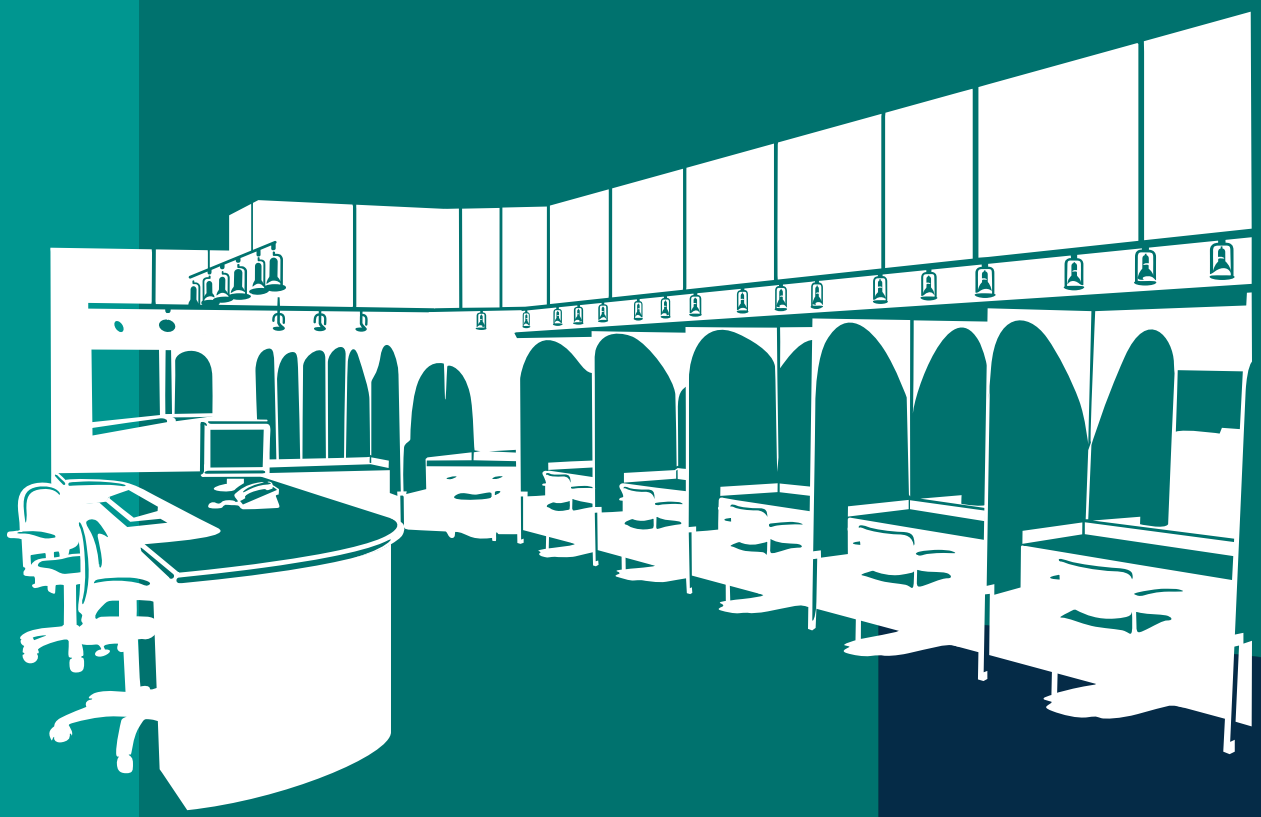

A Helping Hand:

Legal Issues Related to Assisted Injection at Supervised Injection Facilities

Canadian HIV/AIDS Legal Network | Réseau juridique canadien VIH/sida

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Canadian HIV/AIDS Legal Network
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About the Canadian HIV/AIDS Legal Network

The Canadian HIV/AIDS Legal Network (www.aidslaw.ca) promotes the human rights of people living with and vulnerable to HIV/AIDS, in Canada and internationally, through research, legal and policy analysis, education, and community mobilization. The Legal Network is Canada's leading advocacy organization working on the legal and human rights issues raised by HIV/AIDS.

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Executive summary

According to the current legal framework and professional guidelines in Canada, safe injection facility (SIF) staff cannot assist clients in the administration of their drugs and SIF clients cannot help each other inject. However, recent evaluations show that the HIV prevalence rate for people who require assistance when injecting illegal drugs is double that of those who do not, raising serious public health concerns. Women are more than twice as likely as men to require assisted injection and twice as likely to report not knowing how to inject as the reason for requiring assistance.

This paper considers the prohibition on assisted injection in SIFs through the lens of the *Canadian Charter of Rights and Freedoms* and suggests that the ban may run afoul of the prohibition on discrimination and the right to life, liberty and security of the person.

Permitting assisted injection at SIFs may result in legal liability under criminal and civil law for those who assist. This research identifies areas of criminal and civil liability under Canadian law for health service providers and others who might provide assisted injections. It is difficult to reach firm conclusions on how the law may be applied in cases where death or serious injury arises following assisted injection, because the law in this area is relatively new. Certain offences, which may at first glance appear to represent a problem, may in fact not be applicable. Other offences may represent greater difficulty.

Law and policy reforms may be necessary to reconcile the law with human rights principles. One possible reform would be to modify the current legal framework governing the operation of SIFs, together with a guarantee that the practice of assisted injection will not be prosecuted. These and other possible ways forward are discussed in the following pages.

Introduction

Supervised injection facilities (SIFs) — also called "safe injection sites," "supervised injection centres," "safe consumption centres" and variants thereof — are legally sanctioned health facilities that enable the consumption of pre-obtained drugs with sterile equipment under the supervision of health professionals.[1] SIFs constitute a specialized health intervention within a wider network of services for people who use drugs.

According to the operational guidelines of most SIFs, facility staff cannot physically assist clients in injecting drugs, and clients cannot help inject each other. While this policy does not represent a problem for many SIF clients, it adversely affects those who have difficulty injecting themselves. In particular, the prohibition on assisted injections may represent a barrier to equitable access to these health facilities for women (who

[1] K. Dolan, "Drug consumption facilities in Europe and the establishment of supervised injecting centres in Australia," *Drug and Alcohol Review* 19 (2000): pp. 337–346; W. Schneider, *Guidelines for the Operation and Use of Consumption Rooms* (materialien Nr.4), Akzept e.V and C von Ossietzky Universitat Oldenburg, 2000.

are frequently injected by their male partners or friends) and people with disabilities, who as a result of this restriction are unable to benefit from such facilities.

In 2002, the Canadian HIV/AIDS Legal Network released an extensive report entitled *Establishing Safe Injection Facilities in Canada: Legal and Ethical Issues*.[2] The report examined a range of relevant legal issues under both Canadian and international law, and recommended a number of steps that would enable the implementation of SIFs. As part of a much larger recommendation about the issues to be addressed in the regulatory framework governing SIFs, the Legal Network stated that the framework "should only allow clients to self-inject, prohibiting staff from assisting with injection."[3]

Since the report was released, Canada's first officially sanctioned SIF was established in Vancouver in 2003. As appears to be common with SIFs in various jurisdictions, the regulatory framework governing SIFs in Canada only permits self-injection by clients. However, after three years of research and evaluation of the operation and impact of this particular SIF in Vancouver, it is now clear that this restriction may impede the realization of the SIF's full health benefits in ways that may be discriminatory. It is therefore necessary to revisit the question of assisted injection.

This paper examines assisted injection in SIFs in more detail, with a view to informing the development of policies that would overcome its prohibition.

- First, this paper discusses recent public health research regarding assisted injection.
- Second, it outlines two possible forms of assisted injection in a SIF: medically assisted injection (performed by a health professional, most likely a nurse) and assisted injection performed by someone designated by the SIF client.
- Third, it discusses the applicable human rights law (particularly under the *Canadian Charter of Rights and Freedoms*) that might apply to assisted injection.
- Fourth, it discusses potential criminal liability for SIF staff and clients under the *Controlled Drugs and Substances Act* and the *Criminal Code*. There is no known research that examines potential criminal liability raised by the practice of assisted injections in SIFs.[4] The analysis below considers how certain offences might be applicable.
- Fifth, the paper considers the prospect of civil liability that could arise in some circumstances of assisted injection.
- Sixth, the paper discusses the current status of assisted injection under professional codes of conduct, such as nursing standards of practice.
- Finally, the paper provides an overview of various avenues of legal reform that might address the legal liabilities involved in the practice of assisted injections.

A cautionary note is required. It is difficult to foresee all potential legal issues that might be associated with assisted injection at SIFs. The discussion below considers some of the more obvious legal issues. Such legal issues have, to the best of our knowledge, never been considered by courts. The legal analysis that follows is informed by the closest available legal reasoning.

[2] R. Elliott, I. Malkin and J. Gold, *Establishing Safe Injection Facilities in Canada: Legal and Ethical Issues*, Canadian HIV/AIDS Legal Network, 2002, on-line via www.aidslaw.ca/drugpolicy.

[3] Ibid., at 54.

[4] For an overview of criminal offences that could apply in the context of an unauthorised SIF, see R. Elliott et al., *Establishing Safe Injection Facilities in Canada: Legal and Ethical Issues*, at 36.

However, the extent to which pre-existing jurisprudence can be applied to the practice of assisted injections at SIFs is unclear. It is important to note that those court cases that have considered assisted injections have resulted from assisted injections in non-medicalized environments. Such cases have considered how the criminal law applies to assisted injections, but have not (because of the particular situations that led to the charges) considered the practice of assisted injection in a SIF. Thus, for a number of reasons, it is impossible to reach incontrovertible conclusions on how the courts would consider assisted injections at SIFs. Necessarily, the legal analysis that follows is speculative rather than definitive.

Public health research regarding assisted injection

Sharing contaminated injection equipment is the primary factor driving the HIV epidemic among people who use illegal drugs.[5] Recent studies have demonstrated that even when people who use drugs have access to sterile needles, a number of factors may make individuals vulnerable to sharing syringes and subsequent HIV infection.[6] One such vulnerability is the need for assisted injection. It has long been demonstrated that requiring assisted injection is associated with syringe sharing in Vancouver's Downtown Eastside (DTES) and in other settings outside of Canada.[7] A recent analysis from Vancouver, which was undertaken after the opening of Vancouver's SIF, suggested that requiring assisted injection has become the strongest predictor of syringe sharing.[8]

A recent study conducted among participants in the cohort of the Vancouver Injection Drug User Study (VIDUS), found that people in Vancouver's DTES who needed help injecting drugs had an HIV incidence double that of those who did not.[9] Researchers examined the prevalence of assisted injection and its impact on HIV incidence, and found that 41% of participants reported requiring assisted injection during the six months prior to their interview. Among participants who required assisted injection, cumulative HIV incidence at 36 months was 16.1%, compared to 8.8% among participants who did not require help injecting. In other words, after adjusting for other known risk factors, those who required assisted injection had twice as high a rate of becoming HIV-positive.

Sharing contaminated injection equipment is the primary factor driving the HIV epidemic among people who use illegal drugs.

The characteristics of individuals who reported providing (rather than receiving) assisted injection have also been investigated in order to better understand the dynamics of this practice.[10] Research with the VIDUS cohort found that individuals who provided assisted injection — often know as "hit doctors" — were almost four times more likely to lend their own used syringes, compared to those who did not provide help injecting. Help was most often provided to a casual friend (47.2%) or close friend (41.5%). Of those individuals in VIDUS who reported receiving compensation for providing help, the most common forms of compensation were drugs (89.6%) and money (45.85%).

[5] D. Des Jarlais, "Structural interventions to reduce HIV transmission among injecting drug users," *AIDS* 14 (2000): S41-6.

[6] E. Wood, M. Tyndall and P. Spittal et al. "Factors associated with persistent high-risk syringe sharing in the presence of an established needle exchange programme," *AIDS* 16 (2002): pp. 941-3; E. Wood, M. Tyndall and P. Spittal et al., "Unsafe injection practices in a cohort of injection drug users in Vancouver: could safer injecting rooms help?" *Canadian Medical Association Journal* 165 (2001): pp. 405-10.

[7] E. Wood et al., "Requiring help injecting as a risk factor for HIV infection in the Vancouver epidemic: Implications for HIV prevention," *Canadian Journal of Public Health* 94(5) (2003): pp. 355-359; A. Kral et al., "Risk factors among IDUs who give injections to or receive injections from other drug users," *Addiction* 94(5) (1999): pp. 675-683; C. Tompkins et al., "Exchange, deceit, risk and harm: the consequences for women of receiving injections from other drug users," *Drugs: Education, Prevention & policy* 13(3) (2006): pp. 281-297.

[8] T. Kerr et al., "Safer injection facility use and syringe sharing in injection drug users," *Lancet* 366 (2005):316-18.

[9] J. O'Connell, T. Kerr, K. Li et al. "Requiring help injecting independently predicts incident HIV infection among injection drug users," *Journal of Acquired Immune Deficiency Syndrome* 40(1) (2005): pp. 83-88.

[10] N. Fairbairn et al., "Risk profile of individuals who provide assistance with illicit drug injections," *Drug and Alcohol Dependence* 82 (2006) pp. 41-46.

Research on assisted injection has revealed a gender dimension to this vulnerability. Specifically, women in Vancouver are more than twice as likely as men to require assisted injection.[11] This finding is consistent with results of a San Francisco study in which female participants were found more likely than male participants to have been injected by someone else.[12] It has also been suggested that some women are "second on the needle" in the context of sexual relationships, whereby men first inject themselves and then inject their partners using the same equipment.[13]

Self-reported reasons for requiring assisted injection among VIDUS participants were recently examined.[14] Among the study's 70 male participants, the common reasons for needing help injecting were having no viable veins (77%) and shaky hands due to anxiousness and/or being "drug sick" (i.e., suffering from withdrawal symptoms) (43%). Only 7.1% of men attributed requiring help to not knowing how to inject. Among the 81 female participants, the most common reasons for needing help injecting were having no viable veins (72%), preference for being injected in the jugular vein (known as "jugging") (46%), and shaky hands due to anxiousness and/or being "drug sick" (27%). (These percentages add up to more than 100% because participants could attribute requiring assistance to more than one reason.) Almost twice as many women as men reported not knowing how to inject as their reason for requiring assisted injection.

In summary, there are many factors driving the practice of assisted injection, including gender dynamics, a lack of knowledge of and experience with injecting, loss of viable veins, preference for jugular injection, and inability to self-inject due to shakiness caused by anxiety and/or drug sickness.

[11] J. O'Connell, T. Kerr, K. Li et al., "Requiring help injecting independently predicts incident HIV infection among injection drug users"; E. Wood et al., "Requiring help injecting as a risk factor for HIV infection in the Vancouver epidemic: Implications for HIV prevention".

[12] J. Evans et al., "Gender differences in sexual and injection risk behaviour among active young injection drug users in San Francisco (the UFO Study)," *Journal of Urban Health* 80 (2003): pp. 137-146.

[13] See, for example, R. Freeman, G. Rodriguez and J. French, "A comparison of male and female intravenous drug users' risk behaviors for HIV infection," *American Journal of Drug and Alcohol Abuse* 6(2)(1994): pp. 129-57; R. MacRae and E. Aalto, "Gendered power dynamics and HIV risk in drug-using sexual relationships," *AIDS Care* 12(2000): pp. 505-515.

[14] E. Wood et al., "Requiring help injecting as a risk factor for HIV infection in the Vancouver epidemic: Implications for HIV prevention".

Forms of assisted injection

There are currently only two authorized SIFs in Canada.[15] Under current SIF protocols, nurses may supervise injections that take place in SIFs. If required, they may advise clients on venous access and safer injecting but they may not perform the venipuncture or administer the drug to the client.

Assisted injection at SIFs could potentially take two forms. The first would involve assistance from a staff member with health/medical training — in most cases, a nurse.[16] The second would involve assistance from someone designated by the SIF client (e.g., someone who is not necessarily a medical professional and who may also be a client of the SIF).[17]

[15] Insite, the first authorized SIF in North America, operates in Vancouver's Downtown Eastside (DTES). The Dr Peter Centre, a HIV/AIDS health care centre, runs a day health program and a residence with 24-hour care for people with HIV/AIDS. As part of the day health program, the Dr Peter Centre offers harm reduction services including nursing supervision of injection drug use. The North American Opiate Medication Initiative (NAOMI), a clinical trial of prescribed heroin, also provides that trial participants will consume the medically prescribed heroin on-site. The NAOMI trial is currently ongoing in Vancouver and Montréal.

[16] The 327 Carrall Street SIF, which preceded Insite in the DTES, opened on 7 April 2003 and closed on 7 October 2003. The 327 Carrall Street SIF was without official exemption from Canadian laws on illegal drugs. The facility had guidelines for individuals who came to the SIF seeking assistance with their injections. Individuals requesting assistance had to first undergo training on how to self-inject. Clients learned how to find a peripheral vein, prepare drugs for injection, tie-off using a tourniquet, test the strength of their drugs, insert a syringe and inject, and care for their veins. Clients were requested to attempt self-injection twice after receiving these instructions. If they were still unable to self-inject, another client or a SIF staff could assist them, as long as gloves were worn and only sterile syringes were used. All of the 215 individuals who received these instructions during 327 Carrall Street's operation were eventually able to locate a peripheral vein for self-injection. See T. Kerr et al., "Harm reduction activism: a case study of an unsanctioned, user-run safe injection site," *Canadian HIV/AIDS Policy and Law Review* 9(2) (2004): pp. 13-19; T. Kerr et al. "A description of a peer-run supervised injection site for injection drug users," *Journal of Urban Health* 82(2) (2005): pp. 267-75. Staff-assisted injection was reported as a practice in EVA, a SIF that operated in Barcelona and was recently closed (for other reasons). See M. Anoro, E. Ilundain and O. Santisteban, "Barcelona's safer injection facility-EVA: A harm reduction program lacking official support," *Journal of Drug Issues* 33(3) (2003): pp. 689-711.

[17] Peer-assisted injection is reportedly allowed at 'Quai 9', a SIF in Geneva. See S. Solai et al., "Ethical reflections emerging during the activity of a low threshold facility with supervised drug consumption room in Geneva, Switzerland," *International Journal of Drug Policy* 17 (2006): pp. 17-22. For the protocol of the injection room, see F Benninghoff et al., *Evaluation de Quai 9 «Espace d'accueil et d'injection» à Genève,* Institut universitaire de médicine sociale et préventive, Lausanne, 2003, annex 4.

Human rights law: the rights to health and freedom from discrimination

International law

International human rights instruments recognize health as a fundamental human right. Countries that have ratified such instruments, including Canada, are obliged to take positive steps to realize progressively the right of every person to the highest attainable standards of physical and mental health.[18]

The principle of non-discrimination is also a recognized right in international law. For example, the United Nations *Universal Declaration of Human Rights*, which includes the right to health (art. 25), states that everyone is entitled to "all the rights and freedoms set forth in the Declaration without distinction of any kind" (art. 2). The *International Covenant on Economic, Social and Cultural Rights* also recognizes the right of "everyone to the highest attainable standard of physical and mental health" to be exercised without discrimination.[19]

Canadian constitutional law

The *Canadian Charter of Rights and Freedoms* ("the *Charter*") outlines fundamental constitutional rights under Canadian law, and applies to all state action, including laws, policies and programs of federal, provincial and municipal governments. Although the Supreme Court of Canada has ruled that the *Charter* does not confer a "freestanding constitutional right to health care", it has also found that "where the government puts in place a scheme to provide health care, that scheme must comply with the *Charter*".[20] It is arguable that by enabling SIFs — for example, by means of a federal government exemption to the *Controlled Drugs and Substances Act* (CDSA) — the government is putting in place a scheme to provide, or facilitate the provision of, health care services. Therefore, in doing so, it must comply with the *Charter.* The two sections of the *Charter* that apply most directly are s. 7 and s. 15.

Charter s. 7: Rights to life, liberty and security of the person

Everyone has the right to life, liberty and security of the person and the right not to be deprived thereof except *in accordance with the principles of fundamental justice.*

The deprivation of s. 7 rights in the context of health has been examined by Canadian courts. In a number of cases, the courts have determined whether the rights to life, liberty or security of the person were infringed by (a) regulatory or criminal restrictions on a person's autonomy to make fundamental health care decisions and (b) health care schemes that granted inadequate access or delayed access to medical care.

The violation of a s. 7 right involves two elements: First, there must be a deprivation of the rights to life, liberty or security of the person, and second, such deprivation must not be in accordance with the principles of fundamental justice.

Is there a deprivation of the right to liberty?

The ability of the state to impinge upon individual liberty has on occasion been limited by the courts when it comes to matters concerning health. The liberty interest protected in s. 7 includes the right to choose in

[18] See particularly, *International Covenant on Economic, Social and Cultural Rights*, 999 UNTS 3 (entered into force 23 March 1976), art. 12; *Charter of the United Nations* TS 993 (entered into force 24 October 1945), art. 55; *Universal Declaration on Human Rights*, UN GA Resolution 217 A(III), UN Doc. A/810 (adopted and proclaimed 10 December 1948), art. 25. For a discussion of these instruments, customary international law and international drug treaties in context of the right to health and the establishment of SIF trials, see R. Elliott et al., *Establishing Safe Injection Facilities in Canada: Legal and Ethical Issues*, at 24; I. Malkin et al., "Supervised Injection Facilities and International Law," *Journal of Drug Issues* 33 (2003): pp. 539-578.

[19] See particularly, *International Covenant on Economic, Social and Cultural Rights*, arts. 2(2) and 12.

[20] *Chaoulli v. Québec (Attorney General)*, [2005] 1 S.C.R. 791 at para. 104.

relation to decisions concerning one's own life. Section 7 protections have been interpreted as including "the right to personal autonomy with respect to control over one's physical and psychological integrity and basic human dignity to the extent of freedom from criminal prohibitions which interfere with these".[21] For example, in *R. v. Parker*, a criminal prohibition against the use of marijuana to alleviate severe pain was considered an infringement of the individual's liberty to choose a medically suitable course of treatment for himself or herself.[22] In another case, *R. v. Chaoulli*, the "loss of control by an individual over one's own health" caused by the prohibition of private health care insurance for services covered by the public health insurance system was held to violate s. 7.

It may be argued that the choice to use a SIF is an expression of personal liberty that reflects an individual's desire to protect his or her physical integrity by injecting drugs under medical supervision. The prohibition of assisted injection at SIFs prevents those in need of assistance from exercising the autonomous choice of protection of physical integrity that is otherwise available to others. Furthermore, the consequences of this prohibition on the individual concerned may be severe.

The prohibition of assisted injection at SIFs prevents those in need of assistance from exercising the autonomous choice of protection of physical integrity that is otherwise available to others.

Is there a deprivation of the right to security of the person?

State restrictions that lead to inadequate access to services, and hence risks to health, have been held by the courts to violate the security of the person interest, contrary to s. 7. Courts' analyses have centred on the extent of the detriment suffered by the individual, caused by state infringement on liberty. The Supreme Court has stated that "not every difficulty rises to the level of adverse impact on security of the person under s.7" but rather the effect must be serious (physically or psychologically) and "relate to a condition that is clinically significant to the current and future health" of the person.[23]

State-imposed increases in mental suffering[24] and additional risks to physical health[25] have been deemed sufficient to infringe upon the security of the person interest. In *R. v. Morgentaler*, the delays caused by the abortion procedures scheme then in existence under the *Criminal Code* were found to jeopardize the right to security of the person, specifically because they created an additional health risk.[26] Consequently, the Supreme Court struck down this section of the *Criminal Code* as unconstitutional. In *R. v. Chaoulli*, the Supreme Court found that the government's failure to ensure access to health care in a reasonable manner, coupled with the prohibition on private health care insurance for those services named in the *Canada Health Act*, led

[21] *Rodriguez v. British Columbia (Attorney General),* [1993] 3 S.C.R. 519 (Supreme Court of Canada) at para 21. In this case, however a majority of the Supreme Court upheld the criminal prohibition on assisting with a suicide, finding that this did not infringe the s. 7 rights of a woman with a severe, degenerative disability who sought assistance to end her life at a time and in a manner of her choosing.

[22] *R. v. Parker,* [2000] 49 O.R. (3d) 481 (Ontario Court of Appeal).

[23] *Chaoulli v. Québec (Attorney General),* [2005] at para 123.

[24] For example, *Blencoe v. British Columbia,* [2002] 2 S.C.R. 307 (Supreme Court of Canada).

[25] For example, see *R. v. Morgentaler,* [1988] 1 S.C.R. 30 (Supreme Court of Canada); *Chaoulli v. Québec (Attorney General),* [2005].

[26] Abortions at the later stages of pregnancy tend to be more complicated and may carry a greater risk of harm to the patient. See *R. v. Morgentaler,* [1988] at para. 120.

to increased risks of complications and death, and therefore interfered with the security of the person interest protected by s. 7.[27]

The prohibition on assisted injection in SIFs limits access to the health care services provided at those facilities. The prohibition may in effect deter persons who require assistance injecting from gaining access to services that a SIF provides, such as medical supervision of injection, the use of clean syringes, and information on counselling and addiction treatment. It is arguable that this prohibition creates an additional health risk for an already vulnerable group.

It may also be argued that the prohibition on assisted injection at SIFs further infringes upon the s. 7 right to security of the person by coupling a medical choice with potential criminal sanction. The right to security of the person may be infringed when individuals are forced to choose between commission on a crime to obtain effective medical treatment and inadequate treatment. The Ontario Court of Appeal has discussed such scenarios in two cases, both of which were upheld by the Supreme Court. In *R. v. Parker,* the prohibition against the possession of marijuana under the CDSA was struck down because it forced a man with severe epilepsy to choose between, on the one hand, the commission of a crime to obtain marijuana to combat life-threatening seizures that were unresponsive to conventional treatment, and, on the other hand, inadequate treatment.[28] Similarly, in *R. v. Hitzig*, portions of the *Marijuana Medical Access Regulations* were deemed unconstitutional for maintaining the possibility of criminal sanction for the purchase of marijuana for medical use.[29] This scheme was particularly difficult for disabled persons who could not grow their own marijuana and unfairly exposed individuals to the risk of imprisonment should they attempt to obtain medicine that they were otherwise legally permitted to receive.

It may be argued that the prohibition against assisted injection at SIFs places individuals in a similar dilemma to those considered above. Persons who require assistance injecting must choose between risking HIV infection or possibly fatal overdose from injecting without medical supervision, or risking arrest (or administrative sanctions) for receiving an unauthorized assisted injection at a SIF. It is important to note that s. 7 does not only protect the individual against state action through direct application of the criminal law, but also against indirect state actions that nevertheless enforce and secure compliance with the law.[30] The fact that assisted injections are prohibited at SIFs is fundamentally a reflection of criminal sanction. As was the case in *Hitzig*, the existing exemption may not be sufficiently broad to accommodate the needs of some of those who most need to benefit from the health services of SIFs. In particular, women and persons with disabilities are specially exposed to decisions between health and criminal law compliance, in violation of their s. 7 right to security of the person (raising equality concerns that are addressed further below).

For the above reasons, the prohibition against assisted injection at SIFs may be considered by the courts as a deprivation of the s. 7 rights of those who require assistance injecting.

Is the deprivation in accordance with the principles of fundamental justice?

It is also necessary to determine whether such deprivation is justified in accordance with the principles of fundamental justice. Under s. 7, the deprivation of life, liberty or security of the person may be permissible so long as it is done in accordance with the principles of fundamental justice. However, the phrase "principles of fundamental justice" is incompletely defined in case law and has been called "of necessity general and abstract".[31] Therefore, a difficulty rests in determining which legal concepts or principles are so important as to be deemed aspects of fundamental justice and which are not. Broadly speaking, principles of fundamental justice include those "legal principles that are capable of being identified with some precision and are

[27] *Chaoulli v. Québec (Attorney General),* [2005].

[28] *R. v. Parker,* [2000].

[29] *Hitzig v. Canada,* [2003] 231 D.L.R. (4th) 104 (Ontario Court of Appeal).

[30] *Hitzig v. Canada,* [2003] at para 102.

[31] *Hitzig v. Canada,* [2003] at para. 106.

fundamental in that they have general acceptance among reasonable people."[32] The violation of any one principle of fundamental justice is sufficient to ground a case for s. 7 infringement.

One primary principle of fundamental justice is the rule that there must be a rational connection between the infringement of an individual's rights, and the beneficial purposes intended and realized by the government that necessitate that infringement. The reasoning behind this need for a rational connection goes to the balancing that is required between the constitutional rights of the individual and countervailing interests of the state. As McLachlin J stated in the case of *Cunningham v. Canada*, "[t]he principles of fundamental justice are concerned not only with the interest of the person who claims his liberty has been limited, but with the protection of society. Fundamental justice requires that a fair balance be struck between these interests, both substantively and procedurally".[33] That is, in some circumstances it may be rational for individual rights to be subordinated to compelling collective interests, and to do so is itself a basic tenet of Canada's legal system "lying at or very near the core of our most deeply rooted juridical convictions".[34] However, where a state action infringes upon the life, liberty or security of the person while doing little or nothing to enhance the state interest, it can properly be seen as arbitrary and therefore not in accordance with the principles of fundamental justice.[35] Such laws have been deemed "manifestly unfair"[36] and "unnecessary."[37]

The Supreme Court has articulated that laws are not arbitrary in the context of a s. 7 infringement if the restriction on life, liberty or security of the person has both a theoretical connection to the legislative objective, as well as a real factual link.[38] The need for a real factual link between the infringement and the goal is absolutely necessary and "competing but unproven 'common sense' arguments amounting to little more than assertions of belief" are to play no role in the calculation.[39] What matters are the actual effects of the law, not simply the intended outcome. In addition, "the more serious the impingement on the person's liberty and security, the more clear must be the connection" and "where an individual's very life may be at stake, the reasonable person would expect a clear connection in theory and in fact, between the measure that puts life at risk and the legislative goals."[40]

In the case at hand (and assuming the government's intentions behind its criminal laws regarding controlled substances are valid and rational), there is little rational connection between the underlying criminal law goals and the continued prohibition of assisted injection within a SIF. Injection drug use (more precisely, the offence of possession) at SIFs is already exempted from criminal prosecution. Having taken the initial decision to uphold the public health, medical and scientific benefits of such facilities over its criminal law intentions, prohibiting assisted injection within a SIF does not advance the government's criminal law goals — and a government decision to expand access to those who require assistance with injection would not undermine those goals. In fact, such a prohibition on assisted injection may undermine the state's interest in mitigating the harms caused by injection drug use, which is the very purpose of exempting SIFs from criminal law. Increasing access to SIFs to those who require assisted injection may facilitate the health-related purposes of mitigating the harms associated with drug use. Without a rational connection between the object and effects of the law, a principle of fundamental justice is breached and the infringement of s. 7 might not stand.

[32] *Chaoulli v Québec (Attorney General),* [2005] at para. 127.

[33] *Cunningham v. Canada,* [1993] 2 S.C.R. 143 (Supreme Court of Canada) at 151-2.

[34] *Hitzig v. Canada,* [2003] at para. 134.

[35] *Rodriguez v. British Columbia (Attorney General),* [1993] at para 147, cited with approval in *R. v. Parker,* [2000] at para 113.

[36] *R. v. Morgentaler,* [1988].

[37] *R. v. Parker,* [2000].

[38] *Chaoulli v Québec (Attorney General),* [2005].

[39] *Chaoulli v Québec (Attorney General),* [2005] at para 138.

[40] *Chaoulli v Québec (Attorney General),* [2005] at para 131.

Another principle of fundamental justice relevant to this discussion is the protection of human life and dignity. Respect for the dignity of the person and the rule of law form the foundation of the Canadian system for the administration of justice and is essentially expressed through fundamental principles of law.[41] The protection of human life in particular has been considered by the Supreme Court and has been used to uphold the prohibition against assisted suicide (under *Criminal Code* s. 241), despite the necessary infringement upon autonomy that such a law entails.[42]

However, in this case, the protection of human life might best be served through increased access to SIFs, and the protection of autonomy and security of the person, rather than through an infringement of rights. SIFs provide health care, medical supervision and counselling, which protect human life and dignity. The prohibition on assisted injection for those persons who require it may aggravate the health of already vulnerable individuals and might not be in accordance with the principle of fundamental justice, which demands the protection of human life and dignity.

In summary, the prohibition of assisted injection at SIFs may be seen as a violation of the s. 7 rights to life, liberty and especially security of the person. Such violations are permitted only if done in accordance with the principles of fundamental justice. Principles of fundamental justice, such as the requirement that rights deprivations must relate to a valid and rational purpose and the principle of protection of human life and dignity, may be breached in the case of prohibitions on assisted injection at SIFs.

[P]rohibiting assisted injection within a SIF does not advance the government's criminal law goals — and a government decision to expand access to those who require assistance with injection would not undermine those goals.

Charter s. 15(1): Equality in access to health services

Every individual is equal before and under the law and has the right to the equal protection and equal benefit of the law without discrimination and, in particular, without discrimination based on race, national or ethnic origin, colour, religion, sex, age or mental or physical disability.

The right to equality before and under the law reflects one of Canada's most fundamental values and, as such, is entrenched in the *Charter* "to remedy the imposition of unfair limitations upon opportunities, particularly for those persons or groups who have been subject to historical disadvantage, prejudice, and stereotyping".[43] As interpreted by Canadian courts, s. 15 does not impose upon the government a positive duty to provide a service to ameliorate disadvantage suffered by a group of people identified by grounds explicitly listed in the *Charter* (race, national or ethnic origin, colour, religion, sex, age or mental or physical disability) or by analogous grounds (e.g., sexual orientation, marital status).[44] However, when a treatment or service is offered by the government, s. 15 requires that it be done in a way that is non-discriminatory, which may involve an obligation

[41] *Hitzig v. Canada*, [2003] at para. 111.

[42] *Rodriguez v. British Columbia (Attorney General)*, [1993].

[43] *Law v. Canada*, [1999] 1 S.C.R. 497 (Supreme Court of Canada) at para. 42.

[44] *Auton v. British Columbia (Attorney General)*, [2004] 3 S.C.R. 657 (Supreme Court of Canada).

on the part of government to take positive steps to ensure that disadvantaged groups benefit equally from services offered to the general public.[45]

A test for the infringement of s. 15 was established in *Andrews v. Law Society of British Columbia* and refined in *Law v. Canada*.[46] To prove the infringement, three criteria must be satisfied:

1. There has been a distinction in the treatment received by a particular person or group;

2. The distinction is based upon one or more of that person or group's personal characteristics, such as those enumerated in, or analogous to, the characteristics listed in s. 15; and

3. The distinction is discriminatory.

A distinction in treatment between persons who require assisted injection and those who are able to self-inject is evident in the fact that only self-injection is currently permitted at SIFs. Persons who cannot self-inject are denied the medically supervised injection that SIFs provide to other clients.

The second issue is whether the distinctive treatment is based upon a personal characteristic analogous to, or enumerated within, those listed in s. 15(1). To address this issue, it is necessary to consider the different groups of persons who require assisted injection and the underlying reasons that bring about their need.

A distinction in treatment based on physical or mental disability is explicitly covered by s. 15(1). Thus, those who require assisted injection due to physical or mental disabilities may be covered. It is also worth noting that dependence on alcohol or drugs (either actual or perceived) is itself considered a disability for the purposes of anti-discrimination law.[47] There is also evidence that a disproportionate number of those who require assisted injection are women.[48] A wide range of factors causes this group to require assistance, including the lack of injecting experience, lack of financial resources, and social or gender imbalance.[49]

It might be argued that deterring disabled persons or persons of one sex from a SIF was not an intended effect of the current exemption letter. However, the Supreme Court has held on several occasions that *direct* discrimination is not necessary to ground a claim under s. 15(1).[50] Rather, *systemic* discrimination (also sometimes referred to as *incidental*, *indirect* or *adverse-effects* discrimination) exists when the law has a disproportionately adverse effect on persons defined by one or more of the prohibited grounds of discrimination. This could arise, for example, from the failure to recognize the special disadvantage or

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[45] *Eldridge v. British Columbia (Attorney General)*, [1997] 3 S.C.R. 624 (Supreme Court of Canada).

[46] *Andrews v. Law Society of British Columbia*, [1989] 1 S.C.R. 143 (Supreme Court of Canada); *Law v. Canada*, [1999].

[47] For example, the *Canadian Human Rights Act* defines disability as any previous or existing mental or physical disability and includes disfigurement and previous or existing dependence on alcohol or a drug: R.S.C 1985, c. H-6, s. 25. The Federal Court of Appeal has expressly confirmed that it would be contrary to the Supreme Court's interpretation of human rights legislation to limit the definition of disability only to dependence on legal drugs; therefore, dependence on illegal drugs also constitutes a disability under the Canadian Human Rights Act: *Canada (Human Rights Commission) v. Toronto-Dominion Bank*, [1998] 4 F.C. 205. In British Columbia, the B.C. Human Rights Tribunal has determined that chemical dependence is a disease, and is thus a disability under the British Columbia provincial Human Rights Code: *Williams v. Elty Publications Ltd.*, [1992] 20 C.H.R.R. D/52, [1992] B.C.C.H.R.D. No 25; *Handfield v. North Thompson School District*, [1995] 25 C.H.R.R. D/452, [1995] B.C.C.H.R.D. No 4. In Alberta, dependence on a chemical substance has been found to constitute a physical or mental disability under the *Alberta Human Rights, Citizenship and Multiculturalism Act*: *Alberta (Human Rights Commission) v. Elizabeth Metis Settlement*, [2003] 2003 ABQB 342, A.J. No 484. In Ontario, the 1996 case of *Entrop v. Imperial Oil Ltd.* determined that actual and former drugs users are protected against discrimination by the prohibition on discrimination based on disability under the Ontario Human Rights Code: (1996), 23 C.H.R.R. D/196, [1996] O.H.R.B.I.D. No 30 (Ontario Board of Inquiry), affd *Imperial Oil Ltd. v. Ontario (Human Rights Commission) (re Entrop)*, [1998] 35 C.C.E.L. (2d) 56, [1998] O.J. No 422 (Divisional Court), varied but affirmed on this point *Entrop v Imperial Oil Ltd et al.*, [2000] 50 O.R. (3d) 18 (Ontario Court of Appeal). Similarly, it has been held that drug dependence is a handicap in the sense of article 10 of the Quebec *Charter of Rights and Freedoms*: *Lapointe v. Doucet*, [1999] J.T.D.P.Q. No 16 (Quebec Human Rights Tribunal).

[48] J. O'Connell et al., "Requiring help injecting independently predicts incident HIV infection among injection drug users".

[49] R. MacRae and E. Aalto, "Gendered power dynamics and HIV risk in drug-using sexual relationships"; J. O'Connell et al., "Requiring help injecting independently predicts incident HIV infection among injection drug users".

[50] *Eldridge v. British Columbia (Attorney General)*, [1997];*Vriend v. Alberta*, [1998] 1 S.C.R. 493 (Supreme Court of Canada); *Tétreault-Gadoury v. Canada (Employment and Immigration Commission)*, [1991] 2 S.C.R. 22 (Supreme Court of Canada).

requirements of a particular group. Therefore, although the prohibition on assisted injection within SIFs was not specifically designed to exclude disabled persons or women, the fact that in effect the prohibition creates a distinction among those who can benefit from the health service, based on grounds such as disability or sex, may be sufficient to ground a claim that s. 15(1) of the *Charter* has been breached.

The third requirement to ground a *Charter* s. 15(1) infringement claim is that the distinction is discriminatory.[51] Discrimination as it pertains to the *Charter* right to equality need not be intentional, but generally involves the imposition of a burden or the denial of a legal benefit. The case of *Eldridge v. British Columbia* involved the failure of the B.C. government to provide sign language interpretation services, as an insured benefit under the province's public health insurance plan, to three deaf individuals during the latter stages of pregnancy and childbirth. The three deaf individuals suffered discrimination from the failure to ensure that they benefited equally from insured medical services offered to everyone. The Supreme Court held that the B.C. government had not reasonably accommodated those with hearing disabilities.[52] The Supreme Court noted that it has "repeatedly held that once the state does provide a benefit, it is obliged to do so in a non-discriminatory manner."[53] Furthermore, "adverse effects discrimination is especially relevant in the case of disability. The government will rarely single out disabled persons for discriminatory treatment. More common are laws of general application that have a disparate impact on the disabled."[54]

Reasoning by analogy, those who require assisted injection are also being denied the benefits that are provided to others who use a SIF, such as injecting under medical supervision, injecting without fear of criminal sanction, access to clean syringes and information on addiction treatment, and emergency response in the event of an overdose.

The Supreme Court has also identified a number of additional factors relevant to establishing a claim of discriminatory treatment.[55] These include the aggravation of a pre-existing disadvantage, the nature of the interests affected by the government act or omission, and the harm to human dignity that results.

According to the Supreme Court, "probably the most compelling factor favouring a conclusion that a differential treatment imposed by legislation is discriminatory will be, where it exists, pre-existing disadvantage, vulnerability, stereotyping, or prejudice experienced by the individual or group".[56] As a group, people who inject drugs are disadvantaged by addiction and vulnerability to disease and infection, and certainly subject to pernicious prejudice and stigmatization. As already noted, dependence on a drug has been recognized as a form of disability under Canadian human rights law. Therefore, injection drug use, even on its own, may be recognized as a pre-existing disadvantage. The compounded element of requiring assisted injection further increases the disadvantage and vulnerability related to drug addiction, since those requiring such assistance may be even more vulnerable to harm if denied access to such help within a health facility such as a SIF. The Supreme Court has stressed that the government must take special measures to ensure that disadvantaged groups are able to benefit equally from government services: "To argue that governments should be entitled to provide benefits to the general population without ensuring that disadvantaged members of society have the resources to take full advantage of those benefits bespeaks a thin and impoverished vision of s. 15(1)."[57]

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[51] *Andrews v. Law Society of British Columbia*, [1989].

[52] *Eldridge v. British Columbia (Attorney General)*, [1997].

[53] See *Tétreault-Gadoury v. Canada (Employment and Immigration Commission)*, [1991]; *Haig v. Canada (Chief Electoral Officer)*, [1993] 2 S.C.R. 995 (Supreme Court of Canada) at pp. 1041-42; *Native Women's Association of Canada v. Canada*, [1994] 3 S.C.R. 627 (Supreme Court of Canada) at 655.

[54] *Eldridge v. British Columbia (Attorney General)*, [1997].

[55] *Law v. Canada*, [1999].

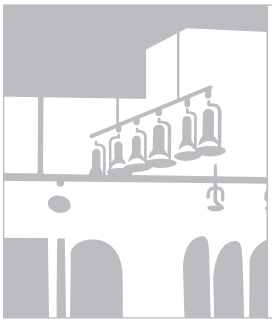
[56] *Law v. Canada*, [1999] at para. 63.

[57] *Eldridge v. British Columbia (Attorney General)*, [1997].

The prohibition on assisted injection may also be found to be discriminatory, based upon the nature of the interest affected. The more severe or localized the consequences of differential treatment, the more likely that discrimination will be found.[58] In this case, the consequences to the individual who requires assisted injection may be severe, in that the prohibition on assisted injection at SIFs removes the benefits of medically supervised injection, including measures to prevent death from overdose, should this occur.

Discrimination may also be demonstrated when the distinction in treatment causes harm to the human dignity of an individual or group. As stated by the Supreme Court:

> Human dignity within the meaning of the equality guarantee does not relate to the status or position of the individual in society per se, but rather concerns the manner in which a person legitimately feels when confronted with a particular law . . . Human dignity is harmed when individuals and groups are marginalized, ignored, or devalued, and is enhanced when laws recognize the full place of all individuals and groups within Canadian society.[59]



The prohibition of assisted injection may marginalize those who require assistance by denying them the increased safety and health resources provided at SIFs.

The prohibition of assisted injection may marginalize those who require assistance by denying them the increased safety and health resources provided at SIFs. It may also ignore the serious risks to health and security that are maintained when the health-protecting benefits of the SIF are withheld, due to the prohibition on assisted injection, from whose who are likely to be most vulnerable to harm. The human dignity of people requiring assistance may therefore be harmed by the current state of the law, and as such the prohibition against injection assistance at SIFs should be seen as discriminatory.

In summary, claiming the infringement of s. 15(1) equality rights requires the demonstration of a distinction in treatment, based on enumerated or analogous grounds, which is discriminatory. The prohibition against assisted injection at SIFs may meet the requirements for this claim.

Charter s. 1: Can prohibiting assisted injection be justified?

The Canadian Charter of Rights and Freedoms *guarantees the rights and freedoms set out in it subject only to such reasonable limits prescribed by law as can be demonstrably justified in a free and democratic society.*

Section 1 of the *Charter* permits the state to infringe upon *Charter* rights insofar as such limitations can be "demonstrably justified in a free and democratic society". Therefore, even if s. 7 and s. 15 rights are infringed, it is also necessary to consider whether the government will be able to justify such infringements under s. 1. The test to determine what can be accepted as "demonstrably justified" under this section has been outlined by

[58] *Egan v. Canada,* [1995] 2 S.C.R. 513 (Supreme Court of Canada).

[59] *Law v. Canada*, [1999] at para. 53.

the Supreme Court in *R. v. Oakes* and subsequent cases.[60] To justify the infringement of a *Charter* right by a law or government policy or action, the government must demonstrate that:

- the objective of the government measure is of sufficient importance to warrant overriding a constitutional right — meaning that, at a minimum, it must relate to concerns which are pressing and substantial;
- the measure is rationally connected to the achievement of this objective and is not arbitrary, unfair or based on irrational considerations;
- the measure impairs as little as possible the right in question; and
- the harm done by limiting the right does not outweigh either the importance of the measure's objective or the benefits of the measure.

Pressing and substantial purpose to justify limiting Charter *rights*

In practice, it has not been difficult for governments to satisfy the requirement that the rights infringement be relative to a pressing and substantial purpose. In the absence of any clear statement from the government as to why its CDSA s. 56 exemptions for SIFs permit only possession of a controlled substance for self-injection, it is difficult to know for certain what objectives it seeks to pursue by maintaining the possibility of criminal prosecution in the event of assisted injection — which makes it difficult to subject the prohibition to proper constitutional analysis. The failure to permit assisted injection within the SIF may reflect the desire not to condone, within the facility, behaviours that technically amount to trafficking under the CDSA (albeit not of any quantity of drugs other than what clients have already themselves brought to the facility for their own use), or that may amount to other offences under the *Criminal Code*, as discussed later in this paper. It could also be argued that the government may not want to subject nurses or doctors to the ethical predicament of deciding whether to assist in the injection of drugs of unknown quality or potency. Additionally, the government may be attempting to decrease the use of drugs generally.

Rational connection between government objective and limit on Charter *rights*

The above purposes must also be rationally connected to the means undertaken to achieve them. In this respect, the prohibition of assisted injection arguably fails s. 1 scrutiny. Neither criminal activity nor drug use is deterred by denying those who require assisted injection from utilizing SIFs.[61] On the contrary, the prohibition of assisted injection at SIFs may increase the health risks of already vulnerable and marginalized persons by maintaining conditions that are conducive to health complications, including the spread of HIV and death by overdose.

The ethical predicament faced by doctors and nurses approached with requests for assisted injection is certainly a valid concern. However, it could be noted that the prohibition of assisted injection at SIFs takes the choice away from medical professionals who might rather assist with an injection than see a client turned away at the door or struggle with multiple injection attempts, and thereby come to greater harm. A blanket prohibition on assisted injection may protect health staff who would prefer not to assist, but it creates an ethical dilemma for those who believe it is within their competence and duty to help. The objective of protecting the preferences of some practitioners could also be met by leaving the decision as a voluntary choice.

[60] *R. v. Oakes*, [1986] 1 S.C.R. 103 (Supreme Court of Canada). See also: *R. v. Edwards Books and Art*, [1986] 2 S.C.R. 713 (Supreme Court of Canada); *Dagenais v. CBC*, [1994] 3 SCR 835 (Supreme Court of Canada); *Thompson Newspaper Co. v. Canada (Attorney General)*, [1998] 1 SCR 877 (Supreme Court of Canada).

[61] By similar reasoning, the creation of barriers to medical access caused by government imposed criminal regulations sanctioning the purchase of medical marijuana has been deemed not rationally connected to government objectives, and therefore not justified under s. 1: *Hitzig v. Canada*, [2003].

Minimal impairment of Charter *rights*

The s. 1 requirement that rights infringement be proportional to the benefits brought by that infringement includes the requirement that rights be only minimally impaired. That is, if rights are to be infringed, the level of infringement must not exceed the minimum required to fulfill the desired purpose. It may be that the blanket prohibition of assisted injection at SIFs might not meet the minimal impairment requirement.[62]

Proportionality between harms and benefits of the measure

The harm done by limiting the right must not outweigh either the importance of the measure's objective or the benefits of the measure. It is unclear whether a prohibition on assisted injection would meet this requirement. The consequences of denying assisted injection to a SIF client can be severe. At the most extreme, it may result in a heightened risk of death from overdose, given that the client will seek assistance outside the SIF, in circumstances where timely access to emergency intervention is far less likely.[63] Given that the objective served by the prohibition on assisted injection is unclear, it is hard to assess just how important that objective is, or how successful a ban on assisted injections is in actually achieving that objective. Finally, given the serious harms that may flow from such a restriction on the delivery of a SIF's full health benefits, and the evidence that such benefits are in fact denied to particular populations in a manner that amounts to indirect discrimination, it is difficult to conclude that the objective(s) and benefits (whatever those might be speculated to be) so clearly outweigh the harms as to be justifiable.

It may be that s. 1 does not justify the infringement of s. 7 or s. 15 rights caused by the prohibition of assisted injection at SIFs.

[62] For example, the Supreme Court of Canada has held that the total denial of access to a medical service by a disabled or disadvantaged group in particular (in that case the hearing impaired) did not meet the minimal impairment requirement. See *Eldridge v. British Columbia (Attorney General)*, [1997].

[63] The characteristic of requiring help with injecting is a strong risk factor for non-fatal overdose. See T. Kerr et al., "Predictors of non-fatal overdose among a cohort of polysubstance-using injection drug users," *Drug and Alcohol Dependence* 87(1) (2007): pp. 39-45.

Current legal framework

Potential criminal offences

This section considers potential criminal liability under both the *Controlled Drugs and Substances Act* (CDSA) and the *Criminal Code* for SIF staff and/or clients if staff were to assist a client with injection or if clients were to help other clients inject.

CDSA offences

Using the example of Insite in Vancouver, this SIF currently operates under an exemption from the federal Minister of Health pursuant to s. 56 of the CDSA. This section states:

> The Minister may, on such terms and conditions as the Minister deems necessary, exempt any person or class of persons or any controlled substance or precursor or any class thereof from the application of all or any of the provisions of this Act or the regulations if, in the opinion of the Minister, the exemption is necessary for a medical or scientific purpose or is otherwise in the public interest.

Insite's current ministerial exemption is explicitly for the scientific purpose of permitting research on a pilot SIF. Under the letter from the Minister, while staff and clients are "within the interior boundaries of the site", they are exempted from the prohibition on simple possession of a controlled substance set out in s. 4(1) of the CDSA. The exemption reads:

> The following classes of persons are hereby exempted as set out below from the application of subsection 4(1) of the CDSA as that provision applies to the possession of the controlled substances specified below:
>
> - All staff members are exempted, while they are within the interior boundaries of the site, from the offence of simple possession of any controlled substance in the possession of a research subject or that is left behind by a research subject within the interior boundaries [of] the site, if such possession [is] to fulfil their functions and duties in connection with the pilot research project;
>
> - Research subjects are exempted, while they are within the interior boundaries of the site, from the offence of simple possession of a controlled substance intended for self-injection, if possession of the controlled substance is for the purpose of self-injection by the research subject; this exemption does not cover controlled substances that are self-administered by other means other than injection, e.g., smoking, inhaling, etc.

Possession

As noted above, according to the current exemption, staff and "research subjects" (i.e., clients) are exempt from prosecution under subsection 4(1) of the CDSA (possession of a controlled substance) when they are within the interior boundaries of the SIF. The current exemption also applies to staff with respect to "any controlled substance in the possession of a research subject or that is left behind by a research subject within the interior boundaries [of] the site, if such possession [is] to fulfill their functions and duties in connection with the pilot research project." The current exemption applies to clients with respect to "a controlled substance intended for self-injection, if possession of the controlled substance is for the purpose of self-injection by the research subject." If the substance is possessed for some other purpose, that possession remains an offence under the CDSA for which a person may be prosecuted criminally.

Pursuant to s. 2(1) of the CDSA, possession means "possession within the meaning of subsection 4(3) of the *Criminal Code*", under which there are three forms of possession:

- personal possession;
- constructive possession; and
- joint possession.

In instances of personal possession, the Crown must establish the following three elements:

- physical contact with the substance;
- knowledge of what the substance is; and
- some measure of control.[64]

It may be assumed that charges of possession (as personal possession) could be brought against SIF staff or clients if possession of the controlled substance was for the purpose of assisted injection. Charges of possession might be brought against a client or a nurse who was helping inject, in situations where the controlled substance was under the physical control of that person.

Insite's current ministerial exemption is explicitly for the scientific purpose of permitting research on a pilot SIF.

In addition to the clients and/or staff actually involved in assisted injection, possession charges might also be brought against others present at the SIF at the time of an assisted injection. Under the *Criminal Code* definition mentioned above, the offence of possession may apply not only where a person has a drug in his or her personal possession but also:

- where a person "knowingly" has the drug in the actual possession or custody of another person, or has the drug in any place for the use or benefit of himself or herself or of another person (also known as constructive possession); or
- "[w]here one of two or more persons, with the knowledge and consent of the rest, has anything in his custody or possession, it shall be deemed to be in the custody and possession of each and all of them" (also known as joint possession).[65]

Joint possession is the more relevant form for this discussion. The important concepts are *knowledge* and *consent*. Because possession of a drug for purposes other than self-injection would fall outside the scope of the current exemption, anyone at a SIF who prosecutors could prove knew and consented to someone else having possession of a controlled substance for the purposes of assisted injection could also potentially be liable for possession.

[64] B. MacFarlane, R. Frater and C. Proulx, *Drug Offences in Canada* (Aurora, ON: Canada Law Book, 1998), Chapter 4 ("Possession") at p. 4ff.

[65] *Criminal Code*, R.S.C. 1985, c. C-46, s. 4(3).

For joint possession to be made out, there must be evidence of a measure of control on the part of the accused.[66] While SIF staff and clients might have *knowledge* that possession of a controlled substance was for the purposes of assisted injection, they would also have to have some measure of control over that possession in order for them also to have *consent* to possession for those purposes and therefore be criminally liable. In *R. v. Colvin and Gladue*, for example, the British Columbia Court of Appeal overturned possession convictions against two accused who were visiting a person in his room while he was in possession of morphine.[67] While the accused knew their host had morphine, as mere visitors they were not in a position to exercise any control over it. Consorting with the true possessor was not enough to satisfy the knowledge and consent requirements of possession within the meaning of the *Criminal Code*. In *R. v. Chambers*, however, the accused was found guilty of possession because she had the power to grant or withhold her consent to her room being used to store someone else's cocaine.[68]

Therefore, it is possible that SIF staff or clients administering an injection risk liability for possession (as personal possession). In addition, it is possible that SIF staff, or others who knew that controlled substances were possessed on the facility's premises for the purposes of assisted injection and who were in a position to authorize that procedure, risk liability for possession (as joint possession).

Trafficking

Under the CDSA, trafficking of a controlled substance is partially defined as "to sell, administer, give, transfer, transport, send or deliver the substance",[69] whether or not the substance is provided in exchange for money or something else of value. As such, there are various modes of trafficking.

The act of assisted injection appears most closely related to the mode "administer." A handful of cases have held that the act of injecting a controlled substance into another person does in fact constitute trafficking under the CDSA. In *R. v. Creighton*, the accused injected cocaine into a consenting friend, leading to her death. He was subsequently convicted of unlawful act manslaughter, with trafficking as the underlying unlawful act. In upholding the conviction, the Supreme Court confirmed that the act of injecting another person with cocaine falls within the definition of trafficking as defined in the *Narcotic Control Act* (the precursor to the CDSA).[70] In *R. v. Worrall*, an Ontario trial court found that a charge of trafficking may be established without proof of the actual act of injecting.[71] In *Worrall*, the accused was found guilty of unlawful act manslaughter (discussed in greater detail below) after the victim died of a heroin overdose. The underlying unlawful act (for the purpose of making out the offence of unlawful act manslaughter) was trafficking. There was some evidence at trial that the accused had injected the victim, and other evidence that the accused had simply supplied the victim with a syringe prepared with heroin. The court found that in the circumstances of the case, providing a drug-loaded syringe to another person with the knowledge and encouragement that they self-inject is legally equivalent to injecting that person: "It is beyond dispute that injecting another person with a syringe known to contain heroin is trafficking in heroin, a controlled substance. And so is supplying another with a syringe containing heroin with the intention that the other person may inject him or herself with the drug."[72]

Therefore, it is possible that staff or clients of a SIF who inject another person risk liability for trafficking.

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[66] *R. v. Terrence*, [1983] 1 S.C.R. 357 (Supreme Court of Canada).

[67] *R. v. Colvin*, [1942] 78 CCC 282 (B.C. Court of Appeal).

[68] *R. v. Chambers*, [1985] 20 C.C.C. (3d) 440, 9 O.A.C. 228 (Ontario Court of Appeal).

[69] *Controlled Drugs and Substances Act*, S.C. 1996, c.19, s. 2(1).

[70] *R. v. Creighton*, [1993] 3 S.C.R. 3 (Supreme Court of Canada).

[71] *R. v. Worrall*, [2004] 189 C.C.C. (3d) 79 (Ontario Superior Court of Justice).

[72] *R. v. Worrall*, [2004].

Criminal Code offences

Homicide

Potentially, a person who receives assisted injection could die as a result of an overdose or other complication. Therefore, the homicide provisions of the *Criminal Code* must be considered. In the *Criminal Code*, culpable homicides are divided into the offences of murder, manslaughter or infanticide; only the first two are relevant to the present analysis. As set out below, it is unlikely that murder charges could be sustained in cases where one person has assisted another in injecting a controlled substance at a SIF; however, the situation would be much less clear in the case of manslaughter charges.

Murder

An assisted injection resulting in death would likely fall outside the scope of the definition of murder outlined in s. 229 of the *Criminal Code*. Murder has been recognized by the Supreme Court as carrying the greatest level of stigma and punishment available in Canadian law (i.e., minimum term of imprisonment for life).[73] As such, murder convictions are reserved for those acts leading to death that carry the greatest moral blame.

(1) Intentional or reckless homicide

Culpable homicide is murder where it can be proven beyond a reasonable doubt that the accused, in his or her own mind, intends to cause death, or alternatively, intends to cause bodily harm that he or she knows is likely to cause death (ss. 229(a)(i) and (ii) of the *Criminal Code* respectively). Whether the accused had this intent is determined by a jury, instructed to draw the "common sense inference that sane and sober people intend the natural and probable consequences of their actions".[74] Intent need not be synonymous with desire or motive; the accused may both regret and still intend the death.[75] However, proving the required intention for a murder conviction under this part of the *Criminal Code* will most likely require that the result of death, or bodily harm likely to cause death, was within the purpose underlying the actions of the accused.[76] Merely being reckless as to the possibility of death or bodily harm is insufficient to found a murder charge;[77] there must be actual knowledge on the part of the accused that death is likely to result.

How, then, might this offence apply to the situation in which one person assists another in injecting an illegal drug at a SIF, and the injected person subsequently dies (e.g., from an overdose or from having injected a substance that was adulterated)? Since there would be no intent to cause death, or to cause bodily harm that the assisting person knows is likely to cause death, it seems highly unlikely that the person who assisted with the injection could be found guilty of murder under s. 229(a) of the *Criminal Code*.

(2) Homicide in the course of effecting unlawful purpose

A murder conviction may also result where a person, *for an unlawful object*, does anything that he or she knows is likely to cause death, and thereby causes death. It is not relevant whether the person wanted to achieve that unlawful object without causing death or injury to anyone (s. 229(c)). The unlawful object desired by the person must be some additional object beyond the act that resulted in the death.[78] As long as the person did the act for some unlawful purpose (other than to bring about the very act that resulted in death),[79] and did so knowing that the act was likely to cause death, this amounts to murder under this section of the *Criminal Code*. This is the

[73] *R. v. Martineau*, [1990] 43 C.C.C. (2d) 417 (Court of Appeal), affd [1990] 2 S.C.R. 633 (Supreme Court of Canada).

[74] *R. v. Seymour*, [1996] 2 S.C.R. 252 (Supreme Court of Canada).

[75] *R. v. Kirkness*, [1990] 3 S.C.R. 74 (Supreme Court of Canada).

[76] *R. v. Kirkness*, [1990].

[77] *R. v. Dempsey,* [2002] 165 C.C.C. (3d) 440 (B.C. Court of Appeal).

[78] *Martin's Annual Criminal Code, 2005* (Ontario: Canada Law Book Inc., 2005), p. CC/426.

[79] *R. v. Tousignant,* [1986] 51 C.R. (3d) 84 (Ontario Supreme Court- High Court of Justice).

least demanding murder provision — the prosecution only has to prove the accused intended the unlawful act that he or she knows is likely to cause death.

Again, how might this apply to the circumstance of assisting a client with injecting a controlled substance in a SIF? It is unlikely that possessing or trafficking a controlled substance would satisfy this requirement of an act, done for a separate unlawful purpose, which is likely to cause death. The offence of possession is unlikely to be a basis for a murder charge or conviction under s. 229(c) because possession alone could not be considered "likely to cause death". While the act of injecting the other person technically constitutes trafficking under the CDSA, as discussed above, this would be the very same act that led to the death of the person who died from an overdose or other complication. Since the act that resulted in death and the act for an unlawful purpose are the same (i.e., injection), it is unlikely that an unlawful act murder charge for assisted injection could be made out using trafficking as the underlying offence.

The offence of possession is unlikely to be a basis for a murder charge or conviction under s. 229(c) because possession alone could not be considered "likely to cause death".

Manslaughter

Any culpable homicide that does not constitute murder (or infanticide) is manslaughter (*Criminal Code* s. 236). Forms of culpable homicide are outlined in s. 222(5) and include situations where a person causes the death of a human being by means of an unlawful act or by criminal negligence.

All forms of manslaughter share a maximum penalty of life imprisonment (s. 236).

(1) Unlawful act manslaughter

Unlawful act manslaughter pursuant to *Criminal Code* s. 222(5)(a) requires that, in causing the death of the victim, the accused commit an underlying unlawful act that is objectively dangerous in that it is likely to injure another person.[80] In addition to proving the mental element required for that underlying offence, the Crown must also demonstrate that a reasonable person would foresee that the unlawful act risks causing bodily harm that is more than trivial or transitory.[81] Unlawful act manslaughter is distinguishable from murder committed in the course of pursuing an unlawful object because it does not require proof that the accused himself or herself actually foresaw the likelihood of death; rather, it only requires proof that there was a risk of non-trivial bodily harm that an ordinary person could foresee.[82]

Trafficking a controlled substance by injecting it into another person has been held to be a sufficiently dangerous underlying act that a reasonable person would foresee the likelihood that serious bodily harm could occur. In Canada, the injection of a controlled substance into a person's body has been considered as trafficking, and trafficking has been used to support the charge of unlawful act manslaughter in cases where assisted injection has led to the death of the injected person.[83] In *Creighton*, mentioned above, the accused was

[80] *R. v. DeSousa,* [1992] 2 S.C.R. 944 (Supreme Court of Canada).

[81] *R. v. Creighton,* [1993].

[82] *R. v. DeSousa,* [1992]; *R. v. Creighton,* [1993].

[83] *R. v. Creighton,* [1993]; *R. v. Worrall,* [2004].

found guilty of unlawful act manslaughter for injecting a friend with cocaine, with her consent, when she died as a consequence of the injection.[84] In *Worrall*, the accused was found guilty of supplying his brother with a syringe loaded with heroin, when his brother died as the result of a heroin overdose. The court held that "the inference that a reasonable person would foresee, from the injection of heroin, a risk that the recipient would suffer bodily harm that was neither trivial nor transitory . . . is irresistible".[85]

In Canada, trafficking (rather than administering a noxious thing) may be considered as the underlying unlawful act for the purposes of unlawful act manslaughter. Therefore, in cases where a person who received assisted injection died as a result of an overdose or other complication, the person administering the injection could theoretically be convicted of unlawful act manslaughter.

However, the good intentions that might compel a health professional to assist a client with injection might — and should — be considered relevant by a court. For example, in its decision as to the illegality of assisted suicide in *Rodriguez*, the majority of the Supreme Court pointed out that "a doctor may deliver palliative care to terminally ill patients without fear of criminal sanction", despite the fact that this involves "the administration of drugs designed for pain control in dosages which the physician knows will hasten death." The distinction between the legality of such an act as part of palliative care and the criminality of such an act if done to assist in a suicide is based upon intention — in the case of palliative care, the intention is to ease pain, whereas the "intention to undeniably cause death" makes assisting suicide illegal.[86] In the case of assisted injection, the intention would be to prevent avoidable harm or reduce the risks associated with drug use among persons unable to self-inject safely.

In the United Kingdom, the unlawful act of administering a noxious thing (discussed, in the Canadian context, below) has also been used to ground a conviction of manslaughter.[87] In *R. v. Cato*, the accused and a friend had been injecting each other with heroin over the course of an evening. Both suffered from overdose symptoms but only the friend died as a result. It was held that the administration of heroin to another person qualified as an offence under the U.K.'s *Offences against the Person Act 1861* (s. 23) which prohibits the administration of a noxious thing. The death in that case was therefore considered the result of unlawful act manslaughter. Note that in Canada, however, the mental element required for a conviction pursuant to the offence of "administering a noxious thing" (*Criminal Code* s. 245) is interpreted more narrowly.[88] Therefore, in the Canadian context, administration of a noxious thing may not as readily be used to ground unlawful act manslaughter due to the different description of intent required in Canadian law.[89]

(2) Manslaughter by criminal negligence

Under *Criminal Code* section 222(5)(b), a conviction for manslaughter may also arise from situations in which the accused caused the death of another person through criminal negligence. Criminal negligence is defined at s. 219 of the *Criminal Code*, which states that

> Every one is criminally negligent who
>
> (a) in doing anything, or
>
> (b) in omitting to do anything that is his or her duty to do,
>
> shows wanton or reckless disregard for the lives or safety of other persons.[90]

[84] *R. v. Creighton*, [1993].

[85] *R. v. Worrall*, [2004] at para 74.

[86] *Rodriguez v. British Columbia (Attorney General)*, [1993].

[87] *R. v. Cato*, [1976] 1 All E.R. 260 (U.K. Court of Appeal – Criminal Division).

[88] *R. v. Burkholder*, [1977] 2 A.R. 119, 34 C.C.C. (2d) 214 (Alberta Supreme Court – Appellate Division).

[89] For a more thorough discussion of the mental element of 'administration of a noxious thing', see page 25 of this paper.

[90] The *Criminal Code* clarifies that, for the purposes of the definition of criminal negligence, a person has a "duty" to do something if this is a *legal* duty: s. 219(2).

Criminal negligence may lead to bodily harm or death. If death occurs, the Crown has the option of charging the accused with either *manslaughter by criminal negligence* under s. 222(5)(b) or with *criminal negligence causing death* under s. 220. These provisions are similar, as both carry a maximum penalty of life imprisonment. The legal analysis is also the same.

The definition of criminal negligence in the *Criminal Code* is potentially confusing in its use of the word "reckless" to describe the disregard for others shown by the accused, because *recklessness* and *negligence* are two different standards of fault in Canadian criminal law:

- Recklessness, the higher standard of fault, is subjective — the accused person must have actually been aware of a risk of bringing about the result prohibited by the criminal law, but persisted nevertheless.[91]

- Negligence, on the other hand, is an objective standard of fault — it holds the accused person to the standard of what the "reasonable person," in the circumstances, would have foreseen to be a risk of harm or the care that such a person would have taken in light of such a risk.

Notwithstanding the confusing use of the word "reckless" in the *Criminal Code* definition, the case law has made it clear that the objective fault standard of negligence applies in determining whether an accused is guilty of criminal negligence (whether it causes death or merely bodily harm). The prosecution need not prove that a reasonable person would have foreseen that his or her conduct risked causing death, only that a reasonable person would have foreseen the risk of bodily harm that is neither trivial nor transitory.[92]

However, the courts have also clarified that in order for negligence to attract *criminal* punishment, it must be more severe or gross than merely simple negligence (which would be sufficient for someone to be liable for damages in a civil lawsuit).[93] According to the Supreme Court, the reckless or wanton disregard that amounts to criminal negligence is practically defined as a "marked departure from the standard of care that a reasonable person would observe in the accused's situation".[94]

In the context of injection by a non-medical professional (and outside a SIF), criminal negligence was found in *Creighton*, where the accused injected cocaine of unknown quality and potency into a consenting friend. In applying the objective standard of the care that the "reasonable person" would take in the circumstances, the courts at all levels took the approach that the reasonable person should be deemed to be someone with the considerable experience in drug use possessed by the accused — meaning that his special knowledge and experience as to drug use was relevant in establishing the mental element of objective foresight of the risk of harm. As noted with approval by several judges of the Supreme Court, the trial judge had concluded not only that the risk of death or serious bodily harm was objectively foreseeable by the reasonable person with the accused's experience, but that he in fact foresaw such a risk in injecting his friend with cocaine, given his familiarity with the drug and its "lethal nature". Furthermore, he failed to act with the care that a reasonably prudent person would have taken in such circumstances because he knew she already had consumed a substantial amount of the same narcotic, and he failed to consider the quantity used to inject her.[95]

[91] *Sansregret v The Queen*, [1985] 1 S.C.R. 570 (Supreme Court of Canada).

[92] *R. v. Pinske*, [1988] 30 B.C.L.R. (2d) 114 (B.C. Court of Appeal), affd [1989] 2 S.C.R. 979 (Supreme Court of Canada); *R. v. DeSousa*, [1992]; *R. v. Creighton*, [1993] at paras. 74-88.

[93] *R. v. City of Sault Ste. Marie*, [1978] 2 S.C.R. 1299 (Supreme Court of Canada); *Sansregret v The Queen*, [1985]; *R. v. Creighton*, [1993] at para. 113 (per McLachlin J. et al.); *R. v. Gosset*, [1993] 3 S.C.R. 76 (Supreme Court of Appeal); *R. v. Finlay*, [1993] 3 S.C.R. 103 (Supreme Court of Canada).

[94] *R. v. Anderson*, [1990] 1 S.C.R. 265 (Supreme Court of Canada) at 270; *R. v. Morrissey*, [2000] 2 S.C.R. 90 (Supreme Court of Canada) at para. 19; *R. v. Hundal*, [1993] 1 S.C.R. 867 (Supreme Court of Canada); *R. v. Creighton*, [1993] at para. 144.

[95] *R. v. Creighton*, [1993] at paras. 37, 52 (per Lamer C.J. et al.).

Given judgments such as *Creighton*, it may be that liability for criminal negligence could be imposed in cases of assisted injections following which the injected person dies. This finding may be made despite any personal beliefs on the part of staff or clients as to the safety of the drug or quantity injected. However, in *Creighton*, the injection was not performed by a medical person in a SIF, nor was it clear that the accused injected the friend because she was unable to inject herself or required assistance with injecting to perform this task more safely.

Some jurisprudence dealing with situations of injections resulting in death suggest that courts have tended to be lenient towards medical professionals and have only rarely imposed upon them convictions for criminal negligence under the *Criminal Code*. Rather, cases of medical malpractice are generally resolved in civil courts or through professional board sanctions. In *R. v. Giardine* for example, a trial court held a doctor was not criminally negligent after accidentally administering a lethal drug to a patient. The doctor had relied upon a nurse's identification of the drug, and his failure to confirm its identity was not a sufficiently reckless act. Rather, "to render a medical practitioner criminally responsible it must be shown that his negligence or incompetence showed such a disregard for the life and safety of his patient as to amount to a crime against the state and conduct deserving punishment."[96] This reasoning echoed that of an earlier, cited decision of the Ontario Court of Appeal considering the question of criminal liability for negligence, in which the court stated that "[t]o constitute crime there must be a certain moral quality carried into the act before it becomes culpable."[97] In a separate case, *R. v. Omstead*, a nurse who mistakenly caused the overdose death of a patient after administering the wrong drug was found not criminally negligent, despite having committed errors in standard precautionary procedures.[98] While she was mistaken in her belief as to the nature of the drug, that belief was reasonably held; therefore, there was not criminal negligence on her part. Reasonable belief is to be determined by considering "whether a reasonable person, having had the accused's set of experiences could have had the same perception as the accused did when placed in the accused's situation."[99]

In the case of assisting a SIF client with injection, what must certainly be weighed in the balance is the additional risk of harm, through unsafe injection practice, that is avoided by providing the assistance.

To assist in the injection of a controlled substance of uncertain quality and potency is arguably a dangerous activity that may in itself place a patient's life or health at risk. In doing so, however, it is unclear whether a medical practitioner would meet the degree of disregard for life or safety that is necessary to found a charge of criminal negligence. In the case of assisting a SIF client with injection, what must certainly be weighed in the balance is the additional risk of harm, through unsafe injection practice, that is avoided by providing the assistance. Consider as well that, in most circumstances, the drugs being injected at a SIF are acquired by the clients themselves[100] and it is the clients who have made the decision to inject those drugs. The SIF and its staff do not have knowledge of the exact contents of the substance acquired by the client, nor do they have full

[96] *R. v. Giardine*, [1939] 71 C.C.C. 295 (Ontario Court of Appeal).

[97] *R. v. Greisman*, [1926] O.J. No. 17 (Ontario Supreme Court – Appellate Division).

[98] *R. v. Omstead*, [1999] O.J. No. 570 (Ontario Court of Justice).

[99] *R. v. Charlebois*, [2000] 2 S.C.R. 674 (Supreme Court of Canada).

[100] This would obviously not be the case in a setting such as a trial of heroin prescription (e.g., NAOMI), where the drug being injected under medical supervision is provided by a health professional.

knowledge of the injecting history or immediate health condition of the client at the time of injecting. The SIF's function is to minimize some of the risks of harm associated with injection by making the practice as safe as possible, while accepting that clients are injecting substances that may be harmful. Consequently, it would not be reasonable to hold the health professional liable for whatever injury is caused by the substance itself. It would be perverse to penalize the health professional for an outcome that results from the nature or quantity of the substance that the client himself or herself decided to inject, where the health professional intends to make the act of injecting less risky. Furthermore, drug overdoses at SIFs can be treated quickly by medical staff on site. The availability of supervisory care and counselling may further support the argument that doctors and nurses assisting with an injection are not acting in criminally negligent fashion, but rather are acting reasonably by using their professional skills and training in administering injections with the purpose of preventing or reducing harm.

Criminal negligence causing bodily harm

The definition of criminal negligence in s. 219 of the *Criminal Code* also applies to situations in which the act or omission of the accused causes bodily harm, but not death. Criminal negligence that leads to bodily harm is punishable by imprisonment for a term not exceeding 10 years (s. 221). As with the discussion (above) regarding criminal negligence causing death, it may be that assisted injections that result in bodily harm involve liability for causing harm by criminal negligence. However, the same countervailing policy considerations noted above might also mitigate this liability.

Administering a noxious thing

The *Criminal Code* makes it an offence to administer a noxious thing with the intent to cause harm. Section 245 reads as follows:

> Everyone who administers or causes to be administered to any person or causes any person to take poison or any other destructive or noxious thing is guilty of an indictable offence and liable
>
> a) to imprisonment for a term not exceeding fourteen years, if he intends thereby to endanger the life or to cause bodily harm to that person; or
>
> b) to imprisonment for a term not exceeding two years, if he intends thereby to aggrieve or annoy that person.

A conviction under this section requires proof of not only the physical act of administering a noxious thing, but also proof of the mental intention to endanger life, cause bodily harm or to aggrieve or annoy.

The definition of a "noxious thing" is articulated in *R. v. Burkholder.*[101] It includes any substance that, in light of all circumstances of its administration, is capable of causing or will cause in the normal course of events, the outcomes listed in s. 245 (i.e., endangering a person's life, causing bodily harm, or aggrieving or annoying a person). Relevant circumstances to be considered include the substance's inherent characteristics, the quantity administered, and the manner in which it is administered. All factors taken together are required to determine whether a substance is noxious or not.

In the context of assisted injection, a court may likely conclude that an illegal drug of uncertain quality and potency constitutes a noxious thing. Such a drug is arguably capable of endangering life or causing bodily harm even in the normal course of use. Drugs that may be injected, such as cocaine, have in their inhalable forms been held to be noxious by Canadian courts.[102] In *Worrall*, already mentioned above, the Ontario Court of Appeal concluded that a reasonable person would foresee a risk that injecting heroin could cause bodily

[101] *R. v. Burkholder,* [1977] at (A.R.) paras. 22-25 (A.R.).

[102] E.g., *R. v. McDowell*, [2002] 2002 ABPC 1999, A.J. No. 1565 (Alberta Provincial Court – Criminal Division) (QL), affirmed 2002 ABCA 65, 363 A.R. 109 (Alberta Court of Appeal).

harm that is neither trivial nor transitory; although this was not a case in which the court was considering a charge of administering a noxious thing, this finding suggests heroin would easily be considered a noxious thing by courts for the purposes of s. 245.[103] Heroin's potential to cause harm has also led it to be held as a noxious substance in the United Kingdom. In *R. v. Cato*, a man was convicted under the U.K.'s *Offences Against the Person Act, 1861* of administering a noxious thing after injecting a friend with heroin, and thereby causing death.[104] Therefore, the physical elements required for the offence of administering a noxious thing may be satisfied by the act of injecting another person with at least some of those substances that are currently controlled under the CDSA.

In order to secure a conviction for administering a noxious thing, the Crown must also prove, beyond a reasonable doubt, the mental element of the offence — namely, that the accused intended to endanger life, cause bodily harm, or aggrieve or annoy the person who was assisted in injecting. (Mere recklessness as to the possibility that one of these outcomes might occur is not sufficient to establish the required mental element.)[105] In *Burkholder*, the court acquitted a man charged with administering a noxious thing for injecting procaine (a local anaesthetic) into a woman's genital area. The court found that the accused's intentions were to satisfy a "nefarious enterprise" and "perversion", but that "the section is not directed against perverted practices" so long as the accused does not intentionally cause bodily harm. In addition, the fact that bodily harm actually occurs is not sufficient to prove that the accused intended to cause harm.[106] In *R. v. Ssenyonga*, an HIV-positive man could not be found guilty of administering a noxious thing (i.e., his semen) by having unsafe sex with three women who later became HIV-positive. In dismissing this charge at a preliminary inquiry, the court found "no evidence that the accused could have foreseen the certainty or substantial certainty of infecting the complainants" and therefore the court could not infer subjective intent to do so.[107]

Absent highly unusual circumstances, it is unlikely that someone who assists a client at a SIF with the act of injecting does so with the intent to endanger life, cause bodily harm or otherwise aggrieve or annoy that person. To the contrary, in providing assisted injection, the intention is to reduce the harm that would or might otherwise be suffered by the person who cannot self-inject or can only do so at greater risk of harming himself or herself. As just noted, the actual occurrence of an overdose following an assisted injection (or other harm suffered as a result of the substance injected) is also insufficient on its own to prove intent, particularly since in many cases, the person assisting with the act of injecting will have no or little knowledge of the contents of the substance the client is choosing to inject, and cannot reasonably be expected to have that knowledge. Therefore, the mental element for the offence of administration of a noxious thing would not be satisfied by the practice of an assisted injection at a SIF. A person who assists with an injection with the intent only to reduce harm is unlikely to be liable under this section.

Assault

Section 265(a) of the *Criminal Code* makes it an offence to apply physical force intentionally to another person, directly or indirectly, without his or her consent. Assault that wounds, maims, disfigures or endangers the life of a person constitutes the indictable offence of aggravated assault and is punishable by up to 14 years' imprisonment (s. 268). Assault that falls short of this degree of harm, but which causes bodily harm that is neither trivial nor transitory, is an indictable offence punishable by up to 10 years' imprisonment (s. 267). If serious bodily harm does not occur, the assault is punishable either as a summary conviction offence, or more seriously, as an indictable offence punishable by up to 5 years' imprisonment (s. 266).

[103] *R. v. Worrall*, [2004].

[104] *R. v. Cato*, [1976].

[105] *R. v. Burkholder*, [1977].

[106] *R. v. Czarnecki*, [2000] M.J. No. 215 (Manitoba Court of Queen's Bench).

[107] *R. v. Ssenyonga*, [1992] 73 C.C.C. (3d) 216 (Ontario Court – Provincial Division). The accused did stand trial, however, on charges of criminal negligence causing bodily harm.

The definition of force under this section is broad and likely includes the injection of a controlled substance without consent. To support an assault charge, the Crown must prove that force was applied in the absence of consent. Therefore, a defence to assault is made out if the accused can prove that his or her actions were done with the consent of the person to whom the force was applied. However, as discussed further in the next section (see Potential criminal defences), the extent to which the defence of consent may be available for the person charged with assault for injecting another person may depend on the extent to which harm ensues from the injection. In short, in cases where there is minimal bodily harm as a result of the injection, consent will operate as a defence to any charge of assault. If, however, the harm that ensues becomes more serious, it becomes less clear whether this defence will be available.

Potential criminal defences

Consent

It is unclear how the courts would treat the issue of consent arising from a situation where serious bodily harm occurs as a result of assisted injection undertaken with the consent of the person injected, whether at a SIF or otherwise. Both the *Criminal Code* and existing case law establish that consent may not be available as a defence in certain circumstances.

A person who assists with an injection with the intent only to reduce harm is unlikely to be liable under this section [s. 245].

No legally valid consent to death

Canadian criminal law does not allow a person to consent to death, effectively prohibiting assisted suicide. Section 14 of the *Criminal Code* states:

> No person is entitled to consent to have death inflicted on him, and such consent does not affect the criminal responsibility of any person by whom death may be inflicted on the person by whom consent is given.

Canadian case law also raises a question as to whether a person's consent to being injected by another person would serve as an adequate defence. In the case of *R. v. Manhas*, the accused injected a female friend with morphine, as she indicated she wanted to commit suicide. Despite the fact that the injection was consensual, the accused was found guilty of manslaughter.[108] A similar result was seen in *R. v. Creighton*, discussed earlier: the defence of consent was not available against charges of manslaughter in a case where the victim suffered a fatal overdose after the accused injected a friend with cocaine with the victim's consent.

Depending on how these cases are interpreted and the facts of a particular situation, it might be that the defence of consent is not available to a criminal charge in the case where death occurs following an assisted injection. However, it may also be possible to distinguish these two cases. In *Manhas*, the accused injected the deceased woman with the intent of assisting her in committing suicide, which is clearly prohibited under s. 14 of the *Criminal Code*. But this provision of the *Criminal Code* and this particular judgment should not

[108] *R. v. Manhas*, [1982] B.C.J. No. 686 (B.C. Court of Appeal).

be understood as precluding a client using a SIF from giving legally valid consent to being injected by another person. In such a case, absent some unusual circumstance in which the client actually seeks to commit suicide on the premises of the SIF — an unlikely choice, given that medical intervention in the event of overdose or other complication is one of the benefits of such a facility — the person seeking assistance with injection is not consenting to death or to some act that is likely to cause death. Rather, he or she is consenting to being injected by another person with a substance he or she has acquired or selected precisely in order to avoid unnecessary harm from the actual act of injection.

The *Creighton* case presents more difficulty. In that case, even though the deceased friend had consented to being injected with cocaine by the accused, he was nonetheless convicted of manslaughter, not only of *unlawful act manslaughter* (because of the underlying unlawful act of trafficking a narcotic) but also of *manslaughter by criminal negligence* (because he knew he was injecting a dangerous substance capable of causing death or serious bodily harm, knew his friend already had a substantial amount of cocaine in her system, and failed to consider the quantity he injected). The trial judgment is unreported, so it is uncertain whether the question of the defence of consent was discussed by the trial judge, and neither the Ontario Court of Appeal nor the Supreme Court of Canada addressed this issue in their judgments, which focussed on other doctrinal questions. But it seems implicit in the fact that courts at all levels upheld the accused's conviction that his friend's consent to being injected was either deemed irrelevant to his criminal liability, or that this defence was raised and rejected at trial (and not taken further on appeal).

It is unclear how the courts would treat a charge of assault arising from a situation where serious bodily harm occurs as a result of assisted injection undertaken with the consent of the person injected.

It should be remembered that the injection in *Creighton* did not take place in a SIF, and the facts were more egregious than is likely to be the case for assisted injections in a SIF. The accused knew that the friend he injected already had a substantial quantity of cocaine in her system, and took no care with the quantity injected into her. In addition, once she suffered an overdose, after unsuccessfully attempting to resuscitate her, he did not call for emergency assistance. Rather, after having cleaned the premises of fingerprints, he left the deceased while she was still convulsing and only returned several hours later, at which point he called for emergency assistance. The circumstances under which an assisted injection may take place in a SIF are likely to be considerably different, so that the judgment in *Creighton* may be distinguished.

Consent to serious bodily harm not legally valid for public policy reasons

Aside from the explicit prohibition in the *Criminal Code* on consenting to death, Canadian case law has also established that, for public policy reasons, consent cannot be given in some circumstances to (non-fatal) bodily harm. In *R. v. Jobidon*, the Supreme Court held that a person cannot consent to serious bodily harm in situations such as street brawls.[109] However, it is worth noting that an assisted injection in a SIF may involve additional considerations with respect to consent. In a medical context, an assisted injection serves the purpose of harm reduction and might be distinguished from the purely destructive street brawl scenario considered in *Jobidon*. It is unclear how the courts would treat a charge of assault arising from a situation where serious bodily harm occurs as a result of assisted injection undertaken with the consent of the person injected.

[109] *R. v. Jobidon*, [1991] 2 S.C.R. 714 (Supreme Court of Canada).

Necessity

The defence of necessity is enabled through the general provision in s. 8(3) of the *Criminal Code*, which recognizes all common law defences. It is also mentioned in the context of medical procedures under s. 216. In general terms, necessity "covers all cases where non-compliance with the law is excused by emergency or justified by the pursuit of some greater good".[110] The legal requirements for this defence are outlined by the Supreme Court in *Perka v. The Queen* and include:

1. an imminent risk or peril;
2. proportionality between the peril avoided and the harm inflicted by the illegal act; and
3. the absence of any reasonable legal alternative.[111]

According to *Perka*, "the key to the defence of necessity as an excuse rests with the involuntariness of the act, where the actor's 'choice' to break the law is no true choice at all but remorselessly compelled by normal human instincts."[112] The peril should also be direct and immediate. In *R. v. Plesnik*, for example, an Ontario trial court held that the accused could not be convicted for an illegal act when he acted with the reasonable and honestly held belief that it was necessary to act immediately to protect a family member from permanent injury or possibly death.[113] It is arguable that assisted injection at a SIF may be provided out of necessity to reduce the harms faced by those who cannot self-inject.

Additionally, a necessity defence requires proportionality between the peril avoided and the harm inflicted upon others as a result of the illegal act. That is to say, the accused cannot have avoided a smaller harm to himself or herself at the expense of causing a greater harm to society. For example, the defence of necessity succeeded in a case where a man slapped his girlfriend to prevent her from harming herself and attempting to kill her fetus using a baseball-sized rock.[114] The harm caused by the slap was less than the harm that would have been suffered by herself and the fetus had he not acted.

In the case of assisted injection, it is arguable that enabling a wider group of persons who inject drugs to benefit from the health-protecting services of a SIF does not cause additional harm to society. Assisted injections currently take place under situations that are potentially more dangerous to society in general, as well as to those who rely upon and provide assisted injection. To allow assisted injections at SIFs would therefore likely decrease the harm to both individuals using drugs and society, rather than increase it. The proportionality requirement for a necessity defence may be considered satisfied.

The third requirement for the defence of necessity is the lack of a reasonable legal alternative. This means that if the accused could have carried out his or her purpose via other legal means, he or she is obliged to do so. For example, in the first case of *R. v. Morgentaler*, brought before the advent of the *Charter*, the majority of the Supreme Court denied a necessity defence to a physician charged with performing an unlawful abortion. The defence was rejected because there was insufficient evidence to indicate that a delay in the woman's access to an abortion left no reasonable legal alternative, as the *Criminal Code* as it then stood provided for a scheme

[110] *R. v. Salvador,* [1981] 59 C.C.C. (2d) 521.

[111] *Perka v. The Queen,* [1984] 2 S.C.R. 233 (Supreme Court of Canada).

[112] Ibid.

[113] *R. v. Plesnik*, [1983] O.J. No. 792 (Ontario Provincial Court – Criminal Division). In this case, a man's belief that his mother was suffering a heart attack was a sufficiently imminent peril to excuse his driving her to a hospital while drunk. The fact that she was not actually suffering from a heart attack was deemed irrelevant. The accused was convicted, however, for continuing to drive drunk even after the peril to his mother had passed.

[114] *R. v. Manning,* [1994] B.C.J. No. 1732 (B.C. Provincial Court).

under which abortions could occur.[115] In contrast, there is currently no manner provided for by law that would allow a person who requires assistance injecting a controlled substance, possessed without legal authorization, to receive such assistance. Therefore, the third requirement for the necessity defence could be made out.

Potential civil liability

The preceding sections addressed the question of possible criminal liability and the defences that may be available, with respect to a person who assists a client with injection at a SIF if the client should suffer some harm as a result of the injection. This section considers whether there might be civil liability on the part of the assisting individual, or conceivably the SIF or those responsible for it, in the event that a client suffers some harm following an assisted injection.

Battery

It was noted above that under the criminal law there is a general prohibition on consenting to death or to serious bodily harm. Obviously, however, medical procedures may often carry significant risks of harm, or even death, and it is accepted that, in such a context, a patient may consent to such risks. However, if medical care is carried out without a patient's consent (except in the case of an emergency), the health care provider has committed the tort of *battery*. (A tort is a civil wrong, other than a breach of contract, for which someone can sue for a remedy, most commonly monetary compensation.) Therefore, consent is a defence to a civil suit for battery. In general terms, there are four elements to valid consent:

- It must be given voluntarily;
- It must be given by a patient who has capacity;
- It must be specific as to the treatment and the provider; and
- It must be informed.

The accepted standard for informed medical consent has been outlined by the Supreme Court in a pair of leading cases, *Hopp v. Lepp* and *Reibl v. Hughes*, as requiring the disclosure of all material risks (significant risks that pose a real threat to the patient's life, health or comfort), as well as unusual risks (uncommon risks, known to occur only occasionally but involving serious consequences).[116] The Supreme Court stated in *Reibl v. Hughes* that in those cases where the consent to a medical procedure is not valid because it was not adequately informed, then the appropriate cause of action is a civil suit for the tort of *negligence* (see below), as opposed to battery. The tort of battery should be "confined to those cases where surgery or treatment has been carried out without any consent at all, or has gone beyond or differed from the procedures for which consent was given".[117] Additionally, consent in the medical context is vitiated if granted in response to fraud or lies.[118] Otherwise, consent may be considered as a defence against battery.

It is unlikely that a civil suit for battery could be brought against a person who assists with an injection in a SIF. No such assistance is provided without the consent of the person being injected; it is clear what procedure is being undertaken and to what end; and the person being injected at a SIF is clearly aware that being injected with the illegal substance may carry some risk of harm, including possibly death. If requesting assisted injection, he or she is also clearly aware that there is some risk of harm associated with the act of injecting itself — indeed, it is in order to reduce this risk that she or he has requested assistance.

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[115] *R. v. Morgentaler*, [1976] 1 S.C.R. 616 (Supreme Court of Canada). The section setting out this scheme was subsequently struck down as unconstitutional in its infringement of women's *Charter* s. 7 right to security of the person: *R. v. Morgentaler,* [1988].

[116] *Hopp v. Lepp*, [1980] 2 S.C.R. 192 (Supreme Court of Canada); *Reibl v. Hughes*, [1980] 2 S.C.R. 880 (Supreme Court of Canada).

[117] *Reibl v. Hughes*, [1980].

[118] *Gerula v. Flores,* [1995] O.J. No. 2300 (Ontario Court of Appeal).

Negligence

For civil liability to flow from an assisted injection — whether from the act of injecting itself, or the consequences of the injection — the conduct of the person doing the injection would have to be found to be negligent by a court. To succeed with a suit for negligence, a plaintiff has to show that:

- the defendant owed a duty of care to the plaintiff;
- the behaviour of the defendant fell below the accepted standard of care;
- the breach of the standard of care results in damages (e.g., physical harm); and
- these damages were the direct result of the defendant's actions.

Organizations can be vicariously liable for the torts of their employees when these persons are acting in the course of their duties. Therefore, a SIF could be civilly liable if one of its staff members performed his or her duties negligently.

SIFs have been established only recently in Canada; Insite, the first officially sanctioned SIF, began operations in September 2003. Unsurprisingly, there are no court cases that clarify the standard of care that SIF staff owe to clients. As in any other health facility, SIF staff owe a duty of care to clients. Even in cases where a client using the SIF was badly harmed or death resulted from an injection, as long as the defendant's behaviour did not fall below the standard of care to be expected of a reasonably prudent person in the same circumstances, the defendant cannot be held liable.

It is unlikely that a civil suit for battery could be brought against a person who assists with an injection in a SIF. No such assistance is provided without the consent of the person being injected . . .

The medical standard of care in regards to civil liability has been well established as being that of a practitioner who possesses the skill, knowledge and judgment of the average practitioner in his or her field.[119] Injuries or accidents resulting from the exercise of this average standard of care do not lead to civil liability. When determining the standard of care, courts would probably take into account factors such as:

- whether the SIF had policies and procedures in place and whether the employees followed them;
- whether the policies and procedures in place were reasonable;
- professional standards enunciated by professional colleges or regulators for the kinds of staff that do the work (e.g., nurses regulated by a college of nurses are subject to certain standards); and
- policies and procedures of SIF in other countries, given that there are so few SIFs in Canada.

[119] *Crits v. Sylvester*, [1956] O.R. 132 (Ontario Court of Appeal), affirmed [1956] S.C.R. 991 (Supreme Court of Canada); *Yepremian v. Scarborough General Hospital,* [1980] 110 D.L.R. (3d) 513 (Ontario Court of Appeal); *ter Neuzen v. Korn,* [1995] 3 S.C.R. 674 (Supreme Court of Canada).

A protocol for assisted injections at SIFs and relevant practice standards of the professional regulating body (e.g., the provincial college of nurses) would be useful in establishing the appropriate standard of care, and would provide a measure of guidance, as well as legal comfort, to health practitioners working in SIFs who may be called upon to assist a client with injecting so as to prevent avoidable harm.

A protocol would also help indirectly in addressing the question of insurance coverage in the event of a civil suit against the SIF and/or its staff. The SIF should already possess general liability insurance; health professionals working in a SIF will also be required, as a condition of licensing, to have professional liability insurance in place to cover them in their practice. Such liability insurance policies are designed to protect the insured organization from having to pay damages when sued. The insurer would be required under the terms of the policy to pay the costs of defending the civil suit and any damages awarded (within the limits of the coverage provided by the policy). Such policies often state that if the liability arises as a result of an illegal activity, the insurance coverage is void; hence the importance of resolving the issue of criminal liability that has been discussed in detail above.

It should also be considered that, even in the event of injury following an assisted injection, the law also provides for the defence of "voluntary assumption of risk" (*volenti non fit injuria*). In other words, should a SIF client who received assisted injection suffer harm as a result of the substance injected, it should be a complete defence that she or he voluntarily assumed the risks attendant upon injecting that substance. This is especially true since she or he acquired the substance and brought it to the SIF in order to inject it, and the assisting person did not necessarily have any knowledge of either the contents of that substance or whether, and to what extent, the client already had other substances in his or her system. It may strengthen such a defence — and perhaps is even required to make it out — were a SIF to require any client who requests assisted injection, whether from a health practitioner on staff or from another client, to sign a waiver stating that she or he discharge any right to sue the person assisting them, the SIF or its staff, should some harm befall her or him as a result of the substance injected.[120] (At least in the case of a trained health professional, it does not seem likely that a waiver could be enforced if it purported to absolve the professional of liability for performing the injection itself negligently, since this is precisely the medical procedure for which the assistance of a trained professional is sought and would be offered. But signing a waiver relating to any harms that might ensue from the substance itself is certainly an expression of the reality that the client is voluntarily assuming the risks of ingesting that substance.) Successfully making out a defence of voluntary assumption of risk by the client being assisted with injecting would mean that the defendant SIF or assisting person would be entirely absolved of liability.

In the alternative, if this were not successful, it would at least be very likely that the defence of contributory negligence could be made out, such that the client who received assistance with injection was deemed at least partly — perhaps even mostly — responsible for the injuries suffered as a result of the substance injected. This doctrine has been long established in the common law and has also been codified by statute in each province and territory.

Occupier's liability

Occupier's liability is a form of liability imposed on the person or entity that negligently exercises control over premises (e.g., failing to address a hazard on the site that could cause reasonably foreseeable injury to someone). As a general proposition, SIF could be sued under the law of occupier's liability if someone is injured at the facility as a result of the facility's failure to take reasonable care to prevent damage from some 'unusual danger' of which the occupier knows or ought to be aware.

[120] *Kelliher v. Smith*, [1931] S.C.R. 672 (Supreme Court of Canada); *Dyck v. Manitoba Snowmobile Association*, [1985] 1 S.C.R. 589 (Supreme Court of Canada); *Dube v. Labar*, [1986] 1 S.C.R. 549 (Supreme Court of Canada); *Crocker v. Sundance Northwest Resorts Ltd.*, [1988] 1 S.C.R. 1186 (Supreme Court of Canada).

However, allowing assisted injections within a SIF should not be seen as raising any particular, additional concerns about possible occupier's liability. In the case of a client using a SIF and seeking assisted injection, it would be hard to claim that harms that are risked by injecting controlled substances are "unusual." As long as the SIF took reasonable steps to ensure that any assisted injections were performed by persons who were either qualified health professionals or, in the case of peer-assisted injection, had received a demonstration from SIF staff on how to inject in ways that reduce risk — a standard part of the services offered by SIFs — then it would seem unlikely that allowing assisted injections on the site would carry any additional risk of civil liability for the occupier. In addition, in the context of SIFs, reasonable steps would likely also include having an on-site medical team to deal with overdoses or other complications following injection, as well as on-site security to protect people who use the facility (e.g., against the risk of violence should some conflict arise). Again, these considerations apply generally to SIFs and are not specific to the situation of allowing assisted injection on site.

Professional practice standards

At the time of this writing, the greatest experience with SIFs in Canada has been in the province of British Columbia. In addition, it is predominantly professional nurses who have been supervising injections performed by clients using such sites, and who would likely be the health professionals most often called upon to assist with injecting, should this be permitted. Therefore, for purposes of illustration, we use the example of professional practice standards governing nurses in British Columbia for the brief discussion below of how professional practice standards could or should be interpreted and applied to the specific question of a health professional assisting a SIF client who is unable to self-inject.

The practice standard on the administration of medicines of the College of Registered Nurses of British Columbia (CRNBC)[121] states:

> Nurses do not administer medications they determine to be inappropriate. Nurses take formal steps to address concerns, including consulting and advocating on behalf of the client, as necessary. Nurses support the right of clients to be knowledgeable about their medications and, where appropriate, to self-administer medication.

It could be argued that in most cases arising in a SIF, administration of a medication is not involved in the case of a controlled substance that a client has acquired and seeks to inject with assistance at the site.[122] If strictly interpreted in this fashion, the CRNBC practice standard might not prohibit a nurse from assisting a client with an injection. This, however, remains a contentious question.

[P]rohibiting or refraining from assisted injection leads to foreseeable and avoidable harms, which would seem to run counter to aiming for the highest quality of care achievable.

The CRNBC practice standard requires nurses to adhere to seven "rights" of medication administration: right drug, right client, right dose, right time, right route, right reason and right documentation."[123] It might be suggested that it would be difficult for nurses to make out right drug and right dose in situations where the drugs have been acquired outside the SIF.[124] On the specific issue of the administration of controlled substances, the CRNBC standard states:

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[121] College of Registered Nurses of British Columbia, *Practice Standard for registered Nurses and nurse Practitioners: Administration of Medications*, 2005.

[122] The situation would be different, of course, in the context where what is being injected is heroin that has been prescribed to the client/patient (e.g., in the context of the NAOMI trial). In that case, the heroin would certainly be a "medication". But in this case, there should also be less concern, as a matter of law or good professional practice, about a nurse or other health professional actually performing the injection for the client/patient. The client/patient has given his or her informed consent to receiving the heroin, knowing the risks associated with both the act of injection and with ingesting the substance itself, it has been legally prescribed by a physician, and the heroin is of a certain guaranteed quality and composition known to the prescribing physician. In such circumstances, there would be no basis for any civil or criminal liability or professional discipline on the part of the professional assisting with the injection — again, as long as reasonable knowledge, skill and care were used in actually performing the injection, as would be the case with performing any other injection on a patient.

[123] College of Registered Nurses of British Columbia, *Practice Standard for registered Nurses and nurse Practitioners: Administration of Medications*.

[124] This would obviously be less of a concern in situations such as NAOMI, where what is being injected is heroin that has been prescribed to the client/patient, or where drug testing has been able to establish the nature of the controlled substance and its purity.

> Nurses comply with federal regulations in receiving and administering narcotics and controlled substances.

Although not made explicit, there is a strong implication that assisting a SIF client to inject an illegal substance would run counter to the scope of practice defined by the CRNBC.

However, it is worth noting that other documents governing good nursing practice may qualify this understanding. The Canadian Nurses Association's *Code of Ethics for Registered Nurses* states that "[n]urses must strive for the highest quality of care achievable."[125] It also states that "[n]urses must not discriminate in the provision of nursing care based on a person's race, ethnicity, culture, spiritual beliefs, social or marital status, sex, sexual orientation, age, health status, lifestyle, mental or physical disability and/ or ability to pay."[126] The Code has been adopted by the CRNBC in its "Professional Standards for Registered Nurses and Nurse Practitioners".

Nurses working in a SIF may find themselves in a difficult position when it comes to the question of assisting with injection of illegal substances. The reality is that some clients who inject illegal drugs are, for a variety of reasons, unable to self-inject. If they are not permitted to receive assisted injection at the SIF, they are at even greater risk of harm, either from being forced to attempt self-injection at the SIF, or receiving injection outside the SIF, perhaps without the benefit of sterile equipment, likely at greater risk of violence or arrest, and almost certainly without the benefit of immediate medical intervention in the event of overdose or other complication from a botched injection. In such a case, prohibiting or refraining from assisted injection leads to foreseeable and avoidable harms, which would seem to run counter to aiming for the highest quality of care achievable. In addition, as noted above, those at greater risk because of an inability to self-inject safely will disproportionately be those with certain kinds of disabilities and women. This means that a prohibition on assisted injection may indirectly discriminate by denying the full benefits of a health facility such as a SIF to these groups. Given such circumstances, it is understandable that some health professionals will feel that their professional and ethical obligation is to assist the patient at the SIF in minimizing the risk of harm involved with the act of injecting — and correspondingly, that they should be allowed, as a matter of law and of good practice, to do so without fear of criminal or civil liability or professional discipline, as long as they act with the knowledge, skill and care of a reasonable practitioner in the circumstances.

This signals a need for law-makers and the professional associations and regulatory bodies of relevant health professionals to clarify the legal situation of assisted injection. Nurses' associations and colleges can play a particularly important role in developing appropriate guidance for nurses who are dealing with patients injecting controlled substances. While it is not within the power of colleges of nurses or nurses' professional associations to address nurses' risk of liability for certain criminal offences in the event of death or serious bodily harm following an assisted injection, the standard-setting function played by these bodies obviously has a direct impact on nurses' liability to professional discipline, and an important indirect influence on questions of possible civil liability. As noted above, such guidance would assist in establishing the parameters of what is permitted and required, as a matter of good practice and hence as a matter of civil law, of nurses faced with requests for assisted injection from SIF clients who cannot self-inject or can do so only at the risk of injuring himself or herself.

[125] College of Registered Nurses of British Colombia, *Professional Standards for Registered Nurses and Nurse Practitioners*, 2005, p. 19.

[126] Canadian Nurses Association, *Code of Ethics for Registered Nurses*, 2002, p. 15.

Possible ways forward

As suggested by the discussion in the preceding sections, concerns about heightened risks of civil liability for permitting assisted injections within a SIF are likely overstated, and can reasonably be addressed by taking precautions to ensure that assisted injection is done with care. Clearer guidance from regulatory bodies about proper practice in assisting a client with injection is needed to clarify health professionals' legitimate concerns about professional discipline. The analysis above suggests that concerns about criminal liability for certain kinds of offences, in the event that a client suffers death or bodily harm following an assisted injection, can perhaps be set aside. But with respect to certain other criminal offences, concerns remain, particularly given the current state of the criminal law jurisprudence as it might be applied to the act of assisted injection within a SIF. (We stress again that this is relatively new legal territory, and that the application of some offences to the situation of harms arising from assisted injection within a SIF has not yet been considered by the courts.) In our view, therefore, it would be particularly important to ensure that risks of criminal liability for assisting a SIF client to inject are removed or minimized to the greatest extent possible, in the interests of ensuring that some of those most vulnerable to the harms associated with unsafe drug injection are able to reap fully the benefits of these health facilities. Therefore, in this final section, we consider some options for achieving this objective.

Legislative reform

The most straightforward route would be to clearly remove the possibility of criminal liability for assisted injections at SIFs by way of legislative amendments to the relevant provisions of the CDSA and the *Criminal Code*. In order to become law, realistically these amendments would have to emanate from the federal Cabinet, which has jurisdiction over criminal law and the CDSA.[127] Legislative reform, however, is a time-consuming process, and the controversy and debate these amendments would generate may make such an approach unrealistic.

Modified ministerial exemption under CDSA s. 56

Assisted injections at SIFs could be enabled under a modified s. 56 exemption, explicitly providing for assisted injections in certain circumstances. Section 56 of the CDSA gives the federal Minister of Health the authority to grant any class of persons an exemption from the application of all or any of the provisions of the CDSA, if the Minister is of the opinion that the exemption is necessary for a medical or scientific purpose or is otherwise in the public interest. A modified s. 56 exemption might state that if applicable guidelines on assisted injection were followed, staff and clients would be exempt from the application of the CDSA offences relevant to the question of assisted injection — namely, possession and trafficking. This would evidently need to be complemented by necessary changes to the existing guidelines governing SIFs to set out the parameters governing assisted injections.

However, the power of the Minister of Health under s. 56 does not extend beyond the CDSA, and it would not be possible to exercise the power in a way that removed other forms of liability, such as under the *Criminal Code*.

Regulations pursuant to CDSA s. 55

Under s. 55 of the CDSA, the federal Cabinet has extensive powers to make a wide range of regulations respecting the application of the Act.[128] The Cabinet has an open-ended authority to:

[127] The passage rate for private members bills is extremely low in Canada, and it would be unlikely that amendments brought by a sympathetic member of Parliament would have any success.

[128] The section actually assigns these powers to the Governor in Council, which is the Governor General acting on the advice of the Privy Council. In effect, the formal authority of the Privy Council is exercised by the Prime Minister and the federal Cabinet.

> Make regulations for carrying out the purposes and provisions of the Act, including the regulation of the medical, scientific and industrial applications and distribution of controlled substances . . . and the enforcement of this Act . . . and, without restricting the generality of the foregoing, may make regulations
>
> (a) governing . . . (the) administration, possession or obtaining of or other dealing in any controlled substances or precursor or any class thereof;
>
> (b) respecting the circumstances in which, the conditions subject to which and the persons or classes of persons by whom any controlled substances or precursor or any class thereof may be . . . administered, possessed, obtained or otherwise dealt in, as well as the means by which and the persons or classes of persons by whom such activities may be authorized; [. . .]
>
> (c) exempting, on such terms and conditions as may be specified in the regulations, any person or class of persons or any controlled substance or precursor or any class thereof from the application of this Act or the regulations.

Section 55 thus empowers the Cabinet to make decisions about who can administer and possess drugs, what drugs can be administered, in what circumstances those drugs can be administered and possessed, and how these activities can be authorized. For example, current regulations allow a medical practitioner to prescribe, sell or provide a controlled drug to a patient, if that controlled drug is required for the treatment of a specified number of conditions.[129] The CDSA prohibitions on, among other offences, possession and trafficking would not apply to the practitioner in these circumstances.

[C]oncerns about heightened risks of civil liability for permitting assisted injections within a SIF are likely overstated, and can reasonably be addressed by taking precautions to ensure that assisted injection is done with care.

The Cabinet has authority to enact comprehensive regulations addressing potential CDSA offences related to the practices of assisted injections at SIFs. However, as with the s. 56 ministerial exemption, the power of the Cabinet under s. 55 does not extend beyond the CDSA, and it would not be possible to exercise this power in a way that removed other forms of liability, such as liability for *Criminal Code* offences.

A policy of non-prosecution

As noted above, if the Minister of Health or the Cabinet were to endorse a new exemption or regulations, respectively, governing assisted injections, then any offence not covered by that exemption or those regulations (e.g., under the *Criminal Code*) could still potentially apply. Therefore, it may be beneficial to have a policy of non-prosecution for offences arising in the context of assisted injection. Under Canada's constitution, while the power to legislate criminal law lies with the federal government, the responsibility and authority for the "administration of justice" lies with the provinces.[130] This means that a non-prosecution policy might need to be adopted by provincial ministries of attorney general in the jurisdiction in which the SIF operates.

[129] *Food and Drug Regulations*, C.R.C., c. 870, s. G.04.001.

[130] *Constitution Act, 1867* (U.K.), 30 & 31 Vict., c. 3, reprinted in R.S.C. 1985, App. II, No. 5, at ss. 91-92.

Again using the example of British Columbia, pursuant to s. 2(e) of the province's *Crown Counsel Act*, the Criminal Justice Branch of the provincial Ministry of Attorney General, is responsible for the development "of policies and procedures in respect of the administration of criminal justice in British Columbia."[131] A publication put out by the Ministry succinctly outlines two of the primary responsibilities of Crown counsel:

> Generally, before charges are approved, Crown counsel must be able to say 'yes' to two questions based on the available evidence. One, is there a substantial likelihood of conviction and two, does the public interest require a prosecution?[132]

A strong argument could be made that the public interest requires that potential prosecutions flowing from assisted injections *not* occur. The scientific evidence has established the health protection and promotion benefits of SIFs. There are reasons to believe that prohibiting assisted injection denies those benefits, at least in part, to some of those who may have greatest need of assistance in order to avoid suffering preventable harm. The fact that such barriers may also amount to a discriminatory denial of access to health services on grounds that are prohibited under the *Charter* must also be relevant to this assessment. Consider as well that SIFs, like other health facilities, generally operate with the support, including financial, of governments that have recognized their benefits for both persons who use drugs and communities more broadly. Finally, in the case of medically assisted injection, regard should be had to the professional ethical obligation of the health professional to assist clients using the health facility in protecting and promoting their health as best they can.

[131] *Crown Council Act*, R.S.B.C., 1996, c. 87, s. 2.

[132] Ministry of the Attorney General (British Columbia), Criminal Justice Branch, *Role of Crown Counsel*, 2004. Available at www.ag.gov.bc.ca/public/criminal-justice/CrownCounsel.pdf .

Conclusions

The prohibition on assisted injection denies the full realization of the health benefits of SIFs for some of those who may be most vulnerable to harm without such assistance, and may run counter to ss. 7 and 15 of the *Charter*. Concerns about civil liability, or professional discipline in the case of regulated health professionals who assist clients with injection, need to be addressed but are likely surmountable, particularly with leadership from the relevant professional regulatory bodies in providing guidance to their members who may be called upon to assist with injection of some clients at a SIF. Criminal liability for certain offences may not be likely, or may be removed entirely through certain legal mechanisms, but under the current legal framework, it remains possible that assisted injections could result in serious criminal liability for those who assist. These concerns might be addressed through the combination of a modified exemption, whether by the federal Minister of Health or the federal Cabinet, pursuant to the CDSA, in conjunction with a policy of non-prosecution for certain *Criminal Code* offences that might be adopted by the relevant provincial attorney general.

Whatever the mechanism or measures ultimately adopted, there is an urgent need for action and political leadership to ensure that the health benefits to be gained from a SIF can be realized for those in particular need of assistance. It should be recalled that Insite was established in Vancouver in 2003 only after years of education and advocacy that engaged local community interests and leaders, as well as municipal, provincial and federal officials. As has been the case elsewhere, while there was much opposition to the facility at the outset, the experience to date has shown that communities have come to realize the benefits of such a facility, both as a service that saves lives and protects the health of its clients, and as a measure that generates broader public benefits for the community at large in its struggles with the consequences of addiction, poverty, and marginalization.[133] The law, particularly the criminal law in its current formulation as best can be determined, poses some challenges. Yet the law, including Canada's obligations to respect, protect and fulfill the human right to the highest attainable standard of health for all persons — with a particular attention required to the needs of the most vulnerable — also demands action, and may provide solutions, if the willingness to take up the challenges can be found.

[133] E. Wood et al., "Summary of findings from the evaluation of a pilot medically supervised safer injecting facility," *CMAJ* 175(11) (2006): 1399-1404.

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