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Injection Drug Use and HIV/AIDS

2002/2003

Injection Drug Use and HIV/AIDS: The Facts

This info sheet reviews what is known about HIV/AIDS and injection drug use in Canada.

This is one of a series of 12 info sheets on injection drug use and HIV/AIDS: legal and ethical issues.

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Canadian Strategy on HIV/AIDS

The Urgency of the Situation

Canada is in the midst of a public health crisis concerning HIV/AIDS, hepatitis C (HCV), and injection drug use. The spread of HIV (and other infections such as HCV) among injection drug users in Canada merits serious and immediate attention.

- The number of HIV infections attributable to injection drug use has been unacceptably high. In 1999, *34.1 percent of the estimated 4,190 new HIV infections were among injection drug users*. Over 60 percent of new HCV infections are related to injection drug use.
- There have been several studies documenting a rise in the prevalence and incidence of HIV among injection drug users in the larger cities of Canada, but *a rise in the number of injection drug users with HIV infection has also been observed outside major urban areas*.
- Given the geographic mobility of injection drug users and their social and sexual interaction with non-users, the dual problem of injection drug use and HIV infection is one that *ultimately affects all of Canadian society*.

Studies undertaken in different parts of Canada illustrate the urgency of the problem:

- HIV prevalence among injection drug users in *Montréal* increased from approximately five percent prior to 1988 to 19.5 percent in 1997;
- in *Vancouver*, HIV prevalence among injection drug users increased from four percent in 1992-93 to 23 percent in 1996-97; in *Victoria*, from six percent in the early 1990s to 21 percent in 1999;
- HIV prevalence among injection drug users in *Toronto* increased from 4.8 percent in 1992-93 to 8.6 percent in 1997-98;
- in *Ottawa*, a 1992-93 study found an HIV prevalence of 10.3 percent among persons who attended needle exchange programs; a 1996-97 study showed that prevalence had increased to 20 percent;
- data from needle exchange programs in *Québec City* and smaller cities in Québec indicate that HIV prevalence among injection drug users is 9 percent in Québec City and as high as 9.6 percent in some semi-urban areas;
- in *Winnipeg*, HIV prevalence among injection drug users increased from 2.3 percent in 1986-90 to 12.6 percent in 1998.

Risk Behaviours

Drug injection and sexual risk behaviours among injection drug users are prevalent:

- The sharing of needles is a very efficient mode of transmission of HIV (and other infections),

and is relatively common among injection drug users. Sharing of other injection drug equipment such as spoons/cookers, filters and water is also associated with HIV and HCV transmission.
- A shift from heroin use to increasing use of cocaine may be a significant factor in the escalation of HIV prevalence and incidence. Cocaine users typically have a high injection rate; they may inject as much as twenty times a day. Rates of injectable cocaine use are especially high in Vancouver, Toronto, and Montréal, but cocaine use is also an increasing problem in other cities.
- Sexual risk behaviours are also prevalent. Many injection drug users are involved in unprotected commercial sex, and condom use with regular and casual partners is low.

The Populations Most Affected

The problem of injection drug use and HIV and HCV infection affects all of Canadian society. However, some populations are particularly affected.

Women injection drug users in Canada are at high risk of HIV infection. For women, the proportion of AIDS cases attributed to injection drug use increased from 0.5 percent during the period before 1989 to 45 percent in 1998. Since then, there has been a slight decrease to 34.6 percent in 2000. For men, the increase has also been pronounced, but less dramatic: from 0.8 percent before 1989 to 19.8 percent in 2000.

Injection drug use is a severe problem among *street youth*: for example, one-third of a sample of Montréal street youth had injected drugs in the previous six months.

Injection drug use is also a problem among *prisoners*. Estimates of HIV prevalence among prisoners vary from one to four percent in men and from one to ten percent in women, and in both groups infection is strongly associated with a history of injection drug use. Once in prison, many continue injecting. For example:

- In a federal prison in British Columbia, 67 percent of inmates responding to one survey reported injection drug use either in prison or outside, with 17 percent reporting drug use *only in prison*.
- In a 1995 inmate survey conducted by the Correctional Service of Canada, 11 percent of 4285 federal inmates self-reported having injected since arriving in their current institution.

Finally, *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 among clientele using needle exchange programs and counselling/referral sites.

Additional Reading

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Second, revised and updated version, 2002. The information in this series of info sheets is taken from *Injection Drug Use and HIV/AIDS: Legal and Ethical Issues*, prepared by the Canadian HIV/AIDS Legal Network, but was updated in 2002. Copies of the paper and info sheets are available on the Network website at www.aidslaw.ca/Maincontent/issues/druglaws.htm and through the Canadian HIV/AIDS Clearinghouse (email: aids/sida@cpha.ca). Reproduction is encouraged, but copies may not be sold, and the Canadian HIV/AIDS Legal Network must be cited as the source of this information. For further information, contact the Network at info@aidslaw.ca. **Ce feuillet d'information est également disponible en français.**

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Injection Drug Use and HIV/AIDS

2002/2003

The Current Legal Status of Drugs

What is the impact of the current legal status of drugs and drug use on efforts to prevent HIV and HCV infection among injection drug users and on the provision of care, treatment, and support to drug users with HIV/AIDS and/or HCV? What are alternatives to the current legal regime on drugs and drug use?

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The Criminalization of Drugs in Canada

Since the early 1900s, criminal statutes aimed at the control of particular drugs have existed in Canada. The *Opium and Drug Act* promulgated in 1911, and then the *Narcotic Control Act* and the *Food and Drugs Act* governed drug use for 85 years. In 1997, the *Controlled Drugs and Substances Act* (CDSA) was proclaimed.

In general, under the CDSA, the *unauthorized* possession, manufacture, cultivation, trafficking, export and import of substances listed in several Schedules appended to the CDSA constitute criminal offences. Currently, those Schedules list cannabis, heroin, methadone, cocaine, barbiturates, amphetamine, and a large array of other substances as "controlled." In addition, under certain circumstances, it is an offence to seek or obtain a "controlled" substance from a practitioner, such as a physician. Finally, the CDSA makes it a criminal offence to possess, import, export, traffic, etc, not only the drugs themselves but also "any thing that contains or has on it a controlled substance and that is used ... in introducing the substance into a human body." This means that if a syringe or other equipment used for injecting drugs contains residue of a drug, that equipment is a "controlled substance" and the person with the syringe could be found guilty of possession.

The Impact of the Current Legal Status

Several major reports released since1997 have concluded that the legal status of drugs in Canada hinders efforts to prevent the spread of HIV among injection drug users, and efforts to provide care, treatment, and support to HIV-positive injection drug users.

Care, Treatment and Support for Injection Drug Users Living with HIV/AIDS: A Consultation Report stated that the pharmacological effects of the illegal drugs used by injection drug users are not in themselves necessarily harmful. The report pointed out that much of the harm is secondary, caused either by the legal status of the drugs themselves, or by things such as dangerous injecting practices, criminal behaviour, and uncertain drug strength or purity that result from the legal status of drugs. The report further pointed out that the legal status of drugs is a barrier to utilization by injection drug users of much of the addiction and medical services system; and that treatment approaches, admission protocols, and staff and public attitudes are more reflective of the legal status of drugs than of the treatment needs of injection drug users.

The *National Action Plan* prepared by the Task Force on HIV, AIDS and Injection Drug Use also observed that the legal status of drugs in Canada contributes to the difficulties encountered in addressing HIV among injection drug users.

More Harm than Good

Many others have pointed out that the criminal approach to drug use may increase harms from drug use:

- Because drugs can only be purchased on the underground market, they are of unknown strength and composition, which may result in overdoses or other harm to the drug user.
- Fear of criminal penalties and the high price of drugs cause users to consume drugs in more efficient ways, such as by injection, that contribute to the transmission of HIV and HCV.
- Because sterile injection equipment is not always available, drug users may have to share needles and equipment.
- Significant resources are spent on law enforcement, money that could instead be spent on prevention and the expansion of treatment facilities for drug users.

The most pronounced effect is to push drug users to the margins of society. This makes it difficult to reach them with educational messages; makes users afraid to go to health or social services; may make service providers shy away from providing education on safer use of drugs, for fear of being seen as condoning use; and fosters anti-drug attitudes toward the user.

Alternatives Are Possible

In the context of drug use, is it appropriate then to use the criminal law rather than other means of social intervention? In a Government of Canada report entitled *The Criminal Law in Canadian Society*, it was stated that "[t]he criminal law should be employed only to deal with conduct for which other means of social control are inadequate or inappropriate, and in a manner which interferes with individuals rights and freedoms only to the extent necessary for the attainment of its purpose." This would seem to preclude the use of the criminal law in dealing with at least some activities relating to drugs. Other, less harmful means are available to respond to the use of drugs in a fashion that still maintains (and in fact, may encourage) social order and protection of the public.

Alternatives to the current approach to drug use and drug users are possible. Alternatives *within the current prohibitionist policy* that would not require any changes to the current legal framework could include the de facto decriminalization of cannabis possession for personal use, medical prescription of heroin, explicit educational programs, etc. Alternatives *to the current prohibitionist approach* may require that Canada denounce several international drug-control conventions.

Alternatives Are Necessary

In 2001, Health Canada acknowledged that "[f]undamental changes are needed to existing legal and policy frameworks in order to effectively address IDU as a health issue." From an ethical perspective, considering alternatives to the current approach is not just possible, but required. Some aspects of current drug policy must be reversed because of their intolerable social consequences. Ethical principles demand a more coherent and integrated drug policy that can withstand rational inquiry and scrutiny, is responsive to the complexity of the current situation, and allows for public and critical discussion.

Overarching Directions for Future Action

1. Canada must reverse the negative impacts of the current legal status of drugs on drug users and on those who provide services to them.
2. Canada must move to adopt alternatives to the current approach to reducing drug use, and the harms of drug use, among Canadians.

Additional Reading

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McAmmond D. *Care, Treatment and Support for Injection Drug Users Living with HIV/AIDS: A Consultation Report*. Ottawa: Health Canada, March 1997.

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3

Injection Drug Use and HIV/AIDS

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Drug Use & Provision of Health and Social Services

What legal and ethical issues arise in circumstances in which drug use is permitted in the course of providing health care and social services – primary health care, community clinics, pharmacy services, residential care, palliative care, housing services – to drug users? (see also info sheet 10 for a discussion of issues specific to safe injection facilities)

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Background

Tolerating drug use in the course of providing health care and social services departs from the principle of abstinence as the only acceptable premise, standard, or goal in providing services to drug users. That principle is deeply ingrained in drug policies and programs in North America. It has, however, been questioned by service providers who feel they cannot provide proper care, treatment, and support if they must insist on their clients being abstinent. Some hospices feel they should not close their doors to a client who is not (yet) ready to stop using. Some hospitals prefer to allow their patients to continue using while receiving medical care, rather than let them suffer withdrawal symptoms that could interfere with their medical treatment.

Legal Issues

From a purely legal perspective, professionals who tolerate or permit illegal drug use on the premises may be prosecuted under the *Controlled Drugs and Substances Act* (CDSA) or face professional discipline such as fines or the suspension or revocation of their licences.

Criminal liability

1. Staff at health care or other social services may be liable for **possession** under the CDSA if they know that an illicit drug is present on their premises and if they have some measure of control over the drug. Staff who collect used syringes or drug paraphernalia that contain residue of illegal drugs may also be found guilty of possession.
2. Staff who store a patient/resident's illegal drugs and provide them at specific intervals could likely be convicted of **trafficking**. The term "traffic" is broadly defined in the CDSA to include selling, administering, giving, transferring, sending, or delivering an illegal substance. It is also a criminal offence to "offer" to do any of the above acts.
3. Staff permitting or tolerating drug use may be liable for aiding or abetting a person to commit a crime. Aiding is providing assistance in the commission of a crime. Abetting means being at the crime and encouraging its commission.
4. Staff may also be responsible for criminal negligence. This may occur if, by tolerating or facilitating the possession of drugs, a staff member caused or contributed to the bodily harm or death of a patient. It must be proved that the accused did something or failed to do something that he or she had a legal duty to do. For example, staff at healthcare facilities likely have a duty to protect the well-being of patients. It must also be proved that the conduct of the staff member was a "marked departure" from the standard of behaviour expected of the "reasonably prudent person in the circumstances."

Civil Actions

Professional codes of conduct may prohibit health-care professionals from allowing patients to ingest or inject illegal drugs. Physicians, nurses, and other health-care providers may be subject to disciplinary measures by the bodies that govern their professions.

A facility or employee might also face civil liability for allowing or tolerating the possession of illegal drugs. For example, if a hospital allowed a patient to possess and use illegal drugs in the hospital, and the patient suffered harm, the hospital might be found liable for negligent care of the patient. The extent of the duty would vary with the type of institution. A hospital or treatment facility staffed by medical personnel would have a greater responsibility than would a residential facility that simply houses drug users.

Avoiding Liability

Although those who operate facilities could be subject to criminal charges or civil lawsuits, they may have legal defences available to them. A facility or employee facing civil liability or criminal prosecution might claim that allowing the use of illegal drugs was a *necessity* for the treatment of the patient and/or that, in the circumstances, it would be *negligent to prohibit* possession of a controlled substance by a patient, as this might interfere with essential medical treatment.

Furthermore, hospitals or other facilities might be able to arrange access to specific drugs under existing legislation, so that drugs that would otherwise be illegal can be allowed or even administered to patients. Health Canada's Special Access Program is an example of a program that could prevent criminal charges being brought against those working in facilities.

Finally, the CDSA contains a provision that allows the Minister of Health to exempt illegal drugs from the application of the Act or the regulations if it is in the public interest or if the drugs will be used for medical or scientific purposes. Similarly, the Governor in Council has the authority under the Act to pass a regulation allowing the distribution of illegal drugs for medical or scientific purposes.

Ethical Issues

The basic ethical issue is the imperative to care adequately for HIV-positive drug users. According to principles of ethics, behaviour should not be imposed on drug-dependent persons that exceeds their current level of ability. Drug-dependent persons should be treated for their illnesses, fed, and provided with shelter – their dignity and self-worth must be nurtured and their drug needs tolerated so that they can begin to address their difficult circumstances. Attempting to free a person from addiction is not the value to be pursued when that person, dependent on drugs for many years, is in the final stages of a terminal illness such as AIDS. In a palliative care setting, helping the dying to die with dignity is the highest ethical imperative.

Recommendations

1. In the long term, laws should be changed so as to enable provision of currently illegal drugs to drug users while they are in care, so as to remove a barrier to drug users accessing health care and other social services and to remove the threat of criminal liability for service providers who wish to provide care, treatment, and support without insisting on abstinence by patients who use illegal drugs.
2. In the short term, measures should be undertaken to ensure better care, treatment, and support of HIV-positive injection drug users. In particular, professional associations should develop ethical and practice guidelines for service providers in different areas of care involving HIV/AIDS and injection drug use.

Additional Reading

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Injection Drug Use and HIV/AIDS

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Treatment

Is it legal and ethical to make cessation of drug use a condition for treatment of a drug user?
Is it legal and ethical to withhold antiretroviral drugs from HIV-positive drug users?

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Compelling Abstinence

Abstinence

The principle of abstinence, rooted in a law-enforcement model, has dominated drug policy in North America. Persons who use illicit drugs are viewed as deserving of punishment rather than in need of care, treatment, and support.

Proponents of the abstinence approach prohibit drug users who seek health services from using drugs. They argue that abstinence from non-medicinal drugs is a fundamental component of healthy behaviour, and view total and permanent abstinence from drug use as the only sign of successful treatment.

Harm-Reduction Approaches

In recent years, however, AIDS and the transmission of HIV and HCV, both within the drug-user population and to other members of society, have caused a fundamental re-evaluation of the services and programs provided to drug-dependent persons. It is being slowly recognized that complete withdrawal from drugs is not a goal that is attainable for many drug users. Moreover, only a minority of drug users are prepared to contemplate participation in abstinence-based programs. Therefore, addiction treatment and other health-care services that stipulate abstinence as a precondition to participation will deter many drug users from obtaining treatment.

Harm-reduction strategies attempt to reduce the specific harms associated with drug use without requiring abstinence from all drug use. Thus, they seek to reduce the likelihood that drug users will contract or spread HIV, hepatitis, and other infections, overdose on drugs of unknown potency or purity, or otherwise harm themselves or other members of the public. They are based upon a hierarchy of goals, and stress short-term, achievable, pragmatic objectives rather than long-term, idealistic goals.

There are several components to a comprehensive harm-reduction approach. They include: (1) the provision of medical services to drug users; (2) the availability of different models of treatment programs; (3) the provision of mental health services; (4) street outreach strategies; (5) needle exchanges and the availability of condoms; (6) the provision of housing and clothing; (7) peer support groups for drug users; (8) vocational services; and (9) the inclusion of drug users in the design and planning of harm-reduction strategies.

Lack of Access to Antiretroviral Drugs

Advances in antiretroviral therapy (ART) have improved the survival and quality of life of many HIV-positive people and have reduced morbidity and mortality. However, drug users are not offered ART with the same frequency as other HIV-positive individuals. Physicians often do not receive adequate training in medical school, residency training, or

continuing education programs regarding the care of drug users. Mental illness, psychosocial problems, and chronic liver disease are some of the reasons physicians are reluctant to prescribe ART to drug users. In addition, some physicians believe that drug users are incapable of following the prescribed regimen for antiretroviral therapy. They are concerned that if ART is not conscientiously followed, resistance to the therapy will develop.

However, several measures can be taken by physicians to ensure optimal outcomes for drug users who use ART. They include simplifying regimens by reducing dose frequencies and pill numbers. A particularly important factor is a physician/patient relationship characterized by trust and accessibility.

Legal Issues

Compelling abstinence as a condition of medical treatment, or withholding antiretroviral therapy from drug users, may violate the *Canadian Charter of Rights and Freedoms*, human rights codes, professional codes of conduct, and international human rights conventions.

Ethical Issues

It is unethical to insist on cessation of drug use as a condition of medical treatment if this is beyond the capabilities of the drug user.

It is also unjust to judge people as likely to be noncompliant with ART simply because they are drug users, and to withhold ART on this basis. Adherence to treatment is profoundly affected by systems of care. When the health-care system is adapted to meet the needs of socially marginalized and indigent persons, there is a vast improvement in adherence to treatment. Ethics therefore requires that we not reduce an assessment of treatment compliance to simply the personal characteristics of people with HIV/AIDS. At the same time, there may be situations where it may be justified to delay or, at the extreme, refuse ART. Such a decision would be ethically unjustifiable if it is reached without honouring the characteristics of an authentic healing relationship: humanity (respect for the full biological and biographical particularity of the person with HIV/AIDS), autonomy (respect of the person's way of life and life plans); lucidity (transparent sharing of all relevant information); and fidelity (understanding and respect for the expectations of the sick).

Recommendations

1. Health-care professionals should ensure that the provision of services to drug users is not contingent upon a drug user's agreement to enter drug treatment programs.
2. Health-care professionals must not withhold or refuse treatment simply because a person with HIV/AIDS is a drug user.
3. The governing approach in providing care and treatment to HIV-positive drug users should be to adapt the therapeutic regimen to the needs of drug users, rather than require drug users to adapt to the therapeutic regimen.
4. A network of physicians who have experience and/or interest in the delivery of health care and treatment to drug users should be established.
5. Public health should offer or make available support to drug users who require assistance in adhering to HIV therapies.

Additional Reading

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Prescription of Opiates & Controlled Stimulants

What legal and ethical issues are raised in the context of prescribing opiates and controlled stimulants to drug users in Canada?

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Legal Issues

Criminal Liability

The *Controlled Drugs and Substances Act* (CDSA) and the Narcotic Control Regulations forbid medical practitioners from administering, prescribing, giving, selling, or furnishing a narcotic to any person except as allowed by the Regulations. The Regulations further provide that:

- Where the Minister of Health "deems it to be in the public interest, or in the interests of science," the Minister may authorize any person to possess a narcotic.
- The Minister may also authorize a practitioner to provide methadone to a person under their treatment, or to provide a narcotic (other than heroin) to any person who is also authorized by the Minister to possess a narcotic.
- A person in charge of a hospital may permit methadone to be supplied or administered to an in-patient or out-patient of the hospital, upon receipt of a prescription or written order signed and dated by a practitioner who is authorized by the Minister to prescribe methadone.
- A practitioner may only provide heroin to a patient of a hospital.
- Apart from these restrictions, a practitioner is permitted to prescribe a narcotic only to a patient under their professional treatment, and only if the narcotic is required for the condition for which the person is receiving treatment.

Thus, there are some carefully circumscribed situations in which practitioners can prescribe narcotics, including opiates, but methadone is the only opioid permitted for long-term treatment of drug users.

In situations where a physician has no right to prescribe, penalties for prescribing may flow under the Regulations. In addition, if a physician actually possesses a drug and gives it to a patient (or offers to give it) when the physician has no legal right to possess the drug, the physician may commit three offences under the CDSA – possession, possession for the purposes of trafficking, and trafficking.

Civil Responsibility

Professional statutes in each province regulate the behaviour of health-care professionals. The right to practise medicine may be revoked or suspended if a physician commits an act of professional misconduct. This may occur if the physician provides or prescribes an illegal drug to his or her patient.

Physicians may also be civilly responsible for negligence if the drug prescribed causes the patient harm. In such an action, it must be proved that the doctor did not have a reasonable degree of skill or knowledge, or did not exercise the degree of care reasonably expected of the average prudent doctor. Failure to explain "material risks" of the medication

to the patient, or prescribing medication in a manner that causes "reasonable foreseeable" injury to the patient constitutes negligence. The care that must be exercised by a doctor is dependent on the nature of the drug and the patient to whom it is prescribed.

Methadone Maintenance Treatment

As mentioned above, currently methadone is the only opioid approved for the long-term treatment of drug-dependent persons in Canada. Although methadone maintenance treatment (MMT) has many advantages (for details, see info sheet 9), there are some limitations. Methadone is effective for heroin addiction, but it is not a treatment for dependence on cocaine, amphetamine, and other non-opiate drugs. In addition, methadone is not indicated for multiple addictions. Finally, methadone is addictive. In fact, the withdrawal symptoms from methadone may be worse and more difficult to manage than the withdrawal symptoms from heroin. Thus, MMT it is not a sufficient solution to many of the problems associated with drug dependency, and it is necessary to explore other methods of addressing it.

In particular, members of the scientific and medical community in Canada, as well as drug users, have advocated that drugs other than methadone ought to be provided to drug-dependent individuals. They say that Canada has fallen far behind other countries such as Britain, where physicians are permitted to prescribe heroin, cocaine, morphine, amphetamine, as well as other drugs; or Switzerland, where in 1994 the government began a multi-year, multi-city scientific trial to provide drugs to long-term dependent users in order to assess the effects on their health, social integration, and behaviour. In 1997, the heroin maintenance experiment was declared a success: crime dropped by 60 percent, unemployment by 50 percent, and significant public funds were saved due to a reduction in the costs of criminal procedures, imprisonment, and disease treatment.

A Heroin Trial in Canada?

Because of the limitations of MMT, in recent years many have taken the position that heroin substitution and heroin maintenance are reasonable alternatives that have a place in an overall public health approach to injection drug use in Canada. Canadian and US researchers have developed a protocol (North American Opiate Medications Initiative) aimed at assessing the effectiveness of heroin prescription with respect to attracting and retaining those resistant to conventional treatments. This randomized clinical study will include a control group receiving oral methadone, while the experimental group will receive an injectable opiate with or without oral methadone. The study will last two years and the experimental treatment one year. The protocol is awaiting approval.

Ethical Issues

From an ethical perspective, it may be imperative to conduct such a trial. Indeed, methodologically sound research and clinical trials are an integral part of the fundamental ethical imperative that doctors and other professionals should *know* what they are doing when they intervene in the bodies, minds, and lives of persons dependent on drugs. It can be argued that those who oppose methodologically sound clinical trials of opiate-assisted treatment programs are promoting the therapeutic abandonment of those who cannot benefit from existing treatments.

Recommendations

1. In the longer term, Health Canada should develop plans to permit physicians to prescribe opiates and controlled stimulants.
2. In the shorter term, trials involving the prescription of heroin should be authorized, funded, and initiated in Canada.

Additional Reading

Brissette S. Medical prescription of heroin – a review. *Canadian HIV/AIDS Policy & Law Review* 2001; 6(1/2): 1, 92-98. Available at www.aidslaw.ca/Maincontent/otherdocs/Newsletter/vol6nos1-22001/heroin.htm.

Fischer B. The case for a heroin substitution treatment trial in Canada. *Canadian Journal of Public Health* 1997; 88: 367.

www.drugpolicy.org/. The website of the Drug Policy Alliance (formerly the Lindesmith Center) contains many articles and reports on heroin maintenance.

Second, revised and updated version, 2002. The information in this series of info sheets is taken from *Injection Drug Use and HIV/AIDS: Legal and Ethical Issues*, prepared by the Canadian HIV/AIDS Legal Network, but was updated in 2002. Copies of the paper and info sheets are available on the Network website at www.aidslaw.ca/Maincontent/issues/druglaws.htm and through the Canadian HIV/AIDS Clearinghouse (email: aids/sida@cpha.ca). Reproduction is encouraged, but copies may not be sold, and the Canadian HIV/AIDS Legal Network must be cited as the source of this information. For further information, contact the Network at info@aidslaw.ca. **Ce feuillet d'information est également disponible en français.**

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7

Injection Drug Use and HIV/AIDS

2002/2003

Information About the Use & Effects of Drugs

This info sheet discusses the legal and ethical issues associated with ensuring that health-care providers, drug users, and the general public have accurate and complete information on illicit drugs and their effects.

This is one of a series of 12 info sheets on injection drug use and HIV/AIDS: legal and ethical issues.

CANADIAN HIV·AIDS LEGAL NETWORK | RÉSEAU JURIDIQUE CANADIEN VIH·SIDA

Canadian Strategy on HIV/AIDS

What Is the Issue?

There is not enough provision of accurate and complete information on illegal drugs to health-care providers, drug users, and the general public. This lack of (accurate) information has a negative impact on provision of care, treatment, and support, as well as on prevention efforts.

Educational Programs Based on Abstinence

Many existing educational programs, particularly those for youth, are based on a zero tolerance philosophy. Abstinence from drug use is the primary objective. Youth are often told that any drug use beyond one-time experimentation with an illegal drug constitutes drug abuse, that alcohol and cigarettes are "stepping stones" to the consumption of drugs, and that use of drugs such as marijuana will lead to consumption of narcotics such as heroin and cocaine. Policy analysts see such a "Just Say No" curriculum as inherently dangerous:

> When kids are told that illegal drugs, including marijuana, are extremely dangerous and addictive, and then learn through experimentation that this is false, the rest of the message is discredited. Honest drug education is one key to ensuring that individuals know how to make informed decisions. But such an approach is inconsistent with the "Just Say No" campaign.

To be effective, they argue, drug education should be based on realistic assumptions about drug use: "Programs must address the needs of individuals within their social context and be as flexible, open, and creative as the young people they must educate."

Harm-Reduction Education Programs

Harm-reduction educational programs take a nonjudgmental approach to the use of drugs. They try to provide accurate information on the composition and effects of different substances and recommend sources of assistance to persons who use drugs. Programs geared to adolescents attempt to provide young persons with skills in assessment, communication, assertiveness, conflict resolution, and decision making.

Educational programs based on harm-reduction objectives try to: reduce the prevalence of unsafe frequencies and methods of ingesting drugs; decrease the rate of heavy or dependent consumption; reduce experimentation with drugs most likely to cause medical problems; and improve the ability of users and others to respond to drug-related problems.

Some government ministries and agencies in Canada have published information for the public based on harm-reduction principles. However, the amount of drug education and publications distributed to youth, drug users, and the public that are based upon these principles remains small.

Nor do health-care providers such as physicians, pharmacists, and nurses generally receive an adequate education on drug addiction, illegal drugs, and treatments for drug-dependent persons. For example, a study conducted in British Columbia involving medical students and residents concluded that more time should be devoted in the curriculum to drugs other than alcohol.

Legal Issues

Provincial health officials, according to public health laws, are responsible for providing health education to members of the public. However, officials have the authority to decide what types of materials will be distributed and to which sectors of the public the material will be directed. Therefore, the principles upon which educational material on drugs is based and whether it is directed to youth, drug users, or members of the public fall within the discretion of government health officials.

It would be difficult, if not impossible, to use the law to address the failure to provide accurate information about illegal drugs and their effects.

Ethical Principles

However, according to ethical principles, individuals in society should have accurate and comprehensive information on all matters that require decision, choice, and action. It is ethically wrong to tailor or suppress the information about illegal drugs that individual users, professionals, and citizens generally need to know to act responsibly.

Drug users, in the name of personal autonomy, have a responsibility to seek out the most reliable and comprehensive information available to guide them in the choices and decisions that will advance or frustrate their own life plans, and perhaps the life plans of the person with whom they interact or to whom they are bound.

Health-care professionals have the responsibility to assure that they master the drug-use information and knowledge they need to care for those whose needs fall within their professional mandate. They also have a responsibility to signal to the health-care community, to the research community, and to society where, in their experience, there is a dearth of needed information and knowledge.

The responsibility of the general public – that is, of *citizens* and their *government representatives* – to become adequately informed about drug use and the effects of such use derives from their central role and power in the formulation, passage, and implementation of public policy regarding all aspects of drug use, including: the criminalization of drug use; prevention and education programs; harm-reduction programs; and care, treatment, and support of drug users.

Recommendations

1. Federal, provincial, and territorial health officials should provide funding for the development and wide distribution of accurate, unbiased, and nonjudgmental information on illegal drugs for health-care providers, drug users, and members of the public.
2. Provincial and territorial governments, government agencies, and community-based organizations should develop education programs based on harm-reduction principles.
3. Provincial and territorial ministries of education and health should undertake an evaluation of school programs on illegal drugs.
4. Universities and colleges should ensure that the curricula of health-care professionals include accurate, unbiased, and nonjudgmental materials, presentations, and discussions about drugs, drug use, and harm-reduction approaches to drug use.

Additional Reading

Riley D. Injection Drug Use and HIV/AIDS: Policy Issues. In: *Injection Drug Use and HIV/AIDS: Legal and Ethical Issues. Background Papers*. Montréal: Canadian HIV/AIDS Legal Network, 1999, at C39-51. Also available at www.aidslaw.ca/Maincontent/issues/druglaws.htm.

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8

Injection Drug Use and HIV/AIDS

2002/2003

Needle Exchange Programs

This info sheet explains how the rules and regulations that govern needle exchange programs in Canada serve as barriers to HIV prevention and to care, treatment, and support of injection drug users.

This is one of a series of 12 info sheets on injection drug use and HIV/AIDS: legal and ethical issues.

CANADIAN HIV·AIDS LEGAL NETWORK | RÉSEAU JURIDIQUE CANADIEN VIH·SIDA

Canadian Strategy on HIV/AIDS

The Purposes of Needle Exchange Programs

Needle exchange programs (NEPs) are an important strategy in a harm-reduction approach to injection drug use. A fundamental rationale for their establishment is that injection drug users typically share needles and syringes, a frequent mode of transmission of HIV and hepatitis C (HCV). The philosophy underlying NEPs is that if injection drug users are provided with sterile syringes and needles, this will reduce the sharing of drug equipment and thus decrease the transmission of bloodborne diseases such as HIV and HCV.

In addition to distributing sterile injection equipment, NEPs are a useful way of getting in touch with injection drug users in order to provide education and counseling, and to connect them to health-care services and drug treatment programs.

Do They Work?

Studies have concluded that NEPs

- are effective in reducing the spread of HIV;
- do not increase the number of injection drug users or lower the age of first injection; and
- do not increase the number of needles discarded in a community, or change the locations where needles are disposed.

Needle Exchange Programs in Canada

The first NEP in Canada was established in 1989 in Vancouver. Within a few months NEPs were established in Montréal and Toronto. This was soon followed in other major Canadian cities. Currently, it is estimated that there are well over 100 NEPS. Nevertheless, only a small proportion of injection drug users have access to NEPs. Many problems remain:

- In some NEPs there is a limit on the number of syringes distributed to injection drug users at each visit. Individual quotas may be imposed, and/or new syringes may only be exchanged for used syringes. Such limitations may be well-intentioned but have restricted access to sterile injection equipment. Generally, the number of needles distributed in Canada is significantly lower than the number required by injection drug users.
- The number of NEPs in Canada remains insufficient, and NEPs are generally located in large cities. Persons who live in rural areas or in small towns have little access to such programs. Moreover, NEPs have often been centralized within large cities, limiting access even within them.
- Although injection drug use is prevalent in prisons, there are no NEPs in federal and provincial prisons.
- The hours of operation of NEPs are often very restricted. In rural areas, needles provided in community clinics or hospital emergency departments may be available for only two hours each week.

- In many places, pharmacists continue to be reluctant to provide syringes to injection drug users. Many are concerned about the potential negative effects on business revenue if they provide them. This is a problem, as pharmacies, particularly in rural areas, may be one of the few places in which sterile syringes may be obtained.
- Not all NEPs offer health care, counselling and support services.

Legal Issues

It is legal in Canada to give or sell sterile syringes to injection drug users. However, NEP staff and drug users may be criminally charged under the *Controlled Drugs and Substances Act* for possessing traces of illegal drugs contained in used syringes. It is also worth noting that while there is no legal obligation to volunteer information on illegal drug use or to answer police questions, NEP personnel can be compelled by subpoena to give evidence and to produce the facility's records at trial.

Ethical Issues

> The governing purpose or end of NEPs programs is the reduction or elimination of a constellation of harms that accompany addiction to drugs and injection drug use. The NEPs ... are means to achieve that end.
>
> However, these programs do not work as effective means when they are operative in ways that impose restrictions that condemn the programs to fall far short of the needs of the persons for whom they were designed.

Because of all the limitations mentioned above, the ethical principles of autonomy and dignity, beneficence and non-maleficence, justice and fairness and utilitarianism are not followed in some NEPs in Canada. Beneficence and non-maleficence is the maximimization of good and the minimization of harm to the drug user. Autonomy and dignity involves the right of the drug user to self-determination, namely the right to make informed decisions regarding the course of action to be taken. Justice and fairness means that sufficient resources must be provided to address the problems of drug users. Finally, the principle of utilitarianism means that measures must be taken to ensure the maximization of good to society.

Recommendations

1. The federal, provincial, territorial, and municipal governments should ensure that needle exchange programs are easily accessible to injection drug users in all parts of Canada.
2. The federal government should repeal criminal laws that subject drug users and needle exchange staff to criminal liability for having in their possession drug paraphernalia containing residue of illegal substances.
3. Correctional systems should make sterile injection equipment available in prisons.
4. Pharmacists' associations as well as licensing bodies should encourage pharmacists to distribute sterile syringes.

Additional Reading

Hankins C. Syringe exchange in Canada: good but not enough to stem the HIV tide. *Substance Use and Misuse* 1998; 33: 1129. Discusses the history and current deficiencies of needle exchange programs in Canada.

Health Canada. *HIV/AIDS Epi Update: Risk Behaviours Among Injection Drug Users in Canada*. Ottawa: May 2001. Contains references to the studies that have shown that NEPs work. Available at www.hc-sc.gc.ca/hpb/lcdc/bah/

There are many articles on "Needle Exchange/ Syringe Availability & HIV/AIDS" on the Drug Policy Alliance website at www.lindesmith.org /library/syringe_index.html. A research brief on "syringe access," last updated in March 2001, states that "every established medical, scientific, and legal body to study the issue has concluded that improved access to sterile syringes is an effective method to reduce the spread of infectious diseases."

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9

Injection Drug Use and HIV/AIDS

2002/2003

Methadone Maintenance Treatment

This info sheet discusses how the rules and regulations that govern methadone maintenance programs in Canada can serve as barriers to prevention, care, treatment, and support of drug users.

This is one of a series of 12 info sheets on injection drug use and HIV/AIDS: legal and ethical issues.

CANADIAN HIV·AIDS LEGAL NETWORK | RÉSEAU JURIDIQUE CANADIEN VIH·SIDA

Canadian Strategy on HIV/AIDS

Methadone Maintenance Treatment

Methadone remains the only opioid approved for long-term treatment of opiate dependence. It is a synthetic narcotic drug used to treat persons who are dependent on heroin and morphine. In contrast to the short-acting drugs administered by injection, it is a long-acting opioid that can be orally ingested. A drug user need only receive a single dose of methadone in a 24- to 36-hour period. Methadone does not cause euphoria or sedation. This is to be contrasted with the shorter action and dramatic highs and lows of heroin, morphine, and other opiates. The long-lasting effect of methadone allows a drug user to seek employment and, as well, facilitates reintegration into the community.

The safety and effectiveness of methadone maintenance treatment (MMT) has been documented in scientific and medical publications. MMT programs have been credited with decreasing opioid use, reducing criminality, and improving the general health of the drug user. Moreover, MMT reduces individual mortality and morbidity. Another important benefit of MMT is that it helps decrease the spread of HIV, as methadone is typically administered orally rather than by syringe. MMT has thus become a "critical resource in the struggle against injection drug use and AIDS." Methadone clinics are also potentially excellent sites for disease prevention and education. Patients can be offered screening and counselling for transmissible diseases; and can be provided information on safe sex, on the dangers of sharing needles, and on methods for cleaning syringes.

History of MMT in Canada

In 1959, Vancouver physician Dr Robert Halliday obtained approval from the federal Department of Health to conduct a study of methadone as a method of treating opiate-dependent persons. Dr Halliday was successful in establishing that methadone maintenance was a legitimate form of treatment for drug-dependent persons. By 1972, two dozen methadone treatment programs existed in Canada. The Commission of Inquiry into the Non-Medical Use of Drugs, known as the Le Dain Commission, stated in the early 1970s that methadone "is the cheapest and most effective weapon we have for dealing with large-scale heroin dependence." The Commission recommended that methadone maintenance be available to persons dependent on opiates throughout Canada.

Possible misuses of methadone became a concern of the federal government in the early 1970s. In 1972, the government passed regulations to the *Narcotic Control Act* that stated that no doctor or pharmacist could prescribe, administer, give or sell methadone to any person unless so authorized by the federal government. The regulations had a drastic impact on the methadone programs that existed in Canada. Between 1972 to 1975, methadone prescribers as well as patients involved in methadone programs decreased by one-third.

In the mid-1990s, the federal government transferred licensing and control of methadone programs to the provinces. Some provinces have delegated to the College of Physicians and Surgeons the responsibility of regulating the methadone maintenance programs. It is still necessary for physicians to obtain federal authorization to prescribe and administer methadone to their patients.

Barriers to Effective Programs

Restrictions imposed in methadone treatment programs have occurred for several reasons. They include philosophical opposition to methadone treatment, and reliance on such treatment to achieve abstinence from drugs. In many ways, MMT provides a clear example of how regulations "can reduce the public health effectiveness of a controversial program for unpopular people." The US Institute of Medicine concluded that policies place "too much emphasis on protecting society from methadone and not enough on protecting society from the epidemics of addiction, violence, and infectious diseases that methadone can help reduce." The same observation has been made in Canada, where it has been stated that the rules and regulations of methadone programs are often barriers to effective care of injection drug users. In January 1999, an Ontario physician wrote:

> Tremendous controversy exists about the severe restrictions applied to patients taking methadone – restrictions which do not apply in any fashion to the prescribing of other equally or more dangerous narcotics. It would take a treatise to explain the political and philosophic history underlying the severity of standards which must be met by Ontario methadone patients.

Programs have been criticized for the array of rules and regulations to which patients are subjected. They include rigorous assessment procedures, mandatory daily visits, abstinence as a condition of treatment, and random urine sampling. Other issues include:

- The number of heroin-dependent persons in many parts of Canada who have been treated with methadone, although it has increased in recent years, remains low.
- Funding of methadone programs in Canada is inadequate, and in many provinces too few physicians and pharmacists participate in providing MMT.
- Access to MMT in prisons remains limited. In the federal and in many - but not all - provincial systems, inmates who were already on MMT outside can continue such treatment in prison. However, MMT should be available also to opiate-dependent prisoners who were not receiving it prior to incarceration.

Recommendations

1. Federal, provincial, and territorial governments should take measures to ensure that methadone maintenance programs are more accessible to opiate-dependent persons in all provinces and territories.
2. Government health officials and Colleges of Physicians and Surgeons should ensure that comprehensive services are available to persons who participate in methadone programs, including primary health care, counselling, education, and support services.
3. Correctional systems should ensure that prisoners who were on MMT prior to incarceration are able to continue their treatment while incarcerated, and that prisoners are able to start such treatment in prison whenever they would have been eligible for it outside.

Additional Reading

Fischer B. Opiate Addiction Treatment, Research, and Policy in Canada - Past, Present and Future Issues. In M Rihs-Middel et al (eds). Proceedings of Symposium Heroin-Assisted Treatment for Dependent Drug Users: State of the Art and New Research Participants Perspectives: Scientific Findings and Political Perspectives. Bern: University of Bern, 10-12 March 1999. Discusses the history of MMT in Canada, the effect of the 1972 regulations, and the obstacles to MMT that currently exist for injection drug users.

[US]Institute of Medicine. *Federal Regulation of Methadone Treatment.* Washington DC: National Academy Press, 1995.

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10

Injection Drug Use and HIV/AIDS

2002/2003

Safe Injection Facilities

This info sheet explains what safe injection facilities are and why Canada should support trials of safe injection facilities.

This is one of a series of 12 info sheets on injection drug use and HIV/AIDS: legal and ethical issues.

CANADIAN HIV•AIDS LEGAL NETWORK | RÉSEAU JURIDIQUE CANADIEN VIH•SIDA

Canadian Strategy on HIV/AIDS

Another partial solution to the crisis of injection drug use, HIV/AIDS, and HCV (as well as overdoses) that has been suggested is the establishment – initially by way of a trial – of safe injection facilities (SIFs – also known as "supervised injection facilities" or "sites").

What Are Safe Injection Facilities?

SIFs are places in which drug users are able to inject using clean equipment under the supervision of medically trained personnel. The drugs are not provided by anyone at the facility, but are brought there by the drug users. The professional staff do not help to administer the drugs, but assist users in avoiding the consequences of overdose, blood borne diseases or other negative health effects (such as abscesses) that may otherwise result from using unclean equipment and participating in unsafe injecting practices.

SIFs also help direct drug users to treatment and rehabilitation programs, and can operate as a primary health care unit. Facilities provide free sterile equipment, including syringes, alcohol, dry swabs, water, spoons/cookers, and tourniquets. The facilities are intended to reduce incidents of unsafe use of injection drugs and to prevent the negative consequences that too often result from unsafe injection. They are not "shooting galleries," which are not legally or officially sanctioned and are often unsafe because they do not offer hygienic conditions, access to sterile injection equipment, supervision and immediate access to health-care personnel, or connections to other health and support services.

There are three main ways in which SIFs can be effective at improving public health: (1) preventing fatal overdoses, (2) preventing the spread of blood borne diseases and other injuries caused by unsafe injecting, and (3) acting as a gateway to education, treatment and rehabilitation.

The Debate

Some have suggested that establishing SIFs sends the wrong message to the community – namely, that injection drug use is acceptable and has official support. It is argued that this will contribute to increased use. In fact, in cities in Europe that have SIFs the total number of drug users has decreased.

Another concern is that the introduction of SIFs would increase the concentration of drug users in the area in which the SIF is located, thereby affecting the quality of life in the neighbourhood. In reality, SIFs are expected to reduce nuisance and visibility problems: crime, violence, loitering, drug dealing and property damage could be diminished, and many needles would be disposed of safely rather than discarded on the streets. European studies support this contention, with police reporting declines in street robbery, car break-ins, and heroin trafficking and related offences after the introduction of injection facilities.

Other Countries' Experiences

SIFs *can* be established. This is demonstrated by their successful implementation as pragmatic, practical and effective harm reduction strategies in one Australian and many Swiss, German and Dutch cities. SIFs have been instituted in places where high-level public drug scenes existed with typically associated harmful consequences, such as deteriorating health conditions and increasing public nuisances. SIFs now appear to be accepted in those jurisdictions, despite some initial opposition.

Legal Issues

International law demands that trials of SIFs be undertaken, as part of the international legal obligation to provide people with the highest standard of health possible. Furthermore, international drug conventions do not prevent the trial of SIFs. In fact, those treaties relevant to drugs expressly permit scientific and medical experimentation.

Concerns about criminal and civil liability, often exaggerated, also are not insurmountable obstacles to implementing SIFs. Nevertheless, it is advisable to establish a clear framework for the legal operation of safe injection facilities.

Conclusion

SIFs are an important component of a comprehensive harm reduction strategy. Canada cannot sit by, refusing to implement them as one reasonable measure demonstrated to have been effective in other countries, while HIV, HCV, and other preventable harms continue to befall drug users. Government policymakers have a legal and moral obligation to at least allow and support trials of SIFs as measures that are permissible under drug control treaties, further our human rights obligations, and are required out of logic, compassion and basic decency.

Finally, in many ways, it seems odd to have gone so far as to establish needle exchanges, but to stop short of providing SIFs. At present, publicly funded programs operate to provide syringes and needles to injection drug users with the clear understanding they will be used to administer prohibited drugs. In these circumstances, to shrink from the provision of safe, sanitary premises where users can safely inject is somewhat short-sighted.

SIFs could sit comfortably alongside needle exchanges as another important strategy designed to combat some of the harmful effects of injection drug use. Any differences between these measures are neither meaningful nor significant enough to deny the trial of this initiative, when the ultimate, positive public health effects are likely to be substantial.

Recommendations

1. Health Canada should fund the operation and evaluation of a multi-site scientific research trial of SIFs.
2. Federal, provincial/territorial and municipal officials with responsibilities in the areas of health, social services and law enforcement should collaborate to ensure that trials of SIFs can occur as soon as possible.
3. The federal government should create a regulatory framework under the *Controlled Drugs and Substances Act* (CDSA) to govern SIFs that would eliminate the risk of criminal liability for staff and clients and reduce the risk of civil liability for operating such facilities.
4. Until such a framework is in place, the federal Minister of Health should grant ministerial exemptions from the application of the provisions of the CDSA making it an offence to possess a controlled substance to designated SIFs and to their staff and clients, so that such facilities can operate on a trial basis.

Additional Reading

Elliott R, Malkin I, Gold J. *Establishing Safe Injection Facilities in Canada: Legal and Ethical Issues*. Montréal: Canadian HIV/AIDS Legal Network, 2002. Everything you need to know about SIFs. Available at www.aidslaw.ca/Maincontent/issues/druglaws.htm.

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11

Injection Drug Use and HIV/AIDS

2002/2003

An Obligation to Act

Since the early 1990s, Canada has been in the midst of a public health crisis concerning HIV/AIDS, hepatitis C, and injection drug use. Its response to this crisis has been far from being concerted and effective. Much more can and must be done to prevent the further spread of HIV and other infections among injection drug users, and to provide care, treatment, and support to those already living with HIV or AIDS. Indeed, much more must be done, because current approaches do not withstand ethical scrutiny.

This is one of a series of 12 info sheets on injection drug use and HIV/AIDS: legal and ethical issues.

CANADIAN HIV·AIDS LEGAL NETWORK | RÉSEAU JURIDIQUE CANADIEN VIH·SIDA

Canadian Strategy on HIV/AIDS

Another Public Health Tragedy

Canada is in the midst of a public health crisis concerning HIV/AIDS, hepatitis C (HCV) and injection drug use. The number of infections attributable to injection drug use has been unacceptably high. In 1999, 34.1 percent of the estimated 4,190 new HIV infections were among injection drug users. Over 60 percent of new HCV infections are related to injection drug use.

Canada's response to this crisis has been far from being concerted and effective. Indeed, the lack of appropriate action has led some to conclude that another public health tragedy, comparable to the blood tragedy in the 1980s, is underway, illustrating that little if anything has been learned from the lessons taught by that tragedy. As Skirrow says:

> A marginalized community (in this case injection drug users) is experiencing an epidemic of death and disease resulting not from anything inherent in the drugs that they use, but more from the ineffective and dysfunctional methods that characterize our attempts to control illegal drugs and drug users. There is the same unwillingness to carefully analyze the problem or to depart from traditional methods and conventional thought that was integral to the blood tragedy. There is a struggle for power and control over the issue between law enforcement and public health. There is a profound lack of understanding among decision-makers and many health professionals regarding the nature of the community and individuals at risk.

Much More Must Be Done

The legal status of drugs in Canada contributes to the difficulties encountered in addressing HIV among injection drug users. However, much can be done now, without waiting for much-needed legal changes, within the current legal framework, to facilitate prevention efforts and efforts to provide care, treatment, and support to HIV-positive injection drug users. Indeed, much must be done, as ethical analysis reveals, because current approaches do not withstand ethical scrutiny. As Roy has stated:

> It is *ethically* wrong to continue the current approaches to the control of drug use when these approaches fail to achieve the goals for which they were designed; create harms equal to or greater than those they purport to prevent; and intensify the marginalization of vulnerable people.
>
> It is *ethically* wrong to continue to tolerate complacently the tragic gap that exists between what can and should be done in terms of comprehensive care for drug users and what is actually being done to meet these persons' basic needs.
>
> It is *ethically* wrong to continue policies and programs that so unilaterally and utopically insist on

abstinence from drug use that they ignore the more immediately commanding urgency of reducing the suffering of drug users and assuring their survival, their health, and their growth into liberty and dignity.

It is *ethically* wrong utterly to neglect to organize the studies needed to deliver the knowledge required to care more adequately for persons who use drugs and are HIV-infected.

It is *ethically* wrong to exclude HIV-infected drug users from participation in clinical trials when that exclusion is based not on scientific reasons but rather on prejudice, discrimination, or simply on considerations of clinical-trial convenience for the investigators.

It is *ethically* wrong to tailor or suppress the information about illegal drugs that individual users, professionals, and citizens generally need to know in order to act responsibly.

It is *ethically* wrong to set up treatment or prevention programs in such a way that what the program gives with one hand, it takes away with the other.

It is *imperative* that persons who use drugs be recognized as possessing the same dignity as all other human beings.

Much More Must Be Done NOW

In 1997, the National Task Force on HIV, AIDS and Injection Drug Use, in its *National Action Plan*, called for "immediate action ... at all levels of governmental and community leadership." In particular, the Task Force demanded that: policy and legislative issues be addressed; prevention and intervention efforts be enhanced; treatment options for substance use and HIV be improved; issues specific to Aboriginal populations receive special and urgent attention; and issues unique to women be addressed. The Task Force "strongly reconfirmed" the responsibility of the federal Minister of Health to show leadership on this issue, in partnership with key ministries (Justice, Solicitor General, Corrections) through initiating action, monitoring implementation, and evaluating outcomes.

In 1999, the Canadian HIV/AIDS Legal Network released its report on *Injection Drug Use and HIV/AIDS: Legal and Ethical Issues*. In **2001**, Health Canada responded to the report and its recommendations with a commitment to "strengthening and expanding efforts with respect to injection drug use." Also in 2001, five federal/provincial/territorial committees released a document on "reducing the harms associated with injection drug use in Canada."

Nevertheless, **in 2002**, the crisis is ongoing. Governments are continuing their half-hearted responses. Yet people continue to become infected in alarming numbers. Implementing the recommendations in the *National Action Plan* and in *Injection Drug Use and HIV/AIDS: Legal and Ethical Issues* must become an urgent priority.

Additional Reading

Krever H, The Honourable Mr Justice. *Commission of Inquiry on the Blood System in Canada: Final Report*. Volumes 1-3. Ottawa: Minister of Public Works and Government Services Canada, 1997. After this report, governments should know better than to continue fragmented, reactive approaches to the public health crisis of HIV/AIDS and HCV among injection drug users.

Roy D. Injection Drug Use and HIV/AIDS: An Ethics Commentary on Priority Issues. In: *Injection Drug Use and HIV/AIDS: Legal and Ethical Issues. Background Papers*. Montréal: Canadian HIV/AIDS Legal Network, 1999.

Skirrow J. Lessons from Krever – a personal perspective. *Canadian HIV/AIDS Policy & Law Newsletter* 1999; 4(2/3): 35-41. Compares the blood tragedy with the new public health tragedy of HIV/AIDS among injection drug users.

Jürgens R. Health Canada commits to strengthening efforts with respect to injection drug use and HIV/AIDS. *Canadian HIV/AIDS Policy & Law Review* 2001; 6(1/2): 86-89. Reviews recent Canadian developments. Available at www.aidslaw.ca/Maincontent/otherdocs/Newsletter/vol6nos1-22001/drugpolicy.htm.

Second, revised and updated version, 2002. The information in this series of info sheets is taken from *Injection Drug Use and HIV/AIDS: Legal and Ethical Issues*, prepared by the Canadian HIV/AIDS Legal Network, but was updated in 2002. Copies of the paper and info sheets are available on the Network website at www.aidslaw.ca/Maincontent/issues/druglaws.htm and through the Canadian HIV/AIDS Clearinghouse (email: aids/sida@cpha.ca). Reproduction is encouraged, but copies may not be sold, and the Canadian HIV/AIDS Legal Network must be cited as the source of this information. For further information, contact the Network at info@aidslaw.ca. **Ce feuillet d'information est également disponible en français.**

Funded by Health Canada, under the Canadian Strategy on HIV/AIDS. The views expressed are those of the author and do not necessarily reflect the views or policies of the Minister of Health.

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Injection Drug Use and HIV/AIDS

2002/2003

Essential Resources

There is a vast amount of literature on injection drug use and HIV/AIDS. This info sheet provides information about a number of selected, essential resources - articles, books, reports, and journals that provide crucial information and/or recommendations on injection drug use and HIV/AIDS, particularly the legal and ethical issues raised.

This is one of a series of 12 info sheets on injection drug use and HIV/AIDS: legal and ethical issues.

CANADIAN HIV·AIDS LEGAL NETWORK | RÉSEAU JURIDIQUE CANADIEN VIH·SIDA

Canadian Strategy on HIV/AIDS

Beyerstein B, Alexander B. Why treat doctors like pushers? *Canadian Medical Association Journal* 1985; 132: 337-340.
Criticizes the prohibitionist approach to drug policy in Canada in which doctors are vulnerable to prosecution as traffickers for prescribing narcotics. Advocates that doctors should have the legal authority to prescribe drugs according to their judgment of patient needs.

Bruckner T. *The Practical Guide To The Controlled Drugs and Substances Act*. Toronto: Thomson Canada Limited, 1997.
Discusses the provisions of the *Controlled Drugs and Substances Act* and provides commentary on the difficulties that some of the provisions raise for the treatment of patients who are drug users.

Bruneau, J et al. High rates of HIV infection among injection drug users participating in needle exchange programs in Montreal: results of a cohort study. *American Journal of Epidemiology* 1997; 146(12): 994-1006.
Discusses the purpose of needle exchange programs and the history of needle exchange programs in Montréal.

Canadian Centre on Substance Abuse & Canadian Public Health Association. *HIV, AIDS and Injection Drug Use: A National Action Plan*. Ottawa: The Centre & The Association, 1997.
Emphasizes that "Canada is in the midst of a public health crisis concerning HIV and AIDS, and injection drug use," and that "[i]mmediate action is required at all levels of governmental and community leadership." Contains numerous recommendations. A must! Available at www.ccsa.ca.

Canadian Centre on Substance Abuse. *Syringe Exchange: One Approach To Preventing Drug-Related HIV Infection. A Discussion Paper*. Ottawa: The Centre, 1994.
Discusses the philosophy underlying syringe exchange programs and recommends ways to maximize their effectiveness. Available at www. ccsa.ca.

Canadian HIV/AIDS Legal Network. *Injection Drug Use and HIV/AIDS: Legal and Ethical Issues*. Montréal, The Network, 1999.
The report on which this series of info sheets is based. A must! See also Health Canada's response to the report (*infra*, Health Canada, 2001). Available at www.aidslaw.ca/Maincontent/issues/druglaws.htm.

Clark PA. The ethics of needle-exchange programs. *AIDS & Public Policy Journal* 1998; 13(4): 131-139.
Concludes that needle-exchange programs are "both a necessary and a vital part of a broader comprehensive strategy for preventing HIV transmission among intravenous-drug users."

Drucker E. Drug prohibition and public health: 25 years of evidence. *Public Health Reports* 1999; 114(1): 14-29 (reprinted in *The Drug Policy Letter* 1999; 40: 4-18).
Finds that the damage done by the drug war overwhelms the claim that US zero tolerance is protecting the public health. "The cure is worse than the disease."

Elliott R, Malkin I, Gold J. *Establishing Safe Injection Facilities in Canada: Legal and Ethical Issues*. Montréal: Canadian HIV/AIDS Legal Network, 2002.
Everything you need to know about SIFs. Available at www.aidslaw.ca/Maincontent/issues/druglaws.htm.

Erickson PG, DM Riley, YW Cheung, PA O'Hare. *Harm Reduction: A New Direction for Drug Policies and Programs*. Toronto: University of Toronto Press, 1997.
A collection of papers originally presented at the Fifth International Conference on the Reduction of Drug-Related Harm, Toronto, Canada, March 1994.

Federal/Provincial/Territorial Committee on Injection Drug Use. *Reducing the Harm Associated with Injection Drug Use in Canada.* Working Document. Ottawa: March 2001.
Available at www.aidslaw.ca/Maincontent/issues/druglaws.htm. Acknowledges the severity of the problem, and maps out what governments could and should do. Will they act on it?

Fischer B. Prescriptions, power, and politics: the turbulent history of methadone maintenance in Canada. *Journal of Public Health Policy* 2000; 21(2): 187-210.
Traces the turbulent history in Canada of methadone treatment, regulations and policy. Concludes that the regulations and policy have hindered the treatment of drug-dependent persons.

Fischer B. The case for a heroin substitution treatment trial in Canada. *Canadian Journal of Public Health* 1997; 88: 367. Puts forth the view that in light of the public health problems associated with injection drug users, professionals should be permitted to treat drug users with illegal drugs such as heroin.

Hadaway P, Beyerstein BL, Youdale JVM. Canadian drug policies: irrational, futile and unjust. *Journal of Drug Issues* 1991; 21(2): 183-197.
Argues that, while protection of individual freedom and civil liberties is highly valued in Canada, Canadians allow the erosion of these rights in the service of the War on Drugs.

Hankins C. Syringe exchange in Canada: good but not enough to stem the HIV tide. *Substance Use and Misuse* 1998; 33: 1129.
Discusses the history and current deficiencies of needle exchange programs in Canada.

Health Canada. *HIV/AIDS Epi Update: HIV/AIDS Among Injecting Drug Users in Canada* (and *Risk Behaviours Among Injecting Drug Users in Canada*). Ottawa: May 2001.
Essential info about the HIV/AIDS epidemic among injection drug users in Canada, with numerous references. Regularly updated. Available at www.hc-sc.gc.ca/hpb/lcdc/bah/.

Health Canada. *Hepatitis C & Injection Drug Use*. Ottawa: 2001.
Available at www.hc-sc.gc.ca/hppb/hepatitis_c/aboutfacts.html.

Health Canada. *Injection Drug Use and HIV/AIDS. Health Canada's Response to the Report of the Canadian HIV/AIDS Legal Network*. Ottawa: 2001.
Health Canada's response to the 1999 report on *Injection Drug Use and HIV/AIDS: Legal and Ethical Issues* by the Canadian HIV/AIDS Legal Network. Available at www.aidslaw.ca/Maincontent/issues/druglaws.htm.

***HIV/AIDS in Prisons: Info Sheets 1-13*. Montréal: Canadian HIV/AIDS Legal Network, 2nd edition, 2001.**
13 info sheets with essential information on HIV/AIDS and drug use in prisons. Available at www.aidslaw.ca/Maincontent/issues/prisons.htm.

Joint United Nations Programme on AIDS. *Drug Use and HIV/AIDS. UNAIDS Statement Presented at the United Nations General Asembly Special Session on Drugs*. Geneva: UNAIDS Best Practice Collection Key Material, March 1999 (UNAIDS 99.1E).
The UNAIDS statement on drug use and HIV/AIDS. Significantly, it endorses a harm-reduction approach to drug use. Available at www.unaids.org.

Kerr T. *Safe Injection Facilities: Proposal for a Vancouver Pilot Project*. Prepared for the Harm Reduction Action Society. Vancouver, 2000.
Proposes a Vancouver pilot safe injection facility.

Kerr T, A Palepu. Safe injection facilities in Canada: Is it time? *Canadian Medical Association Journal* 2001;165(4):436-7.
An editorial arguing that it is indeed time for safe

injection facilities in Canada. Available at www.cma.ca/cmaj/vol-165/issue-4/0436.asp.

Kirby M. Sex, Drugs and the Family. [Australian] *National AIDS Bulletin* 1994; 7(12): 20-22.
Points out that the subject of human rights of persons using drugs has been ignored until now by most lawyers and virtually all judges: "Putting it quite bluntly, it is an uncivilised act to punish people, with long periods of imprisonment, who are addicted to particular drugs. The problem is, and should be treated as, one of public health concern, not one of law and order."

Loue S, Lurie P, Lloyd L. Ethical issues raised by needle exchange programs. *Journal of Law, Medicine & Ethics* 1995; 23: 382-388.
Discusses ethical principles underlying the establishment of needle exchange programs.

MacFarlane B. *Drug Offences In Canada*. Toronto: Canada Law Book Inc, 3rd edition, 1997.
Provides a comprehensive discussion of drug laws in Canada.

Malkin I. Establishing supervised injecting facilities: a responsible way to help minimise harm. *Melbourne University Law Review* 2001; 25(3): 680.
Argues that, for legal and ethical reasons, supervised injecting facilities should be established.

McAmmond D. *Care, Treatment and Support for Injection Drug Users Living with HIV/AIDS: A Consultation Report.* Ottawa: Health Canada, March 1997.
Identifies issues that need to be addressed in order to provide effective HIV/AIDS care, treatment, and support to injection drug users (particularly those who are street-involved or marginalized), and proposes initiatives that might begin to address these issues.

MacPherson D. *A Framework for Action: A Four Pillar Approach to Drug Problems in Vancouver*. City of Vancouver: 2001 (2nd, revised version).
The latest effort toward a coordinated attack on Vancouver's drug problem. Available at www.city.vancouver.bc.ca. See also a review of the framework by Skirrow in the *Canadian HIV/AIDS Policy & Law Review* 2001; 6(1/2): 89-91 (available at www.aidslaw.ca/Maincontent/otherdocs/Newsletter/vol6nos1-22001/drugpolicy.htm

Millar J. *HIV, Hepatitis, and Injection Drug Use in British Columbia-Pay Now or Pay Later?* Office of the Provincial Health Officer, BC Ministry of Health, 1998.
The report of the provincial health officer in British Columbia, stating that "the continuation of this epidemic [of HIV among injection drug users] represents a failure of societal values and attitudes." With many recommendations.

Mitchell CN. A justice-based argument for the uniform regulation of psychoactive drugs. *McGill Law Journal* 1986; 31: 212-263.
Argues that modern drug control legislation is founded upon myth and prejudice rather than on principles of justice and scientific validity. Makes justice-based reform proposals.

Nadelmann E, McNeely J, Drucker E. *International Perspectives in Substance Abuse: A Comprehensive Textbook*. Baltimore: Williams & Wilkins, 3rd edition, 1997.
Emphasizes the importance of taking a harm reduction approach to the public health problem of injection drug use and HIV/AIDS. Endorses the orientations of countries such as Britain, Switzerland, and The Netherlands.

O'Brien M. Needle exchange programs: ethical and policy issues. *AIDS & Public Policy Journal* 1989; 4(2): 75-82.
Analyzes arguments in favour of and against needle exchange programs.

O'Connor P, Selwyn P, Schottenfeld R. Medical care for injection-drug users with human immunodeficiency virus infection. *The New England Journal Of Medicine* 1994; 331(7): 450-459.
States that drug users are less likely to receive therapy for HIV than other HIV-positive persons. Suggests ways for doctors to improve the care of HIV-positive patients who are drug users.

Poulin C et al. The epidemiology of cocaine and opiate abuse in urban Canada. *Canadian Journal of Public Health* 1998; 89 (4):234-238.
Data pertaining to prevalence of use, law enforcement, treatment, morbidity and mortality, from Vancouver, Calgary, Montréal, Toronto, Winnipeg and Halifax.

Riley D. *The Harm Reduction Model. Pragmatic Approaches to Drug Use from the Area Between Intolerance and Neglect*. Ottawa: Canadian Centre on Substance Abuse, 1993.
Explains the concept of harm reduction and contains a list of suggested readings and videos on the subject. Available at www.ccsa.ca.

Sherer R. Adherence and antiretroviral therapy in injection drug users. *Journal of the American Medical Association* 1998; 280(6): 567-56.
Presents reasons for which doctors are relunctant to prescribe antiretroviral therapy (ART) to injection drug users. Suggests ways in which injection drug users can adhere to the medical regimen of ART.

Solomon RM, Usprich SJ. Canada's drug laws. *Journal of Drug Issues* 1991; 21(1): 17-40.
Traces the history of Canadian drug legislation until 1991 – legislation that, they argue, originated and developed in response to racial and political factors rather than reasoned analysis.

Strathdee S et al. Barriers to use of free antiretroviral therapy in injection drug users. *Journal of the American Medical Association* 1998; 280: 547.
A Canadian study that found that many HIV-positive injection drug users are not receiving ART.

Strathdee S et al. Needle exchange is not enough: lessons from the Vancouver injecting drug use study. *AIDS* 1997; 11(8): F59-65.
Concludes that while needle exchange programs are crucial, they are only one component of a comprehensive program that should include counselling, support and education.

Ward J, Mattick RP, Hall W (eds). *Methadone Maintenance Treatment and Other Opioid Replacement Therapies*. Amsterdam: Harwood Academic Publishers, 1998.
An excellent book with 18 articles on all aspects of methadone maintenance treatment and other opioid replacement therapies.

For More Resources ...

contact the Resource Centre of the Canadian HIV/AIDS Legal Network: www.aidslaw.ca/maincontent.htm#rc.

Selected Journals and Websites

Canadian HIV/Policy & Law Review
Required reading for all those working on, or interested in, HIV/AIDS and drug policy in Canada and internationally. Available at www.aidslaw.ca/Maincontent/otherdocs/Newsletter/newsletter.htm

International Journal of Drug Policy
The official journal of the International Harm Reduction Association (www.ihra.net/). Publishes material on the social, political, legal, and health contexts of psychoactive substance use, both licit and illicit. Order info at www.elsevier.com/locate/drugpo.

www.aidslaw.ca
The website of the Canadian HIV/AIDS Legal Network. Contains a section on drug laws and policies (at www.aidslaw.ca/Maincontent/issues/druglaws.htm).

http://canadianharmreduction.com/
The website of the Canadian Harm Reduction Network, dedicated to reducing the harms associated with drugs and drug policies.

www.ccsa.ca
The website of the Canadian Centre on Substance Abuse. Features articles and news on subjects such as hepatitis and injection drug use; harm reduction: concepts and practice; syringe exchange, etc.

www.cfdp.ca
The Canadian Foundation for Drug Policy's site. Canada's most comprehensive resource about drug law and policy reform.

www.drugpolicy.org
The Drug Policy Alliance's (formerly: Lindesmith Center's) excellent website. A must! Features a searchable database of thousands of library documents on drug policy from economic, criminal justice, and public health perspectives, a subject index of full-text materials online, and a great list of links to other sites.

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