CANADA:
Drug policy and economic, social, and cultural rights

Submission to the Committee on Economic, Social, and Cultural Rights

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Canadian HIV/AIDS Legal Network and
International Centre on Human Rights and Drug Policy
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I. General Information: Drug policy and economic, social and cultural rights

Canada is a party to the three main UN drug control conventions, which aim to control illicit drugs by reducing supply and demand, in particular through requiring States Parties to adopt varying degrees of prohibitions and sanctions on a range of designated controlled substances, while also providing some degree of (often contested) flexibility for States Parties in their approach.[1] However, Canada must also fulfill its domestic constitutional obligations under the *Canadian Charter of Rights and Freedoms*, as well as those under international human rights law, including the *International Covenant on Economic, Social and Cultural Rights,* which Canada has ratified. These human rights obligations bind the state in its response to drugs.

Yet, when poorly developed and implemented, drug policies can lead to serious violations of economic, social, and cultural rights, including discriminatory arrest and penalization, denial of social benefits and custodial rights, police harassment and violence, arbitrary detention of minority groups, coercive medical treatment, systemic denial of essential medical interventions, and other violations of the right to health. Many of these policies and practices fuel stigma, exacerbate existing inequality, and undermine the progressive obtainment of entitlements guaranteed under the ICESCR. The health and human rights of indigenous communities across the globe have been acutely affected, including indigenous communities in Canada.

In 2007, the Government of Canada launched a new National Anti-Drug Strategy. This new strategy expanded a punitive drug control framework, eliminating the long-standing element of *harm reduction* as part of the Government's response to drugs. This new model then led to a series of "tough on crime" laws, policies and other measures by the Government of Canada, including mandatory minimum sentences for certain drug-related offenses and active efforts by the federal government to prevent the introduction of evidence-based harm reduction programs across the country.

In light of the Committee's current review of Canada's implementation of the International Covenant on Economic, Social, and Cultural Rights, please find below a brief overview of our main concerns related to Canadian drug law and policy.

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[1] United Nations, *Single Convention on Narcotic Drugs* (1961), as amended by the 1972 Protocol amending the *Single Convention on Narcotic Drugs*; United Nations, *Convention on Psychotropic Substances* (1971); United Nations, *Convention against Illicit Traffic in Narcotic Drugs and Psychotropic Substances* (1988).

II. Issues related to general provisions of the Covenant

Maximum available resources

The new drug strategy introduced in 2007 directed the majority of new funding towards law enforcement under the *Controlled Drugs and Substances Act*.[2] A review conducted in 2009 showed that law enforcement received the overwhelming majority of funding for the drug strategy (70%) while prevention (4%), treatment (17%) and harm reduction (2%) combined only received (less than) a quarter of the overall funding.[3] Despite obligations under the ICESCR (Articles 2 and 12) to ensure maximum available resources are directed towards the progressive realization of the right to the highest attainable standard of health, budgetary allocation for essential health interventions, including drug dependence treatment and harm reduction for some of Canada's most vulnerable communities, has been displaced by politically-motivated enhancement of the enforcement of punitive laws, including mandating minimum periods of incarceration, including for small-scale drug offences.

Non-discrimination

We are concerned that Canada's current national drug policy does not adequately reflect the principle of non-discrimination – and in fact, in both intent and effect, actively discriminates in various ways contrary to its international human rights obligations under various conventions, including ICESCR. We note three examples in brief below: (1) the ongoing criminalization of possession of substances for personal use; (2) recently-enacted mandatory minimum prison sentences for certain drug offences; and (3) recently-enacted impediments to access to health services.

First, Canada's ongoing **criminalization of possession of controlled substances for personal consumption** further stigmatizes and marginalizes people who use drugs. It amounts to criminalization of people with addiction – which is recognized as a disability under Canadian law.[4] It also runs contrary to recommendations from a variety of international bodies, including the Office of the UN High Commissioner for Human Rights (OHCHR)[5] and various UN specialized agencies such as UNAIDS, WHO and UNODC.[6]

Second, despite opposition from public health officials and leading human rights experts, in 2012 the federal Parliament enacted the *Safe Streets and Communities Act*, which created new **mandatory minimum sentences of incarceration for certain drug offences**.[7] While the federal government of the day claimed the law only

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[2] Canadian Drug Policy Coalition, *Getting to tomorrow: a report on Canadian drug policy*, 2013, online: http://drugpolicy.ca/report/CDPC2013_en.pdf;

[3] K. De Beck et al., "Canada's new federal 'National Anti-Drug Strategy': an informal audit of reported funding allocation," *International Journal of Drug Policy* 2003; 20(2):188-191.

[4] *Canadian Human Rights Act*, RSC 1985, c. H-6. Section 25 of the Act defines "disability" as follows: "disability means any previous or existing mental or physical disability and includes disfigurement and previous or existing dependence on alcohol or a drug."

[5] UN General Assembly, *Study on the impact of the world drug problem on the enjoyment of human rights: Report of the United Nations High Commissioner for Human Rights,* UN Doc. A/HRC/30/65 (4 September 2015), online: http://www.ohchr.org/EN/HRBodies/HRC/RegularSessions/Session30/Documents/A_HRC_30_65_E.docx.

[6] E.g., UNAIDS, *A Public Health And Rights Approach to Drugs* (Geneva, 2015), online: http://aidsdatahub.org/sites/default/files/publication/A_public_health_and_rights_approach_to_drugs_2015_0.pdf;

[7] *Letter to Government Expressing Opposition to Bill S-10,* February 6, 2011, online: http://uhri.cfenet.ubc.ca/content/view/88; Canadian Bar Association, *Submission on Bill C-10, Safe Streets and Communities Act,* at http://www.cba.org/cba/submissions/PDF/11-45-eng.pdf; Canadian HIV/AIDS Legal Network, *Brief to*

targets "serious drug crimes," the new minimum prison sentences mandated by the new law are likely to disproportionately affect individuals from vulnerable and marginalized populations, thus perpetuating systemic discrimination already well-documented in the criminal justice and correctional systems.[8] In fact, the disproportionate, discriminatory impact of mandatory minimum sentences for drug offences affects in particular the following populations:

- **people struggling with problematic substance use**, as reflected in the fact that the federal prison system's own data reports that some 80% of those incarcerated federally have experience of either former or current substance use;
- **Indigenous people**, who both experience substantially higher rates of addiction and are vastly over-represented in Canada's prisons – and both of these facts are ones of which the Supreme Court of Canada and other courts have repeatedly taken judicial notice;
- **black people**, whose rates of incarceration in federal prisons have significantly increased in recent years, according to the federal correctional ombudsman, far out of proportion to their representation in the Canadian population as a whole; and
- **women**, given the even higher proportion of problematic drug use reported among women – and particularly among Indigenous women – in Canadian prisons than among men.

With regard to the disproportionate, discriminatory impact on the grounds of disability (i.e., addiction), race and sex of such harsher, punitive drug policy, we draw to the Committee's attention the concerns raised by the ombudsman for Canada's federal prison system. In his 2014 report to the Minister responsible for that system, the Correctional Investigator of Canada indicated that "upon admission, 80% of federally sentenced male offenders have a substance abuse problem," and further observed:

> The most visible change during my tenure as Correctional Investigator has been the growth in the overall size, complexity and diversity of the offender population. It is not a new observation that some of Canada's minority, vulnerable or disadvantaged groups are disproportionately involved in the criminal justice system. These trends are accelerating within federal prisons. Since March 2005, the federal inmate population has increased by 17.5%. Over the same period, the Aboriginal population grew by 47.4% and Black offenders by over 75%. These groups now comprise 22.8% and 9.8% of the total incarcerated population respectively. The federally sentenced women population has increased 66%, with the Aboriginal women count growing by 112%.[9]

The Correctional Investigator noted that predictable consequences of mass incarceration have materialized, including overcrowding, increases in rates of violence and self-injury in prisons, and increased use of segregation.[10] All of these raise further concerns regarding the right to health, as well implicate breaches of other human rights standards (e.g., regarding cruel, inhuman or degrading treatment).

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the Standing Senate Committee on Legal and Constitutional Affairs, in relation to the Committee's study on Bill C-10 (2012), online: http://www.aidslaw.ca/site/wp-content/uploads/2013/04/Senate-brief_C-10_2012-ENG.pdf.

[8] British Columbia Civil Liberties Association, *More Than We Can Afford: The Costs of Mandatory Minimum Sentencing,* 2014, online: https://bccla.org/our_work/more-than-we-can-afford-the-costs-of-mandatory-minimum-sentencing/.

[9] Office of the Correctional Investigator of Canada, *Annual Report: 2013-2014,* 2014 at p. 2, available at http://www.oci-bec.gc.ca/cnt/rpt/pdf/annrpt/annrpt20132014-eng.pdf.

[10] Ibid.

Third, we note that **discrimination impedes access to health care** – which remains a challenge for people who use drugs as they continue to suffer from stigma and judgmental attitudes by health care professionals[11] and as the federal government has taken active measure to prevent access to evidence-based health services. This includes the enactment in 2015 by Parliament of the so-called *Respect for Communities Act* (Bill C-2, *An Act to amend the Controlled Drugs and Substances Act*), which legislated an unjustifiably onerous application process for an exemption from Canada's drug laws so as to permit the effective operation of supervised injection facilities without risk of criminal prosecution for clients and staff.[12] This legislation has been widely condemned by public health and human rights experts as flying in the face of a previous decision of the Supreme Court of Canada finding that the denial of such an exemption constituted an impermissible, unconstitutional breach of the rights to life, liberty and security of the person of people with addictions needing access to such a health service (the internationally-recognized "Insite" supervised injection site in Vancouver).[13] It is hard to conceive of such barriers being legislated to impede other, evidence-based (and internationally recommended) health services responding to a well-documented public health need. This further reflects the discriminatory measures adopted by the Government of Canada to impede the realization of the highest attainable standard of health in the case of people struggling with addiction (which, as noted above, amounts to discrimination on the basis of disability, including under well-established Canadian anti-discrimination law such as the *Canadian Human Rights Act*).

Rights of Indigenous peoples

Canadian's punitive approach to illicit drugs has had a particularly harsh impact on indigenous peoples, who represent less than 5 per cent of the Canadian population[14] but account for half of all new HIV cases attributed to injecting drug use.[15] Indigenous peoples are also disproportionately represented in prisons where they comprise 23 per cent of the population. Indigenous women represent 33 per cent of all women sent to federal institutions.[16] Moreover, and as reported by the federal Correctional Investigator, Indigenous peoples are more likely to serve more of their sentence behind bars, be held in segregation or with maximum security populations, and be disproportionately prone to self-injury while in prison. This tragic situation is directly linked to current drug policy. As revealed by a research study looking at a sample of Indigenous people enrolled in the Aboriginal Offender Substance Abuse Program of the Correctional Service of Canada (CSC), almost all (96%) indicated that substance use was related to their current offence; 85% reported they were under the influence at the time of their offence.[17] Resources spent on enforcement of Canada's drug laws – including laws that now mandate minimum prison sentences in various circumstances – continue to fuel incarceration and undermine health and human rights, instead of protecting and promoting the health and well-being of Indigenous peoples in Canada.

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[11] L. Van Boekel et al., "Stigma among health professionals towards patients with substance use disorders and its consequences for healthcare delivery: Systematic review," *Drug and Alcohol Dependence* 2013; 131: 23-35.
[12] Canadian HIV/AIDS Legal Network, Canadian Drug Policy Coalition, *An Injection of Reason: Critical Analysis of Bill C-2* (2014), online: http://www.aidslaw.ca/site/an-injection-of-reason-critical-analysis-of-bill-c-2/.
[13] *Canada (Attorney General) v. PHS Community Services Society*, 2011 SCC 44.
[14] Statistics Canada, *Aboriginal Peoples in Canada: First Nations People, Métis and Inuit,* 2011, available at http://www12.statcan.gc.ca/nhs-enm/2011/as-sa/99-011-x/99-011-x2011001-eng.cfm.
[15] Public Health Agency of Canada, *HIV and AIDS in Canada. Surveillance report to December 31, 2013* (2014), online: http://www.phac-aspc.gc.ca/aids-sida/publication/survreport/2013/dec/assets/pdf/hiv-aids-surveillence-eng.pdf.
[16] Office of the Correctional Investigator of Canada, *Annual Report: 2013-2014* (2014), available at http://www.oci-bec.gc.ca/cnt/rpt/pdf/annrpt/annrpt20132014-eng.pdf.
[17] Ibid., p. 43.

III. Issues related to the specific provisions of the Covenant

Article 6 (the right to work), Article 10 (protection of the family, mothers and children), and Article 11 (the right to an adequate standard of living)

Many Canadians have a criminal record because they were once found in possession of drugs, most often cannabis.[18] Having a criminal record can have serious repercussions on individuals' access to housing, employment and ability to travel.[19] Criminal convictions combined with substance use also affect parental rights. According to the Correctional Investigator of Canada, 3 in 4 incarcerated women are also mothers to children under the age of 18. At the time of their arrest, almost two-thirds were single caregivers and over half reported having had experiences with child protection services – often due to problematic substance use, mental health concerns or issues of abuse/neglect. And maintaining family relationships between women and their children throughout their incarceration present many challenges.[20]

Right to health (Article 12): retrogressive measures regarding health goods, services and information

As noted above, pursuant to the adoption in 2007 of a new National Anti-Drug Strategy in Canada, federal funding was diverted away from harm reduction measures (which were excised entirely from the strategy despite their long-standing presence as a key element of a "balanced" approach), in favour of enhancing law enforcement responses to drugs with greater funding. Such action signals a deliberate, retrogressive measure, putting people who use drugs at increased risk of harm. Harm reduction includes such evidence-based health services as **needle and syringe programs** (NSPs) and **supervised consumption services** (SCS), which prevent overdose and the transmission of communicable diseases such as HIV and HCV, and can increase access to treatment and to other health and social services.

The most recent surveillance data indicates that 12.8% of new HIV infections in Canada are attributable to injection drug use.[21] Harm reduction programmes are therefore, essential for protecting the right to health of people who use drugs, yet multiple barriers hinder access to these programs in Canada – including the federal government's active efforts to hinder the introduction of new SCS in Canada (see discussion of Bill C-2 above). Similarly, access to treatment for problematic substance use, including **opioid substitution therapy** (OST), is limited and is generally underfunded across the country[22] and some municipalities have enacted bylaws to prevent the operation of methadone clinics or NSPs, prompting at least one provincial Human Rights Commission to express its concern about this manifestation of disability-based discrimination.[23]

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[18] Centre for Addiction and Mental Health, *Cannabis Framework Policy* (2014), p.6 available at http://www.camh.ca/en/hospital/about_camh/influencing_public_policy/Documents/CAMHCannabisPolicyFramework.pdf.
[19] Ibid.
[20] Office of the Correctional Investigator of Canada, *Annual Report: 2013-2014,* 2014 at p. 46, available at http://www.oci-bec.gc.ca/cnt/rpt/pdf/annrpt/annrpt20132014-eng.pdf.
[21] Public Health Agency of Canada, *HIV and AIDS in Canada. Surveillance report to December 31, 2013* (2014), online: http://www.phac-aspc.gc.ca/aids-sida/publication/survreport/2013/dec/assets/pdf/hiv-aids-surveillence-eng.pdf.
[22] Canadian Drug Policy Coalition, *Getting to tomorrow: a report on Canadian drug policy* (2013), online: http://drugpolicy.ca/report/CDPC2013_en.pdf; A. Klein, *Sticking Points: Barriers to access to needle and syringe programs in Canada* (Canadian HIV/AIDS Legal Network, 2007), online: http://www.aidslaw.ca/site/sticking-points-barriers-to-access-to-needle-and-syringe-programs-in-canada/.
[23] E.g. "Anti-Harm Reduction Bylaw Challenge Accepted By BC Human Rights Tribunal," *Abbotsford Today*, July 18, 2013, available at http://www.abbotsfordtoday.ca/anti-harm-reduction-bylaw-challenge-accepted-by-bc-human-rights-tribunal/; see also various letters from the Ontario Human Rights Commission to several Ontario municipalities expressing concern

Unnecessary barriers to **heroin-assisted treatment** (HAT) for those for whom other treatment options have failed is yet another example of how a punitive, prohibitionist approach to illicit drugs continues to prevent access to evidence-based health services in Canada. Contrary to evidence-based recommendations from her own department (Health Canada), the former federal Minister of Health introduced new regulations criminalizing the prescription of HAT, undermining evidence-based medical practice and denying access to those for whom it had been clinically indicated. Following the launch of a challenge to those new regulations as breaching constitutional rights, a court of first instance, concerned about the harms to the health and security of the person of those denied access to medication issued a temporary injunction in 2014 blocking the harmful regulations from coming into force while the merits of the challenge proceed to a full hearing,[24] but the matter remains unresolved at this time and hence cause for human rights concern about deliberate government action to block access to evidence-based medical treatment.[25]

Guaranteeing **access to medical cannabis** is another example of a constitutional battle that individuals and organizations have been forced to undertake as a result of Canadian drug policy-relying on courts' decisions to safeguard the right to health of people who use drugs is not an acceptable alternative to policy based on human rights, public health and evidence.

While data on the number of people dying of **overdose** in Canada is limited and partial, the available figures indicate that overdose deaths due to medical and non-medical drug use are now a significant source of mortality (e.g., the third leading cause of accidental death in Ontario), with opioid deaths on the rise in recent years in several provinces.[26] Other measures, in addition to supervised consumption services, can be taken to reduce overdose death, such as making naloxone readily available and by reducing barriers to accessing emergency services during a drug overdose. Current policy and legislation hinder these efforts. The criminalization of drug use and possession in Canada also deter witnesses of overdoses from calling emergency services.[27] On a positive front, the newly-appointed federal Minister of Health announced in mid-January 2016 that her department would be taking regulatory steps to ease access to naloxone by allowing use without a prescription.[28] This is a welcome step toward safeguarding the health of people who use drugs and are at risk of fatal opioid overdose, and the Government of Canada is to be commended. But other legislative measures are needed, as indicated here.

Right to health in prison

High rates of incarceration of people who use drugs in Canada, and the extent of unsafe injection drug use in prisons, pose an ongoing threat to the health and safety of prisoners and to public health more generally. However, Canadian prison authorities consistently refuse to implement comprehensive, evidence-based harm

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with discriminatory by-laws or other measures impeding operation of methadone clinics for people with opioid dependence: http://www.ohrc.on.ca/en/search/site/methadone.

[24] See decision of the Supreme Court of British Columbia in *Providence Health Care Society v. Canada (Attorney General), 2014 BCSC* 936, online at: http://bit.ly/YIW0HO.

[25] D. King, "The HAT Injunction, what does it mean?" posted on May 29, 2014, available at http://www.pivotlegal.org/the_hat_injunction_what_does_it_mean.

[26] Canadian Drug Policy Coalition, *Opioid overdose prevention and response in Canada,* 2013; other statistics from coroners' offices and health ministries (obtained by Pivot Legal Society in 2015 and on file).

[27] Ibid.

[28] Health Canada Statement on Change in Federal Prescription Status of Naloxone, January 14, 2016, online: http://news.gc.ca/web/article-en.do?nid=1027679.

reduction services in prisons, contravening the obligation to take steps to realize progressively the right to the highest attainable standard of health.

To date, **prison-based needle and syringe programs** (PNSPs) have been introduced in over 60 prisons of varying sizes and security levels in countries such as Luxembourg, Moldova, Germany, Romania, Spain and Switzerland.[29] Evaluations, including by the Government of Canada's own Public Health Agency,[30] have consistently demonstrated that PNSPs reduce the use of non-sterile injecting equipment and resulting blood-borne infections, do not lead to increased drug use or injecting, reduce drug overdoses, lead to a decrease in abscesses and other injection-related infections, facilitate referral of users to drug treatment programmes, and have not resulted in needles being used as weapons against prisoners or staff.[31] PNSP are supported by the UN's specialized technical agencies[32] and the High Commissioner for Human Rights,[33] as well as the UN Special Rapporteur on torture,[34] as a matter of sound public health policy and human rights. They have also been recommended by the Canadian and Ontario Medical Associations,[35] the Canadian Human Rights Commission[36] and the Correctional Investigator of Canada.[37]

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[29] R. Lines et al., *Prison Needle Exchange: Lessons from a comprehensive review of international evidence and experience* (Canadian HIV/AIDS Legal Network, 2006); R. Jürgens, *Interventions to Address HIV/AIDS in Prisons: Needle and Syringe Programmes and Decontamination Strategies* (WHO, UNODC & UNAIDS, 2007); UNODC, *A handbook for starting and managing needle and syringe programmes in prisons and other closed settings*, Advance copy, 2014.

[30] PHAC, *Prison needle exchange: Review of the evidence* (Ottawa: PHAC, April 2006).

[31] Lines et al., op. cit.; Jürgens, op. cit., H. Stöver and J. Nelles, "10 years of experience with needle and syringe exchange programmes in European prisons: A review of different evaluation studies," *International Journal of Drug Policy* 2003; 14: 437-444.

[32] WHO, *WHO Guidelines on HIV Infection and AIDS in Prisons*, 1993; UNODC, WHO and UNAIDS, *HIV/AIDS Prevention, Care, Treatment and Support in Prison Settings: A Framework for an effective National Response* (Geneva/Vienna, 2006); UNAIDS, "Statement on HIV/AIDS in Prisons to the UN Commission on Human Rights at its Fifty-second session, April 1996," in *Prison and AIDS: UNAIDS Point of View*, 1997; UNODC, A handbook for
starting and managing needle and syringe programmes in prisons and other closed settings (Advance copy),

[33] *International Guidelines on HIV/AIDS and Human Rights*, *Consolidated Version*, UN Doc. HR/PUB/06/9, Office of the UN High Commissioner for Human Rights and UNAIDS (Geneva, 2006).

[34] J. Mendez, Interim report to the UN General Assembly of the Special Rapporteur on torture and other cruel, inhuman or degrading treatment or punishment [regarding revisions to the UN Standard Minimum Rules on the Treatment of Prisoners), UN Doc. A/68/295 (August 2013), para. 71.

[35] Canadian Medical Association, Resolution 26 of 17 August 2005; Ontario Medical Association, *Improving our Health: Why is Canada Lagging Behind in Establishing Needle Exchange Programs in Prisons? A Position Paper by the Ontario Medical Association*, October 2004.

[36] Canadian Human Rights Commission, Protecting Their Rights: A Systemic Review of Human Rights in Correctional Services for Federally Sentenced Women (Ottawa: Canadian Human Rights Commission, 2003), Recommendation No. 4.

[37] Correctional Investigator of Canada, Annual Report of the Correctional Investigator 2004–2005 (Ottawa: Correctional Investigator Canada, 2004), Annex B at 47. With respect to the right to health in prisons, it should also be noted a recent report by the Correctional Investigator of Canada, obtained under access-to-information legislation, found that health services are inadequately resourced in federal prisons, to the point that newly-admitted prisoners, including those with serious mental health issues, are sometimes being denied prescription medications for 30 days or more while waiting for an assessment by prison physicians. Missing HIV medications or anti-psychotic medications can have serious health consequences; missing pain medication could force prisoners to resort to the use of other, prohibited drugs in an attempt to self-medicate for pain. See: P. White, "New inmates denied medicine due to drug-plan flaw: prison ombudsman," *The Globe & Mail*, 30 April 2015, online: http://www.theglobeandmail.com/news/national/processing-delays-leave-new-inmates-without-prescriptions-for-weeks/article24177961/.

Under international law, prisoners retain all rights except insofar as those are necessarily limited by incarceration.[38] This includes the right to the highest attainable standard of health.[39] Prisoners have a right to a standard of health care equal to that available outside of prisons (the "principle of equivalence"),[40] which necessarily includes preventive measures comparable to treatment and services available in the community.[41] Despite this, while NSPs have been operating in communities across Canada for more than two decades, with funding from various levels of government, no such program operates in a single Canadian prison. A constitutional challenge is proceeding against the Canadian federal government for failing to protect the human rights of prisoners by refusing to implement PNSP in the Canadian federal prison system.[42]

IV. Recommendations

We propose that the Committee recommend that Canada, in keeping with its obligations under the Covenant:

- conduct a review of its national drug law and its National Anti-Drug Strategy, with a view towards a comprehensive series of reforms that, based on the best available evidence, will respect human rights and protect individual and public health;

- ensure a full integration of the principle of non-discrimination to safeguard against systemic discrimination of marginalised groups including Indigenous peoples, people who use drugs, minority groups (including ethno-racial minorities) and people living in poverty;

- revise mandatory sentencing laws and policies as they relate to drug offences, to adequately address the disproportionate impact such measures have on vulnerable groups, including on their right to health;

- remove criminal or other penalties for minor drug offences such as possession for personal use;

- redirect the resources currently dedicated to enforcement of such legislation (with harmful consequences for health) to improving access to a comprehensive series of evidence-based health services for preventing, treating and reducing the harms associated with problematic drug use – including improved access to needle and syringe programs, opioid substitution treatment, prescription of heroin for opioid-dependent persons in accordance evidence-based clinical guidelines, and overdose prevention medications and programs; and

- work with health experts, including civil society groups, to implement equivalent access to harm reduction services for people in Canadian prisons, including prison-based needle and syringe programs.

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[38] *Basic Principles for the Treatment of Prisoners*, UNGAOR, 45th Sess., Supp. N 49A, UN Doc A/45/49 (1990), Principle 5.
[39] CESCR, *General Comment 14*, op. cit. As HIV and HCV are potentially fatal diseases, the right to life is also relevant in considering states' obligation to take effective measures to prevent HIV and HCV transmission in prisons: UN Human Rights Committee, *General Comment No. 6: The right to life (Article 6)*, 16th Sess., (1982) UN Doc. HRI\GEN\1\Rev.1 at 6, para 5.
[40] *Basic Principles for the Treatment of Prisoners*, UNGAOR, 45th Sess., Supp. N 49A, UN Doc A/45/49 (1990), Principle 9.
[41] CESCR, *General Comment 14*, op. cit., para. 34.
[42] For more information about the lawsuit, please visit: www.prisonhealthnow.ca.