

Drug policy and human rights: the Canadian context

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I. Human rights and drug policy

Canada is a party to the three main UN drug control conventions, which aim to control illicit drugs by reducing supply and demand, in particular through requiring States Parties to adopt varying degrees of prohibitions and sanctions on a range of designated controlled substances, while also providing some degree of (often contested) flexibility for States Parties in their approach.¹ Yet Canada must also fulfill its domestic constitutional obligations under the *Canadian Charter of Rights and Freedoms*, as well as those under international human rights law, including the *International Covenant on Economic, Social and Cultural Rights*, the *International Covenant on Civil and Political Rights*, the *Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment* and other core human rights treaties, all of which Canada has ratified.

When poorly developed and implemented, drug policies can lead to serious human rights violations, including police harassment and violence, arbitrary detention, disproportionate sentencing and incarceration, torture and other ill-treatment, discrimination, and violations of the right to health. Yet this flies in the face of “the health and welfare of mankind” which is ostensibly the foundational concern

¹ United Nations, *Single Convention on Narcotic Drugs* (1961), as amended by the 1972 Protocol amending the *Single Convention on Narcotic Drugs*; United Nations, *Convention on Psychotropic Substances* (1971); United Nations, *Convention against Illicit Traffic in Narcotic Drugs and Psychotropic Substances* (1988).

of the international drug control regime² -- or, as described by the United Nations Office on Drug and Crime (UNODC), that “one of the stated aims of the international drug control conventions is to protect the health of individuals and society from the dangerous effects of drug use.”³ Ill-advised drug policy can not only exacerbate the harms sometimes associated with the use of controlled substances, but also contribute to the risk of other preventable harms, including blood-borne infections such as HIV and hepatitis C virus (HCV) and overdoses. Under international law, Canada must respect, protect and fulfil the right to life⁴ and the right of “everyone to enjoy the highest attainable standard of physical and mental health.”⁵ Under the latter obligation, States Parties have a binding legal obligation to take steps to realize the right to health, including steps “necessary for... prevention, treatment and control of epidemic, endemic... and other diseases” and “the creation of conditions which would assure to all medical services and medical attention in the event of sickness.”⁶

Such human rights obligations bind the state in its response to drugs. Indeed, UN Member States at the Commission on Narcotic Drugs (CND) have repeatedly reaffirmed that their responses to “the world drug problem” must be carried out “in full conformity with the purposes and principles of the Charter of the United Nations and other provisions of international law and, in particular, with full respect for ... all human rights and fundamental freedoms...”⁷ They have also specifically recognized that “there is an insufficient emphasis on human rights and dignity in the context of drug demand reduction efforts, in particular regarding access to the highest attainable standard of health services,” and therefore there is a need to “ensure that drug demand reduction measures respect human rights and the inherent dignity of all individuals and facilitate access for all drug users to prevention services and health-care and social services, with a view to social reintegration.”⁸ The CND has reiterated this more recently, with states again recognizing “the need to base programmes for the treatment and rehabilitation of drug use disorders on scientific evidence while respecting human rights and human dignity.”⁹

The UN General Assembly has also repeatedly recognized that all aspects of States’ responses to drugs must be in conformity with human rights standards – including in the *Political Declaration* on “the world drug problem” adopted by the 1998 UN General Assembly Special Session on Drugs,¹⁰ then again a decade later following the global review of the implementation of that Declaration,¹¹ and most recently in its December 2014 resolution regarding its upcoming special session on the subject in 2016.¹² These

² E.g., see the first clause of the Preamble to the 1961 Single Convention.

³ UNODC, *From coercion to cohesion: Treating drug dependence through health care, not punishment. Discussion paper based on a scientific workshop held in Vienna from 28 to 30 October 2009*, 2010, p. 1.

⁴ *International Covenant on Civil and Political Rights* (1966), 993 UNTS 3, Article 6.

⁵ *International Covenant on Economic, Social and Cultural Rights*, Article 12(1).

⁶ *International Covenant on Economic, Social and Cultural Rights*, Article 12(2).

⁷ CND Resolution 51/12 (2008), UN Doc. E/CN.7/2008/15; *Political Declaration and Plan of Action on International Cooperation towards an Integrated and Balanced Strategy to Counter the World Drug Problem*, in Commission on Narcotic Drugs, Report of the Fifty-second Session, ECOSOC Official Reports, 2009, Supp. No. 8, UN Doc. E/2009/28, E/CN.7/2009/12 (pp. 37ff). See also subsequent resolutions: CND Resolution 53/2 (2010), UN Doc. E/CN.7/2010/18; UN Doc. E/CN.7/2010/18 (pp. 8-10); CND Resolution 53/8 (2010), UN Doc. E/CN.7/2010/18 (pp. 24-26).

⁸ CND, *Political Declaration* (2009), *supra*, at paras. 5, 6(a).

⁹ CND Resolution 54/5 (2011), in Commission on Narcotic Drugs, Report on the fifty-fourth session, ECOSOC Official Reports 2011, Supp. No. 8, UN Doc. E/CN.7/2011/15 (p. 12).

¹⁰ UN General Assembly, Resolution S-20/2 (1998), UN Doc. A/RES/S-20/2.

¹¹ UN General Assembly, Resolution 64/182 (2009), UN Doc. A/RES/64/182.

¹² UN General Assembly, Resolution 69/200 (2014), UN Doc. A/RES/69/200.

are but a few of the numerous occasions on which UN Member States have declared that drug control efforts must comply with human rights.¹³

Despite these repeated pronouncements, in implementing the international drug control conventions, most countries have adopted a predominantly repressive approach to drug policy, focusing heavily on reducing supply through law-enforcement strategies and losing sight of one of the conventions' main objectives to promote the "health and welfare of mankind."¹⁴ This is perhaps not surprising, given the overall orientation of the conventions themselves toward measures of prohibition and punishment; the flexibilities that do exist, to some degree, under the conventions have often been disregarded or narrowly interpreted by Member States (with some important exceptions).

It is now increasingly recognized that repressive drug control laws and policies around the world have failed to fight crime or reduce drug use and drug-related harm, but have rather contributed to mounting human rights violations against people who use drugs and fueled the HIV and HCV epidemic by undermining access to harm reduction services and treatment for people who use drugs. It is in this context that international experts, including the Global Commission on Drug Policy¹⁵ and the Global Commission on HIV and the Law,¹⁶ as well as the UN Special Rapporteur on the right to the highest attainable standard of health,¹⁷ have urged States to end failed policies and adopt an approach to drug policy respectful of human rights and public health principles. In particular, the Global Commission on Drug Policy has called on States to prioritize community health and safety in designing drug policies by ending the criminalization and marginalization of people who use drugs, investing in evidence-based prevention, health and treatment for those in need (including harm reduction services), focusing repressive actions on violent criminal organizations in ways that undermine their powers and reach, while prioritizing the reduction of violence and allowing and encouraging diverse experiments in legally regulating markets.¹⁸

The 2016 UN General Assembly Special Session on Drugs (UNGASS) represents an important opportunity for the international community to engage in an open dialogue on drug policy and finally move away from the "war on drugs" – whose many harms include systemic and widespread violations of human rights. Because human rights and drug policy are inevitably linked, the Office of the High Commissioner for Human Rights (OHCHR) and the Human Rights Council each has an important role to play in this

¹³ See also the following General Assembly Resolutions: Resolution 60/178 (2005), UN Doc. A/RES/60/178; Resolution 61/183 (2006), UN Doc. A/RES/61/183; Resolution 62/176 (2007), UN Doc. A/RES/62/176; Resolution 63/197, UN Doc. A/RES/63/197 (2008); Resolution 65/233 (2010), UN Doc. A/RES/65/233; Resolution 66/183 (2011), UN Doc. A/RES/66/183; Resolution 67/193 (2012); UN Doc. A/RES/67/193; Resolution 68/197 (2013), UN Doc. A/RES/68/197.

¹⁴ Preamble to the 1961 *Single Convention on Narcotic Drugs*.

¹⁵ Global Commission on Drug Policy, *War on drugs. Report of the Global Commission on Drug Policy*, 2011; *The War on drugs and HIV/AIDS. How criminalization of drug use fuels the global pandemic. Report of the Global Commission on Drug Policy*, 2012; *The Negative impact of the war on drugs on public health: the hidden hepatitis C epidemic. Report of the Global Commission on Drug Policy*, 2013.

¹⁶ Global Commission on HIV and the Law, *Risks, Rights and Health*, July 2012.

¹⁷ UN, General Assembly, *Report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health*, A/65/255 (August 6, 2010).

¹⁸ Global Commission on Drug Policy, *War on Drugs: Report of the Global Commission on Drug Policy*, 2011; *The War on drugs and HIV/AIDS – How criminalization of drug use fuels the global pandemic: Report of the Global Commission on Drug Policy*, 2012; Global Commission on Drug Policy, *Taking control. Pathways to drug policies that work*, 2014; all online www.globalcommissionondrugs.org.

discussion. We welcome the March 2015 resolution of the Human Rights Council requesting the OHCHR to prepare a study of this issue, and are pleased to submit this commentary regarding certain human rights implications of drug policy in the context of a particular Member State.

II. Drug policy in Canada: the context

As described by the Global Commission on Drug Policy, “[p]unitive approaches to drug policy are severely undermining human rights in every region of the world.”¹⁹ Canada is no exception. Human rights violations continue to occur in the context of Canada’s implementation of a punitive drug strategy, including violations of the right to life, the right to health, the prohibition on arbitrary detention and ill treatment, and the right to equality and non-discrimination. The health and other human rights of Indigenous people in Canada continue to be particularly adversely affected.

The Government of Canada launched a new National Anti-Drug Strategy in 2007. In contrast with previous national strategies, which reflected a widespread national consensus among service providers, researchers and affected populations, this new strategy eliminated the long-standing element of *harm reduction* as part of the Government’s response to drugs, a retrogressive step putting people who use drugs at increasing risk of harm. Harm reduction includes such evidence-based health services as needle and syringe programs (NSPs) and supervised consumption services (SCS), which prevent overdose and the transmission of communicable diseases such as HIV and HCV, and can increase access to treatment and to other health and social services.

Instead, the new strategy expanded a punitive approach to drug policy in Canada, with the bulk of new funding focused on enforcement of criminal prohibitions related to substances scheduled under the *Controlled Drugs and Substances Act*.²⁰ A review conducted in 2009 showed that law enforcement received the overwhelming majority of funding for the drug strategy (70%) while prevention (4%), treatment (17%) and harm reduction (2%) combined only received a quarter of the overall funding.²¹ The federal government’s punitive approach to drugs continue to be accompanied by new “tough on crime” laws, including legislation introducing mandatory minimum sentences for certain drug-related offenses despite health and human rights, and active attempts from the federal government to prevent the implementation of new harm reduction programs across the country.

III. Specific human rights concerns resulting from Canada’s approach to drug policy

Right to life

The hostility of the Government of Canada to harm reduction is costing lives by preventing access to evidence-based health services that prevent overdoses and disease, even where local governments have been supporting of their implementation.

This hostility has been most evident with regard to Insite, Vancouver’s supervised injection facility, which has decreased deaths from overdose in addition to decreasing syringe-sharing and the risk of HIV

¹⁹ Global Commission on Drug Policy, *Taking control. Pathways to drug policies that work*, 2014, p. 12.

²⁰ Canadian Drug Policy Coalition, *Getting to tomorrow: a report on Canadian drug policy*, 2013, online: http://drugpolicy.ca/report/CDPC2013_en.pdf;

²¹ K. De Beck et al., “Canada’s new federal ‘National Anti-Drug Strategy’: an informal audit of reported funding allocation,” *International Journal of Drug Policy* 2003; 20(2):188-191.

and HCV transmission, and increasing referrals to addiction treatment services.²² Despite Insite's proven effectiveness in protecting the life and health of people who use drugs, the Government signaled it would likely discontinue the legal exemption from the *Controlled Drugs and Substances Act* that permits it to operate without risk of clients or staff being criminally prosecuted for drug possession; this prompted court actions seeking to preserve the exemption so as to allow Insite to continue operating. The Government then appealed initial court decisions upholding Insite's exemption as a matter of constitutional rights.

Finally, in September 2011, the Supreme Court of Canada ruled unanimously that Canada had unconstitutionally violated the human rights of people with addictions – specifically, the rights to life, liberty and to security of the person protected by Canada's *Charter of Rights and Freedoms*.²³ The Court found that the government's effective decision to deny an exemption to Insite was "arbitrary," in that it undermined public health and safety, which are ostensibly the very purposes of Canada's drug laws. The Court said such a decision was also "grossly disproportionate," since "the potential denial of health services and the correlative increase in the risk of death and disease to injection drug users outweigh any benefit that might be derived from maintaining an absolute prohibition on possession of illegal drugs on Insite's premises." As the Court declared: "Insite saves lives. Its benefits have been proven." It ruled that shuttering Insite would constitute an impermissible violation of the human rights of some of those who are most vulnerable; the criminal prohibition on drug possession could not be allowed to extend so far as to impede access to such health services for people with addictions. The Court therefore ordered the Minister to grant an ongoing exemption to Insite to protect these human rights.

Several projects to implement supervised consumption services are being considered across Canada. However, Bill C-2, *An Act to amend the Controlled Drugs and Substances Act*, was introduced by the federal government in response to the Supreme Court's ruling in the Insite case. Currently before the federal Parliament, Bill C-2 will create unreasonable barriers to their implementation. Contrary to the letter and spirit of the Supreme Court of Canada's decision protecting human rights, the bill provides that exemptions will only be granted in "exceptional circumstances" and set out onerous conditions purposely designed to impede the establishment of supervised consumption services.²⁴

While data on the number of people dying of overdose in Canada is limited and partial, the available figures indicate that overdose deaths due to medical and non-medical drug use are now a significant source of mortality (e.g., the third leading cause of accidental death in Ontario), with opioid deaths on

²² For a two-page summary of research findings about Insite, see Urban Health Research Institute, BC Center for Excellence in HIV/AIDS, *Insight into Insite*, 2010, available at http://www.cfenet.ubc.ca/sites/default/files/uploads/docs/insight_into_insite.pdf. For a more in-depth view of research studies (including many of the studies cited in this document), see BC Center for Excellence in HIV/AIDS, Vancouver Coastal Health and Urban Health Research Institute, *Findings from the evaluation of Vancouver's Pilot Medically Supervised Safer Injecting Facility – Insite*, revised in 2009, available at http://uhri.cfenet.ubc.ca/images/Documents/insite_report-eng.pdf

²³ *Canada (Attorney General) v. PHS Community Services Society*, 2011 SCC 44.

²⁴ Bill C-2, *An Act to amend the Controlled Drugs and Substances Act*. The text of Bill C-2 is available at <http://www.parl.gc.ca/LEGISInfo/BillDetails.aspx?Mode=1&billId=6254806&Language=E>. For more information about Bill C-2 and its implications for the implementation of supervised consumption services in Canada, see Canadian HIV/AIDS Legal Network, Canadian Drug Policy Coalition, *An Injection of Reason: Critical Analysis of Bill C-2*, 2014 at <http://www.aidslaw.ca/site/an-injection-of-reason-critical-analysis-of-bill-c-2/>

the rise in recent years in several provinces.²⁵ Other measures, in addition to supervised consumption services, can be taken to reduce overdose death, such as making naloxone (a treatment for opioid overdose recommended by the World Health Organization) more readily available and cost effective and by reducing the barriers to calling emergency services during a drug overdose. But again, current policy and legislation hinder these efforts. For example, because of the way it is regulated, naloxone can only be dispensed with a prescription, which limits access to people who use drugs, their family and friends. The criminalization of drug use and possession in Canada also deter witnesses of overdoses from calling emergency services. In the United States, several states have passed “Good Samaritan immunity” laws in recognition that fear of criminal justice involvement should not be a barrier to calling an ambulance in the event of an overdose. But there is no such legislation in Canada.²⁶

Right to health

According to the UN Committee on Economic, Social and Cultural Rights (CESCR), one core aspect of the right to health is the obligation “[t]o ensure the right of access to health facilities, goods and services on a non-discriminatory basis, especially for vulnerable or marginalized groups.”²⁷ Yet the Government of Canada has opposed evidence-based harm reduction programs and even taken “deliberately retrogressive measures,” which the CESCR has noted presumptively violate the right to health.²⁸

The most recent surveillance data indicates that 12.8% of new HIV infections in Canada are attributable to injection drug use.²⁹ Harm reduction programs, including needle and syringe programs (NSP) and supervised consumption services (SCS) are proven to lessen the harms associated with drug use, including by reducing transmission of HIV and HCV. They are, therefore, essential for protecting the right to health of people who use drugs, yet multiple barriers hinder access to these programs in Canada – including the federal government’s current, active efforts to make it impossible or very difficult to open new SCS in Canada (see discussion of Bill C-2 above).

Similarly, access to treatment for problematic substance use, including opioid substitution therapy (OST), is limited and can greatly vary from one province to another. Because the focus has been put on law enforcement rather than public health, treatment and harm reduction services are generally underfunded across the country³⁰ and in some provinces bylaws have been enacted to prevent the

²⁵ Canadian Drug Policy Coalition, *Opioid overdose prevention and response in Canada*, 2013; other statistics from coroners’ offices and health ministries (obtained by Pivot Legal Society in 2015 and on file).

²⁶ Ibid.

²⁷ UN Committee on Economic, Social, and Cultural Rights, *General Comment 14: The right to the highest attainable standard of health*, 22nd Sess., (2000) UN Doc E/C.12/2000/4, para. 43(a).

²⁸ UN Committee on Economic, Social, and Cultural Rights, *General Comment 3: The nature of States parties’ obligations*, 5th Sess., (1990) UN Doc E/1991/23, para. 9; and see CESCR, *General Comment 14*, *ibid.*, paras. 32 and 48.

²⁹ Public Health Agency of Canada, *HIV and AIDS in Canada. Surveillance report to December 31, 2013* (2014), online: <http://www.phac-aspc.gc.ca/aids-sida/publication/survreport/2013/dec/assets/pdf/hiv-aids-surveillance-eng.pdf>.

³⁰ Canadian Drug Policy Coalition, *Getting to tomorrow: a report on Canadian drug policy* (2013), online: http://drugpolicy.ca/report/CDPC2013_en.pdf; A. Klein, *Sticking Points: Barriers to access to needle and syringe programs in Canada* (Canadian HIV/AIDS Legal Network, 2007), online: <http://www.aidslaw.ca/site/sticking-points-barriers-to-access-to-needle-and-syringe-programs-in-canada/>.

implementation of methadone clinics or NSPs as a result of persisting stigma and discrimination against people who use drugs.³¹

Unnecessary barriers to heroin-assisted treatment (HAT) for those for whom other treatment options (opioid substitution or abstinence-based treatment) have failed is yet another example of how a punitive, prohibitionist approach to illicit drugs continues to prevent access to evidence-based health services in Canada, with terrible consequences for the most vulnerable people who use heroin. Studies, including those conducted in Canada, have shown that prescribing heroin in a supervised, medical setting can improve physical and mental-health, increase retention rates, reduce illicit “street” heroin use and money spent on drugs as well as criminal activity.³² In 2013, Health Canada authorized British Columbia doctors to prescribe diacetylmorphine (the active ingredient of heroin) to a number of individuals who participated to a successful but ending research trial. This authorization is the result of advocacy efforts by the participants themselves who realized that, were this any other health issue, people would not have been denied access to effective treatment. Shortly thereafter, the Federal Minister of Health not only condemned officials in her department (Health Canada) but introduced new regulations criminalizing the prescriptions, interfering with the evidence-based practice of medicine by physicians and denying access to treatment to those for whom it had been clinically indicated. A constitutional challenge to those new regulations is now before the courts.³³

Guaranteeing access to medical cannabis is another example of a constitutional battle that individuals and organizations have been forced to undertake as a result of Canadian drug policy – it is only through repeated bouts of constitutional litigation in Canada’s courts that patients have secured access (still often inadequate and burdened with multiple barriers) to cannabis for medicinal use as a matter of human rights under the country’s *Charter of Rights and Freedoms*. Relying on courts’ decisions to safeguard the right to health of people who use drugs is costly and time-consuming, and it is certainly not an acceptable alternative to policy based on human rights, public health and evidence.

Arbitrary detention, torture and other forms of ill treatment

Canada’s punitive approach to drugs has resulted over the past decade in restrictions on the use of conditional sentences or probation, and for the first time, the introduction of mandatory minimum sentences in the *Controlled Drugs and Substances Act*. Evidence shows that mandatory prison terms for drug offences are not effective in reducing crime or illicit drug use, but impose significant human and societal costs while undermining public health³⁴—thereby impeding the realization of the right to the highest attainable standard of health. Despite warnings from the United States, where mandatory

³¹ E.g. “Anti-Harm Reduction Bylaw Challenge Accepted By BC Human Rights Tribunal,” *Abbotsford Today*, July 18, 2013, available at <http://www.abbotsfordtoday.ca/anti-harm-reduction-bylaw-challenge-accepted-by-bc-human-rights-tribunal/>; see also various letters from the Ontario Human Rights Commission to several Ontario municipalities expressing concern with discriminatory by-laws or other measures impeding operation of methadone clinics for people with opioid dependence: <http://www.ohrc.on.ca/en/search/site/methadone>.

³² NAOMI Team, *Reaching the Hardest to Reach –Treating the Hardest-to-Treat, Summary of the Primary Outcomes of the North American Opiate Medication Initiative (NAOMI)*, 2008.

³³ D. King, “The HAT Injunction, what does it mean?” posted on May 29, 2014, available at http://www.pivotlegal.org/the_hat_injunction_what_does_it_mean.

³⁴ Canadian HIV/AIDS Legal Network, *Brief to the Standing Senate Committee on Legal and Constitutional Affairs, in relation to the Committee’s study on Bill C-10 (2012)*, available at http://www.aidslaw.ca/site/wp-content/uploads/2013/04/Senate-brief_C-10_2012-ENG.pdf; “Mandatory Minimum Sentences for Drug Offences: Why Everyone Loses,” Briefing Paper (Canadian HIV/AIDS Legal Network, 2006), online: <http://www.aidslaw.ca/site/mandatory-minimum-sentences-for-drug-offences-why-everyone-loses/>.

minimum sentences for drug offences have resulted in a dramatic explosion of the prison population,³⁵ and despite concerns about the negative social and health impact of such policies expressed by Canadian public health officials, jurists, criminologists and other drug policy and human rights experts,³⁶ the so-called *Safe Streets and Communities Act* became law in 2012. Contrary to the federal government's claim that the law only targets "serious drug crimes," new mandatory minimum sentences are likely to disproportionately affect individuals from vulnerable and marginalized populations, such as people struggling with problematic substance use, Aboriginal people and other disadvantaged groups, thus perpetuating systemic discrimination.³⁷

Mandatory sentences are also profoundly unjust because they do not allow judges to properly account for the moral culpability or degree of responsibility of a person in light of all the relevant circumstances. The Supreme Court of Canada has ruled that a mandatory minimum sentence constitutes a cruel and unusual punishment contrary to the *Canadian Charter of Rights and Freedom* if it is possible for a sentence, in a specific matter or reasonable hypothetical case, to be "grossly disproportionate", given the circumstances of the case.³⁸ In a recent decision, the Supreme Court struck down the mandatory minimum sentencing scheme for crimes involving prohibited and restricted firearms.³⁹ The Supreme Court highlighted how mandatory minimum sentences have the potential to frustrate proportionality in sentencing, and set out the harms that can flow from mandatory minimum sentencing schemes.⁴⁰ An appeal of mandatory minimum sentencing for a drug offence is currently pending before the Supreme Court of Canada.⁴¹

It comes to no surprise that Canada's "tough on crime" agenda has led to significant increases in incarceration in federal prisons with disproportionate impact on the most marginalized and vulnerable groups including people who use drugs. In his 2014 report to the Minister of Public Safety and Emergency Preparedness, the Correctional Investigator of Canada indicated that "upon admission, 80% of federally sentenced male offenders have a substance abuse problem," and further observed:

The most visible change during my tenure as Correctional Investigator has been the growth in the overall size, complexity and diversity of the offender population. It is not a new observation

³⁵ B. Stevenson, *Drug Policy, Criminal Justice and Mass Imprisonment: Background Paper* (Global Commission on Drug Policy), 2011, online: http://www.globalcommissionondrugs.org/wp-content/themes/gcdp_v1/pdf/Global_Com_Bryan_Stevenson.pdf,

³⁶ *Letter to Government Expressing Opposition to Bill S-10*, February 6, 2011, online: <http://uhri.cfenet.ubc.ca/content/view/88>; Canadian Bar Association, *Submission on Bill C-10, Safe Streets and Communities Act*, at <http://www.cba.org/cba/submissions/PDF/11-45-eng.pdf>; Canadian HIV/AIDS Legal Network, *Brief to the Standing Senate Committee on Legal and Constitutional Affairs, in relation to the Committee's study on Bill C-10* (2012), online: http://www.aidslaw.ca/site/wp-content/uploads/2013/04/Senate-brief_C-10_2012-ENG.pdf.

³⁷ British Columbia Civil Liberties Association, *More Than We Can Afford: The Costs of Mandatory Minimum Sentencing*, 2014, online: https://bccla.org/our_work/more-than-we-can-afford-the-costs-of-mandatory-minimum-sentencing/.

³⁸ *R. v. Smith*, [1987] 1 S.C.R. 1045.

³⁹ *R. v. Nur*, 2015 SCC 15.

⁴⁰ British Columbia Civil Liberties Association, "*R. v. Nur, R. v. Charles*," updated April 2015, online: https://bccla.org/our_work/r-v-nur-r-v-charles/.

⁴¹ K. Hollet, "Supreme Court of Canada to hear challenge to mandatory minimum sentencing for drug users," April, 30, 2015, online: <http://www.pivotlegal.org/supreme-court-of-canada-to-hear-challenge-to-mandatory-minimum-sentencing-for-drug-users>.

that some of Canada's minority, vulnerable or disadvantaged groups are disproportionately involved in the criminal justice system. These trends are accelerating within federal prisons. Since March 2005, the federal inmate population has increased by 17.5%. Over the same period, the Aboriginal population grew by 47.4% and Black offenders by over 75%. These groups now comprise 22.8% and 9.8% of the total incarcerated population respectively. The federally sentenced women population has increased 66%, with the Aboriginal women count growing by 112%.⁴²

Predictable consequences of mass incarceration have materialized, including: overcrowding, increases in rates of violence and self-injury in prisons and increased use of segregation.⁴³ Moreover, given the absence of harm reduction programs in prison, the incarceration of people who use drugs, or may have a greater vulnerability to initiating drug use have also deepened the threats to individuals and the public health crisis in Canadian prisons.

Right to health in prison

High rates of incarceration of people who use drugs in Canada, and the extent of unsafe injection drug use in prisons, pose an ongoing threat to the health and safety of prisoners and to public health more generally. However, Canadian prison authorities has consistently refused to implement comprehensive, evidence-based harm reduction services in prisons, contravening the obligation to take steps to realize progressively the right to the highest attainable standard of health. Such refusal also discriminates against people with a disability (problematic substance use), Indigenous people and women. Eighty percent of people incarcerated in federal prisons have a history of problematic substance use.⁴⁴ The legacy of centuries of colonization, disenfranchisement, poverty and systematic destruction of culture, family and communities have unsurprisingly produced higher levels of trauma and social conditions that result in the Indigenous peoples of Canada being disproportionately incarcerated and also disproportionately experiencing high prevalence of both addictions and infection with HIV and HCV.⁴⁵ Among people incarcerated in Canadian prisoners, a higher proportion of women than men report a history of injection drug use, often associated to underlying factors such as sexual or physical abuse or violence.⁴⁶

The complete absence of sterile syringes, and punishment if caught using drugs, lead prisoners to use non-sterile, often makeshift, injecting equipment. In 2010, the Correctional Service of Canada (CSC) reported that 17% of men and 14% of women in federal prisons indicated having injected drugs while imprisoned, and among these, 55% of men and 41% of women reported using a needle previously used by someone else.⁴⁷ Therefore, it is not surprising that HIV prevalence among federal prisoners is 15

⁴² Office of the Correctional Investigator of Canada, *Annual Report: 2013-2014*, 2014 at p. 2, available at <http://www.oci-bec.gc.ca/cnt/rpt/pdf/annrpt/annrpt20132014-eng.pdf>. (We note that in this submission, outside of passages directly quoted from other sources, we prefer to avoid the stigmatizing term "offender" when referring to people who have been, or are, incarcerated.)

⁴³ Ibid.

⁴⁴ CSC Review Panel, *A Roadmap to Strengthening Public Safety* (Ottawa: Government of Canada, 2007)

⁴⁵ For a detailed overview of the evidence, see S. Chu & R. Elliott, *Clean Switch: The Case for Prison Needle and Syringe Programs in Canada* (Canadian HIV/AIDS Legal Network, 2009).

⁴⁶ Ibid.

⁴⁷ D. Zakaria et al., *Summary of Emerging Findings from the 2007 National Inmate Infectious Diseases and Risk-Behaviours Survey* (Ottawa: CSC, March 2010).

times the estimated prevalence in the Canadian population as a whole, and HCV is 30 times more prevalent.⁴⁸

To date, prison-based needle and syringe programs (PNSPs) have been introduced in over 60 prisons of varying sizes and security levels in countries such as Luxembourg, Moldova, Germany, Romania, Spain and Switzerland.⁴⁹ Evaluations, including by the Government of Canada's own Public Health Agency,⁵⁰ have consistently demonstrated that PNSPs reduce the use of non-sterile injecting equipment and resulting blood-borne infections, do not lead to increased drug use or injecting, reduce drug overdoses, lead to a decrease in abscesses and other injection-related infections, facilitate referral of users to drug treatment programmes, and have not resulted in needles being used as weapons against prisoners or staff.⁵¹ PNSPs are supported by the UN's specialized technical agencies⁵² and the High Commissioner for Human Rights,⁵³ as well as the UN Special Rapporteur on torture,⁵⁴ as a matter of sound public health policy and human rights. They have also been recommended by the Canadian and Ontario Medical Associations,⁵⁵ the Canadian Human Rights Commission⁵⁶ and the Correctional Investigator of Canada.⁵⁷

⁴⁸ Ibid. This publication reports HIV prevalence 15 times higher than in the general population, and HCV prevalence 39 times higher. However, recent data show a slightly higher prevalence in the Canadian general population. As a result, HCV prevalence in prison is now considered 30 times higher than in the general population (instead of 39 times). See Trubnikov M, Yan P, Archibald C. Estimated Prevalence of Hepatitis C Virus infection in Canada, 2011; Canadian Public Health Agency, Fact Sheet: People in Prison, 2012).

⁴⁹ R. Lines et al., *Prison Needle Exchange: Lessons from a comprehensive review of international evidence and experience* (Canadian HIV/AIDS Legal Network, 2006); R. Jürgens, *Interventions to Address HIV/AIDS in Prisons: Needle and Syringe Programmes and Decontamination Strategies* (WHO, UNODC & UNAIDS, 2007); UNODC, *A handbook for starting and managing needle and syringe programmes in prisons and other closed settings*, Advance copy, 2014.

⁵⁰ PHAC, *Prison needle exchange: Review of the evidence* (Ottawa: PHAC, April 2006).

⁵¹ Lines et al., op. cit.; Jürgens, op. cit.; H. Stöver and J. Nelles, "10 years of experience with needle and syringe exchange programmes in European prisons: A review of different evaluation studies," *International Journal of Drug Policy* 2003; 14: 437-444.

⁵² WHO, *WHO Guidelines on HIV Infection and AIDS in Prisons*, 1993; UNODC, WHO and UNAIDS, *HIV/AIDS Prevention, Care, Treatment and Support in Prison Settings: A Framework for an effective National Response* (Geneva/Vienna, 2006); UNAIDS, "Statement on HIV/AIDS in Prisons to the UN Commission on Human Rights at its Fifty-second session, April 1996," in *Prison and AIDS: UNAIDS Point of View*, 1997; UNODC, *A handbook for starting and managing needle and syringe programmes in prisons and other closed settings* (Advance copy),

⁵³ *International Guidelines on HIV/AIDS and Human Rights, Consolidated Version*, UN Doc. HR/PUB/06/9, Office of the UN High Commissioner for Human Rights and UNAIDS (Geneva, 2006).

⁵⁴ J. Mendez, Interim report to the UN General Assembly of the Special Rapporteur on torture and other cruel, inhuman or degrading treatment or punishment [regarding revisions to the UN Standard Minimum Rules on the Treatment of Prisoners], UN Doc. A/68/295 (August 2013), para. 71.

⁵⁵ Canadian Medical Association, Resolution 26 of 17 August 2005; Ontario Medical Association, *Improving our Health: Why is Canada Lagging Behind in Establishing Needle Exchange Programs in Prisons? A Position Paper by the Ontario Medical Association*, October 2004.

⁵⁶ Canadian Human Rights Commission, *Protecting Their Rights: A Systemic Review of Human Rights in Correctional Services for Federally Sentenced Women* (Ottawa: Canadian Human Rights Commission, 2003), Recommendation No. 4.

⁵⁷ Correctional Investigator of Canada, *Annual Report of the Correctional Investigator 2004–2005* (Ottawa: Correctional Investigator Canada, 2004), Annex B at 47. With respect to the right to health in prisons, it should also be noted a recent report by the Correctional Investigator of Canada, obtained under access-to-information legislation, found that health services are inadequately resourced in federal prisons, to the point that newly-admitted prisoners, including those with serious mental health issues, are sometimes being denied prescription medications for 30 days or more while waiting for an assessment by prison physicians. Missing HIV medications or

Under international law, prisoners retain all rights except insofar as those are necessarily limited by incarceration.⁵⁸ This includes the right to the highest attainable standard of health.⁵⁹ Prisoners have a right to a standard of health care equal to that available outside of prisons (the “principle of equivalence”),⁶⁰ which necessarily includes preventive measures comparable to treatment and services available in the community. According to the CESCR, “States are under the obligation to respect the right to health by, *inter alia*, refraining from denying or limiting equal access for all persons, including prisoners or detainees... to preventive...health services.”⁶¹ Despite this, while NSPs have been operating in communities across Canada for more than two decades, with funding from various levels of government, no such program operates in a single Canadian prison. Canada has also failed to address the concern that denial of such health services is effectively deadly discrimination on the basis of disability, sex and race/ethnicity, given the disproportionate impact on women, Indigenous people and people with addictions (recognized as a disability under Canadian anti-discrimination law) in Canada’s prisons. A constitutional challenge is proceeding against the Canadian federal government for failing to protect the human rights of prisoners by refusing to implement PNSP in the Canadian federal prison system.⁶²

Rights of Indigenous peoples

Canadian’s punitive approach to illicit drugs had particularly harsh impact on Indigenous people. Indigenous people represent less than 5 per cent of the Canadian population,⁶³ but account for half of all new HIV cases attributed to injecting drug use.⁶⁴ Indigenous people are also disproportionately represented in prisons where they comprise 23 per cent of the population; Indigenous women represent 33 per cent of all women sent to federal institutions.⁶⁵ Moreover, and as reported by the federal Correctional Investigator, Indigenous people are more likely to serve more of their sentence behind bars, be held in segregation or with maximum security populations, and be disproportionately prone to self-injury while in prison. This tragic situation is directly linked to current drug policy. As revealed by a research study looking at a sample of Indigenous people enrolled in CSC’s Aboriginal Offender Substance Abuse Program, almost all (96%) indicated that substance use was related to their current offence; 85%

anti-psychotic medications can have serious health consequences; missing pain medication could force prisoners to resort to the use of other, prohibited drugs in an attempt to self-medicate for pain. See: P. White, “New inmates denied medicine due to drug-plan flaw: prison ombudsman,” *The Globe & Mail*, 30 April 2015, online: <http://www.theglobeandmail.com/news/national/processing-delays-leave-new-inmates-without-prescriptions-for-weeks/article24177961/>.

⁵⁸ *Basic Principles for the Treatment of Prisoners*, UNGAOR, 45th Sess., Supp. N 49A, UN Doc A/45/49 (1990), Principle 5.

⁵⁹ CESCR, *General Comment 14*, op. cit. As HIV and HCV are potentially fatal diseases, the right to life is also relevant in considering states’ obligation to take effective measures to prevent HIV and HCV transmission in prisons: UN Human Rights Committee, *General Comment No. 6: The right to life (Article 6)*, 16th Sess., (1982) UN Doc. HRI\GEN\1\Rev.1 at 6, para 5.

⁶⁰ *Basic Principles for the Treatment of Prisoners*, UNGAOR, 45th Sess., Supp. N 49A, UN Doc A/45/49 (1990), Principle 9.

⁶¹ CESCR, *General Comment 14*, op. cit., para. 34

⁶² For more information about the lawsuit, please visit: www.prisonhealthnow.ca.

⁶³ Statistics Canada, *Aboriginal Peoples in Canada: First Nations People, Métis and Inuit*, 2011, available at <http://www12.statcan.gc.ca/nhs-enm/2011/as-sa/99-011-x/99-011-x2011001-eng.cfm>.

⁶⁴ Public Health Agency of Canada, *HIV and AIDS in Canada. Surveillance report to December 31, 2013* (2014), online: <http://www.phac-aspc.gc.ca/aids-sida/publication/survreport/2013/dec/assets/pdf/hiv-aids-surveillance-eng.pdf>.

⁶⁵ Office of the Correctional Investigator of Canada, *Annual Report: 2013-2014* (2014), available at <http://www.oci-bec.gc.ca/cnt/rpt/pdf/annrpt/annrpt20132014-eng.pdf>.

reported they were under the influence at the time of their offence.⁶⁶ Resources spent on enforcement of Canada's drug laws – including laws that now mandate minimum sentences in various circumstances – continue to fuel incarceration and undermine health and human rights, instead of protecting and promoting the health and well-being of Indigenous people in Canada.

Discrimination and the right to equality

People who use drugs in Canada continue to face discrimination and hostility across the country. And criminalization further stigmatizes and marginalizes people who use drugs. Many Canadians have a criminal record because they were once found in possession of drugs, most often cannabis.⁶⁷ Having a criminal record can have serious repercussions on individuals' access to housing, employment and ability to travel.⁶⁸ Criminal convictions combined with substance use also affect parental rights. According to the Correctional Investigator of Canada, 3 in 4 incarcerated women are also mothers to children under the age of 18. At the time of their arrest, almost two-thirds were single caregivers and over half reported having had experiences with child protection services – often due to problematic substance use, mental health concerns or issues of abuse/neglect. And maintaining family relationships between women and their children throughout their incarceration present many challenges.⁶⁹

Access to health care is also a challenge for people who use drugs as they continue to suffer from stigma and judgmental attitudes by health care professionals⁷⁰ and as the federal government takes active measure to prevent access to evidence-based health services. Bill C-2, an *An Act to amend the Controlled Drugs and Substances Act*, currently before the Parliament, is a good example of discrimination with regarding to health services by the federal government. The text imposes an unjustifiably onerous application process for an exemption to establish supervised consumption services – barriers that would not be imposed on other health services. For instance, it requires letters of “opinion” from at least five different bodies, including police and governmental authorities. Applicants must also conduct consultations with a “broad range of [local] community groups” and submit a detailed report summarizing the “opinions” of consulted groups. While support from local authorities, communities and police can facilitate the implementation of supervised consumption services, legally requiring their opinions does nothing to build constructive cooperation. It only allows for decisions to be based on unjustified, misinformed and/or politically oriented positions, which may be contrary to the constitutional rights of people who use drugs, an already stigmatized and criminalized population.⁷¹ In essence, the bill subjects access to evidence-based, life-saving health services for people who use drugs to hurdles that would never be deemed acceptable in the case of access to services by people with other health conditions; it is discrimination being legislated by the federal government.

⁶⁶ Ibid., p. 43.

⁶⁷ Centre for Addiction and Mental Health, *Cannabis Framework Policy* (2014), p.6 available at http://www.camh.ca/en/hospital/about_camh/influencing_public_policy/Documents/CAMHCannabisPolicyFramework.pdf.

⁶⁸ Ibid.

⁶⁹ Office of the Correctional Investigator of Canada, *Annual Report: 2013-2014*, 2014 at p. 46, available at <http://www.oci-bec.gc.ca/cnt/rpt/pdf/annrpt/annrpt20132014-eng.pdf>.

⁷⁰ L. Van Boekel et al., “Stigma among health professionals towards patients with substance use disorders and its consequences for healthcare delivery: Systematic review,” *Drug and Alcohol Dependence* 2023; 131: 23-35.

⁷¹ Canadian HIV/AIDS Legal Network, Canadian Drug Policy Coalition, *An Injection of Reason: Critical Analysis of Bill C-2* (2014), online: <http://www.aidslaw.ca/site/an-injection-of-reason-critical-analysis-of-bill-c-2/>.

IV. Recommendations

Canada, like many other countries around the world has adopted a punitive and criminal approach to illicit drugs. This approach has had disastrous social, health and security costs. Identifying specific instances of such human rights infringements from countries around the world can and should inform the OHCHR's study of the intersection between human rights and the "world drug problem" as requested by the UN Human Rights Council. The 2016 UNGASS represents an opportunity to assess critically current approaches to drug policy, and UN human rights institutions must help ensure that drug policies internationally are based on public health and human rights.

In particular, we recommend that:

- The Human Rights Council should assert strongly – and continue to assert – that drug policies, and their implementation, must be consistent with human rights principles, protecting and promoting the rights of people who use drugs and other marginalized populations that are currently disproportionately affected by the war on drugs, including in particular people with problematic substance use, Indigenous people, other ethno-racial minorities and women, as well as people who are in prison.
- The High Commissioner for Human Rights should actively engage in the 2016 UNGASS, and the preparatory process leading up to it. The key objective of such engagement should be to ensure that the deliberations and outcomes of the UNGASS are guided by Member States' over-arching obligation – as affirmed repeatedly by States themselves – to ensure that all aspects of drug control are in conformity with their human rights obligations under international law.
- The High Commissioner for Human Rights should identify options for ensuring greater, formal human rights oversight of the existing drug control infrastructure and of States' actions in the implementation of drug policy. This should include consideration of how existing human rights treaty bodies can better integrate attention to human rights abuses against people who use drugs, and other human rights violations in the course of implementing drug policy, into their respective mandates.
- The High Commissioner for Human Rights should explore options for developing human rights guidance on drug policy to assist states, international organizations and treaty bodies in taking concrete steps to protect and promote human rights in the context of drug policy. This should be done in consultation with experts in drug policy, human rights and health, researchers and civil society organizations.