Harm Reduction in Federal Prisons in Canada

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ABSTRACT

Canada is in the midst of an alarming opioid overdose crisis, with impacts not just on those in the community but also those who are incarcerated. While some limited focus has been directed towards minimizing the harms of substance use in carceral settings, current approaches remain inadequate in addressing these harms. By way of comparison with successful community programs, this paper critically appraises recent harm reduction programming that has been established in federal prisons and identifies key shortcomings in their implementation. It further argues that these programs may not comply with sections 7 and 15 of the *Charter*, falling short of both domestic and international standards of prison healthcare.

Keywords: Harm Reduction; Substance Use; Federal Prisons; Professionally Accepted Standards; Accessibility; Equivalence of Care.

I. INTRODUCTION

Opioid use and related overdoses continue unabated in Canada. Although there has been significant attention paid to policy responses to this national problem, limited attention has been given to the implications of this crisis on people in prison. This is particularly concerning, as drug use in the carceral setting can lead to serious and well-identified harms – harms which to date have remained substantially under-addressed.

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Some of the most promising short-term responses to the overdose crisis involve the use of evidence-based harm reduction approaches, and the Canadian government has started to implement programming of this sort in federal institutions. However, these programs, as they currently exist, have significant problems which severely limit their accessibility and efficacy.

This paper contributes to the literature by critically appraising these programs, particularly by analysing them through sections 7 and 15 of the *Canadian Charter of Rights and Freedoms* (*Charter*).[1] Part II outlines the prevalence of addiction issues in both communities and federal prisons and demonstrates how harm-reduction initiatives are desirable methods for reducing the health risks associated with substance use. Given the resounding success of harm-reduction programming in community settings, it is argued that Canada should be looking to implement similarly accessible treatment options for incarcerated individuals.

Then in Part III, the state of drug policy in federal prisons is outlined, and shortcomings surrounding harm reduction in federal prisons are investigated. Following this, various constitutional avenues to compel improvement to these programs are explored. Both section 7 and 15 *Charter* arguments are employed to indicate that Canada may be obligated to provide more effective harm-reduction programming than that which is currently available in federal prisons.

Ultimately, the Canadian government has indicated a commitment to providing what amounts to life-saving healthcare for incarcerated individuals who use drugs, but the efficacy of these measures is being seriously undermined. As will be shown, current harm reduction programming in federal prisons needs to be made significantly more accessible – only then can the harms that result from institutional drug use truly be addressed.

II. Defining the Problem – The Current State of Addiction, and Why Harm Reduction Can Help

[1] *Canadian Charter of Rights and Freedoms*, ss 7, 15, Part I of the *Constitution Act, 1982*, being Schedule B to the *Canada Act 1982* (UK), 1982, c 11.

A. The Prevalence of Addiction in Canadian Communities and Prisons

Canada is unquestionably in the midst of a severe and pressing opioid overdose crisis. Between the period of January 2016 and December 2021, 29,052 apparent opioid-toxicity deaths and 30,860 opioid-related poisoning hospitalizations have been reported.[2] These opioid-related deaths have not only been numerous, but also have been increasing yearly: 2829 in 2016, 3921 in 2017, 4406 in 2018, 3698 in 2019, 6638 in 2020, and 7560 in 2021.[3] Due to these alarming numbers and based on a recognition that "harms related to opioids, stimulants, and other substances extend beyond overdoses (poisonings) and deaths," Health Canada has long recognised this trend as an "ongoing public health crisis."[4]

Given that Canada is generally combating high rates of addiction and overdose, it is no surprise that addiction issues are also prevalent in federal prisons. In a 2007 survey conducted by Dr. Zakaria and colleagues for the Correctional Service of Canada ("CSC"), 33% of men and 27% of women self-reported using non-injection drugs while in prisons, and 16% of men and 15% of women reported using injection drugs.[5] These numbers likely underrepresent the actual rates of drug use in prisons, given that the data was obtained through self-reporting methods. Indeed, as noted by Dr. Zakaria in a subsequent CSC report, "underreporting of undesirable, illegal, and/or stigmatizing behaviour may be exacerbated in the correctional environment."[6] The prevalence of drug use in federal prisons has risen since 2007, given that in 2018 the CSC acknowledged "a substantial rise in the

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2 Health Canada, "Opioid- and Stimulant-related Harms in Canada" (Ottawa: Health Canada, March 2022), online: <health-infobase.canada.ca/substance-related-harms/opioids-stimulants> [perma.cc/L2TQ-Y6JP].

3 Health Canada, "Apparent Opioid and Stimulant Toxicity Deaths" (2022) at 20-21, online (pdf): <health-infobase.canada.ca/src/doc/SRHD/Update_Deaths_2022-06.pdf> [perma.cc/TT2A-56HM].

4 Health Canada, "Opioid- and Stimulant-related Harms in Canada," *supra* note 2.

5 Dianne Zakaria et al, "Summary of Emerging Findings from the 2007 National Inmate Infectious Diseases and Risk-Behaviours Survey" (2010) at 12 and 15, online (pdf): <www.csc-scc.gc.ca/005/008/092/005008-0211-01-eng.pdf> [perma.cc/9AZ3-FLWN].

6 Dianne Zakaria, "Relationships between Lifetime Health Risk Behaviours and Self-Reported Human Immunodeficiency Virus and Hepatitis C Virus Infection Status among Canadian Federal Inmates" (2012) at 1, online (pdf): <www.publicsafety.gc.ca/lbrr/archives/cn21491-eng.pdf> [perma.cc/987Z-TD87].

number of overdose incidents as a result of problematic opioid use, which mirrors community trends."[7]

The effect of high rates of drug use in prisons extends beyond the prevalence of overdose-related death. Given the limited access to needles and syringes in an institutional setting, needle-sharing is a common practice.[8] This is concerning, as rates of communicable disease are significantly higher in federal prisons than in the community. For example, a 2016 study by Dr. Fiona Kouyoumdjian and colleagues reported that 30% of those in federal prisons had Hepatitis C, and between 1-2% of men and 1-9% of women were infected with HIV.[9] These numbers are incredibly high compared to national infection rates of 0.0311% and 0.0064% for Hepatitis C and HIV, respectively.[10] Needle sharing, particularly given a lack of access to sterilization equipment in federal institutions, is undoubtedly a contributor to these abnormal rates of infection.[11] Thus, not only does addiction in prison lead to high rates of overdose, but also contributes to the spread of communicable disease.

Addiction issues in prisons, then, need to be treated as a public health crisis, rather than a criminal justice issue. Given that drug use in federal institutions is a direct contributor to both disease and death, measures

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7 Correctional Service Canada, "Response to the 45th Annual Report of the Correctional Investigator 2017-2018" (last modified 30 October 2018), online: <www.csc-scc.gc.ca/publications/005007-2808-en.shtml> [perma.cc/N8BF-6CQ8].

8 See Emily van der Meulen et al, "A Legacy of Harm: Punitive Drug Policies and Women's Carceral Experiences in Canada" (2017) 28:2 Women Crim Justice 81 at 89; Emily van der Meulen et al, "Recommendations for Prison-Based Needle and Syringe Programs in Canada" (2016) at 15, 16 and 25, online (pdf): <www.ryerson.ca/content/dam/criminology/tank/faculty/PNSP%20Report%20Jan%202016.pdf> [perma.cc/W79X-E2VY]; Canada HIV Legal Network, "Former Prisoner Steve Simons Writes why a Prison Needle Exchange Program is Needed" (Published 17 August 2020), online: <www.hivlegalnetwork.ca/site/former-prisoner-steve-simons-writes-why-a-prison-needle-exchange-program-is-needed/?lang=en> [perma.cc/U5JV-9DBF].

9 Fiona Kouyoumdjian et al, "Health status of prisoners in Canada" (2016) 62 Can Fam Physician 215 at 217.

10 See Health Canada, "Report on Hepatitis B and C in Canada" (2019) at 10, online (pdf): <www.canada.ca/content/dam/themes/health/publications/diseases-conditions/report-hepatitis-b-c-canada-2016/report-hepatitis-b-c-canada-2016.pdf> [perma.cc/XZX7-QE2K]; AC Bourgeois et al, "HIV in Canada—Surveillance Report, 2016" (2017) 43:12 Can Communicable Disease Report 248 at 250.

11 See Kouyoumdjian et al, *supra* note 9 at 217.

should be taken to minimize these serious impacts. The drug crisis facing this country is not only ongoing in the community, but also in the federal prison population.

The question of how to best craft policy to address addiction in federal prisons does not only require an understanding that addictions and their related harms are prevalent in carceral populations, but also why this is the case. Essentially, it is important to understand how addiction intersects with the criminal justice system. After all, not only is there a high rate of drug use within federal prisons, but also many individuals already dealing with substance use upon entry into these institutions. Research by the CSC in 2012 found that nearly three quarters of males admitted to federal prisons had alcohol or drug dependencies, and noted substance use is a significant area of need for these individuals.[12] It is therefore important to understand how addiction and incarceration are linked to make informed policy decisions.

Perhaps the most obvious link between addiction and the criminal justice system involves Canada's continued approach of criminalizing drugs. This results in the criminalization of those struggling with addiction. After all, the obvious consequence of incarcerating individuals who have engaged in activities stemming from addiction – such as use and possession of illicit drugs – is the substantial presence of people with addictions in federal prisons.

A more fundamental link, however, involves understanding how social determinants of health relate to both addiction and criminalization. It is well recognized that factors such as homelessness, unemployment, food insecurity, and histories of trauma can be linked to substance dependency.[13] These very same social factors are prevalent among incarcerated individuals.[14] The result: those subject to criminalization and imprisonment may well also be suffering from addiction-related issues.

Further, imprisonment itself is considered a social determinant of substance use.[15] The very act of criminalizing an individual can be traumatic,

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12 Correctional Services Canada, "Offender Substance Use Patterns – Aboriginal and Non-Aboriginal Offenders" (2012), online (pdf): <www.csc-scc.gc.ca/005/008/092/rs12-10-eng.pdf> [perma.cc/QH2E-D7WS].

13 See Nick Kerman et al, "'It's not just injecting drugs': Supervised consumption sites and the social determinants of health" (2020) 213 Drug Alcohol Depend at 2.

14 See Kouyoumdjian et al, *supra* note 9 at 216-217.

15 See Kerman et al, *supra* note 13 at 2.

with high rates of physical and sexual violence in prisons.[16] The prison experience can also be negative due to isolation, insufficient exercise and programming, overcrowding, and poor nutrition.[17] Given the conditions in federal prisons and the subsequent stigma and financial burdens upon release, it is no wonder the experience of imprisonment itself can lead to substance use.

Substance use has, and will continue, to persist in federal prisons. As highlighted by James Gacek and Rosemary Ricciardelli, incarcerated individuals "do not suddenly master their addictions and the challenges associated with drug use; as such the sale, distribution, and use of drugs and substances in Canadian prisons endures."[18] The relationship between addiction and incarceration has both causal and correlational components, and the underlying social factors at play are numerous and interrelated. There is simply no way that the profound connection between substance use and incarceration can be overlooked. Any policy adopted to address the addiction crisis in federal prisons must be sensitive to these realities and designed to tackle the actual harms that substance use presents.

B. The Case for Harm Reduction Methods

Eradicating addiction in Canada would require mass social upheaval and reorganization. While focus should be on implementing programs to target the root cause of addiction in Canadian communities, short-term efforts should also be made to minimize the harmful impacts of substance use. After all, there is a continued, serious risk of death and disease in federal institutions.

Perhaps the best short-term approach to limiting the negative effects of addiction in prisons involves the implementation of harm reduction methods. Harm reduction is understood as "interventions aimed at reducing the negative effects of health behaviors without necessarily

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16 See Jens Modvig, "Violence, sexual abuse and torture in prisons" in Stefan Enggist et al, eds, *Prisons and Health* (Copenhagen: World Health Organization, 2014) at 19-24.

17 See Adelina Iftene, "Incarceration in Canada: Risks to and Opportunities for Public Health" in Tracey M Bailey, C Tess Sheldon & Jacob J Shelly, eds, *Public Health Law and Policy in Canada*, 4th ed (Toronto: LexisNexis Canada, 2019) 477 at 479.

18 James Gacek & Rosemary Ricciardelli, "Constructing, Assessing, and Managing the Risk Posed by Intoxicants within Federal Prisons" (2020) 43:3 Man LJ 273 at 288.

extinguishing the problematic health behaviors completely."[19] Common harm reduction approaches in the addiction context include both Needle Syringe Programs ("NSPs") which seek to reduce rates of communicable disease by providing clean syringes to users, as well as safe consumption sites ("SCSs") which aim to reduce overdose and increase access to and enrollment in treatment programs. In both instances, the overarching goal of these interventions are not to prevent substance use itself, but rather to limit harms stemming from use.

Clearly, these approaches are seen as desirable by the Canadian government and the CSC, as evidenced by the establishment of the Prison Needle Exchange Program ("PNEP") and Overdose Prevention Site ("OPS"). By implementing these programs, the CSC has taken an active role in limiting disease and overdose in federal institutions. Unfortunately, both the PNEP and OPS fall short in addressing harms related to substance abuse compared to more successful programs implemented outside of prisons.

Some community harm reduction programs outside of federal prisons have been effective.[20] While criticism of such programming exists, there is strong evidence favouring both needle-exchange and safe consumption as methods of reducing problematic outcomes of substance use. Indeed, such methods have been widely adopted by various organizations and experts as best-practice for the reduction of substance use-related harms in communities.

First considering NSPs, there is overwhelming consensus that such programming is effective. For example, a study by Louisa Degenhardt and colleagues noted that there was strong evidence which "shows that these programmes reduce risk from injections, thereby increasing safe injection."[21] NSPs have been found to both limit the spread of HIV in a cost-effective way, and to increase access to treatment programming.[22] The use of NSPs is endorsed by medical professionals, with the Canadian Nurses Association highlighting the effectiveness of such programs in a variety of

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19 See Mary Hawk et al, "Harm reduction principles for healthcare settings" (2017) 14:70 Harm Reduction J at 1.

20 *Ibid* at 2.

21 Louisa Degenhardt et al, "Prevention of HIV infection for people who inject drugs: why individual, structural, and combination approaches are needed" (2010) 376:9737 Lancet 285 at 286.

22 See Hawk et al, *supra* note 19 at 2.

discussion papers and position statements.[23] Such programs are also supported by international organizations: the World Health Organization ("WHO") concludes in a 2004 report that "the evidence to support the effectiveness of NSPs in substantially reducing HIV must be regarded as overwhelming," and "a number of careful studies in several developed countries and some transitional countries have demonstrated convincingly that needle syringe programmes are cost-effective."[24] Other international bodies, such as the United Nations Office on Drugs and Crime ("UNDOC") and the Joint United Nations Programme on HIV/AIDS ("UNAIDS"), have endorsed NSPs as harm-reduction methods integral to the reduction of communicable disease in injection drug users.[25] Finally, health advocacy groups such as the Canadian HIV Legal Network, as well as the Prisoners with HIV/AIDS Support Action Network significantly support NSPs and their efficacy .[26]

The main criticisms of NSPs tend to focus on the possibility of an uptick in drug use resulting from increased access. However, such an outcome is

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[23] Canadian Nurses Association, "Harm Reduction and Illicit Substance Use: Implications for Nursing" (2017) at 31-34, online (pdf): <ohrn.org/wp-content/uploads/2021/07/Harm-Reduction-and-Illicit-Substance-Use-Implications-for-Nursing.pdf> [perma.cc/B9NC-DMJV]; Canadian Nurses Association, "Focus on Harm Reduction for Injection Drug Use in Canadian Prisons: A Supplement to CNA's Harm Reduction Discussion Paper" (2016) at 5, online (pdf): <ohrn.org/wp-content/uploads/2021/07/Harm-Reduction-in-Canadian-Prisons-Companion-Paper.pdf> [perma.cc/6TXR-BTX5]; Canadian Nurses Association et al, "Harm Reduction and Substance Use" (2018), online: <canac.org/wp-content/uploads/2018/04/joint_position_statement_harm_reduction_and_substance_use.pdf> [perma.cc/9LNC-4ZKF].

[24] World Health Organization, "Effectiveness of Sterile Needle and Syringe Programming in Reducing HIV/AIDS Among Injecting Drug Users" (2004) at 28, online (pdf): <apps.who.int/iris/bitstream/handle/10665/43107/9241591641.pdf?sequence=1&isAllowed=y> [perma.cc/C3YB-N759].

[25] UNDOC, "A handbook for starting and managing needle and syringe programmes in prisons and other closed settings" (2017) at 9, online (pdf): <www.aidsdatahub.org/sites/default/files/resource/unodc-starting-and-managing-needle-and-syringe-programmes-prisons-2017.pdf> [perma.cc/SJ8K-FMBM]; WHO, UNDOC and UNAIDS, "Interventions to address HIV in prisons: Needle and syringe programmes and decontamination strategies" (2007) at 12, online (pdf): <http://apps.who.int/iris/bitstream/handle/10665/43758/9789241595810_eng.pdf> [perma.cc/UFC6-S3DE].

[26] See Van der Meulen et al, "Recommendations for Prison-Based Needle and Syringe Programs in Canada," *supra* note 8 at 15, 16 and 25.

not supported by any evidence. As noted by the WHO, "after almost two decades of extensive research, there is still no persuasive evidence that needle syringe programmes increase the initiation, duration or frequency of illicit drug use or drug injecting."[27] This conclusion is supported by the Canadian Nurses Association, who highlight that "needle distribution and recovery services have not been found to increase substance use, initiation into substance use or injection substance use, nor have they been found to increase rates of crime, public disorder or public nuisance, such as discarded needles."[28]

There is an abundance of evidence supporting the efficacy of SCSs as harm reduction measures. Insite, the first safe consumption site in Canada, was established in 2003, and is considered a resounding success. As noted by Dr. Maria Zlotorzynska and her colleagues, "A large body of peer reviewed research, published in leading medical journals, has documented the various benefits of the program, including reductions in syringe sharing and fatal overdoses, and increased uptake of addiction treatment."[29] The Canadian Nurses Association has recognized Insite as being incredibly effective at reducing overdose-related deaths, finding that the program may have prevented approximately 2-13 deaths per year between 2003 and 2016.[30] Indeed, reported statistics from the site indicate over 3.6 million visits since its establishment in March 2003, with 6440 overdose interventions but zero deaths, suggesting an incredible number of saved lives over the course of the program's life.[31] Even the Supreme Court of Canada (SCC) has recognized the benefits of Insite, with Chief Justice McLachlin noting in *Canada (AG) v PHS Community Services Society* that "Insite has saved lives and improved health. And it did those things without increasing the incidence of drug use and crime in the surrounding area."[32]

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27 World Health Organization, "Effectiveness of Sterile Needle and Syringe Programming in Reducing HIV/AIDS Among Injecting Drug Users," *supra* note 24 at 28.

28 Canadian Nurses Association, "Harm Reduction and Illicit Substance Use: Implications for Nursing," *supra* note 23 at 32.

29 Maria Zlotorzynska et al, "Supervised injection sites: Prejudice should not trump evidence of benefit" (2013) 185:15 Can Med Assoc J 1303 at 1303.

30 Canadian Nurses Association, "Harm Reduction and Illicit Substance Use: Implications for Nursing," *supra* note 23 at 39-40.

31 Vancouver Costal Health, "Insite user statistics" (last modified July 2019), online: <www.vch.ca/public-health/harm-reduction/supervised-consumption-sites/insite-user-statistics> [perma.cc/4TNR-RPYG].

32 *Canada (AG) v PHS Community Services Society*, 2011 SCC 44 at para 19 [*PHS Community Services*].

In addition to the direct benefit of safe injection reducing overdose-related death, SCSs have other positive impacts. In a 2020 study by Nick Kerman and colleagues, interview participants frequently cited social connectedness, sense of community, emotional support, stress reduction, feelings of safety and security, and help accessing health care resources as benefits of SCSs.[33] Increased access to health and addiction care was also noted by the Canadian Nurses Association as a benefit to SCSs, citing a large body of research both domestically and internationally.[34] Thus, not only do safe consumption sites have short-term impacts of reducing overdose and other health risks, but also lead to longer-term effects in the form of greater access to health and addiction services, as well as other related social supports.

Criticism of SCSs is largely based on a fear of increased drug use and related criminal activity, however such a critique is also refuted by the literature. Dr. Maria Zlotorzynska and colleagues note in their article that "the feared negative consequences of opening Insite have failed to materialize" and "although concerns persist that supervised injection facilities attract crime and increase drug use, research undertaken in Vancouver has shown that such fears are unfounded."[35] Research by Thomas Kerr and colleagues also echo this sentiment, with their study – related to Insite specifically – noting that "over 40 peer-reviewed studies have been published which speak to the many benefits and lack of negative impacts of this site."[36] Any fears related to increased crime and public disorder resulting from SCSs simply do not seem to be well-founded.

The overwhelming evidentiary support for harm reduction methods such as NSPs and SCSs makes clear that they should be a priority in addressing the opioid crisis. These programs have a large amount of support from a wide array of organizations, both internationally and within Canada, due to their efficacy in reducing the harms of substance use. Given the relatively recent shift in Canadian drug policy and mounting evidence in favor of these methods, clearly harm reduction must be at the center of Canada's approach to addiction.

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33 Kerman et al, *supra* note 13 at 3-4.

34 Canadian Nurses Association, "Harm Reduction and Illicit Substance Use: Implications for Nursing," *supra* note 23 at 41.

35 Zlotorzynska et al, *supra* note 29 at 1303.

36 Thomas Kerr et al, "Supervised injection facilities in Canada: past, present, and future" (2017) 14:28 Harm Reduction J at 2.

III. HARM REDUCTION IN FEDERAL PRISONS – AN ARGUMENT FOR IMPROVEMENT

Given the efficacy of harm reduction methods in community settings, both needle exchange and safe consumption programs are being rolled out in Federal prisons. Unfortunately, these programs are insufficient to pass constitutional muster. There is an array of shortcomings in these programs when compared to community counterparts. These differences reflect failings of the policy's design by the Federal government. Indeed, valid section 7 and 15 *Charter* arguments can – and have – been raised.[37]

This section outlines the programming in Federal prisons and documents and their main shortcomings. Then, it offers arguments for why these programs are inadequate to pass constitutional muster under sections 7 and 15 of the Charter.

Much of the analysis that follows relies on the recent decision in *Simons v Ontario (Minister of Public Safety)*.[38] In *Simons*, the prison needle exchange program was challenged under both sections 7 and 15(1) of the *Charter*. The case was brought on behalf of lead applicant Steve Simons by various advocacy organizations, including Canadian HIV/AIDS Legal Network, Prisoners with HIV/AIDS Support Action Network, Canadian Aboriginal AIDS Network and Catie. Ultimately, the Ontario Superior Court of Justice dismissed the challenge, in large part due to the continuing rollout and evolution of the program. Nonetheless, the reasoning in this decision was highly informative and may leave the door open for future challenges under the *Charter* should prison harm reduction programs remain unchanged. *Simons* is thus an excellent case study in how Canadian courts may approach a constitutional challenge, and the ways in which they could find success.

A. Current Prison Drug Policy – An Overview

1. The Abstinence-Based Approach in Prison Drug Policy

Since 1987, the Canadian government has been implementing drug strategies to combat the rising addiction and overdose rates in both the

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37 See *Simons v Ontario (Minister of Public Safety)*, 2020 ONSC 1431 [*Simons*].

38 *Ibid*.

community and prisons.[39] These strategies have tended to focus on "the key pillars of prevention, treatment, enforcement and, at times, harm reduction."[40] This formal stated policy has changed over the years, but has often placed strong emphasis on deterrence and criminalization.

This was particularly apparent in the period between 2006 – 2015, where the approach by successive conservative governments focused on preventative and enforcement measures. In 2007, the National Anti-Drug Strategy was established, stating a goal of creating "safer and healthier communities," while notably leaving out harm reduction in this strategy.[41] Implementation of this strategy vastly favoured law enforcement initiatives, with comparatively little funding allotted to treatment, research, prevention, or harm reduction methods.[42] Further, during this time the *Drug-Free Prisons Act* was established, which effectively modified the *Corrections and Conditional Release Act* ("CCRA") to be tougher on drug use in prisons by placing granted parole in jeopardy when a positive urinalysis test has been obtained.[43]

The best evidence of harsh drug-free policies can be seen by analyzing the CCRA.[44] This legislation confers power on the CSC to oversee federal prisons. The most directly relevant provision in this legislation is section 40(i), which states that "an inmate commits a disciplinary offence who **(i)** is in possession of, or deals in, contraband."[45] Contraband is defined in section 2(1) of the CCRA, where it states that "***contraband"*** includes " (a) an intoxicant."[46] An intoxicant is defined in this section as "a substance that, if taken into the body, has the potential to impair or alter judgment, behaviour or the capacity to recognize reality or meet the ordinary demands of life, but does not include caffeine, nicotine or any authorized medication used in accordance with directions given by a staff member or a registered

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39 See Health Canada, "The New Canadian Drugs and Substances Strategy" (last modified 12 December 2016), online: <www.canada.ca/en/health-canada/news/2016/12/new-canadian-drugs-substances-strategy.html> [perma.cc/GJW3-JUH8].

40 *Ibid.*

41 *Ibid.*

42 See Kora DeBeck et al, "Canada's New Federal 'National Anti-Drug Strategy': An Informal Audit of Reported Funding Allocation" (2009) 20:2 Intl J Drug Policy 188.

43 *Drug-Free Prisons Act*, SC 2015, c 30; *Corrections and Conditional Release Act,* SC 1992, c 20 [CCRA].

44 CCRA, *supra* note 43.

45 *Ibid*, s 40(i) [emphasis in original].

46 *Ibid*, s 2(1) [emphasis in original].

health care professional."[47] When these sections are understood together, it becomes clear that the legislation mandates that the CSC provide disciplinary measures whenever any drug other than caffeine, nicotine, or prescription medication is possessed or dealt.

There is some leeway under the *CCRA* for disciplinary offences to be resolved informally.[48] This does not, however, change the fundamentally drug-free nature of the *CCRA*. By categorizing any instance of possessing or distributing intoxicating substances as a disciplinary offence, Parliament has taken a firm stance against the use or possession of any drugs within federal institutions.

2. A Push for Harm Reduction Programming in Federal Prisons

The current governmental policy, named the Canadian Drugs and Substances Strategy ("CDSS"), was implemented by the Liberal government in 2016, and formally restored harm reduction as a pillar of Canada's drug strategy.[49] This marked a refreshing new direction for the Canadian government, and seemed to open the door for more evidence-based approaches to the drug crisis in this country.

This shift in governmental policy has already led to the implementation of some harm reduction methods in federal prisons. First, since 2018 the CSC has been rolling out their PNEP, implemented to date at 11 federal institutes.[50] This program is stated to be "consistent with the Canadian Drug and Substances Strategy and based on comprehensive and informed evidence."[51] The stated goals of this program are to reduce needle sharing in the prison population, facilitate referral to treatment programs, and reduce transmission of communicable diseases and other infections related to injection drug use.[52]

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47 *Ibid*, s 2(1).

48 *Ibid*, s 41(1).

49 See Health Canada, "The New Canadian Drugs and Substances Strategy," *supra* note 39.

50 See Correctional Services Canada, "The Prison Needle Exchange Program" (Ottawa: Health Canada, last modified 15 December 2021), online: <www.csc-scc.gc.ca/health/002006-2004-en.shtml> [perma.cc/8434-ZQNS].

51 *Ibid*.

52 Correctional Services Canada, "Prison Needle Exchange Program" (Ottawa: Health Canada, last modified 28 August 2019), online: <www.csc-scc.gc.ca/health/002006-2005-en.shtml> [perma.cc/YY7B-99UT].

Participation in the PNEP requires consultation with a health professional for education on safe consumption, as well as risks and other harms stemming from drug use.[53] Those who wish to participate must then gain approval from the Institutional Head or Deputy Warden, who will determine if there are any security risks associated with participation.[54] Successful participants of the PNEP are provided kits with clean needles, subject to a one-to-one syringe exchange and prohibition from altering the provided PNEP kits in any way.[55] It should be noted, however, that the PNEP does not override existing rules related to contraband materials, and all illicit drugs still remain prohibited, as do drug-related paraphernalia not part of the provided PNEP kits.[56]

The other major harm reduction initiative undertaken by the CSC is the establishment of an OPS at Drumheller Institution in Alberta. This service is also noted to be consistent with Canada's stated drug strategy, as well as "another component to CSC's harm reduction measures."[57] The OPS is part of "ongoing efforts to help prevent fatal and non-fatal overdoses, reduce the sharing of needles, reduce the transmission of infectious diseases, including HIV and HCV, reduce the occurrence of skin infections, and facilitate referrals to other health care services and programs."[58]

The OPS at Drumheller Institution provides access to "consumption rooms," with health care staff available for education and counselling, as well as to respond to any overdose or other emergency situation.[59] The site is stated to be open from 7:00 am – 7:00 pm every day, with participants of the OPS remaining for 30 minutes or longer as needed for appropriate monitoring to occur.[60] As is the case for community-based safe-injection

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53 *Ibid.*

54 *Ibid.*

55 See Office of the Correctional Investigator of Canada, *Office of the Correctional Investigator: Annual Report 2018-2019* (2019) at 16, online (pdf): <www.oci-bec.gc.ca/cnt/rpt/pdf/annrpt/annrpt20182019-eng.pdf> perma.cc/FDH9-K48Z].

56 See Correctional Services Canada, "Prison Needle Exchange Program," *supra* note 52.

57 See Correctional Services Canada, "The Overdose Prevention Service" (Ottawa: Health Canada, last modified 28 August 2019), online: <www.csc-scc.gc.ca/health/002006-2002-en.shtml> [perma.cc/Q8XC-KADL].

58 See Correctional Services Canada, "Overdose Prevention Service" (Ottawa: Health Canada, last modified 28 August 2019), online: <www.csc-scc.gc.ca/health/002006-2003-en.shtml> [perma.cc/WFS7-X86H].

59 *Ibid.*

60 *Ibid.*

sites, participants will bring their own substances to use at the OPS, so long as it is "a quantity of their substance that is suitable for a personal single use."[61] To use the OPS, a prospective participant must meet with Health Services prior to accessing the program.[62]

The existence of this program does not in any way change the overall drug policy in prisons. Much like the PNEP, while participation in the program itself may not be a disciplinary offence, drugs are still considered contraband. As noted by the CSC: "participants using the OPS will not be disciplined solely for using the service. However, if caught with illicit drugs outside of the OPS, they may face disciplinary measures and/or criminal charges."[63]

Thus, while there has been some push for evidence-based approaches to dealing with addiction in federal prisons in recent years, these more progressive programs have been implemented within a statutory framework that still disciplines and criminalizes drug use. There is a clear tension between longer-standing policies of prevention and deterrence, and these newer harm-prevention initiatives. Indeed, as can be seen by the operational details of both the PNEP and OPS, there appear to be varying and contradictory underlying philosophies guiding the implementation of these programs. Without further policy change, these programs are unlikely to live up to their full potential.

3. Shortcomings of these Prison Harm Reduction Programs

When comparing the highly effective harm reduction programs in communities to the implementation of the PNEP and OPS in federal prisons, various shortcomings of the prison programs begin to present themselves. Given the current policy in these institutions to punish the possession of intoxicants, both the PNEP and OPS fall short of effectively addressing addictions through harm reduction. These programs also present additional negative impacts on inmates' rights to privacy and may act to further stigmatize their addictions.

Turning first to the PNEP, several criticisms have been leveraged against its implementation. Firstly, there is serious concern that such a program cannot have meaningful impacts given the current drug-free environment of federal institutions. This was an issue expressed by the Office of the

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61 *Ibid.*

62 *Ibid.*

63 *Ibid.*

Correctional Investigator ("OCI") in their 2018-2019 annual report, noting that "harm reduction seeks to inform and empower individuals in reducing the harms associated with drug use," but that "CSC will fail to meet this objective if it continues to stigmatize and punish drug use behind its walls."[64]

Another related concern involves the confidentiality of participants of the program. As noted by the Canadian HIV Legal Network in a policy brief, "CSC's PNEP violates prisoners' confidentiality at many points without reasonable justification."[65] For example, the focus by the CSC on security necessitates routine inspections of participants and their cells to ensure the PNEP kits are accounted for, which can lead to undue intrusion.[66] This security-first approach also requires approval by an institutional head via a threat assessment, which necessarily identifies prospective participants as individuals engaged in the prohibited and stigmatized activity of substance use.[67] There are clear drawbacks to this approach – participation in the program is severely limited by the need to identify oneself to the institution, given that drug use is a highly stigmatized, and indeed prohibited, activity within federal institutions. In fact, the PNEP is the only program in the world that has such an approach.[68] The OCI has also criticized this breach of confidentiality, noting that while it is often difficult to meet the same standard of confidentiality in a federal institution, "patient confidentiality and 'need to know' principles [still] need to be respected to the extent possible."[69]

The most problematic outcome of these restrictive policies is the incredibly low participation in the PNEP. Indeed, the OCI noted that "as of April 2019, perhaps not surprisingly, there were only a handful of individuals enrolled in the program."[70] This clearly stems from the identified confidentiality and stigma concerns. Many prospective

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64 Office of the Correctional Investigator, *Annual Report 2018-2019*, *supra* note 55 at 16.

65 Canadian HIV Legal Network, "The Correctional Service of Canada's Prison Needle Exchange Program Policy Brief" (2019), online: <www.hivlegalnetwork.ca/site/prison-based-needle-and-syringe-programs/?lang=en>.

66 *Ibid*.

67 *Ibid*.

68 *Ibid*; see Canada HIV Legal Network, "Former Prisoner Steve Simons Writes why a Prison Needle Exchange Program is Needed," *supra* note 8.

69 Office of the Correctional Investigator, *Annual Report 2018-2019*, *supra* note 55 at 16.

70 *Ibid*.

participants are likely unable to trust the provision of clean injection kits from an institution that labels illicit drugs as contraband and punishes those who possess them. After all, by outing oneself as a user, there is fear not only of discipline, but also of the potential barriers to programming and release that this discipline may create. Perceived risks in accessing the PNEP clearly deters widespread use and ultimately hinders its important health impacts.

Similar concerns exist regarding the OPS. While there is far less available information on the specifics of this new program, the continued criminalization and stigma of drug use certainly presents ongoing barriers to effective and widespread use. This is concerning as low usage of the OPS serves to limit many of the benefits of the programming, such as the support, security, and connectedness seen in community based SCSs.[71] Essentially, the accessible and welcoming nature of SCSs should be understood as contributing to their widespread success, but the abstinence-based policies of federal prisons make such qualities unattainable for the CSC's OPS.

The foregoing discussion demonstrates the various ways in which prison harm reduction programs are simply not to the same standards as community programming. Low enrollment through continued drug-free approaches severely hinders their effectiveness. So, while proper implementation of PNEPs and OPSs is capable of seriously curbing rates of disease and overdose in federal prisons, the programs as they stand now are simply insufficient. Canada has recognized and committed to harm reduction, but the CSC programs certainly fall short of meeting this goal.

B. Section 7 of the *Charter* – How Current Harm-Reduction Programming Infringes the Right to Security of the Person

Section 7 of the *Charter* protects against deprivations of life, liberty, and security of the person except in accordance with the principles of fundamental justice. Thus, when a law or state action: (1) infringes an individual's life, liberty, or security of the person; and (2) this infringement does not accord with principles of fundamental justice, then the state act is in contravention of Section 7 of the *Charter*. The failure of both the PNEP and OPS in providing effective and accessible harm-reduction can certainly be understood as constituting a breach of section 7. Indeed, there is reason

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71 See Kerman et al, *supra* note 13 at 3-4.

to believe that these programs fail to meet the requisite healthcare standard, and thus infringe section 7.

As noted above, the PNEP has already been challenged in *Simons* – a challenge that was unsuccessful. This decision is highly informative for understanding the constitutionality of prison harm reduction programming. The outcome itself may be discouraging for those who hoped to see improvement in the PNEP, however there are several reasons to remain optimistic about the success of future challenges.

First, the *Charter* challenge in *Simons* morphed from a challenge originally addressed at the general lack of any NSP in federal prisons. The original argument was that a failure to provide Safe Injection Equipment ("SIE") contravened s. 86 of the *CCRA*. These were not litigated due to the PNEP's establishment, but Justice Belobaba characterized the original sections 7 and 15(1) challenges as "compelling constitutional arguments."[72] Indeed, he noted with regards to the section 15(1) argument in particular, that "if this were still 2012 with no PNEP and the constitutional challenge was focused only on the impugned provisions of the *CCRA* that prohibit SIE, the arguments about discrimination on the basis of disability, sex and race would have been compelling."[73] This indicates that the CSC may be constitutionally mandated to provide some form of harm reduction programming in federal institutions. At minimum, *Simons* seems to suggest that the CSC is required to roll out PNEPs to all federal prisons, and significant delays in doing so may be in contravention of the *Charter*.

Second, Justice Belobaba's unwillingness to find the government in breach of the Charter was in part due to the PNEP being a relatively new program that was not yet fully implemented, and characterizes the challenges as "premature."[74] He thus affords the CSC a high degree of deference, suggesting that because there may be "further design changes," allowing the application to proceed would be "neither prudent nor just."[75]

Finally, his dismissal of the section 7 application was based largely on insufficient evidence to ground the claim.[76] This will be discussed in more detail below, but his decision does not demonstrate that the PNEP is

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72 *Simons*, *supra* note 37 at para 9.
73 *Ibid* at para 80.
74 *Ibid* at para 22.
75 *Ibid* at para 24.
76 *Ibid* at para 48.

implemented in a constitutional manner, but rather that there was a lack of empirical evidence before him to support a finding that section 7 had been infringed.

For these reasons, the decision in *Simons* does not prevent a future *Charter* challenge from succeeding. Indeed, as will be argued in the following sections, there remain serious questions about whether the PNEP and OPS truly meet the standard required by section 7 of the *Charter*.

1. The Deficiencies of the PNEP and OPS Engage Section 7

As has been outlined by the SCC,[77] the first step in a section 7 *Charter* analysis is to determine if an individual's rights to life, liberty, or security of the person is being engaged. This step requires that an applicant prove on a balance of probabilities that the impugned law or state action has a "sufficient causal connection" to the right being deprived.[78] When the effects of the PNEP and OPS are considered in light of their stated objectives, it is clear that security of the person is engaged by this programming.

i. Goals of CSC Harm Reduction Programming

To reasonably assess if a section 7 interest is being engaged, the goals of the CSC in implementing the PNEP and OPS must be understood. Indeed, it is the purpose and objective of the impugned law or act that is central to a section 7 analysis.[79] As noted above, the stated goals for both the PNEP and OPS include the reduction of needle sharing, facilitating referral to treatment programs, and reducing transmission of communicable diseases and other infections related to injection drug use, with the OPS having the additional goal of reducing overdose generally.[80] These goals suggest the programming to be primarily health-focused – the CSC has created the PNEP and OPS to respond to legitimate health risks associated with addiction in federal prisons. This is further supported by section 3(a) of the *CCRA*, which indicates that the safety and humane treatment of prisoners are the primary purpose of the federal correctional system.[81] Thus, these

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77 *Canada (AG) v Bedford*, 2013 SCC 72 at para 58 [*Bedford*].

78 *Ibid* at para 76.

79 *Ibid*.

80 See Correctional Services Canada, "The Prison Needle Exchange Program," *supra* note 50; Correctional Services Canada, "The Overdose Prevention Service," *supra* note 57.

81 *CCRA*, *supra* note 43, s 3(a).

programs can be broadly understood as having the objective of minimizing the health risks of substance use through the provision of evidence-based health interventions.

ii. The Correct Standard of Prison Healthcare

Additionally, it is important to establish the proper standard on which to gauge the success or failure of the healthcare-focused goals of these programs. After all, any assessment of whether health-focused objectives are being met – and the consequences of meeting or failing to meet these objectives – requires reference to some minimum constitutional standard. Both steps of the section 7 test require that the CSC programming fall short of requisite prison healthcare standards: in the first step to demonstrate a sufficient causal connection between state action and the deprivation of a protected interest, and in the second step to establish if the purpose of the legislation runs counter to its effects in a manner inconsistent with the principles of fundamental justice.

The bare minimum standard that the CSC must meet in their provision of healthcare can be found in section 86 of the *CCRA*.[82] Section 86(1) states that "the Service shall provide every inmate with (a) essential health care; and (b) reasonable access to non-essential health care," and section 86(2) indicates that "the provision of health care under subsection (1) shall conform to professionally accepted standards."[83] Thus, if the PNEP and OPS were deemed necessary as "essential healthcare," or if their provision was understood as constituting "reasonable access to non-essential healthcare," then under section 86(2) such programs would be required to be delivered in a way conforming to "professionally accepted standards."[84]

Given the large body of literature on both NSPs and SCSs, including the most effective method of delivering these programs, one could envision an argument that failure to deliver the PNEP or OPS in a way consistent with this literature would constitute a breach of the CSC's legal obligations. In fact, this was the exact argument made in *Simons*.[85] The challenge in *Simons* was based on an alleged failure to provide reasonable and effective access to SIE in accordance with professionally accepted standards, by

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82 *Ibid.*

83 *Ibid*, s 86.

84 *Ibid.*

85 *Simons*, *supra* note 37.

utilizing a security-based model rather than a healthcare-focused one.[86] Such failure was said to breach the section 7 rights of injection drug users in federal prisons by depriving them of their security of the person in a manner inconsistent with the principles of fundamental justice. Thus, the healthcare standard on which the decision in *Simons* was based was that of the provision of services that conformed to professionally accepted standards.

It should be noted here that while this legislative standard informs the minimum level of healthcare that the CSC must provide, international instruments suggest that a higher standard may be constitutionally required. Indeed, international consensus may mandate that healthcare in prisons be provided at a level equivalent to that in the community. Such a heightened standard was not considered in *Simons*, and is not legislatively mandated in Canada, but may be necessary when constitutional principles related to international norms are properly applied. The justification for and consequences of this heightened standard will be engaged with separately later in this paper.

iii. How Security of the Person is Engaged

The SCC has repeatedly indicated that where health and well-being are being impaired by the state, security of the person is engaged.[87] For example, in *Bedford*, the court found that where measures aimed at minimizing the risks of dangerous activity were being prevented by the state, security of the person was implicated.[88] Similarly, in *PHS Community Services Society*, the SCC determined that certain provisions in the *Controlled Drugs and Substances Act*, which in effect prevented individuals from accessing harm reduction treatments from Insite, engaged section 7 of the *Charter*.[89] Chief Justice McLachlin, writing for the Court, noted that "where a law creates a risk to health by preventing access to health care, a deprivation of the right to security of the person is made out."[90] Given that both the drug-free prison legislation and the security-focused aspects of the prison harm-reduction

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86 *Ibid* at para 47.

87 See e.g. *R v Monney*, [1999] 1 SCR 652 at para 55, 171 DLR (4th) 1, citing *Singh v Minister of Employment and Immigration*, [1985] 1 SCR 177, 17 DLR (4th) 422; *Chaoulli v Quebec (Attorney General)*, 2005 SCC 35 at para 123.

88 *Bedford*, *supra* note 77 at para 60.

89 *PHS Community Services*, *supra* note 32 at para 93.

90 *Ibid*.

programs can be understood as preventing individuals from accessing healthcare that would minimize the various risks associated with addiction, security of the person is clearly engaged.

This conclusion may appear to directly conflict the finding in *Simons*, where the applicants were unable to convince Justice Belobaba that section 7 was engaged.[91] It is worthwhile, however, to consider Justice Belobaba's approach to this step of the section 7 analysis.[92] Essentially, Justice Belobaba found insufficient evidence to support the existence of "professionally accepted standards."[93] The applicants contented that a healthcare-centred model free of risk assessment criteria was accepted as this standard, but Justice Belobaba was unconvinced by the evidence presented. Further, the connection purported to exist between the impugned measure and section 7 interest was found to be speculative.[94] When speaking of expert testimony regarding how involvement of security staff limited access to the PNEP, Justice Belobaba noted that "these beliefs and opinions are offered as bald assertions without research support."[95]

The section 7 challenge therefore did not fail due to foundational problems with the underlying argument, but rather a lack of evidence to discharge burden of proof. Were a challenge to be made that proved the existence of a "professionally accepted standard" and tangible connection between low accessibility to the PNEP and its security-based approach, it would seemingly have real merit.

In fact, despite the finding in *Simons*, there is strong reason to believe that a causal connection between the program deficiencies and the security of individuals could be supported in a future challenge. As noted above, the incredibly low participation in the PNEP has been linked by various groups – including the OCI and the Canadian HIV Legal Network – to the security-focused nature of this programming. This approach is particularly problematic for those who are deemed unable to participate in the PNEP – for them, no other means of managing the risks associated with their

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91 *Simons*, *supra* note 37.

92 *Ibid* at para 49, citing *Bedford* at para 76. The first step of the analysis requires that there be "sufficient causal connection" between the impugned measure (failure to conform to professional standards) and the s. 7 interest (here, security of the person) for s. 7 to be engaged.

93 *Simons, supra* note 37 at para 48.

94 *Ibid* at paras 50-51.

95 *Ibid* at para 51.

addictions exist, and they are essentially forced to engage in needle-sharing and other risky activity. Similarly, drug free prison policies provide clear barriers to program participation, as individuals who would otherwise use these programs must weigh access against the risk of identifying themselves as a user to institutional agents. These concerns are not simply speculative – drug control approaches have been found to deter access to treatments and programming, to contribute to the stigmatization of users, and lead to unsafe consumption practices.[96] In an institutional setting, where there is far less privacy and far greater state control, these impacts would only be heightened. Thus, it is unquestionable that evidence of this causal connection exists – it simply has not yet been brought before a Canadian court.

C. The PNEP and OPS Do Not Accord with Principles of Fundamental Justice

It is well established law that section 7 will be infringed where a law or state action can be proven to be arbitrary, overbroad, or grossly disproportionate.[97] These requirements are clearly explained by Chief Justice McLachlin in *Bedford*: A law is arbitrary when it "bears no connection to its objective," overbroad when "there is no rational connection between the purposes of the law and some, but not all, of its impacts," and is grossly disproportionate when "the seriousness of the deprivation is totally out of sync with the objective of the measure."[98] With regards to the PNEP and OPS, it is their overbreadth and arbitrariness that are of concern.

1. Arbitrariness

In *Simons*, Justice Belobaba was unconvinced that the PNEP was contrary to any principle of fundamental justice. With respect to both arbitrariness and overbreadth, it was conceded by Justice Belobaba that there were no known instances of SIE that have been provided through a PNEP being used to cause harm.[99] Nonetheless, he found that a reasonable perception of risk stemming from providing SIE to prisoners was "neither

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96 See UNGA, *Right of everyone to the enjoyment of the highest attainable standard of physical and mental health*, UNGAOR, 65th Sess, UN Doc A/65/255 (6 August 2010) <undocs.org/A/65/255>.

97 See *Bedford*, supra note 77; *R v Malmo-Levine*, 2003 SCC 74.

98 *Bedford*, *supra* note 77 at paras 111, 112, 120 [emphasis in original].

99 *Simons*, *supra* note 37 at para 56.

speculative nor irrational" and ultimately deemed the PNEP's security-based approach to not be arbitrary.[100]

Despite this finding in *Simons*, the legislation can clearly be seen as arbitrary when its healthcare-focused goals are considered in light of the previously discussed prison healthcare standards. With respect to both the PNEP and OPS, implementation almost certainly falls short of the requisite "professionally accepted standard." To start, one can look to *PHS Community Services Society* for circumstances where there was a finding of arbitrariness. In that case, the SCC determined that a ministerial decision to not exempt Insite from the *CDSA* was in effect arbitrary on the basis that such an exemption would clearly further the health and safety goals of this legislation.[101] Essentially, given the well-understood benefits that Insite provides to the health and safety of the community, allowing the *CDSA* to have effect within Insite can only be understood as causing increased risks to users. Similarly, one can view drug-free prison legislation and security-focused approaches to harm reduction implementation as undermining the known benefits of NSPs and SCSs. Thus, the CSC can be understood as conducting the PNEP and OPS in an arbitrary manner, given its effect is in opposition with the healthcare-focused objectives this programming.

Further, there are a few ways that professional standards could be conceptualized which would suggest the programming to be arbitrary. Firstly, the PNEP could be compared to the standards of community NSPs. Making a comparison in this way clearly suggests defects in the PNEP. For instance, confidentiality is a core component in most community NSPs,[102] and thus a failure of the PNEP to ensure confidentiality could certainly be

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100 *Ibid* at paras 58, 64.

101 *PHS Community Services*, *supra* note 32 at 131, 136.

102 See The Canada Addiction Treatment Centers characterizes their needle exchange program as "a confidential and free program" that is run out of pharmacies and clinics, CATC, "Harm Reduction Services," online <canatc.ca/harm-reduction-services/> [perma.cc/CQ24-VHJD]; Halifax's Mainline program notes that respecting confidentiality of clients is central to their code of conduct, "Our Commitment to You," online <mainlineneedleexchange.ca/our-commitment/> [perma.cc/TLA8-78DU]; Vancouver Costal Health characterizes their harm reduction programs, including their NSPs, as "free and confidential", "Harm Reduction," online <www.vch.ca/public-health/harm-reduction> [perma.cc/7BMC-J8K8]; and Peel Public Health's needle exchange program is also "free and confidential," "NEP Overview," online <www.peelregion.ca/health/needle-exchange/index.htm> [perma.cc/A665-H7W8].

seen as falling short of professional standards. More fundamentally though, accessibility for all injection drug users is of paramount importance to community NSPs,[103] and so any significant barriers to access – such as the approval process of the PNEP that prevents some inmates from accessing the service at all – ought to be considered falling short of professional standards.

The PNEP can also be compared to other prison needle exchange programs and doing so also suggests that professional standards are not being met by the CSC. For instance, studies on needle exchange programs in Moldova and Luxembourg attributed their initial ineffectiveness to a lack of trust that the programs were confidential, and UNDOC have therefore suggested that prison NSPs must be conducted in a way that promotes this confidentiality and trust.[104] UNDOC has also indicated that "[p]risoners who inject drugs should have easy and confidential access to sterile drug injecting equipment, syringes and paraphernalia."[105] It therefore seems clear that trust, confidentiality, and accessibility are standards for prison NSPs that have been accepted by experts. To the extent that these standards are not being met by the PNEP, such programming can clearly be understood as being arbitrarily implemented.

2. Overbreadth

There is also reason to view the PNEP, OPS, and surrounding policy as overbroad on the basis that less restrictive means of implementing these

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[103] See Providing access to safe injection equipment is the very point of these programs, and so maximizing accessibility is considered centrally important to their effectiveness. See e.g. Carol Strike et al, "Ontario Needle Exchange Programs: Best Practice Recommendations" (2006) at 140, online (pdf): <www.ohtn.on.ca/Documents/Knowledge-Exchange/Needle-Exchange-Best-Practices-Report.pdf> [perma.cc/6GD9-6RNP], where delivery models that maximize accessibility were recognized as best practice. See also Canada HIV/Aids Legal Network, "Sticking Points: Barriers to Access to Needle and Syringe Programs in Canada" (2007) at 3, online (pdf): <lib.ohchr.org/HRBodies/UPR/Documents/Session4/CA/CANHIVAIDS_LN_CAN_UPR_S4_2009_anx4_StickingPoints.pdf>; Carol Strike & Miroslav Miskovic, "Scoping out the literature on mobile needle and syringe programs—review of service delivery and client characteristics, operation, utilization, referrals, and impact" (2018) 15:6 Harm Reduction J at 2.

[104] UNDOC, "A Handbook for Starting and Managing Syringe Programs in Prisons and other Closed Settings" (2014) at 43-44.

[105] UNDOC, "HIV prevention, treatment and care in prisons and other closed settings: a comprehensive package of interventions" (2013) at 3.

programs are possible. There is little evidence to suggest that a security-focused approach to the PNEP is necessary. The CSC themselves refer to UNDOC findings that prison NSPs "are not associated with increased assaults on prison staff or inmates," and that they in fact "contribute to workplace safety."[106] Further, as was found in *Simons*, "thus far not a single incident involving harmful use of a needle or syringe has been documented in any prison where there is access to SIE through a PNEP."[107] The need for security screening is therefore questionable, and so limiting access on such a basis can only be seen as overly restrictive.

In this way, even if the implementation of these programs cannot be seen as arbitrary overall, they can certainly be understood as imposing unnecessary restrictions on the accessibility and effectiveness of the programming – directly conflicting with the purpose of the PNEP and OPS.

On the basis of arbitrariness and overbreadth, it seems as though a section 7 *Charter* violation can be readily supported. If so, it is unlikely that the PNEP and OPS implementation can be saved under section 1. After all, the SCC has found that infringements of section 7 are "not

easily saved by section 1."[108] In any event, a section 1 balancing of the salutary effects of the PNEP and OPS against the deleterious effects of its poor implementation would suggest that these programs could not be saved. These programs, as implemented, provide very little actual benefit to incarcerated individuals given their low accessibility. Given the clear rates of overdose, infection, and other use-related harms, the negative impacts of these barriers to accessibility suggests that the CSC's harm reduction methods, as currently implemented, cannot be saved under section 1.

IV. Section 15(1) – How Prison Drug Policy Denies Access to Harm Reduction for Injection Drug Users

Like section 7, there is good reason to view the CSC's approach to harm reduction as being contrary to section 15(1). The inability of these programs to conform with international or legislative standards of healthcare

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106 Correctional Services Canada, "The Prison Needle Exchange Program," *supra* note 50.

107 *Simons*, *supra* note 37.

108 See *Charkaoui v Canada (Citizenship and Immigration)*, 2007 SCC 9 at para 66; *R v Ruzic*, 2001 SCC 24 at para 92; *Winnipeg Child and Family Services v KLW*, 2000 SCC 48 at para 42.

provision, when paired with their disproportionate impacts on those with addiction, clearly constitutes a distinction based on enumerated grounds. Additionally, the link between addiction and other forms of marginalization makes arguments on related grounds compelling as well.

Given that *Simons* also involved a section 15(1) challenge, it is worth discussing this decision at the outset and why it failed. Because the challenge was predicated on the denial of "effective access to SIE/essential health care to all [Injection Drug Use] inmates in accordance with professionally accepted standards," it was ultimately determined that this standard was never proven, as no "distinction" relevant to the first part of the test could be proven to exist.[109] In his analysis, however, Justice Belobaba did note that addiction is indeed an enumerated ground on which a section 15(1) claim could be based.[110] Thus, much like the section 7 challenge, the main shortcoming of the challenge rested on insufficient evidence of an accepted standard with which to compare to the PNEP. Were such evidence to exist, the challenge would have real merit.

The test for a breach of section 15(1) involves two main considerations: (1) Does the law, on its face or in its impact, create a distinction based on an enumerated or analogous ground; and (2) is the distinction discriminatory?[111] In spite of *Simons*, there is good reason to believe that both can be answered in the affirmative in relation to the PNEP and OPS implementation.

A. Step 1 – The Law Creates a Distinction Based on an Analogous Ground

For the first step, it must be understood that addiction has been considered a disability by Canadian courts and thus falls under an enumerated ground.[112] Therefore, the main question at this first step is if the effects of the prison drug legislation and harm reduction programming is to create a distinction for those with addictions. Such a distinction can be seen to exist.

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109 *Simons*, *supra* note 37 at paras 82-83.

110 *Ibid* at para 80.

111 See *Quebec (Attorney General) v Alliance du personnel professionnel et technique de la santé et des services sociaux*, 2018 SCC 17 at para 25.

112 See *Simons*, *supra* note 37 at para 80; *Canada (Attorney General) v Bedford*, 2012 ONCA 186 at para 356.

The distinction being created is best understood with reference to the healthcare standards for the prison population at large. As discussed above, there is at minimum a requirement that healthcare be provided to "professionally accepted standards." Beyond this minimum standard, though, there may in fact be a requirement (as will be discussed below), that healthcare be equivalent to that of the community. Either way, as noted in the previous section on section 7, such standards do not seem to be met by these programs. Current policy therefore leads to individuals with addictions being unable to access appropriate healthcare services, a clear distinction when compared to the minimal impacts on incarcerated individuals without addictions.

Additionally, there is some reason to believe that other enumerated grounds could be engaged, as women, Indigenous people, or those with mental illness may also be disproportionately affected by this programming. For instance, use of injection drugs has been found to be linked to high prevalence of HIV/HVC infection for Aboriginal people, and both women and those with mental illness have been found to be at increased risk to share drug paraphernalia.[113] Thus, for those populations, where harm reduction would be of particular benefit, a failure to provide such services in a way that conforms to appropriate prison healthcare standards would constitute a distinction on an enumerated ground.

B. Step 2 – The Distinction Discriminates

With respect to the second step of the analysis, it can be said that the distinction is discriminatory in nature. In *Kahkewistahaw First Nation v Taypotat*, the SCC noted that this step would be made out where the distinction had "the effect of perpetuating arbitrary disadvantage on the claimant."[114] Similarly, in *Fraser v Canada (Attorney General)*, the Court required that the distinction "imposes burdens or denies a benefit in a manner that has the effect of reinforcing, perpetuating, or exacerbating disadvantage."[115] As noted in the above section 7 analysis, the way these

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113 See Public Health Agency of Canada, "Population-Specific HIV/AIDS Status Report – Aboriginal Peoples" (2010) at 28; Carol Strike et al, *Best Practice Recommendations for Canadian Harm Reduction Programs that Provide Service to People Who Use Drugs and are at Risk for HIV, HCV, and Other Harms: Part 1* (Toronto, ON: 2013) at 37.

114 *Kahkewistahaw First Nation v Taypotat*, 2015 SCC 30 at para 16.

115 *Fraser v Canada (Attorney General)*, 2020 SCC 28 at para 27.

harm reduction services are being provided is arbitrary, confers little in the way of benefits for those they are intended to help, and prevents many individuals from minimizing the very real risks of substance use in prisons. Given that the government's purpose is to combat the very real issue of disease and overdose in prisons, that they are not making such health interventions accessible only acts to continue to perpetuate the disadvantage these marginalized individuals are experiencing. Therefore, there is good reason to view these programs as being in breach of section 15(1) *Charter* obligations as well.

V. INTERNATIONAL STANDARDS – WHY HEALTHCARE IN PRISONS SHOULD BE EQUIVALENT TO THAT OF THE COMMUNITY

As discussed in the previous sections, there are compelling reasons to view current harm reduction programming as falling short of professional standards – this on its own highlights constitutional concerns with the PNEP and OPS. These concerns, however, become even more significant when international standards are considered.

When looking to international standards of prison healthcare, there is a clear consensus that prison systems ought to provide equivalent care to that of communities. Indeed, there is a general principle echoed in a variety of international instruments whereby "prison health services are obliged to provide prisoners with care of a quality equivalent to that provided for the general public in the same country."[116] This principle has been recognized at an international level by bodies such as the United Nations and WHO.[117] Most notably, this principle is expressed in The United Nations Standard Minimum Rules for the Treatment of Prisoners (the "Mandela Rules"), with rule 24 stating that:

> 1. The provision of health care for prisoners is a State responsibility. Prisoners should enjoy the same standards of health care that are available in the community, and should have access to necessary health-care services free of charge without discrimination on the grounds of their legal status.

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116 Gérard Niveau, "Relevance and limits of the principle of "equivalence of care" in prison medicine" (2007) 33 J Med Ethics 610 at 610.

117 *Ibid*. See also *Basic Principles for the Treatment of Prisoners*, GA Res 45/111 (1990), r 9; UNAIDS, *WHO Guidelines on HIV Infection and AIDS in Prisons*, UN Doc UNAIDS/99.47/E (1999) at 4.

> 2. Health-care services should be organized in close relationship to the general public health administration and in a way that ensures continuity of treatment and care, including for HIV, tuberculosis and other infectious diseases, as well as for drug dependence.[118]

The Mandela Rules have not been adopted into Canadian domestic law and are therefore not of binding force on the Canadian government.[119] Nonetheless, these rules "represent an international consensus of proper principles and practices in the management of prisons and the treatment of those confined," and "reflect a general shift in social views regarding acceptable treatment or punishment."[120]

Indeed, in recent years there has been a trend in Canadian jurisprudence to accept international standards as being informative in *Charter* analyses. The SCC in *Suresh v Canada (Minister of Citizenship & Immigration)* found that "the principles of fundamental justice expressed in s. 7 of the Charter and the limits on rights that may be justified under s. 1 of the Charter cannot be considered in isolation from the international norms which they reflect."[121] In *CCLA v Canada*, the Ontario Superior Court directly adopted the reasoning in *Suresh*, and found the Mandela Rules to be relevant in sections 7 and 1 analysis.[122] The *BCCLA v Canada* decision by the British Columbia Supreme Court similarly relied on *Suresh* to apply international standards to a constitutional analysis.[123] In *Brazeau v AG (Canada)*, the Ontario Superior Court relied on the Mandela Rules to determine that administrative segregation violated the *Charter*.[124] In *R v Capay*, the Ontario Superior Court directly endorsed the *CCLA* decision, finding the Mandela Rules to establish international consensus as to the correct standards of treatment of prisoners.[125] Finally, the Ontario Superior Court in *Francis v Ontario* relied on a variety of the above caselaw, and the

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118 UN-Doc A/Res/70/175 (17 December 2015) ["Mandela Rules"].

119 *Canadian Civil Liberties Assn v Canada (AG)*, 2019 ONCA 243 at para 29; *British Columbia Civil Liberties Assn v Canada (AG)*, 2019 BCCA 228 at para 71.

120 *Canadian Civil Liberties Assn v Canada (AG)*, 2019 ONCA 243 at paras 28,29.

121 *Suresh v Canada (Minister of Citizenship & Immigration)*, 2002 SCC 1 at para 59.

122 *CCLA v Canada*, 2017 ONSC 7491 at para 154 [*CCLA*].

123 *BCCLA v Canada,* 2018 BCSC 62 at para 560.

124 *Brazeau v AG (Canada)*, 2019 ONSC 1888 at paras 372-373.

125 *R v Capay*, 2019 ONSC 535 at para 157.

Mandela Rules were again recognized as an international consensus on prison management and prisoner treatment.[126]

This higher standard of healthcare is important, as it is not being met by the current PNEP. Most notably, barriers to access programming in institutions is far higher than the barriers in communities. There are large degrees of variation in the implementation of NSPs in a community setting, but such programming tends to be run by healthcare providers and essentially never records identifying information. In this way, participants can maintain a degree of anonymity. The PNEP, on the other hand, does not uphold such confidentiality, posing a significant barrier to access. This can be seen as a direct failure to meet community standards for these programs in contravention of rule 24(1) of the Mandela Rules, but also as threatening continuation of care upon entry to federal institutions contrary to rule 24(2).

Similarly, how the OPS is implemented creates significant barriers to access the site – barriers that do not exist in the community setting. The security-focused approach in federal prisons directly limits the accessibility of the OPS in a way that does not exist in community SCSs. In this way, the overall prohibition of drugs in federal institutions appears to cause this harm reduction initiative to fall short of the equivalence of care requirement.

Thus, to conform with international standards, Canada's drug-free prison policy must be dramatically altered, or even done away with completely. The approach taken by the CSC is severely limiting the effectiveness of this programming, leaving many in prisons unable to access this potentially life-saving healthcare. These programs fall well short of what is expected by the larger international community, further evidencing their unconstitutional character.

VI. CONCLUSION

Response to the drug crisis in federal prisons is a very real and pressing concern. There are significant documented harms resulting from substance use in these institutions and Canada and the CSC are best positioned to address them. Based on a diverse array of evidence from community programs, it is contended here that the only responsible way to address these harms in a prudent and timely manner is through the continued

126 *Francis v Ontario*, 2020 ONSC 1644 at paras 61, 106, 112, & 269.

establishment and improvement of harm reduction programs such as the PNEP and OPS. Such programs, if properly implemented, can minimize overdose and communicable disease, as well as promote access to addiction treatment programming; in stark contrast to abstinence-based policy which has continued to remain ineffective given the profound relationship between addiction and underlying social factors. Thus, evidence-based harm reduction methods remain the best avenue in addressing this public health crisis.

Unfortunately, both the PNEP and OPS are currently insufficiently implemented, raising serious constitutional concerns. The CSC is likely constitutionally obliged to offer harm reduction programming at all federal institutions, yet slow and incomplete rollout has left most incarcerated individuals without access. Further, even if these programs were in effect within all federal institutions, the PNEP and OPS are still insufficient in their current form. They certainly do not reach the equivalence of care standard as mandated by the Mandela Rules, with continued prohibition of drugs in federal institutions and the security-focused approach to harm reduction programming presenting severe barriers to access that are simply not present in the community. This lack of accessibility may also indicate that the programs fall short of professionally accepted standards, and thus contravene sections 7 and 15(1) of the *Charter*. While such a finding has not yet been made in Canadian courts, the continued development and acceptance of harm reduction strategies by both experts and international bodies can only make such a legal conclusion more likely in the future.

Ultimately, the CSC is uniquely situated to take major steps in response to Canada's drug crisis. They are empowered to provide access to proven and effective programming for some of society's most vulnerable individuals. Unfortunately, while they should be commended for the establishment of the existing programs, it is undeniable that much more work must be done for these programs to be considered a success. Until then, many Canadians in custody will continue to suffer.