Beyond Insite:

Charter Protection of a Safe Smoking Facility

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I. Insite

Since 2003, Insite, North America's first medically supervised injection facility, has provided drug-addicted residents of Vancouver's Downtown Eastside (DTES) with a safe and clean facility where they can inject drugs under medical supervision, thereby ameliorating the risks of disease transmission and death from overdose.

Prior studies of Vancouver's overdose deaths and health conditions in the DTES illustrated the extent of the health crisis in the DTES and provided the impetus for Insite's opening. In 1994, a report by British Columbia's Chief Coroner J.V. Cain found that annual illicit drug overdoses in Vancouver had risen from 18 in 1988 to 200 in 1993.[1] In 1998, the leading cause of death among males aged 30-49 was injection drug overdose.[2] Furthermore, in 1997 the rate of HIV infection was estimated to be approximately 27% among injection drug users, an epidemic level of infection;[3] for hepatitis C (HCV), the estimated rate was an astonishing 88%.[4] Clearly, injection drug use was a pressing health issue.

There was also at this time a growing recognition that abstinence-based strategies of controlling illegal drug use were often ineffective and impractical and that a successful drug strategy in Vancouver required adoption of harm reduction methods.[5] Based in part on the positive results on individual and public health achieved by drug consumption rooms in Europe,

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[1] Office of the Chief Coroner, *Report of the Task Force into Illicit Narcotic Overdose Deaths in British Columbia* (Victoria, BC: Ministry of the Attorney General, 1994) at 9.

[2] Donald MacPherson, *A Framework for Action: A Four-Pillar Approach to Drug Problems in Vancouver (Revised)* (Vancouver: City of Vancouver, 2001) at 14. [MacPherson]

[3] *PHS Community Services Society v. Attorney General of Canada*, 2008 BCSC 661 at para. 24. [*PHS Community Services Society* (2008)]

[4] John S. Millar, *HIV, Hepatitis, and Injection Drug Use in British Columbia – Pay Now or Pay Later?* (Victoria, BC: B.C. Ministry of Health, 1998) at 8.

[5] MacPherson, *supra* note 2 at 60.

it was suggested that Vancouver's drug strategy include the creation of safe injection or drug consumption facilities.[6] To this end, the federal government in 2003 granted Insite a legal exemption under s. 56 of the *Controlled Drugs and Substances Act (CDSA)*, paving the way for Insite's opening.[7]

Although the operation of Insite has certainly not been without controversy, the peer-reviewed scientific literature demonstrates that Insite has provided a number of benefits to both the individual users and to the community, including reduced public injecting, lower rates of needle sharing, and an increased rate of seeking addiction treatment among its clients.[8] Furthermore, while some analysis has concluded that there is insufficient data to make long-term conclusions about the positive effects of Insite,[9] studies seeking to directly identify negative effects of Insite have found no evidence of such effects.[10]

The initial s. 56 exemption was granted for a term of 3 years beginning in September 2003 and was subsequently extended until June 30, 2008.[11] Despite the apparent success of the Insite supervised injection facility, it became clear that no further exemptions would be granted by the federal Conservative government.[12] In anticipation of the expiration of the exemption, PHS Community Services Society (the non-profit operator of Insite) and two of Insite's clients, as well as the Vancouver Area Network of Drug Users (VANDU), sought declarations that

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[6] MacPherson, *supra* note 2 at 63.

[7] Urban Health Research Initiative, *Findings from the Evaluation of Vancouver's Pilot Medically Supervised Safer Injection Facility – Insite* (Vancouver: British Columbia Centre for Excellence in HIV/AIDS, 2009) at 5. [UHRI Findings]

[8] *Ibid.*

[9] For example, see Expert Advisory Committee, "Vancouver's INSITE service and other supervised injection sites: What has been learned from research? – Final report of the Expert Advisory Committee", online: Health Canada <http://www.hc-sc.gc.ca/ahc-asc/pubs/_sites-lieux/insite/index-eng.php>. [EAC Report]

[10] UHRI Findings, *supra* note 7 at 5.

[11] *PHS Community Services Society v. Canada (Attorney General)*, 2010 BCCA 15 at para. 10. [*PHS Community Services Society* (2010)]

[12] *Ibid.* at para. 10.

application of ss. 4(1) (prohibition of drug possession) and 5(1) (prohibition of drug trafficking) of the *CDSA* to the Insite facility is unconstitutional as it constitutes (1) an invalid federal interference with the provincial constitutional power with respect to health care, or alternatively (2) a violation of the s. 7 *Charter of Rights and Freedoms* 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.[13] PHS was successful on its *Charter* argument at trial[14] and succeeded on both *Charter* and federalism grounds at the British Columbia Court of Appeal.[15] The federal government has announced that they are appealing the decision.[16]

II. Crack Smoking in Vancouver

Since 1996 there has been a dramatic increase in crack cocaine smoking in the DTES. In a survey of injection drug users in 1996, 3.5% reported daily crack smoking over the past six months. This number had increased to 41.7% by 2007.[17] Injection drug users surveyed in 2007 indicated that crack cocaine was the easiest drug to obtain in the DTES, with approximately 90% of injection drug users indicating that they could obtain crack within 10 minutes.[18] Additionally, the median price of crack cocaine per 0.1 gram reported by injection drug users remained

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[13] *PHS Community Services Society (2008)*, *supra* note 3 at para. 5.

[14] *PHS Community Services Society* (2008), *supra* note 3.

[15] *PHS Community Services Society* (2010), *supra* note 11.

[16] Camille Bains, "Ottawa takes injection battle to top court" *The Globe and Mail* (9 February 2010), online: <http://www.theglobeandmail.com/news/politics/ottawa-takes-injection-battle-to-top-court/article1461577>.

[17] Urban Health Research Initiative, *Drug Situation in Vancouver* (Vancouver: British Columbia Centre for Excellence in HIV/AIDS, 2009) at 8. [Drug Situation in Vancouver]

[18] Drug Situation in Vancouver, *supra* note 17 at 32.

constant at $10 between 2000 and 2007.[19] These statistics together indicate a failure of law enforcement and abstinence-based strategies to impact either the supply or demand of crack cocaine in the DTES. While the current federal government's National Anti-Drug Strategy will increase efforts to reduce drug supply through law enforcement, evidence from other jurisdictions worldwide suggests that these efforts will be unlikely to succeed.[20]

In light of these statistics and the continuing failure of law enforcement efforts, as well as emerging evidence linking crack smoking to risk of HIV and HCV infection, there have recently been increasingly loud calls to adopt a harm-reduction approach with respect to crack smoking which would include the creation of supervised smoking facilities.[21] In fact, a supervised crack smoking room was originally planned for Insite.[22] The operators of Insite have previously applied for approval to open a crack smoking room, but have not received a response.[23] Considering the refusal of the federal government to renew the s. 56 exemption with respect to the safe injection facility, it can be assumed that the success of obtaining federal approval at this time is practically nonexistent.

The ruling in *PHS Community Services*, however, raises the possibility that application of s. 4(1) and s. 5(1) to a safe smoking facility would similarly violate s. 7 of the *Charter* and so would be unconstitutional, thus making a legal exemption under s. 56 of the *CDSA* unnecessary for such a facility's operation. This paper aims to address this possibility.

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[19] Drug Situation in Vancouver, *supra* note 17 at 33.

[20] *Ibid.* at 47.

[21] Wendy Stueck, "B.C.'s top medical health officer calls for crack-inhaling rooms" *The Globe and Mail* (20 October 2009), online: <http://www.theglobeandmail.com/news/national/bcs-top-medical-health-officer-calls-for-crack-inhaling-rooms/article1330227/>.

[22] Susan Boyd, Joy L. Johnson & Barbara Moffat, "Opportunities to learn and barriers to change: crack cocaine use in the Downtown Eastside of Vancouver" (2008) 5 Harm Reduction Journal 34 at 37. [Boyd]

[23] Mike Howell, "Insite operators seek crack smoking room" *The Vancouver Courier* (30 October 2009), online: <http://www2.canada.com/vancouvercourier/news/story.html?id=35bb7337-6fd9-4da5-8599-eb38b8780dd7>.

III. Comparison between Injected and Smoked Drugs

At the trial level, Pitfield J found that the evidence adduced by the PHS Community Services Society, the Vancouver Area Network of Drug Users (VANDU) and Canada together supported three 'incontrovertible' conclusions that were not disputed by Canada:

1. Addiction is an illness. One aspect of the illness is the continuing need or craving to consume the substance to which the addiction relates.
2. Controlled substances such as heroin and cocaine that are introduced into the bloodstream by injection do not cause Hepatitis C or HIV/AIDS. Rather, the use of unsanitary equipment, techniques, and procedures for injection permits the transmission of those infections, illnesses or diseases from one individual to another; and
3. The risk of morbidity and mortality associated with addiction and injection is ameliorated by injection in the presence of qualified health professionals.[24]

These conclusions were referred to as 'critical findings of fact' by Rowles J in the British Columbia Court of Appeal.[25] These findings of fact proved essential in Rowles J ruling, with the agreement of Huddart J, that s. 4(1) of the *Controlled Drugs and Substances Act (CDSA)*[26] infringed the *Charter*[27] s. 7 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.

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[24] *PHS Community Services Society* (2008), *supra* note 3 at para. 87.

[25] *PHS Community Services Society* (2010), *supra* note 11 at para. 25.

[26] *Controlled Drugs and Substances Act*, S.C. 1996, c. 19..

[27] *The Constitution Act, 1982*, being Schedule B to the *Canada Act 1982* (U.K.), 1982, c. 11.

These findings of fact were made specifically in relation to the use of injection drugs, including heroin and cocaine. This investigation will therefore begin by determining whether the same or similar facts apply in the context of drugs which are smoked.

1. The Nature of Addiction

The effects of cocaine (including injected cocaine, snorting of its powdered form, and smoking of crack cocaine) differ significantly from those of heroin (including injected heroin, snorting of its powdered form, and 'chasing the dragon', or inhalation of the vapours of heated heroin). The vast majority of Insite users inject either heroin or cocaine, although many other drugs are also injected using the facility.[28] The decision in *PHS Community Services* did not differentiate between different types of injected drugs in finding s. 4(1) of the *CDSA* unconstitutional with respect to Insite. It should be noted that the representative plaintiffs in *PHS Community Services*, Dean Edward Wilson and Shelly Tomic, described themselves as long-time injectors of both heroin and cocaine,[29] and in a different factual situation a distinction might be made between heroin and cocaine users. It is therefore relevant to inquire into whether differences in the effects of cocaine and heroin would justify discriminating between the use of different drugs within a drug consumption facility.

Administration of heroin creates sensations of warmth, contentment, well-being and euphoria in the user.[30] The regular user rapidly develops tolerance, necessitating increasingly

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[28] Mark W. Tyndall et al., "Attendance, drug use patterns, and referrals made from North America's first supervised injection facility" (2006) 83 Drug and Alcohol Dependance 193 at 195.

[29] *PHS Community Services Society* (2008), *supra* note 3 at paras. 61-68.

[30] United Nations Office on Drugs and Crime, *Terminology and Information on Drugs*, 2d ed. (New York: United Nations, 2003) at 27. [Terminology]

larger doses to achieve the same effects.[31] The user also rapidly develops physical and psychological dependence.[32] Once dependence has developed, cessation of heroin use (without using methadone as a substitute) results in severe and debilitating physical withdrawal symptoms which have been compared to a bout of influenza[33] and which can last 7-10 days.[34] Shelly Tomic, one of the representative plaintiffs in *PHS Community Services*, described the symptoms of heroin withdrawal as "like having pneumonia, the flu and food poisoning all at once… sometimes to the point where you throw up and you get fever, chills and severe achiness."[35]

Cocaine also creates feelings of physical and mental well-being, exhilaration and euphoria.[36] As a stimulant, cocaine use also results in increased alertness and energy.[37] Studies suggest that little lasting tolerance develops to the effects of cocaine, although during a single crack binge of repeated use acute tolerance may develop.[38] When the effects of cocaine begin to subside, the user experiences a 'crash' including feelings of dysphoria, fatigue, irritableness and mild depression which may lead to repeated short-term use.[39] In extreme cases, some sources suggest respiratory failure may occur during the crash.[40] Notably, cessation of cocaine use does not result in the severe physical symptoms characteristic of heroin withdrawal.[41]

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[31] World Health Organization, *Neuroscience of psychoactive substance use and dependance* (Geneva: World Health Organization, 2004) at 80. [Neuroscience]

[32] Terminology, *supra* note 30 at 27.

[33] *Ibid.* at 28.

[34] Neuroscience, *supra* note 31 at 80.

[35] *PHS Community Services Society* (2008), *supra* note 3 at para. 68.

[36] Terminology, *supra* note 30 at 17.

[37] *Ibid.*

[38] Neuroscience, *supra* note 31 at 91.

[39] *Ibid.* at 89.

[40] Terminology, *supra* note 30 at 18.

[41] Neuroscience, *supra* note 31 at 91.

Because of the absence of physical withdrawal symptoms associated with cocaine, the question therefore arises as to whether the cocaine user has less of a continuing need or craving to consume cocaine than does the heroin user to consume heroin. Certainly the presence of intense physical withdrawal symptoms plays a role in encouraging repeated heroin use,[42] as confirmed by Ms. Tomic in her testimony that she had used heroin to counter withdrawal symptoms and "to get functional again".[43] However, while early theories of drug dependance stressed the importance of withdrawal symptoms in drug dependance, modern studies have recognized that the existence of withdrawal symptoms is neither a necessary nor a sufficient condition for developing drug dependance[44] and is thus insufficient to explain heroin dependance.[45]

One factor which is necessary for drug dependence to develop is drug reward, or the pleasant experiences felt by the user when using the drug.[46] These pleasant feelings explain why people use drugs in the first place. On its own, however, drug reward is also insufficient to account for drug dependance.[47]

Modern theories of drug dependence point to activation of certain neurotransmitter pathways as the biological mechanism underlying drug dependence. All dependence-producing drugs activate the mesolimbic dopamine pathways in the brain, regardless of the primary pharmacological mechanism of the drug.[48] The usual role of these neural pathways is to

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[42] Neuroscience, *supra* note 31 at 80.

[43] *PHS Community Services Society* (2008), *supra* note 3 at para. 68.

[44] Neuroscience, *supra* note 31 at 50.

[45] *Ibid.* at 80.

[46] *Ibid.* at 49.

[47] *Ibid.*

[48] *Ibid.*

reinforce those behaviours critically important to survival, such as eating and reproducing.[49] Natural stimuli such as food also increase dopamine levels, but drugs such as cocaine have an effect several times as strong.[50] This powerful effect results in the drug user perceiving the drugs also as being critically important to survival. It is this perception which can lead to characteristic behaviours of drug dependance such as the user's singular focus on obtaining more of the drug at the expense of other goals.[51] This intense drug craving has been likened to feelings of hunger, both in its underlying biological causes and in its outward effects.[52]

Because (1) withdrawal symptoms are neither a necessary nor a sufficient condition for drug dependance; (2) all dependance-producing drugs activate the mesolimbic dopamine system; and (3) strong activation of this system leads to the drugs being perceived as critically important for survival, it would appear that the differing effects of the drugs on the users of the drugs, including the presence or absence of physical withdrawal symptoms, would not justify discriminating between different drugs in a drug consumption facility. Furthermore, as this underlying mechanism of addiction is common to all situations of drug dependance, this conclusion applies equally to addicts of the same drugs who use the drugs in different ways. The evidence indicates that addiction is equally an illness regardless of which particular drug the user is addicted to or the manner in which it is administered. Heroin addiction is an illness, and so too is crack addiction.

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[49] Neuroscience, *supra* note 31 at 49.

[50] *Ibid.*

[51] *Ibid.*

[52] Saul Shiffman, "Comments on Craving" (2000) 95 (Supplement 2) Addiction S171 at S171.

2. Disease Transmission and Crack Smoking

It is well-accepted that needle sharing among injection drug users carries a very high risk of direct transmission of blood-borne diseases such as HIV and hepatitis C virus (HCV)[53] and is the most common way blood-borne diseases are transmitted between injection drug users.[54] Two random surveys of Insite users carried out between 2003 and 2004 found that 88% of users were HCV-positive[55] and 17% were HIV-positive.[56] Prior to the opening of Insite, in 2001 it was found that injection drug use was responsible for 50% of new HIV infections and 80% of new HCV infections reported annually in Vancouver.[57]

There is evidence emerging which points towards a possible link between crack smoking and disease transmission. In 2007, an outbreak of pneumococcal pneumonia swept through the DTES, and it was noted that a substantial proportion of cases occurred among regular crack users.[58] In a recent study using data from the Vancouver Injection Drug Users Study, injection drug users reporting daily crack smoking were found to be nearly 3 times as likely to contract HIV over the approximately 9.5 year study period, after adjusting for other known risk factors for HIV transmission.[59] Similarly, a study of non-injecting drug users who attended a drug

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[53] MacPherson, *supra* note 2 at 46.

[54] UHRI Findings, *supra* note 7 at 37.

[55] Evan Wood et al., "Prevalence and correlates of hepatitis C infection among users of North America's first medically supervised safer injection facility" (2005) 119 Public Health 1111.

[56] Mark Tyndall et al., "HIV seroprevalence among participants at a supervised injection facility in Vancouver, Canada: Implications for prevention, care and treatment" (2006) 3 Harm Reduction Journal 36.

[57] MacPherson, *supra* note 2 at 14.

[58] Boyd, *supra* note 22 at 36.

[59] Kora DeBeck et al., "Smoking of crack cocaine as a risk factor for HIV infection among people who use injection drugs" (2009) 181 Canadian Medical Association Journal 585 at 587. [DeBeck]

addiction facility in Spain found a higher prevalence of hepatitis C among non-injecting drug users than in the general population.[60]

One possible cause of this association between crack use and HIV or HCV infection is by disease transmission through open oral sores caused by crack smoking.[61] Frequent crack smokers often have oral lesions caused by burns from hot crack pipes or by cuts from broken glass pipes.[62] It is possible that these oral sores may leave traces of blood on crack pipes, leading to disease transmission to other users with open sores through sharing crack pipes or through oral sex.[63] Supporting this theory, a Spanish study found that HCV infection was more prevalent among those non-injecting drug users who reported sharing crack pipes.[64] Furthermore, another study which aimed to identify the presence of HCV on crack pipes did positively identify the presence of HCV on a crack pipe used by an HCV-positive individual with a large oral sore on the lip, demonstrating the plausibility of disease transmission through sharing crack pipes.[65]

In respect of the Vancouver study on the association of crack use with HIV, the authors were unable to evaluate whether oral sores or crack pipe sharing were risk factors, as the VIDUS study did not collect that data.[66] Other factors may be at play. For instance, crack users may be part of social networks with a higher percentage of HIV-positive individuals, or their crack

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[60] Juan Macías et al., "High prevalence of hepatitis C virus infection among noninjecting drug users: association with sharing the inhalation implements of crack" (2008) 28 Liver International 781 at 781. [Macías]

[61] DeBeck, *supra* note 59 at 588.

[62] Courtney L.C. Collins et al., "Rationale to Evaluate Medically Supervised Safer Smoking Facilities for Non-Injecting Illicit Drug Users" (2005) 96 Canadian Journal of Public Health 344 at 345.

[63] DeBeck, *supra* note 59 at 588.

[64] Macías, *supra* note 60 at 780.

[65] B. Fischer et al.,"Hepatitis C virus transmission among oral crack users: viral detection on crack paraphernalia" (2008) 20 European Journal of Gastroenterology & Hepatology 29 at 31.

[66] DeBeck, *supra* note 59 at 588.

bingeing might have caused them to forget subsequent high-risk behaviour when providing information to VIDUS.[67] There is evidence that crack cocaine smokers are more likely to engage in risky sexual and drug related behaviours that could lead to HIV or HCV infection.[68] It is possible that these factors and others could account for the increased risk of contracting HIV associated with crack usage.

On the other hand, evidence of crack smoking habits among DTES crack smokers indicates that risky crack smoking practices are common. In a 2006 survey, 43.7% of crack smokers reported using broken pipes and 46.8% reported sharing pipes on a daily or weekly basis.[69] Crack smoking practices are also clearly affected by the realities of living in the DTES. A lack of private space and safe housing leads most crack users to smoke outdoors in public spaces. Interviews with crack users revealed that many users were consequently concerned about smoking crack in a hurry to avoid the police, conditions which may result in less concern about maintaining safe smoking practices.[70] All of these factors indicate that the unsafe crack smoking practices necessary for the suspected disease transmission to take place are common occurrences in the DTES.

In conclusion, scientific evidence does indicate an association between smoking crack and infection with HIV and HCV. The evidence also points towards the sharing of crack smoking paraphernalia, a common practice in the DTES, as a possible mechanism of disease transmission among crack smokers with open oral sores from broken or hot crack pipes.

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[67] DeBeck, *supra* note 59 at 588.

[68] Kate Shannon et al., "Potential community and public health impacts of medically supervised safer smoking facilities for crack cocaine users" (2006) 3 Harm Reduction Journal 1 at 2. [Shannon]

[69] Boyd, *supra* note 22 at 37.

[70] *Ibid.* at 39.

However, this possible mechanism of transmission is not as well-established as the clear link between injection drug use and disease transmission, and further study is needed to firmly establish its scientific validity.

3. The Effect of a Safe Smoking Facility on the Risk of Morbidity and Mortality

A. Morbidity – Disease Transmission

By providing clean injection equipment, clean water and alcohol swabs, guidance concerning safe injection practices and medical supervision, safe injection facilities ameliorate the risk of disease transmission associated with injections occurring within the facility. Surveys of Insite users have indicated that more consistent use of Insite correlates with overall positive changes in injection practices.[71] One evaluation of the success of Insite concluded that more objective evidence of ongoing changes in injection practices outside of Insite is needed before it can be concluded that Insite has had an effect on the overall rate of HIV infection.[72] However, it can safely be said that the risk of an individual injection drug user contracting HIV or HVC during a particular injection is practically eliminated when that injection occurs within the Insite facility.

By providing medical supervision and safe smoking equipment, such as clean crack pipes with rubber mouthpieces to prevent burns, and by prohibiting the sharing of crack pipes, a safe smoking facility would facilitate safe smoking practices that could prevent the development of oral lesions and reduce or eliminate the possibility of any transmission of HIV or HCV occurring

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[71] Jo-Anne Stoltz et al., "Changes in injecting practices associated with the use of a medically supervised safer injection facility" (2007) 29 Journal of Public Health 35 at 35.

[72] EAC Report, *supra* note 9.

within the facility. Surveys of DTES indicate a high willingness of crack cocaine smokers to use a safe smoking facility, with 69% of crack smokers indicating affirmatively that they would use such a facility were one made available.[73] Taken together, this indicates that a safe smoking facility would have the potential to reduce the occurrence of risky crack-smoking practices.

However, as mentioned above, although crack smoking is associated with a higher risk of HIV and HCV infection, the mechanism of transmission underlying this correlation has not been confirmed. While it is hypothesized that this transmission may occur through oral lesions and the sharing of crack pipes, without more evidence it cannot be concluded with certainty that disease transmission actually does occur in this manner. Thus while the use of safe injection facilities clearly prevents disease transmission from occurring, it is not certain that safe smoking rooms would do so, although the evidence does point towards safe smoking facilities having that effect.

B. Mortality – Overdose

Overdose is a common cause of death among injection drug users.[74] The symptoms of heroin overdose are well-defined and include reduced level of consciousness, constricted pupils and respiratory depression which can lead to death.[75] The symptoms of cocaine overdose are more varied and can include convulsions, seizures, stroke, cerebral hemorrhage and heart

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[73] Shannon, *supra* note 68 at 5.

[74] Thomas Kerr et al., "Drug-related overdoses within a medically supervised safer injection facility" (2006) 17 International Journal of Drug Policy 436 at 436.

[75] Sharlene Kaye & Shannon Darke, "Non-fatal cocaine overdose among injecting and non-injecting cocaine users in Sydney, Australia" (2004) 99 Addiction 1315 at 1316. [Kaye]

failure.[76] As cocaine is a stimulant, overdose does not inexorably lead to loss of consciousness.[77] Deaths due to cocaine overdose are generally a result of seizures, cardiac arrhythmias or respiratory failure.[78]

A study of overdose incidents occurring at Insite between March 1, 2004 and August 30, 2005 recorded 336 such incidents, with 13 overdoses occurring for every 10,000 injections.[79] Exclusively opioids were involved in 77% of overdoses (244), while exclusively stimulants were involved in 15% (41).[80] None of these overdose episodes, however, resulted in fatalities.[81] Another study estimated that 453 overdose events occurring at Insite over a 52-month period could have resulted in between 8 and 51 deaths had these overdoses occurred outside the facility.[82] To date, no overdose fatalities have occurred at Insite.[83,84]

While studies indicate that the risk of heroin overdose is much lower when heroin is smoked rather than injected, overdose by smoking heroin is possible.[85] One study conducted in London indicated that 31% of heroin injectors had experienced a non-fatal overdose, in comparison to only 2% of heroin smokers.[86] In regards to fatal overdoses, an Australian study of 953 heroin-related fatalities found 4 cases where the heroin had been administered by smoking,

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[76] Terminology, *supra* note 30 at 17.

[77] Kaye, *supra* note 75 at 1316.

[78] *Ibid.* at 1315.

[79] Kerr, *supra* note 74 at 438.

[80] *Ibid.*

[81] *Ibid.*

[82] M-J. S. Milloy et al., "Estimated Drug Overdose Deaths Averted by North America's First Medically-Supervised Safer Injection Facility" (2008) 3:10 PLoS ONE 1 at 1.

[83] EAC Report, *supra* note 9.

[84] Insite website, online: <http://supervisedinjection.vch.ca/research/supporting_research/>.

[85] Shane Darke and Joanne Ross, "Fatal heroin overdoses resulting from non-injecting routes of administration, NSW, Australia, 1992-1996" (2000) 95 Addiction 569 at 569. [Darke]

[86] Darke, *supra* note 85 at 569.

with only a single case where heroin was the only drug used.[87] A similar study in Sweden found a higher rate, with 7 out of 239 fatal heroin-related deaths occurring in connection with heroin smoking.[88]

It is also possible to overdose by smoking cocaine, though the risk of overdose is similarly lower when cocaine is smoked rather than injected.[89] A study of fatal cocaine overdoses in Australia found that out of 146 cocaine-related overdose deaths, in 1% of cases the route of cocaine administration was by smoking, compared to 86% by injection (the particular form of cocaine smoked, crack or otherwise, was unspecified).[90]

As of 2004, drug consumption facilities allowing drug smoking were operating in Switzerland, Germany and the Netherlands, with smoking being the primary method of consumption in the Dutch facility.[91] While detailed statistics on inhalation overdoses at these facilities do not appear to be readily available, one source does indicate a rate of 1 overdose per 8000 inhalations at a Swiss facility.[92] Despite this lack of data, the fact that not a single overdose death had occurred at any of these facilities as of 2004,[93] despite millions of drug consumptions, indicates that any overdoses resulting from drug smoking were successfully treated.

In conclusion, while the risk of overdose is significantly less when heroin and cocaine are smoked as opposed to injected, overdose is still possible and can be fatal. While data on the

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[87] Darke, *supra* note 85 at 572.

[88] I. Thiblin et al., "Fatal intoxication as a consequence of intranasal administration (snorting) or pulmonary inhalation (smoking) of heroin" (2004) 139 Forensic Science International 241 at 242.

[89] Kaye, *supra* note 75 at 1316.

[90] Shane Darke et al., "Cocaine-related fatalities in New South Wales, Australia 1993-2002" (2005) 77 Drug and Alcohol Dependance 107 at 109.

[91] Dagmar Hedrich, European Monitoring Centre for Drugs and Drug Addiction, *European Report on Drug Consumption Rooms* (Luxembourg: Office for Official Publications of the European Communities, 2004) at 20. [Hedrich]

[92] Hedrich, *supra* note 91 at 44.

[93] *Ibid.* at 55.

number of overdoses from drug smoking in European consumption facilities is lacking, the absence of any overdose fatalities in those facilities from all methods of consumption suggests that medical supervision ameliorates the risk of mortality resulting from drug overdose via smoking.

IV. Charter s. 7 Analysis

1. The Right to Life

In *PHS Community Services Society*, the trial judge held that s. 4(1) of the *CDSA* engages the right to life with respect to the activities of injection drug users at Insite.[94] It does so because its application would prevent healthier and safer injection within Insite where the risk of death from overdose can be managed, and would force the user to inject in unsafe environments where there is a significant risk of morbidity or death.[95] Whether death results from overdose or from illness contracted through unsafe injection, the root cause in both cases is the illness of addiction, and a law preventing access to health care services that can prevent death therefore engages the right to life.[96] These findings were upheld on appeal.[97]

As discussed above, while the risks of overdose when smoking cocaine or heroin are much lower than when cocaine or heroin are injected, overdose is still possible and deaths do occur. Although data regarding European safe smoking facilities is sparse, the fact that none of these facilities have suffered an overdose death after millions of drug inhalations suggests that

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[94] *PHS Community Services Society* (2008), *supra* note 3 at para. 140.

[95] *Ibid.*

[96] *PHS Community Services Society* (2008), *supra* note 3 at para. 142.

[97] *PHS Community Services Society* (2010), *supra* note 11 at para. 36.

drug smoking while in the presence of medical supervision can prevent death. Therefore, a case can be made that the application of s. 4(1) of the *CDSA* to users of a safe smoking facility would engage the right to life by forcing crack smokers to smoke crack in locations where the risk of death from overdose could not be managed.

It is debatable whether application of s. 4(1) would engage the right to life in respect of the transmission of HIV and HCV. Although there is evidence that crack smokers have a higher risk of contracting HIV and HCV than non-crack smokers, and evidence of potential transmission through unsafe crack smoking practices, this link is not as well-established as is the link between needle sharing and blood-borne disease transmission. The Supreme Court of Canada has found, in *Chaoulli v. Quebec*,[98] that an increased *risk* of death resulting from excessive surgical waiting times engages the right to life. However, in that case the evidentiary link between waiting times and risk of death was well-established,[99] whereas here the evidence demonstrating a potential link between unsafe crack smoking practices and disease transmission is more circumstantial.

To engage the *Charter* right to life, the threat to life must flow from the actions of the state.[100] It was argued by Canada in *PHS Community Services Society* that the threat to the life of injection drug users resulted from the individual's choice to inject drugs rather than from state action.[101] The trial judge found, however, that the nature of addiction means that injection drug users are not exercising a choice when injecting drugs,[102] a finding confirmed on appeal.[103] As

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[98] *Chaoulli v. Quebec*, [2005] 1 S.C.R. 791. [*Chaoulli*]

[99] *Chaoulli*, *supra* note 98 at para. 40.

[100] *PHS Community Services Society* (2008), *supra* note 3 at para. 141.

[101] *Ibid.*

[102] *Ibid.* at para. 142.

[103] *PHS Community Services Society* (2010), *supra* note 11 at para. 42.

discussed above, smoking of crack by drug addicts is of the same nature and cannot be characterized as a choice once the user has become addicted. Therefore, to the extent that the application of s. 4(1) to a safe smoking facility would infringe the right to life of its users, this infringement would flow from the actions of the state and not from any 'choice' of drug addicts.

2. The Right to Liberty

Any law that comprehends the possibility of imprisonment engages the right to liberty and must therefore conform to the principles of fundamental justice.[104] As the *CDSA* comprehends the possibility of prosecution and incarceration for drug possession, it therefore engages the right to liberty.[105] This applies equally in the context of crack cocaine as in the context of injection drugs.

In *Blencoe v. British Columbia*, a majority of the Supreme Court of Canada opened the possibility that the liberty interest is not restricted to protection of mere physical restraint and could be engaged by a law which prevents a person from making 'fundamental personal choices'.[106] The British Columbia Court of Appeal adopted this reasoning in *PHS Community Services Society* and found that the application of s. 4(1) of the *CDSA* to Insite users would infringe their right to liberty "by foreclosing a choice to minimize the potentially life-threatening hazards of overdose and other serious and life-threatening illnesses through the health services

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[104] Peter W. Hogg, *Constitutional Law of Canada, 2007 student ed.* (Scarborough, Ontario: Thomson Carswell, 2007) at 1033. [Hogg]

[105] *PHS Community Services Society* (2008), *supra* note 3 at 143.

[106] *Blencoe v. British Columbia*, [2000] S.C.R. 307 at para. 54.

offered at Insite."[107] Although the risk of overdosing by smoking crack cocaine is less than overdosing by injecting drugs, and although the risk of contracting HIV or HCV through unsafe crack smoking practices is based on circumstantial evidence, a reasonable argument can nevertheless be made that it is a 'fundamental personal choice' to be able to avoid these potentially life-threatening risks by smoking crack within a supervised smoking facility. Thus application of the *CDSA* to a supervised smoking facility would engage the right to liberty in this second way as well.

3. The Right to Security of the Person

As with the right to life, the trial judge found in *PHS Community Services Society* that application of s. 4(1) of the *CDSA* to Insite users threatens security of the person. It does so by denying drug addicts access to a health care facility which may lead to rehabilitation and where the risk of morbidity associated with infectious disease is reduced or eliminated.[108] This conclusion flowed from the finding that consuming drugs is not a choice for drug addicts; addiction is a disease, one symptom of which is the continuing need to consume illegal drugs which will invariably occur in the short-term, if not the long-term.[109] Again, these findings were upheld on appeal.[110]

Addicts of crack cocaine similarly have a continuing need to consume the drug, a need which precludes choice. As already discussed, the sharing of crack smoking equipment occurs

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[107] *PHS Community Services Society* (2010), *supra* note 11 at para. 42.

[108] *PHS Community Services Society* (2008), *supra* note 3 at para. 144.

[109] *Ibid.* at para. 146.

[110] *PHS Community Services Society* (2010), *supra* note 11 at para. 45.

frequently in the DTES and carries a potential risk of disease transmission, although the evidence supporting this method of transmission is circumstantial rather than direct. However, a safe smoking facility would provide a vital point of contact between health care providers and addicts which may lead to rehabilitation. Thus there is a good argument that application of s. 4(1) of the *CDSA* to a safe smoking facility would infringe the right to security of the person by denying access to a health care facility.

The Supreme Court of Canada has held that the right to security of the person protects not only physical health but also psychological integrity.[111] *R. v. Parker* addressed the issue of whether prohibition of marijuana possession infringed s. 7 rights in respect of the medical use of marijuana to prevent epileptic seizures.[112] The Ontario Court of Appeal found that this prohibition violated the accused's right to security of the person, not only in respect of the accused's physical integrity but also in respect of his psychological integrity through the stress caused by denying the accused access to medication.[113] Therefore, it could reasonably be argued that application of s. 4(1) to a safe smoking facility would infringe a crack smoker's right to security of the person by inflicting psychological stress, as the crack user would be forced to smoke crack in a manner which may potentially lead to illness or death. It would be reasonable for a crack user to want to avoid the risk of transmission of serious diseases through unsafe crack smoking practices, even if such risks are only suspected and are not conclusively proved with direct evidence. Thus this approach might enable a finding of infringement of security of the

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[111] *New Brunswick v. G.(J.)*, [1999] 3 S.C.R. 46 at para. 61.

[112] *R. v. Parker*, [2000] 49 O.R. (3d) 481. [*Parker*]

[113] *Parker*, *supra* note 112 at para. 97.

person despite the potential evidential shortfalls with respect to crack smoking and disease transmission.

Overall, application of s. 4(1) of the *CDSA* could reasonably be argued to infringe the right to life, the right to liberty, and the right to security of the person.

4. Principles of Fundamental Justice

An infringement of the rights to life, liberty or security of the person are only breaches of s. 7 of the *Charter* if the deprivation is not in accordance with the principles of fundamental justice.[114]

In *R. v. Heywood*, the Supreme Court of Canada established the doctrine of 'overbreadth'.[115] Laws which are 'overbroad', or broader than necessary to accomplish their purpose, are contrary to the principles of fundamental justice and therefore unconstitutional if they infringe the right to life, liberty and security of the person.[116]

On appeal, Rowles J, with agreement by Huddart J, found that ss. 4(1) and 5(1) of the *CDSA*, if applied to Insite, are not in accord with the principles of fundamental justice because they are overbroad.[117] Rowles J described the trial judge's findings as follows:

> The import of the judge's analysis is that, by virtue of their long-term addictions to hard drugs combined with their poverty, mental and physical disabilities, histories of

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[114] Hogg, *supra* note 104 at 1045.

[115] *R. v. Heywood*, [1994] 3 S.C.R. 761.

[116] Hogg, *supra* note 104 at 1078.

[117] *PHS Community Services Society* (2010), *supra* note 11 at para. 77.

> sexual and physical abuse, homelessness, genetic, psychological, sociological and familial problems, this very vulnerable population is one where the possession offence provisions of the *CDSA* have no salutary effect and fail to meet the objective of Parliament by its enactment.[118]

Rowles J also agreed with the trial judge that applying s. 4(1) and 5(1) of the *CDSA* to Insite would force addicts to inject in public in squalid conditions, risking their own health and the health of others.[119] In this way, "the blanket prohibition contributes to the very harm it seeks to prevent."[120] All of these factors apply equally to addicted crack smokers in the DTES, many of whom are the same individuals who use the Insite facility to inject drugs.[121]

Rowles J also found that application of ss. 4(1) and 5(1) of the *CDSA* to Insite would not accord with the principles of fundamental justice because of the grossly disproportionate effect they would have on the addicts who use Insite's safe injection site and health care facilities.[122] Application "would deny persons with a very serious and chronic illness access to necessary health care and would come without any ameliorating benefit to those persons or to society at large."[123] Addiction to smoking crack cocaine is equally a chronic and serious, and a supervised smoking facility would provide health care by preventing overdoses, by potentially preventing the spread of disease and by providing a point of contact between crack users and the health care system, giving them access to treatment programs. Therefore the application of ss. 4(1) and 5(1) of the *CDSA* to a supervised smoking facility would similarly have a grossly disproportionate

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[118] *PHS Community Services Society* (2010), *supra* note 11 at para. 70.

[119] *Ibid.* at para. 75.

[120] *PHS Community Services Society* (2008), *supra* note 3 at para. 152.

[121] Drug Situation in Vancouver, *supra* note 17 at 8.

[122] *PHS Community Services Society* (2010), *supra* note 11 at para. 76.

[123] *Ibid.*

effect on the users of a supervised smoking facility and would be contrary to the principles of fundamental justice.

Smith J, in dissent, found that PHS had provided no evidence which would demonstrate that Parliament could achieve its legislative objectives of protecting health and public safety of all Canadians through some alternative or narrower means.[124] Therefore Smith J did not find that the principles of fundamental justice were violated because of overbreadth.[125]

Earlier in her dissent, however, Smith J had cited the comments of McLachlin and Major J in *R. v. Chaoulli* with regards to the infringement of s. 7 interests:[126] "[t]he more serious the impingement on the person's liberty and security, the more clear must be the connection" and "[w]here the 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".[127] Application of ss. 4(1) and 5(1) of the *CDSA* to the Insite facility would risk the lives of the users. Studies of the Insite facility have demonstrated that the operation of Insite has not encouraged former injection drug users to relapse,[128] has not discouraged current users from ceasing injection,[129] and has not promoted new users from commencing injection.[130] In light of these findings, it is respectfully submitted that Rowles J and Huddart J were correct in finding that application of ss. 4(1) and 5(1) to the Insite facility would violate the principles of

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[124] *PHS Community Services Society* (2010), *supra* note 11 at para. 303.

[125] *Ibid.* at para. 304.

[126] *Ibid.* at para. 260.

[127] *Chaoulli*, *supra* note 98 at para. 131.

[128] T. Kerr et al., "Impact of a medically supervised safer injection facility on community drug use patterns: A before and after study" (2006) 332 British Medical Journal 220 at 220.

[129] *Ibid.*

[130] T. Kerr et al., "Circumstances of first injection among illicit drug users accessing a medically supervised safer injection facility" (2007) 97 American Journal of Public Health 1228 at 1228.

fundamental justice because of overbreadth, as Parliament could achieve its objectives with a narrower law that exempted Insite from such application.

5. Section 1 of the Charter

Lamer J of the Supreme Court of Canada has said, in obiter, that a law could be contrary to the principles of fundamental justice yet still be upheld under s. 1 as a reasonable limit prescribed by law that could be demonstrably justified in a free and democratic society.[131] Lamer J limited this statement to exceptional conditions, such as natural disasters and war.[132] Other judges, however, have expressed the opinion that such a law could not be reasonably justified.[133] A majority of the Court has never upheld a law under s. 1 after finding it to be contrary to the principles of fundamental justice.[134] Therefore, it is unlikely that the application of ss. 4(1) and 5(1) of the *CDSA* to a safe smoking facility would be upheld if such application was found to be contrary to s. 7 of the *Charter* according to the analysis above.

CONCLUSION

In consideration of the nature of addiction, crack use in the Downtown Eastside, the risks of morbidity and mortality resulting from crack smoking, and the decision in *PHS Community*

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[131] *Re B.C. Motor Vehicle Act*, [1985] 2 S.C.R. 486.

[132] *Ibid.*, para. 518.

[133] *Ibid.*, para. 523.

[134] Hogg, *supra* note 104 at 832.

Services Society,[135] a strong argument can be made that application of ss. 4(1) and 5(1) of the *CDSA* to a safe smoking facility would violate the s. 7 Charter right to life, liberty and security of the person in a manner not in accordance with the principles of fundamental justice.

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[135] *PHS Community Services Society* (2010), *supra* note 11.