pilot project started in August 1997. Soon, such schemes will be implemented in all prisons. Finally, in Australia a study concluded that needle and syringe exchange is feasible.

Canadian developments

No Canadian prison systems have yet started pilot needle- distribution projects. However, a few systems, including the federal prison system, are studying the issue. Those opposed to making needles available have said that this would be seen as condoning drug use. In reality, however, it is not an endorsement of illicit drug use by inmates. Rather, it is a pragmatic public health measure that recognizes that injection drug use in prisons is a reality, all efforts to eliminate it notwithstanding. *Not* undertaking pilot needle-distribution studies, in the knowledge that HIV

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51 *HIV/AIDS in Prisons: Final Report*, supra, note 41, at 59.

52 J Nelles, A Fuhrer. *Drug and HIV Prevention at the Hindelbank Penitentiary. Abridged Report of the Evaluation Results of the Pilot Project*. Berne: Swiss Federal Office of Public Health, 1995 (the first-ever evaluation of a needle-distribution program; available in English, French, or German. Copies: Swiss Federal Office of Public Health, 3001 Berne, Switzerland). See also J Nelles et al. *Drug, HIV and Hepatitis Prevention in the Realta Cantonal Men's Prison: Summary of the Evaluation*. Berne: Swiss Federal Office of Public Health, 1999 (the evaluation of another needle-distribution program).

and other infections are being transmitted in prisons, could be seen as condoning the spread of infections among prisoners and to the general public.

What Can We Learn?
1. The experience of prisons in which needles have been made available shows that they can be made available in a manner that is non-threatening to staff and indeed seems to increase staff's safety.

2. There are several models of distribution of sterile injection equipment. Thus far, every institution has chosen its own model. What can and should be done in a particular institution depends on many factors: the size of the institution, the extent of injection drug use, the security level, whether it is a prison for men or for women, the commitment of health-care staff, and the "stability" of the relations between staff and inmates.

3. A good way for a prison system to start a needle-distribution program and to overcome objections is to treat it first as an experiment and to evaluate it after the first year of operation.

Recommendation

26. Sterile injection equipment needs to be made available in prisons. In prison systems where distribution has not yet started, selection of prisons in which pilot projects can be undertaken should begin immediately.

Responding to Drug Use

Generally, federal and provincial prison systems need to adopt a more pragmatic approach to drug use, acknowledging that the idea of a drug-free prison is no more realistic than the idea of a drug-free society and that, because of HIV/AIDS and HCV, they cannot afford to continue focusing on the reduction of drug use as the primary objective of drug policy.

Reduction of drug use is an important goal, but reduction of the spread of HIV and other infections - in particular, HCV - is more important: unless prison systems act aggressively to reduce the spread of infections, there may be slightly reduced rates of drug use in prisons, but many more prisoners living with HIV/AIDS and/or HCV and other infections. At a minimum, they need to coordinate their efforts in the areas of HIV/AIDS and of drug use, to make sure that any programs they undertake with the aim of reducing drug use does not result in an increase in harms from that use.

Particular concern exists with regard to urinalysis programs, which should be evaluated by external experts in terms of their impact on drug use and HIV prevention efforts, but also their cost effectiveness. At a minimum, testing for traces of cannabis products should be stopped. This would substantially reduce the costs of urinalysis programs and ensure that inmates fearing detection would not switch from relatively harmless cannabis products to other, more harmful

drugs used by injecting. This approach is already used, for example, in prisons in Switzerland and Germany. Commenting on it, the warden of one prison has said:

> There is no question in my mind that it would be a mistake to test for marijuana. The tests are very expensive and inmates might use more dangerous, less detectable drugs. And then, to be honest, use of marijuana does not really bother staff. They can live with it, it does not create any problems. We have to be pragmatic, and focus on AIDS as the major problem.[53]

Recommendation

27. Federal and provincial prison systems need to adopt a more pragmatic approach to drug use, acknowledging that, because of HIV/AIDS and HCV, they cannot afford to continue focusing on the reduction of drug use as the primary objective of drug policy: reduction of drug use is an important goal, but reduction of the spread of HIV and other infections - in particular, HCV - is more important.

At a minimum, they need to coordinate their efforts in the areas of HIV/AIDS and of drug use; allow for evaluation of existing education, treatment, and, where applicable, urinalysis programs, by external experts; and offer a greater variety of treatment options to inmates, including in drug-free prisons or wings.

Drug Policy

Finally, many of the problems raised by HIV/AIDS in prisons are the result of Canada's drug policy, which instead of providing drug users with much-needed treatment, care, and support, criminalizes their behaviour and puts many of them in prison.

The financial and human costs of this policy are enormous, and prison systems are burdened with a problem society fails to deal with, and that they are even less equipped to deal with. As the World Health Organization has stated, "[g]overnments may...wish to review their penal admission policies, particularly where drug abusers are concerned, in the light of the AIDS epidemic and its impact on prisons."[54] Indeed, as emphasized by the Expert Committee on AIDS and Prisons, reducing the number of drug users who are incarcerated needs to become an

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53 Personal communication with Mr Fäh, Warden of Oberschöngrün Penitentiary, on 1 March 1996.

54 World Health Organization. Statement from the Consultation on Prevention and Control of AIDS in Prisons, Global Programme on AIDS. Geneva: WHO, 1987.

immediate priority.[55] Many of the problems created by HIV infection and by drug use in prisons could be reduced if alternatives to imprisonment, particularly in the context of drug-related crimes, were developed and made available.

Recommendation

28. Reducing the number of drug users who are incarcerated needs to become an immediate priority. In order to reduce the problems created by HIV, other infectious diseases, and drug use in prisons, alternatives to imprisonment, particularly in the context of drug-related crimes, need to be developed and made available.

55 Expert Committee on AIDS and Prisons, supra, note 48, at 6.

Conclusion

Canada is in the midst of a public health crisis concerning HIV/AIDS, HCV and injection drug use. The number of infections attributable to injection drug use has been unacceptably high. In 1999, 34.1 percent of the estimated 4,190 new HIV infections were among injection drug users. Over 60 percent of new HCV infections are related to injection drug use.

Canada's response to this crisis has been far from being concerted and effective. Indeed, the lack of appropriate action has led some to conclude that another public health tragedy, comparable to the blood tragedy in the 1980s, is underway, illustrating that little if anything has been learned from the lessons taught by that tragedy. As Skirrow says:

> A marginalized community (in this case injection drug users) is experiencing an epidemic of death and disease resulting not from anything inherent in the drugs that they use, but more from the ineffective and dysfunctional methods that characterize our attempts to control illegal drugs and drug users. There is the same unwillingness to carefully analyze the problem or to depart from traditional methods and conventional thought that was integral to the blood tragedy. There is a struggle for power and control over the issue between law enforcement and public health. There is a profound lack of understanding among decision-makers and many health professionals regarding the nature of the community and individuals at risk.[56]

Much more can be done to reduce the harms from injection drug use in Canada. Indeed, much more *must* be done, as ethical analysis reveals, because current approaches do not withstand ethical scrutiny. As Roy has stated:

> It is *ethically* wrong to continue the current approaches to the control of drug use when these approaches fail to achieve the goals for which they were designed; create harms equal to or greater than those they purport to prevent; and intensify the marginalization of vulnerable people.
>
> 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. ...

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56 Skirrow J. Lessons from Krever - a personal perspective. *Canadian HIV/AIDS Policy & Law Newsletter* 1999; 4(2/3): 35-41. Compares the blood tragedy with the new public health tragedy of HIV/AIDS among injection drug users.

> It is *ethically* wrong to tailor or suppress the information about illegal drugs that individual users, professionals, and citizens generally need to know in order to act responsibly.
>
> It is *ethically* wrong to set up treatment or prevention programs in such a way that what the program gives with one hand, it takes away with the other.
>
> It is *imperative* that persons who use drugs be recognized as possessing the same dignity as all other human beings.[57]

Much more must be done now

In 1997, the National Task Force on HIV, AIDS and Injection Drug Use, in its *National Action Plan*, called for "immediate action ... at all levels of governmental and community leadership."[58] In particular, the Task Force demanded that: policy and legislative issues be addressed; prevention and intervention efforts be enhanced; treatment options for substance use and HIV be improved; issues specific to Aboriginal populations receive special and urgent attention; and issues unique to women be addressed. The Task Force "strongly reconfirmed" the responsibility of the federal Minister of Health to show leadership on this issue, in partnership with key ministries (Justice, Solicitor General, Corrections) through initiating action, monitoring implementation, and evaluating outcomes.

In 1999, the Canadian HIV/AIDS Legal Network released its report on *Injection Drug Use and HIV/AIDS: Legal and Ethical Issues*.

In 2001, Health Canada responded to the Legal Network's report and its recommendations with a commitment to "strengthening and expanding efforts with respect to injection drug use."[59] Also in 2001, five federal/provincial/territorial committees released their document on "reducing the harms associated with injection drug use in Canada."

Nevertheless, in 2002, the crisis is ongoing. Governments are continuing their half-hearted responses. Yet people continue to become infected in alarming numbers. Implementing the recommendations in the *National Action Plan*, in *Injection Drug Use and HIV/AIDS: Legal and Ethical Issues*, and in *Establishing Safe Injection Facilities in Canada: Legal and Ethical Issues* (the most relevant of which are repeated here) must become an urgent priority.

Finally, as Skirrow has pointed out, we can no longer afford to tiptoe

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57 Roy, supra, note 16.

58 Supra, note 5.

59 Supra, note 8.

> around such issues as the degree to which the consequences of drug use result to a significant degree from our legal response to drugs; or that the consumption of potentially harmful drugs is something virtually everyone does at some point in their lives; or that drug use is not the same as drug addiction; or that people who develop serious drug problems are often dysfunctional in many ways, with this dysfunction usually preceding their introduction to drugs.[60]

It is safer, and very much easier, to skip over the hard issues, agree that drugs are *the* problem, and then move on to repackaging the failed program approaches of the past. But we can no longer afford to do this.

Skirrow says:

> We have chosen to place drugs at the centre - rather than, say, economic opportunity, educational attainment, family dysfunction, risk taking behaviours or any of the other determinants of whether or not someone uses drugs, and whether or not a serious problem results from that use....
>
> Prevention to get us out of this mess must focus on the many factors that start people on this path in the first place. Few of these have much to do with drugs themselves. True prevention will focus on how to better prepare all young people for the challenges of our complex, dangerous, and often unforgiving society. It will develop much better ways of dealing with the mentally ill, and with the unique economic and social problems that Aboriginal peoples face. Surely it is more sensible to deal with these matters upstream from the streets of Vancouver.
>
> In the end, our success in dealing with any problem, and certainly with drugs, depends on the clarity of our understanding, and our courage.[61]

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60 Skirrow J. A review of "A Framework for Action: A Four Pillar Approach to Drug Problems in Vancouver. *Canadian HIV/AIDS Policy & Law Review* 2001; 6(½): 89-91.

61 Id.

Summary of Recommendations

Drug Laws and Policies

1. In the long term, federal and provincial governments should establish a more constructive alternative to the current legal framework, and provide the research, educational, and social programming required to reduce the harms of drug use. Governments, and all Canadians, must:

- acknowledge the extent of drug use and the diversity of drug users in Canada;
- acknowledge that Canada's current drug laws have a disproportionate impact on the most vulnerable in Canadian society, including Aboriginal people, racial minorities, and women;
- acknowledge that current laws increase rather than decrease the harms from drug use and, in particular, marginalize drug users;
- recognize the human rights of drug users, and recognize the ways in which current laws and treaties violate the human rights of drug users in Canada; and
- if necessary, denounce international drug-control conventions if these present insurmountable barriers to implementing more constructive drug- control policies and laws in Canada that are based on a harm-reduction model.

2. In the short term, under the existing legal framework, the federal and provincial governments should fund research on the differential impact of current drug legislation, policies, and practices according to race, class, gender, and other socioeconomic factors.

3. In consultation with drug users and community-based agencies providing services to drug users, the federal and provincial governments should assess the positive outcomes of initiatives such as diversion policies, alternative measures, and the pilot projects implementing such alternatives. If assessed favourably, such initiatives should be further expanded to temper the punitive approach currently reflected in Canadian drug laws and policies.

4. The federal government should make use of its regulatory and exemption powers under current legislation to expressly exclude injection equipment containing traces of illegal drugs from the definition of "controlled substance" in the *Controlled Drugs and Substances Act*.

5. The federal government should take the necessary steps to clarify that those operating needle exchange or distribution programs are not liable to criminal prosecution under the drug paraphernalia provisions of the *Criminal Code* for the "sale" of "instruments or literature for illicit drug use."

6. The federal government should use its regulatory and exemption power under the *Controlled Drugs and Substances Act* to decriminalize the possession of small amounts of currently illegal drugs for personal use, at least when medically prescribed by a qualified and authorized health-care professional.

7. The federal government should ensure that there is a fair and timely process by which Canadians and their health-care professionals can apply for medical access to currently illegal drugs.

Education on Drugs

8. Federal, provincial, and territorial health officials should provide funding for the development and wide distribution of accurate, unbiased, and nonjudgmental information on illegal drugs for health-care providers, drug users, and members of the public.

9. Provincial and territorial governments, government agencies, and community-based organizations should develop education programs based on harm-reduction principles.

10. Provincial and territorial ministries of education and health should undertake an evaluation of school programs on illegal drugs.

11. Universities and colleges should ensure that the curricula of health-care professionals include accurate, unbiased, and nonjudgmental materials, presentations, and discussions about drugs, drug use, and harm-reduction approaches to drug use.

Needle Exchange Programs

12. The federal, provincial, territorial, and municipal governments should ensure that needle exchange programs are easily accessible to injection drug users in all parts of Canada.

13. The federal government should repeal criminal laws that subject drug users and needle exchange staff to criminal liability for having in their possession drug paraphernalia containing residue of illegal substances.

14. Pharmacists' associations as well as licensing bodies should encourage pharmacists to distribute sterile syringes.

Methadone Maintenance Treatment

15. Federal, provincial, and territorial governments should take measures to ensure that methadone maintenance programs are more accessible to opiate-dependent persons in all provinces and territories.

16. Government health officials and Colleges of Physicians and Surgeons should ensure that comprehensive services are available to persons who participate in methadone programs, including primary health care, counselling, education, and support services.

Heroin Prescription

17. In the longer term, Health Canada should develop plans to permit physicians to prescribe opiates and controlled stimulants.

18. In the shorter term, trials involving the prescription of heroin should be authorized, funded, and initiated in Canada.

Supervised Injection Facilities

19. The federal government should update Canada's Drug Strategy to expressly support trials of safe injection sites as harm reduction measures that are an important component of the overall policy response to the harms associated with injection drug use.

20. 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.

21. 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 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 of 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.

22. 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 CDSA making 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.

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

24. 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 sites can occur as soon as possible.

Correctional Facilities

Methadone Maintenance Treatment

25. Correctional systems should ensure that prisoners who were iin a methadone maintenance program prior to incarceration are able to continue methadone maintenance treatment while incarcerated, and that prisoners are able to start such treatment in prison whenever they would be eligible for it outside.

In addition, opiate-dependent prisoners should have other treatment options, including methadone detoxification programs with reduction-based prescribing, which should be routinely offered to all opiate-dependent prisoners on admission.

Needle Exchange

26. Sterile injection equipment needs to be made available in prisons. In prison systems where distribution has not yet started, selection of prisons in which pilot projects can be undertaken should begin immediately.

Responding to Drug Use

27. Federal and provincial prison systems need to adopt a more pragmatic approach to drug use, acknowledging that, because of HIV/AIDS and HCV, they cannot afford to continue focusing on the reduction of drug use as the primary objective of drug policy: reduction of drug use is an important goal, but reduction of the spread of HIV and other infections - in particular, HCV - is more important.

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Drug Policy

28. Reducing the number of drug users who are incarcerated needs to become an immediate priority. In order to reduce the problems created by HIV, other infectious diseases, and drug use in prisons, alternatives to imprisonment, particularly in the context of drug-related crimes, need to be developed and made available.