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**FIXING TO SUE: IS THERE A LEGAL DUTY TO
ESTABLISH SAFE INJECTION FACILITIES IN BRITISH
COLUMBIA?***

CRAIG JONES[†]

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[†] LL.M. (Harvard Law School); LL.B. (University of British Columbia); of the Bar of British Columbia.

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I. INTRODUCTION

A “safe injection facility” (“SIF”) is a place in which the users of intravenous street drugs, such as heroin and cocaine, can self-administer those drugs under the supervision of trained medical personnel and in sanitary conditions, in order to prevent death by overdose and the spread of blood-borne diseases through needle sharing.

In British Columbia, litigation against the government for its continued refusal to sponsor SIFs has been proposed.¹ However, it is not entirely clear upon what grounds such a suit would proceed.

Professor Ian Malkin, senior lecturer in law at the University of Melbourne, in considering whether state governments in Australia might be sued for their inaction with respect to the establishment of safe injection facilities, has suggested that a lawsuit is both possible and desirable. The professor wrote:

The unwillingness of governments to grapple seriously and respond appropriately to the possibilities of containing the transmission of the HIV virus and hepatitis C and reducing incidences of overdose is careless. Accountability for unreasonable conduct — by not taking reasonable enough measures to prevent the transmission of disease or

¹ Lawsuits have been proposed both against governments, as discussed in Malkin, *infra* note 2, and even by governments to force recalcitrant communities to accept SIFs, as mooted by one member of the Fraser Valley British Columbia Health Region Board: “Addicts Need a Safe Place to Shoot Up” *Abbotsford News* (17 July 2001).

overdoses — is possible through the use of a common law negligence action. Acting reasonably in this context requires the introduction of measures such as the provision of supervised injecting facilities.²

Professor Malkin's argument, however persuasive philosophically, does not examine in depth the many hurdles such an action would face. When considering the issue of government liability for inaction in the face of a health crisis, it is not enough to simply establish "carelessness" or assert that reasonable behaviour "requires" the introduction of safe injection facilities. One must show, according to the standards applied by the courts, the existence of a duty owed by the government to at-risk intravenous drug users. Once that difficult hurdle is overcome, the appropriate standard of care must be defined, and the breach of that care through government inaction must be shown. Then, it must be demonstrated that the breach of duty caused the harm complained of. Finally, it must be noted that any negligence claim against the government is particularly difficult when the act or omission complained of was in fact a decision taken at high level of government as a matter of policy.

Despite these obstacles, there are some recent decisions in Canada, both in tort and constitutional law, which might make such a lawsuit uniquely possible here. Indeed, at least one Vancouver organization is seeking the status of a non-profit society to pursue "strategic litigation" in the area.³

The purpose of this article is to explore the grounds on which a lawsuit or petition might be brought in British Columbia for the failure of the government to provide adequate and effective

² I. Malkin, "Establishing Supervised Injecting Facilities: A Morally and Legally Responsible Way to Help Minimise Harm" (University of Melbourne, 2001) [unpublished]. Professor Malkin had similarly explored liability in negligence with respect to prisoners' access to sterile injection equipment: I. Malkin, "The Role of the Law of Negligence in Preventing Prisoners' Exposure to HIV While in Custody" in R. Jürgens, ed., *HIV/AIDS in Prisons: Final Report* (Ottawa: Canadian HIV/AIDS Legal Network & Canadian AIDS Society, 1996) at Appendix 1, online: Aidslaw Homepage <<http://www.aidslaw.ca/maincontent/issues/prisons/download1.html#HTML>> (date accessed: 29 June 2001).

³ See Pivot Society Meeting Minutes (August 14, 2001), online: PIVOT Homepage <<http://www.arakni.com/pivot/index.shtml>> (date accessed: 16 October 2001). Subsequent to the writing of this article, I made a joint written presentation on SIFs to Vancouver City Council on May 2nd 2002. I have no other affiliation with the PIVOT organization.

treatment for drug addicts through the implementation of safe injection facilities. The focus is on two possible causes of action: liability in negligence, along the lines proposed in Australia by Professor Malkin, and also a claim under sections 7 and 15 of the *Canadian Charter of Rights and Freedoms*.⁴ I also discuss the use of unwritten constitutional principles as possible guides in the interpretation of the relevant legislation and in a potential judicial review of the exercise of ministerial discretion thereunder.

It will be apparent that I believe there is sufficient merit to advance such a claim on any or all of these grounds. I do not go so far as to predict an outcome of such a case, although I suspect that my own preference might be inferred. However, I think it important to emphasize here that, although the idea of special legal rights for injection drug users might appear at this point to be radical, these rights *are* within reach of the law as it now stands. By this, I mean that no previously-decided case need be overturned, and no statute need be struck down, in order for the arguments advanced in this article to prevail. In fact, a solution might only require a reasoned, compassionate and principled application of the current jurisprudence, driven by a frank recognition that maintenance of the *status quo* has become simply intolerable.

II. FACTUAL BACKGROUND

A. THE SCOPE OF THE PROBLEM

British Columbia is locked in an injection drug-based health crisis of astonishing proportions.

Drug overdosé deaths, once a relatively rare phenomenon, became by 1994 the leading cause of death in British Columbia among adults between the ages of 30 and 49.⁵ In Vancouver alone, in the first nine months of 2000, over 200 people died of injection

⁴ *Canadian Charter of Rights and Freedoms*, Part I of the *Constitution Act, 1982*, being Schedule B to the *Canada Act 1982* (U.K.), 1982, c. 11 [hereinafter *Charter*].

⁵ British Columbia, *Report of the Task Force into Illicit Narcotic Overdose Deaths in British Columbia* (Burnaby: Office of the Chief Coroner, 1994).

drug overdoses.⁶ Meanwhile, non-fatal overdoses may strike 15% of Vancouver's injection drug users in any given six month period.⁷

Moreover, the unsanitary conditions and abject poverty in which most injection drug use occurs help to explain a further disturbing statistic: almost as many drug users die of HIV/AIDS as from overdoses.⁸ It has been estimated that as many as 400 B.C. users become HIV-positive annually.⁹ As a result, perhaps one in three Vancouver injection drug users is HIV positive.¹⁰ Further exacerbating the problem is that such persons are less likely to receive adequate treatment from physicians than other HIV-positive patients.¹¹

Nor is AIDS the only serious illness associated with injection drug uses. Every year in B.C., 1600 new cases of hepatitis C can be attributed to needle-sharing by injection drug users and, as a result, B.C. accounts for more than half of all hepatitis C cases in Canada, and 88% of its injection drug users are said to carry the disease.¹² Tuberculosis, hepatitis B, syphilis and a host of other

⁶ British Columbia, *Safe Injection Facilities: Proposal for a Vancouver Pilot Project* by T. Kerr (Vancouver: Harm Reduction Action Society, 2000) (citing data from the B.C. Coroner's office).

⁷ *Ibid.* at 13.

⁸ G. Bohn, "Where the Drugs Are" *The Vancouver Sun* (21 November 2000) A16: *The Vancouver Sun* reported that, of the 105 deaths of participants in the ongoing Vancouver Injection Drug Use Survey (VIDUS) study since 1996, 31 had died of overdoses and 26 of AIDS.

⁹ Kerr, *supra* note 6 at 14.

¹⁰ In Vancouver, the rate was reported as 23% in 1996-97 (versus 4% in 1992-93): Bureau of HIV, AIDS, STD and TB, "HIV/AIDS Among Injection Drug Users in Canada" in *HIV/AIDS Epidemic Update* (Ottawa: Health Canada, 1999). However, the VIDUS study puts that figure at 33%: S. Strathdee et al., "Determinants of HIV seroconversion in injection drug users during a period of rising prevalence in Vancouver" (1997) 8(7) *Int J STD AIDS* 437; S. Currie et al., "Community incidence and prevalence data for the VIDUS Project" *VIDUS Project Update #6* (18 July 2000) 2.

¹¹ S. Strathdee et al., "Barriers to use of free antiretroviral therapy in injection drug users" (1998) 280 *JAMA* 547; P. O'Connor et al., "Medical care for injection-drug users with human immunodeficiency virus infection" (1994) 331(7) *JAMA* 450.

¹² Kerr, *supra* note 6, citing *inter alia* M. Maclean, *Vancouver drug epidemiology and drug crime statistics 2000* (Vancouver: Canadian Community Epidemiology Network on Drug Use (June 21, 2000)) [draft].

medical conditions are also said to be “epidemic” among injection drug users.¹³

In the particularly hard-hit Downtown Eastside of Vancouver, the average life expectancy for a male is 57,¹⁴ twenty years below the national average and roughly the same as that for a man in Bangladesh.¹⁵ A vastly disproportionate number of the area’s injection drug users are of First Nations ancestry. Moreover, a high proportion of drug users are so-called “dual-diagnosis” cases, whereby they suffer from both drug addiction and mental disorders such as schizophrenia.¹⁶

The escalating mortality rate in the Downtown Eastside has driven the Vancouver Health Board to declare a public health emergency, which has received international attention.¹⁷

It is not necessary here to describe in detail the host of secondary social problems often associated with injection drug use, such as prostitution, nuisance, crime, child abuse or neglect, and so on. Nor do I wish to engage in the debate over whether these problems can be most accurately attributed to drug use *per se*, or to the questionable policy of criminalization. Whether safe injection facilities have any positive impact on these aspects of ‘indirect’ drug-related harm is irrelevant for our present inquiry, which is concerned principally with the direct harm suffered by users in the absence of such a program. The scope of the harm currently befalling the users of injection drugs under the present regime appears to be well established. The next preliminary question that must be answered is, do safe injection facilities help?

¹³ Kerr, *supra* note 6.

¹⁴ Bohn, *supra* note 8.

¹⁵ United Nations Development Program (UNDP), *Human Development Report 1998*, online: Human Development Resource Center <<http://hdr.undp.org>> (date accessed: 20 June 2001).

¹⁶ Kerr, *supra* note 6 at 14, citing P. Parry “Something to eat, a place to sleep and someone who gives a damn: HIV/AIDS and injection drug use in the DTES” *Final project report to the DTES community, Minister of Health and the Vancouver-Richmond Health Board* (Vancouver: Vancouver/Richmond Health Board, 1997).

¹⁷ D.L. Brown, “Injection Centers Sought for Vancouver Addicts” *The Washington Post* (26 August 2001).

B. SAFE INJECTION FACILITIES

Safe injection facilities are central features of harm-reduction initiatives in other countries. SIFs have been established in the Netherlands since the 1970s, in Switzerland (beginning in 1986) and in Germany (two cities post-1987, and others subsequent to 1994).¹⁸ Recently, in May of 2001, a single trial facility was established in Sydney, within Australia's notorious Kings Cross district, after vigorous political and media opposition¹⁹ and an unsuccessful court challenge by the local Chamber of Commerce.²⁰ Other Australian states have begun separate processes, which may see such facilities operating there soon.²¹

The SIFs currently in operation in Europe and Australia have three health related objectives: to provide sanitary conditions and clean equipment for injection drug use, to provide supervision by of medically-trained personnel who can intervene immediately in the case of an overdose and to provide a "gateway" through which injection drug users can interface with the health care system.²² Professor Malkin describes the typical layout of the European facilities:

Generally, a facility includes a café, counselling room and medical care clinic and injecting rooms, described as having a 'sterile ambience'. The injecting rooms are small, and contain stainless steel tables where clients prepare and inject their drugs using materials provided by the facility (such as needles, candles, sterile water, spoons, towels, cotton pads, bandages and bins). Most importantly, as would be the case in the proposed Australian facilities, staff cannot help drug users with their injections. A staff member has to be present in the injecting room at all times; doctors work a few hours each

¹⁸ K. Dolan et al., "Drug consumption facilities in Europe and the establishment of supervised injecting centres in Australia" (2000) 19 *Drug and Alcohol Review* 337 at 338-340.

¹⁹ D. Hoare "A Timely Injection of Balance" *The Australian* (31 May 2001).

²⁰ *Kings Cross Chamber of Commerce and Tourism Inc. v. The Uniting Church of Australia Property Trust (NSW) & ors.*, [2001] NSWSC 245, online: LEXIS (Australia: NSWUNR) [hereinafter *Kings Cross*].

²¹ Dolan et al., *supra* note 18.

²² *Ibid.* at 338. Dolan et al. describe a fourth "expected benefit" from the European centres: "reduction in public nuisance (including inappropriately discarded injecting equipment, public injecting and intoxication and visible drug dealing)."

week, and the facilities are open 7 hours a day, 5 to 6 days per week. All staff are trained to resuscitate clients, and all can make referrals to drug treatment centres and counselling. [citations omitted]²³

It is generally asserted that, in areas served by safe injection facilities in European cities, there has been a marked decrease in overdose death and in the spread of blood-transmitted disease among injection drug users.²⁴ While it is difficult, statistically, to precisely gauge the effectiveness of the facilities, because their implementation has been, in each case, part of an aggressive enlightened harm reduction strategy,²⁵ a comprehensive survey of the European literature conducted by a team of Australian researchers leaves little room for doubt that disease, hospitalization and death has been reduced markedly in those cities that have SIFs. Moreover, the Australian survey found that SIFs in Europe “have contributed to a stabilization of or improvement in general health and social functioning of clients,” as a result of, *inter alia*, the improved access to health services for addicts.²⁶ A similar review by New York’s Lindesmith Center agreed that the literature supports the effectiveness of the European strategy,²⁷ and the *Economist* recently ran an 11-part series of articles lauding the European harm reduction efforts, and even supported the “wise” Swiss program, in which heroin is prescribed for the most desperate addicts.²⁸

With respect to overdose deaths, however, one figure bears explicit mention: since the implementation of the European programs, with at least 42 safe injection facilities across the continent and several million injections supervised, not a single

²³ Malkin, *Establishing Supervised Injecting Facilities*, *supra* note 2 at 30-31.

²⁴ For example, overdose deaths in Frankfurt, Germany, fell from 147 in 1991 to 26 in 1997 while remaining steady in the rest of Germany not serviced by SIFs; HIV among injection drug users in Frankfurt fell from 63-65% in 1985 to 12-15% in 1994. Other health statistics were similarly impressive: P. Coffin et al., *Safer Injection Rooms* (Research Summary) (New York: Lindesmith Center, 1999). See also Kerr, *supra* note 6 at 32-35.

²⁵ Kerr, *ibid.*

²⁶ Dolan et al., *supra* note 18 at 340-341.

²⁷ Coffin et al., *supra* note 24.

²⁸ “A Survey of Illegal Drugs: Better Ways” *The Economist* (28 July 2001) 48.

overdose death from an SIF injection has been reported, and hospitalization of overdose patients has been reduced by as much as 90%.²⁹ Early evidence from the single site in Australia bears out this experience. In the first few weeks of operation, medical personnel at the Kings Cross facility reportedly revived four overdosed addicts who might have died in the absence of immediate intervention.³⁰

Even more recently, two widely-reported studies published in the *Canadian Medical Association Journal* (CMAJ) indicated that needle-exchange programs were not proving particularly effective at safeguarding the health of injection drug users and strongly endorsed SIFs as a necessary health-care initiative, both to prevent the spread of disease and to provide for such users with necessary access to the British Columbia health care system.³¹ Such programs were described in an accompanying commentary as an "ethical imperative."³² Yet, while the federal and provincial governments are well aware of the problem and have gone so far as to study the feasibility of a trial SIF in Canada,³³ and although both the Vancouver Health Board and the city's Mayor have publicly endorsed the idea,³⁴ no such facility has yet been officially proposed, let alone planned.

²⁹ Dolan et al., *supra* note 18 at 34; Coffin et al, *supra* note 24 at 2.

³⁰ M. Fife, "Addicts Revived in Drug Room" *The Age* (22 Jun 2001), online: *The Age* <<http://www.theage.com.au/news/national/2001/06/22/FFXQTX0F7OC.html>> (date accessed: 28 July 2001).

³¹ E. Wood et al., "Unsafe injection practices in a cohort of injection drug users in Vancouver: Could safer injecting rooms help?" (2001) 165(4) CMAJ 405; A. Palepu et al., "Hospital utilization and costs in a cohort of injection drug users" (2001) 165(4) CMAJ 415.

³² T. Kerr & A. Palepu, "Safe injection facilities in Canada: Is it time?" (2001) 165(4) CMAJ 436 at 437.

³³ *Ibid.*, citing *Reducing the harm associated with injection drug use in Canada* (Ottawa: Federal, Provincial and Territorial Advisory Committee on Population Health, 2001).

³⁴ Brown, *supra* note 17.

III. NEGLIGENCE OF GOVERNMENT

A. ESTABLISHING A DUTY OF CARE

The progress of Crown liability in negligence has had a long and difficult history in the common law world. However, it is now settled in Canada that the test designed by Lord Wilberforce in *Anns v. Merton London Borough Council*,³⁵ as restated by Wilson J. in *City of Kamloops v. Nielsen*,³⁶ "should be applied in any case where negligence or misconduct has been alleged against a government agency."

In *Kamloops*, Wilson J. summarized the two questions that must be asked in order to determine whether a private law duty of care exists between a public authority and the plaintiff:

(1) is there a sufficiently close relationship between the parties (the local authority and the person who has suffered the damage) so that, in the reasonable contemplation of the authority, carelessness on its part might cause damage to that person? If so,

(2) are there any considerations which ought to negative or limit (a) the scope of the duty and (b) the class of persons to whom it is owed or (c) the damages to which a breach of it may give rise?³⁷

According to the criteria set forth in *Kamloops*, the proximity or neighbourhood test familiar from *Donoghue v. Stevenson*,³⁸ may well establish a *prima facie* duty of care on the part of the provincial government.

As the evidence of the efficacy of SIFs mounts, it becomes increasingly difficult for the government to argue that death and disease that result from the absence of SIFs are not foreseeable. Indeed, in the face of such statistics, the harm from inaction may well be said to have been actually foreseen.

However, this is not the end of the inquiry. The next question that needs to be answered is whether the statutory provisions

³⁵ [1978] A.C. 728 [hereinafter *Anns*].

³⁶ [1984] 2 S.C.R. 2 [hereinafter *Kamloops*].

³⁷ *Ibid.* at 10-11.

³⁸ [1932] A.C. 562 (H.L.).

pursuant to which the public authority must act serve to restrict the scope of that duty or enact specific conditions for its exercise.

The *Canada Health Act*³⁹ states that the primary objective of Canadian health care policy is “to protect, promote and restore the physical and mental well-being of residents of Canada and to facilitate reasonable access to health services without financial or other barriers.” The federal financial support for B.C.’s health care system is contingent on provincial compliance with five criteria described in sections 8 through 12 of the *Act*: public administration, comprehensiveness, universality, portability and accessibility.

The provincial counterpart to the *Canada Health Act*, the *Medicare Protection Act*,⁴⁰ states in its preamble an intention to “confirm and entrench universality, comprehensiveness, accessibility, portability and public administration as the guiding principles of the health care system” and emphasizes the fundamental value that access to necessary medical care must be based solely on need and not the ability to pay. Section 3(3) of the *Medicare Protection Act* assigns to the Medical Services Commission the facilitation of “reasonable access, throughout British Columbia, to quality medical care, health care and diagnostic facility services for residents of British Columbia under the Medical Services Plan.”

B.C.’s *Health Act*⁴¹ states at section 7 that:

7 (1) The minister [of Health] must do the following:

- (a) take account of the interests of health and life among the people of British Columbia;
- (b) especially study the vital statistics of British Columbia;
- (c) endeavour to make an intelligent and profitable use of the collected records of death and of sickness among the people;

³⁹ R.S.C. 1985, c. C-6, s. 3.

⁴⁰ R.S.B.C. 1996, c. 286.

⁴¹ R.S.B.C. 1996, c. 179.

(d) make sanitary investigations and inquiries about the cause of disease, and especially of an epidemic;

(e) inquire into the causes of varying rates of mortality and the effect of locality, employment and other circumstances on health;

(f) make suggestions as to the prevention and interception of contagious and infectious diseases the minister believes most effective and proper, and as will tend to prevent and limit as far as possible the rise and spread of disease... [emphasis added]

If it is demonstrated, through the “investigations,” “inquiries” and “study” the minister is obliged to undertake, that safe injection facilities “will tend to prevent and limit as far as possible the rise and spread of disease,” it would appear that he or she has an obligation, at the very least, to “make suggestions” that they be implemented. Moreover, the requirement that the minister “make intelligent and profitable use” of epidemiological studies might require more affirmative action still. There appears to be nothing in the broad discretionary powers of the Minister under the *Health Act* or the Medical Services Commission under the *Medicare Protection Act* that suggest either would be unable to provide supervision for safe injection facilities if it was thought to be beneficial. The provincial legislature has been silent on the issue.

Also of concern is the matter of Canada’s ratification of certain international agreements. For instance, the *International Covenant on Economic, Social and Cultural Rights* imposes obligations on its signatories to take steps “to achieve the full realization” “of the highest attainable standard of physical health,” and to take steps “necessary for... the prevention, treatment, and control of epidemic[s]... and other diseases.”⁴² While it would be proving too much to say that such high-minded commitments in and of themselves bind Canada or the provinces to facilitate SIFs, this does not mean that such provisions are irrelevant. Their relevance, though, may lie in their use as aids in interpreting the particular legislation. It is a fundamental principle that statutes in Canada be interpreted so as to conform to international law wherever

⁴² *International Covenant on Economic, Social and Cultural Rights* (1976), 993 U.N.T.S. 3, [1976] Can. T.S. 46, Article 12 [hereinafter *International Covenant*].

possible.⁴³ It follows then that if the health provision scheme set out in federal and provincial legislation is interpreted as being consistent with the language of the *International Covenant*, there is a possible requirement that, when faced with an “epidemic,” the relevant Ministers take “necessary” steps to control it. Nevertheless, on this argument, the mandate must be seen as coming from domestic legislation, not simply from international covenant.

Even without the assistance provided by international agreements, the duties described in section 7 of the *Health Act* are more onerous than those imposed by the respective *Police Acts* of Ontario⁴⁴ and British Columbia,⁴⁵ each of which were found to establish a duty to the public generally in *Doe v. Metropolitan Toronto (Municipality) Commissioners of Police*⁴⁶ and *Mooney v. A.-G.*⁴⁷ In each of those cases, the duty to the public generally was translated into a duty to individual victims of violence where negligent performance of duty foreseeably led to the commission of serious crimes.⁴⁸ As I have suggested above, assuming reports

⁴³ P. Côté, *The Interpretation of Legislation in Canada*, 3rd ed. (Toronto: Carswell, 2000) at 367-389. After reviewing the cases on point, the author notes at 367, “[a] statute is not void or inoperative simply because it [violates a treaty or rule of international law]. There is a presumption, however, that the legislature does not intend such a result.” It is not certain whether and to what extent such a principle extends to the provinces within the realm of their exclusive powers. The federal government cannot, according to *Attorney General for Canada v. Attorney General for Ontario*, [1937] A.C. 326 (the “Labour Conventions Case”), sign away provincial legislative authority through international agreement. However, if the federal government has the constitutional power to legislate nationally in the field of health, and coordinate provincial efforts in this respect (and it appears that it does), it stands to reason that provincial legislation should, where possible, be interpreted as consistent with international law in the same area, unless there is an explicit exception.

⁴⁴ *Police Services Act*, R.S.O. 1990, c. P.15.

⁴⁵ *Police Act*, R.S.B.C. 1996, c. 367. Pursuant to s. 7(2) of the *Police Act*, police officers are to “perform the duties and functions respecting the preservation of peace, the prevention of crime and offences against the law and the administration of justice assigned ... to peace officers by the commissioner, under the regulations or under any Act.”

⁴⁶ (1990), 74 O.R. (2d) 225 (Ont. H.C.J.).

⁴⁷ [2001] B.C.J. No. 1160 (S.C.), online: QL (BCJ).

⁴⁸ Note that in *Mooney, ibid.*, despite the finding of duty and breach, the plaintiff failed on the issue of causation because she could not prove that the attacks by her violent ex-husband would not have occurred even if the police had properly followed up on her complaint.

of the efficacy of the European SIFs are accurate, it is difficult to argue that disease and death in B.C. is not a foreseeable consequence of the absence of such facilities.

B. A “PURE POLICY” DECISION?

Even assuming the *prima facie* existence of a duty of care in the government with respect to intravenous drug abusers, any potential plaintiff or plaintiff class will still need to convince the court that, under the second branch of the *Anns/Kamloops* test, there are no considerations which ought to negative or limit the duty, its scope or the damages.

This is a question which is obviously impossible to answer in the abstract. Certainly, courts considering this aspect of *Anns* are frequently careful to draw a distinction between decisions which are “operational” (i.e. how a duty is carried out) and “pure policy” decisions, favouring liability for negligence with respect to the former but not the latter.

The Supreme Court of Canada in *Brown v. British Columbia (Minister of Transportation and Highways)*⁴⁹ set out the general guidelines to determine whether a decision is “policy” as opposed to “operational.” Cory J., writing for the majority, cited the “most helpful guidelines set out by Mason J. of the Australian High Court in *Sutherland Shire Council v. Heyman*.”⁵⁰ Mason J. wrote:

The distinction between policy and operational factors is not easy to formulate, but the dividing line between them will be observed if we recognize that a public authority is under no duty of care in relation to decisions which involve or are dictated by financial, economic, social or political factors or constraints. Thus budgetary allocations and the constraints which they entail in terms of allocation of resources cannot be made the subject of a duty of care. But it may be otherwise when the courts are called upon to apply a standard of care to action or inaction that is merely the product of administrative direction, expert or professional opinion, technical standards or general standards of reasonableness. [Emphasis added by Cory J.]⁵¹

⁴⁹ [1994] 1 S.C.R. 420 [hereinafter *Brown*].

⁵⁰ (1985), 60 A.L.R. 1.

⁵¹ *Brown*, *supra* note 49 at 434.

There is little doubt that a decision regarding whether or not to establish safe injection facilities can be characterized as fitting quite comfortably within the traditional view of a “policy decision” as described by Mason J. However, that is not the end of the matter, as Cory J. reiterates in *Brown*:

It will always be open to a plaintiff to attempt to establish, on a balance of probabilities, that the policy decision was not *bona fide* or was so irrational or unreasonable as to constitute an improper exercise of governmental discretion. This is not a new concept. It has long been recognized that government decisions may be attacked in those relatively rare instances where the policy decision is shown to have been made in bad faith or in circumstances where it is so patently unreasonable that it exceeds governmental discretion. The test to be applied when a policy decision is questioned is set out in *City of Kamloops v. Nielsen*, [1984] 2 S.C.R. 2, at p. 24, by Wilson J. in these words:

In my view, inaction for no reason or inaction for an improper reason cannot be a policy decision taken in the *bona fide* exercise of discretion. Where the question whether the requisite action should be taken has not even been considered by the public authority, or at least has not been considered in good faith, it seems clear that for that very reason the authority has not acted with reasonable care.⁵²

If then, a plaintiff can establish that government inaction was the result of grossly insufficient consideration of the problem, or lack of good faith, liability can still attach under the *Kamloops* test, even if the decision can be classified as one of pure “policy.” This may be so especially where the very duty established by the statute in question, as we have seen, emphasises the Minister’s responsibility to conduct investigations into the causes of disease and to “make intelligent and profitable use” of the information gathered. In other words, the rather unique wording of the *Health Act* seems to require a higher level of deliberative decision-making than those found in equivalent legislation.⁵³

⁵² *Ibid.* at 435-6.

⁵³ Contrast this duty with the far less onerous investigative and corrective duties imposed by British Columbia’s *Attorney General Act*, R.S.B.C. 1996, c. 22, the *School Act*, R.S.B.C. 1996, c. 412 or the *Police Act*, *supra* note 45.

C. THE STANDARD OF CARE

The wording of the authorizing statute might also be used to both restrict the ‘neighbourhood’ within which a duty is owed, and to reduce the standard of care applicable to government action.⁵⁴ But beyond the dictates of the *Health Act*, what is the standard of care to be expected of a reasonably prudent government on this issue? Or, if the decision is one of “policy,” what is the standard of care expected of a government deciding after appropriate consideration and in good faith on this issue?

Again, as evidence mounts as to the effectiveness of SIFs in Europe at preventing the spread of disease and overdose deaths, it will be increasingly difficult to argue that inaction is a reasonably prudent course to take in all circumstances. At what historical point the evidence can be said to be sufficient to enable a reasonably prudent person to reach such a conclusion will of course be a matter of evidence, but the cases indicate that the actions of other countries in averting the spread of disease can assist in establishing the acceptable standard at any particular date.

In *Walker Estate v. York Finch General Hospital*,⁵⁵ the Supreme Court of Canada considered whether the Canadian Red Cross Society (the “CRCS”) breached the acceptable standard of care with respect to procedures used to screen blood donors with HIV and AIDS in the 1980s. The Court confirmed that the trial judge was correct to consider the prevailing practice in the United States. At that time, although both countries possessed the same knowledge of the potential risks of AIDS, only the American blood agencies decided that donor screening should include “specific questions calculated to detect a potential donor’s possible exposure to the causative agent of AIDS.” At trial, Borins J. noted that the CRCS should have adopted the same protective procedures:

⁵⁴ See *Rothfield v. Manolakos* [1989] 2 S.C.R. 1259. In fact the duty provisions in the *Health Act*, S.B.C. 1893, c. 15, appear to be fundamentally unique to that Ministry, possibly in recognition of the degree of importance attached to the maintenance of health and the prevention of communicable disease in the Province. The provisions, incidentally, date to the nineteenth century, with the duty imposed at that time assigned to a Provincial Board of Health rather than the Minister.

⁵⁵ [2001] 1 S.C.R. 647 [hereinafter *Walker Estate*].

These [American] standards were promulgated in 1983 when neither the virus responsible for AIDS had been isolated, nor the transmission of HIV through blood had been established. The available scientific evidence was sufficient for the blood banking community and the FDA to recognize the catastrophic potential to public health if steps were not taken at once, as best as one could, to guard against the suspicion that blood from certain high risks groups could cause the spread of the new disease. There was no need for the CRCS to reinvent the scientific wheel, so to speak. The evidence was there for the CRCS to act on. Although it recognized the risk of [transfusion associated AIDS], for reasons which were never satisfactorily explained, it never took advantage of the unique opportunity which it had to act on the scientific data on which the American blood banking community had acted and declined to follow the American lead in donor screening.⁵⁶

The Court of Appeal in *Walker Estate*⁵⁷ confirmed the trial decision with respect to standard of care and noted that Borins J. was right to consider “all of the evidence” relevant to the assessment of CRCS’s approach. Interestingly, the Court also found that the value of the American evidence was supported by the fact that the CRCS initially planned to adopt the American practice.

In a decision separate from the class proceedings, but based on the same factual background, Macdonald J. found that the duty to haemophiliac recipients of tainted blood was owed, not simply by the Red Cross Society, but also by the federal government, which had failed to expedite the process of approving a heat-treating process which could have eliminated HIV from blood products. In *Robb v. Canadian Red Cross Society*, the court held that:

Canada, as regulator of the blood industry, owed a duty of care to the plaintiffs. The [Bureau of Biologics at the federal Health Department] was dealing with haemophiliacs, a sick and vulnerable population in the midst of the AIDS epidemic. The haemophiliac population was totally dependant on the [Bureau] for regulatory approval of the heat-treated blood products. Thus, the [Bureau], like the CRCS, must be held to a high standard of care. Given that the language of the second

⁵⁶ *Walker Estate v. York-Finch General Hospital* (1997), 39 C.C.L.T. (2d) 1, [1997] O.J. No. 4017 at para. 164 (Gen. Div.), online: QL (OJ).

⁵⁷ *Walker Estate v. York-Finch General Hospital* (1999), 43 O.R. (3d) 461 (C.A.).

recommendation of the Consensus Conference contemplated that the [Bureau] would expedite licensing, the content of the [Bureau's] duty of care was exactly this, to expedite the licensing.⁵⁸

The breach of this duty of care was the delay caused by the [Bureau]'s bureaucratic lethargy in failing to respond to the crisis in a manner that was commensurate with the magnitude of that crisis.

Macdonald J. therefore found the Red Cross liable for 75 percent of the plaintiffs' damages and the federal government for the remaining 25 percent. However, it is instructive to note that the plaintiffs' concomitant claim against the Ontario government failed because the decisions it had made, however flawed, were of a "policy" nature and were not "operational."⁵⁹

In terms of responding to a potential healthcare crisis, *Walker Estate* and *Robb* establish that the courts are not at all reluctant to compare Canada's response to health crises against that of other countries.⁶⁰ Such an approach is entirely consistent with that frequently taken in products liability cases.⁶¹ It is therefore

⁵⁸ [2000] O.J. No. 2396 at paras. 139-40 (S.C.), online: QL (OJ) [hereinafter *Robb*].

⁵⁹ Indeed Macdonald J.'s finding in *Robb, ibid.*, in this respect is of concern, if not directly on point. She said at para. 151 that:

I agree that Ontario did not "provide" blood services any more that it can be said that it provides cancer treatment, by-pass surgery or any other medical treatment. Ontario was under no duty to provide such services. Its responsibility was circumscribed by the obligation to pay the costs of such services to the extent that such payments are mandated by the province's health insurance legislation: see *Cameron v. Nova Scotia (Attorney General)* (1999), 177 D.L.R. (4th) 611 (N.S.C.A.). Payments made by Ontario to the CRCS or any other provider of health services are discretionary payments not made under contract or any other legally enforceable obligation: see *St. Joseph's Island Hospital Ass'n v. Plummer Memorial Hospital* (1996), 24 O.T.C. 73 (Gen. Div.).

I say these comments are not directly on point because in *Robb* the evidence indicated that the provincial government took no part in the decisions which were found to have marked the failure to adopt appropriate measures, and Ontario's role was primarily limited to providing funding and support to the Canadian Red Cross Society.

⁶⁰ Although MacDonald J. in *Robb, supra* note 58 at paras. 71-95, did not explicitly consider the disparity between the Canadian and US responses to the crisis, the evidence of the failure to live up to the standard of care was nonetheless based on its slowness to adopt US-developed methods of ensuring a safe blood supply.

⁶¹ See for instance the Ontario Court of Appeal decision in *Buchan v. Ortho Pharmaceuticals (Can.) Ltd.* (1986), 12 O.A.C. 361 (C.A.), where the Canadian subsidiary of a birth-control pill manufacturer was found liable for failing to warn of the

possible that, in their efforts to curb the spread of drug related disease, Holland, Switzerland and Germany may have established a standard of care which, when faced with a similar (or worse) epidemic, a reasonable and prudent government should adopt, should a court conclude they have a duty to do so.

The government may well argue, in defence to a negligence action, that safe injection facilities are illegal under federal law for one of two reasons: Either because allowing persons to be in illegal possession of narcotics on one's premises is deemed to be "constructive possession"⁶² contrary to the *Controlled Drug and Substances Act*,⁶³ in which repossessing used and discarded needles may technically be considered "possession" of a controlled drug (i.e. the residue) under section 2(2) of that *Act*; or because the provision of clean needles constitutes trafficking in "drug paraphernalia" contrary to section 462.1 of the *Criminal Code*.⁶⁴

These questions of potential criminal liability have been extensively canvassed elsewhere⁶⁵ and I will deal with them in more detail later in this article when discussing "reasonable accommodation" under section 1 of the *Charter*. I note at this point that, however small the chance that an SIF or its employee would be charged criminally, the government could still defend itself in a negligence action on the basis that the court cannot properly require it to violate the existing criminal law in order to satisfy a reasonable standard of care. To put it another way, the government cannot be unreasonable in refusing to do what is

risk of stroke inherent in the product. In that case, the American warning insert, which did alert consumers to the risk, was found to have established the appropriate standard of care.

⁶² A category described in B. MacFarlane, *Drug Offences In Canada*, 3rd ed. (Toronto: Canada Law Book, 1996) at 4.

⁶³ R.S.C. 1996, c. 19, s. 2(2).

⁶⁴ R.S.C 1985, c. 46, s. 462.1. Unused syringes are arguably exempt from this section because they are likely "devices" pursuant to the *Food and Drugs Act*, R.S.C. 1985, c. F-27. At any rate the authorities have to date shown no interest in prosecuting the existing needle-exchange programs operating in major Canadian cities.

⁶⁵ See E. Oscapeella & R. Elliott, *Injection Drug Use and HIV/AIDS: A Legal Analysis of Priority Issues* (Montréal: Canadian HIV/AIDS Legal Network, 1999). See also R. Jürgens & R. Elliott, eds., *Injection Drug Use and HIV/AIDS: Legal and Ethical Issues* (Montréal: Canadian HIV/AIDS Legal Network, 1999), online: [Aidslaw Homepage <http://www.aidslaw.ca>](http://www.aidslaw.ca) (last modified: 12 June 2001).

illegal.⁶⁶ Thus, any potential plaintiff relying on the common law must be prepared to demonstrate that the government could have acted without breaking the criminal law. With respect to offences under the *Controlled Drug and Substances Act*, this may not present any real barrier as exemptions to the application of that *Act* may be granted by Ministerial order,⁶⁷ and indeed it is arguable that the federal Minister of Health would have a duty to grant such an exemption if it was requested by his or her provincial counterpart for the operation of an SIF.

D. CAUSATION AND AFFIRMATIVE DEFENCES

There is no doubt that a government faced with a lawsuit by heroin or cocaine addicts would take advantage of a battery of common law defences, including voluntary assumption of risk, contributory negligence and perhaps even *ex turpi causa*. Moreover, the government will argue that any harm suffered was caused by the addict's use of drugs, not by government inaction.

Whether such affirmative defences as voluntary assumption of risk and contributory negligence, or the reduction of damages based on the 'fault' of the plaintiff,⁶⁸ have any relevance with respect to addicted persons is questionable at best, given courts' sympathetic approach to the effect of drug addiction on the ability

⁶⁶ Legislative standards are relevant to the common law standard of care: see *R. v. Saskatchewan Wheat Pool*, [1983] 1 S.C.R. 205. Though the two are not necessarily co-extensive: see *Ryan v. Victoria (City)*, [1999] 1 S.C.R. 201. However, as Professor Thayer put it, it would be an "unjust reproach to the ordinary prudent man to suppose he would do such a thing in the teeth of the ordinance": Thayer, "Public Wrong and Private Action" (1914) 27 Harv. L. Rev. 317.

⁶⁷ *Supra* note 63, s. 56.

⁶⁸ *Negligence Act*, R.S.B.C. 1996, c. 333, ss. 1, 2 and 4, apportion the liability of 2 or more persons according to the "fault" of each.

to exercise free will⁶⁹ and the recognition of drug addicts as disabled persons for the purposes of human rights law.⁷⁰

Similarly, the *ex turpi* defence (that the court should not assist a plaintiff whose claim arises out of his or her own illegal or immoral conduct) has been limited in its application to the point where, if it indeed has any application today, it is inapt for claims of compensatory damages,⁷¹ and perhaps inapplicable altogether where the illegal or immoral activity of the plaintiff that might otherwise bar recovery is driven by desperation for an addictive drug.⁷² Nevertheless, the *ex turpi* defence might still operate to restrict remedies which, like punitive damages or injunctive relief, go beyond simple compensation.

In order to satisfy the requirement of causation, since *Snell v. Farrell*⁷³ and the subsequent decision of *Athey v. Leonati*,⁷⁴ the plaintiff only has to prove that the alleged negligence "materially contributed" to the harm in a way which was more than trivial. Again, given a demonstrated disparity in disease and death rates between injection drug users who can avail themselves of SIFs and those who cannot, meeting this threshold seems eminently possible.

⁶⁹ See for example the trial, appeal and Supreme Court of Canada decisions in *Norberg v. Wynrib* (1988), 27 B.C.L.R. (2d) 240, 50 D.L.R. (4th) 167 (B.C.S.C.); (1990), 44 B.C.L.R. (2d) 47, 66 D.L.R. (4th) 553, [1990] 4 W.W.R. 193 (B.C.C.A.); [1992] 2 S.C.R. 226 (S.C.C.) [hereinafter *Norberg* cited to S.C.R.]. See also the two decisions of the New South Wales Court of Appeal: *Grey v. Simpson* (3 April 1978), Docket C.A. 327 of 1977, [1978] NSW LEXIS 6, online: LEXIS (Australia, NSWUNR); *Yates v. Jones* (7 December 1989), Docket C.A. 618 of 1987, [1989] NSW LEXIS 10893, online: LEXIS (Australia, NSWUNR).

⁷⁰ *Entrop v. Imperial Oil Ltd.* (1995), 23 C.H.R.R. D/196 (Ont. Bd. of Inquiry), [2000] O.J. No. 2689 (Ont. C.A.).

⁷¹ *Hall v. Hebert*, [1993] 2 S.C.R. 159.

⁷² *Norberg*, *supra* note 69. Estey J. in *Canada Cement LaFarge Ltd. v. British Columbia Lightweight Aggregate Ltd.*, [1983] 1 S.C.R. 452 at 476, said that "cases where a tort action has been defeated by the *ex turpi causa* maxim are exceedingly rare." In *Norberg*, the Court said at 262:

To apply the doctrine of *ex turpi causa* in this case would be to deny the appellant damages on the same basis that she succeeded in the tort action: because she acted out of her desperation for Fiorinal, surely public policy would not countenance giving to the appellant with one hand and then taking away with the other.

⁷³ [1990] 2 S.C.R. 311.

⁷⁴ [1996] 3 S.C.R. 458.

IV. THE CONSTITUTIONAL DIMENSION

A. SECTION 7 OF THE *CHARTER*

The seminal case of *R. v. Morgentaler*⁷⁵ offers some hope that injection drug users might avail themselves of the *Charter*'s section 7 guarantees to assist their claim for SIFs. This section provides that:

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.⁷⁶

In *Morgentaler*, it was found by four of the seven judges that the cumbersome administrative system established to allow (otherwise illegal) abortions was a violation of the "security of the person" guarantee in section 7, and that this was not in accordance with the principles of fundamental justice. Beetz J. held that:

"Security of the person" within the meaning of s. 7 of the *Charter* must include a right of access to medical treatment for a condition representing a danger to life or health without fear of criminal sanction. If an act of Parliament forces a pregnant woman whose life or health is in danger to choose between, on the one hand, the commission of a crime to obtain effective and timely medical treatment and, on the other hand, inadequate treatment or no treatment at all, her right to security of the person has been violated.⁷⁷

There is certainly a directly analogous argument available to injection drug users; a challenge that might be launched against both the provincial and federal governments because, as in *Morgentaler*, each is responsible for part of the problem.

While application of section 7 outside of the criminal sphere is not unheard of, it is rare. Following *Morgentaler*, in *Rodriguez v. British Columbia*⁷⁸ (a challenge to the *Criminal Code* prohibition against assisted suicide), a majority of the Supreme Court of

⁷⁵ [1988] 1 S.C.R. 30 [hereinafter *Morgentaler*].

⁷⁶ *Charter*, *supra* note 4.

⁷⁷ *Morgentaler*, *supra* note 75 at para. 68.

⁷⁸ [1993] 3 S.C.R. 519 [hereinafter *Rodriguez*].

Canada broadly defined “security of the person” as encompassing notions of personal autonomy, control over one’s physical and psychological integrity free from state interference and basic human dignity. More recently, the court has held that psychological stress caused by the ministerial seizure of a child can trigger security of the person protections, but that such an imposition is not in violation of the principles of fundamental justice provided that the parents are afforded representation in the relevant hearings.⁷⁹

Under such broad definitions, it is certainly possible to classify the harm suffered by injection drug users in the absence of SIFs as the type of harm which could, on its face, be deserving of section 7 protection. This is not the end of the inquiry, however.

The difficulty with the application of section 7 lies not with the classification of the harm, but rather with the attribution of the harm to government action. In *Operation Dismantle Inc. v. The Queen*,⁸⁰ Dickson J. (as he then was) concluded that the causal link between the actions of government (approving missile testing by the United States) and the alleged *Charter* violation (infringement of security of the person due to an alleged increased threat of nuclear war) was too “uncertain, speculative and hypothetical to sustain a cause of action.” In separate concurring reasons, Wilson J. reiterated the requirement of direct causation between the actions of the state and the alleged deprivation:

It is not necessary to accept the restrictive interpretation advanced by Pratte J., which would limit s. 7 to protection against arbitrary arrest or detention, in order to agree that the central concern of the section is direct impingement by government upon the life, liberty and personal security of individual citizens. At the very least, it seems to me, there must be a strong presumption that governmental action which concerns the relations of the state with other states, and which is therefore not directed at any member of the immediate political community, was never intended to be caught by s. 7 even although

⁷⁹ *New Brunswick (Minister of Health and Community Services) v. G. (J)*, [1999] 3 S.C.R. 46.

⁸⁰ [1985] 1 S.C.R. 441 at 447 [hereinafter *Operation Dismantle*].

such action may have the incidental effect of increasing the risk of death or injury that individuals generally have to face.⁸¹

Most recently, in *Blencoe v. B.C. (Human Rights Commission)*,⁸² the majority of the Supreme Court reiterated that the guarantee of “security of the person” provided by section 7 protected against a broad range of harm outside the criminal realm, but only where the harm suffered was a result of state action. In that case, Mr. Blencoe, a former B.C. Cabinet Minister, had been accused of sexual harassment before the Human Rights Tribunal. Exorbitant delays resulted and Mr. Blencoe’s reputation continued to suffer, but the majority of the Supreme Court found that the public excoriation was not the result of the delays, but rather from the publicity surrounding the complaints.

This requirement of “direct harm” by the state is difficult to reconcile with the decision of the majority in *Morgentaler*. In that case, no one alleged that the state was responsible for women’s pregnancies, but only that interference of the state with the treatment of problematic pregnancy considerably exacerbated the harm. In both cases the harm was exacerbated by direct government involvement in the process – either through the intervention of the ‘review board’ in *Morgentaler* or through the criminal prohibition in *Rodriguez*. In *Rodriguez*, although the criminal prohibition did not *cause* the plaintiff’s disease, it did condemn her to a far more painful and traumatic death by denying her the option of enlisting a sympathetic third party in her demise.

The majority in *Blencoe* distinguished *Rodriguez* and *Morgentaler* by citing the applicable rule as one of “but for”: “In the absence of government involvement [i.e. through criminalization of assisted suicide], Mrs. Rodriguez would not have suffered a deprivation of her s. 7 rights. The same cannot be said of the facts in the case at bar.”⁸³

So, while *Rodriguez*, *Morgentaler* and even *Blencoe* might provide some support for a claim against criminalization of injection drug possession *per se*, such an analysis suggests that

⁸¹ *Ibid.* at 490.

⁸² [2000] 2 S.C.R. 307 [hereinafter *Blencoe*].

⁸³ *Ibid.* at para. 69.

there can be no section 7 “security of the person” claim for government *inaction* with respect to SIFs. That the harm suffered by injection drug users cannot be directly attributed to the state will likely be fatal to a section 7 claim, and it would not be necessary to proceed to the second part of the section 7 analysis, which asks whether the infringement was in accordance with the principles of fundamental justice.

B. SECTION 15 OF THE *CHARTER* AND ADDICTION AS A DISABILITY

1. RECENT DISCRIMINATION JURISPRUDENCE

Section 15 of the Canadian Charter of Rights and Freedoms provides that:

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 and, in particular, without discrimination based on race, national or ethnic origin, colour, religion, sex, age or mental or physical disability.

The Supreme Court of Canada has suggested that failure to accommodate is in itself an actionable form of discrimination. In *Eaton v. Brant County Board of Education*, Sopinka J. described the essence of the discrimination against the disabled as the government’s failure to make reasonable accommodation:

The principal object of certain of the prohibited grounds is the elimination of discrimination by the attribution of untrue characteristics based on stereotypical attitudes relating to immutable conditions such as race or sex. In the case of disability, this is one of the objectives. The other equally important objective seeks to take into account the true characteristics of this group which act as headwinds to the enjoyment of society’s benefits and to accommodate them. Exclusion from the mainstream of society results from the construction of a society based solely on ‘mainstream’ attributes to which disabled persons will never be able to gain access. Whether it is the impossibility of success at a written test for a blind person, or the need for ramp access to a library, the discrimination does not lie on the attribution of untrue characteristics to the disabled individual. The blind person cannot see and the person in a wheelchair needs a ramp. Rather, it is the failure to make reasonable accommodation, to fine-

tune society so that its structures and assumptions do not result in the relegation and banishment of disabled persons from participation, which results in discrimination against them. [emphasis added]⁸⁴

Similarly, in *Eldridge v. British Columbia*,⁸⁵ the Court found that the courts below had been labouring under the faulty assumption that government was under no obligation to ameliorate disadvantage that it did not have a hand in creating. The Court set out an analysis whereby the denial of accommodation was a *prima facie* infringement of section 15, and the question of whether the accommodation, or lack thereof, was “reasonable” was considered under section 1’s “saving provision.”

Eldridge dealt with the absence in B.C. hospitals of sign-language interpreters for the deaf. The Court reviewed the relevant statutory framework for the provision of health services and found there was nothing in the statutes that forbade the provision of such services; their absence was due to an administrative decision regarding the allocation of funds. As such, the issue was not a challenge to the validity of the various statutes themselves, but rather to the decisions (or lack thereof) made by the executive and by hospitals pursuant to them.

An argument available following *Eldridge*, therefore, would be that the failure to provide SIFs is unconstitutional discrimination against persons with disabilities, i.e. drug addicts. Such an argument, if successful, would propel the plaintiff past several of the hurdles presented by the negligence approach because it cannot be defeated by resort to the defence of ‘policy decision’. Even the most basic policy decisions of the Cabinet are reviewable under the *Charter* for constitutional defect,⁸⁶ and must in the end be made “reasonably,” which is arguably a lower threshold than that of whether the decisions are “so irrational or unreasonable as to constitute an improper exercise of governmental discretion,” as required by the negligence analysis of policy decisions in *Brown*, as previously discussed. Notwithstanding this, however, a section 15 analysis presents particular hurdles of its own.

⁸⁴ [1997] 1 S.C.R. 241 at para. 67 [hereinafter *Eaton*].

⁸⁵ [1997] 3 S.C.R. 624 at paras. 75-80 [hereinafter *Eldridge*].

⁸⁶ *Operation Dismantle*, *supra* note 80.

Recently, in *Granovsky v. Canada (Minister of Employment and Immigration)*,⁸⁷ the Supreme Court articulated a three step test for determining whether section 15 rights have been infringed in cases of “temporary” disability. Those steps were summarized in the headnote to *Granovsky* as follows:

- (1) whether there is a differential treatment for the purpose of s. 15(1);
- (2) whether this treatment was based on one or more of the enumerated and analogous grounds; and,
- (3) whether the differential treatment brings into play the purpose of s. 15(1), i.e., does the law, in purpose or effect, perpetuate the view that persons with temporary disabilities are less capable or less worthy of recognition or value as human beings or as members of Canadian society?⁸⁸

Differential treatment, as already established, does not necessarily mean ‘direct’ discrimination. This is set out in *Law v. Canada (Minister of Employment and Immigration)*, where the Court asked:

[D]oes the impugned law (a) draw a formal distinction between the claimant and others on the basis of one or more personal characteristics, or (b) fail to take into account the claimant’s already disadvantaged position within Canadian society resulting in substantively differential treatment between the claimant and others on the basis of one or more personal characteristics? If so, there is differential treatment for the purpose of s. 15(1).⁸⁹

Binnie J. in *Granovsky* reiterates this principle:

Section 15(1) ensures that governments may not, intentionally or through a failure of appropriate accommodation, stigmatize the underlying physical or mental impairment, or attribute functional limitations to the individual that the underlying physical or mental impairment does not entail, or fail to recognize the added burdens which persons with disabilities may encounter in achieving self-

⁸⁷ [2000] 1 S.C.R. 703 [hereinafter *Granovsky*].

⁸⁸ *Ibid.* at 707.

⁸⁹ [1999] 1 S.C.R. 497 at para. 39 [hereinafter *Law*].

fulfilment in a world relentlessly oriented to the able-bodied. [emphasis added]⁹⁰

The Court in *Law* cautioned that there was no single approach appropriate for section 15 cases:

In accordance with McIntyre J.'s caution in *Andrews, supra*, I think it is sensible to articulate the basic principles under s. 15(1) as guidelines for analysis, and not as a rigid test which might risk being mechanically applied. Equality analysis under the Charter must be purposive and contextual. The guidelines which I review below are just that -- points of reference which are designed to assist a court in identifying the relevant contextual factors in a particular discrimination claim, and in evaluating the effect of those factors in light of the purpose of s. 15(1).⁹¹

Nevertheless, in the last two years, the Supreme Court has demonstrated a remarkable rigidity of approach; its decisions have applied *Law*'s test without much elaboration, even in cases where the discrimination is arguably indirect.⁹²

2. ARE INJECTION DRUG USERS A SECTION 15 GROUP?

In the case of safe injection facilities, the discrimination is best characterized as indirect. Every citizen is denied safe injection facilities. This, however, only matters to injection drug users, in

⁹⁰ *Granovsky, supra* note 87 at para. 33.

⁹¹ *Law, supra* note 89 at para. 6.

⁹² In *M. v. H.*, [1999] 2 S.C.R. 3, for instance, the Court struck down a provincial provision extended certain benefits to "spouses", but defined that term as restricted to couples of the opposite sex. This was not, on the face of it, discriminatory against homosexuals, because some gays and lesbians do become married to members of the opposite sex, for whatever reason, and would thus gain the benefit of the law. Of course, the legislation was clearly discriminatory (albeit by omission) against "same sex couples", and obviously such discrimination would have a massively disproportionate effect on gays and lesbians. But this is quite different from finding that the legislation directly discriminated. That this distinction completely escaped the court's analysis (see the decision of the majority at para. 2: "This differential treatment is on the basis of... sexual orientation") is significant. In the ordinary course, the court would have to either define "member of a same sex couple" as an analogous s. 15 ground, as they did with homosexuality in *Vriend v. Alberta*, [1998] 1 S.C.R. 493 [hereinafter *Vriend*], or consider evidence of the disproportionate impact upon gays and lesbians of the law, as with the deaf in *Eldridge, supra* note 85. The fact that the Court did not go through these motions shows the extent to which the current s. 15 jurisprudence has collapsed into what is essentially a judicial "smell test" under *Law, supra* note 89.

the same way that the denial of a wheelchair ramp is universal, but is felt particularly keenly by those to whom stairs are of no use.

Canadian courts, as noted, have had little difficulty accepting the characterization of drug addiction as a physical impairment worthy of equality protection.⁹³ Ryan J.A., writing for the Court of Appeal in *R. v. Nguyen*,⁹⁴ quoted with approval a description by the B.C. Supreme Court in *R. v. Ping Li*⁹⁵ of the “sub-class of people who, by falling prey to heroin addiction, become effectively disabled from functioning as useful, self-supporting, productive members of society.” There is no principled reason why such a protection should not extend beyond human rights legislation to section 15 of the *Charter*.⁹⁶ Certainly, injection drug users can be said to be “suffering social, political and legal disadvantage in our society,” a criterion for a section 15 claim as described by Wilson J. in *R. v. Turpin*.⁹⁷ Moreover, the use of section 15 to encourage the implementation of safe injection regimes has been advocated before in Canada, at least in the prison setting.⁹⁸

Although consideration of whether any plaintiff is protected by section 15 is only one part of the analysis, it may be important at this point to emphasize that the promotion and protection of

⁹³ *Entrop*, *supra* note 70. See also *Toronto Dominion Bank v. Human Rights Commission* (1998), 163 D.L.R. (4th) 193 (F.C.A.), considering testing for illegal narcotics discriminatory against dependent users.

⁹⁴ [1995] B.C.J. No. 552 at para. 13 (C.A.), online: QL (BCJ).

⁹⁵ (19 November 1993), Vancouver CC930521 (B.C. S.C.).

⁹⁶ If such a principle is indeed limited to human rights cases, then there is nothing of course to prevent a litigant from bringing his complaint through that process. Indeed, in the human rights and labour relations settings, even restriction of smoking has been deemed to be discrimination on the basis of physical disability: see *Cominco Ltd. v. United Steelworkers of America, Local 9705*, [2000] B.C.D.L.A. LEXIS 76, online: LEXIS (Canada, BCDLA); and alcoholism has long been recognized as worthy of equality protection: *Canadian Union of Distillery Workers v. Hiram Walker & Sons Ltd.* (1976), 77 C.L.L.C. 16086 (B.C. L.R.B.).

⁹⁷ [1989] 1 S.C.R. 1296 at 1333.

⁹⁸ See the discussion in R. Elliott, “Prisoners’ Constitutional Right to Sterile Needles and Bleach” in R. Jürgens, ed., *HIV/AIDS in Prisons: Final Report* (Ottawa: Canadian HIV/AIDS Legal Network & Canadian AIDS Society, 1996) at Appendix 2. The author focused also on the constitutional prohibition against “cruel and unusual punishment,” which of course is not applicable outside the context of incarceration.

“dignity” has emerged as “the overarching goal of section 15(1).”⁹⁹ This issue, especially with respect to novel claims such as that of injection drug users, must be recognized and emphasized. If evidence exists that injection drug users in countries with more enlightened harm reduction policies live a more dignified existence than they do here (and it is difficult to imagine that this would not be so, if given only the relative rates of overdose deaths), then it must be presented.

3. IS THE ABSENCE OF SIFs “DISCRIMINATION”?

Not fully separable from the definition of the affected group is the question of whether the law is discriminating against that group. I say that this issue is ‘not fully separable’ because, in adverse effect cases, the group is, at least contextually, defined to a degree by the fact of discrimination. This is particularly so where the proposed section 15 group (in this case injection drug users) is a subset of an enumerated group (the physically and mentally disabled), the former alleging a special and further denial of “dignity” on the basis of the discrimination.

In *Granovsky*, Binnie J. for the Court described a section 15 analysis appropriate for disability claims:

The true focus of the s. 15(1) disability analysis is not on the impairment as such, nor even any associated functional limitations, but is on the problematic response of the state to either or both of these circumstances. It is the state action that stigmatizes the impairment, or which attributes false or exaggerated importance to the functional limitations (if any), or which fails to take into account the “large remedial component” ... or “ameliorative purpose” of s. 15(1) ... that creates the legally relevant human rights dimension to what might otherwise be a straightforward biomedical condition. [citations omitted, emphasis added]¹⁰⁰

Binnie J. again emphasized that section 15 addresses the state’s response to the disability, rather than the disability itself:

⁹⁹ G. G. Mitchell, “Developments in Constitutional Law: The 1998-99 Term – State Craft and Status Quo” (2000) 11 S.C.L.R. (2d) 101 at 165.

¹⁰⁰ *Granovsky*, *supra* note 87 at para. 26.

The “purposive” interpretation of s. 15 puts the focus squarely on the third aspect of disabilities, namely on the state’s response to an individual’s physical or mental impairment. If the state’s response were, intentionally or through effects produced by oversight, to stigmatize the underlying physical or mental impairment, or to attribute functional limitations to the appellant that his underlying physical or mental impairment did not warrant, or to fail to recognize the added burdens which persons with temporary disabilities may encounter in achieving self-fulfilment, or otherwise to misuse the impairment or its consequences in a discriminatory fashion that engages the purpose of s. 15, an infringement of equality rights would be established.¹⁰¹

There appears to be little doubt that the current official response to drug addiction, with its emphasis on criminalization and incarceration,¹⁰² “stigmatizes” the disability. It is difficult to imagine any other clinically-recognized disease where manifestation of one principal symptom of the disorder (compulsive use, and thus possession, of the drugs to which one is addicted¹⁰³) is *ipso facto* a criminal offence.¹⁰⁴ Moreover, it is certainly not fanciful to suggest that the lack of access to sanitary and safe injection conditions is a failure “to recognize the added burdens” faced by injection drug users in accessing the health system generally. The question that remains, therefore, is whether we can move from the general to the specific, and suggest that lack of safe injection facilities alone violate section 15.

Here, attention must be given to the third component of the *Granovsky* test: whether failure to provide SIFs “perpetuate[s] the view that [addicts] are less capable or less worthy of recognition or

¹⁰¹ *Ibid.* at para. 80.

¹⁰² It has been estimated that the B.C. Government alone spends over \$60 million per year on drug-related law enforcement: E. Single et al., *The Costs of Substance Abuse in Canada* (Ottawa: Canadian Centre on Substance Abuse, 1996).

¹⁰³ American Psychiatric Association, *Diagnostic and Statistical Manual of Mental Disorders: DSM-IV*, 4th ed. (Washington, D.C.: American Psychiatric Association, 1994) at 175-272.

¹⁰⁴ It might be argued that certain sexual deviances such as paedophilia also might fall within this category. Even if such an analogy is medically appropriate, which is questionable in itself, there is an important further distinction: one can be a paedophile without ever committing a crime, if the deviant inclination is not allowed to manifest as physical action. This is not the case with heroin or cocaine addiction, conditions defined by the use of the drugs as much as by the inclination for them that develops.

value as human beings or as members of Canadian society.” However, such an interpretation is in the face of the widespread bias that drug addiction (and its attendant dangers) is a result of the free choice of the addict. Such a view permeates the criminalization approach to drug use and perhaps the public consciousness as well, and thus deserves some consideration.

I do not dispute here that the *first* use of heroin or cocaine by a non-addicted person could be characterized as a criminal act by a legal free agent. However, given the drugs’ addictive nature, it appears that, by the second, third or fourth time, the drug-taking has taken on an entirely different character: it has become a self-administered treatment for the illness of addiction. At this point, surely, the just and proper reaction on the part of society should no longer be opprobrium (assuming for the sake of argument that condemnation was *ever* justified), but instead focus upon management of the ongoing disease and its attendant risks.

To do otherwise, it seems, is to uncritically adopt a policy of ‘blaming the victim’. Any association of the progression of addiction with the original “immoral” criminal act is arguably no different from the historical association of AIDS, syphilis and teenage pregnancy with the “sins” of homosexuality, prostitution and premarital sex. Such moralizing inevitably has led to the unwillingness of the stigmatized to expose themselves to society generally or to the health care system in particular, with profoundly negative – and entirely foreseeable – results: incredibly, sexually transmitted diseases still go mostly undiagnosed,¹⁰⁵ and the stigmatization of out-of-wedlock pregnancy results in literally hundreds of newborn babies being abandoned to die in alleys and dumpsters because their mothers are unwilling or unable to either access abortion procedures or have their children in hospital.¹⁰⁶

¹⁰⁵ “[S]ocial stigma and lack of public awareness concerning STDs often inhibits frank discussion between health care providers and patients about STD risk and the need for testing. Thus, most STDs go undiagnosed.” American Social Health Association, “Sexually Transmitted Diseases in America: How Many Cases and at What Cost?” (December 1998), online: Kaiser Family Foundation Homepage <http://www.kff.org/content/archive/1447/std_rep.html> (date accessed: 29 June 2001).

¹⁰⁶ A nationwide newspaper survey indicated at least 105 “discarded babies” were found in 1998 (33 of them dead). The actual numbers are likely far higher because most will never be discovered: “Havens for Abandoned Babies” *Christian Science Monitor* 93:89 (3 April 2001) 10; There is no doubt that social stigma is one of the leading factors in such cases: M. Oberman, “Mothers Who Kill: Coming to Terms with Modern American

Our refutation of such an approach cannot rely entirely on the emergence of a consensus that the “sin” which led to the condition requiring treatment is not a “sin” at all. Rather, our actions should be based on our present compassion for the sick and vulnerable. In general, we have taken this lesson to heart, except with respect to injection-drug addiction, perhaps (as noted earlier) the last medical condition to which official, legislated stigma still attaches. To force a person to admit to criminal activity and a shameful addiction in order to get treatment for his disability can be characterized as an abject failure to “recognize the burdens” of addiction. In such circumstances, the alternative of supervised, sanitary injection facilities may in fact be constitutionally mandated as the minimum accommodation reasonably required to preserve the users’ sense of “value” or “worth” as human beings within the terms of *Granovsky*.

One final issue with respect to the question of “discrimination” concerns the identification of a group with which the target group can be compared. In other words, in asserting that injection drug users have been denied an access or a service owed them, we must answer the question, “compared to whom?” Identifying the “comparator” group in the case of SIF drug users, like so many aspects of constitutional equality analysis, depends on how the claim is characterized. If it is characterized, as in *Eldridge*, as the lack of equal access to a service available to all (i.e. healthcare), then the “comparator” group is the general population who do not suffer from the disability.¹⁰⁷ If, as in *M. v. H.*¹⁰⁸ or *Granovsky*, one group has been offered a benefit (opposite sex spouses and permanently disabled persons, respectively), but another denied it (same-sex partners and the temporarily disabled), then the “comparator” group would more appropriately be those who do receive the benefits sought. Because here there is no *particular* benefit being extended to others, but denied by omission to injection drug users, a narrow comparator analysis is not, in my

Infanticide” (1996) 4(1) American Criminal Law Review 1; S. Pitt & E. Bale, “Neonaticide, Infanticide and Filicide: A Review of the Literature” (1995) 23(3) Bulletin of the American Academy of Psychiatry and the Law 375.

¹⁰⁷ *Eldridge*, *supra* note 85 at para. 80.

¹⁰⁸ *Supra* note 92.

view, appropriate, and the broad comparison made in *Eldridge* infinitely preferable. This is consistent too with the emphasis on “dignity,” which in this case must focus upon the misery and despair that uniquely characterizes the lives of many injection drug users.

Nevertheless, the question of “comparator” cannot be easily dismissed, and the possible permutations provide an eloquent example both for the importance of the process of “characterization” in constitutional litigation and the vagueness that surrounds it. Consider, for example, the access to health care provided to wheelchair-bound persons, who are assisted by special ramps, elevators, and workers who, as part of their job description, will ensure that these physically disabled persons are accommodated. Blind persons too are accommodated in the healthcare system through brail buttons on elevators, and by staff and doctors who will read out information to unseeing patients when required. Since *Eldridge*, the deaf, as we have already noted, are accommodated through the provision of sign-language interpreters. If one could demonstrate that injection drug users cannot access hospitals without the “interface” of SIFs and their staff, then perhaps the appropriate “comparator” would be other classes of disabled persons. If nothing else, though, this brief alternative “comparator” analysis demonstrates the profound challenges faced by plaintiffs in characterizing their claims in cases alleging discrimination by omission.

4. POSITIVE ACTION: *ELDRIDGE* AND *AUTON*

It is no longer possible to suggest that section 15 cannot mandate positive action on the part of the government. In *Eaton, supra*, Sopinka J. said:

In *Andrews v. Law Society of British Columbia*, [1989] 1 S.C.R. 143, at p. 169, McIntyre J. stated that the “accommodation of differences . . . is the essence of true equality.” This emphasizes that the purpose of s. 15(1) of the *Charter* is not only to prevent discrimination by the attribution of stereotypical characteristics to individuals, but also to ameliorate the position of groups within Canadian society who have

suffered disadvantage by exclusion from mainstream society as has been the case with disabled persons.¹⁰⁹

The leading case in this respect is the Supreme Court's decision in *Eldridge, supra*, where it was found that the failure of provincial health authorities to provide funding for sign language interpreters for the deaf was unconstitutional. The Court found that the absence of such interpreters had an obvious and particular impact on the hearing impaired – and thus constituted discrimination on the basis of a disability contrary to section 15. The following passage from *Eldridge* is worth repeating in its entirety:

The principle that discrimination can accrue from a failure to take positive steps to ensure that disadvantaged groups benefit equally from services offered to the general public is widely accepted in the human rights field. In *Re Saskatchewan Human Rights Commission and Canadian Odeon Theatres Ltd.* (1985), 18 D.L.R. (4th) 93 (Sask. C.A.), leave to appeal refused, [1985] 1 S.C.R. vi, the court found that the failure of a theatre to provide a disabled person a choice of place from which to view a film comparable to that offered to the general public was discriminatory. Similarly, in *Howard v. University of British Columbia* (1993), 18 C.H.R.R. D/353, it was held that the university was obligated to provide a deaf student with a sign language interpreter for his classes. “[W]ithout interpreters”, the Human Rights Council held, at p. D/358, “the complainant did not have meaningful access to the service.” And in *Centre de la communauté sourde du Montréal métropolitain inc. v. Régie du logement*, [1996] R.J.Q. 1776, the Quebec Tribunal des droits de la personne determined that a rent review tribunal must accommodate a deaf litigant by providing sign language interpretation. Moreover, the principle underlying all of these cases was affirmed in *Haig, supra*, where a majority of this Court wrote, at p. 1041, that “a government may be required to take positive steps to ensure the equality of people or groups who come within the scope of s. 15.”

It is also a cornerstone of human rights jurisprudence, of course, that the duty to take positive action to ensure that members of disadvantaged groups benefit equally from services offered to the general public is subject to the principle of reasonable accommodation. The obligation to make reasonable accommodation for those adversely affected by a facially neutral policy or rule extends

¹⁰⁹ *Eaton, supra* note 84 at para. 66.

only to the point of “undue hardship”; see *Simpsons-Sears, supra*, and *Central Alberta Dairy Pool, supra*. In my view, in s. 15(1) cases this principle is best addressed as a component of the s. 1 analysis. Reasonable accommodation, in this context, is generally equivalent to the concept of “reasonable limits.” It should not be employed to restrict the ambit of s. 15(1).

In my view, therefore, the failure of the Medical Services Commission and hospitals to provide sign language interpretation where it is necessary for effective communication constitutes a *prima facie* violation of the s. 15(1) rights of deaf persons. This failure denies them the equal benefit of the law and discriminates against them in comparison with hearing persons.¹¹⁰

The absence of safe injection facilities adversely impacts intravenous drug users in a number of ways. First of all, their disability makes them susceptible to contracting communicable diseases at rates astronomically greater than those of their healthy fellow citizens. Secondly, they are uniquely susceptible to sudden death by overdose, again as a result of their disability. Finally, their addiction coupled with the already-mentioned high rate of mental illness, keeps them out of regular contact with the medical care system until and unless some catastrophe occurs which requires their hospitalization.

Each of these adverse effects can be ameliorated to some extent by the institution of safe injection facilities staffed with competent medical personnel. When the deprivation suffered by injection drug users is characterized this way, i.e. simply as equal access to the healthcare system, the claim seems to fit within the purview of *Eldridge*, where the Court emphasised that:

Their claim is not for a benefit that the government, in the exercise of its discretion to allocate resources to address various social problems, has chosen not to provide. On the contrary, they ask only for equal access to services that are available to all.¹¹¹

In other words, to bring oneself comfortably within the *Eldridge* decision, one would have to characterize the deprivation as a service to which other British Columbians are entitled. That is to

¹¹⁰ *Eldridge, supra* note 85 at paras. 78-80.

¹¹¹ *Ibid.* at para. 92.

say, ordinary citizens are no more entitled to SIFs than addicts are, so the plaintiff will be assisted if he can successfully characterize the deprivation, not simply as that of safe injection facilities, but rather of effective access to healthcare itself.

However, there is some indication that courts are willing to recognize that the “egalitarian promise”¹¹² set out in section 15 may, in some cases, necessitate specialized government action beyond simply the equality of access paradigm established in *Eldridge*.

One striking – in fact arguably extreme – application of the *Eldridge* decision can be found in *Auton (Guardian ad litem of) v. British Columbia (Attorney General)*.¹¹³ In that case, the petitioners succeeded in forcing the provincial government to provide funding for effective early treatment of autistic children. The case is of particular interest because the services sought were for children of pre-school age. In other words, the petitioners didn’t want access to an existing system equal to that of non-disabled persons (as in *Eldridge*); they wanted government funding for an entirely independent system of treatment. This is a point which the *Eldridge* Court had explicitly avoided deciding.

Madame Justice Allan in *Auton #2*, however, agreed that such affirmative steps are necessary, and that the failure to effectively treat childhood autism is in fact discrimination. As such, the *Auton #2* decision goes far beyond *Eldridge*, arguably imposing upon the government a positive obligation to reasonably treat any recognized disorder. In her decision, Allan J. said that:

The petitioners are the victims of the government’s failure to accommodate them by failing to provide treatment to ameliorate their mental disability. That failure constitutes direct discrimination. Further, the petitioners’ disadvantaged position stems from the government’s failure to provide effective health treatment to them, not from the fact that their autistic condition is characterized, in part, by an inability to communicate effectively or at all.¹¹⁴

¹¹² *Ibid.* at para. 92.

¹¹³ (2000), 78 B.C.L.R. (3d) 55 (S.C.) [hereinafter *Auton #2*].

¹¹⁴ *Ibid.* at para. 132. This last sentence in the passage was offered by way of clarification. The *Eldridge*, *supra* note 85, decision had emphasized the importance of communication as a fundamental right, and it was unclear the extent to which a denial of communication was necessary to make a case under the Supreme Court’s decision.

In reaching this conclusion, Madame Justice Allan relied upon the principal psychiatric diagnostic text, the DSM-IV, which does indeed recognize autism as a mental disorder. Reading the DSM-IV in combination with the stated purposes of Canada's and British Columbia's health care provision statutes¹¹⁵ meant that exclusion of effective treatment for autism was, in Allan J.'s view, directly discriminatory.¹¹⁶ It is of considerable assistance, then, that the DSM-IV also accords 'official' recognition to the disease of addiction to heroin and cocaine.¹¹⁷

Since *Auton #2*, there have been two other cases which reinforce the idea that refusal to provide funding can rise to the level of section 15 discrimination, providing that the result was that the complaining group was "demeaned" or their "sense of self worth...denied"¹¹⁸ or caused "to be treated differently and in a stereotypical manner reflecting an assumption or presumption of personal or group characteristics."¹¹⁹ In both cases the argument was unsuccessful, but the failure in each appears attributable to failure on this single point. As I have pointed out, evidence of the

¹¹⁵ Principally the *Canada Health Act*, R.S.C. 1985, C-6 and the *Medicare Protection Act*, R.S.B.C. 1996, c. 286.

¹¹⁶ Allan J.'s conclusion in this respect illustrates the difficulty in distinguishing between adverse effect and direct discrimination. Because both autistic and non-autistic children alike were denied the provision of "Lovass Autism Treatment," the discrimination is arguably in fact "indirect" or "adverse effect," because the deprivation does not effect those who are not suffering from autism. Examining the test from *Granovsky*, *supra* note 87, it would appear that inaction is as actionable as unequal action, and thus Allan J.'s elaborate exposition upon the statutory scheme may have been analytically unnecessary.

¹¹⁷ *Supra* note 103.

¹¹⁸ *Shulman et al. v. Ontario (A.-G.) et al.*, [2001] Ont. Sup. C.J. LEXIS 2790 online: LEXIS (Canada, OSCJ) at 19 [hereinafter *Shulman*], citing *Irshad v. Ontario* (2001), 43 O.R. (3d) 43 (Ont. C.A.). In *Shulman*, at 11, the Court found that the "withholding of the benefit for hearing aid evaluations and re-evaluations in no way reflects the stereotypical application of presumed group or personal characteristics."

¹¹⁹ *Xeni Gwet'in First Nations Government v. Riverside Forest Products Ltd.*, [2001] B.C.D. Civ. LEXIS 1729 online: LEXIS (Canada, BCDCIV), [2001] A.C.W.S.J. 233403, 109 A.C.W.S. (3d) 868 (B.C.S.C.). The Plaintiffs sought an order that the federal and Provincial governments fund its ongoing land claims litigation, arguing *inter alia* that to refuse to do so was a violation of s. 15. The Court phrased the question as "[d]oes the refusal to fund have the effect of demeaning the plaintiffs' human dignity?," citing *Law*, *supra* note 91, and *Lovelace v. Ontario*, [2000] 1 S.C.R. 950, and answered in the negative (funding was granted on other grounds).

“demeaning” or “denial of self-worth” characteristics in the case of intravenous drug users might be considerably easier to come by; it does not seem too much of a stretch to suggest that the abhorrent conditions suffered by IV drug users is in part caused by the lack of medical attention afforded their conditions. This, again, is particularly so when their plight is compared to that of persons similarly situated in countries where SIFs are available.

To sum up the question of section 15 breach, then, a prospective SIF plaintiff could argue that the absence of such facilities is a discriminatory denial of equal access to the healthcare system, relying principally on *Eldridge*. An argument based on the principles of *Auton #2*, which would likely be advanced at the same time, asserts further that, notwithstanding the denial of equal access to the universal system, there is a further positive obligation on the government to do what is reasonable to redress the particular harms suffered by injection drug users, at least to the point of funding SIFs.

C. ADDICTION AND ABORIGINAL PEOPLES

It is a particularly tragic aspect of the incomprehensibly bleak existence led by many of Canada’s Aboriginal peoples that they are notoriously overrepresented among injection drug users in our inner cities, and accordingly bear far more than their share of the consequences in disease and death.¹²⁰ The Canadian HIV/AIDS Legal Network concludes that:

[E]xisting data clearly indicate that Aboriginal people are overrepresented in groups most vulnerable to HIV, such as sex-trade workers and prisoners. In particular, they are overrepresented among inner city injection drug use communities, including those using needle exchange programs and counseling/referral sites. [emphasis added]¹²¹

¹²⁰ For instance, Kerr, *supra* note 6, cites P. Parry’s statistics that fully 17% of new HIV infections are in Aboriginal people, who represent perhaps between 3 and 4% of the general population.

¹²¹ “Injection Drug Use and HIV/AIDS: The Facts” in *Injection Drug Use and HIV/AIDS: Legal and Ethical Issues* (Montreal: Canadian HIV/AIDS Legal Network, 1999), online: Aidslaw Homepage <<http://www.aidslaw.ca/Maincontent/issues/druglaws/c-info-dla1.htm>> (date accessed: 29 June 2001).

While their physical position may be precarious, Aboriginal persons' legal position under the *Charter* might be even stronger than that of other injection-drug users. This is because their claim would not rely upon the characterization of drug addicts as "disabled" to engage section 15's protections. Because race is itself an enumerated ground within section 15, the government's duty following *Eldridge* is to "recognize" the additional burdens faced by Aboriginals and do what is "reasonable" to assist. Could an abnormally high incidence of deadly disease not qualify as an "additional burden" faced by those of Aboriginal ancestry? Isn't the institution of safe injection sites, absent a demonstration of prohibitive cost, a "reasonable" step to ease the particular hardship suffered by Aboriginal injection drug addicts?

Obviously, any such action would have to overcome the natural reluctance of courts to begin mandating government action to redress harms disproportionately felt by Aboriginal peoples, which might lead to lawsuits based on the harms of suicide, alcoholism, high rates of incarceration, domestic violence and even poverty. However, the question of the social wisdom of such programs, and the cost of addressing each "adverse effect" of Aboriginal existence, can in such cases be taken into account in the section 1 inquiry when determining "reasonableness."

In other areas, the governments are already moving to address the special "burdens" faced by Aboriginals, burdens apparent only through review of statistics. In recognition of the high incarceration rates among Aboriginal persons, for instance, the federal government has enacted a section of the *Criminal Code* which requires a sentencing judge to consider all relevant circumstances, including the Aboriginal ancestry of the accused, when determining whether imprisonment is justified in a particular case.¹²² The Supreme Court of Canada, reviewing these provisions in *R. v. Gladue* described the background:

Not surprisingly, the excessive imprisonment of aboriginal people is only the tip of the iceberg insofar as the estrangement of the aboriginal peoples from the Canadian criminal justice system is concerned. Aboriginal people are overrepresented in virtually all aspects of the system. As this Court recently noted in *R. v. Williams*, [1998] 1

¹²² *Criminal Code of Canada*, R.S.C. 1985, c. 47, s. 718.2(e).

S.C.R. 1128, at para. 58, there is widespread bias against aboriginal people within Canada, and “[t]here is evidence that this widespread racism has translated into systemic discrimination in the criminal justice system.”¹²³

Later:

The drastic overrepresentation of Aboriginal peoples within both the Canadian prison population and the criminal justice system reveals a sad and pressing social problem. It is reasonable to assume that Parliament, in singling out Aboriginal offenders for distinct sentencing treatment in s. 718.2(e), intended to attempt to redress this social problem to some degree. The provision may properly be seen as Parliament’s direction to members of the judiciary to inquire into the causes of the problem and to endeavour to remedy it, to the extent that a remedy is possible through the sentencing process.¹²⁴

The Court in *Gladue* declined to address whether such ameliorative sentencing guidelines were permitted by section 15(2) of the *Charter* (or indeed if they were in and of themselves discriminatory under s. 15(1)), but rather left the question tantalizingly open. Nevertheless, Cory and Iacobucci JJ., writing for the Court, emphasized the ameliorative role of the sentencing guidelines:

There is no constitutional challenge to s. 718.2(e) in these proceedings, and accordingly we do not address specifically the applicability of s. 15 of the *Charter*. We would note, though, that the aim of s. 718.2(e) is to reduce the tragic overrepresentation of Aboriginal people in prisons.¹²⁵

The Court has made, therefore, both explicit and implicit recognition of widespread discrimination against Aboriginal peoples in Canada, and has supported its conclusion in this respect mainly from evidence of grossly disproportionate harm suffered by Aboriginal peoples in their interaction with the legal system. It follows, therefore, that a similar disproportionate impact upon Aboriginals involved with (or rather, *not* involved with) British

¹²³ [1999] 1 S.C.R. 688 at para. 61 [hereinafter *Gladue*].

¹²⁴ *Ibid.* at para. 64.

¹²⁵ *Ibid.* at para. 87.

Columbia's health regime might form the basis for a separate and distinct claim to relief under section 15 of the *Charter*.

D. THE SECTION 1 ANALYSIS

If an infringement of section 15 has been found, the question will then turn to whether it can be "demonstrably justified in a free and democratic society" as required by the *Charter*'s 'saving provision', section 1. Traditionally, this question has been analysed through resort to what is called the *Oakes* test,¹²⁶ which is summarized by Iacobucci J. in *Egan v. Canada*:

First, the objective of the legislation must be pressing and substantial. Second, the means chosen to attain this legislative end must be reasonable and demonstrably justifiable in a free and democratic society. In order to satisfy the second requirement, three criteria must be satisfied: (1) the rights violation must be rationally connected to the aim of the legislation; (2) the impugned provision must minimally impair the *Charter* guarantee; and (3) there must be a proportionality between the effect of the measure and its objective so that the attainment of the legislative goal is not outweighed by the abridgement of the right. In all s. 1 cases the burden of proof is with the government to show on a balance of probabilities that the violation is justifiable.¹²⁷

In *Eldridge*, however, the *Oakes* analysis was considerably truncated. La Forest J. held that, even assuming that the rest of the criteria were satisfied, the failure of the government to reasonably accommodate deaf patients could not be described as 'minimal impairment'.

In other words, although La Forest J. was not explicit on this point, the impairment cannot be "minimal" until everything "reasonable" has been done to accommodate the disability. Thus, in cases of indirect discrimination under section 15, the question of "minimal impairment" will be of principal concern.

This approach can be said to interpolate the government's opportunity to justify an infringement of section 15 within the consideration of the infringement itself, and blurs the distinction between the analysis of breach and the question of reasonableness.

¹²⁶ In *R. v. Oakes*, [1986] 1 S.C.R. 103 [hereinafter *Oakes*].

¹²⁷ [1995] 2 S.C.R. 513 at para. 182 [hereinafter *Egan*].

The strongest argument at the section 1 stage may well be that of “illegality.” In other words, the provincial government may claim that it cannot be blamed for failing to act when it could have been in breach of the criminal law if it had. As noted earlier, it is highly questionable whether any operator or staff of an SIF could be said to be “in possession” within the meaning of the *Controlled Drug and Substances Act*. Likewise, a person assisting an injection drug user through a needle exchange or disposal, or by providing medical services, is unlikely to be deemed an “accessory after the fact” to the user’s possession, or otherwise found criminally liable. Importantly, possession and trafficking aside, Parliament has not seen fit to make the *administration* of a controlled substance by an addict an offence. This means that facilitating the safe use of drugs possessed by another might not run afoul of that *Act*, even if it otherwise applied.

Further support for the argument that the criminal law would not be interpreted to interfere with the operation of a government-sponsored safe injection facility can be found in the decision of the New South Wales Supreme Court in *Kings Cross Chamber of Commerce and Tourism Inc v. The Uniting Church of Australia Property Trust (NSW) & ors.*¹²⁸ That case was a challenge to the State’s pilot SIF by various local business interests. At the conclusion of his judgment, Mr. Justice Brian Sully noted that, on the face of it, the legislation passed by the state which permitted the SIF to be established¹²⁹ was difficult to reconcile with the relevant federal laws. While in Australia the criminalization of narcotics is generally a state matter,¹³⁰ the federal *Customs Act*¹³¹ prohibits the possession of any illegally imported substance (as the heroin used in the Sydney SIF would certainly have been). Arguments were advanced that the federal government “occupied the field” and that its law was paramount over the state legislation providing for the establishment of the facility. His Lordship rejected this idea:

¹²⁸ *Supra* note 20.

¹²⁹ *Drug Summit Legislative Response Act 1999* (NSW).

¹³⁰ See e.g. the *Drug Misuse & Trafficking Act 1985* (NSW), which is the relevant New South Wales legislation.

¹³¹ *Customs Act 1901* (Cth).

As to section 109 [federal paramountcy clause] of the *Commonwealth Constitution*, it is sufficient to say that there is in hand no evidence whatsoever to suggest that it was ever within the contemplation of the Commonwealth Parliament that the *Customs Act* should in the requisite constitutional sense cover the field so as to be inconsistent with the proposed operation of a medically supervised injecting centre licensed pursuant to the *Drug Summit Act*. The *Customs Act* is undoubtedly an important piece of public legislation, and it has important public work to do; but that work has no connection with the putting into effect of a precisely and carefully controlled social experiment aimed at alleviating some of the worst consequences of individual addiction to substances such as heroin. [emphasis added]¹³²

It is a similarly persuasive argument that, should the British Columbia government or a health board establish an SIF pursuant to B.C.'s health legislation, such an act would be beyond the constitutional reach of the federal government. Of course, all this presupposes that the federal government would object to such a facility, and there is, at present, no evidence that this will be the case.¹³³

The most important consideration with respect to the effect of criminality and the section 1 analysis is that, under section 56 of the *Controlled Drugs and Substances Act*, the federal Minister of Health can grant exemptions for "medical purposes" or simply because she is of the opinion that to do so is "in the public interest." This is a very important provision because it permits a plaintiff to argue: (a) that the provincial government has not fulfilled its obligation to "reasonably accommodate" until it has at least requested of the federal government that an exemption be granted and (b) that failure or refusal to grant an exemption would in itself be a violation of section 15, and thus beyond the power of the federal Minister of Health in any event. Undoubtedly, if the question of illegality is advanced by the provincial government, the federal Crown should become a party to the action as well; that is, if the plaintiff does not include Canada as a defendant already.

¹³² *Kings Cross*, *supra* note 20 at para. 101.

¹³³ The government of Canada's official position remains that "substance abuse is primarily a health issue" and that "[the] criminal law should be employed to deal only with that conduct for which other means of social control are inadequate or inappropriate, and which interfere with individual rights and freedoms only to the extent necessary for the attainment of its purpose": Kerr, *supra* note 6 at 19. See also Author's Note, *infra*.

The question of “reasonable accommodation” arguably supersedes the other two branches of the *Oakes* test in an indirect discrimination case. Rational connection has little application when it is an administrative failure to act that is being complained of; at least to the extent that acting “unreasonably” could never be said to be rationally connected to the purposes of a statutory regime. Similarly, “proportionality” is also inextricable from “reasonable accommodation.” Could an unreasonable failure ever be a proportional response to a problem? Could a reasonable decision ever be disproportionate?

In the end, in my view, if the failure to provide SIFs is found to be discriminatory, the question of whether their provision is “reasonable” or “unreasonable” accommodation is the only question that will need to be answered at the section 1 stage, and it will likely be analysed, as in *Eldridge*, under the “minimal impairment” branch of *Oakes*.

E. A “QUASI-CONSTITUTIONAL” ARGUMENT

There is one additional way in which the protection of minorities might bear upon the issues discussed here. There is a principle emerging in jurisprudence that certain unwritten constitutional principles such as “Charter values”¹³⁴ – including the protection of minorities – can be used as a guide to statutory interpretation and judicial decisionmaking.

In the case of *Lalonde v. Ontario*,¹³⁵ this principle has been extended to the point where it might also act as a restriction on executive decision making. In the *Lalonde* case, Ontario francophones challenged an executive decision to close the Montfort Hospital, the sole French language hospital in their area.

¹³⁴ For instance, evidence of the robustness of an *indirect* application of constitutional principles can be found in decisions restricting injunctions in private disputes that tended to interfere with constitutional protections. Most recently, in *R.W.D.S.U., Local 558 v. Pepsi-Cola Canada Beverages (West) Ltd.*, [2002] S.C.J. No.7 (S.C.C.), online: QL (SCJ), an injunctive ban on secondary picketing was found to be wrongful. The Court unanimously found that private rights must be balanced against “Charter values,” and activity which enjoyed constitutional protection could not be tortious at common law.

¹³⁵ (December 7, 2001) Docket C33807 (Ont. C.A.) [hereinafter *Lalonde*].

The Ontario Court of Appeal dismissed challenges on the basis that the decision was an unconstitutional violation of section 15 or 16(3) rights of francophones, but upheld the trial court's decision¹³⁶ that the closure was nevertheless inconsistent with the unwritten constitutional protection of minorities.

The Court's decision was nuanced and fascinating. It held that these principles required that the statute, which ostensibly granted the Minister the discretion to act "in the public interest" (the *French Language Services Act*¹³⁷), must be "given a liberal and generous interpretation;" and that the ability of the Minister to limit Montfort's services must be "reasonable and necessary," something the government had not demonstrated. Interpretation of what was "reasonable and necessary" must itself be made with the protection of the francophone minority in mind:

In exercising its discretion as to what is in the public interest, the Commission was required by the fundamental principles of the Constitution to give serious weight and consideration to the importance of Montfort as an institution to the survival of the Franco-Ontarian minority.

Therefore, the Minister's exercise of discretion was held to be *ultra vires* the *Act* (as read in view of the constitutional protections), not strictly unconstitutional *per se*.

Lalonde may be a landmark decision, but it does not stand alone. Indeed, the Ontario Court of Appeal considered its decision in the case to be rooted in the principle expressed in *Roncarelli v. Duplessis*,¹³⁸ where Rand J. stated "there is no such thing as absolute and untrammelled 'discretion'."¹³⁹

In the prior case of *Arsenault-Cameron v. Prince Edward Island*,¹⁴⁰ the Supreme Court struck down a decision of the Minister of Education not to establish a French-language school. The Minister had argued that the school was not warranted because

¹³⁶ (1999), 48 O.R. (3d) 50.

¹³⁷ R.S.O. 1990, c. F. 32.

¹³⁸ [1959] S.C.R. 121 at 140.

¹³⁹ *Lalonde*, *supra* note 135 at para. 171.

¹⁴⁰ [2000] 1 S.C.R. 3.

of an insufficient number of francophone students in the area. In reply, Major and Bastarache JJ. wrote:

The Minister has a duty to exercise his discretion in accordance with the dictates of the *Charter*; see *Operation Dismantle Inc. v. The Queen*, [1985] 1 S.C.R. 441; *Slaight Communications Inc. v. Davidson*, [1989] 1 S.C.R. 1038. In reaching his decision, the Minister failed to give proper weight to the promotion and preservation of minority language culture and to the role of the French Language Board in balancing the pedagogical and cultural considerations. This was essential to giving full regard to the remedial purpose of the right. The approach adopted by the Minister therefore increased the probability that his decision would fail to satisfy constitutional review by the courts.¹⁴¹

If a similar challenge was brought on behalf of injection drug users, the argument would proceed by way of petition pursuant to the *Judicial Review Procedures Act*.¹⁴² First, a decision by the government not to fund SIFs must be identified or created through an application for funding that is rebuffed (if no such decision is positively made but rather no reply is made, an argument must be made that this itself constitutes a reviewable decision). At the judicial review, the petitioners would make the argument that the Minister's exercise of his or her discretion in failing to provide the SIF services pursuant to the *Health Act* is unreasonable in that it is inconsistent with the mandate contained in the unwritten constitutional principle of the protection of minorities. To tie it in with the language of that *Act* (discussed in depth *supra* section III.A.), the requirement that the Minister act to make "intelligent and profitable use" of public health evidence must be read in context with a duty to protect minorities. If recent jurisprudence is any indication, the inquiry in such a case would be broad and purposive.

V. 'POLICY' AND 'REASONABLENESS'

There is, as is now apparent, an important question that requires attention as to whether a court would apply a negligence analysis, a

¹⁴¹ *Ibid.* at 27.

¹⁴² R.S.B.C. 1996, c. 241.

Charter review or a quasi-constitutional argument to restrict discretion. That is, do safe injection facilities do more harm than good?

Recall that, under the two part-test from *Anns* and *Kamloops* discussed earlier, once a duty has been established through the operation of statute and foreseeability, the question turns to whether there is any policy reason for limiting the scope of the duty, determining the standard of care or limiting recovery. Similarly, under the *Charter*, a plaintiff is expected to show that his disability or burden could have been “reasonably accommodated” by the government through the provision of SIFs. Reasonableness also informs the questions of interpretation and discretion discussed under the rubric of “quasi-constitutional” arguments.

In any case, a successful plaintiff must be able to overcome arguments that SIFs, on balance, would have a negative impact on society overall and would thus be “unreasonable.” It may be alleged, for instance, that such facilities encourage drug use through state condonation and reduction of risk; that they concentrate and perhaps exacerbate criminal activity such as property crime and violence; and that they contribute to various public nuisances such as prostitution, open drug dealing, discarded needles and so on. Such nuisance arguments made by governments may have a powerful impact on courts’ analysis of “reasonableness.”¹⁴³

The burden is also on the plaintiff in a negligence action to demonstrate that there is no valid ‘policy’ objection.¹⁴⁴ Similarly, while the state ostensibly bears the burden of justification under section 1 of the *Charter*, this has often proven a relatively simple one to meet, and occasionally no evidence from the Crown on this

¹⁴³ The Supreme Court of Canada, while recognizing that criminal prohibition of public soliciting for the purposes of prostitution constituted an infringement of the *Charter* right to free expression, held it to be “reasonable,” principally in light of the nuisance associated with the crime: *Reference Re ss. 193 and 195.1(1)(c) of the Criminal Code*, [1990] 1 S.C.R. 1123.

¹⁴⁴ Undoubtedly under the test in *Kamloops*, *supra* note 36, and *Brown*, *supra* note 49, the burden is on the plaintiff to overcome the “pure policy” defense with an allegation that the inaction complained of was an unreasonable exercise of policy discretion.

point is required.¹⁴⁵ When one considers the courts' inherent reluctance to impose their will on the legislative or executive branches with respect to broad questions of public policy, it might be said that the burden is in fact upon the plaintiff, and is a heavy one indeed.

In a review of the literature produced to date on SIFs, there is nothing to suggest that such facilities in Europe or Australia have increased or exacerbated drug use, crime or nuisance. Indeed, the material appears to suggest otherwise.¹⁴⁶ However, this observation must come with two important caveats: first, much of the English-language literature on the topic is produced and distributed by activists in order to generate support for SIFs and other harm-reduction measures; and second, as already noted, European SIFs have been implemented as only one part of a broader, enlightened harm-reduction strategy. It is therefore difficult to conclude from these reports that safe injection facilities, on their own, would be as harmless and beneficial here as they might appear to be in Europe.¹⁴⁷ However, the decisions of various

¹⁴⁵ The majority in *R. v. Jones*, [1986] 2 S.C.R. 284, in effect took judicial notice of the satisfaction of the *Oakes* criteria, and even the minority, which did engage in the *Oakes* exercise, held that "a court must be taken to have a general knowledge of our history and values and to know at least the broad design and workings of our society." Similarly, in *Gray v. R.* (1989), 44 C.C.C. (3d) 222 (C.A.), the Manitoba Court of Appeal found that in its section 1 analysis, "it is undesirable to proceed on the basis of evidence." The court was happier with undertaking its section 1 analysis on the basis of "common sense."

¹⁴⁶ See for instance Dolan et al., *supra* note 18; Coffin et al., *supra* note 24; Fife, *supra* note 30, notes that fears expressed by critics before the opening of the Sydney SIF had not been manifest:

The trial, an initiative of the 1999 New South Wales Drug Summit, was fiercely opposed by the Kings Cross Chamber of Commerce, a group of businesses and residents who believed it would be a "honey-pot," attracting more drug users to the area...

Police had reported no additional drug activity in the area and the centre had not attracted drug users from other areas to Kings Cross, said Dr Van Beek.

Prior to the establishment of the SIF, one local business had gone so far as to spread spoilt yoghurt on the pavement outside its store to discourage addicts from lying there. The shop planned to abandon the practice once the SIF was open: E. Duff, "Heroin War - First Shots Fired" *The Sun Herald* (April 8 2001), online: <<http://www.smh.com.au/news/>> (date accessed: 26 July 2001).

¹⁴⁷ While this argument is susceptible to the retort that, if SIFs alone are insufficient then perhaps a broader program on the European model is legally required, one ought to keep in mind that the more expensive the proposed program, the less likely is it to be

Australian states, noted earlier, to proceed with SIF programs – decisions made after extensive review of the European experience – provide some weight against an argument that they cause disproportionate harm.

Needless to say, such a cost/benefit analysis is a difficult factual question, the resolution of which is beyond the scope of this paper, yet critical to the successful resolution of a case against the government. Answering it will require expert evidence and perhaps the testimony of European officials. Due to Australia's cultural and legal similarities with Canada, it might also be expected that the mounting evidence from the embryonic Sydney program may prove extremely persuasive. It is of further assistance that Canadian studies, which have looked at the question of fiscal impact, either broadly or narrowly, have endorsed SIFs as a cost-saving, as well as life-saving measure.¹⁴⁸ In an accompanying commentary, two of the studies' authors concluded that:

Safe injection facilities serve a unique and important function, particularly in terms of providing immediate response to overdoses, increasing use of health and social services, and reducing the problems described earlier that are associated with injecting drugs in public.¹⁴⁹

VI. WHAT REMEDY?

There are at least three methods for seeking the redress that are mooted in this article. The first would be an individual lawsuit by a drug addict who has contracted a communicable disease as a result of needle sharing practices in the absence of safe injection facilities, or perhaps by the estate of a person who has died of an overdose that might have been prevented had the SIFs been

considered a "reasonable" requirement under *Eldridge*, *supra* note 85, or *Auton* #2, *supra* note 113. There is, therefore, substantial appeal for a *Charter* applicant (and probably also for a plaintiff in negligence) in keeping the analysis focused on safe injection facilities alone, if the available evidence bears out the cost-benefit analysis.

¹⁴⁸ E. Wood et al., "Unsafe injection practices in a cohort of injection drug users in Vancouver: Could safer injecting rooms help?" (2001) 165(4) CMAJ 405; A. Palepu et al., "Hospital utilization and costs in a cohort of injection drug users" (2001) 165(4) CMAJ 415.

¹⁴⁹ T. Kerr & A. Palepu, "Safe injection facilities in Canada: Is it time?" (2001) 165(4) CMAJ 436 at 437.

available. The second type of action would be a class action under B.C.'s *Class Proceeding Act*,¹⁵⁰ brought on behalf of groups of persons who have suffered such harm. The third would be an application for review of an executive decision under the *Judicial Review Procedure Act*.¹⁵¹

In a lawsuit, the plaintiff or class representative plaintiff could seek damages for injuries sustained, or they could seek a declaratory decision compelling the government to implement a safe injection program, or both. In either type of action, the latter remedy could be equitable or constitutional. In the case of a petition for judicial review, the relief sought would be an order declaratory of the parties' rights and remittance.¹⁵²

A. COMMON LAW, EQUITABLE AND STATUTORY REMEDIES

In an individual action or class proceeding by persons who have contracted disease in the absence of safe injection facilities, the principal claim would most likely be one for damages. If a class action is certified with sufficiently broad-defined class definitions, the aggregate amount could be staggering, as will be discussed in Part VII below.

It would also be open to the plaintiffs to argue that equitable principles demand that the government be ordered, by mandatory injunction, to provide the absent services. Likely though, such an order would be unnecessary, as a finding of negligence, even in an individual action, would almost certainly lead to government action to head off further claims. On the other hand, absent a constitutional element to the judicial decision, the government response could be to pass legislation barring any further claims and possibly defeating those already underway.¹⁵³

¹⁵⁰ R.S.B.C. 1996, c. 50.

¹⁵¹ R.S.B.C. 1996, c. 242.

¹⁵² The *Judicial Review Procedure Act* is subject to the *Crown Proceeding Act*, R.S.B.C. 1996, c. 89, s. 11(2) of which specifically disallows mandatory orders to issue against the Crown. In their place, the court may declare the rights of the parties, and remit to the decision making government body for reconsideration.

¹⁵³ In Saskatchewan, the *Agricultural Safety Net Act*, S.S. 1990-91, c. A-14.2 as amended by S.S. 1992, c. 51, effectively defeated certain persons' rights to enforce claims for breach of contract, and extinguished claims that were even then before the courts. It was upheld as constitutional (not offending the rule of law) by the Saskatchewan Court

There is considerable question about the extent to which the Crown itself is immune to mandatory orders of a court. The traditional rule is that *mandamus* cannot lie against the Crown, with a modern exception possibly existing when it is required as a constitutional remedy.¹⁵⁴ The rule, however, does not extend to immunize designated Crown officials who are legally required to perform the duty ordered.¹⁵⁵ Therefore plaintiffs in an SIF suit would be well advised to include as defendants those individual persons whom they believe ought to be compelled to act. This would likely include both the provincial and federal Ministers of Health, because, as discussed earlier, the decision to allow SIFs may be made by them pursuant to the provincial *Health Act* and the federal *Controlled Drug and Substances Act*. Failure to name individual defendants may be fatal to a mandatory remedy at common law,¹⁵⁶ although a declaratory judgment could be made in its place.¹⁵⁷ As discussed earlier, it would appear that the only remedy available through the *Judicial Review Procedure Act* would be a judgment declaratory of the parties' rights.¹⁵⁸

The ability of the government to legislate away a common law suit represents a very serious concern for potential litigants of large-scale claims. In such circumstances, the political environment may eventually determine the outcome of the suit. While it might have been politically untenable to pass legislation denying recovery to recipients of innocent tainted blood infusions or victims of eugenic sterilization,¹⁵⁹ the same might not be true

of Appeal in *Bacon v. Saskatchewan Crop Insurance Corp.*, [1999] 11 W.W.R. 51, S.J. No. 302 (QL) (Sask. C.A.).

¹⁵⁴ *Air Canada v. British Columbia (A.-G.)* (1986), 32 D.L.R. (4th) 1 (S.C.C.).

¹⁵⁵ See for example *Johns-Manville Canada Inc. v. Newfoundland* (1985), 51 Nfld. & P.E.I.R. 338 (Nfld. S.C.).

¹⁵⁶ *Newfoundland Assn. of Provincial Court Judges v. Newfoundland* (2000), 191 D.L.R. (4th) 225, [2000] N.J. No. 258 at paras. 219-31 (Nfld. C.A.), online: QL (NJ).

¹⁵⁷ *Crown Proceeding Act*, *supra* note 152, s. 11(2)(b).

¹⁵⁸ See discussion in note 152, above.

¹⁵⁹ In 1998 the Alberta government introduced a bill which would have prevented 703 victims of involuntary sterilization in the 1950's and 60's from suing for compensation, while invoking the *Charter's* 'notwithstanding clause' to escape constitutional challenge. As a result of the ensuing public outcry, the decision was retracted within twenty four hours of its announcement: Bill 26, *Institutional Confinement and Sexual*

with respect to the users of illegal drugs, who enjoy growing, but still far from complete, public sympathy.¹⁶⁰

B. CONSTITUTIONAL REMEDIES

Section 24(1) of the *Charter* provides as follows:

S. 24(1) Anyone whose rights or freedoms, as guaranteed by this Charter, have been infringed or denied may apply to a court of competent jurisdiction to obtain such remedy as the court considers appropriate and just in the circumstances.

In applying section 24(1), the Courts will exercise a wide discretion to fashion remedies that are both just and appropriate to the particular violation.¹⁶¹ However, the delicate constitutional relationship between the judiciary and the legislature means that the courts “should be loath ... to detail what legislation the Government...must enact in order to meet its constitutional obligations.”¹⁶²

Similarly, courts are traditionally “loath” to order the government to spend money to address inequality. Nevertheless, if availability of funds is to be made an issue with respect to which remedies are appropriate, the courts will expect the government to demonstrate through evidence the difficulty in affording the solution proposed by the plaintiffs. LaForest J. for the Court held in *Eldridge* that:

The respondents have presented no evidence that this type of accommodation, if extended to other government services, will unduly strain the fiscal resources of the state. To deny the appellants’ claim on such conjectural grounds, in my view, would denude s. 15(1) of its

Sterilization Compensation Act, Havelock: First Reading — 775 (*Mar. 10 aft.*); Ministerial Statement — 812-13 (*Mar. 11 aft.*); Bill will not be proceeded with, online: Alberta Assembly Homepage <<http://www.assembly.ab.ca/pro/bills/s-bill98.htm>>.

¹⁶⁰ F. Bula, “Safe-injection sites near reality in Vancouver” *The Vancouver Sun* (18 June 2001) B1.

¹⁶¹ See *Perera v. Canada (A.G.)*, [1998] 3 F.C. 381 (F.C.A.); *Dixon v. British Columbia (A.-G.)* (1989), 35 B.C.L.R. (2d) 273 at 307-8 (B.C.S.C.); *Osborne v. Canada (Treasury Board)*, [1991] 2 S.C.R. 69.

¹⁶² *Reference Re Public Schools Act (Man.)*, [1993] 1 S.C.R. 839 at 860. See also *Mahe v. Alberta*, [1990] 1 S.C.R. 342.

egalitarian promise and render the disabled's goal of a barrier-free society distressingly remote.¹⁶³

A similar evidentiary failure was made by the B.C. Supreme Court in *Auton #2*, where Allan J. took notice of the apparent lack of post-*Eldridge* crisis to brush aside the government's 'floodgates' argument as similarly "conjunctural."¹⁶⁴

Of course, in the case of safe injection facilities, any economic argument the government would advance would be undermined by the apparent consensus among experts that such sites may be far more cost-effective than treatment of the diseases and overdoses that result in their absence.¹⁶⁵

In a subsequent decision of the *Auton* case, *Auton (Guardian ad Litem) v. A.-G. (British Columbia)*¹⁶⁶ ("*Auton #3*"), Madam Justice Allan, having found in *Auton #2* that a treatment program for autistic children was a constitutional requirement, accepted the Crown's submission that such a program was being implemented, and that it would meet the government's constitutional obligations. However, she also retained for the Court a "limited supervisory role," and granted the petitioners leave to return for a mandatory order if the program was not set up in a timely manner. As noted above, though, the question as to what extent mandatory orders may be made against the Crown remains uncertain.¹⁶⁷

¹⁶³ *Eldridge*, *supra* note 85 at para. 92.

¹⁶⁴ *Auton #2*, *supra* note 113 at para. 150: "As it turns out, accommodation for the deaf has been made without catastrophic results to the health care system."

¹⁶⁵ It has been estimated that the cost to government in Ontario of a single untreated opiate user is as high as \$33,761 (\$29,164 for law enforcement and \$4,597 for health care): *Kerr*, *supra* note 6, citing J.S. Millar, *HIV, Hepatitis, and Injection Drug Use in British Columbia – Pay Now or Pay Later?* (Victoria: Office of the Provincial Health Officer, 1998). *Kerr* also cites statistics that the costs in B.C. are the highest in Canada, in excess of \$207 million per year. According to UBC health economist Robin Hanvelt, if an injection drug user contracts HIV, the provincial government can expect to spend \$134, 559 for lifetime treatment; lost productivity will approach half a million dollars: *Kerr*, *supra* note 9 at 16, citing R. Hanvelt et al., "The economic costs and resource impacts of HIV/AIDS in British Columbia" *NHRDP Project No. 6610-2372-AIDS* (Ottawa: Health Canada, 1999).

¹⁶⁶ (2001), 84 B.C.L.R. (3rd) 259 (C.A.).

¹⁶⁷ That such an order can be made in a constitutional case was confirmed in *Manitoba Provincial Judges' Assn. v. Manitoba*, [1997] 3 S.C.R. 3, though without any discussion as to the full scope of the remedy.

There is also plenty of scope within section 24(1) for an award of damages for the constitutional violation. In *Krznic v. Chevrette*,¹⁶⁸ the Court awarded \$5,000 for loss of opportunity to work and \$7,773 for pecuniary loss to a police officer whose employer had failed to accommodate his disability contrary to section 15. Pardu J. stated:

The duty to accommodate the needs of disabled persons promotes the independence, and individual self-worth of vulnerable persons. Whether the infringement of the right is committed maliciously or merely negligently may make little difference to the victim.¹⁶⁹ In my view, the Plaintiff in this case should be fully compensated for his financial loss.

In *Auton #3*, damages were similarly awarded to the petitioners.

One final advantage of the constitutional remedy ought to be mentioned here. It has been noted that a defendant government might invoke the criminal law with respect to possession or paraphernalia to attempt to escape liability in a negligence action. Success on a constitutional ground, however, would make such objections moot. To the extent that the criminal law (or any other law for that matter) prevents the government from doing what it is constitutionally required to do by section 15, those laws too are unconstitutional¹⁷⁰ or, at the very least, must be “read down” (interpreted in such a way to preserve the equality rights of injection drug users). Because criminal narcotics laws are federal, constitutional remedy would have to be sought in such a case against both levels of government.

C. A CLASS ACTION?

Although a petition for judicial review promises to be the speediest and most cost-effective way of bringing these issues before the courts, there are substantial arguments in favour of launching a lawsuit on a class, rather than individual, basis. Significant to

¹⁶⁸ (1997), 154 D.L.R. (4th) 527 (Ont.Gen.Div.).

¹⁶⁹ *Ibid.* at 550.

¹⁷⁰ Section 52(1) of the *Constitution Act, 1982*, being Schedule B to the *Canada Act* (U.K.), 1982, c.11 [hereinafter *Constitution Act, 1982*] states that “any law that is inconsistent with the provisions of the Constitution [including, by virtue of s. 52(2)(a), the *Charter*] is, to the extent of the inconsistency, of no force or effect.”

potential plaintiffs (who in the case of injection drug users are likely to be impecunious) is the question of expense: representative plaintiffs in class actions are in most circumstances not liable for costs if the action is unsuccessful,¹⁷¹ and class action suits are generally taken by lawyers on a contingency fee basis.

Also, in British Columbia, the class representative need not be a member of the class.¹⁷² This would allow activists to launch the action on behalf of injection drug users who are themselves unwilling or unable to come forward or to devote the sustained energy required for the conduct of a suit over a period of years. Moreover, subclasses can be established for groups whose members have suffered particular types of harm, even as the litigation progresses.¹⁷³

A further advantage is that the potential for a large damage award is multiplied by the numbers within the class. There are currently said to be 12,000 injection drug users in the Lower Mainland area.¹⁷⁴ Applying the epidemiological statistics discussed earlier in this article,¹⁷⁵ a potential class of persons who, for instance, have contracted either HIV or hepatitis C (and might have benefited from SIFs) may number over 10,000.¹⁷⁶ These are roughly the same number of Canadians who were allegedly infected as a result of the errors in blood donor screening by the Canadian Red Cross and both levels of government from 1985 to 1995, which was the subject of the Krever Inquiry, a class action

¹⁷¹ *Class Proceeding Act*, R.S.B.C. 1996, c. 50, s. 37.

¹⁷² The class representative normally must be a member of the class, unless it is necessary to allow a substitute in order "to avoid a substantial injustice to the class": *Class Proceeding Act*, *ibid.* at s. 2(1).

¹⁷³ Provided that there is at least one qualified class upon certification: *Peppiatt v. Royal Bank of Canada* (1993), 16 O.R. (3d) 133 (Ont. Gen. Div.) [hereinafter *Peppiatt*].

¹⁷⁴ Precise statistics on the number of users are not available. The most reliable estimates appear to be around 12,000 users in the Lower Mainland, with some 4700 in the Downtown Eastside: M.E. McLean, *Vancouver Drug Use Epidemiology – 2001: Vancouver and B.C. Site report for the Canadian Community Epidemiology Network on Drug Use* (January 2002), online: <<http://www.ccsa.ca/ccendu/Reports/2001Vancouver>>; see also Health Canada, *Consortium to characterize injection drug users in Canada (Montreal, Toronto and Vancouver) – final report*. (Ottawa: Health Canada, 1998).

¹⁷⁵ See *supra* note 7 through 10 and accompanying text.

¹⁷⁶ Extrapolated from the 1/3 rate of HIV infection as noted, *supra* note 10, and the 88% figure for Hepatitis as noted, *supra* note 12.

lawsuit that resulted in a settlement of approximately \$1.5 billion dollars.¹⁷⁷ While one might not responsibly draw a *direct* comparison between the two cases, it is possible to envision recovery that might be substantial indeed.

In order to certify a class proceeding in British Columbia, the Court must be convinced there are “common but not necessarily identical issues of fact” or “common but not necessarily identical issues of law that arise from common but not necessarily identical facts.”¹⁷⁸ This standard is far more relaxed than the U.S. requirement, which requires that the common issues “predominate,”¹⁷⁹ and has made ‘mass tort’ class actions far easier in British Columbia than in most American jurisdictions. In fact, in B.C., even a single issue common to the class which will advance the proceedings can trigger certification, providing that a class proceeding is seen to be “preferable.”¹⁸⁰ In other words, the action can be certified to determine whether the government has met the standard of care expected of it, leaving individualistic issues of duty, causation and damages to a series of subsequent trials if global settlement is not achieved.¹⁸¹

¹⁷⁷ The terms of the settlement and the reasons for approval are described in the decisions of Smith J. in *Endean v. Canadian Red Cross Society* (1999), 68 B.C.L.R. (3d) 350, [2000] 1 W.W.R. 688 (B.C.S.C.) [hereinafter *Endean*] and the decision of Winkler J. in *Parsons v. Canadian Red Cross Society*, [1999] O.J. No. 3572 (S.C.), online: QL (OJ) [hereinafter *Parsons*]. See also the decision of Morneau J. in *Honhon c. Canada (Procureur général)*, [1999] J.Q. No. 4370 (S.C.), online: QL (JQ). The Defendants established a “fund” of about \$1.5 billion to settle all three actions, with the proviso that any subsequent individual judgments from individual plaintiffs who had ‘opted-out’ would be deducted from the fund, thus providing a single, global, ‘cap’ on damages. Winkler J. required that this provision be altered, so that any deduction made from the fund for the damages awarded to the opt-out plaintiff would be no greater than that to which the opt-out plaintiff would have been entitled had he or she remained a member of the class, and thus that the defendants were still liable to ‘top up’ the settlement amount to match the individual damage awards. This aspect of the decision was also endorsed by Smith J. in *Endean*.

¹⁷⁸ *Class Proceeding Act*, *supra* note 171, s. 1.

¹⁷⁹ *Endean v. Canadian Red Cross Society* (1997), 148 D.L.R.(4th) 158 (B.C.S.C.) at 167.

¹⁸⁰ *Harrington v. Dow Corning Corporation* (1996), 22 B.C.L.R. (3d) 97 at 105, 110 (S.C.).

¹⁸¹ The recent Supreme Court of Canada approval of certification of the question of liability for sexual abuse at the Jericho School for the Deaf, with allegations of negligence spanning decades, is perhaps the broadest application yet of class proceedings to allegations of governmental wrongdoing: *Rumley v. British Columbia* (2001), 205 D.L.R. (4th) 39 (S.C.C.).

The advantages of proceeding on this basis are obvious; a plaintiff could relatively quickly proceed to trial on the issue of liability without having to amass the necessarily difficult individualistic evidence with respect to damages. Pressure on the defendant to reach a global settlement would increase exponentially if and when the common issue or issues are resolved in the class's favour. Moreover, a *de facto* mandatory global settlement might be imposed by the courts, as it was at the close of the 'tainted blood' litigation.¹⁸²

There are, however, some difficulties in proceeding on a class basis when the relief sought is principally declaratory or equitable. It was suggested in *Guimond v. Quebec*, for instance, that combining an action for damages under s. 24(1) of the *Charter* with a declaratory action for invalidity under section 52 of the *Constitution Act*, unless the "facts . . . warrant a departure from the general rule."¹⁸³ However, here, there is no attack on the validity of any statute, thus no section 52 remedy is sought, and it would appear that Courts are not averse to awarding both section 24 remedies and damages for negligence concurrently.¹⁸⁴

There is also a possible objection, as expressed by Gonthier J. in *Guimond* (albeit in *obiter*), that it is "generally undesirable" to pursue a class action when the relief sought is declaratory. However, British Columbia courts have shown themselves more concerned with the availability of alternatives to class proceedings than to whether a procedure is simply "preferable," and have not precluded class certification in constitutional cases.¹⁸⁵ The main difficulty with launching an individual action with respect to SIFs is that plaintiffs' counsel might be reluctant to undertake such a complex and risky action if substantial recovery is not possible.

¹⁸² *Supra* note 145 and accompanying text.

¹⁸³ [1996] 3 S.C.R. 347 at para. 19 [hereinafter *Guimond*].

¹⁸⁴ In *Jane Doe v. Metropolitan Toronto (Municipality) Commissioners of Police* (1998), 160 D.L.R. (4th) 697 (Ont. Gen. Div.), the Court stated that the plaintiff was entitled to one award of damages to compensate her and not to additional damages arising out of the *Charter* breach, but implied that, were it not for her ability to recover damages for the defendants' negligence, she could have properly been compensated for the breach of her *Charter* rights under s. 24.

¹⁸⁵ See e.g. *Nanaimo Immigrant Settlement Society v. British Columbia* (2001), 84 B.C.L.R. (3d) 208 (C.A.), distinguishing *Guimond*, *supra* note 182.

Since enhancing access to the courts is one of the accepted purposes of class proceedings, arguing the class proceeding as the only practicable avenue of relief ought to provide persuasive support for certification under what is sometimes called the “access to justice” rationale, as enunciated in *Abdool v. Anaheim Management Ltd.*¹⁸⁶

VII. CONCLUSION

The argument that the governments’ inaction with respect to safe injection facilities constitutes actionable negligence, while persuasive and intrinsically appealing, would be a difficult case to make. However, the incorporation of a constitutional or quasi-constitutional claim, either within the context of the same lawsuit or through direct petition to the courts relying entirely on the *Charter* or *Judicial Review Procedure Act*, might substantially increase the chances of success. In either case, it will have to be demonstrated that safe injection facilities in British Columbia would indeed be as effective here as they appear to be in Europe, and that there would be no unreasonable cost to society, either fiscally or socially, if they were implemented here.

Because even a constitutional challenge could be effectively defeated through recourse to the *Charter*’s notwithstanding clause, no lawsuit of this type could prevail in a political vacuum. In the end, the success of a litigative strategy depends to some degree on the tolerance of the community at large and at least a limited consensus that injection drug use, and its attendant hazards, are principally a health problem, not a moral or criminal one.

Nevertheless, as seminal decisions such as *Edwards v. Canada*,¹⁸⁷ *Brown v. Board of Education*,¹⁸⁸ and *Vriend v. Alberta*¹⁸⁹ make clear, litigation can play an important role in

¹⁸⁶ (1995), 121 D.L.R. (4th) 496 (Ont. Gen. Div.).

¹⁸⁷ [1930] A.C. 124 (H.L.): establishing that women were presumed to be “persons” for the purposes of statutory interpretation, and more particularly were allowed to hold a seat in the Canadian Senate.

¹⁸⁸ 347 U.S. 483 (1954): which triggered the end of racial segregation in Southern U.S. schools.

¹⁸⁹ [1998] 1 S.C.R. 493: mandating (through ‘reading in’) inclusion of protection for homosexuals in Alberta’s human rights legislation.

advancing changes in social policy, and courts are occasionally willing to be 'ahead of their time' on important questions of equality and justice. Time will tell whether the courts will be part of a similar social epiphany on the question of injection drug use and the wisdom of harm reduction.

At the very least, it might be hoped that governments and official bodies will take a hard look at their duties to injection drug users, both legal and moral, and take appropriate steps to fulfill their obligations to this group of uniquely and terribly vulnerable persons.

AUTHOR'S NOTE

This article was initially written in the summer of 2001 and early drafts were circulated for comment and criticism among some Vancouver-area interested lawyers, activists and government officials. In the intervening time, I have been informed of several important developments at the government level on the issue of Safe Injection Facilities that provide some promise that change in Vancouver may be imminent.

Perhaps most significantly, news from the pilot facility in Sydney, Australia, continues to be very encouraging. In a 6-month progress report issued jointly by University of New South Wales researchers and the NSW Attorney-General's Office in January, 2002,¹⁹⁰ the authors noted that the facility had supervised 11,237 safe visits by injection drug users, with a large number of clients also taking advantage of clean needle dispensing, treatment programs or other medical care. Eighty-seven overdoses were treated on-site, with only two of the overdose victims requiring further observation in a hospital. The study concludes:

All opioid overdoses were managed with no adverse sequelae. The opportunity to provide immediate intervention allowed the majority of these overdoses to be managed with oxygen alone. This is consistent with the experience in European supervised injecting centres...¹⁹¹

In late 2001, Vancouver's Mayor Philip Owen (to his credit an outspoken advocate of harm reduction strategies including SIFs) set out aggressive plans for the drug problem in the Downtown Eastside, including the establishment of a resource centre for the area's injection drug-using population.¹⁹² Around the same time, in November 2001, Health Minister Allan Rock announced that the Federal Government will "do everything we can to facilitate [pilot SIFs] in cities across the country if those cities decide this is part

¹⁹⁰ J. Kaldor et al., *Six Month Progress Report on the Medically-Supervised Injection Centre (MSIC)* (Sydney: University of New South Wales, 2002).

¹⁹¹ *Ibid.* at 10.

¹⁹² The strategy foresees the creation of SIFs and is based on the City's policy paper: *A Framework for Action: A Four-Pillar Approach to Drug Problems in Vancouver* by D. MacPherson (Vancouver: City of Vancouver, April 24, 2001), online: <http://www.drugpolicy.org/library/pdf_files/frameworkforaction.pdf> (date accessed: 1 February 2002).

of the strategy that they want.” Significantly, Minister Rock referred to injection drug addiction as “an issue of people who are ill,” and not an appropriate subject for the criminal law.¹⁹³ It would therefore appear that provincial acquiescence and appropriate funding remain the last barriers to the institution of a pilot SIF in Vancouver.

In December of 2001, a Vancouver church group announced its willingness to establish an SIF in Vancouver without government approval. Rev. Ruth Wright is quoted as saying: “We don’t particularly want to break the law, but we can’t afford -- in terms of human life -- to see this stalled much longer...safe-injection sites are the next step, and we need them as quickly as possible.”¹⁹⁴

- CEJ.

¹⁹³ “Safe Injection Site a Go if B.C. Wants It” *The Vancouver Sun* (15 November 2001) A1.

¹⁹⁴ P.T. Chattaway & M. Johnstone, “Grappling with Drug Use” (2002), online: <<http://www.canadianchristianity.com/cgi-bin/bc.cgi?bc/bccn/0102/grappling>> (date accessed: 1 February 2002); see also “Church Threatens to Open Injection Site” *The Vancouver Sun* (1 December 2001) B1.