HOW CANADIAN LAWS AND POLICIES ON "ILLEGAL" DRUGS CONTRIBUTE TO THE SPREAD OF HIV INFECTION AND HEPATITIS B AND C

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INTRODUCTION

This paper outlines how current Canadian drug laws and policies foster the spread of HIV infection and other potentially fatal blood-borne diseases, such as Hepatitis B and C[1] among drug users. It discusses how these conditions can then be spread even to those who do not use these drugs or who have no direct contact with drug users. The paper also outlines policies, practices and laws that would help prevent the spread of HIV infection and other blood-borne diseases. Among these is a change in Canada's drug laws from a punitive system of criminal prohibition to regulatory models that seek above all to reduce drug-related harms.

This paper makes one well-founded assumption -- that Canada will never and can never be a "drug-free" society. Our response to drugs must therefore recognize that some people -- no matter what legal strictures are imposed on them -- will continue to use the types of drugs we now call illegal. We must therefore reshape our laws and policies to minimize the harm to drug users and to society at large.

The extent of infection in Canada

Health Canada's July 1995 quarterly surveillance update, *AIDS in Canada*[2], states that 11,644 cases of AIDS have been reported in Canada as of June 30, 1995. Some 15 per cent of female AIDS cases in Canada can be traced directly to injection drug use. Three per cent of adult male AIDS cases can be traced directly to injection drug use, and 4 per cent of adult male cases can be traced to men who inject drugs and who have sex with other men.

In addition, many AIDS cases arise from sexual contact with persons at risk of carrying the HIV infection. Three per cent of adult male AIDS cases and 37 per cent of adult female AIDS cases can be attributed to this. It is impossible to say how many of the "at risk" contacts became at risk because of drug use or behaviours linked to drug use (such as selling sex to pay the black market price of drugs). However, as more and more intravenous drug users are becoming infected with HIV, the risk of them infecting others who have sex with them will grow. So will the risk of female drug users transmitting HIV infection to future offspring.

These statistics reflect known cases of AIDS in Canada. In addition, there may be 30,000 to 50,000 cases of HIV infection -- the precursor to AIDS -- in Canada. Many of these people will have become infected through injection drug use or contact with infected users. Dr. Stanley de Vlaming, a Vancouver physician with a large clientele of drug users, reports as follows:

> There is currently an epidemic of HIV infection sweeping unabated through the IV drug using community in BC. My clinical experience suggests to me that the incidence of infection among injection drug users in the downtown core of Vancouver now rivals the highest seroprevalence rates in all of North America, putting us in the company

of areas like Brooklyn and Harlem, which have seroprevalence rates of 60%.

Thirty eight of the 60 methadone maintenance patients under my care are HIV positive or have AIDS. While this 63% incidence may reflect some selection bias, I don't think it is very far off the mark as a representation of HIV seroprevalence among injection drug users in Downtown Vancouver. Here at St. Pauls hospital I am consultant for an average of eight injection drug using patients per week. These patients are being admitted with serious complications of injection drug use like endocarditis, sepsis, cellulitis, and pneumonia. Over the last few months I would estimate that fully 50% are HIV positive or are diagnosed as such before they leave.

. . .

I have found almost 90 percent of my HIV positive methadone patients are [Hepatitis C] antibody positive.[3]

The situation in Canadian prisons looks equally grim. In 1994, the Expert Committee on AIDS in Prisons (ECAP) issued its report.[4] A later discussion paper on HIV/AIDS in prisons released in November 1995[5] identified the following developments since the release of the ECAP report:

. a 40 percent increase in the number of known cases of HIV/AIDS in federal correctional institutions over 16 months. In August 1995, 152 federal inmates were known to be HIV positive or have AIDS. In April 1994, the number was 109.

. increasing evidence of behaviours in prisons that bring a high risk of transmitting HIV infection and, increasing evidence that, as a result, HIV is being transmitted in prisons

. the rapid spread of hepatitis C in prisons. From January to August 1995, 223 new cases of active hepatitis C and 22 new cases of hepatitis B were reported in federal prisons in Canada. In addition three studies undertaken in Canadian prisons revealed hepatitis C seroprevalence rates of between 28 and 40 per cent.

The first study was undertaken at the Prison for Women in Kingston. Of the 86.9 per cent of the inmates who participated in the study, 39.8 per cent tested positive for hepatitis C.

The second study was done at Joyceville Institution, another federal institution. Of the 69.8 per cent of inmates who participated in the study, 27.9 per cent tested positive.

A third study of male inmates in British Columbia showed a prevalence rate of 28 per cent.[6]

How HIV and other blood-borne viruses are transmitted

The physical means by which HIV infection and other blood-borne viruses, such as hepatitis B and C are transmitted through drug use are well known:

(a) directly to the person injecting with a contaminated syringe (or other instrument used to inject drugs, or a container of contaminated water used to rinse syringes)

(b) indirectly to other people who have intimate contact with a person who has become infected by contaminated equipment: sexual partners who may be spouses, friends, clients (if the user turns to the sex trade) or, if the user goes to sex trade workers, the sex trade workers themselves

(c) indirectly through donations or sales of blood and organs (at least until such products were screened for HIV infection); in the U.S., drug users may try to sell their blood to get money to buy drugs at the inflated black market price

(d) to children born of mothers who became infected directly through injection practices or indirectly through contact with a person who became infected by injecting.

In some cases, more than one drug-related risk factor may be involved. For example, a man or woman who injects drugs may turn to the sex trade to support his or her drug habit.

Beyond the physical factors, legal and social factors can lead to an increased risk of infection:

(a) Our laws prohibiting certain drugs -- heroin and cocaine, for example -- have encouraged people who use drugs to ingest them in more efficient ways, often by injecting. This happens for several reasons. The high price of illegal drugs means that users cannot afford to waste the drug. They may inject, rather than taking the drug by a less efficient (and more expensive) means, such as orally or

by "snorting". And because the drugs are illegal, users will attempt to keep as little of the drug with them as possible, to avoid detection or to attract lesser punishment if they are caught. The need to keep smaller quantities of drugs means that users will compensate by using more efficient means of taking the drugs -- often injecting them. Finally, drug laws often outlaw substitutes that could be taken by means other than injecting.

(b) Our laws prohibiting certain drugs have created a culture of marginalized people by turning them into criminals for possessing drugs and, in some cases, by driving people away from their traditional social support networks -- non-using family members, friends and co-workers. Users may share syringes out of a sense of solidarity or community -- for the community of drug users may have become one of the few that does not reject them. And because of their marginalization and distrust of authority, it is difficult to reach these users with education about safe injection practices or drug treatment.

(c) Our laws prohibiting certain drugs have fostered a reluctance to educate drug users and non-users about safe injection practices for fear of "condoning" an illegal activity. Ill-informed current drug users may continue to share contaminated syringes and other "works". Novice users may not know enough about the dangers of HIV infection through contaminated equipment to protect themselves if they do start injecting drugs.

(d) Our drug laws and the attitudes they have fostered towards drug users have sometimes generated strong opposition to syringe exchange programs. This has occurred even where syringe exchange programs were permitted by law. Some people simply view syringe exchanges as condoning an illegal and immoral act. In at least one city, syringe shortages resulted in the late 1980s from the reluctance of some pharmacies to sell syringes to addicts. As well, police forces

have been known to threaten to charge those who operate syringe exchange programs with possession of drugs because a syringe may contain drug residue.

(e) The high price of illegal drugs has forced women, men and adolescents into the sex trade to pay for their drug habits. The sex trade itself need not increase the risk of HIV infection as long as the participants practice safe sex. However, some clients pay more for unprotected sex. A drug user desperate to buy expensive drugs may take the immediate risk of becoming infected by a client through unprotected sex simply because it pays better. The user who becomes infected this way may then spread HIV infection to other sexual partners, those who share unclean injection equipment, and (for women) children born after the user becomes infected.

If the drug user is already infected with HIV or hepatitis and does not practice safe sex with clients -- again, because it may pay better -- the user also increases the risk of infecting clients and spreading HIV infection into the non-injecting community.

The pressures to ignore safe sex practices clearly come in part from the user's need to pay an inflated price for drugs. That inflated price is the consequence of prohibition.

(f) Drug users who fear being arrested for possession of illegal drugs (and who also fear having their syringes used as evidence against them) may forego using their own drugs and syringes. Instead, they may go to "shooting galleries" (the drug users' rough equivalent of a tavern or bar), where they are supplied with drugs and syringes. Users can thus avoid being caught with either on the street. However, gallery operators may knowingly or carelessly supply syringes or other injection equipment contaminated with the HIV or hepatitis.

(g) For several reasons, laws prohibiting certain drugs increase the risk of spreading HIV and hepatitis in prisons:

(i) drug laws result in drug users being sent to high-risk prison environments. There, users will continue to want to use drugs, but will have little if any means to protect themselves from HIV infection.[7] Even if users did not inject drugs before going to prison, they may start to do so in prison -- without ready access to clean syringes.

(ii) dependent users desperate to pay the exorbitant black market price of drugs may commit "acquisitive" crimes -- thefts, burglaries and robberies among them. Thus, drug laws are indirectly responsible for other crimes which result in heavily dependent drug users going to prison. In prison, these heavy users will continue to use drugs but will have little if any means to protect themselves -- or others with whom they share injection equipment -- from infection when they do.

(iii) condoms have not been available until recently in Canadian institutions, and are still not available in all of them. In the past, condoms were not made available in part because they could be used to hide illegal drugs. Yet sexual activity continued to occur in prisons. Thus, in part because of current prohibitionist drug laws, no protection from HIV infection or hepatitis was available when inmates were sexually active.

(iv) bleach kits are frequently not available to clean syringes as such kits might be seen as condoning an illegal activity.

(v) there is no legitimate source of access to clean syringes in prisons, in part because this might be seen as condoning an illegal activity. As a result, the considerable injecting that occurs in prisons may be done by the sharing of just a few needles among dozens of users.[8]

(vi) prison authorities have restricted attempts to educate prisoners about safe drug use for fear of being seen as condoning an illegal activity.

(vii) drug testing programs instituted in Canadian prisons may persuade prisoners to switch from drugs that can be detected long after use (like marijuana) to drugs that can be detected only up to a few days after use (like heroin and cocaine). This likely means that drug users will shift from smoking to injecting. With little or no access to clean syringes, this greatly increases the risk of HIV infection.

It is strongly arguable that prison drug testing programs flow in part from the mentality brought about by criminalizing certain drugs. Had these drugs not been outlawed, drug testing might never have been implemented in prisons, or at least testing programs might not be as extensive and punitive -- or as likely to lead inmates to switch to injectable drugs.

(h) Our laws have fostered public attitudes that are vehemently anti-drug and anti-drug user. In this climate, it is difficult to persuade Canadians to care about what happens to people who use drugs. These public attitudes are driven, not by one's inner senses,

but largely by the simple existence of a law saying that some activities are bad.

(i) Our drug laws have fostered the belief among some that drug users don't care about their own lives or health. It is therefore difficult to persuade non-users to care about what happens to users.

(j) Society's condemnation of drugs through the law may lead some drug users themselves to believe that they are less than worthy as human beings because they use drugs. This may compound other problems that lead to low self-esteem and, in turn, more drug use. In turn, drug users may become less concerned about their fate or the fate of those around them -- and therefore be careless about becoming infected with HIV or hepatitis through drug use.

(k) In some countries where people are paid for blood donations, drug users may sell their blood to get enough money for drugs. Blood and other tissue donations are now screened for HIV and hepatitis. However, there remains a very small risk that contaminated blood will enter the blood supply; the more drug users who sell their blood, the greater the likelihood that some contaminated blood will enter the blood supply.

Changing our approach to drugs to reduce the risks of infection

(a) Reducing the physical risks

Education: Education about drugs should discourage harmful drug use of any sort, but the message cannot end there. Some people will continue to

use drugs, or will start using drugs despite knowledge of the possible dangers. The key to reducing the risk of HIV and hepatitis transmission is education about safe injection practices and alternatives to injection.

Research: An important precursor to education is research. Research involves learning more about several aspects of injection drug use, including:

. the modes of transmission (in the context of drugs, this has been fairly well documented, but there are occasional surprises[1])

. the cultural[9] and legal impediments to adopting safer drug-using practices

. why people use drugs

. why they inject instead of ingesting drugs in other ways that carry less risk of infection, and

. the impact of drug- and alcohol-related impairment on risk-taking practices, including unprotected sex and injecting with contaminated equipment.

Research can lead to a better understanding of the mechanisms of HIV transmission and the culture and laws surrounding injection drug use. This should lead to a change in high-risk drug use practices through changes in

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[1] Such as the discoveries that even users who did not share needles might become infected by sharing water to rinse syringes, or that bleach is not as rapidly lethal to the HIV in syringes as previously thought.

culture and laws. It should also lead to the provision of equipment needed to prevent the spread of infection among those who continue to inject, the development of alternatives to injecting, and improved treatment programs for those trying to stop using injectable drugs.

However, legal and social barriers often stand in the way of implementing these risk-reducing measures.

(b) Reducing the risks fostered by the law -- Removing the legal barriers to health promotion

As explained above, current laws favour the spread of HIV and hepatitis infection among drug users, their sexual contacts and their offspring. This section discusses several ways to reverse this damage.

(i) Removing perceived or actual legal impediments to access to clean injection equipment

In some jurisdictions -- many of them American[10] -- syringes are outlawed as "drug paraphernalia". In Canada, the position appears to be that the possession and distribution of syringes is not prohibited. Still, the law needs to be clarified.

Section 462.2 of the *Criminal Code* makes it a criminal offence to sell an "instrument for illicit drug use". The Code defines "selling" to include distributing, whether or not the distribution is made for money[11]. The penalty for a first offence is a fine of up to $100,000, imprisonment for up

to six months, or both. For a second offence, the maximum fine is $300,000 and the maximum imprisonment is one year, or both.

Section 462.1 defines "instrument for illicit drug use" as follows:

> anything designed primarily or intended under the circumstances for consuming or to facilitate the consumption of an illicit drug, but does not include a "device" as that term is defined in section 2 of the *Food and Drugs Act*.

Thus, the *Criminal Code* does not prohibit distributing anything that is considered a "device". The *Food and Drugs Act*[12] defines "device" as follows:

> any article, instrument, apparatus or contrivance, including any component, part or accessory thereof, manufactured, sold or represented for use in
>
> (a) . . . the prevention of a disease . . . in man . . ..

This combination of definitions from the *Criminal Code* and the *Food and Drugs Act* seems to exempt syringes from the drug paraphernalia laws -- at least if the syringe is "represented for use in preventing" HIV infection, and if HIV infection is considered a "disease". In short, it would not be an offence under s. 462.2 of the *Criminal Code* to distribute syringes to prevent the spread of HIV infection.

However, the *Narcotic Control Act* complicates the law. The Act bans the possession, sale, distribution etc. of certain drugs that the Act calls narcotics. It defines "narcotic" to mean the actual drug or "anything that contains" the

drug.[13] Furthermore, Bill C-7, the *Controlled Drugs and Substances Act* passed by the House of Commons on October 30, 1995, contains a similar provision. Bill C-7, if enacted, will replace the *Narcotic Control Act.*

Bill C-7 prohibits the possession, sale and various other activities relating to "controlled substances". Controlled substances are defined as those drugs listed in schedules to Bill C-7[14]; as well, a controlled substance means "any thing that contains or has on it a controlled substance and that is used or intended or designed for use . . . in introducing the substance into a human body".[15]

These somewhat distorted concepts of "narcotics" and "controlled substances", when coupled with the *Criminal Code* and *Food and Drugs Act* provisions mentioned above, appear to produce the following state of the law:

> (1) the legal provisions prevent the prosecution of persons who are giving away (or even selling) clean syringes or who simply possess clean syringes. Under both the *Narcotic Control Act* and Bill C-7, syringes are not illegal unless they actually contain an illegal drug.
>
> (2) they likely prevent the conviction of a person -- for example, a syringe exchange program worker -- who receives a dirty syringe containing drug residue. The law probably protects the person from conviction because the prosecutor would have great difficulty that the person **knew** that the syringe contained residue from a particular drug.

However, it is conceivable that a worker would know what drug the used syringe contains if the worker can see something in the syringe and is told by the user what the substance is. This could mean that the worker is guilty of possession of a narcotic under the *Narcotic Control Act.* Under Bill C-7, the worker might have sufficient knowledge to be convicted of possession of a controlled substance in the form of a syringe that contains a controlled substance and is designed for use in introducing the substance into the human body. Thus, syringe exchange program workers could be at risk of being convicted. At the very least, the workers could face harassment by uncooperative police officers or civic authorities.

(3) they put drug users who carry their own used syringes at risk of being charged with possession on the basis of the residue found in the syringe. This would discourage users from carrying their own used, but otherwise safe, syringes. This in turn could increase the chances that the user would share someone else's syringe or use a possibly infected syringe from a shooting gallery. It might also increase the chances that a user would simply discard a syringe after using it, creating a risk of infection for anyone who comes into contact with the syringe.

It seems clear that present paraphernalia and drug laws try to protect syringe exchange programs. However, these laws still leave some uncertainty about the legality of possession of used syringes that contain drug residue. They may also encourage the spread of HIV and other infections by discouraging users from having their own used syringes with them at times when they may not have access to clean syringes.

If the laws prohibiting possession of drugs are not repealed, they should at least be amended to remove any doubt about the legality of all aspects of syringe exchange programs. Otherwise, only by undergoing this tortuous analysis of the law can one conclude that syringe exchange programs are generally legal in Canada. The amendments should state clearly that possession of a syringe containing drug residue would not be an offence.

A clear statement in the law explicitly permitting syringe exchange programs would make those who operate or who contemplate running syringe exchange programs less vulnerable to harassment through threat of prosecution. It would also reduce the incentive for users to forego carrying their own syringes and get possibly contaminated syringes at shooting galleries.

(ii) Changing the law to reduce the number of users placed in high-risk prison environments

Drug users may end up in prison because they possess, import, export, cultivate or traffic drugs or because they commit crimes to feed their expensive drug habits.[16] Criminalizing drugs is therefore directly or indirectly responsible for many people being jailed. Between 1985 and 1990, there were over 16,000 sentenced admissions to provincial jails in Canada for drug-related offences.[17] In addition, in 1992 there were about 1,200 inmates serving time for drug-related offences in federal institutions.[18]

As explained earlier, prisons are extremely high-risk environments for the transmission of HIV, both because of the sharing of scarce injection equipment and unprotected sexual contact. Heavily dependent drug users

will continue to use drugs despite the increased risk of HIV infection through drug use in prisons. One crucial goal must therefore be to reduce the number of drug users being sent to prison.[19]

There are several ways to do this. Many require changing the direction of Canada's drug laws:

. change drug laws so that various activities relating to drugs would no longer be considered a criminal offence that might result in imprisonment. These changes could take any of several forms:

. allowing possession of small quantities for personal use (the Dutch model), but retaining penalties for possession for the purpose of trafficking and trafficking (using this model, some drug users who traffic to support their habit would still end up in prison). A variation would be to move to a "ticketing" system, where persons found in possession of small amounts of a drug would receive a ticket much like a parking ticket. There would be no possibility of imprisonment under the ticketing scheme.

. allowing possession of small quantities for personal use **and** providing the drug to those who register for it as a "dependent" person."[20] Under this scheme, the user would have less incentive to traffic in drugs to support his or her habit and would be less likely to end up in prison for trafficking or related offences. This scheme would also reduce the need for acquisitive crimes and the sex trade to get money to pay the highly-inflated street price of the drugs. In turn, this would

result in fewer drug users going to prison. This scheme would permit maintaining criminal penalties for trafficking, importing, exporting and cultivating.

. regulating drugs in a manner similar to alcohol and tobacco. Possession of any quantity by adults would not be prohibited. Distribution of the drug could be regulated -- perhaps through an agency like a provincial liquor control board or, for some drugs, through other outlets that normally sell tobacco products. Users would not risk imprisonment unless they committed a crime while under the influence, as is the case with alcohol. The price of these drugs would fall -- dramatically in some cases, due to the absence of a black market premium -- and users would therefore be less likely to need to commit other crimes to get the money to buy drugs.

. decriminalizing sex trade-related offences so that drug users who turn to the sex trade to support their habits are not imprisoned in high-risk environments (if their drugs were more readily available through clinics or if the street price were lowered, there would be less need to turn to the sex trade in the first place).

. maintaining current drug laws, but using police and prosecutorial discretion to divert drug users to treatment instead of incarcerating them.

The 8th Annual British Columbia HIV/AIDS Conference issued a strong call for changes to Canada's drug laws at its November 1994

meeting. The following resolution, passed by the overwhelming majority of the delegates attending the final day's plenary session, states:

Statement on drug policy and HIV infection
Passed at the plenary meeting of the 8th Annual B.C. AIDS Conference
Vancouver, B.C., November 8, 1994

Reducing the risk of HIV infection among drug users, and among other Canadians with whom they come into contact, will require many changes to current drug laws and policies. Among the most important are changes to laws that treat drug users as criminals, foster unsafe drug use practices, marginalize users from mainstream Canadian society, drive them to commit crimes or high-risk unprotected sex to maintain their habits, and increasingly place them in prisons where there is an extremely high risk of acquiring HIV infection. Failing to take measures to prevent drug-related HIV infections will cause unnecessary death and impose an enormous economic burden on Canada's health care and social security system.

Our current drug laws do not help drug users, nor do they serve Canadian society. We call for the withdrawal of Bill C-7, the Controlled Drugs and Substances Act now being considered by Parliament. We also strongly urge governments across Canada to promote the following changes:

(a) removing possible legal impediments to access to clean injection equipment, including in institutional settings such as prisons and hospitals

(b) amending drug laws to reduce the number of non-violent drug users placed in high risk prison environments

(c) amending policies to allow for the introduction of measures that will prevent the spread of HIV among prison inmates and, ultimately, among Canadians in open society

(d) amending the law to reduce the ramifications of carrying syringes

(e) helping, through honest public education about the causes and nature of drug use, to reshape public attitudes about drug users

(f) in general, adopting laws and policies that seek to reduce the global harms associated with drug use, rather than focussing solely on interdiction and punishment

(g) complying with constitutional and international human rights obligations that apply to drug users and non-users alike.

(iii) Changing the law to reduce resistance in prisons to syringe exchange programs and other measures aimed at preventing the spread of HIV

Some prisons have refused to make condoms available to inmates at least in part because condoms can be used to hide illegal drugs.[21] Removing the legal prohibition against drugs might reduce pressures to withhold condoms from prisoners, although other pressures remain. (In fact, federal prison authorities now make condoms available to prisoners. However, they might have done so earlier -- thus preventing even more HIV infections in prisons -- if condoms were not so strongly associated with hiding illegal drugs.)

Similarly, removing the legal stigma from drug use might result in less resistance to the distribution of bleach kits in prisons. Prison authorities might even become more open to making injection equipment available to prisoners, although the possible use of syringes as weapons in the violent prison atmosphere must be considered.

A change in drug laws might also relax pressures to do drug testing in prisons -- drug testing that may lead inmates to switch from drugs that are not injected to those that are.[22]

(iv) Changing the law to reduce the fear of carrying syringes

If possession of a drug were no longer illegal, possession of injection equipment would not need to be illegal. Drug paraphernalia laws would largely be unnecessary. This would resolve the possibility of prosecuting those who receive used syringes containing drug residue. As well, users would not fear that the possession of a syringe would be used as evidence in a criminal prosecution for possession of a drug; there would be less incentive to rely on shooting galleries to provide (possibly contaminated) syringes.

(v) Changing the law to help reshape social attitudes

There is little doubt that the law shapes our attitudes towards certain activities that might not otherwise offend us. This may well be the case with at least some of Canada's drug laws. The law has shaped public opinion rather than being shaped, as it should, by public opinion.

How many individuals reject drug users, not because they use drugs, but simply because users are breaking the law? One can easily detect this attitude among government officials and members of the public who balk at measures to control the spread of HIV infection among drug users because these measures may be seen as "condoning" an illegal activity -- drug use (or more accurately, the possession of drugs). Over 20 years ago, the Le Dain Commission noted that many people obey the law simply because it is the law.[23] Presumably, those same people would expect others to obey the law

in the same unquestioning manner. Those who do not obey the law attract social hostility.

Thus, the law may make the public reluctant to help drug users: "What they're doing is illegal and wrong. Let them die." In practical terms, this results in public opposition to syringe exchange programs and education about safe injection practices. It maintains drug users on the margins of society, where they are difficult to reach and help. It may foster an attitude of self-loathing among drug users themselves, making them less concerned about preventing HIV infection.

Of two problems facing society -- drug use and AIDS and other blood-borne diseases -- the greater evil are these diseases, simply because they are invariably (with AIDS) or potentially (with hepatitis) fatal. To the extent that our drug laws foster antipathy or open hostility towards drug users, changes to these laws are necessary unless their supporters can show a valid public interest that outweighs the dangers posed by AIDS and hepatitis. It is hard to conceive of how an objective debate about drug policy and disease could lead to such a conclusion.

The mechanisms for changing the law

At present, the *Narcotic Control Act* makes it a crime to possess or traffic in a drug covered by the Act. This includes heroin, cocaine and marijuana. The *Food and Drugs Act* imposes similar controls, although it is not necessarily an offence to possess a drug if it is a "controlled" drug under the Act. The drug paraphernalia laws are contained mainly in the *Criminal Code*, but the *Food and Drugs Act* is also relevant. Other federal laws are

also implicated in our treatment of drug users. For example, the *Corrections and Conditional Release Act* allows prisoners to be drug tested. As explained above, drug testing may greatly increase the risk of HIV and other blood-borne infections in prisons.

Removing the legal obstacles to the prevention of HIV infection among drug users will therefore require changing these laws and, if it becomes law, the *Controlled Drugs and Substances Act*. Even if Parliament does not change these laws, it should at least reform that laws of evidence so that the possession of a syringe -- clean or containing drug residue -- could not be used in evidence for any criminal charge involving drugs. This would reduce the reluctance of drug users to carry their own syringes.

Removing legal obstacles may also involve Canada pressing for changes to international conventions concerning drugs or renouncing these conventions. These are the *Single Convention on Narcotic Drugs, 1961*, the *Convention on Psychotropic Substances 1971* and the *United Nations Convention against Illicit Traffic in Narcotic Drugs and Substances, 1988*. There is disagreement about the extent to which these conventions in fact prevent Canada from moving to a more health-based and less punitive approach to drugs. To remove all doubt, Canada could either renounce the treaties or press for amendments that would give Canada sufficient flexibility to address drug concerns in the most helpful way possible.

The *Canadian Charter of Rights and Freedoms* may also have a role to play. The issue is not one of amending the *Charter*. Rather it is the interpretation of the *Charter* on drug issues. Even if Canada does not change its federal drug laws, and even if it does not seek to amend or renounce its purported international obligations, courts may interpret some laws about drugs as

violating the *Charter*.[24] Several sections of the *Charter* might be relevant, including the following[25]:

> Section 7: "Everyone has the right to life, liberty and security of the person and the right not to be deprived thereof except in accordance with the principles of fundamental justice."[26]
>
> Section 8: "Everyone has the right to be secure against unreasonable search or seizure."
>
> Section 9: "Everyone has the right not to be arbitrarily detained or imprisoned."
>
> Section 12: "Everyone has the right not to be subjected to any cruel and unusual treatment or punishment."
>
> Section 15(1): "Every individual is equal before and under the law and has the right to the equal protection and equal benefit of the law without discrimination . . ." .

Section 24(1) of the *Charter* permits anyone whose rights and freedoms under the *Charter* have been infringed or denied to apply to a court to get a remedy that the court considers "appropriate and just in the circumstances". Furthermore, section 52(1) states that any law that is inconsistent with the Constitution (which includes the *Charter*) is, to the extent of the inconsistency, of no force or effect.

Another means to change the law as it applies to prisoners, and one certain to be controversial, lies in private criminal prosecutions.[27] These are

prosecutions launched by private individuals rather than by Crown prosecutors. One could argue that prison authorities and government officials who know the extreme risks of HIV infection in prisons and yet who do little or nothing to reduce the risks are criminally negligent. The *Criminal Code* defines criminal negligence. It states:

> 219. (1) Everyone is criminally negligent who
>
> (a) in doing anything, or
> (b) in omitting to do anything that it is his duty to do,
>
> shows wanton or reckless disregard for the lives or safety of other persons.
>
> (2) For the purposes of this section, "duty" means a duty imposed by law.

Section 220 of the Code makes it an indictable offence, punishable by up to life imprisonment, to cause death by criminal negligence. Section 221 makes it an indictable offence, punishable by up to ten years imprisonment, for criminal negligence causing bodily harm.

The argument in support of a private prosecution for criminal negligence might be as follows:[28]

(i) prison authorities and government officials have a legal duty to safeguard those under their control.

(ii) they know that drug use, including injection drug use, is widespread in prisons, putting inmates at risk of HIV infection from injecting drugs or from having sex with persons who have become infected by injecting drugs.

(iii) Even though inmates may be committing institutional offences by injecting drugs or by having intercourse, prison officials and politicians know that this activity cannot be stopped. The legal duty on prison authorities and politicians to safeguard prisoners should therefore extend to finding other means to prevent the spread of HIV infection. This could include any or all of the following:

. education about safe injection practices
. enhanced treatment facilities to help users stop using
. the provision of condoms
. the provision of bleach kits
. the provision of injection equipment
. the provision of substitutes that can be taken orally or smoked.

If prison officials and politicians fail to take some or all of these measures, it might be argued that they are criminally negligent for any injury (for example, HIV or hepatitis infection) or death that results.

Once an individual launches a private prosecution, the Attorney General of the province may decide to take over conduct of the case. Sometimes the Attorney General will continue with the prosecution. However, the Attorney General may equally decide to "stay" the charges or withdraw them.

If a prosecution for criminal negligence were successful, Parliament and prison authorities would clearly have to reconsider the laws and policies that increased the risk of HIV infection in prisons. This might even include a reconsideration of drug laws that are directly or indirectly (through compelling users to commit crimes to get money for high-priced black market drugs) responsible for drug users going to prison.

Finally, lawsuits against prison officials and politicians for *civil* negligence might also be effective in securing changes to policies and laws.

(c) Reducing the risks caused by social factors: Other policies and practices that would help prevent the spread of HIV infection among drug users

Securing changes to the law is only one means to reduce the risk of HIV infection among drug users. Many measures independent of the law -- or at least partly independent -- can also reduce the risks.

> **Helping injectors to stop using drugs**: If a person is injecting drugs in a way that may be causing personal harm or harm to others, every effort should be made to help the person to stop using drugs. This means readier access to treatment and counselling.

Helping those who continue to use drugs to use them safely: Abstinence is simply not a practical goal in every case. Those who continue to use drugs should be encouraged to do any or all of the following:

. take the drug by some means (orally or by "snorting", for example) that does not involve the use of possibly contaminated syringes. In the United Kingdom, for example, non-injectable drugs in the form of "reefers" -- herbal or tobacco cigarettes injected with heroin, methadone, cocaine or amphetamine -- are prescribed to drugs users who might otherwise risk infection from a shared syringe.[29]

. switch to another drug that is not usually injected

. inject with uncontaminated syringes and avoid other dangerous practices related to injecting (such as sharing a container of contaminated water to rinse syringes). This may require helping users to change the social "etiquette" of drug taking.

. use drugs in a way that does not impair their judgment to the extent that they might engage in other high-risk practices, such as unprotected sex, while under the influence.

. use condoms to reduce the risk of transmission to sexual partners and offspring.

Trying to bring drug users back from the margins of society: Drug users who do not feel driven to the margins of society may be more highly motivated to protect their health by using drugs more safely. Says one group of Dutch researchers:

> The more society marginalizes drug users, the less can the drug user be expected to behave in a responsible way, i.e. not lending his or her needles to others, not throwing used needles in parks and gutters, always using condoms and refraining from becoming pregnant when seropositive.[30]

Measures that aim to help users see themselves as part of society, rather than as outcasts, are vital. If it is not possible to bring drug users into the mainstream, the focus should turn to helping the peer groups of users to assume the same role -- encouraging safer drug use and other behaviours.

One Australian authority, Dr. Alex Wodak, notes that some groups of injection drug users seem more vulnerable to high risk behaviour than others. These include people with no history of drug treatment, youth and the homeless.[31] Measures to improve the economic lot of the young and the dispossessed are therefore part of the preventive equation as well.

Careful structuring of syringe exchange programs: Syringe exchange programs must be effectively designed. Programs must be non-judgmental. Moralizing simply risks driving users underground or further underground. Programs must ensure respect for the user's confidentiality. They should be linked to education and treatment

programs and they should have the cooperation of the police, if possible. Programs must also be accessible; this may mean locating in areas frequented by those who inject drugs or possibly even using mobile distribution vans.

Honest public education about AIDS, hepatitis and drug use: Much resistance to syringe exchange programs seems to stem from public misunderstandings about the benefits of syringe exchange programs. This requires explaining that protecting injection drug users from HIV infection will ultimately protect the non-using community -- the so-called "general population". It will also require explaining the human and financial savings that flow from preventing HIV and hepatitis infections. It will involve explaining that syringe exchange programs are not intended to and do not appear to increase the number of drug users. On a more global scale, it will require helping the general public to understand drug users as members of society, not as outcasts. In short, the public education message must reflect a balance between the altruism of the general community of non-users and their self-interest in preventing the spread of HIV infection to their community.

Because so many factors that increase the risk of HIV and hepatitis infection are related to the law, public education must also honestly assess the possible benefits of changing our drug laws from punitive criminal laws to health-based alternatives. It is essential that members of the public understand the link between the present law and high-risk behaviours -- including injection drug use, reluctance to carry syringes, the use of shooting galleries as an alternative,

marginalization, the sex trade and placement of drug "offenders" in high-risk prisons.

Obtaining police support: Even if syringe exchanges are legal in Canada, police attitudes can have a major impact on the effectiveness of such programs. Police who "stake out" syringe exchange clinics to see who is using drugs will only drive users away. Police harassment of users and program workers with threats of prosecution under Canada's somewhat unclear laws can also diminish the effectiveness of the programs. Educating the police about the value of syringe exchange programs is therefore essential.

Making appropriate forms of HIV and hepatitis testing available: Drug users who have engaged in high risk behaviours should be encouraged (with appropriate pre- and post-test counselling) to be tested. To reduce their reluctance to be tested, they should be offered anonymous testing if they wish. In some jurisdictions, changes to the law may be necessary to permit establishing anonymous testing centres, although such centres have been set up even where they are not technically allowed.

Prison programs: The Expert Committee on AIDS in Prisons[32] identified several programs to reduce the risks of HIV infection associated with drug use in prisons. They included:

. access to anonymous HIV testing, and testing by personnel independent of Correctional Service Canada

. the availability to all prisoners of education about HIV infection and AIDS

. education about safe drug use practices and treatment options

. the availability of condoms, dental dams and water-based lubricant (to prevent the spread of HIV from infected persons during sexual activity)

. availability of bleach

. research to identify ways and develop measures, including access to sterile injection equipment, that will further reduce the risk of HIV transmission

. access to methadone to reduce the risk of infection from injecting

. consideration of the concern that drug testing programs in prisons may encourage inmates to switch from non-injected drugs to drugs that are more likely to be consumed by injecting.[33]

Conclusion

Some important strategies, such as syringe exchange programs, have already been adopted in this country. Opposition to syringe exchange programs and education programs has generally been less fierce than in the United States, for example. Still, many crucial preventive strategies, such as the reform of drug laws, remain a distant hope. Until very recently, Canada had not experienced the catastrophic rates of HIV infection among drug users typical of many American and European cities. This has now changed, with rapidly rising rates of infection in Vancouver, and almost certainly in other Canadian cities, among those who inject drugs. The experience of other countries shows that the rate of HIV and hepatitis infection can explode within a very brief period. Canada is now witnessing that explosion.

Endnotes

1 The hepatitis B virus infects people of all ages. It is one of the fastest-spreading sexually transmitted diseases, and also can be transmitted by sharing unclean needles or by any behaviour in which a person's mucous membranes are exposed to an infected person's blood, semen, vaginal secretions, or saliva. While the initial sickness is rarely fatal, ten percent of people who get hepatitis B are infected for life and run a high risk of developing serious, long-term liver diseases -- such as cirrhosis of the liver or liver cancer -- which can cause serious complications or death. A safe, effective vaccine that prevents hepatitis B is available.

Hepatitis C is less likely than the other hepatitis viruses to cause serious illness at first (only one-quarter of the people infected actually develop symptoms). About half of those infected develop chronic liver disease. Like hepatitis B, hepatitis C can be spread by contact with infected blood, such as through sharing unclean needles, and possibly semen, vaginal secretions, and saliva.

2 Division of HIV/AIDS Epidemiology, Laboratory Centre for Disease Control, July 1995.

3 S. de Vlaming, "HIV and the Injection Drug User", paper presented to the 9th Annual B.C. HIV/AIDS Conference, Vancouver, B.C., November 5 - 7, 1995 [footnote omitted].

4 Correctional Service Canada, *HIV/AIDS in Prisons: Final Report of the Expert Committee on AIDS and Prisons* (Ottawa: Minister of Supply and Services Canada 1994).

5 Ralf Jürgens, *HIV/AIDS in Prisons: A Discussion Paper prepared for the Canadian AIDS Society and the Canadian HIV/AIDS Legal Network* (15 November 1995) at 21.

6 Note 5 above, at pages 28-29. The Jürgens report notes at page 29 that similar figures for hepatitis C infection are reported by other prison systems.

7 One study reviewed by the Expert Committee on AIDS in prisons concluded that "HIV infection in prisons will increase if there is an increase in the proportion of IV drug users imprisoned and if there is an increase in HIV infection amongst IV drug users in the general community": Correctional Service Canada, *HIV/AIDS in Prisons: Final Report of the Expert Committee on AIDS and Prisons* (Ottawa: Minister of Supply and Services Canada 1994) at 65.

8 The Expert Committee on AIDS in Prisons acknowledged that it is difficult to determine exactly how much injection drug use occurs in prisons. However, the Committee stated, "it is also agreed that, in Canada and elsewhere, injection drug use is prevalent in prisons and that the scarcity of needles often leads to needle sharing." *Ibid.* at 64.

9 Such as why some users continue to share syringes, even when they know the risk of HIV and other infections.

10 An October 1993 American study found that about half the needle exchange programs in the United States were legal: School of Public Health, University of California, Berkeley, Institute for Health Policy Studies, University of California, San Francisco, *The Public Health Impact of Needle Exchange Programs in the United States and Abroad* (The Regents of the University of California, 1993) at iii.

11 Section 462.1.

12 Section 2.

13 Section 2.

14 Section 2(1).

15 Section 2(2)(b)(ii).

16 A recent (September 28, 1995) *Globe and Mail* article cited a confidential report by the European Banking Federation claiming that Canadian banks have the dubious distinction of being the most robbed in the industrialized world. Thieves "have to come back more often in Canada," said Pascal Kerneis, who compiled the study at the federation's headquarters in Brussels. "Most of the robberies in Canada are hit-and-run for drug money" (The Globe article did not explain how the Federation reached this conclusion; however, the pressures on addicts to pay the exorbitant black market price of drugs is clearly an incentive to commit acquisitive crimes of one form or another, bank robberies or not.)

Of course, drug users may also end up in prison by committing crimes of violence when under the influence, or they may commit crimes that have nothing to do with their drug use.

17 D. Riley, "Drug Use in Prisons: A Harm Reduction Approach", paper presented to the B.C. AIDS Conference, November 1992. Dr. Riley's source for this information was Correctional Service Canada, Research and Statistics Branch, *Forum on Corrections Research, 2* (4), (Ottawa, Correctional Service Canada, 1990).

18 Riley, *ibid.*

19 In its Final Report, the Expert Committee on AIDS in Prisons said:

> Reducing the number of drug users who are incarcerated in federal penitentiaries is one possible way that HIV transmission in prisons may be lessened. Many of the problems created by HIV infection and by drug use in prisons could be reduced if alternatives to imprisonment, particularly in the context of drug-related crimes, were developed and made available: *Supra* note 7 at 6.

20 Some cities in Britain and Switzerland register those dependent on drugs and supply them with small quantities so that they will not resort to crime to pay high street prices for drugs: *New York Times*, July 10, 1994.

21 Some authorities would also argue that condoms can be used as weapons. Furthermore, sexual intercourse among prisoners is prohibited; dispensing condoms could be seen as condoning behaviour that violates prison regulations.

22 Prison officials may claim, however, that drug testing is done to reduce the demand for drugs. Decreased demand will reduce the violence associated with the illegal drug trade in prisons. Of course, the drug trade in prisons is generated in part by imprisoned drug users who continue to want drugs. Changes to the law that would end penalties for possession and reduce the need for acquisitive crime would result in fewer drug users going to prison. As well, decriminalizing drugs outside prisons might weaken the financial forces that make drug trafficking in prisons so profitable.

23 Commission of Inquiry into the Non-medical use of Drugs, *Final Report* (Ottawa, 1973) at 55. "Many people obey the law simply because it is the law. With them, the law has moral authority, quite apart from any adverse consequences of violation. They obey the law out of a sense of moral obligation to do so."

24 This has already been done in cases concerning mandatory drug testing, the imposition of criminal penalties for possession of marijuana, and the imposition of criminal penalties for the manufacture and distribution of literature promoting the use of illegal drugs. In a judgment released October 5, 1994, Madam Justice Ellen MacDonald of the Ontario Court's General Division declared unconstitutional the part of section 462.2 of the *Criminal Code* prohibiting the manufacture and distribution of literature promoting illicit drug use. The judge said the law infringes society's right to freedom of expression as guaranteed under the *Charter*. *The Globe and Mail*, October 7, 1994.

25 Section 1 of the *Charter* would of course act as a limit on the expression of these rights. Section 1 states:

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

26 One could, for example, argue that laws or policies interfering with syringe exchanges violate this right.

27 There is one very recent precedent for a private criminal prosecution of prison workers. In September, 1994, the mother of a prisoner who died after being taken forcibly from his cell at Kingston Penitentiary laid charges of manslaughter and criminal negligence against six correctional officers. The charges were laid privately before a justice of the peace instead of by the police. The Ontario Attorney General could intervene to prevent the case from going to trial: The Globe and Mail, September 20, 1994, p. A5.

28 The legal arguments concerning criminal negligence would of course be much more sophisticated than those raised here. This report merely raises the broad arguments.

29 These programs are mentioned in the Addiction Research Foundation, "Best Advice: Prevention Strategies: Injection Drug Users and AIDS" (Addiction Research Foundation, 1991). Equivalent programs in Canada would require changes to our criminal laws prohibiting the dispensation of these drugs.

30 E. Buning, G. van Brussel, G. van Santen, "The impact of harm reduction drug policy on AIDS prevention in Amsterdam" in P. O'Hare, R. Newcombe, A. Matthews, E. Buning and E. Drucker, ed., *The reduction of drug-related harm* (New York, Routledge: 1992) 30 at 37.

31 A. Wodak, "A Dutch Smorgasbord: Research on HIV/AIDS and Injecting Drug Users", (1993) 4 International Journal of Drug Policy 5 at 26.

32 See note 7, above.

33 *Ibid.* at 76.