HALCO
HIV & AIDS Legal Clinic Ontario

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ARCH
Disability Law Centre

Brief to the Toronto Board of Health regarding Supervised Injection Services in Toronto

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Toronto

1240 Bay Street, Suite 600, Toronto, Ontario, Canada M5R 2A7
Telephone: +1 416 595-1666 Fax: +1 416 595-0094
info@aidslaw.ca www.aidslaw.ca
Charitable Registration #141110155 RR0001

1. Background

About the Canadian HIV/AIDS Legal Network

The Canadian HIV/AIDS Legal Network promotes the human rights of people living with and affected by HIV and AIDS, in Canada and internationally, through research, legal and policy analysis, education and community mobilization. As Canada's leading organization working on the legal and human rights issues raised by HIV and AIDS, the Legal Network intervened before the Supreme Court of Canada in *Canada (Attorney General) v. PHS Community Services Society* to bring its expert perspective to the Court on evidence-based policies, practices and services to reduce harms that can arise from the use of psychoactive drugs by people currently unable or unwilling to stop.

About HALCO

The HIV & AIDS Legal Clinic Ontario (HALCO) is a poverty law clinic serving the legal needs of low-income people in Ontario who are living with HIV/AIDS. The clinic is a charitable, non-share capital corporation with nine members on the Board of Directors, the majority of whom are HIV positive.

HALCO delivers five kinds of services: legal representation; summary advice, brief services, and referrals; public legal education; community development; and law reform. In 2015, the clinic handled over 3500 requests for legal services and delivered over 70 workshops. The clinic provides services in many areas of the law, including social assistance, housing, immigration, health, privacy, employment, insurance and human rights.

About ARCH Disability Law Centre

ARCH Disability Law Centre (ARCH) is a specialty legal aid clinic dedicated to defending and advancing the equality rights of persons with disabilities in Ontario. ARCH provides legal services to help Ontarians with disabilities live with dignity and participate fully in our communities. We work with Ontarians with disabilities and the disability community on law reform and policy initiatives, community development, legal advice and referrals, public legal education and precedent-setting litigation**.** In all of its work, ARCH adopts a broad and liberal approach to defining disability that includes past and perceived disabilities.

The Canadian HIV/AIDS Legal Network, HALCO and ARCH appreciate the opportunity to comment on the (March 7, 2016) Report from the Medical Officer of Health to the Toronto Board of Health on the integration of supervised injection services into existing clinical health services and to draw the Board's attention to certain elements which are particularly relevant from the perspective of public health and human rights, including relevant Canadian and international law and practice.

Health and Social Benefits of Supervised Injection Services

As indicated by the Medical Officer of Health, health programs such as supervised consumption services (SCSs), also referred to as supervised injection sites (SISs), have numerous health and social benefits for both people who inject drugs and the community.[1] Studies from around the world have documented the positive impact of supervised consumption services and with over 90 SCSs currently operating internationally, there is longstanding experience with their successful operation. SCSs have been demonstrated to be effective in attracting the most marginalized people who inject drugs, promoting safer injection conditions that prevent the spread of blood-borne infections such as HIV and hepatitis C virus (HCV), enhancing access to primary health care and drug treatment, and reducing overdose and overdose-related deaths.[2] These outcomes are particularly relevant in Toronto in light of a municipal study indicating that 61 percent of people who injected drugs in the six months prior to the study tested positive for HCV and 5 percent tested positive for HIV.[3] Increase in overdose-relateddeath is also a major concern in Toronto, where 206 people died from overdose in 2013 (a 41% increase compared to 2004).[4]

At the community level, SCSs address public order and safety concerns associated with public drug use by reducing public drug use and associated disturbances,[5] helping to prevent crime in the neighbourhoods around the facilities,[6] reducing costs to health and law enforcement systems,[7] and promoting community integration and improved quality of life for people who use drugs. Again, this is particularly relevant in Toronto where the Toronto and Ottawa Supervised Consumption Assessment Study (TOSCA) found that 54% of people who inject drugs injected in a public place such as a washroom or stairwell, and 46% injected on the street or in an alley in the six months prior to being interviewed.[8]

Extensive research documenting the positive public health and safety outcomes of SCSs, and the conclusion of TOSCA that Toronto would benefit from SCSs integrated into health services already serving people who inject drugs, prompted the Toronto Board of Health in July 2013 to approve a report from the Medical Officer of Health supporting implementation of SISs in Toronto and in September 2015, to approve a report on trends, prevention and response for overdose.[9]

The Toronto Board of Health is not isolated in its support for SCSs. In Canada, numerous other health experts and agencies also support the implementation of SCSs, including the Canadian Medical Association; the Canadian Nurses Association; the Canadian Association of Nurses in HIV/AIDS Care; the Registered Nurses' Association of Ontario; l'Ordre des infirmières et infirmiers du Québec; the Canadian Public Health Association; the Health Officers Council of British Columbia; the Urban Public Health Network; Public Health Physicians of Canada; Vancouver Coastal Health; l'Institut national de santé publique du Québec; Médecins du Monde Canada; Association des médecins spécialistes en santé communautaire du Québec; and l'Association des intervenants en toxicomanie du Québec.[10]

Montreal has recently applied for an exemption to implement integrated supervised consumption services and several other projects to implement SCSs are being considered across the country. Moreover, Health Canada recently granted a four-year exemption to Insite and a two-year exemption to the Dr. Peter Center, both SCSs in Vancouver. The federal government's support

for SCSs was further affirmed by an unprecedented statement on March 15 by Canada at the UN Commission on Narcotic Drugs in Vienna, in which an assistant deputy minister of health expressed Canada's support for "evidence-based harm reduction measures" such as supervised injection sites.[11]

Toronto needs supervised consumption services. We strongly endorse Dr. McKeown's recommendations and elaborate below the legal and human rights arguments bolstering these recommendations.

2. Canadian and International Law

Ontario Public Health Standards 2008

The *Ontario Public Health Standards 2008, revised October 2015* ("Standards") are published as the guidelines for the provision of mandatory health programs and services by the Minister of Health and Long-Term Care, pursuant to Section 7 of the *Health Protection and Promotion Act*.[12] In the section of the Standards addressing blood-borne infections, the stated goal is to "prevent or reduce the burden of sexually transmitted infections and blood-borne infections." [13]

Among the mandated "outcomes" of boards of health is that "[p]riority populations have access to harm reduction services to reduce the transmission of sexually transmitted infections and blood-borne infections."[14] This confers on those boards a responsibility to ensure access to "a variety of harm reduction program delivery models which shall include the provision of sterile needles and syringes and may include other evidence-informed harm reduction strategies in response to local surveillance [emphasis added]."[15]

In addition to the numerous evaluations of SCSs that provide compelling evidence that SCSs reduce risk behaviours that cause HIV and HCV infection, there is also evidence demonstrating local need and feasibility. As noted above, a majority of people who inject drugs in Toronto are infected with HCV and a disproportionate number are HIV-positive. The TOSCA study further demonstrated the feasibility of SCSs in Toronto, especially if integrated within existing organizations. SCSs consequently reflect a health service that is wholly consistent with the obligation of the Toronto Board of Health to provide "priority populations" such as people who inject drugs with access to a critical harm reduction service.

Human Rights Law in Ontario

Given the seriousness of the dangers associated with unsafe injection drug use, including high rates of overdose-related death in Toronto, implementing life-saving harm reduction services such as SCSs where needed is necessary to fully protect the right of people with addiction to be free from discrimination in accessing health supports and services. This is consistent with well-established Canadian and Ontario anti-discrimination laws that prohibit discrimination based on disability.

Ontario's *Human Rights Code* ("Code") applies to the provision of health supports and services in Ontario and prohibits discrimination on the ground of disability. The Code also prohibits both direct and indirect or constructive discrimination. Indirect discrimination happens even when a

service user or a group of service users (such as persons who inject drugs) are not explicitly excluded but are not able to access services because of limitations related to a disability or other ground protected by the Code. In these cases, the Code requires the service provider to provide accommodation to assist service users to the point of undue hardship. Undue hardship includes considerations about cost, outside funding, and health and safety.[16]

It is settled law that "disability" under the Code includes addictions (and specifically includes addiction to illegal drugs).[17] Furthermore, persons who inject drugs may also have mental health conditions and/ or other disability-related needs because of concomitant medical conditions (such as HIV and HCV). These other conditions are also included in the ground of "disability" protected under the Code. These intersecting conditions give rise to an inordinately high level of societal stigma, exclusion, and physical and psychological barriers to accessing health services and supports. The risks associated with unsafe injection drug use are exacerbated by the fear and anxieties related to injection in public places. SCSs mitigate those risks and health inequities by providing sterile equipment, education, treatment of concomitant medical conditions, supervision and emergency help available at an SCS.[18] Thus, SCSs accommodate the disability-related needs of persons who inject drugs.

A service provider must accommodate a person's disability-related needs unless it amounts to undue hardship, but that threshold is very high. Risks to safety have to be real and material, not just perceived: they must "reflect an accurate understanding of risk based on objective evidence rather than stereotypical views."[19] In assessing a "risk to public safety, consideration will be given to the increased numbers of people potentially affected and the likelihood that a harmful event may happen."[20] In the face of potential fear and resistance, research demonstrates that SCSs benefit the broader community by reducing overdose, transmission of HIV and HCV, public drug use and publicly-discarded injection equipment — while being cost-effective and not leading to an increase in crime in the surrounding area.[21]

Public health authorities cannot ignore the compelling evidence that SCSs reduce risk behaviours that cause HIV and HCV infection, and promote the health and safety of the broader community. To fulfill its Code obligations, health authorities must provide appropriate services to address barriers facing persons who inject drugs in accessing health services and implement or facilitate the implementation of SCSs. The Code requires that health authorities accommodate people who inject drugs and ameliorate the unique disability-related barriers associated with this population so that they can equally benefit from the broader public health mandate "to prevent or reduce the burden of sexually transmitted infections and blood-borne infections"[22] through a "comprehensive health promotion approach".[23]

Canadian Charter of Rights and Freedoms

Section 56.1 (2) of the *Controlled Drugs and Substances Act* (CDSA) permits the federal Minister of Health to issue exemptions from the application of the CDSA to activities taking place at a supervised consumption site if the exemption "is necessary for a medical purpose."[24] In a unanimous 2011 decision, the Supreme Court of Canada ordered the Minister to grant Insitean extended exemption from the criminal prohibition on drug possession in the CDSA, thus permitting it to continue to operate.[25] The Court held that the Minister's refusal to extend Insite's CDSA exemption violated the *Canadian Charter of Rights and Freedoms* ("Charter"). In its

decision, the Court recognized that "Insite has saved lives and improved health. And it did those things without increasing the incidence of drug use and crime in the surrounding area."[26]

While extensive criteria for exemption applications have been set by the previous federal government in the 2015 *Respect for Communities Act*, the Health Minister's discretion in deciding whether to approve any particular request for an exemption to run a SCS must be exercised in a way that respects the Charter which guarantees the rights to life, liberty and security of the person (section 7). With respect to Insite, the Court declared that the Health Minister had violated the Charter rights of people who need access to this health facility to reduce the risk of blood-borne infections such as HIV and HCV and the risk of dying from overdose. With respect to future exemptions, the Court indicated that the Minister will need to strike the appropriate balance between achieving public health and public safety, and consider whether denying an exemption would cause deprivations of life and security of the person that are not in accordance with the principles of fundamental justice. Most importantly, the Court held that the Minister should generally grant an exemption where "the evidence indicates that a supervised injection site will decrease the risks of death and disease, and where there is little or no evidence of a negative impact on public safety."[27]

Section 15 of the Charter, which guarantees "equality before and under the law" and "equal protection and equal benefit of the law" without discrimination based on "mental or physical disability," also requires equal access to adequate health services and supports, including SCSs. The Charter protects the equality interests of persons with disabilities, including persons who inject drugs.[28] There is little dispute that substance dependence (or perceived substance dependence) constitutes a "disability" within the meaning of the Charter.[29] The Charter provides relief from government policies that exacerbate health inequities, particularly as they affect disadvantaged groups, including persons who inject drugs. The *Constitution Act* also sets out governments' constitutional commitment by "promoting equal opportunities for the well-being of Canadians."[30] The Charter's equality protections rely on a substantive understanding of equality; government failures to identify and address health inequities faced by persons who use drugs reflect, perpetuate and reinforce their social and economic exclusion and disadvantage on the ground of disability, in contravention of section 15.

International law

Harm reduction — including access to overdose prevention — is a key element of the rights to health and to life, human rights that are recognized in numerous international instruments including the *International Covenant on Economic, Social and Cultural Rights* (ICESCR) and the *International Covenant on Civil and Political Rights* (ICCPR), both of to which Canada is a party. Accordingly, the Canadian government has an obligation to ensure, at a minimum, a range of harm reduction interventions for people who use drugs, including overdose, and HIV and HCV prevention.

For example, the ICESCR states that the right to "enjoyment of the highest attainable standard of physical and mental health" requires Canada to take steps that are necessary for, *inter alia*, "the prevention, treatment and control of epidemic …. diseases" and the "creation of conditions which would assure access to all medical services and medical attention in the event of sickness."[31] Both these requirements of the right to health support access to harm reduction

services, given that (1) addiction is an illness of which drug use is an aspect and for which harm reduction services are a necessary form of medical services and attention, and (2) harm reduction services help prevent and control epidemic diseases such as HIV and HCV.

In 2001, 2006, and 2011, UN General Assembly members committed themselves to ensuring "a wide range of prevention programmes" for HIV and AIDS, including "harm reduction efforts related to drug use."[32] UNAIDS, the UN Development Programme, UNICEF, the UN Office on Drugs and Crime, and the World Health Organization have repeatedly urged states to implement and scale up harm reduction measures to address HIV.[33]

The UN Human Rights Council's Special Rapporteur on the right to health has frequently affirmed the essential nature of harm reduction services.[34] And the UN Committee on Economic, Social and Cultural Rights (UNCESCOR) — the independent body of expert jurists that monitors states' compliance with their Covenant obligations — has interpreted article 12 of the ICESCRto require, at a minimum, that states ensure a range of harm reduction interventions, including overdose prevention.[35]

The Office of the UN High Commissioner for Human Rights recently reminded states of the "longstanding evidence that a harm reduction approach is the most effective way of protecting rights, limiting personal suffering, and reducing the incidence of HIV."[36]

In a 2015 recent report, the High Commissioner explicitly acknowledged that

> "providing drug users with access to drug consumption rooms can contribute to preventing the transmission of diseases and to reducing damage to the veins, as well as encourage users to make use of treatment and other services. Drug consumption rooms have contributed to reducing overdose rates and increased access to medical and social services."[37]

Canada's obligations to persons who use drugs must also be interpreted in light of its ratification of the UN *Convention on the Rights of Persons with Disabilities* (*CRPD*).[38] The Convention affirms that persons with disabilities have an inherent right to life and that parties must "also ensure access to appropriate and affordable services for disability-related needs." [39]

3. Recommendations

We urge the Toronto Board of Health to continue to show leadership in recognizing the science and human rights principles that support SCSs as an important health service for people who inject drugs at greatest risk of harm and by ensuring such services can operate where they are needed by

1) Approving the recommendations of the Toronto Medical Officer of Health in his March 7, 2016 report.
2) Facilitating the implementation of SCSs in Toronto, including by providing support to Toronto Public Health (The Works), Queen West - Central Toronto Community Health Centre and South Riverdale Community Health Centre in developing exemption applications pursuant to Section 56.1 of the CDSA.

[1] See Toronto Medical Officer of Health, *Supervised Injection Services for Toronto: Next Steps*, March 7, 2016.
[2] See, for example, D. Hedrich, *European report on drug consumption rooms*, European Monitoring Centre for Drugs and Drug Addiction, February 2004; C. Potier et al, "Supervised injection services: What has been demonstrated? A systematic literature review," *Drug and Alcohol Dependence*, 145(2014): 48–68. In Canada, Vancouver's supervised consumption service Insite has been particularly thoroughly evaluated: since 2003, more than 30 articles on Insite have been published in the world's leading peer-reviewed scientific and medical journals. For a two-page summary of research findings about Insite, see Urban Health Research Initiative of the BC Center for Excellence in HIV/AIDS, *Insight into Insite*, 2010. Available at www.cfenet.ubc.ca/sites/default/files/uploads/docs/insight_into_insite.pdf. For a more in-depth overview of research studies (including many of the studies cited in this document), see Urban Health Research Initiative of the BC Center for Excellence in HIV/AIDS, *Findings from the evaluation of Vancouver's Pilot Medically Supervised Safer Injecting Facility – Insite*. Revised in 2009. Aailable at http://uhri.cfenet.ubc.ca/images/Documents/insite_report-eng.pdf
[3] L. Challacombe et al., *Toronto Phase 3 I-Track Report*, HIV Social, Behavioural & Epidemiological Studies Unit, Dalla Lana School of Public Health, University of Toronto, 2013.
[4] Supra note 1, p. 4.
[5] See, for example, E. Wood et al, "Changes in public order after the opening of a medically supervised safer injecting facility for illicit injection drug users," *Canadian Medical Association Journal* 171 (2004): 731–734; *European report on drug consumption rooms*, supra, pp. 61–64; and *Final report on the evaluation of the Sydney Medically Supervised Injecting Centre*, supra.
[6] E. Wood et al, "Impact of a medically supervised safer injecting facility on drug dealing and other drug-related crime," *Substance Abuse Treatment, Prevention, and Policy* 1 (May 8, 2006): 13.
[7] See *European report on drug consumption rooms*, supra, p. 48; D. MacPherson. *A framework for action: A four-pillar approach to drug problems in Vancouver*, City of Vancouver, April 2001, pp. 20–21; *Final report on the evaluation of the Sydney Medically Supervised Injecting Centre*, supra, pp. 192–193.
[8] A.M. Bayoumi and C. Strike (co-principal investigators), *Report of the Toronto and Ottawa Supervised Consumption Assessment Study*, 2012.
[9] See *Supervised Injection Services for Toronto*, supra.
[10] Canadian HIV/AIDS Legal Network and Canadian Drug Policy Coalition, *An Injection of Reason: Critical Analysis of Bill C-2*, 2014.
[11] *Notes for an Address by Hilary Geller during the General Debate on the Special Session of the UN General Assembly on the World Drug Problem at the 59th Session of the United Nations Commission on Narcotic Drugs*, March 15, 2016. Available at www.unodc.org/documents/commissions/CND/CND_Sessions/CND_59/Statements_15_March_AM/Canada.pdf
[12] *Health Protection and Promotion Act*, R.S.O. 1990, c. H.7.
[13] Ontario Public Health Standards 2008, p. 50. Revised October 2015. Available at www.health.gov.on.ca/en/pro/programs/publichealth/oph_standards/docs/ophs_2008.pdf
[14] Ibid., p. 51.
[15] Ibid., p. 53.
[16] Ontario Human Rights Commission, "Policy on preventing discrimination based on mental health disabilities and addictions," p. 44. The *Canadian Human Rights Act* (1985) defines disability as including previous or existing dependence on alcohol or a drug.
[17] Ibid., p. 7.
[18] *Injection of Reason: Critical Analysis of Bill C-2*, pp. 4 and 6.
[19] Supra note 1, pp. 45.
[20] Ibid.
[21] See Appendix A of Toronto Drug Strategy, *Supervised Injection Services Toolkit*, June 2013.
[22] Supra note 13.
[23] Supra note 13, p. 52.
[24] *Controlled Drugs and Substances Act* (S.C. 1996, c. 19), sections 56.1 (2) and (3).
[25] *Canada (Attorney General) v PHS Community Services Society*, 2011 SCC 44.
[26] Ibid., para 19.
[27] Ibid., para 152.
[28] *Canadian Charter of Rights and Freedoms*, Part I of the *Constitution Act, 1982*, being Schedule B to the *Canada Act 1982* (U.K.), 1982, c. 11, s. 15: "Every 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, national or ethnic origin, colour, religion, sex, age or mental or physical disability."

[29] *Abbotsford (City) v. Shantz*, 2015 BCSC 190, paras 81 and 233. See also *McNeill v. Ontario (Ministry of Solicitor General and Correctional Services)*, [1998] OJ No 2288, para 33, where the Court suggested that addiction to alcohol (and not nicotine addiction) constitutes a disability within the meaning of s .15.

[30] Schedule B to the *Canada Act 1982* (U.K.), 1982, c. 11, s. 36.

[31] *International Covenant on Economic, Social and Cultural Rights*, General Assembly Resolution 2200A (XXI) of December 16, 1966, entry into force on January 3, 1976, articles 2 and 12.

[32] *Declaration of Commitment on HIV/AIDS*, GA Res S-26/2, UNGAOR, 26th Special Sess, UN Doc A/RES/S-26/2, (2001), para. 52; *Political Declaration on HIV/AIDS*, GA Res 60/262, UNGAOR,60th Sess, UN Doc A/RES/60/262, (2006) para. 22; *Political Declaration on HIV and AIDS: Intensifying Our Efforts to Eliminate HIV and AIDS* GA Res 65/277, UNGAOR, 65TH Sess, UN Doc A/RES/65/277, (2011), para. 59.

[33] See, for example, World Health Organization, *A strategy to halt and reverse the HIV epidemic among people who inject drugs in Asia and the Pacific: 2010–2015*, (Geneva: WHO Press, 2010); UNAIDS, UNICEF, and World Health Organization, *Towards Universal Access: Scaling up priority HIV/AIDS interventions in the health sector, Progress Report 2010*; United Nations Development Programme, *HIV/AIDS in Eastern Europe and the Commonwealth of Independent States: Reversing the Epidemic, Facts and Policy Options*, (Bratislava: United Nations Development Programme, 2004).

[34] *Report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, Paul Hunt*, UNHRC, 4th Sess, UN Doc A/HRC/4/28/Add.2, (2007); *Report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health (Report to the UN General Assembly)*, UNGAOR, 65th Sess, UN Doc A/65/255, (2010).

[35] See, for example, Committee on Economic, Social and Cultural Rights concluding observations for Russia, UNESCOR, 46th Sess, UN Doc E/C.12/RUS/CO/5 (2011), para. 29, and Concluding observations of the Committee on Economic, Social and Cultural Rights: Ukraine, UNESCOR, 39th Sess, UN Doc E/C.12/UKR/CO/5, (2008); Concluding observations of the Committee on Economic, Social and Cultural Rights: Tajikistan, UNESCOR, 37th Sess, UN Doc E/C.12/TJK/CO/1, (2006); and UN Committee on Economic, Social and Cultural Rights, Concluding observations of the Committee on Economic, Social and Cultural Rights: Mauritius, UNESCOR, 44th Sess, UN Doc E/C.12/MUS/CO/4, (2010).

[36] UN Office of the High Commissioner for Human Rights, "High Commissioner calls for focus on human rights and harm reduction in international drug policy" (March 10, 2009).

[37] UN High Commissioner for Human Rights, *Study on the impact of the world drug problem on the enjoyment of human rights*, HRC, 30th session, UN Doc, A/HRC/30/65 (2015), para 16.

[38] United Nations' *Convention on the Rights of Persons with Disabilities*, (2006), December 13, 2006, U.N.T.S. vol. 2515, p.3 [CRPD], (entered into force on May 3, 2008, accession by Canada on March 11, 2010). Available at www.un.org/disabilities/documents/convention/convention_accessible_pdf.pdf

[39] *Convention on the Rights of Persons with Disabilities*, Articles 10 and 28.