

Injection Drug Use and HIV/AIDS

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This is one of a series of 13 info sheets on legal and ethical issues related to injection drug use and HIV/AIDS.

1. Injection Drug Use and HIV/AIDS in Canada: The Facts

2. The Current Legal Status of Drugs in Canada
3. International Law: Drug Control and Human Rights
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The Urgency of the Situation

Canada is in the midst of a public health crisis related to HIV/AIDS, hepatitis C (HCV) and injection drug use. The spread of HIV (and other infections such as HCV) among injection drug users in Canada merits serious and immediate attention.

- The number of HIV infections attributable to injection drug use is unacceptably high. In 2002 a national study estimated that 30% of new HIV infections which occurred in Canada were among injection drug users. According to the Centre for Infectious Disease Prevention and Control (CIDPC), in 1996 and 1997 the percentage of new positive HIV test reports attributed to injection drug use peaked at over 33 percent. The figure has shown a gradual decline since, but new HIV infections among injection drug users remain a significant problem. In 2003 and the first six months of 2004, injection drug use represented 18% of HIV positive test reports to the CIPDC. Recent figures from Health Canada sentinel centres across the country indicate that between 55% and 80% of injection drug users test positive for HCV.

Injection Drug Use and HIV/AIDS in Canada: The Facts

This info sheet reviews what is known about HIV/AIDS and injection drug use in Canada.

- There have been several studies documenting a rise in the prevalence and incidence of HIV among injection drug users in the larger cities of Canada, but *a rise in the number of injection drug users with HIV infection has also been observed outside major urban areas.*
- The health of people who use illicit drugs is a matter of concern in its own right. Given the geographic mobility of injection drug users and their social and sexual interaction with non-users, the dual problem of injection drug use and HIV infection is also one that *ultimately affects all of Canadian society.*
- HIV prevalence among injection drug users in *Toronto* was 5.1% in 2003;
- Data from needle exchange programs in *Québec City* and smaller cities in Québec indicate that HIV prevalence among injection drug users is 9 percent in Québec City and as high as 9.6 percent in some semi-urban areas;
- In *Winnipeg*, HIV prevalence among injection drug users increased from 2.3 percent in 1986-90 to 12.6 percent in 1998, while in Calgary HIV prevalence among injection users attending that city's needle exchange program increased from 2.2 percent in 1992 to 3.3 percent in 1998.

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

- In 2002, HIV prevalence among injection drug users in Montreal and Ottawa was found to be 23.3 percent and 19.7 percent respectively;
- In *Vancouver*, the Vancouver Injection Drug User Study (VIDUS) reports that the current HIV prevalence is 35% for injection drug users participating in that study; in Victoria, HIV prevalence rose from six percent in the early 1990s to 16 percent in 2003;

Risk Behaviours

Drug injection and sexual risk behaviours among injection drug users are prevalent:

- The sharing of needles is a very efficient mode of transmission of HIV (and other infections), and is relatively common among injection drug users. Sharing of other injection drug equipment such as spoons/cookers, filters and water is also associated with HIV and HCV transmission.

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- A shift from heroin use to increasing use of cocaine may be a significant factor in the escalation of HIV prevalence and incidence. Cocaine users typically have a high injection rate; they may inject as much as twenty times a day. Rates of injectable cocaine use are especially high in Vancouver, Toronto and Montréal, but cocaine use is also an increasing emerging problem in other cities.
- Sexual risk behaviours are also prevalent. Many injection drug users are involved in unprotected commercial sex, and condom use with regular and casual partners is low.

The Populations Most Affected

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

Women injection drug users in Canada are at high risk of HIV infection. For women, the proportion of HIV positive test reports attributed to injection drug use peaked at over 47% in 1999, and has declined since. Injection drug use accounted for almost 30% of HIV positive test reports among adult women in the first six months of 2004. Findings from the VIDUS study in Vancouver show that during the period May 1996 and December 2000, HIV incidence rates among female IDU in Vancouver were about 40% higher than those of male IDU.

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

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

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

Finally, *Aboriginal people* are overrepresented in groups most vulnerable to HIV, such as sex-trade worker and prisoners. According to Health Canada, 63 percent of all new HIV infections among Aboriginal people in 2002 were attributable to injecting drug use, a significantly higher proportion than the 30% attributed to IDU among new infections overall.

Additional Reading

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The Criminalization of Drugs in Canada

Since the early 1900s, Canada has had criminal statutes aimed at the control of particular drugs. The *Opium and Drug Act* of 1911, and later the *Narcotic Control Act* and the *Food and Drugs Act*, governed drug use for 85 years. In 1997, the *Controlled Drugs and Substances Act* (CDSA) was proclaimed.

In general, under the CDSA, the *unauthorized* possession, manufacture, cultivation, trafficking, export and import of substances listed in several Schedules attached to the CDSA are criminal offences. Currently, those Schedules list cannabis, heroin, methadone, cocaine, barbiturates, amphetamine and a large array of other substances as “controlled.” In addition, under certain circumstances, it is an offence to seek or obtain a “controlled” substance from a practitioner, such as a physician. Finally, the CDSA makes it a criminal offence to possess, import, export, or traffic not only the drugs themselves but also “any thing that contains or has on it a controlled substance and that is used ... in introducing the substance into a human body.” This means that if a syringe or other equipment used for

The Current Legal Status of Drugs in Canada

What is the impact of the current legal status of drugs on efforts to prevent HIV and HCV infection among injection drug users and on the provision of care, treatment, and support to drug users with HIV/AIDS and/or HCV? What are alternatives to the current legal regime?

injecting drugs contains residue of a drug, that equipment is technically a “controlled substance” and the person with the syringe could be found guilty of possession. There are ways to get exemptions from criminal liability under the CDSA (see other info sheets in this series for more information).

The Impact of the Current Criminalization of Drugs

Several major reports released since 1997 have concluded that the legal status of drugs in Canada hinders efforts to prevent the spread of HIV among injection drug users, as well as efforts to provide care, treatment, and support to HIV-positive injection drug users.

Care, Treatment and Support for Injection Drug Users Living with HIV/AIDS: A Consultation Report (1997) recognized that the pharmacological effects of the illegal drugs used by injection drug users are not in themselves necessarily harmful. The report pointed out that much of the harm is secondary, caused either by the legal status of the drugs themselves, or by things such as dangerous injecting practices, criminal behaviour, and uncertain drug strength or purity that result in

part from the legal status of drugs. The report further pointed out that the legal status of drugs is a barrier drug users accessing much of the addiction and medical services system; and that treatment approaches, admission protocols, and staff and public attitudes are more reflective of the stigmatizing illegal status of drugs than of the treatment needs of drug users.

The *National Action Plan* (1997) prepared by the Task Force on HIV, AIDS and Injection Drug Use also observed that the legal status of drugs in Canada contributes to the difficulties encountered in addressing HIV among injection drug users.

More Harm than Good

Many others have pointed out that the criminal approach to drug use may increase harms from drug use:

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

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

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

Alternatives Are Possible

In the context of drug use, is it appropriate to use the criminal law rather than other means of social intervention? In a landmark Government of Canada report entitled *The Criminal Law in Canadian Society* (1982), it was stated that “[t]he criminal law should be employed only to deal with conduct for which other means of social control are inadequate or inappropriate, and in a manner which interferes with individuals rights and freedoms only to the extent necessary for the attainment of its purpose.” This would seem to preclude the use of the criminal law in dealing with at least some activities relating to drugs. Other less harmful means are available to respond to the use of drugs in a fashion that still maintains (and in fact, may encourage) social order and protection of the public.

Alternatives to the current approach to drug use and drug users are possible. Alternatives *within the current prohibitionist policy* that would not require any changes to the current legal framework could include the de facto decriminalization of cannabis possession for personal use, medical prescription of heroin, explicit educational programs, etc. But while these measures are important, more fundamental change in our approach is required. Alternatives *to the current prohibitionist approach* may require that Canada withdraw from several international drug-control conventions.

Alternatives Are Necessary

In 2001, Health Canada acknowledged that “[f]undamental changes are needed to existing legal and policy frameworks in order to effectively address IDU as a health issue.” Considering alternatives to the current approach is not just possible, but ethically required. Some aspects of current drug policy must be reversed because of their intolerable social consequences. Ethical principles demand a more coherent and integrated drug policy that can withstand rational inquiry and scrutiny, is responsive to the complexity of the current situation, and allows for public and critical discussion.

Overarching Directions for Future Action

1. Canada must reverse the negative impacts of the current legal status of drugs on drug users and on those who provide services to them.
2. Canada must move to adopt alternatives to the current approach to reducing drug use, and the harms of drug use, among Canadians. Drug use, and the harms sometimes associated with it, need to be treated as health issues rather than questions of criminal prohibition and punishment.

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Injection Drug Use and HIV/AIDS: Global Health Challenges

Injecting drug use is increasingly prevalent in the world. Recent estimates suggest that there are over 13 million people injecting drugs in the world, with the majority living in the developing world.

Globally, the number of countries reporting HIV infection among injecting drug users has more than doubled in the last decade, from 52 in 1992 to 114 in 2003. Injecting drug use is now believed to account for 10% of new HIV infections in the world, although this figure is significantly higher in Central and Eastern Europe and the former Soviet Union and Asia. One estimate based on UNAIDS figures suggests that the use of contaminated injection equipment accounts for approximately 30% of new infections outside of Africa.

The Prohibitionist Approach

The United Nations drug control regime is based on three treaties:

- *Single Convention on Narcotic Drugs* (1961);
- *Convention on Psychotropic Substances* (1971); and

International Law: Drug Control and Human Rights

What is the current state of drug use around the world? What is the impact of the prohibitionist approach to drugs currently reflected in international treaties? What is the relationship between human rights law and harm reduction measures?

- *Convention against Illicit Traffic in Narcotic Drugs and Psychotropic Substances* (1988).

Three international bodies administer these treaties:

- the UN Commission on Narcotic Drugs, which consists of UN member states and makes UN policy on drug control;
- the UN Office on Drugs and Crime (UNODC), a UN agency responsible for assisting states in implementing the treaties and which has recently become a co-sponsor of the Joint UN Programme on HIV/AIDS (UNAIDS); and
- the International Narcotics Control Board (INCB), an “independent and quasi-judicial control organ” monitoring states’ implementation of the three conventions.

In practice, these three UN conventions underpin an approach to drug use and drug users that seeks to prohibit drug use through punitive legislation and criminal enforcement rather than considering drug addiction as a public health issue in need of a health-based response.

Using the criminal law framework to deal with drug use is an approach premised upon the effectiveness of those measures to eliminate – or substantially reduce – drug use. Despite the stated aims of the UN General Assembly and drug control bodies to live in “a drug free world” by 2008, the available literature shows that production, trafficking, and illicit drug use have stabilised at high levels in the developed world and increasing problems are being experienced in developing countries.

In addition to not having any significant sustained effect in reducing or eliminating drug use, drug policies which are primarily or wholly dependent on the criminal law framework have been shown to negatively affect the health and human rights of injecting drug users. Partly as a result of this prohibitionist approach, injection drug users are often among the most marginalised and vulnerable members of society, vulnerable to human rights abuses and to harms such as HIV infection.

Many countries require imprisonment or institutionalisation for possession of small amounts of illegal substances (e.g. amounts for personal use). In some countries, legislation provides for forced HIV testing, forced treatment, prison terms, forced labour, or

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even the death penalty. Prisons and mandatory treatment facilities are characterised by high rates of HIV infection, continued risk behaviours associated with HIV infection (notably drug use and sex with little or no access to protective measures such as condoms or sterile injection equipment), transmission of other blood-borne diseases (such as hepatitis C) and a lack of treatment and support for detainees living with HIV. The harsh policing practices of enforcing drug prohibition often lead to egregious human rights abuses such as assaults, torture and extra-judicial executions, while also encouraging risky injection practices and impeding drug users' access to health services, thereby fuelling HIV transmission.

Harm Reduction and Human Rights

In contrast to a prohibitionist approach, harm-reduction strategies attempt to reduce the specific harms associated with drug use without requiring abstinence from all drug use, although this can certainly remain a legitimate goal for some people. Thus, they reduce the likelihood that drug users will contract or spread HIV, hepatitis and other infections, overdose on drugs of unknown potency or purity, or otherwise come to harm. Such measures often carry benefits for communities affected by aspects of the drug trade, such as reducing acquisitive crime, injection-related litter and public nuisance. Harm reduction strategies with a demonstrated capacity to improve public health include needle exchange programs, substitution maintenance therapy (such as methadone), outreach, safer injection facilities, peer-driven interventions, and support for drug user groups to deliver services and advocate for the rights and welfare of people who use drugs.

The flexibility of the United Nations drug control regime with respect to harm reduction measures is a matter of growing debate. An increasing

number of countries – such as Australia, the Netherlands, Germany, Switzerland and increasingly Canada – have taken the position that the terms of the UN drug conventions do not present an insurmountable legal impediment to developing harm reduction initiatives. In such countries, various measures have been implemented so as to reduce HIV risk and other harms among drug users, despite the fact that these States have ratified the UN drug control treaties.

The growing role of injection drug use in fuelling the HIV epidemic has highlighted how urgently such measures are needed. It is also increasingly recognized that harm reduction measures are concrete actions that government can and should take to give effect to the human right to the highest attainable standard of health.

International human rights law establishes an obligation on a majority of States to respect, protect and fulfil the right to the highest attainable standard of health. The most comprehensive expression of this right is found in Article 12 of the International Covenant on Economic, Social and Cultural Rights (ICESCR). The ICESCR is a legally binding treaty that imposes both positive and negative obligations on those States that have ratified it. While the ICESCR was concluded before the HIV epidemic began, the Committee that oversees the ICESCR has stated that a government's duties to respect, protect and fulfil the right to health includes "the establishment of prevention and education programs for behaviour-related health concerns such as sexually-transmitted diseases, in particular HIV/AIDS." Even those few States which have not ratified this treaty are bound to respect other countries' efforts to realize the human rights commitments they have made.

In the 2001 *Declaration of Commitment on HIV/AIDS*, all member states of the UN General Assembly committed to "promote and protect the health of those identifiable groups which currently have high or

increasing rates of HIV infection... as indicated by factors such as... drug using behaviour." In particular, states undertook to provide "information, education and communication" aimed at reducing risk-taking behaviour and ensure expanded access to essential commodities, including sterile injecting equipment, and harm-reduction efforts related to drug use.

The Way Forward

Despite clear evidence that harm reduction measures reduce the risk of HIV transmission (in addition to other harms), millions of injecting drug users around the world have no access, or inadequate access, to such services. Respect for human rights requires that laws and policies regarding drug use be structured around harm reduction measures. Harm reduction programmes represent concrete measures to respect, protect and fulfil the fundamental human rights of injection drug users. Where international drug control treaties, and the bodies that push for their implementation, are blocking or undermining harm reduction measures, then they are at odds with states' legal obligations to protect and promote health as a matter of basic human rights. In such cases, states must reconsider their interpretation or ratification of such treaties, and should withdraw from them when necessary.

Overarching Directions for Future Action

1. Governments must recognize the harms caused by the prohibitionist approach to health and to human rights. They must refrain from legislating and executing laws and policies that lead to the denial of human rights and undermine public health, and instead pursue more humane, pragmatic and evidence-based policies.

2. Governments must take concrete measures to respect, protect and fulfil the human rights of drug users, including the right to health. This includes harm reduction measures, as part of a comprehensive response to harmful drug use.
3. Governments must not let international drug control treaties be interpreted or implemented in ways that are detrimental to public health or to human rights, including by impeding or undermining proven harm reduction measures. Governments committed to harm reduction approaches to drug use must state this commitment clearly in international bodies. When necessary, governments should amend or withdraw from treaties that are damaging to health and to human rights, in line with their obligations under international human rights law.

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www.hrw.org

Human Rights Watch has produced a series of excellent reports on human rights abuses in the context of the "war on drugs", including analyzing the detrimental impact on efforts to respond to HIV among drug users.

www.soros.org/initiatives/ihrd

The website of the International Harm Reduction Development Program, at the Open Society Institute, contains valuable information about harm reduction and the human rights of drug users.

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Drug Use and the Provision of Health & Social Services

What legal and ethical issues arise in circumstances in which drug use is permitted in the course of providing health care and social services – primary health care, community clinics, pharmacy services, residential care, palliative care, housing services – to drug users?



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Background

Tolerating drug use in the course of providing health care and social services departs from the principle of abstinence as the only acceptable premise, standard, or goal in providing services to drug users. That principle is deeply ingrained in drug policies and programs in North America. It has, however, been questioned by service providers who feel they cannot provide proper care, treatment and support if they must insist on their clients abstaining from drugs. For example, some providers of hospice services feel they should not close their doors to a client who is not ready to stop using. Some health care providers prefer to allow their patients to continue using while receiving medical care, rather than let them suffer withdrawal symptoms that could interfere with their medical treatment.

Legal Issues

From a purely technical perspective, professionals who tolerate or permit illegal drug use on the premises may be prosecuted under the *Controlled Drugs and Substances Act* (CDSA) or face professional discipline such as fines or the suspension or revocation of their licences.

Criminal liability

1. Staff at health care or other social services may be liable for **possession** of a controlled substance under the CDSA if they know that an illicit drug is present on their premises and if they have some measure of control over the drug. Staff who collect used syringes or drug paraphernalia that contain residue of illegal drugs might also technically be found guilty of possession. However, this is mostly a theoretical risk.
2. Staff who store a patient/resident's illegal drugs and provide them at specific intervals could likely be convicted of **trafficking**. The term "traffic" is broadly defined in the CDSA to include selling, administering, giving, transferring, sending, or delivering an illegal substance. It is also a criminal offence to "offer" to do any of these things.
3. Staff permitting or tolerating drug use may be liable for **aiding or abetting** a person to commit a crime. Aiding is providing assistance in the commission of a crime. Abetting means being at the crime and encouraging its commission.

4. Staff may also be responsible for **criminal negligence** causing death or bodily harm. This may occur if, by tolerating or facilitating the possession of drugs, a staff member caused or contributed to the bodily harm or death of a patient. It must be proved that the accused either did something that had this effect, or failed to do something that he or she had a legal duty to do. For example, staff at health-care facilities likely have a duty to protect the well-being of patients. It could be argued that providing illicit drugs or permitting their use is contrary to this duty, although this is open to debate depending on the specific circumstances. It must also be proved that the conduct of the staff member was a "marked departure" from the standard of behaviour expected of the "reasonably prudent person in the circumstances."

Civil Actions or Disciplinary Proceedings

Professional codes of conduct may prohibit health-care professionals from allowing patients to ingest or inject illegal drugs. Physicians, nurses and other health-care providers may be subject to disciplinary measures by the bodies that govern their

professions if they breach these codes. A facility or employee might also face civil liability for allowing or tolerating the possession of illegal drugs. For example, if a hospital allowed a patient to possess and use illegal drugs in the hospital and the patient suffered harm, the hospital might be found liable for negligent care of the patient. The extent of the duty would vary with the type of institution. A hospital or treatment facility staffed by medical personnel would have a greater responsibility than would a residential facility that simply provides housing to drug users.

Avoiding Liability

Although those who operate facilities could be subject to criminal charges or civil lawsuits, they may have legal defences available to them. A facility or employee facing civil liability or criminal prosecution might claim that allowing the use of illegal drugs was a *necessity* for the treatment of the patient and/or that, in the circumstances, it would be *negligent to prohibit* possession of a controlled substance by a patient, as this might effectively interfere with their access to essential medical treatment.

Furthermore, hospitals or other facilities may arrange for legal access to specific drugs under existing legislation, so that drugs that would otherwise be illegal can be allowed or even administered to patients. Health Canada's Special Access Program is an example of a program that could prevent criminal charges being brought against those working in facilities.

Finally, the CDSA says the Minister of Health or the federal Cabinet may grant exemptions from the Act if this is in the public interest or if the controlled substance will be used for medical or scientific purposes. In April 2001, the Marijuana Medical Access Regulations came into force, allowing people who are suffering from certain conditions, including HIV/AIDS, to apply for

authorization to use marijuana as treatment in managing their medical condition. In 2003, Health Canada granted an exemption to Vancouver Coastal Health to operate "Insite", Canada's first officially sanctioned safe injection site, in Vancouver's Downtown Eastside. In 2005, the North American Opiate Medical Initiative (NAOMI) began a clinical trial of prescription heroin therapy for chronically addicted heroin users in Vancouver, Toronto and Montréal (see other info sheets for further information).

Ethical Issues

The basic ethical issue is the imperative to care adequately for HIV-positive drug users. According to ethical principles, behaviour should not be imposed on drug-dependent persons that exceeds their current level of ability. Drug-dependent persons should be treated for their illnesses, fed, and provided with shelter - their dignity and self-worth must be nurtured and their drug needs tolerated so that they can begin to address their difficult circumstances. Attempting to free a person from addiction is not the goal to be pursued when that person, dependent on drugs for many years, is in the final stages of a terminal illness such as AIDS. In a palliative care setting, helping the dying to die with dignity is the highest ethical imperative. If this requires tolerating their use of illegal drugs, this ethical requirement must be considered by the service provider, and should also inform the application of the law to that situation.

Recommendations

1. In the long term, laws should be changed to permit provision of currently illegal drugs to drug users while they are in care. This would remove a barrier to drug users accessing health care and other social services and would remove the threat of criminal liability for service providers who wish to provide care, treatment, and support without insisting on abstinence by patients who use illegal drugs.
2. In the short term, measures should be undertaken to ensure better care, treatment, and support of people who use illegal drugs, including people living with HIV/AIDS. In particular, professional associations should develop ethical and practice guidelines for service providers in different areas of care involving HIV/AIDS and injection drug use.

Additional Reading

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Injection Drug Use and HIV/AIDS

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Treatment

Is it legal and ethical to make abstinence from drug use a condition for treatment of a drug user? Is it legal and ethical to withhold antiretroviral drugs from drug users living with HIV/AIDS?



Compelling Abstinence

Abstinence

The principle of abstinence is rooted in a law-enforcement model that reflects and perpetuates the stigma surrounding drug use and drug users. A focus on abstinence, often to the exclusion of other approaches, has dominated drug policy in North America. Persons who use illicit drugs are viewed as deserving of punishment rather than in need of care, treatment, and support.

Proponents of a strict abstinence approach prohibit drug users who seek health services from using drugs. They argue that abstinence from non-medicinal drugs is a fundamental component of healthy behaviour, and view total and permanent abstinence from drug use as the only sign of successful treatment.

Harm Reduction Approaches

In recent years, however, AIDS and the transmission of HIV and HCV, both among drug users and to others, have caused a fundamental re-evaluation of the services and programs provided to drug-dependent persons. It is being slowly recognized that complete withdrawal from drugs is not a goal that is attainable for some drug users.

Moreover, only a minority of drug users are prepared to contemplate participation in abstinence-based programs. Therefore, addiction treatment and other health-care services that stipulate abstinence as a precondition to participation will deter many drug users from obtaining treatment.

Lack of Access to Antiretroviral Drugs

Advances in antiretroviral therapy (ART) have improved the survival and quality of life of many HIV-positive people and have reduced morbidity and mortality. However, drug users are not offered ART with the same frequency as other HIV-positive individuals. For example, in British Columbia ART is offered free to all people with HIV infection who are eligible for ART. Despite this, it was found that in 2001 only 60% of eligible drug users received ART. One-third of British Columbia residents who died of HIV-related causes did not access ART. People who did not get treatment were most likely First Nations, female, poor and/or injection drug users.

In Canada, physicians often do not receive adequate training in medical school, residency training, or continuing education programs

regarding the care of drug users. Mental illness, psychosocial problems and chronic liver disease are some of the reasons physicians are reluctant to prescribe ART to drug users. In addition, some physicians believe that drug users are incapable of following the prescribed regimen for antiretroviral therapy. They are concerned that if ART is not conscientiously followed, resistance to the therapy will develop.

Several measures can be taken by physicians to ensure optimal outcomes for drug users who use ART. They include simplifying regimens by reducing dose frequencies and pill numbers. A particularly important factor is a physician/patient relationship characterized by trust and accessibility. Other initiatives to make treatment more accessible to drug users include extended opening hours and treatment systems which are integrated in a single site, such as providing substitution therapy and needle exchange along with ART treatment.

Globally, there are a number of initiatives underway related to access to ART for people living with HIV/AIDS. The World Health Organisation is coordinating a global campaign to treat three million people in the developing world by 2005 (the "3 by

5” initiative). While the campaign has enormous potential, one major challenge is to ensure equitable access to ART for drug users living with HIV/AIDS. Implementing harm reduction measures into policies and programs will be critical to ensuring drug users get access to anti-retroviral treatment.

Legal Issues

Compelling abstinence as a condition of medical treatment, or withholding antiretroviral therapy from drug users simply because they use illegal drugs, may violate the *Canadian Charter of Rights and Freedoms*, human rights codes, professional codes of conduct and international human rights conventions. Anti-discrimination law is evolving. This kind of policy or practice could be characterized as discrimination based on the disability of drug dependence, which has been recognized as unlawful discrimination in Canadian law.

Ethical Issues

It is unethical to insist on abstaining from drug use as a condition of medical treatment if this is beyond the capabilities of the drug user. It is also unjust to judge people as likely to be noncompliant with ART simply because they are drug users and to withhold ART on this basis. Adherence to treatment is profoundly affected by systems of care. When the health-care system is adapted to meet the needs of socially marginalized and indigent persons, there is a vast improvement in adherence to treatment. It is unethical to reduce an assessment of treatment compliance to simply whether a person uses, or is addicted to, illegal drugs. At the same time, there may be situations where it may be justified to delay or, at the extreme, refuse ART. Such a decision would be ethically unjustifiable if it is reached without honouring the characteristics of an authentic healing

relationship: humanity (respect for the full biological and biographical particularity of the person with HIV/AIDS), autonomy (respect of the person’s way of life and life plans); transparency (sharing of all relevant information); and fidelity (understanding of, and respect for, the expectations of the sick).

Recommendations

1. Health-care professionals should ensure that the provision of services to drug users is not contingent upon a drug user’s agreement to enter drug treatment programs.
2. Health-care professionals must not withhold or refuse treatment simply because a person with HIV/AIDS is a drug user.
3. The governing approach in providing care and treatment to HIV-positive drug users should be to adapt as much as possible the therapeutic regimen to the needs of drug users, rather than require drug users to adapt to the therapeutic regimen.
4. A network of physicians who have experience and/or interest in the delivery of health care and treatment to drug users should be established.
5. Public health should offer or make available support to drug users who require assistance in adhering to HIV therapies.

Additional Reading

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Provision of Controlled Drugs

What legal issues are raised in the context of prescribing or allowing the possession of certain controlled drugs in Canada?



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Criminal Regulation

The *Controlled Drugs and Substances Act* (CDSA) and the Narcotic Control Regulations forbid medical practitioners from administering, prescribing, giving, selling, or furnishing a narcotic to any person except as allowed by the Regulations. The Act and the Regulations provide that:

- Where the Minister of Health “deems it to be in the public interest, or in the interests of science,” the Minister may authorize any person to possess a narcotic.
- The Minister may also authorize a practitioner to provide methadone to a person under their treatment, or to provide a narcotic (other than heroin) to any person who is also authorized by the Minister to possess a narcotic.
- A person in charge of a hospital may permit methadone to be supplied or administered to an in-patient or out-patient of the hospital, upon receipt of a prescription or written order signed and dated by a practitioner who is authorized by the Minister to prescribe methadone.

- A practitioner may only provide heroin to a patient of a hospital.
- Apart from these restrictions, a practitioner is permitted to prescribe a narcotic only to a patient under their professional treatment, and only if the narcotic is required for the condition for which the person is receiving treatment.

Thus, there are some carefully circumscribed situations in which practitioners can prescribe narcotics, including opiates, but methadone is the only opioid currently permitted for long-term treatment of drug users in Canada.

In situations where a physician has no right to prescribe a controlled substance, penalties for prescribing may flow under the Narcotic Control Regulations. In addition, if a physician actually possesses a controlled substance and gives it to a patient (or offers to give it) when the physician has no legal right to possess the drug, the physician may commit three offences under the CDSA - possession of a controlled substance, possession for the purposes of trafficking, and trafficking.

Civil and Professional Liability

Professional statutes in each province regulate the behaviour of health-care professionals. If a physician commits an act of professional misconduct, his or her right to practise medicine may be revoked or suspended or other penalties may be applied. This may occur if the physician provides or prescribes an illegal drug to his or her patient.

Physicians might also be civilly responsible for negligence if the drug prescribed causes the patient harm. In such a civil lawsuit, it must be proved that the doctor did not have a reasonable degree of skill or knowledge, or did not exercise the degree of care reasonably expected of the average prudent doctor. Failure to explain “material risks” of the medication to the patient, or prescribing medication in a manner that causes “reasonable foreseeable” injury to the patient, constitutes negligence. The care that must be exercised by a doctor is dependent on the nature of the drug and the patient to whom it is prescribed.

Medical Marijuana

The Marijuana Medical Access Regulations and the necessary amendment to the Narcotic Control Regulations came into force on July 30, 2001. The regulations allow the use of marijuana by people who are suffering from serious illnesses, where (a) conventional treatments are inappropriate or are not providing adequate relief of the symptoms related to the medical condition or its treatment, and (b) where the use of marijuana is expected to have some medical benefit that outweighs the risk of its use. The Regulations do not address the issue of legalizing marijuana generally.

The Regulations outline three categories of individuals who can apply to Health Canada to possess marijuana for medical purposes. Category 1 refers to people with a terminal illness with an expected life span of less than 12 months. Category 2 refers to people who suffer from specific symptoms associated with certain medical conditions, including HIV/AIDS. Category 3 refers to people who have symptoms associated with a serious medical condition or conditions, other than those covered by the other two Categories.

An application for authorization to possess marijuana for medical purposes must be made to Health Canada's Office of Cannabis Medical Access, accompanied by medical declaration from a physician or a specialist. In all categories, applicants must provide a medical declaration that states, among other things, that all conventional treatments have been reasonably tried or considered and that the benefits of using marijuana outweigh the potential risks.

If granted an authorization, patients can either grow their own marijuana, designate someone else to grow for them (who must get a licence to produce marijuana), or apply for access to dried marijuana grown by

a private company under contract for Health Canada. Holders of an authorization may possess a 30 day supply. As of February 2005, just over 700 people had been granted authorizations to possess marijuana for medical purposes.

In October 2004, proposed amendments to the Marijuana Medical Access Regulations were published for public comment. The proposed amendments followed a number of court cases which revealed serious problems with the previous system. Among other things, the proposed amendments would streamline the application process, reduce from three to two the categories of symptoms making a person eligible to apply and provide for a pilot project distributing marijuana to authorized patients through pharmacies. The proposed amendments do not address the issue of cost of marijuana. Consumers of medical marijuana remain responsible for cost, without consideration of their ability to pay and without compensation, either through medical insurance, provincial health insurance or income tax credits.

Methadone Maintenance Treatment

As mentioned above, currently methadone is the only opioid approved for the long-term treatment of drug-dependent persons in Canada. Methadone maintenance treatment (MMT) has many advantages, has been widely recognized as an important form of treatment for people addicted to opioids, and is a critical element of a comprehensive "harm reduction" approach to drug use. Because it is taken orally, it can eliminate or reduce the sharing of needles to inject opioids. Furthermore, accessing legal methadone as a substitute for illegal heroin can also help stabilize living patterns for those opioid-dependent people whose daily routine involves a constant, often chaotic pursuit

for the next "fix". However, there are some limitations. Methadone is effective for heroin addiction, but it is not a treatment for dependence on cocaine, amphetamine and other non-opiate drugs. In addition, methadone is not indicated for multiple addictions. Finally, methadone is itself addictive. In fact, for some people the withdrawal symptoms from methadone may be worse and more difficult to manage than the withdrawal symptoms from heroin. Thus, MMT is not a sufficient solution by itself to many of the problems associated with drug dependency, and it is necessary to explore additional methods of addressing it.

Canada's Prescription Heroin Trial

It is estimated that some 10-20% of people addicted to heroin do not benefit from MMT. In recent years many have taken the position that heroin substitution and heroin maintenance are reasonable alternatives that have a place in the overall public health approach to injection drug use in Canada. Following years of preparation, the North American Opiate Medication Initiative (NAOMI) began in February 2005. NAOMI is a clinical trial to test whether prescription heroin can attract and retain heroin users who have not been successful in previous MMT or abstinence-based treatment programmes. The trial will run for two years and involve 470 participants in three sites (Vancouver, Toronto and Montréal.) Approximately half of the participants will receive heroin and half will receive methadone. The participants will have direct access to social workers and physicians and the study will track the degree to which participants are able to improve their physical health and social indicators (such as social functioning, employment, illegal activities, housing, etc.).

The NAOMI trial is funded by the Canadian Institutes of Health research and approved by Health Canada. The heroin is legally available under an exemption for federally approved scientific studies.

While the trial is a first for North America, heroin-assisted therapy is not new. It has been studied in a number of countries in Europe. In Britain, heroin has been available for the management of addiction since 1926. Currently, physicians in Britain are permitted to prescribe heroin, cocaine, morphine, amphetamine, as well as other drugs. In Switzerland, the government began a multi-year, multi-city scientific trial in 1994 to provide heroin to long-term dependent users in order to assess the effects on their health, social integration, and behaviour. In 1997, the Swiss heroin maintenance trial was declared a success: crime had dropped by over 50% and the employment rate doubled for those participating in the trial. Following these results, the Swiss public voted in a referendum in favour of establishing the programme long-term. Similarly, in the Netherlands, two simultaneous heroin prescription trials were conducted between 1998 and 2001: one examining injection heroin, the other examining inhalable heroin. The researchers found improved physical and mental health and social functioning in those receiving prescription heroin in combination with methadone compared with those who received only methadone treatment. Similar trials have been planned or undertaken in a number of other countries.

Such results from other countries are encouraging, although the specific conditions of both the Dutch and Swiss contexts mean the results cannot be automatically applied to the North American context. Therefore, the NAOMI study will assess whether heroin-assisted therapy could be effective in Canada.

Recommendations

1. Health Canada should address the remaining barriers to access to cannabis for therapeutic purposes under the Marihuana Medical Access Regulations, particularly the issue of cost for those who cannot otherwise afford to pay.
2. In the longer term, Health Canada should develop plans to permit physicians to prescribe both opiates and controlled stimulants, informed by the best available evidence.
3. In the shorter term, the NAOMI trial should be supported and careful attention given to the results of the trial, particularly regarding the appropriateness of establishing heroin prescription in Canada on a long-term basis.

Additional Reading

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Van den Brink et al. "Medical Co-prescription of Heroin: Two Randomised Control Trials." Central Committee of the Treatment of Heroin Addicts, 2002. The results of the Dutch prescription heroin trials. Available at www.ccbh.nl/ENG/index.htm.

For more information about the NAOMI clinical trial of prescription heroin, go to www.naomistudy.ca.

www.drugpolicy.org

The website of the Drug Policy Alliance (formerly the Lindesmith Center) contains many articles and reports on heroin maintenance.

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Drug Users & Studies of HIV/AIDS & Illegal Drugs

What legal and ethical issues are raised by (a) the absence of scientific trials on the impact of illegal drugs on the immune system; (b) the absence of trials on the interactions between HIV/AIDS drugs and illegal drugs, and (c) the exclusion of drug users from many scientific trials involving drugs for HIV/AIDS?

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Historical Background

After World War II, concerted efforts were made to exclude vulnerable people from participating in scientific and medical trials in order to protect against medical exploitation. *The Nuremberg Code*, *the International Code of Medical Ethics* and the *Declaration of Helsinki* were developed to protect people from medical and scientific exploitation. People belonging to ethnic and minority groups, mentally challenged individuals and socially marginalized persons were precluded from being research subjects in experimental medical studies. This exclusion has its roots in research conducted in the nineteenth and first half of the twentieth century. During this period, ethically questionable medical experiments were performed in many countries on vulnerable people.

A Change in Perspective

Although the protection of research subjects remains an important concern, it is also increasingly recognized that there should be equitable access to voluntary participation in clinical trials, based on informed consent. This is because socially marginalized and economically disadvantaged persons, women, and members of minority

groups often suffer discrimination and injustice by their exclusion from, or under-representation in, clinical trials of promising new treatments. The Canadian 1998 *Tri-Council Policy on Ethical Conduct for Research Involving Humans* therefore states that “[m]embers of society should neither bear an unfair share of the direct burdens of participating in research, nor should they be unfairly excluded from the potential benefits of research participation.”

Drug Users and Studies of HIV/AIDS and Illegal Drugs

There is a lack of adequate clinical information upon which to base treatment of HIV-positive drug users. Drug users are often excluded from, or underrepresented in, studies of HIV/AIDS drugs. In addition, there is little research into the effects of currently illegal drugs on the immune system, or the interaction between HIV/AIDS drugs and currently illegal drugs. This hinders the provision of optimal care, treatment, and support to HIV-positive injection drug users, who may have a wider range of immunological deficiencies and a different history of the disease and may respond differently to treatments than other HIV-positive persons.

Legal Issues

Legal Authority to Conduct Research

Provisions in the *Controlled Drugs and Substances Act* enable researchers and drug users to participate in clinical trials involving illegal drugs. The Minister of Health and the Governor in Council have the authority to exempt persons from the Act if the exemption is for medical or scientific purposes or if it is in the public interest. Because they represent important medical and scientific research projects, the Minister of Health has approved Canada's first official safe injection facility (Insite, in Vancouver's Downtown Eastside) as well as the North American Opiate Medication Initiative (NAOMI), which will run clinical trials in Vancouver, Toronto and Montreal.

Legal Duties in Conducting Research

There is no positive legal duty to conduct research on the impact of illegal drugs on the immune system and on interactions between HIV/AIDS drugs and illegal drugs. The federal and provincial Ministers of Health are empowered by legislation to conduct research and, as noted above, may grant legal authorization to others to enable research dealing

with illegal drugs. But it is doubtful whether the broadly worded statutory mandates of health officials to “promote and preserve” the health of Canadians could or would be interpreted by the courts as imposing positive obligations on government to conduct specific kinds of research.

However, once undertaken, medical research is governed or affected by law or other forms of policy. Legal and ethical considerations must be taken into account in research design and it might be possible to resort to the *Canadian Charter of Rights and Freedoms* or human rights statutes to challenge the exclusion of drug users from studies. It might also be possible to challenge the refusal of government authorities or private institutions to permit research involving illegal drugs.

For example, one might argue that the exclusion of drug users from various studies is in breach of the Charter guarantees of equal protection and equal benefit of the law (s 15) and of the rights to life and security of the person (s 7). However, the Charter generally applies only to government institutions (s 32). The extent of the Charter’s reach into the quasi-public sector, such as hospitals and universities that might be conducting research into HIV/AIDS drugs, is the subject of an evolving debate. The parameters of the reported court decisions in this area do not yet reveal any clear principles.

Ethical Issues

Health-care professionals have an ethical obligation to pursue the knowledge required to fulfill the clinical responsibilities of treatment, care, and support. To systematically exclude injection drug users (or women, or other vulnerable populations) from clinical trials is equivalent to a refusal to obtain knowledge necessary to adequately treat those who are often most in need of care. It is scientifically unfounded to assume that HIV-positive drug users have a course of disease that closely

resembles that in HIV-positive persons who do not use drugs. Furthermore, it is known that some drugs interact unfavourably with antiretroviral drugs. As mentioned above, HIV-positive injection drug users may have a wider range of immunological deficiencies, a different history of HIV disease, and may respond differently to treatments than other HIV-positive persons. It is therefore clinically and ethically wrong to exclude these people from studies that can inform whether antiretroviral treatment for HIV-positive drug users needs to be adjusted from the treatment approaches used in people who do not use controlled substances.

Recommendations

1. The Canadian Institutes of Health Research and pharmaceutical companies, in consultation with community groups and drug users, should develop a comprehensive research agenda that identifies priorities in research for injection drug users.
2. As a general principle, clinical researchers and professional associations should take measures to ensure the removal of barriers to the participation of drug users in clinical trials of drugs used to treat people living with HIV/AIDS.

Additional Reading

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Council of Canada. *Tri-Council Policy Statement: Ethical Conduct for Research Involving Humans*. Ottawa: Public Works and Government Services Canada, August 1998. States that “[n]o group should be categorically excluded ... from access to clinical trials” and that “[s]pecial efforts should be made to reach out to previously excluded populations.”

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Information About the Use & Effects of Drugs

This info sheet discusses the legal and ethical issues associated with ensuring that health-care providers, drug user, and the general public have accurate and complete information on illicit drugs and their effects.



What Is the Issue?

Health-care providers, drug users and the general public do not receive enough accurate and complete information on illegal drugs. This has a negative impact on HIV prevention efforts and on access to informed and appropriate care, treatment and support for people living with HIV/AIDS.

Educational Programs Based on Abstinence

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

When kids are told that illegal drugs, including marijuana, are extremely dangerous and addictive, and then learn through experimentation that this is

false, the rest of the message is discredited. Honest drug education is one key to ensuring that individuals know how to make informed decisions. But such an approach is inconsistent with the “Just Say No” campaign.

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

Harm-Reduction Education Programs

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

Educational programs based on harm-reduction objectives try to: reduce the prevalence of unsafe frequencies and methods of ingesting drugs; decrease

the rate of heavy or dependent consumption; reduce experimentation with drugs most likely to cause medical problems; and improve the ability of users and others to respond to drug-related problems.

Some government ministries and agencies in Canada have published information for the public based on harm-reduction principles. However, the extent of the information accessible to youth, drug users and the public that is based on these principles remains limited.

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

Legal Issues

Provincial health officials, according to public health laws, are responsible for providing health education to members of the public. Officials have the authority to decide what types of materials will be distributed

and to which sectors of the public the material will be directed. Therefore, the principles upon which educational material on drugs is based and whether it is directed to youth, drug users, or members of the public fall within the discretion of government health officials. However, it would be difficult to use the law to address the failure to provide accurate information about illegal drugs and their effects.

Ethical Principles

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

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

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

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

Recommendations

1. Federal, provincial and territorial health officials should provide funding for the development and wide distribution of accurate, unbiased, and non-judgmental information on illegal drugs for health-care providers, drug users and members of the public.
2. Provincial and territorial governments, government agencies, and community-based organizations should develop education programs based on harm-reduction principles.
3. Provincial and territorial ministries of education and health should undertake an evaluation of school programs on illegal drugs to assess whether these can be made more effective in reducing harms associated with the misuse of drugs by youth.
4. Universities and colleges should ensure that the curricula of health-care professionals include accurate, unbiased and nonjudgmental materials, presentations and discussions about drugs, drug use and harm-reduction approaches to drug use.

Additional Reading

Injection Drug Use and HIV/AIDS: Legal and Ethical Issues. Background Papers. Canadian HIV/AIDS Legal Network, 1999. In particular, see the paper on "Ethical Issues" by Dr. David Roy and the paper on "Policy Issues" by Dr. Diane Riley. These documents are available at www.aidslaw.ca/Maincontent/issues/druglaws.htm

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Needle Exchange Programs

This info sheet explains how the rules and regulations that govern needle exchange programs in Canada serve as barriers to HIV prevention and to care, treatment and support of injection drug users.



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The Purposes of Needle Exchange Programs

Needle exchange programs (NEPs) are a crucial component of a harm-reduction approach to injection drug use. Injection drug users often share needles and syringes, a frequent mode of transmission of HIV and hepatitis C (HCV). The rationale underlying NEPs is that if injection drug users are provided with sterile syringes and needles, this will reduce the sharing of drug equipment and thus decrease the transmission of bloodborne diseases such as HIV and HCV.

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

Do They Work?

Studies have concluded that NEPs

- are effective in reducing the spread of HIV;
- do not increase the number of injection drug users or lower the age of first injection; and

- do not increase the number of needles discarded in a community, or change the locations where needles are disposed.

Needle Exchange Programs in Canada

The first NEP in Canada was established in 1989 in Vancouver. Within a few months NEPs were established in Montréal and Toronto. This was soon followed in other major Canadian cities. Currently, it is estimated that there are over 200 NEPs. Nevertheless, only a small proportion of injection drug users have access to NEPs. Many problems remain:

- In some NEPs there is a limit on the number of syringes distributed to injection drug users at each visit. Individual quotas may be imposed, and/or new syringes may only be exchanged for used syringes. Such limitations may be well-intentioned but have restricted access to sterile injection equipment. Generally, the number of needles distributed in Canada is significantly lower than the number required by injection drug users.

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

Legal Issues

It is legal in Canada to give or sell sterile syringes to injection drug users. It is theoretically possible that NEP staff and drug users may be criminally charged under the *Controlled Drugs and Substances Act* for possessing traces of illegal drugs contained in used syringes. While it is unlikely that such a law would be enforced against NEP staff, the risk is probably greater for drug users. However, a policy of enforcing the law in this fashion would undermine the effectiveness of NEPs, as well as increase the likelihood that injection drug users would abandon used injection equipment (instead of disposing of it at a NEP).

Ethical Issues

The governing purpose or end of NEPs is the reduction or elimination of a constellation of harms that accompany addiction to drugs and injection drug use. The NEPs ... are means to achieve that end.

However, these programs do not work as effective means when they are operative in ways that impose restrictions that condemn the programs to fall far short of the needs of the persons for whom they were designed.

Because of all the limitations mentioned above, the ethical principles of respect for autonomy and dignity, beneficence and non-maleficence, and justice and fairness are not followed in some NEPs in Canada. The principles of beneficence and non-maleficence require the maximization of good and the minimization of harm to the drug user. Respecting autonomy and dignity requires that we respect the right of the drug user to self-determination, namely the right to make informed decisions regarding their own welfare, even while recognizing that sometimes the ability to act autonomously can be compromised by addiction. Justice and fairness means that resources must be provided to address the health problems of drug users; their health cannot be seen as less deserving of concern because it is a question of addiction to illegal drugs.

Recommendations

1. The federal, provincial, territorial and municipal governments should ensure that needle exchange programs are easily accessible to injection drug users in all parts of Canada.
2. The federal government should repeal criminal laws that expose drug users and needle exchange staff to criminal liability for having in their possession drug paraphernalia containing residue of illegal substances.
3. Correctional systems should make sterile injection equipment available in prisons.
4. Pharmacists' associations as well as licensing bodies should encourage pharmacists to distribute sterile syringes as another avenue for drug users to access clean equipment.

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World Health Organization. *Effectiveness for sterile needle and syringe programming in reducing HIV/AIDS among injection drug users*. World Health Organisation, 2004. Available at www.who.int/hiv/pub/prev_care/en/effectivenesssterileneedle.pdf. One of the WHO's technical papers in its "Evidence for Action" series, this document evaluates the available research regarding the effectiveness of needle exchange programmes in reducing the risk of HIV transmission among injection drug users.

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Methadone Maintenance Treatment

Methadone remains the only opioid approved for long-term treatment of opiate dependence. It is a synthetic narcotic drug used to treat persons who are dependent on heroin and morphine. In contrast to the short-acting drugs administered by injection, it is a long-acting opioid that can be orally ingested. A drug user need only receive a single dose of methadone in a 24- to 36-hour period. Methadone does not cause euphoria or sedation. This is to be contrasted with the shorter action and dramatic highs and lows of heroin, morphine and other opiates. The long-lasting effect of methadone allows a drug user to seek employment and facilitates reintegration into the community.

The safety and effectiveness of methadone maintenance treatment (MMT) has been documented in scientific and medical publications. MMT programs have been credited with decreasing opioid use, reducing criminality and improving the general health of the drug user. Moreover, MMT reduces individual mortality and morbidity. Another important benefit of MMT is that it helps decrease the spread of HIV, as methadone is typically administered

Methadone Maintenance Treatment

This info sheet discusses how the rules and regulations that govern methadone maintenance programs in Canada can serve as barriers to prevention, care, treatment and support of drug users.

orally rather than by syringe. MMT has thus become a “critical resource in the struggle against injection drug use and AIDS.” Methadone clinics are also potentially excellent sites for disease prevention and education. Patients can be offered screening and counselling for transmissible diseases; and can be provided information on safe sex, on the dangers of sharing needles and on methods for cleaning syringes.

History of MMT in Canada

In 1959, Vancouver physician Dr Robert Halliday obtained approval from the federal Department of Health to conduct a study of methadone as a method of treating opiate-dependent persons. Dr Halliday was successful in establishing that methadone maintenance was a legitimate form of treatment for drug-dependent persons. By 1972, two dozen methadone treatment programs existed in Canada. The Commission of Inquiry into the Non-Medical Use of Drugs, known as the Le Dain Commission, stated in the early 1970s that methadone “is the cheapest and most effective weapon we have for dealing with large-scale heroin dependence.” The Commission recommended that methadone maintenance be available to persons dependent on opiates throughout Canada.

Possible misuses of methadone became a concern of the federal government in the early 1970s. In 1972, the government passed regulations to the *Narcotic Control Act* that stated that no doctor or pharmacist could prescribe, administer, give or sell methadone to any person unless so authorized by the federal government. The regulations had a drastic impact on the methadone programs that existed in Canada. Between 1972 to 1975, methadone prescribers as well as patients involved in methadone programs decreased by one-third.

In the mid-1990s, the federal government transferred licensing and control of methadone programs to the provinces. Some provinces have delegated to the College of Physicians and Surgeons the responsibility of regulating the methadone maintenance programs. It is still necessary for physicians to obtain federal authorization to prescribe and administer methadone to their patients.

Barriers to Effective Programs

Despite their availability in a growing number of countries, methadone and other forms of substitution treatment such as buprenorphine are illegal or heavily restricted in a number of



countries. At the end of 2004, both methadone and buprenorphine were formally proposed for inclusion on the World Health Organization's Model List of Essential Medicines. This would represent a major step forward in global efforts to ensure greater access to treatment for injection drug users.

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

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

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

- Although the number of heroin-dependent persons in Canada who have been treated with methadone has increased in recent years, it remains low with inadequate access to methadone in many parts of Canada.
- Funding of methadone programs in Canada is inadequate, and in many provinces too few physicians and pharmacists participate in providing MMT.
- Access to MMT in prisons remains limited. In the federal and in many - but not all - provincial systems, inmates who were already on MMT outside can continue such treatment in prison. However, MMT should be available also to opiate-dependent prisoners who were not receiving it before incarceration, as an important measure to reduce the likelihood of injecting drugs in prison using shared equipment. While policy in some jurisdictions has improved, in practice there are often still barriers to getting methadone in prisons.

Recommendations

1. Federal, provincial and territorial governments should take measures to ensure that methadone maintenance programs are more accessible to opiate-dependent persons in all provinces and territories.
2. Government health officials and Colleges of Physicians and Surgeons should ensure that comprehensive services are available to persons who participate in methadone programs, including primary health care, counselling, education and support services.
3. Correctional systems should ensure that prisoners who were on MMT prior to incarceration are able to continue their treatment while incarcerated and that prisoners are able to start such treatment in prison whenever they would have been eligible for it outside.

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Drug Users: State of the Art and New Research Participants Perspectives: Scientific Findings and Political Perspectives. Bern: University of Bern, 10-12 March 1999. Discusses the history of MMT in Canada, the effect of the 1972 regulations, and the obstacles to MMT that currently exist for injection drug users.

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

What Are Safe Injection Facilities?

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

SIFs also help direct drug users to treatment and rehabilitation programs and can operate as a primary health care unit. SIFs provide free sterile equipment, including syringes,

alcohol, dry swabs, water, spoons/cookers and tourniquets. The facilities are intended to reduce incidents of unsafe use of injection drugs and to prevent the negative consequences that too often result from unsafe injection. They are not “shooting galleries,” which are not legally or officially sanctioned and are often unsafe because they do not offer hygienic conditions, access to sterile injection equipment, supervision and immediate access to health-care personnel, or connections to other health and support services.

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

The Debate

Some have suggested that establishing SIFs sends the wrong message to the community - namely, that injection drug use is acceptable and has official support. It is argued that this will contribute to increased use. In fact, in cities in Europe that have SIFs the total number of drug users has decreased.

Safe Injection Facilities

This info sheet explains what safe injection facilities are, recent developments regarding the Insite site in Vancouver and why Canada should support further trials of such sites.



Another concern is that the introduction of SIFs would increase the concentration of drug users in the area in which the SIF is located, thereby affecting the quality of life in the neighbourhood. In reality, SIFs are expected to reduce nuisance and visibility problems: crime, violence, loitering, drug dealing and property damage could be diminished, and many needles would be disposed of safely rather than discarded on the streets. European studies support this contention, with police reporting declines in street robbery, car break-ins, and heroin trafficking and related offences after the introduction of injection facilities.

Other Countries' Experiences

SIFs have been successfully implemented as pragmatic, practical and effective harm reduction strategies in one Australian, two Spanish and many Swiss, German and Dutch cities. SIFs have been instituted in places where high-level public drug scenes existed with typically associated harmful consequences, such as deteriorating health conditions and increasing public nuisances. SIFs now appear to be accepted in those jurisdictions, despite some initial opposition.

Legal Issues

International law requires that States remove obstacles to conducting trials of SIFs, as part of the international legal obligation to take measures to achieve the highest standard of health possible for everyone. Furthermore, international drug conventions do not prevent such trials. In fact, those treaties relevant to drugs expressly permit scientific and medical experimentation.

Concerns about criminal and civil liability, often exaggerated, also are not insurmountable obstacles to implementing SIFs. Nevertheless, it is advisable to establish a clear legal framework for the operation of safe injection facilities.

Insite- North America's first officially approved SIF

After prolonged and sustained advocacy, Insite was opened in Vancouver's Downtown Eastside in September 2003. Government authorisation for Insite was granted for three years as a scientific research pilot study, in the form of an exemption by the Minister of Health under the Controlled Drugs and Substances Act.

A preliminary review of its first year of operation found that the site provides a secure environment for injection for over 3000 people who inject illicit drugs in Vancouver. The facility averages some 500 to 600 injections per day. In its first year of operation there were over 100 observed overdoses but no fatalities, due to rapid staff interventions. There have been a large number of referrals to counselling and treatment services. Research has indicated that the opening of the SIF was associated with improvements in public order, including reduced public injection drug use and public syringe disposal. Evaluation is ongoing.

Conclusion

SIFs are an important component of a comprehensive harm reduction strategy. There is a substantial body of evidence from SIFs in a number of other countries reflecting the success of such sites as a public health intervention. The results to date from Insite in Vancouver are similarly positive. Given this, Canada cannot sit by and refuse to implement SIFs in other cities in Canada where there is a clear and demonstrable need for interventions to reduce HIV, HCV and other preventable harms to drug users.

Recommendations

1. Health Canada should fund the operation and evaluation of further trials of SIFs in other cities in Canada.
2. Federal, provincial/territorial and municipal officials with responsibilities in the areas of health, social services and law enforcement should collaborate to ensure that trials of SIFs can occur as soon as possible in other cities in Canada.

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An Obligation to Act

Since the early 1990s, Canada has been in the midst of a public health crisis related to HIV/AIDS, hepatitis C and injection drug use. Its response to this crisis has been far from concerted and effective. Much more can and must be done to prevent the further spread of HIV and other infections among injection drug users, and to provide care, treatment, and support to those already living with HIV or AIDS. Indeed, much more must be done, because current approaches do not withstand ethical scrutiny.



Another Public Health Tragedy

Canada is in the midst of a public health crisis related to HIV/AIDS, hepatitis C (HCV) and injection drug use. The number of infections attributable to injection drug use has been unacceptably high. In 2003 and the first six months of 2004, injection drug use represented 18% of HIV positive test reports to the CIPDC. Between 55% and 80% of injection drug users test positive for HCV.

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

A marginalized community (in this case injection drug users) is experiencing an epidemic of death and disease resulting not from anything inherent in the drugs that they use, but more from the ineffective and dysfunctional methods that characterize our attempts to control illegal drugs and drug users. There is the same unwillingness to carefully analyze the problem or to depart from traditional methods and conventional thought that was

integral to the blood tragedy. There is a struggle for power and control over the issue between law enforcement and public health. There is a profound lack of understanding among decision-makers and many health professionals regarding the nature of the community and individuals at risk. (Skirrow, 1999)

Much More Must Be Done

The legal status of drugs in Canada contributes to the difficulties encountered in addressing HIV among injection drug users. However, much can be done now within the current legal framework, to facilitate prevention efforts and efforts to provide care, treatment, and support to HIV-positive injection drug users. Indeed, much *must* be done, because current approaches do not withstand ethical scrutiny. As one ethicist has stated (Roy 1999):

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

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

It is *ethically* wrong to continue policies and programs that so unilaterally and utopically insist on abstinence from drug use that they ignore the more immediately commanding urgency of reducing the suffering of drug users and assuring their survival, their health, and their growth into liberty and dignity.

It is *ethically* wrong utterly to neglect to organize the studies needed to deliver the knowledge required to care more adequately for persons who use drugs and are HIV-infected.

It is *ethically* wrong to exclude HIV-infected drug users from participation in clinical trials when that exclusion is based not on scientific reasons but rather on prejudice, discrimination, or simply on considerations of clinical-trial convenience for the investigators.

It is *ethically* wrong to tailor or suppress the information about illegal drugs that individual users,

professionals, and citizens generally need to know in order to act responsibly.

It is *ethically* wrong to set up treatment or prevention programs in such a way that what the program gives with one hand, it takes away with the other.

It is *imperative* that persons who use drugs be recognized as possessing the same dignity as all other human beings.

Much More Must Be Done NOW

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

In 1998, Canada’s Drug Strategy stated that its long term goal was to reduce the harm associated with drugs. Yet the government’s resource allocation reveals that the focus is still very much on reducing the supply of drugs through enforcement of legal prohibitions, at the expense of harm reduction measures. In 2001, Canada’s Auditor General found that 95 percent of the federal government’s expenditures related to illicit drugs

went to supply-reduction initiatives, while spending on harm reduction initiatives was (and continues to be) comparatively very low.

In 1999, the Canadian HIV/AIDS Legal Network released its report on *Injection Drug Use and HIV/AIDS: Legal and Ethical Issues*. In 2001, Health Canada responded to the report and its recommendations with a commitment to “strengthening and expanding efforts with respect to injection drug use.” Also in 2001, five federal/provincial/territorial committees released a document on “reducing the harms associated with injection drug use in Canada.”

Notwithstanding the recognized problem, and the commitments to take action, in 2005, the crisis is ongoing. Governments are continuing half-hearted responses while people continue to become infected in alarming numbers. Implementing the recommendations in the *National Action Plan* and in *Injection Drug Use and HIV/AIDS: Legal and Ethical Issues* must become an urgent priority.

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Roy D. Injection Drug Use and HIV/AIDS: An Ethics Commentary on Priority Issues. In: *Injection Drug Use and HIV/AIDS: Legal and Ethical Issues. Background Papers*. Montréal: Canadian HIV/AIDS Legal Network, 1999. Available via www.aidslaw.ca.

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

Jürgens R. *Facing up to an epidemic: drug policy in Canada*. October 2004. Reviews recent Canadian developments. Available at www.aidslaw.ca/Maincontent/issues/druglaws/040924-OSIDrugPolicy-Kiev.doc

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Third, revised and updated version, 2005.

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Injection Drug Use and HIV/AIDS

This is one of a series of 13 info sheets on legal and ethical issues related to injection drug use and HIV/AIDS.

1. Injection Drug Use and HIV/AIDS in Canada: The Facts
2. The Current Legal Status of Drugs in Canada
3. International Law: Drug Control and Human Rights
4. Drug Use and the Provision of Health & Social Services
5. Treatment
6. Provision of Controlled Drugs
7. Drug Users and Studies of HIV/AIDS & Illegal Drugs
8. Information about the Use and Effects of Drugs
9. Needle Exchange Programs
10. Methadone Maintenance Treatment
11. Safe Injection Facilities
12. An Obligation to Act

13. Essential Resources

Essential Resources

There is a vast amount of literature on injection drug use and HIV/AIDS. This info sheet provides information about a number of selected, essential resources - articles, books, reports, and newsletters that provide crucial information and/or recommendations on injection drug use and HIV/AIDS, particularly legal and ethical issues.



Bewley-Taylor, DR. Challenging the UN drug control conventions: problems and possibilities. *International Journal of Drug Policy* 2003; 14: 171-179. Outlines the international treaties on drug control and factors to consider in how these could be changed to support harm reduction approaches.

Beyerstein B, Alexander B. Why treat doctors like pushers? *Canadian Medical Association Journal* 1985; 132: 337-340. Criticizes the prohibitionist approach to drug policy in Canada in which doctors are vulnerable to prosecution as traffickers for prescribing narcotics. Advocates that Canadian doctors should have the legal authority to prescribe drugs according to their judgment of patient needs.

Breaking Down Barriers: Lessons on Providing HIV Treatment to Injection Drug Users. International Harm Reduction Development Program, Open Society Institute, 2004. Available via www.soros.org/initiatives/ihrd/articles_publications/publications.

Bruckner T. The Practical Guide To The Controlled Drugs and Substances Act. Toronto: Thomson Canada Limited, 1997. Discusses the provisions of the *Controlled Drugs and Substances Act* and provides

commentary on the difficulties that some of the provisions raise for the treatment of patients who are drug users.

Canadian Centre on Substance Abuse & Canadian Public Health Association. HIV, AIDS and Injection Drug Use: A National Action Plan. Ottawa: The Centre & The Association, 1997. Emphasizes that "Canada is in the midst of a public health crisis concerning HIV and AIDS, and injection drug use," and that "[i]mmediate action is required at all levels of governmental and community leadership." Contains numerous recommendations. Available at www.ccsa.ca.

Canadian Centre on Substance Abuse. Canadian Addiction Survey: Prevalence of Use and Related Harms. November 2004. Available via www.ccsa.ca.

Canadian Centre on Substance Abuse. Needle Exchange Programs: Frequently Asked Questions. Ottawa: The Centre, 2004. Available at www.ccsa.ca.

Canadian Centre on Substance Abuse. Supervised Injection Facilities: Frequently Asked Questions. Ottawa: The Centre, 2004. Available at www.ccsa.ca.

Canadian HIV/AIDS Legal Network. Injection Drug Use and HIV/AIDS: Legal and Ethical Issues. Montréal, 1999. The report on which this series of info sheets is based. The report is accompanied by a companion volume of three background papers on legal, ethical and policy issues discussing each of the areas covered in the main report in more detail. See also Health Canada's response to the report (*infra*, Health Canada, 2001). Available at www.aidslaw.ca/Maincontent/issues/druglaws.htm.

Clark PA. The ethics of needle-exchange programs. *AIDS & Public Policy Journal* 1998; 13(4): 131-139. Concludes that needle-exchange programs are "both a necessary and a vital part of a broader comprehensive strategy for preventing HIV transmission among intravenous-drug users."

Elliott R, Malkin I, Gold J. Establishing Safe Injection Facilities in Canada: Legal and Ethical Issues. Montréal: Canadian HIV/AIDS Legal Network, 2002. Everything you need to know about SIFs. Available at www.aidslaw.ca/Maincontent/issues/druglaws.htm.

Elliott, R. Drug control, human rights, and harm reduction in the age of AIDS. *HIV/AIDS Policy and Law Review* 2004; 9(3): 86-90. An overview

of the UN drug control regime and the relationship between harm reduction and human rights. Available via www.aidslaw.ca/Maincontent/otherdocs/Newsletter/newsletter.htm.

Erickson PG, DM Riley, YW Cheung, PA O'Hare. *Harm Reduction: A New Direction for Drug Policies and Programs*. Toronto: University of Toronto Press, 1997. A collection of papers originally presented at the Fifth International Conference on the Reduction of Drug-Related Harm, Toronto, Canada, March 1994.

Federal/Provincial/Territorial Committee on Injection Drug Use. *Reducing the Harm Associated with Injection Drug Use in Canada*. Ottawa: March 2001. Available at www.hc-sc.gc.ca/hecs-sesc/cds/pdf/injectiondrug_e.pdf. Acknowledges the severity of the problem, and maps out what governments could and should do.

Fischer B. Prescriptions, power, and politics: the turbulent history of methadone maintenance in Canada. *Journal of Public Health Policy* 2000; 21(2): 187-210. Traces the turbulent history in Canada of methadone treatment, regulations and policy. Concludes that the regulations and policy have hindered the treatment of drug-dependent persons.

Hankins C. Syringe exchange in Canada: good but not enough to stem the HIV tide. *Substance Use and Misuse* 1998; 33: 1129. Discusses the history and current deficiencies of needle exchange programs in Canada.

Health Canada. *Hepatitis C & Injection Drug Use*. Ottawa: 2001. Available at www.phac-aspc.gc.ca/hepc/hepatitis_c/pdf/aboutFactsSheet1.pdf.

Health Canada. *Injection Drug Use and HIV/AIDS. Health Canada's Response to the Report of the Canadian HIV/AIDS Legal Network*. Ottawa: 2001. Health Canada's response to the 1999 report on *Injection Drug Use and HIV/AIDS: Legal and Ethical Issues* by the Canadian HIV/AIDS Legal Network. Available at www.aidslaw.ca/Maincontent/issues/druglaws.htm.

Health Canada. *I-Track: Enhanced Surveillance of Risk Behaviours among Injecting Drug Users in Canada. Pilot Survey Report*. February 2004. A study of infectious diseases among injection drug users at various sites across Canada. Available at www.phac-aspc.gc.ca/i-track/index.html.

Health Canada. *HIV/AIDS Epi Update: HIV/AIDS Among Injecting Drug Users in Canada (and Risk Behaviours Among Injecting Drug Users in Canada)*. Ottawa: May 2004. Essential info about the HIV/AIDS epidemic among injection drug users in Canada, with numerous references. Regularly updated. Available at www.phac-aspc.gc.ca/publicat/aids-sida/index.html.

***HIV/AIDS in Prisons: Info Sheets*. Canadian HIV/AIDS Legal Network, 4th edition, 2005.** A set of info sheets with essential information on HIV/AIDS and drug use in prisons. Available at www.aidslaw.ca/Maincontent/issues/prisons.htm.

Human Rights Watch. *Abusing the Users: Police Misconduct, Harm Reduction and HIV/AIDS in Vancouver*. New York: HRW, May 2003. Looks at the human rights abuses against drug users in Vancouver's Downtown Eastside.

Hunt, Neil. *A Review of the Evidence-Base for Harm Reduction Approaches to Drug Use*. Forward Thinking on Drugs Research Paper, 2003. A comprehensive review of harm reduction initiatives and the evidence that has been gathered in support.

Joint United Nations Programme on AIDS. *Drug Use and HIV/AIDS*. UNAIDS Statement Presented at the United Nations General Assembly Special Session on Drugs. Geneva: UNAIDS Best Practice Collection Key Material, March 1999 (UNAIDS 99.1E). Significantly, this UNAIDS statement endorses a harm-reduction approach to drug use. Available via www.unaids.org.

Jürgens R. *Facing up to an epidemic: drug policy in Canada*. October 2004. Reviews recent Canadian developments. Available at www.aidslaw.ca/Maincontent/issues/druglaws/040924-OSIDrugPolicy-Kiev.doc.

Kerr T, Jürgens R. *Methadone Maintenance Therapy in Prisons: Reviewing the Evidence*. Canadian HIV/AIDS Legal Network, 2004. Available via www.aidslaw.ca/Maincontent/issues/prisons.htm. A short backgrounder with key facts and arguments supporting access to MMT for prisoners.

Kerr T, Jürgens R. *Syringe Exchange Programmes in Prisons: Reviewing the Evidence*. Canadian HIV/AIDS Legal Network, 2004. Available via www.aidslaw.ca/Maincontent/issues/prisons.htm. A short backgrounder with key facts and arguments supporting programs to provide prisoners with access to sterile injecting equipment.

Lines R et al. *Prison Needle Exchange: Lessons from a Comprehensive Review of International Evidence and Experience*. Canadian HIV/AIDS Legal Network, 2004. Available at www.aidslaw.ca/Maincontent/issues/prisons.htm. Provides the most comprehensive global review to date of prison needle exchange programs. An essential reference for anyone working on these issues.

MacFarlane B. *Drug Offences In Canada*. Toronto: Canada Law Book Inc, 3rd edition, 1997. Provides a comprehensive discussion of drug laws in Canada.

Malinowska-Sempruch K & Gallagher S, eds. *War on Drugs, HIV/AIDS and Human Rights*. International Debate Education Association, 2004. A collection of essays by leading thinkers and activists working in the areas of harm reduction, drug policy and human rights.

McAmmond D. *Care, Treatment and Support for Injection Drug Users Living with HIV/AIDS: A Consultation Report*. Ottawa: Health Canada, March 1997. Identifies issues that need to be addressed in order to provide effective HIV/AIDS care, treatment, and support to injection drug users (particularly those who are street-involved or marginalized), and proposes initiatives that might begin to address these issues.

MacPherson D. *A Framework for Action: A Four Pillar Approach to Drug Problems in Vancouver*. City of Vancouver: 2001 (2nd, revised version). Sets out a coordinated, multi-faceted response Vancouver's drug problem. Available at www.city.vancouver.bc.ca/fourpillars. See also a review of the framework by Skirrow in the *Canadian HIV/AIDS Policy & Law Review* 2001; 6(1/2): 89-91 (available via www.aidslaw.ca/Maincontent/otherdocs/Newsletter/newsletter.htm).

Malinowska-Sempruch, Hoover J et al. *Unintended Consequences: Drug Policies fuel the HIV epidemic in Russia and Ukraine*. New York: Open Society Institute, 2003. A policy report prepared for the UN Commission on Narcotic Drugs and national governments.

Millar J. *HIV, Hepatitis, and Injection Drug Use in British Columbia- Pay Now or Pay Later?* Office of the Provincial Health Officer, BC Ministry of Health, 1998. The report of the provincial health officer in British Columbia, stating that "the continuation of this epidemic [of HIV among injection drug users] represents a failure of societal values and attitudes." With many recommendations.

Poulin C et al. The epidemiology of cocaine and opiate abuse in urban Canada. *Canadian Journal of Public Health* 1998; 89 (4):234-238. Data pertaining to prevalence of use, law enforcement, treatment, morbidity and mortality, from Vancouver, Calgary, Montréal, Toronto, Winnipeg and Halifax.

Protecting the Human Rights of Injection Drug Users: The Impact of HIV and AIDS. International Harm Reduction Development Program, Open Society Institute, 2005. Available via www.soros.org/initiatives/ihrd/articles_publications/publications.

Rehm J, Fischer B & Haydon E, eds. *Reducing the Risks, Harms and Costs of HIV/AIDS and Injection Drug Use (IDU)*. Ottawa: Health Canada, 2003. A synthesis of the evidence base for development of policies and programs. Conference Paper 4, prepared for 2nd International Policy Dialogue on HIV/AIDS, Warsaw, Poland, 12-14 November 2003.

Riley D. *An Overview of Harm Reduction Programs and Policies around the World*. Ottawa: Health Canada, 2003. Conference paper for the 2nd International Policy Dialogue on HIV/AIDS, 12-14 November 2003, Warsaw, Poland. Reviews the rationale, key features and examples of best practice internationally.

Sherer R. Adherence and antiretroviral therapy in injection drug users. *Journal of the American Medical Association* 1998; 280(6): 567-566. Presents reasons for which doctors are reluctant to prescribe antiretroviral therapy (ART) to injection drug users. Suggests ways in which injection drug users can adhere to the medical regimen of ART.

Solomon RM, Usprich SJ. Canada's drug laws. *Journal of Drug Issues* 1991; 21(1): 17-40. Traces the history of Canadian drug legislation until 1991 - legislation that, they argue, originated and developed in response to racial and political factors rather than reasoned analysis.

Strathdee S et al. Barriers to use of free antiretroviral therapy in injection drug users. *Journal of the American Medical Association* 1998; 280: 547. A Canadian study that found that many HIV-positive injection drug users are not receiving ART.

Strathdee S et al. Needle exchange is not enough: lessons from the Vancouver injecting drug use study. *AIDS* 1997; 11(8): F59-65. Concludes that while needle exchange programs are crucial, they are only one component of a comprehensive program that should include counselling, support and education.

Ward J, Mattick RP, Hall W (eds). *Methadone Maintenance Treatment and Other Opioid Replacement Therapies*. Amsterdam: Harwood Academic Publishers, 1998. An excellent book with 18 articles on all aspects of methadone maintenance treatment and other opioid replacement therapies.

WHO/UNODC/UNAIDS Position Paper: *Substitution maintenance therapy in the management of opioid dependence and HIV/AIDS prevention*. Geneva, 2004. Available via www.who.int/substance_abuse/publications/treatment.

Establishes a joint position in support of substitution maintenance therapy, including the provision of such therapy to people living with HIV/AIDS.

Wolfe D & Malinowska-Sempruch K. *Illicit Drug Policies and the Global HIV Epidemic: Effects of UN and National Government Approaches*. New York: International Harm Reduction Development, Open Society Institute, 2004. Reviews UN and national government responses to injection drug use as human rights violations which contribute to the spread of HIV.

Wood, E et al. Methodology for evaluating Insite: Canada's first medically supervised safer injection facility for injection drug users. *Harm Reduction Journal* 2004, 1:9. Provides preliminary observations on the Insite project and outlines the process for further evaluation of the SIFs impacts. Available at www.harmreductionjournal.com/content/1/1/9.

World Health Organisation. *Effectiveness for sterile needle and syringe programming in reducing HIV/AIDS among injection drug users (Evidence for action technical papers)*, Geneva, 2004. An evaluation of the available research regarding the effectiveness of needle exchange programmes in reducing the risk of HIV transmission among injection drug users. Available at www.who.int/hiv/pub/prev_care/en/effectivenesssterileneedle.pdf.

Journals and Websites

HIV/AIDS Policy & Law Review
Required reading for all those working on, or interested in, HIV/AIDS and drug policy in Canada and internationally. Available at www.aidslaw.ca/Maincontent/otherdocs/Newsletter/newsletter.htm.

International Journal of Drug Policy
The official journal of the International Harm Reduction Association (www.ihra.net/). Publishes material on the social, political, legal, and health contexts of psychoactive substance use, both licit and illicit. Order info at www.elsevier.com/locate/drugpo.

www.ahrn.net

The website of the Asian Harm Reduction Network, with an extensive collection of information and documents about drug use and harm reduction in the region, including the AHRN newsletter.

www.aidslaw.ca

The website of the Canadian HIV/AIDS Legal Network. Contains a section on drug laws and drug policies (at www.aidslaw.ca/Maincontent/issues/druglaws.htm), and numerous articles on the subject published in the *HIV/AIDS Policy & Law Review*.

http://canadianharmreduction.com/

The website of Canadian Harm Reduction Network, which is dedicated to reducing the social, health, and economic harms associated with drugs and drug policies.

www.ccsa.ca

The website of the Canadian Centre on Substance Abuse. Features articles and news on subjects such as hepatitis and injection drug use; harm reduction: concepts and practice; syringe exchange, etc.

www.ceehrn.org

The website of the Central and Eastern European Harm Reduction Network. Contains extensive information and documentation about drug use and harm reduction in the region, including sections on prisons, sex work and substitution treatment.

www.cfdp.ca

The Canadian Foundation for Drug Policy's site. Canada's most comprehensive resource about drug law and policy reform.

www.drugpolicy.org

The excellent website of the Drug Policy Alliance (formerly the Lindesmith Center). Features a searchable database of thousands of library documents from both academic and popular literature focusing on drug policy from economic, criminal justice, and public health perspectives, a subject index of full-text materials online, and a great list of links to other sites.

www.hrw.org

The website of Human Rights Watch. Contains reports from various countries documenting human rights violations against drug users.

www.ihra.net

Website of the International Harm Reduction Association, which organizes international conferences on harm reduction and publishes the *International Journal of Drug Policy*.

www.relard.net

Website of the Latin American Harm Reduction Network, primarily with information in Portuguese and Spanish, with some limited information in English.

www.soros.org/initiatives/ihrd

Website of the International Harm Reduction Development Program of the Open Society Institute, in New York City. Contains extensive information and many excellent publications on harm reduction, drug policy and human rights, including the newsletter *Harm Reduction News*.

For More Resources ...

contact the Canadian HIV/AIDS Legal Network at info@aidslaw.ca

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