



CENTRE ON
DRUG POLICY
EVALUATION

List of Issues Prior to Reporting in Canada: Submission to the United Nations Human Rights Committee

Violations of Articles 1, 2, 6, 7, 9, 10, 17, and 26 of the *International Covenant on Civil and Political Rights*

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INTRODUCTION

1. In advance of the adoption of the List of Issues Prior to Reporting for Canada's periodic review under the *International Covenant on Civil and Political Rights* ("ICCPR"), to be held during the 132nd session (28 June to 23 July 2021), the HIV Legal Network and the Centre on Drug Policy Evaluation (CDPE) would like to provide information to the United Nations (UN) Human Rights Committee on violations of Articles 1, 2, 6, 7, 9, 10, 17, and 26 of the ICCPR with respect to the human rights of people who use drugs.
2. The [HIV Legal Network](#) (formerly the Canadian HIV/AIDS Legal Network) promotes the human rights of people living with, at risk of, or affected by HIV or AIDS, in Canada and internationally, through research and analysis, litigation and other advocacy, public education, and community mobilization. Since the HIV Legal Network's inception, the organization has advocated for drug policies that respect, protect, and fulfill the human rights of people who use drugs, including those who are in prison.
3. The [Centre on Drug Policy Evaluation \(CDPE\)](#) works collaboratively with governments, affected communities, and civil society to improve community health and safety by conducting research and outreach on effective and evidence-based policy responses to substance use. Founded in Vancouver, Canada in 2010 as the International Centre for Science in Drug Policy (ICS DP), the CDPE is now housed within the Li Ka Shing Knowledge Institute at St. Michael's Hospital, a site of Unity Health Toronto, in Toronto, Canada.
4. We are grateful to the UN Human Rights Committee for the opportunity to make this submission focusing on human rights violations against people who use drugs in Canada.

CRIMINALIZING PEOPLE WHO USE DRUGS

Violations of Articles 1, 2, 6, 9, and 26

5. In Canada, "controlled substances" are governed by the federal [Controlled Drugs and Substances Act \(CDSA\)](#), which applies across the country. Under section 4(1) of the CDSA, unauthorized possession of a controlled substance for personal use (or "simple drug possession") is a criminal offence. The penalty for contravening this provision depends on the substance and how it is "scheduled" and can range from a fine to a maximum 7-year sentence.¹
6. "Trafficking" is defined to include any act of selling, administering, giving, transferring, transporting, sending, or delivering of a controlled substance — or offering to do any of these things — unless authorized by a regulation, whether for a profit or for free. The maximum penalty upon conviction for trafficking, or possession for the purpose of trafficking, is life in prison. Importing, exporting, and production of controlled substances are also criminal offences, and trafficking, importing, exporting, or production in certain circumstances are subject to a mandatory minimum prison sentence.

¹ For example, Schedule I includes opioids, cocaine and other coca derivatives, amphetamines, and various other synthetic drugs, Schedule II includes various synthetic cannabinoids, Schedule III includes stimulants, sedatives, and psychedelics, and Schedule IV includes barbiturates, benzodiazepines, steroids, and the psychedelic salvia.

7. While most substance use in Canada is not problematic (and national surveillance indicates there is far higher prevalence of dependence on alcohol, for which production and sale are regulated rather than criminalized²), it is nonetheless an offence to possess controlled substances for personal use or to sell and share controlled substances in limited quantities. In the latter case, the burden of harsher enforcement (and its associated mandatory minimum sentences) falls most heavily on those with drug dependency, particularly those who may engage in small-scale dealing to support their own drug use.³
8. Since 1998, police-reported drug offences have increased,⁴ related in part to increased efforts to crack down on perceived drug crime. For the period 2014 to 2019, police in Canada made more than 540,000 arrests for drug offences, of which 69% were for simple drug possession.⁵ Not only does criminalization lead to the loss of liberty associated with incarceration, but it perpetuates discrimination and exclusion, limits employment and housing opportunities, affects child custody, and restricts travel — constituting **deprivations of the rights to self-determination (Article 1), liberty and security of the person, and freedom from arbitrary arrest and detention (Article 9)**.
9. Punitive drug laws and policies have also fueled deadly stigma and epidemics of preventable illness and death, contributing both to significantly higher rates of HIV and hepatitis C among people who inject drugs in Canada than among the population as a whole⁶ and to an overdose crisis that has resulted in almost 20,000 overdose deaths between January 2016 and September 2020,⁷ with Indigenous Peoples particularly affected.⁸ While the toxic drug supply is largely responsible for these dire numbers, the unregulated market is driven by Canada's long-standing policy of criminalizing drugs and the people who use them. This punitive approach pushes some people to use their drugs in isolation, compromising their ability to take vital safety precautions and deterring people from essential health care and social supports, **depriving people who use drugs of their right to life (Article 6)**.
10. In particular, the criminalization of personal possession and trafficking has hampered the scale-up and operation of supervised consumption services (SCS), which are settings that provide a safe, hygienic environment where people can use drugs with sterile equipment under the supervision of trained staff or volunteers to prevent the transmission of infections and overdose-related deaths. Not only have SCS been one key measure to address

² Statistics Canada, *Mental and substance use disorders in Canada*, 2021.

³ See, for example, *R. v. Hassard*, 2021 ABPC 21; *R. v. Etmanskie*, 2019 NSPC 74; and *R. v. Parenteau*, 2016 BCPC 88.

⁴ Public Safety Canada, *Corrections and Conditional Release Statistical Overview 2018*, August 2019.

⁵ Statistics Canada, *Police-reported crime statistics in Canada: Police-reported crime for selected offences, Canada, 2014 and 2015*, July 20, 2016; Statistics Canada, *Police-reported crime statistics, 2016*, July 24, 2017; Statistics Canada, *Unfounded criminal incidents in Canada, 2017: Police-reported crime for selected offences, Canada, 2017*, July 23, 2018; Statistics Canada, *Police-reported crime statistics, 2018*, July 22, 2019; and Statistics Canada, *Police-reported crime statistics in Canada*, 2019, October 29, 2020.

⁶ See, for example, Public Health Agency of Canada, *Estimates of HIV incidence, prevalence and Canada's progress on meeting the 90-90-90 HIV targets*, 2020 and M. Trubnikov, P. Yan, C. Archibald, "Estimated Prevalence of Hepatitis C Virus infection in Canada, 2011," *Canada Communicable Disease Report*, Volume 40-19 (2014).

⁷ Government of Canada, *Opioid- and Stimulant-related Harms in Canada*, March 2021.

⁸ See, for example, First Nations Health Authority, *First Nations Illicit Drug Deaths Rise during COVID-19 Pandemic*, July 6, 2020 and J. Tarasuk et al., "Findings among Indigenous participants of the Tracks survey of people who inject drugs in Canada, Phase 4, 2017–2019," *CCDR* Volume 47-01, January 2021.

Canada's ongoing overdose crisis, they can also provide a refuge from various forms of violence that women who use drugs may experience on the street. In 2017, Canada replaced some of the onerous legislative requirements to operate SCS with simpler, streamlined requirements, resulting in new SCS being implemented across the country. Yet there remains a need to facilitate the scale-up of SCS across the country and to remove restrictions (imposed by the criminalization of trafficking) on assisted injection administered by SCS staff or peers and on splitting and sharing of controlled substances — restrictions which prevent people from accessing SCS and increase their risk of overdose and criminalization.

11. Notably, the provision of other harm reduction services — including drug checking — are hampered by the criminalization of personal possession and trafficking. Drug checking services provide people who use drugs with information on the chemical composition of their drug samples to facilitate more informed decision-making.⁹ Given the extreme toxicity of the unregulated drug market and staggering loss of life due to overdose fatalities, impediments to the implementation of harm reduction services like drug checking **violate the right to life (Article 6) for people who use drugs.**
12. Canada's drug control framework is also rooted in, and reinforces, racism and colonialism. Troublingly, Black and Indigenous communities in Canada are disproportionately charged, prosecuted, and incarcerated for drug offences, **depriving them of their rights to equality and non-discrimination (Articles 2 and 26), liberty and security of person, and freedom from arbitrary arrest and detention (Article 9).** In Toronto, data collected from 2003 to 2013 indicate Black people with no history of criminal convictions *were three times more likely* to be arrested for cannabis possession than white people with similar backgrounds.¹⁰ A 2019 study of cases between 2007-2013 found that Black youth accused of cannabis possession in Ontario were more likely to be charged and less likely to be cautioned than white youth and youth from other racial backgrounds.¹¹ A 2020 report found that Black and Indigenous people are dramatically overrepresented in drug charges recommended by the Vancouver Police Department. While making up 1% of the city's population, Black people have accounted for 6.4% of drug trafficking and possession charges in Vancouver since 2014; Indigenous people have accounted for almost 18% of drug trafficking and possession charges but are just 2.2% of the city's population.¹² A 2020 study also found that Black and Indigenous people continue to be overrepresented in cannabis possession arrests across Canada.¹³ As the Report of the Commission on Systemic Racism in the Ontario Criminal Justice System concluded more than two decades ago, "persons described as black are most over-represented among prisoners charged with drug offences"¹⁴ — a reality that persists today.
13. An immense body of evidence demonstrates that the continued overwhelming emphasis on drug prohibition — from policing to prosecution to prisons — fails to achieve both the stated

⁹ N. Maghsoudi, J. Tanguay, K. Scarfone, I. Rammohan, C. Ziegler, C. Werb, A. Scheim, "The Implementation of Drug Checking Services for People Who Use Drugs: A Systematic Review," *Qeios*, 2021. doi:10.32388/TXE86U.

¹⁰ J. Rankin and S. Contenta, "Toronto marijuana arrests reveal 'startling' racial divide," *Toronto Star*, July 6, 2017.

¹¹ K. Samuels-Wortley, "Youthful Discretion: Police Selection Bias in Access to Pre-Charge Diversion Programs in Canada," *Race and Justice* 1-24 (2019).

¹² D. Fumano, "New figures reveal the racial disparity in Vancouver drug charges," *Vancouver Sun*, August 7, 2020.

¹³ A. Owusu-Bempah and A. Luscombe, "Race, cannabis and the Canadian war on drugs: An examination of cannabis arrest data by race in five cities," *International Journal of Drug Policy* (2020), 102937.

¹⁴ Commission on Systemic Racism in the Ontario Criminal Justice System, *Report of the Commission on Systemic Racism in the Ontario Criminal Justice System*, 1995.

public health and public safety goals of prohibition (including reducing drug use). It also results in costly damage to the public purse, public health, and human rights, in Canada and globally, including by forcing many people who use drugs to rely on a poisoned unregulated market for supply.

14. During its last review of Canada, the Committee on the Elimination of Discrimination against Women (CEDAW Committee) expressed its concern with the “excessive use of incarceration as a drug-control measure against women” and “the significant legislative and administrative barriers women face to access supervised consumption services.” To address this, the Committee recommended that Canada (i) “reduce the gap in health service delivery related to women’s drug use, by scaling-up and ensuring access to culturally appropriate harm reduction services”; (ii) “establish a transparent process for exemptions permitting the operation of supervised consumption services without risk of criminal prosecution of clients or service providers”; and (iii) “repeal mandatory minimum sentences for minor, non-violent drug-related offences.”¹⁵ In 2017, concerned with the disproportionately high rates of incarceration for Indigenous and Black people in Canada, the UN Committee on the Elimination of Racial Discrimination called on Canada to re-examine its drug policies and to provide “evidence-based alternatives to incarceration for non-violent drug users.”¹⁶
15. These recommendations are in line with those made by other UN human rights bodies. For example, the UN Special Rapporteur on the right to health has stated, “[a]t the root of many health-related problems faced by people who use drugs is criminalization itself, which only drives issues and people underground and contributes to negative public and individual health outcomes.”¹⁷ Most recently, the UN Chief Executives Board for Coordination unanimously adopted a common position on drug policy calling for increased investment in harm reduction measures, respect for the dignity and human rights of people who use drugs in all aspects of drug and social policies, alternatives to conviction and punishment, including the decriminalization of drug possession for personal use, and changes in laws, policies, and practices that threaten health and human rights.¹⁸ Similarly, the *International Guidelines on Human Rights and Drug Policy* recommend that States “decriminalise the possession, purchase, or cultivation of controlled substances for personal consumption.”¹⁹
16. In Canada, there is strong support for the decriminalization of simple drug possession from community organizations, harm reduction and human rights advocates,²⁰ as well as public

¹⁵ Committee on the Elimination of Discrimination against Women, *Concluding observations on the combined eighth and ninth periodic reports of Canada*, CEDAW/C/CAN/CO/8-9, 18 November 2016.

¹⁶ Committee on the Elimination of Racial Discrimination, *Concluding observations on the twenty-first to twenty-third periodic reports of Canada*, CERD/C/CAN/CO/21-23, 25 August 2017 at paras. 15-16.

¹⁷ *Open letter by the Special Rapporteur on the right of everyone to the highest attainable standard of mental and physical health, Dainius Pūras in the context of the preparations for the UN General Assembly Special Session on the Drug Problem (UNGASS), which will take place in New York in April 2016*, to UNODC Executive Director Yury Fedotov, December 7, 2015.

¹⁸ UN Chief Executives Board for Coordination, *Segment 2: common United Nations system position on drug policy*, UN Doc.CEB/2018/2, 18 January 2019.

¹⁹ International Centre on Human Rights and Drug Policy, UNAIDS, UNDP, WHO, *International Guidelines on Human Rights and Drug Policy*, March 2019.

²⁰ Canadian HIV/AIDS Legal Network, “Canada must adopt a human-rights based approach to drug policy,” Statement, November, 22, 2018. The statement was endorsed by Amnesty International Canada, Canadian Aboriginal AIDS Network, Canadian Association of People Who Use Drugs, Canadian Drug Policy Coalition Canadian Nurses Association, Canadian Public Health Association, Criminal Lawyers’ Association, HIV & AIDS Legal Clinic Ontario (HALCO), Moms Stop The Harm, moms united and mandated to saving the lives of Drug Users (mumsDU) and Pivot Legal Society.

health associations and authorities including the Canadian Public Health Association,²¹ Canadian Mental Health Association,²² Canadian Nurses Association,²³ Toronto Board of Health,²⁴ Montreal Public Health,²⁵ Winnipeg Regional Health Authority,²⁶ and Provincial Health Officer of British Columbia.²⁷ Support for a regulated market and safe supply is also growing.²⁸

Case study:

While representing only 3.3% of the population in the province of British Columbia, Indigenous People accounted for a staggering 16% of all overdose deaths in the province in the first half of 2020 and died at 5.6 times the rate of other provincial residents.²⁹ Not only do Indigenous Peoples who use drugs face many barriers to health care, including systemic racism and stigma, they also face far higher rates of arrest and prosecution for drug offences. Decriminalizing people who use drugs would be in line with the Truth and Reconciliation Commission of Canada's calls to Canada to "close the gap" between Indigenous and non-Indigenous communities on health indicators including addiction, to implement community-based alternatives to imprisonment, and to eliminate the overrepresentation of Indigenous People in custody.³⁰

Case study:

In 2015, Cheyenne Sharma, a young Indigenous woman and single mother, was arrested for importing cocaine into Canada. Sharma accepted the assignment, for which she was paid \$20,000, because she was behind in her rent and facing eviction. Her grandmother was a residential school survivor and her mother spent time in foster care. Sharma ran away from home and was raped at 13; at 15, she began selling sex. She gave birth to her daughter at 17, after which she remained unstably housed until her arrest. In light of Sharma's particular circumstances as an intergenerational survivor of colonialism and systemic discrimination, the unique history of Indigenous Peoples in Canada and the fact that this was her first offence, the sentencing judge concluded that the mandated minimum penalty of two years' incarceration for drug importation was unconstitutional.³¹ Despite this ruling, Canada has yet to repeal mandatory minimum sentences for non-violent drug offences.

²¹ Canadian Public Health Association, *Decriminalization of personal use of psychoactive substances*, October 2017.

²² N. Thompson, "Toronto board of health to urge federal government to decriminalize drug use," *The Globe and Mail*, July 16, 2018.

²³ Canadian HIV/AIDS Legal Network et al., "Canada must adopt a human-rights based approach to drug policy," Statement, November 22, 2018.

²⁴ Winnipeg Regional Health Authority, *Position statement on harm reduction*, December 2016.

²⁵ Direction régionale de santé publique de Montréal, « Décriminalisation des drogues pour usage personnel, » news release, July 27, 2018.

²⁶ Canadian Mental Health Association, *Care not Corrections*, April 2018.

²⁷ B.C., Office of the Provincial Health Officer, *Stopping the Harm. Decriminalization of people who use drugs in B.C.*, April 2019.

²⁸ C. Bains, "B.C. doctor [Medical Health Officer of Vancouver Coastal Health] calls for illicit drug regulation to save lives," *Canadian Press*, July 26, 2019; CAPUD, *Safe Supply. Concept Document*, February 2019; BC Centre for Disease Control, *2018 BC Overdose Action Exchange*, October 2018.

²⁹ First Nations Health Authority, *First Nations Illicit Drug Deaths Rise during COVID-19 Pandemic*, July 6, 2020.

³⁰ Truth and Reconciliation Commission of Canada, *Calls to Action*, 2015.

³¹ *R. v. Sharma*, 2018 ONSC 1141.

HUMAN RIGHTS CONCERNS WITH DRUG TREATMENT COURTS

Violations of Articles 2, 9, 10, 17, and 26

17. Drug treatment courts (DTCs) were introduced in Canada in 1998 as a potential alternative to incarceration for adults charged under the CDSA or the *Criminal Code* in cases where their drug dependence was a factor.³² The specialized courts provide supervised drug treatment outside the prison system and usually consist of a judge, prosecutor, defence lawyer, probation officer, court staff, police, and treatment staff. To qualify, an individual is first screened by a prosecutor and then assessed by treatment personnel. While participation is ostensibly voluntary, most programs require an individual to enter a guilty plea to be admitted into the program (thus contending with a lifelong criminal record), after which a judge ultimately decides whether to admit the applicant into the program. In most cases, people are incarcerated when encouraged to apply to the DTC program; if they are accepted into the program, they are released from jail and gain access more quickly than other people to a limited pool of treatment spots. Given the difficulty of obtaining drug treatment and social services without participating in the DTC system, the “choice” to enter drug treatment is marked by a considerable degree of coercion by the state.³³
18. For the duration of the program (approximately one year), a participant is subject to frequent, random urine screening and is compelled to submit to a rigorous treatment regime and to appear personally in court on a regular basis for intrusive judicial supervision. A judge reviews their progress and can impose sanctions including jail time for drug use, breach of curfew, or missed treatment sessions, urine tests, or court appearances. In some courts, participants who repeatedly relapse may be eventually punished with expulsion. To graduate from the program, participants must meet criteria, including in the majority of DTC programs being abstinent from drugs for a certain period. Participants who successfully graduate from the program may receive a non-custodial sentence, which may include a period of probation, restitution, and/or fines. Those who are expelled from or do not complete the program (and have already pled guilty to enter the DTC program) face the traditional criminal sentencing process.
19. Operating on an abstinence model leaves little room for reduced or moderated drug use as an acceptable measurement of progress. This approach dismisses the underlying premise that for many people, drug dependence often stems from the unaddressed social determinants of health resulting in chronic relapses. Moreover, the most powerful tool DTCs have to coerce people into ending substance use and completing treatment is the threat of incarceration. In a punitive model, people who cannot achieve permanent abstinence are deemed failures deserving of punishment. In the case of DTCs, their defining feature is treatment that could be best characterized as quasi-compulsory.³⁴
20. Within the DTC system, the adversarial process is also generally suspended. Lawyers representing participants are considered a member of the “DTC team,” which may alter their perspective of the best interest of the participant. In this new role, many defence lawyers

³² Department of Justice Canada, *Drug treatment funding program evaluation, final report*, April 2015.

³³ Canadian HIV/AIDS Legal Network, *Impaired Judgment: Assessing the Appropriateness of Drug Treatment Courts as a Response to Drug Use in Canada*, 2011.

³⁴ *Ibid.*

may prioritize the drug- and crime-free objective of DTCs, thereby accepting certain penalties and bail conditions as necessary in the treatment process and potentially failing to protect DTC participants from punitive penalties. In this way, participants are stripped of their rights to have a legal defence advancing their interest to be free of punishment, which **violates their rights to due process and to be treated with humanity and respect in the context of the loss of liberty (Article 10).**³⁵

21. At the same time, DTC treatment counsellors are given powers of enforcement and judgment. Treatment counsellors can recommend that participants be sanctioned if they do not follow the treatment suggestions they are given, blurring their roles and responsibilities. Participants are also required to sign release of confidentiality forms upon entry into the DTC, resulting in each participant's treatments being discussed with the DTC team and in open court, raising concerns about the right to confidentiality between participants and therapists. As a consequence of facilitating the rapport between judges and participants, the confidential nature that typically underlies the therapeutic relationship between treatment counsellors and clients can be compromised by the DTC process, inhibiting participants from disclosing personal information to their treatment providers and/or having personal information potentially shared with the DTC team, in open court and/or with other clients and staff. To require the disclosure of personal information in return for their continued freedom from incarceration not only constitutes an affront to DTC participants' dignity, it also **undermines their right to privacy (Article 17).**³⁶
22. Studies by the federal Department of Justice have shown that DTCs present serious problems with accessibility, including the inability of such courts to engage women, Indigenous people, sex workers, racialized people, and youth, as well as difficulties in retaining them once they have entered,³⁷ violating the **right of potential DTC participants to equality and non-discrimination (Articles 2 and 26)**. Evaluations of DTCs have shown that, compared to men, women participants experience greater degrees of poverty and mental illness and are more likely to have children and family responsibilities, which impede their ability to complete the program.³⁸ More broadly, the coercive characteristics of the DTC system result in encroachment on the substance use treatment sphere and can contort the judicial protections of defendants to the point of undermining health needs and infringing on human rights, depriving people who use drugs of the **right to liberty and security of person (Article 9)**. As the UN Special Rapporteurs on the independence of judges and lawyers and on the right to health jointly noted in 2019, "drug courts represent in several cases a threat to human rights standards, to procedural due process and to the health systems' ability to address health issues around drugs."³⁹

³⁵ Ibid.

³⁶ Ibid.

³⁷ Ibid and Department of Justice Canada, *Drug Treatment Court Funding Program Summative Evaluation Final Report*, Evaluation Division Office of Strategic Planning and Performance Management, March 2009.

³⁸ Ibid.

³⁹ UN Human Rights Special Procedures Information Note, "Drug courts pose dangers of punitive approaches encroaching on medical and health care matters, UN Experts say," March 20, 2019.

DENIAL OF EQUIVALENT HEALTH SERVICES TO PEOPLE WHO USE DRUGS IN PRISON

Violations of Articles 2, 6, 7, 9, 10, and 26

23. Canada's repressive approach to drugs has resulted in significant number of people serving a federal sentence (i.e., a prison sentence of 2+ years) in relation to a drug offence.⁴⁰ An estimated 30% of women and 14% of men in the federal system are incarcerated on drug-related charges,⁴¹ while Indigenous and Black women are more likely than white women to be in prison for drug-related offences.⁴² Moreover, 80% of men entering federal prison have a substance use issue,⁴³ and 80% of federally incarcerated women and 92% of federally incarcerated Indigenous women report problematic substance use prior to arrest.⁴⁴ Not surprisingly, research shows that the incarceration of people who inject drugs is a factor driving Canada's HIV and HCV epidemic.⁴⁵
24. In a 2007 national study of federal prisoners, 14% of women admitted to injecting drugs while in prison, many of whom shared their injection equipment.⁴⁶ A lack of harm reduction and other health measures, including prison-based needle and syringe programs, has contributed to significantly higher rates of HIV and HCV in prison compared to the community as a whole.⁴⁷ A 2016 study indicated that about 30% of people in federal prisons, and 30% of women and 15% of men in provincial prisons are living with HCV, and 1–9% of women and 1–2% of men are living with HIV.⁴⁸ Federally incarcerated Indigenous women, in particular, have much higher rates of HIV and HCV than non-Indigenous prisoners, with reported rates of HIV and HCV of 11.7% and 49.1%, respectively.⁴⁹
25. Despite this, Canada does not provide prisoners, who are disproportionately Indigenous and Black, with equivalent access to drug treatment services, including key harm reduction measures, **violating their rights to life (Article 6), not to be subjected to torture or to cruel, inhuman or degrading treatment or punishment (Article 7), security of the person (Article 9), humane treatment in the context of incarceration (Article 10), and equality and non-discrimination (Articles 2 and 26).** As the UN Standard Minimum Rules for the Treatment of Prisoners (Nelson Mandela Rules) recommend, prisoners must enjoy

⁴⁰ In Canada, women who receive a sentence of two years or more are housed in one of five federal women's prisons (located in British Columbia, Alberta, Ontario, Quebec and Nova Scotia) or the "healing lodge" (located in Saskatchewan).

⁴¹ K. DeBeck et al., "Incarceration and drug use patterns among a cohort of injection drug users," *Addiction* 2009 Jan; 104(1): 69–76.

⁴² Office of the Correctional Investigator, *Annual Report of the Office of the Correctional Investigator 2014–2015*, June 26, 2015.

⁴³ *Ibid.*

⁴⁴ Correctional Service Canada, *Substance Use Patterns of Indigenous and Non-Indigenous Women Offenders*, No RIB-19-08, June 2019.

⁴⁵ See, for example, M.W. Tyndall et al., "Intensive injection cocaine use as the primary risk factor in the Vancouver HIV-1 epidemic," *AIDS* 17,6 (2003): pp. 887–893; H. Hagan, "The relevance of attributable risk measures to HIV prevention planning," *AIDS* 17,6 (2003): pp. 911–913.

⁴⁶ D. Zakaria et al., *Summary of emerging findings from the 2007 National Inmate Infectious Diseases and Risk-Behaviours Survey*, Research Report R-211, 2010, Correctional Service of Canada.

⁴⁷ *Ibid.* and F. Kouyoumdjian et al., "Health status of prisoners in Canada: Narrative review," *Canadian Family Physician* 62:3 (March 2016): 215-222.

⁴⁸ F. Kouyoumdjian et al., "Health status of prisoners in Canada," *supra* note 45.

⁴⁹ D. Zakaria et al., *supra* note 44.

the same standards of health care that are available in the community,⁵⁰ including key interventions recommended by the UN Office on Drugs and Crime, UNAIDS and the World Health Organization and numerous other UN entities such as needle and syringe programs and drug-dependence treatment including opioid agonist therapy (OAT).⁵¹ Similarly, the UN Chief Executives Board for Coordination unanimously adopted a common position on drug policy that calls for the provision of equivalent health care services in prison settings.⁵² According to the UN Special Rapporteur on torture and other cruel, inhuman, and degrading treatment or punishment, States should “[e]nsure that all harm-reduction measures and drug-dependence treatment services, particularly opioid substitution therapy (OST), are available to people who use drugs, in particular those among incarcerated populations.”⁵³

26. Not only should these interventions be made available, but incarcerated women should have access to gender-specific health care that is at least equivalent to that available in the community.⁵⁴ In relation to women in prison, the CEDAW Committee in 2016 expressed its concern with the “high rates of HIV/AIDS among female inmates” in Canada and urged Canada to “expand care, treatment and support services to women in detention living with or vulnerable to HIV/AIDS, including by implementing prison-based needle and syringe programmes, opioid substitution therapy, condoms and other safer sex supplies.”
27. In spite of these recommendations, overwhelming evidence of the health benefits of OAT, and World Health Organization guidelines that state OAT should be available to people in prison and be equivalent to community treatment options,⁵⁵ federal and provincial prisoners in Canada continue to experience barriers to OAT, including long waiting lists and inappropriate medication terminations.⁵⁶ As the Correctional Investigator of Canada (Canada's ombudsperson for federal prisons) has noted, Correctional Service Canada has failed to provide adequate drug treatment, programs, and staff at a time when Canada is experiencing an unprecedented overdose crisis.⁵⁷ Moreover, a number of provincial and territorial prisons still do not offer OAT to prisoners or impose severe restrictions on access,⁵⁸ resulting in acute withdrawal among prisoners and an increased risk of use,

⁵⁰ Rule 24 of the *United Nations Standard Minimum Rules for the Treatment of Prisoners (Nelson Mandela Rules)*, UN Doc. A/RES/70/175, December 17, 2015.

⁵¹ UNODC, ILO, UNDP, WHO and UNAIDS, *Policy brief: HIV prevention, treatment and care in prisons and other closed settings: a comprehensive package of interventions*, 2013; Office of the High Commissioner for Human Rights (OHCHR) and UNAIDS, *International Guidelines on HIV/AIDS and Human Rights, Consolidated Version*, U.N. Doc. HR/PUB/06/9, 2006, Guideline 4, para. 21(e); UN Special Rapporteur on torture and other cruel, inhuman or degrading treatment or punishment, *Report of the Special Rapporteur on torture and other cruel, inhuman or degrading treatment or punishment, Manfred Nowak*, UN Doc. A/HRC/10/44, January 14, 2009, para. 74.

⁵² UN Chief Executives Board for Coordination, *Segment 2: common United Nations system position on drug policy*, UN Doc.CEB/2018/2, 18 January 2019.

⁵³ UN Human Rights Council, *Report of the Special Rapporteur on torture and other cruel, inhuman or degrading treatment or punishment, Juan E. Méndez*. Report on the 22nd session, agenda item 3, UN General Assembly, UN doc. A/HRC/22/53, February 1, 2013.

⁵⁴ Rule 10 of *United Nations Rules for the Treatment of Women Prisoners and Non-custodial Measures for Women Offenders*, UN Doc. A/RES/65/229, March 16, 2011.

⁵⁵ World Health Organization, *Guidelines for the Psychosocially Assisted Pharmacological Treatment of Opioid Dependence*, 2009.

⁵⁶ F. Kouyoumdjian et al., “Physician prescribing of opioid agonist treatments in provincial correctional facilities in Ontario, Canada: A survey,” *PLoS One* 2018; 13(2): e0192431 and West Coast Prison Justice Society, *Representative human rights complaint against Correctional Service Canada (CSC) on behalf of federal prisoners with opioid use disorder*, June 4, 2018.

⁵⁷ C. Bains, “Prisons fail to provide adequate addiction treatment: ombudsman,” *Canadian Press*, March 20, 2019.

⁵⁸ Canadian HIV/AIDS Legal Network and PASAN, *Hard Time: HIV and Hepatitis C Prevention Programming for Prisoners in Canada*, 2007.

relapse, and overdose, **violating their rights to life (Article 6), not to be subjected to torture or to cruel, inhuman, or degrading treatment or punishment (Article 7), security of the person (Article 9), humane treatment in the context of incarceration (Article 10), and equality and non-discrimination (Articles 2 and 26).**⁵⁹

28. Access to naloxone, a medication used to counter the effects of an opioid overdose, is also critical in the context of an overdose crisis. In 2016, Health Canada reclassified its status and made naloxone available without a prescription, facilitating free, unrestricted access to naloxone through first line responders, health centres, and pharmacies.⁶⁰ However, prisoners do not receive the same standard of care. In most cases, naloxone continues to be only accessible to prison health care staff; an increasing number of prison authorities also make naloxone accessible to correctional staff. A limited number of prisoners (i.e., those who are already taking OAT or are known to correctional authorities to have a history of opioid use or overdosing) are given take-home naloxone kits only when they are released back into the community.⁶¹
29. As Health Canada itself has noted, “Naloxone is a safe drug and administering naloxone to a person that is unconscious because of a non-opioid overdose is unlikely to create more harm.”⁶² Correctional staff will not always be immediately available in overdose situations, yet a timely response to an opioid overdose can mean the difference between life and death. Prison authorities’ failure to train all prisoners on naloxone administration and provide all prisoners with direct access to naloxone kits (including nasal naloxone sprays) violates prisoners’ **rights to life (Article 6), security of the person (Article 9), humane treatment in the context of incarceration (Article 10), and equality and non-discrimination (Articles 2 and 26).**
30. Similarly, access to sterile injection equipment in prison is extraordinarily limited. While acknowledging the health benefits of needle and syringe programs in prison with the introduction by Correctional Service Canada of a “Prison Needle Exchange Program” (PNEP) in some federal prisons beginning in June 2018, details of the PNEP reveal serious deficiencies that are not in keeping with public health principles or professionally accepted standards for such programs. Most fundamentally, the PNEP violates prisoners’ confidentiality at many points without reasonable justification, and participation is contingent on the approval of both prison health staff and security staff.⁶³ According to the Correctional Investigator of Canada, “Too much of what should be an exclusively health and harm reduction program has been shaped by security concerns,” leading merely a handful of individuals to enroll in the program.⁶⁴ To date, only 11 out of 43 federal prisons have a PNEP and no provincial or territorial prison system in Canada offers this program. The Correctional Investigator consequently recommended that Correctional Service Canada “revisit” the program and participation criteria with the aim of “building confidence and trust,

⁵⁹ C. Bodkin, M. Bonn and S. Wildman, “Fuelling a crisis: Lack of treatment for opioid use in Canada’s prisons and jails,” *The Conversation*, March 4, 2020.

⁶⁰ Health Canada Prescription Drug Status Committee, *Notice: Prescription Drug List (PDL): Naloxone*, 2016.

⁶¹ S. Taylor, “Correctional Service Canada expands take-home naloxone kit program for inmates,” *CBC*, July 13, 2017.

⁶² Government of Canada, *Frequently Asked Questions: Access to naloxone in Canada (including NARCAN™ Nasal Spray)*, June 30, 2017.

⁶³ Canadian HIV/AIDS Legal Network, *The Correctional Service of Canada’s Prison Needle Exchange Program: Policy Brief*, 2019.

⁶⁴ Office of the Correctional Investigator, *Annual report of the Office of the Correctional Investigator, 2018-2019*, 2019.

and look to international examples in how to modify the program to enhance participation and effectiveness.”⁶⁵

Case study:

After more than two decades of advocacy by prison health and human rights organizations, the Correctional Service of Canada introduced a “Prison Needle Exchange Program” (PNEP) in 2018 in response to a lawsuit initiated by a former prisoner and HIV organizations.⁶⁶ While the roll-out of the PNEP was a historic development, representing the first prison-based needle and syringe program in the Americas, the model adopted prioritizes security over clinical need and breaches prisoners’ confidentiality at multiple points, contrary to national and international standards of medical ethics and conduct, public health principles, and best practices as described in UN guidance and elsewhere. A March 2020 interim evaluation of the PNEP revealed extremely low rates of participation: of the nine federal prisons in which the program had been implemented, only four had any participants, and three institutions had not received a single expression of interest in the program.⁶⁷ Low uptake, vocal opposition to the program from correctional officers and Canada’s Official Opposition in Parliament, as well as the indefinite suspension of the PNEP during the COVID-19 pandemic mean the program remains vulnerable to cancellation.

INEQUITIES IN THE REGULATION OF CANNABIS

Violations of Articles 2 and 26

31. As detailed in paragraph 12 above, laws criminalizing cannabis possession for personal use have had a disproportionate negative impact on Black and Indigenous people in Canada, **depriving them of their rights to equality and non-discrimination (Articles 2 and 26).**
32. In October 2018, Canada legalized the possession, production, and sale (i.e., trafficking) of cannabis within certain parameters, while also imposing criminal penalties for any activities outside these parameters.⁶⁸ Despite many heralding the promise of this newly legal market as an opportunity to rectify the injustices experienced by Black and Indigenous people under cannabis prohibition, this has yet to materialize and inequities persist in the legal cannabis market.
33. While the federal government introduced legislation to expedite and remove cost-barriers to record suspensions for simple possession of cannabis charges, few individuals living with the consequences of criminal records and the stigma stemming from prior cannabis convictions have benefited. First, a significant limitation to providing fair and effective amnesty in Canada’s approach is the use of record suspensions rather than expungements. Expungements allow for the destruction or deletion of an individual’s criminal record, while record suspensions can be revoked by subsequent governments or the Parole Board of Canada, can be accessed by some government and law enforcement agencies thereby continuing to risk negative effects on the individual, and can be accidentally disclosed since records are not destroyed. Second, individuals with charges other than simple cannabis possession are not eligible for record suspensions. Given that a simple possession charge

⁶⁵ Ibid.

⁶⁶ Correctional Service Canada, “Correctional Service Canada announces a Prison Needle Exchange Program,” 14 May 2018.

⁶⁷ Lynne Leonard, *Evaluation of the Prison Needle Exchange Program Interim Report*, March 2020.

⁶⁸ *Cannabis Act*, (S.C. 2018, c. 16).

by itself is rare, many of those with criminal records from prior cannabis convictions do not qualify. Third, record suspensions are not automatic and the legislation puts the onus on individuals to apply for relief. Doing so entails an onerous six-step process of gathering documents from various levels and departments of government, which can be prohibitive for those who face barriers such as due to poverty, lack of education, or residing in remote communities.⁶⁹

34. As of 2014, more than 500,000 people in Canada were living with criminal records and the stigma stemming from prior cannabis convictions.⁷⁰ Although the federal government estimates that as many as 10,000 Canadians may be eligible for a record suspension under their program,⁷¹ as of August 2020, only 467 applications had been received and just 265 had been approved.⁷² Given the described limitations, Canada's legislation does not effectively rectify the negative impacts of a criminal record for cannabis charges and disproportionately impacts Black and Indigenous people who are most likely to have been convicted of a cannabis offence, thereby **violating their rights to equality and non-discrimination (Articles 2 and 26)**.
35. Another critical component of equity in Canada's legal cannabis market is diversity in industry leadership to ensure that historically overcriminalized racialized groups are not excluded and further **deprived of their rights to equality and non-discrimination (Articles 2 and 26)**. Research from the CDPE and University of Toronto has shown that Black and Indigenous people, and women, are vastly underrepresented in leadership positions in the Canadian cannabis industry, when compared to their representation in the general population. Conversely, white men are overrepresented.⁷³
36. While there have been some limited initiatives to facilitate greater cannabis industry diversity, there is a notable absence of government regulation and adoption of programs that would structurally address the underrepresentation of racialized groups that were disproportionately targeted and punished under prohibition. Federal, provincial/territorial, and municipal governments in Canada should adopt social equity programs that provide targeted avenues of entry into the cannabis industry, and provide related business and financial support for members of underrepresented groups, including Black and Indigenous people, as well as women.⁷⁴

RECOMMENDED QUESTIONS TO BE INCLUDED IN THE LIST OF ISSUES:

- **Does the federal government commit to decriminalizing the possession of all drugs for personal use through a full repeal of s. 4 of the Controlled Drugs and Substances Act (CDSA)?**
- **Will the federal government commit to decriminalizing the selling and sharing of limited quantities of controlled substances?**

⁶⁹ Campaign for Cannabis Amnesty, *Record Suspensions (Pardons) vs. Expungement*, 2019.

⁷⁰ Centre for Addiction and Mental Health, *Cannabis Policy Framework*, 2014.

⁷¹ Public Safety Canada, *Cannabis Pardons*, 2020.

⁷² Ibid.

⁷³ Centre on Drug Policy Evaluation and University of Toronto, *How Diverse is Canada's Legal Cannabis Industry? Examining Race and Gender of its Executives and Directors*, 2020.

⁷⁴ Ibid.

- Does the federal government commit to minimizing custodial sentences and repealing all mandatory minimum prison sentences for drug offences?
- Does the federal government commit to sustaining and scaling up the number of supervised consumption services (SCS) in Canada, including by providing adequate funding for these services and removing the need for a case-by-case exemption of SCS?
- Does the federal government commit to exempting:
 - the selling and sharing of limited quantities of controlled substances in SCS; and
 - peer-assisted injection and SCS provider-assisted injection in SCS?
- Does the federal government commit to sustaining and scaling up the number of drug checking services in Canada, including by providing adequate funding for these services and removing the need for a case-by-case exemption?
- Does the federal government commit to providing a safe, legal, and regulated supply of drugs to curtail the harms of the unregulated drug market?
- Does the federal government commit to implementing, maintaining, and scaling-up the following health and harm reduction measures in all prisons in Canada in accordance with best practices in public health and professionally accepted standards and in consultation with prisoner groups and community health organizations to ensure operational success, taking into account the need for culturally appropriate and gender-specific programs:
 - prison-based needle and syringe programs;
 - opioid agonist therapy;
 - naloxone;
 - overdose prevention services;
 - safe supply;
 - drug checking;
 - condoms and other safer sex supplies; and
 - safer tattooing programs?
- Does the federal government commit to removing barriers and providing a more inclusive approach to cannabis amnesty, including through automatic expungements for simple possession of cannabis and other charges?
- Does the federal government commit to adopting social equity programs to ensure that historically overcriminalized racialized groups are not excluded from the leadership of Canada's legal cannabis industry?

