B.Y.O. HEROIN: WILL CANADA FINALLY RECOGNIZE THE FUNDAMENTAL RIGHTS OF INJECTION DRUG USERS BY PROVIDING ACCESS TO SAFE INJECTION FACILITIES?

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“Society cannot condone addiction, but in the face of its presence it cannot fail to manage it . . . .”

–Justice Ian Pitfield

I. INTRODUCTION

“Insite,” North America’s first and only safe injection facility, has caused a great deal of turmoil between the Canadian province of British Columbia and the Canadian federal government. Since 2003, Insite has operated as a pilot study under a government-approved exemption from Canada’s federal anti-drug law, the Controlled Drugs and Substances Act (CDSA). On May 27, 2008, the British Columbian Supreme Court issued a controversial decision, in PHS Community Services Society v. Canada (Attorney General), ruling that Sections 4(1) and 5(1) of the CDSA, two of the anti-drug provisions, were inconsistent with Section 7 of the Canadian Charter of Rights and Freedoms (the Canadian Charter or Charter). Insite was granted an immediate extended exemption from the applicable sections of the CDSA until June 30, 2009. In the May 27, 2008, ruling, Justice Ian Pitfield said the federal government would have until the June 2009 deadline “to bring the [CDSA] into compliance with the Constitution” to accommodate the medicinal use of drugs: that is, drug use related to regulated health-care initiatives. The court held
that, as written, the specific sections of the CDSA were unconstitutional.\(^9\) Initially, the court rejected arguments claiming Insite and its patients were immune from federal drug laws.\(^10\) However, after further analysis, the court did find that:

> [users] receive services and assistance at Insite which reduce the risk of overdose that is a feature of their illness, they avoid the risk of being infected or of infecting others by injection, and they gain access to counseling and consultation that may lead to abstinence and rehabilitation. All of this is health care.\(^11\)

From this finding, Insite’s drug users were held to have protection from the federal drug laws under Section 7 of the Charter,\(^12\) which guarantees any individual “life, liberty and security of the person.”\(^13\)

In response, the federal government appealed this decision to the British Columbian Court of Appeal, which dismissed the case on January 15, 2010.\(^14\) The main opponent of the facility, government spokesman and federal Health Minister Tony Clement, believes “supervised injection is not medicine; it does not heal the person addicted to drugs.”\(^15\)

If the court removes the exemption as the federal government demands, Insite will be forced to withdraw its services.\(^16\) Consequently, Vancouver’s once-catastrophic drug scene, which affected the entire community, could return and ultimately leave many untreated users suffering from the disease of addiction.


\(^12\) Canadian Charter of Fundamental Rights and Freedoms, Part I of the Constitution Act, 1982, being Schedule B to the Canada Act 1982, ch. 11, § 7 (U.K.); Mickleburgh, *supra* note 11.


\(^16\) Galloway, *supra* note 9.
A. Vancouver's Injection Drug Problems

Injection drug use poses “major health and social challenges in urban settings throughout the world.” Injection drug users face serious health risks including the potential for fatal overdose and the risk of contracting blood-borne diseases such as HIV and hepatitis B and C. The open drug markets and related crime have had debilitating effects on the community and on public order in these cities. Therefore, the impacts of injection drug use needs to be addressed and managed on both national and international levels.

The British Columbian province—especially the city of Vancouver—has been the center of a drug-related crisis since the mid-1990s. Since the mid-1990s, a well-established illicit drug market has developed in the Downtown Eastside area (DTES), where “the drug scene is open and public.” Further, the increase in the purity of heroin and the introduction of cheap cocaine and crack cocaine in the early 1990s laid the groundwork for the healthcare crisis that British Columbia is now trying to mitigate with the implementation of the Insite facility. In British Columbia, the number of overdose deaths rose from 39 in 1988 to 331 in 1993. By 1994, drug overdose had become “the

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18 Ian Malkin, Establishing Supervised Injecting Facilities: A Responsible Way to Help Minimise Harm, 25 MELB. U. L. REV. 680, 684 (2001). Many injection drug users are hesitant about possessing syringes, as most feel that it will increase their likelihood of prosecution. Lawrence O. Gostin & Zita Lazzarini, Prevention of HIV/AIDS Among Injection Drug Users: The Theory and Science of Public Health and Criminal Justice Approaches to Disease Prevention, 46 EMORY L.J. 587, 660 (1997). This reluctance causes many users to borrow needles when they inject, “thereby creating the very risk . . . that public health [officials] seek[ ] to prevent.” Id. When addicts experience cravings, they are likely to use whatever means are readily available to them; thus, sterile syringes should be easily accessible at all times to users. Id.
19 Kerr et al., supra note 17, at 147–48.
21 Donald MacPherson, City of Vancouver, A Framework for Action: A Four-Pillar Approach to Drug Problems in Vancouver 6 (Nov. 21, 2000) (draft discussion paper), available at http://www.communityinsite.ca/pdf/frameworkforaction.pdf (explaining that the market has been driven by such factors as “poverty; substandard housing; high unemployment; increased availability and low cost of heroin and cocaine; [and] flight of legitimate business from the area”). Sadly, the market has reached practically every Vancouver neighborhood in addition to affecting “surrounding municipalities.” Id.
22 Id. at 3, 5 (“[I]n 1997, the estimated direct costs arising from law enforcement and healthcare related to injection drug use and HIV/AIDS in British Columbia was $96 million annually . . . .”).
23 Id. at 12. As a side note, there should be an understanding that drug overdose is not necessarily contingent upon the intake of large quantities of the substance or with being a regular
leading cause of death” among British Columbian adults between the ages of thirty and forty-nine.24

The National Task Force on HIV, AIDS, and Injection Drug Use declared that “Canada is in the midst of a public health crisis concerning HIV, AIDS, and injection drug use . . . . The number of new HIV infections among injectors is increasing rapidly, with Vancouver now having the highest reported rate in North America.”25 New HIV infections as a result of drug injection has increased,26 and this practice is now responsible for more than half of the new HIV infections in Vancouver.27 It is estimated that as many as 400 British Columbian users become HIV positive each year due to “the unsanitary conditions and abject poverty in which most injection drug use occurs.”28 This number translates to one in three Vancouver injection drug users who are HIV positive.29 In 1997, the prevalence of HIV in Vancouver was between 23% and 28% of all injectors.30 Equally haunting is the fact that Canadians are contracting HIV at a much younger age; the average age at which Canadians become infected has dropped from thirty-two to twenty-three years old.31 However, the spread of HIV is not the only concern, as the spread of hepatitis B and C, syphilis, and tuberculosis are also said to be “epidemic” among injection drug users in Canada.32 In British Columbia, 1,600 new cases of hepatitis C can be “attributed to needle-sharing by injection drug users” each year.33 As follows, British Columbian cases account for “more than half

user. Id. Actually, due to the lack of knowledge regarding “the properties of street heroin” or the effects of mixing heroin and alcohol, any amount may be fatal. Id. See Craig Jones, Fixing to Sue: Is There a Legal Duty to Establish Safe Injection Facilities in British Columbia?, 35 U.B.C. L. Rev. 393, 396-97 (2002) (stating further that “non-fatal overdoses may strike 15% of Vancouver’s injection drug users in any given six month period”).


26 Id. at 331.

27 MacPherson, supra note 21, at 12-13; see also Broadhead et al., supra note 25, at 331 (stating that injectors accounted for 24% of new cases from 1987 to 1990, whereas in 1996 they accounted for 46%).

28 Jones, supra note 24, at 397.

29 See id. (expressing the “disturbing statistic” that “almost as many drug users die of HIV/AIDS as from overdoses”).

30 Broadhead et al., supra note 25, at 330-31.
31 MacPherson, supra note 21, at 13.
32 Jones, supra note 24, at 397-98.
33 Id. at 397.
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hapatitis C cases in Canada"$^{34}$ with extremely high rates of infection among injectors: at a rate of 85% in Vancouver, where the annual incidence rate is at 26%.$^{35}$

Ultimately, the injection-drug-driven health crisis has negatively affected much of the community with many of the users becoming addicts who practice unsafe drug use. Therefore, Vancouver's dilemma raises the question of how the injection-drug problem should be handled, as much of the harm results from the addictive nature of the drugs.

B. Addiction Is a Medical Disease, Not a Criminal Matter

The "moral" model, criminalizing drug addiction, is not the answer.$^{36}$ This approach to handling drug use "presumes that 'illicit drug use is morally wrong'" and therefore users should be punished.$^{37}$ The underlying assumption is that it is possible to attain a drug-free society.$^{38}$ This prohibitionist approach has been credited to the "war on drugs" in the U.S.$^{39}$ However, despite the United States' devotion to a prohibitionist policy, "critics increasingly call [this approach] a failure."$^{40}$ The punishment of drug addicts found "stumbling along the streets" in highly saturated drug areas is "both counterproductive and inhumane."$^{41}$ Medical evidence shows that addiction is a disease that results in involuntary and compulsive behavior.$^{42}$ One aspect of the disease is the continuing need or craving to consume the addictive substance.$^{43}$ The Canadian Society of Addiction Medicine defines addiction as follows:

$^{34}$ Id.
$^{35}$ Broadhead et al., supra note 25, at 331.
$^{36}$ See Andre Picard, One Way to Keep HIV at Bay: International AIDS Conference in Toronto to Put B.C. Safe Drug Site Under Microscope, GLOBE & MAIL (Can.), July 20, 2006, at A13 (arguing that criminalization of drug addicts "has proven, time and time again, to be a failure").
$^{38}$ Id. at 561.
$^{39}$ See id. (noting the "commonly held belief that drug prohibition is, in large part, an American ideological export").
$^{40}$ Id. at 564.
$^{43}$ See id. at 1011 (naming one facet of addiction as "an overpowering desire or need to continue taking the drug and to obtain it by any means").
A primary, chronic disease, characterized by impaired control over the use of a psychoactive substance and/or behaviour [sic] . . . . Common features are change in mood, relief from negative emotions, provision of pleasure, pre-occupation with the use of substance(s) or ritualistic behaviour(s); and continued use of the substance(s) and/or engagement in behaviour(s) despite adverse physical, psychological and/or social consequences. Like other chronic diseases, it can be progressive, relapsing and fatal.44

The prohibitionist approach ignores the feature of “impaired control” described in this definition.45 The inadequacy of the prohibitionist approach toward managing addiction is clearly illustrated by reviewing the four traditional theories of punishment (incapacitation, retribution, deterrence, and rehabilitation).46 First, incapacitation, with its justification in the prevention of future harm to society, does not treat the disease of addiction.47 Rather, the incapacitation of an addicted individual will have no lasting effect, as he will continue “behaving under the compulsion” even after the period of incapacitation is over.48 The justification behind removing the individual from society can be attained by means of “civil commitment or [through placement] in a rehabilitative treatment facility.”49

Second, criminal sentences serve a retributive function by punishing individuals who are viewed as “morally blameworthy” for their actions.50 However, once an individual becomes an addict, substance use and possession are the result of an “overpowering compulsion.”51 Thus, the addict cannot be morally blameworthy for his actions, and therefore, “punishment is not justified.”52

The third theory emphasizes that punishment will deter the commission of like crimes by others.53 However, most experts say the threat of criminal

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44 Canadian Society of Addiction Medicine, Definitions, http://www.csam.org/non_member/definitions/ (last visited Apr. 10, 2010).
45 Id.
46 Grant, supra note 42, at 1020 (quoting William D. McColl, Baltimore City’s Drug Treatment Court: Theory and Practice in an Emerging Field, 55 MD. L. REV. 467, 487 (1996)).
47 Id.
48 Id.
49 See id. (noting that these options “similarly remove[ ] the offender from society”).
50 Id. at 1020.
51 Id. at 1020–21.
52 Id. at 1021.
53 Id.
punishment has little if any deterrent value for drug addicts. Because the addict has a disease that results in involuntary drug use, deterrence of the compulsive behavior is not possible and thus not justified.

The fourth theory, rehabilitation via the penal system, also fails because imprisonment and punishment are not treatments for addiction. The incarceration of addicts does not provide the necessary rehabilitative treatment; rather, it requires “immediate cessation of drug use.” Imprisonment creates a vicious recidivist cycle for drug addicts, starting with arrest and ending with another arrest; once an addict is released, the chances are very high that he will be arrested and imprisoned again for drug use. In conclusion, the traditional justifications offered for criminal punishment do not serve their specified purposes in the context of drug addiction.

Furthermore, sole reliance on criminal law “leads to increased fear, stigma and discrimination” of addicts, who are not typical criminals, but instead are individuals suffering from a disease. The stigma of addiction comes from the perception that addicts are outcasts who have a weakness, making them social inferiors. This discrimination limits addicts’ “access to education, housing, employment, financial assistance and health care.” As a direct result of stigmatization, addicts hide their drug use and avoid the programs designed to help them. One scholar has noted that “[s]uccessful destigmatization requires

54 See id. (citing to Gorham v. United States, 339 A.2d 401, 437 (D.C. 1975) (Fickling, J., dissenting) (“In the case of persons who are already drug dependent, the overwhelming majority of experts agree that the threat of criminal punishment has no deterrent value.”)).

55 See id. (“If addiction is a disease, the involuntary use of drugs or alcohol cannot be deterred.”).

56 See id. (defining rehabilitation as “an effort to change the behavior, character, and attitude of offenders through the penal system”) (quoting William D. McColl, Baltimore City’s Drug Treatment Court: Theory and Practice in an Emerging Field, 55 Md. L. Rev. 467, 488 (1996)).

57 Id.

58 See id. (“Imprisonment of an addict creates a ‘revolving door’ scenario of arrest and conviction, imprisonment, release, and then arrest again. The time of incarceration serves only as a temporary and futile postponement of continued drug abuse.”).

59 See id. at 1020–22 (demonstrating the inefficacy of these four theories of punishment).


62 See id. (stating that this stigma makes it less likely that addicts will talk about their disease and seek treatment).

63 See HIV/AIDS Legal Network Press Release, supra note 60 (expressing that Insite is
viewing the ‘drug problem’ as a public health concern instead of primarily a moral issue.”

Richard Elliott, Executive Director of the Canadian HIV/AIDS Legal Network, stated that “[a]rresting and imprisoning people can’t be considered harm reduction.” The failure of the prohibitionist approach makes it apparent that another solution is needed. Experience makes it clear that health care issues should not be handled under criminal law. Instead, these issues should be considered separately to effectuate the societal goals of reducing crime as well as creating a healthier community.

Part II of this Note will address the “Four Pillar Approach.” Based on the theory of Harm Reduction, this is an approach to negating the harms of drug addiction instead of trying to criminalize drug use under the traditional prohibitionist approach. Additionally, Part II will analyze the success of other countries, such as Germany and Switzerland, in implementing programs like Insite. Part III will evaluate Insite’s implementation and success in Canada and the facility’s current legal status. Part IV considers the arguments presented in the PHS Community Services Society case (PHS case), taking the position that the CDSA is unconstitutional under the Canadian Charter. Part IV will also explore Canada’s legal obligations under various international laws pertaining to human rights and drug policy. Part V concludes by summarizing the arguments for Insite’s continued services, exposing the important and fundamental right of Canadian citizens to access to such programs.

II. HARM REDUCTION: A KEY ELEMENT IN THE FIGHT AGAINST ADDICTION

A. Change of Plans: The Switch from Prohibition to Harm Reduction and Safe Injection Facilities

Due to the lack of success of criminalizing addiction and the increased recognition of addiction as a disease, many countries have begun to develop

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64 Aoyagi, supra note 37, at 573.
65 HIV/AIDS Legal Network Press Release, supra note 60. The United States has spent “billions of dollars on its ‘war on drugs’” and nothing has improved regarding a reduction in “either drug supply or drug consumption.” Id. Instead, these criminal-law approaches to drug addiction have resulted in overpopulating U.S. prisons with “non-violent, often small-scale offenders.” Id.
"balanced [policy] approaches" to drug concerns. Many of these countries have incorporated variations of the popular "Four Pillar" approach, which implements drug programs and policies of harm reduction, treatment, prevention, and enforcement. These approaches include separate enforcement initiatives targeting drug dealers while also maintaining a focus on health interventions to help drug users. The Four Pillar approach has allowed many nations, including Canada, to experiment with different health care initiatives in order to combat the negative ripple effect on the health of communities from injection drug use.

Harm reduction is the first pillar, premised on the belief that addicts will always exist, regardless of government efforts, and that "the most sound public health strategy is to limit the damage [these addicts] do to themselves and others." Harm reduction is rooted in the assumption that a completely drug-free society is an unrealistic goal; therefore, public policy should address the problems accompanying drug use itself. This theory places addiction on "a continuum, with abstinence at one end" and "abuse" at the other. This philosophy emerges from "the belief that existing strategies to combat drug use exacerbated rather than ameliorated the problem." With a focus on the "social and environmental aspects" of drug use, this theory helps drug users "make use of their social contexts and communities to enhance their survival," recognizing that each program should be tailored to the unique characteristics of each local drug-abuse situation. Harm reduction initiatives include needle exchanges, syringe prescriptions and even heroin prescriptions, and safe injection facilities.

Safe injection facilities (SIFs) have become an integral aspect to many countries’ strategies for combating injection drug use. These facilities

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66 Kerr et al., supra note 17, at 148.
67 Id.
68 Id.
69 Id.
70 Picard, supra note 36.
71 Aoyagi, supra note 37, at 572–73.
73 Malkin, supra note 18, at 690 (quoting CANADIAN HIV/AIDS LEGAL NETWORK, INJECTION DRUG USE AND HIV/AIDS — LEGAL AND ETHICAL ISSUES 27, 43 (1999)).
74 Loue, supra note 72, at 324.
75 See id. (expressing that the philosophy stresses the need to take into consideration the "location, client demographics, the drugs being used, and the local legal and political milieus").
76 Id. at 324–26.
77 Id.; see also Wood et al., supra note 20, at 1399 ("Such facilities exist in more than 2 dozen
provide a sanitary space where "users of intravenous street drugs, such as heroin and cocaine, can self-administer those drugs" under medical supervision, while being provided with clean needles that are properly disposed. Since their origination in the Netherlands during the 1970s, SIFs have appeared in multiple cities in countries such as Switzerland and Germany. Generally, studies of SIFs have reported positive results for their clients and the neighborhoods that surround them.

However, opponents of medically supervised SIFs argue that their implementation has "the potential to . . . promote initiation into injection drug use." Health Minister Tony Clement says he opposes SIFs because they do not provide medicine or heal addicts; instead, these services "prolong[ ] the addiction." This is "a form of 'harm addition,' " he insists, as opposed to harm reduction. It is further argued that Insite provides "a safe haven from the criminal law and undermine[s] its national objective and importance." All of Clement's arguments fuel the stigma surrounding drug addicts who use these facilities, similar to assumptions associated with "shooting galleries." However, these harm-reduction programs should not be associated with illegal and unsafe shooting galleries. Instead, legally supervised injection facilities

European cities and, more recently, in Sydney, Australia.

A survey compiling "existing research literature" and observations of eighteen SIFs has highlighted the importance of adding SIFs to a municipality's public health initiative. Broadhead et al., supra note 25, at 329. The survey found that "SIFs target several problems" not addressed by other healthcare programs such as needle exchanges and street-outreach programs: "(1) reducing rates of drug injection and related-risks in public spaces; (2) placing injectors in more direct and timely contact with medical care, drug treatment, counseling, and other social services; [and] (3) reducing the volume of injectors' discarded litter in, and expropriation of, public spaces." Broadhead et al., supra.

Jones, supra note 24, at 394.

Id. at 399.

See See Leo Beletsky et al., The Law (and Politics) of Safe Injection Facilities in the United States, 98 AM. J. PUB. HEALTH 231, 232 (2008) ("Reviews report that SIFs have consistently led to fewer risky injection behaviors and fewer overdose deaths among clients, increased client enrollment in drug treatment services, reduced nuisances associated with public injection, and saved public resources.").

Thomas Kerr et al., Circumstances of First Injection Among Illicit Drug Users Accessing a Medically Supervised Safer Injection Facility, 97 AM. J. PUB. HEALTH 1228, 1228 (2007).

Galloway, supra note 9.


Bailey, supra note 4.

Malkin, supra note 18, at 682.

Id.; see also Broadhead et al., supra note 25, at 333 (explaining that shooting galleries are "spaces in abandoned buildings [or] outdoor areas," and are unsterile, unsupervised locations
“allow injecting drug-users to inject in a safe, hygienic, controlled environment.”

These facilities reduce blood-borne disease transmission by providing sterile injection equipment, enable an immediate medical response to overdoses, and educate users about safe injection practices. SIFs also provide addicts with "information and advice about referrals and counselling [sic]." Increasingly, many cities and states that have accepted these programs have realized that harm reduction, rather than prohibition, is the answer to the likely ever-present use of drugs.

B. A Look at Successful Implementation in Other Countries

Safe injection facilities like Insite have proven effective in providing adequate health care assistance to addicted individuals. Typically, there are two governmental approaches to dealing with illegal drugs; the United States has favored a prohibitionist approach which focuses on criminalizing addiction. Other countries—mainly in Europe—have recognized that attempts to eliminate consumption will not curb illegal trafficking, which was the original goal of the U.S. model of prohibitionist drug control. These countries’ leaders argue that drug traffickers will find a market for drugs regardless of the laws. In addition, countries such as Germany and Switzerland have acknowledged the failures of these anti-drug policies include an "escalation in health risks... and an increase in public nuisance." Thus, many European countries have relaxed their illicit substance laws and have sought other avenues for dealing with their current health care problems.

that do not provide clean needles or proper means of disposal).

Malkin, supra note 18, at 692.

Id.

Id.

See id. at 692, 726–30 (discussing the success of the harm reduction model in Switzerland, Germany, the Netherlands, and New South Wales).


See id. at 496 (noting that a movement has grown in Germany toward accepting that some drug use is inevitable).

Malkin, supra note 18, at 727.

See French, supra note 91, at 501 (describing the effect of liberalized trade on European drug policy and noting that “as free trade spread across Europe, so too did drug legalization” for many European countries).
The idea of harm reduction arose from a consumption crisis in the 1980s, prompting Switzerland and Germany to implement the Four Pillar approach into their respective drug policies. This theory sparked "the search for alternative methods," such as the use of SIFs, which reduce the harmful effects of drug use on society and the individual user. It has been noted that the "[k]ey to the success of [the Four Pillar] approach" is the effective coordination between all of its parts. Since the opening of more than forty-two SIFs in European countries, several million supervised injections have been administered. Among those injected, "not a single overdose death . . . has been reported, and hospitalization of overdose patients has been reduced by as much as 90%." An Australian survey concluded that these European SIFs "have contributed to a stabilization of or improvement in general health and social functioning of clients" in part because of ready access to these health care services. The "range of programs" offered in Switzerland and Germany as part of the Four Pillar approach to addressing illicit drug use has resulted in "declines in HIV infection rates, drug-related overdoses and crime." The approaches to providing injection facilities vary among countries due to inherent differences in legal systems, culture, and public opinion of such measures. For example, some countries have created new legislation focused on providing "full legal protection of injectors and staff" at SIFs. No matter how the programs have been implemented, the process has a tedious evolution, but a necessary one. Canada is in the position to learn from the mistakes and successes of governments in similar situations.

1. Switzerland

Before the introduction of SIFs in the mid-1980s, Switzerland experienced an "HIV/AIDS crisis" due to unsafe injection drug use in many of its cities.

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98 KERR, supra note 96, at 26.
99 Jones, supra note 24, at 400.
100 Id. at 400–01.
101 Id. at 400.
103 Broadhead et al., supra note 25, at 343.
104 See Malkin, supra note 18, at 726 (noting that the crisis led to the opening of SIFs in
During the “1980s and early 1990s Switzerland had one of the highest rates of heroin addiction in Europe.” The first attempts at establishing an “open drug scene” such as the “Needle Park” in Zurich “grew unmanageable” and resulted in multiple programs being shut down by 1995. Around the same time, the federal government revised its drug policy to include the four elements of prevention, therapy, harm reduction, and prohibition (or “repression”). Switzerland’s Narcotics Act “was revised in 1996 to provide for the control of narcotic raw materials” in addition to addressing drug-related medical concerns such as prescription treatments for addicts. This legislation, amended again in 2001, encompassed a broader scope of “preventive measures, therapy, and harm-reduction” considerations. Additionally, the new “long-term strategy” set common goals and clearly defined roles of the Swiss Confederation (the Confederation) and the Swiss Federal Office of Public Health (FOPH). In keeping with its increasingly liberal policy, the government introduced such measures as “drug consumption rooms, needle-exchange services, … methadone programmes and heroin-assisted treatments.” The use of SFIs was “categorized as a ‘medical treatment’ and therefore exempted from police intervention.” Similarly, heroin-assisted treatment would now be allowed for therapeutic purposes under Section 8 of the Narcotics Act, whereas prior to the amendment, heroin fell under the heading of prohibited substances. These treatment programs—substituting methadone or buprenorphine for heroin—have “led to a decline in the number of new heroin users in Zurich.”


\[\text{See Martin Büechi & Ueli Minder, Fraser Inst., Swiss Drug Policy: Harm Reduction and Heroin-Supported Therapy 7 (2001), http://oldfraser.lexi.net/publications/books/drug_papers/UDBuechiMinder.pdf (noting that this policy decision was made in 1991).}\]


\[\text{Id. at 42–43.}\]

\[\text{Büechi & Minder, supra note 107, at 7.}\]


\[\text{KERR, supra note 96, at 69.}\]

\[\text{COLLIN, supra note 108, at 14.}\]

\[\text{Joe Santangelo, Switzerland’s Liberal Drug Policy Seems to Work, Study Says, MED. NEWS TODAY, June 2, 2006, http://www.medicalnewstoday.com/articles/44417.php. The data collected from over 7,250 participants in a substitution-treatment program in Zurich over a}\]
whereas those countries that have not taken such health-care-based approaches—the U.K., Italy, and Australia—have experienced an increase in heroin use.115

The “enforcement” pillar remains an important part of the Confederation’s drug policy, and it has been strengthened to focus more heavily on those who profit from drug trafficking.116 Enforcement strategies have developed with an emphasis on “achieving mutual goals” of bolstering health initiatives and tackling organized crime.117 Successful harm-reduction procedures in Switzerland have led Swiss police forces to shift their focus away from arresting users to “the ‘supply side’ of the drug problem.”118

The Confederation, through its national drug policy, acts as a mechanism for national cooperation between Switzerland’s “cantons, cities, local authorities and private institutions.”119 The federal government’s responsibilities in implementing the national drug policy, as defined in Section 15(c) of the Federal Narcotics Law, primarily require it to act as a vital support team, through the FOPH, for the various cantons, or states.120 The use of “[f]ederal interventions to support measures by the cantons is called [the] ‘principle of complementarity’ ” and is foundational to Swiss anti-drug policy.121 The Swiss constitution places public health and preventative measures in the purview of individual cantons.122 Additionally, “the administration of the Narcotics Act falls under cantonal jurisdiction, as the cantons have authority for criminal procedure.”123 Currently, Section 4 of the Narcotics Act provides that “narcotics and psychotropic substances cannot be cultivated, manufactured, prepared or sold without cantonal authorization, in accordance with conditions set by the Federal Council.”124

thirteen-year period evidenced that “heroin use dropped from 850 new users in 1990 to 150 in 2002.” Id.

115 Id.
116 See COLLIN, supra note 108, at 11.
117 KERR, supra note 96, at 25.
118 See id. (“By focusing on non-using dealers and organized crime, the police in Holland, Switzerland, and Germany now play an effective role in managing the drug problem.”); see also Imogen Foulkes, Swiss Injection Rooms Lead the Way, BBC NEWS, May 23, 2006, http://news.bbc.co.uk/2/hi/europe/5007962.stm (“[The Swiss police] are under orders to prosecute addicts injecting openly in public, but will also point heroin users in the direction of the nearest injection room.”).
119 COLLIN, supra note 108, at 15.
121 BOECHI & MINDER, supra note 107, at 2.
122 Id.
123 COLLIN, supra note 108, at 16.
124 Id. at 14.
Section 8 outlines "the conditions governing the treatment of addicts with medical prescription of certain narcotics." Thus, the individual cantons are responsible for the "law enforcement . . . , prevention, and . . . care and treatment of those dependent upon drugs." In 1994, the government—as requested by the FOPH—began providing heroin to long-term addicts in a "broad scientific trial" after realizing the failed reaction to law enforcement and other anti-drug methods. Between 1994 and 1999, and after implementation of a heroin program, Zurich experienced a drop in drug-related deaths from eighty-nine individuals to only forty-five; many of the survivors “manage[d] to reintegrate into society, including re-entering the workforce and therefore reaffirming their productivity.” In light of the success of health care programs such as needle exchanges and clean injection rooms, the government extended this treatment with a ten-year experimental heroin prescription program in 1998 by means of “an executive order . . . creat[ing] a legal basis” for the medical prescription of heroin. In 2008, roughly 1,300 patients participated in this program in Switzerland, all of whom must meet “strict criteria” before registering. This government-sponsored administration of “pharmaceutically produced heroin . . . cut[s] off . . . the black market supply chain” by negating the need to commit crimes to support the user’s addiction. One doctor stated of his research findings: "As the Swiss population supported this drug policy, this medicalisation of opiate dependence changed the image of heroin use as a rebellious act to an illness that needs therapy. Finally, heroin seems to have become a ‘loser drug’, [sic] with its attractiveness fading for young people.”

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125 Id.
126 BUECHI & MINDER, supra note 107, at 6.
129 See Foulkes, supra note 105 (noting that “[f]or many health professionals,” this was “the next logical step”).
130 BUECHI & MINDER, supra note 107, at 4.
131 Foulkes, supra note 105.
132 Faryal Mirza, Handouts Fix Drug Crime, SWISSINFO.CH, Aug. 11, 2005, http://www.swissinfo.ch/eng/front/Handouts_fix_drug_crime.html?siteSect=105&sid=6001767&cKey=1123755067000&ty=st. The program has been successful in reaching individuals not previously addressed through other health care programs. Id.
133 Frank, supra note 1.
134 See Santangelo, supra note 114 (quoting Dr. Carlos Nordt, Psychiatric University Hospital, Zurich).
On November 30, 2008, "Swiss voters ... approved a radical health policy that offers prescription heroin to addicts on a permanent basis." Switzerland is the first country to implement such an initiative into its health care policy as it leads the way in addressing concerns of access to health care for addicts. Switzerland has carried out the philosophy that "[i]n order to reach out to as many people as possible, it is necessary to offer a number of forms of therapy ...." The key to this policy is that it recognizes the drug problem as a living and breathing animal that will continuously adapt; therefore, it must invest considerable resources to make additional progress in this field.

2. Germany

Similar to Switzerland, Germany has gone through changes in recognizing the necessity to reform its drug policy and assist dependent injection drug addicts. As of 2004, Germany was in the process of implementing the Four Pillar approach into its drug policy framework. In reaction to a worsening drug situation, Germany’s Narcotics Act was amended multiple times between 1982 and 1994 “to include harm reduction interventions” while carrying forward its “main objective” of the protection of public health. Germany took an “immense step” in the direction of negating the effects of drug addiction with a 1992 legal reform. This reform focused on “underlying principles of ‘drug help’ and ‘drug treatment’ in lieu of punishment.” Germany’s recognition of the severe social and health ramifications of drug dependency led it to adopt the principles of treatment and rehabilitation over punishment.

Germany’s constitution “provides that no person may be prosecuted for injuring themselves”; therefore, punishing individual users is unconstitutional.

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136 Id.
138 See Körner, supra note 41, at 583 (“The writer expects that in the years to come there will be an opportunity to achieve a total reform of the German narcotics law, one that will ultimately provide for the implementation of a fourfold model . . . .”).
140 Körner, supra note 41, at 580.
141 Id.
142 See Malkin, supra note 18, at 726–27 (noting that the approach of closing down the “open drug scene” failed and that the HIV/AIDS epidemic led to the introduction of SIFs).
143 Bruce Bullington et al., Trends in European Drug Policies: A New Beginning or More of
However, if the use involves any kind of harm against another, then it may be penalized. In the case of minor offenses relating to personal drug consumption, prosecutors now have discretion on electing to press charges. The court system is responsible for implementing much of the treatment strategies, as they have made “extensive use of [their] discretionary options in the existing laws.” For this reason, there are now “[t]reatment alternatives to incarceration for drug users.” At the same time, amendments to the Narcotics Act heightened the severity of offenses and penalties for “severe drug trafficking.” Law enforcement officers are directed to focus their attention on “drug traffickers and smugglers rather than on mere users.” These changes illustrate how Germany has made changes to its legal system to separate criminalization from providing health care to drug addicts.

Since 1994, city-funded injection rooms have been operating under temporary legal status as a “pragmatic[ ] . . . attempt” to bring order to the epidemic of injection drug use. “[S]pecial” state ordinances have been put in place to narrowly limit the right to use these facilities and to prevent their abuse. In 2000, the German parliament passed a law allowing both safe injection rooms and heroin-dispensing programs. This “legalized the operation of drug consumption rooms under specified conditions and standards.” A “legal prerequisite” for Germany’s sixteen states to offer these services was that each had to issue its own regulations for the operation of the local facilities. This legislative compromise allowed the states to decide if the facilities were to be implemented, and allows them to decide whether existing facilities are to be continued. By 2004, “[a]ll but two of the federal states [had] implemented such [programs].” The narrowly defined

the Same?, 34 J. DRUG ISSUES 481, 485 (2004).
See id. (noting that “passing on the drug to another person” would be illegal).
Drug Policy Alliance Network, supra note 139.
Körner, supra note 41, at 580.
Drug Policy Alliance Network, supra note 139.
Id.
Körner, supra note 41, at 580.
See Frank, supra note 1. In the words of the director of one such injection facility: “The goal is to get people off the streets. They would be [injecting] in train station toilets otherwise.” Id.
Körner, supra note 41, at 582.
Böllinger, supra note 92, at 503, 504.
Heino Stoever, Consumption Rooms—A Middle Ground Between Health and Public Order Concerns, 32 J. DRUG ISSUES 597, 599 (2002).
Id.
Id.
Böllinger, supra note 92, at 503.
requirements for access to the facilities can be seen as Germany’s intended “compliance with its international obligations by rendering the initiatives medical or scientific trials.”

An additional harm-reduction plan, a prescription heroin program, was launched in Germany in view of the success of similar programs in Switzerland. A heroin pilot program was implemented in 2003 to study the comparison between heroin maintenance and methadone maintenance. The purpose of this study was to illustrate which procedures helped long-term addicts the best. In 2006, it was concluded that the majority of heroin users fared better than the methadone users in the study. The resulting “heroin on the state” program would be used only for the worst heroin users. The constant search for new ways to battle addiction expresses the German government’s true willingness to help its citizens with problems of addiction.

III. INSITE: CANADA’S VERY OWN SAFE INJECTION FACILITY

A. Factual Background

In 1997, due to an HIV/AIDS epidemic in the Downtown Eastside area (DTES), the province of British Columbia decided to allocate $3 million to address the spread of this disease and its causes. During the next few years, through extensive investigation of the “public health crisis,” experts decided that “injection drug use ought to be a primary focus of the Health Authority’s efforts in the DTES” through the implementation of harm-reduction strategies. In March of 2000, Vancouver, the British Columbian province, and the federal government entered into the Vancouver Agreement (the Agreement) in an attempt to prevent the fatalities caused by high rates of injection drug use. The Agreement was a five-year commitment to the

157 Malkin, supra note 18, at 729.
159 Id.
160 Id.
161 Id.
162 See PHS Cmty. Servs. Soc’y v. Canada (Att’y Gen.), [2008] 85 B.C.L.R.4th 89, 2008 BCSC 661, ¶ 23–25 (Can.) (expressing that HIV/AIDS were “spreading most rapidly among individuals” involved with, or likely to become involved with, injection drug use).
163 Id. ¶¶ 27–30.
164 MacPherson, supra note 21, at 11.
implementation of a successful “drug strategy” linked to “housing, employment, and social and economic development” of the area.165

The city next adopted a plan set forth in a report entitled A Framework for Action.166 This report was principally authored by Donald MacPherson, who worked closely with the Health Authority and the Vancouver Police Department in developing the Four Pillar strategy for attacking the problem in the DTES.167 The plan involved the integration of various health care services into the city’s policy.168 “In September 2002, the Health Authority proposed a plan which would provide a continuum of services [for clients with substance-abuse issues], including harm reduction . . . .”169 One of the goals of this continuum approach was to increase services that encouraged better protection during “active drug use” and eventually to lead individuals to end their drug use.170 The Health Authority included SIFs as part of this new approach “to complement [its] other health care services.”171

“In March 2003, the Health Authority approved the proposal for a safe injection site . . . in the DTES . . . .”172 The Health Authority authorized an application for an exemption under Section 56 of the CDSA, permitting the Health Authority to open the facility and “study the outcomes associated with its operation.”173 The Health Authority granted the exemption for a three-year term beginning September 12, 2003, then granted an extension for another term, and further extended the term on October 2, 2007, to finally expire June 30, 2008.174

Insite is the first legally supervised injection facility in North America.175 It is run by Vancouver Coastal Health (VCH) in partnership with Portland Hotel Society Community Services (PHS).176 VCH “provides part of the funding” along with support “from the city, the province and the federal

165 See id. (expressing that the goal for the DTES was to create a “healthier and safer community”).
166 PHS, 85 B.C.L.R.4th ¶ 40.
167 Id. ¶¶ 34, 38–39.
168 Id. ¶ 42.
169 Id. ¶ 43. One expert emphasized how this strategy was “a movement away from the traditional abstinence-based model for addiction services.” Id.
170 Id.
171 Id. ¶ 44.
172 Id. ¶ 45.
173 Id.
174 Id. ¶ 46.
175 Insite: Supervised Injection Site, supra note 3.
government." The facility "has 12 injection stalls where [users] can inject pre-obtained illicit drugs under the supervision of nurses" who provide clean injection equipment. Users of the facility, who must be at least sixteen years old, "must sign a user agreement, release and consent form, must agree to adhere to a code of conduct, and cannot be accompanied by children." After injecting, some patients might be sent to the "chill out" lounge or sent to a "treatment room for injection-related conditions," or if needed, "referred to the closest primary care facility." In an effort to expand the programs offered at Insite, the staff set up a program called Onsite in 2007. Onsite is "a detox centre located above Insite" which allows the users to receive immediate detox. Unlike Insite, "Onsite is a drug free environment supported by physicians who are addiction specialists and general practitioners, nurses and peers" to assist in the treatment services. Thus, users are given the option to seek assistance from various programs at one location, depending on their level of addiction.

B. Insite’s Success and Support

Insite’s success as North America’s first SIF is evident from the data collected and all the national and international support it has accumulated since its implementation. The B.C. Centre for Excellence in HIV/AIDS evaluated Insite through data it collected by conducting studies during its three-year pilot period. The evaluation, formally known as the Scientific Evaluation of

177 Id. Health Minister Tony Clement has stated that Insite costs $3 million to operate each year; "others have suggested it costs less." For the Community to Decide, supra note 15. Only $500,000 comes from the federal government; therefore, it would appear that if federal funds were "cut off," additional capital could be provided from "provincial or municipal funds," as the community strongly supports Insite. Id.

178 Wood et al., supra note 20, at 1399; see also PHS, 85 B.C.L.R.4th ¶ 72 ("It goes without saying that the substances brought to Insite by users have been obtained from a trafficker in an illegal transaction.").

179 PHS, 85 B.C.L.R.4th ¶ 73.

180 Id. ¶ 72. Users have to register every time they visit. Id.

181 Id. ¶ 75.

182 Id. ¶ 77.

183 Id.

184 Id.

Supervised Injecting (SEOSI), \textsuperscript{186} determined that "the program results in harm reduction to users and other members of the community, reduces drug-trade litter and increases intake into intervention and addiction treatment programs." \textsuperscript{187} Ongoing studies pertaining to drug use in the community begun prior to Insite's opening allowed researchers to track various patterns, including whether targeted users would take advantage of the facility. \textsuperscript{188} Part of the evaluation process included a study consisting of 1,065 participants pulled as a random sample of users from the Insite facility. \textsuperscript{189} The study collected data on user characteristics such as the number of years of drug use, and when the user first used injection drugs. \textsuperscript{190} Through blood samples, the study also tested HIV levels among users. \textsuperscript{191} The findings indicated that most of the users of the SIF were long-time users, and there was no conclusive evidence that the SIF prompted a significant increase in the initiation of injection drug use in Vancouver. \textsuperscript{192}

An expert committee set up by Health Canada \textsuperscript{193} concluded that since Insite opened as a "pilot project" in 2003, more than 8,000 people have patroned the facility. \textsuperscript{194} Experts say the facility has supervised "more than 220,000 clean injections." \textsuperscript{195} A statistic worth highlighting from the report is that "Insite staff..."
have successfully intervened in more than 336 overdose events since 2006.\textsuperscript{196} Additionally, there have not been any overdose deaths at the facility.\textsuperscript{197} British Columbian Health Minister George Abbott has expressed the vital importance of Insite as “part of the continuum of treatment that we can provide to [a] very vulnerable group of British Columbian [addicts].”\textsuperscript{198} The findings ultimately suggest that there is “a high potential for negative impacts on health and the community” if the facility were to be closed.\textsuperscript{199}

Insite has experienced strong support from the community, as shown by a recent study.\textsuperscript{200} A majority of Vancouver police officers want Insite to remain open or would like to see further expansion in similar health care services.\textsuperscript{201} After the opening of Insite, the police force actually reported that there was a decline in public drug use in the area.\textsuperscript{202} Research showed that “the facility’s opening has not been associated with increases in charges for drug dealing or drug-related crime.”\textsuperscript{203} Surveys also showed that Insite’s users rated the facility as “highly satisfactory,” with “‘self-reports’ from users suggest[ing] a decrease in needle-sharing.”\textsuperscript{204}

Dean Wilson, a heroin addict undergoing methadone treatment, spoke for many addicts about the recent court decision when he said,

I think this will open the doors [sic] to all sorts of ways of treating addiction, rather than criminalizing it . . . . What the judge has said is that all drug addicts are Canadian citizens, that society does care about us, and that addicts have the right to the same kind of health care as everyone else.\textsuperscript{205}

\textsuperscript{196} Joyce, supra note 63.
\textsuperscript{197} Id.
\textsuperscript{198} Bailey, supra note 4. The Health Minister further emphasized that the program “gives us an opportunity to meet with people who, otherwise, would be injecting in back alleys beside dumpsters sometimes with needles that had been used by other users, consequently spreading HIV/AIDS and other intravenous drug-use diseases.” Id.
\textsuperscript{199} Wood et al., supra note 20, at 1403.
\textsuperscript{201} Id.
\textsuperscript{202} Wood et al., supra note 20, at 1401.
\textsuperscript{203} Id. at 1403.
\textsuperscript{204} Joyce, supra note 194. However, this same report “says there is no evidence the site helps reduce HIV infection.” Id.
\textsuperscript{205} Mickleburgh, supra note 11.
One of the main objectives of Insite is education on safe injecting practices, as unsafe injection is a major contributing factor to the rapid spread of HIV.\textsuperscript{206} Research has illustrated that Insite "cut the spread of HIV-AIDS and hepatitis C among drug users."\textsuperscript{207} Additionally, studies showed that the users who "previously required help with injections no longer needed assistance" after the education programs at Insite.\textsuperscript{208} The World Health Organization has recognized the importance of SIFs like Insite by calling it "one of the 'priority interventions' " that other countries need to introduce "to slow the spread of HIV-AIDS."\textsuperscript{209} Joanne Csete, Executive Director of the Canadian HIV/AIDS Legal Network, noted that “[h]ealth professionals from around the world have studied Insite and unequivocally said that it is a success.”\textsuperscript{210} In light of these circumstances, facilities like Insite should be openly considered as viable health care initiatives.

C. Current Status of Insite

Tony Clement, the current federal Health Minister, is still opposed to the operation of Insite even after all the overwhelmingly positive research, claiming the facility is not as beneficial as initially intended.\textsuperscript{211} Many prominent, internationally recognized scientists and doctors are upset with the negative position of Canada’s federal government towards Insite, as they believe that it shows the “federal government has breached international scientific standards through [its] treatment of evidence-based research.”\textsuperscript{212}

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\textsuperscript{206} Wood et al., supra note 20, at 1401. Safe injection procedures are a priority in the fight against the spread of HIV, as the lack of knowledge of appropriate safety measures leads to infection and improper sharing of needles. \textit{Id.}
\textsuperscript{207} See Picard, supra note 36 (stating that having drug users at the facility instead of on the streets will "cut[ ] down on public disorder").
\textsuperscript{208} Wood et al., supra note 20, at 1401.
\textsuperscript{209} Canada’s Health Minister Opposes WHO’s Stance on Safe Injection Sites, supra note 83. A subsequent study conducted only among users of Insite illustrated that “greater exposure to the facility was associated with reduced syringe lending by HIV-infected [users] and reduced syringe borrowing by HIV-negative [users].” Wood et al., supra note 20, at 1402.
\textsuperscript{210} No More Safe Injection Sites, supra note 176. Numerous positive reviews have been published in prestigious “Canadian, British and American medical journals, including the Lancet and the New England Journal of Medicine.” \textit{Id.}
\textsuperscript{211} See Galloway, supra note 9 (“Mr. Clement discounted [the] research, saying many of the studies have been conducted by the same authors who ‘plow their ground with regularity.’ ”). Clement further noted that Insite “saves, at best, one life per year . . . . My job as Health Minister is to balance that one life against any possible negative effect of supervised injection that might take one life elsewhere.” \textit{Id.}
\textsuperscript{212} Press Release, Canada’s Government Continues to Mishandle Research, supra note 185.
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to the tension over Insite’s questionable existence after the exemption expiration, many supporters feared the worst—the federal government’s closing of Insite. Thus, several organizations—PHS Community Services Society and Vancouver Area Network of Drug Users (VANDU)—took action by filing separate complaints against the Canadian federal government, seeking relief based on lack of federal jurisdiction and the unconstitutionality of several sections of the CDSA. Ultimately, and after much debate, the British Columbian Supreme Court held that Sections 4(1) and 5(1) of the CDSA were inconsistent with Section 7 of the Canadian Charter and therefore, if not corrected, they would be held unconstitutional. The federal government appealed to the British Columbia Court of Appeal, which heard the case in late April 2009. The Court of Appeal dismissed the federal government’s appeal, holding that Insite did provide healthcare services that fell within the provincial jurisdiction of British Columbia, therefore leaving Insite free to operate the facility.

The Supreme Court’s reasoning (adopted by the Court of Appeal) in finding for Insite is important to understanding why SIFs should be implemented and continued, not only in British Columbia, but also in the other provinces to address the health concerns that accompany injection drug addiction. This Note emphasizes arguments under both Canadian and international laws in support of Insite and its users, illustrating why such a program should remain a vital and, more importantly, legal option for all Canadians.

The prestigious International Journal of Drug Policy is “the second world-renowned scientific publication” to admonish the Canadian federal government for mishandling research to form negative views of Insite. One of the commentaries in the issue was from Dr. Alex Wodak, “Australia’s foremost addiction specialist,” who criticized the federal government by stating it has “‘ignored science, due process, and public opinion while also risking harm to the country’s international standing.’”


See id. ¶¶ 3, 5–6 (noting that there were also two individuals named as co-plaintiffs in the PHS case).

Id. ¶¶ 158–159.


Id. ¶ 78–79. As such, this Note will refer to the arguments and holding of the Supreme Court case.
IV. ARGUMENTS ILLUSTRATING CANADA’S FUNDAMENTAL OBLIGATIONS

A. Canadian Charter Arguments Supporting Insite

The Canadian Charter contains language evidencing entitlement to health care services such as Insite as a fundamental right for all Canadian citizens. The PHS court held that the criminalization of possession of controlled substances on Insite’s premises violates Section 7 of the Canadian Charter of Rights and Freedoms. Section 7 of the Charter provides that “[e]veryone has the right to life, liberty and security of the person and the right not to be deprived thereof except in accordance with the principles of fundamental justice.”

The CDSA imposes an absolute prohibition on the possession of controlled substances. It therefore prevents access to Insite and safe injection, ultimately infringing on the right to life and security of the person, a move that violates the principles of fundamental justice.

1. Significance of Parallel Arguments in Context of Marijuana Use

Parallel arguments focusing on the provisions of the CDSA that violate Section 7 of the Charter have been evaluated in recent cases involving both the recreational and medical uses of marijuana. In R. v. Malmo-Levine, the Supreme Court of Canada found the prohibition against the recreational use of marijuana to be supported under the criminal-law powers of the federal government. It reasoned that the harms of marijuana create a compelling interest in criminalizing the possession of marijuana for non-medical use.

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219 See PHS, 85 B.C.L.R.4th ¶ 158 (noting that Sections “4(1) and 5(1) of the CDSA are inconsistent with [Section] 7 of the Charter, and of no force and effect”).
221 Controlled Drugs and Substances Act, 1996 S.C., ch. 19, § 4(1) (Can.).
222 PHS, 85 B.C.L.R.4th ¶¶ 140, 144.
223 Id. ¶¶ 152–153. Users’ right to liberty is violated because users risk incarceration for “possession of controlled substances” when they seek health care from the Insite facility. Id. ¶ 143.
226 Id. ¶¶ 73, 77–78. The Court went on to state, “the Constitution cannot be stretched to afford protection to whatever activity an individual chooses to define as central to his or her lifestyle.” Id. ¶ 86.
The CDSA is directed specifically at such use, making the legislation a "proper . . . exercise of the criminal law power." 227

However, unlike the purely recreational use in Malmo-Levine, the clients at Insite are using drugs to feed their addictions—many are past the point of use for enjoyment. 228 As illustrated previously, true addicts lack control of their actions and suffer from the recognized medical disease of drug addiction. 229 Many opponents of Insite claim that drug injection is not medical treatment, but rather that it fuels the individual’s addiction by providing a safe haven for the user. 230 But, “[t]he Canada Health Act states that the primary objective of Canadian health care policy is ‘to protect, promote and restore the physical and mental well-being of residents of Canada and to facilitate reasonable access to health services without financial or other barriers.’” 231 On this basis, Insite seems to be exactly in line with the Canada Health Act as the access to clean needles, medical attention, and counseling are all necessary health care components. The extensive data collected over the past few years on Insite’s operations evidence strong success rates in helping Canadians with their health care needs.

In fact, the Canadian Supreme Court passed up the opportunity to conduct a proper analysis for the medical use of marijuana when it managed to leave open the question in Malmo-Levine. 232 A prior Ontario Court of Appeal case, R. v. Parker, did involve the medical use of marijuana, and ultimately validated the medical use of the controlled substance. 233 Parker was never appealed to the Canadian Supreme Court, and it is worth noting that the Court in Malmo-Levine did not address Parker’s decision as a subject of discussion or adverse analysis. 234 Therefore, it would seem, the Supreme Court’s failure to address the Parker decision indicates that in some situations regarding health care, controlled substance use is permitted.

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227 Id. ¶ 78.
228 Insite, Supervised Injection Site: Our Clients, http://supervisedinjection.vch.ca/our_clients/ (last visited Apr. 10, 2010) (“Many of our clients are older and have been using drugs for a long time. Their long-term drug use and chaotic lives have seriously compromised their overall health.”).
229 See supra Part I.B.
230 See Galloway, supra note 9 (quoting Health Minister Tony Clement, who stated that “supervised injection is not medicine” and also that injection “deepens and prolongs the addiction”).
231 See Jones, supra note 24, at 403 (citing R.S.C., c. C-6, § 3 (1985)).
234 PHS, 85 B.C.L.R.4th ¶ 133.
In comparison to Insite’s situation, Parker concerned the effect of criminal law on an individual claiming a need for marijuana for medical reasons—to control his epilepsy—not for recreational use. The Ontario Court of Appeal held that the prohibition against possession of marijuana—including that intended for medical use—violated Section 7 of the Charter. It reasoned that by “forcing Parker to choose between his health and imprisonment,” the provision violated his right to liberty and security; likewise, this provision also did “not accord with the principles of fundamental justice.” A major principle that can be taken from Parker is that the right or freedom at issue and its purpose must be analyzed in context. Similar to Parker, where the controlled substance is of medical necessity and where the claimant suffers from an illness, the need to inject the substance is a material part of the user’s illness. If the federal government were to close Insite, it would be arbitrarily infringing on the addicts’ health and security by taking away necessary health care options.

2. The Infringement of Right to Life

Section 4(1) of the CDSA, by prohibiting injection, infringes upon the right to life of an addict because it prevents Insite from providing a healthier and counselor-supervised environment for the addict. As a result, the addict is left to inject in unhealthy environments where the risk of disease, overdose, or death is significantly higher. The fact that the individual may have initially chosen to inject does not justify the lack of access to health care services that

235 Parker, 49 O.R.3d ¶¶ 3, 10.
236 Id. ¶ 11.
237 Id. ¶ 10.
238 Id. ¶ 83 (“The dominant aspect of the context in this case is the claim by Parker and other patients that they require access to marihuana for medical reasons. They do not . . . assert a desire for marihuana for recreational use. Parker does not claim a right to use marihuana on the basis of some kind of abstract notion of personal autonomy. The validity of the marihuana prohibition must be assessed in that particular context. The context here is not simply that the marihuana prohibition exposes Parker, like all other users and growers, to criminal prosecution and possible loss of liberty. Rather, Parker alleges that the prohibition interferes with his health and therefore his security interest as well as his liberty interest.”).
239 PHS, 85 B.C.L.R.4th ¶ 146.
240 See supra notes 222–23 and accompanying text.
241 See supra note 222 and accompanying text.
242 PHS, 85 B.C.L.R.4th ¶ 140.
would help overcome such a life-endangering condition as addiction. Judge Pitfield emphasizes this point by expressing that

[however unfortunate, damaging, inexplicable and personal the original choice may have been, the result is an illness called addiction. If the root cause of death derives from the illness of addiction, then a law that prevents access to health care services that can prevent death clearly engages the right to life.]

3. The Infringement of Right to Security

In addition, Section 4(1) of the CDSA risks infringing the right to security guaranteed by the Charter. Under the Charter, “security of the person... must include a right of access to medical treatment for a condition representing a danger to life or health without fear of criminal sanction.” An evident risk exists when addicts are denied access to health care facilities like Insite where the risk of death from infectious disease can be reduced or even negated. Safe injection facilities like Insite fill “a significant service gap in existing public health programs” by “provid[ing] an alternative ‘public’ space for injectors to use.” Additionally, they provide a necessary approach for attaining the optimal end result: a cure for the individual’s illness.

4. Inconsistencies with Principles of Fundamental Justice

The deprivation of health care as applied to Insite users due to the prohibition against possession under Section 4(1) of the CDSA is not in accord with the principles of fundamental justice. In comparison, Parker expressed that such “deprivation by means of a criminal sanction of access to medication reasonably required for the treatment of a medical condition that threatens life or health constitutes a deprivation of security of the person.” In the case of deprivation of medical treatment, certain “principles of fundamental justice” apply. A law that is arbitrary, disproportionate, or overbroad will fail

243 Id. ¶ 146.
244 Id. ¶ 142.
245 Jones, supra note 24, at 414.
246 PHS, 85 B.C.L.R.4th ¶ 144.
247 Broadhead et al., supra note 25, at 339.
249 See id. ¶ 117 (naming various situations when criminal law may deprive fundamental rights to medical treatment).
Charter scrutiny.\textsuperscript{250} Advocates of Insite can point to the simple language of the CDSA to show how the statute does discriminate in its application.\textsuperscript{251} The CDSA does not take the context of the situation into consideration with regards to the fundamental rights that a facility like Insite serves to those addicts that seek its assistance.\textsuperscript{252} Rather, the law “prohibits the management of addiction and its associated risks at Insite.”\textsuperscript{253}

One of the main objectives of the CDSA is to eliminate the link between drugs and organized crime.\textsuperscript{254} The core focus of this objective, however, is illegal trafficking, not the medical condition of users.\textsuperscript{255} So even if the law were to be considered to represent a compelling state interest, the law still cannot be valid if it is arbitrary.\textsuperscript{256} “A law is arbitrary where ‘it bears no relation to, or is inconsistent with, the objective that lies behind [it].’”\textsuperscript{257} The court found that, “instead of being rationally connected to a reasonable apprehension of harm, the [CDSA] contributes to the very harm it seeks to prevent.”\textsuperscript{258} The law also works against the governmental objectives of “fostering individual and community health, and preventing death and disease.”\textsuperscript{259} Furthermore, the proper analysis of balancing interests between the person claiming a violation of rights and the protection of society at large does not seem to be all that challenging, as Insite has proven to have only positive effects on both sides. Each of these propositions evidences the need of the federal government, at the very least, to amend the CDSA to bring it into accord with the principles of fundamental justice.

5. \textit{Time for Recognition of These Rights is Now}

The Canadian federal government still supports the strong prohibitionist argument against the use of hard drugs which are dangerous to both users and

\textsuperscript{250} \textit{PHS}, 85 B.C.L.R.4th ¶ 139.
\textsuperscript{251} \textit{Id}. ¶ 152 (“It treats all consumption of controlled substances, whether addictive or not, and whether by an addict or not, in the same manner. Instead of being rationally connected to a reasonable apprehension of harm, the blanket prohibition contributes to the very harm it seeks to prevent.”).
\textsuperscript{252} \textit{Id}.
\textsuperscript{253} \textit{Id}.
\textsuperscript{254} \textit{Id}. ¶ 148.
\textsuperscript{255} \textit{Id}. ¶ 149.
\textsuperscript{256} \textit{Id}. ¶ 150.
\textsuperscript{258} \textit{Id}. ¶ 152.
\textsuperscript{259} \textit{Id}.
to society.\textsuperscript{260} Once again, however, these arguments are flawed because they "condemn" the consumption of drugs proceeding after the stage of addiction.\textsuperscript{261} "Society cannot condone addiction," but must provide appropriate initiatives to manage and control this epidemic.\textsuperscript{262} Harm-reduction techniques like those used at Insite have proven successful in addressing the risks associated with injection drug addiction; therefore, acceptance of these facilities should be a requirement of the Canadian government's obligation to provide for the welfare of its citizens. Similar health care services for other addictions such as tobacco and alcohol use are not condemned or denied to individuals in need; rather, these treatments are supported by society.\textsuperscript{263} As Judge Pitfield concluded, "I cannot agree with Canada's submission that an addict must feed his addiction in an unsafe environment when a safe environment that may lead to rehabilitation is the alternative."\textsuperscript{264} In conclusion, the federal government needs to recognize the clear benefits of such harm-reduction initiatives in managing the dangerous injection drug crisis.

\textbf{B. Canada's International Law Obligations}

\textit{1. International Human Rights Obligations}

In addition to the strong constitutional arguments supporting the operation of Insite, further force for the acceptance of Insite should be derived from Canada's international obligations. In understanding Canada's international commitments, the analysis should begin with respect to the Universal Declaration of Human Rights (the Universal Declaration).\textsuperscript{265} In 1948, the General Assembly of the United Nations adopted a declaration of fundamental rights and freedoms which it believed should apply to all persons.\textsuperscript{266} Following the Universal Declaration, Canada ratified two treaties pertinent to the expansion of its fundamental principles: the International Covenant on

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\textsuperscript{260} The federal government hopes to take this argument to the Canadian Supreme Court. PHS Cmty. Servs. Soc'y v. Canada (Att'y Gen.), [2010] Carswell (B.C.) 417 (Can.).
\textsuperscript{261} PHS, 85 B.C.L.R.4th ¶ 146.
\textsuperscript{262} Id. ¶ 144.
\textsuperscript{263} Id. ¶ 146.
\textsuperscript{264} Id.
\textsuperscript{266} Ena Chadha & C. Tess Sheldon, Promoting Equality: Economic and Social Rights for Persons with Disabilities Under Section 15, 16 NAT'L J. CONST. L. 27, 31–32 (2004). Even though the Universal Declaration is not an international treaty, it "has acquired the status of customary international law" pertaining to "universal principles and moral norms." Id. at 32.
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Economic, Social, and Cultural Rights (ICESCR), and the International Covenant on Civil and Political Rights (ICCPR).\footnote{International Covenant on Economic, Social and Cultural Rights, \textit{opened for signature} Dec. 19, 1966, 993 U.N.T.S. 3 (ratified by Canada on May 19, 1976) [hereinafter ICESCR]; International Covenant on Civil and Political Rights, \textit{opened for signature} Dec. 19, 1966, 999 U.N.T.S. 171 (ratified by Canada on May 16, 1976) [hereinafter ICCPR]; see also Chadha & Sheldon, \textit{supra} note 266, at 34. These covenants are binding on both the federal and provincial governments of Canada due to the ratification process. Chadha & Sheldon, \textit{supra}.} Therefore, Canada’s ratification of these covenants codified into law a broad range of human rights addressed in the Universal Declaration. These covenants speak to such principles as “rights to life, liberty and human treatment, privacy, a fair trial, equality, freedom of expression, and freedom of religion and assembly.”\footnote{Jennifer E. Dalton, \textit{Aboriginal Self-Determination in Canada: Protections Afforded by the Judiciary and Government}, 21 \textit{Can. J.L. \\& Soc’y} 11, 25 (2006).}

Specifically, the ICESCR explicitly sets out a right to health care and imposes certain obligations to take steps “to achieve the full realization” of the “highest attainable standard of physical and mental health,” and to take additional steps “necessary for . . . [t]he prevention, treatment, and control of epidemic[s] . . . and other diseases.”\footnote{ICESCR, \textit{supra} note 267, art. 12.} Article 12 recognizes this right to health care; it focuses on ensuring that all persons are provided equal access to health care and support.\footnote{\textit{Id.} (“The State Parties to the present covenant recognize the right of everyone to the enjoyment of the highest attainable standard of physical and mental health.”).} This right “has been interpreted to include the right to ‘a system of health protection which provides equality of opportunity for people to enjoy the highest attainable level of health.’”\footnote{Chadha & Sheldon, \textit{supra} note 266, at 36 (quoting U.N. Econ. \\& Soc. Council [ECOSOC], Comm. on Econ., Soc. \\& Cultural Rts., \textit{General Comment No. 14, ¶ 8, U.N. Doc. E/C.12/2000/4} (Aug. 11, 2000)).} The “highest attainable standard” of health carries a “reasonableness” standard that allows the standard to “evolve over time” in response to the ever-evolving medical inventions and shifting social conditions.\footnote{Alicia Ely Yamin, \textit{The Right to Health Under International Law and Its Relevance to the United States}, 95 \textit{Am. J. Pub. Health} 1156, 1156 (2005).}

Scholars have argued that Canada’s recognition of this international “positive right” to health creates a duty for Canada to ensure equal access to care.\footnote{Chadha & Sheldon, \textit{supra} note 266, at 42–43.} Additionally, “[i]nternational norms [provide] standards for evaluating governmental conduct and mechanisms for establishing some degree of
accountability.” Therefore, through these human rights treaties Canada has obligations to its citizens.

2. Canada’s International Obligation Receives Application in the Domestic Legal Context

Canada’s obligation to its citizens should not fall short of providing necessary health care for a deserving group of its citizens. A “fundamental principle” of Canada’s governmental philosophy is that its statutes “be interpreted so as to conform to international law wherever possible.” Therefore, the domestic legislation should be implemented consistently with the international obligations which Canada prides itself on carrying out. It has been argued that “the provisions of the ICESCR” have been incorporated into domestic law “by the enactment of human rights statutes and the Charter itself.” Scholars argue that several international instruments—including the ICESCR and the Universal Declaration—were the founding basis for the Charter. Since much of the Charter’s language and principles derive from international documents, it only seems proper to turn to these documents for further interpretation. Based upon this notion, the “various Charter provisions... constitute[e] binding obligations” on Canada to provide a right to access for health services in a nondiscriminatory manner. This parallelism is further illustrated by reference to Section 15(1) of the Charter, which states that “[e]very individual is equal before and under the law and has the right to the equal protection and equal benefit of the law without discrimination and, in particular, without discrimination based on race... or mental or physical disability.” Thus, Canada, in recognizing addiction as an illness deserving of equal protection and help, cannot neglect its responsibility to provide adequate health care to this dependent class of citizens.

274 Yamin, supra note 272, at 1159.
275 Chadha & Sheldon, supra note 266, at 34–35. However, in Canada, treaties are not “self-executing”; they have to be passed into legislation before they affect domestic laws. Id. at 47.
276 Jones, supra note 24, at 404–05.
277 Chadha & Sheldon, supra note 266, at 46–47.
278 Id. at 50.
279 Id. at 51.
280 Id.
281 Id.
282 Id. at 52.
An alternative argument exists based on the fact that the objectives and principles of Article 12 of the ICESCR are outlined in the Canada Health Act. The language of the Canada Health Act expressing “reasonable access to health services” as the “primary objective of Canadian health policy” correlates to the “highest attainable standard” provision of the ICESCR. This resemblance leads to the “domestic strength” of incorporating the underlying principles of the ICESCR.

It appears that the Charter and the Canada Health Act provide a means through which Canada’s international obligations receive “application in Canadian legal context.” Therefore, it would reasonably follow—consistent with its international obligations—that when an “epidemic” such as the current injection drug problem occurs, Canada must take measurable steps.

3. International Drug Treaties Present Obligations for Action

International treaties on drug use do not bar the coexistence of harm-reduction programs with the treaties’ underlying prohibitionist framework. Actually, the testing and research of innovative techniques to negate the drug problem are a necessity under the treaties. Canada is a signatory to several international treaties addressing the issue of illicit drugs. “[I]t is commonly assumed that these conventions require signatories to adopt a criminal-prohibitionist approach to dealing with illicit injectors.” Each of these conventions contain provisions that aim to “limit the use of drugs to medical and scientific purposes.” Based on the conventions’ public health

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284 Chadha & Sheldon, supra note 266, at 52–53.
285 Id.
286 Id. at 53.
287 Id.
288 Id.
289 See Aoyagi, supra note 37, at 597–99 (noting that “if creating a punishable offense of personal use-related consumption activities would contravene a signatory’s constitution or ‘basic legal concepts,’ that state need not provide for the creation of such an offense”).
290 See Broadhead et al., supra note 25, at 343 (noting that three anti-drug conventions “require signatories to ‘take all practical measures’ for reducing disease and addition”).
291 See id. (“The most notable covenants are the 1961 Single Convention on Narcotic Drugs, the 1971 Convention on Psychotropic Substances, and the relevant portions of the 1998 United Nations Convention against Illicit Traffic in Narcotic Drugs and Psychotropic Substances . . .”).
292 Id.
exceptions, “two recent international reviews found that [these] conventions advocate for the ‘treatment, education, aftercare, rehabilitation and social reintegration’ of injectors, and require signatories to ‘take all practical measures’ ” to reduce the spread of addiction and disease.  

No clear boundary has been defined for what suffices as taking “practical measures,” but Canada already offers a variety of harm-reduction programs such as “needle exchange, street-based outreach, drug treatment, and other services for injectors.” Several countries, including Australia, Germany, the Netherlands, and Switzerland, “have demonstrated [that] there are no treaty-based obstacles to adding SIFs to [the] list” of public health options for addicts, as they have successfully implemented such programs in major cities. Furthermore, internal “[c]onstitutional safeguards” provide immutable rights to citizens which cannot be violated by the international arrangements each country makes abroad.

The explicit language in several provisions referencing drug addiction and treatments clearly evidences a “general consensus” among the international community that drug addicts suffer from an illness and are “in need of treatment and support,” not strict punishment. This consensus is further evidenced by increased attempts to provide new treatments in many countries.

V. CONCLUSION

Canada must act now, as it has both national and international obligations to provide health assistance to its citizens. SIFs such as Insite have been proven to address the very harms that injection drugs cause to both the individual and society. On an international and national level, there has been a paradigm shift in social perceptions of the philosophies underlying the proper choice in drug policy. The new perception of drug-dependent persons as people with an illness has resulted in the evolution of various approaches based on social assistance and public health, rather than on enforcement and

294 Broadhead et al., supra note 25, at 343.
295 Id.
296 Id. at 331, 343.
297 Id. at 331.
298 Bullington et al., supra note 143, at 485.
299 See Garavelli, supra note 97, at 281 (describing the sentiments of the fifty nations to ratify the Convention Against the Illicit Traffic of Narcotic Drugs).
300 Id.
301 Id.
punishment. Canada should follow in the footsteps of many of the European countries by recognizing the flaws in the ill-adapted U.S. drug policy. It must diverge from the prohibitionist model of punishing addicts, and instead provide adequate care.

Insite has proven its success; furthermore, it is engrainged in the Charter that a right to health care is a fundamental guarantee. Studies have clearly indicated that needle exchange programs alone have not proven effective at safeguarding the health of injection drug users. Rather, the studies strongly endorse SIFs as a necessary health care initiative, both to prevent the spread of disease and to provide users with necessary access to the British Columbian health care system. The federal and provincial governments have become aware of drug-related problems, taking action through studies and temporary programs. However, nothing has been done to permanently change the system. With the appeal of the PHS case, the Canadian Supreme Court has the opportunity to provide direction for the federal government on the proper advancement of health care access to users suffering from addiction.

First, the Court needs to recognize that the right to this form of health care is a fundamental right provided under the Charter, the Canada Health Act, and several international treaties. Second, the Court should direct the government to take further action based on the successful implementation of similar programs in other countries. The government can alter its procedural criminal laws to account for the medical and therapeutic use of the drugs. This can be accomplished through clearly defined roles and by narrowly limiting requirements to prevent the abuse of such initiatives. An integral part of the success of SIFs—as evidenced by Switzerland and Germany—is the partnering of local law enforcement to support the healthcare of addicts, instead of criminalizing addiction. Given the ongoing harms associated with injection drug use to the individual and society as a whole, there is great incentive to solidify such programs. Canada must provide healthcare to addicts; acceptance of injection facility programs would be a clear stride forward, and one that the federal government must take in order to help its citizens. The time to recognize the fundamental rights guaranteed to all Canadian citizens is now.