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OVERDUE FOR A CHANGE: SCALING UP SUPERVISED CONSUMPTION SERVICES IN CANADA

KEY FINDINGS + RECOMMENDATIONS



CONTEXT

Supervised consumption services (SCS) consist of providing a safe, hygienic environment in which people can use drugs with sterile equipment under the supervision of trained staff or volunteers.¹ More than 100 such services exist in Australia, Canada and various countries in Europe.² As in many other settings, the implementation of SCS in Canada is highly dependent on political context and vulnerable to changes in government.

Canada is currently facing an unprecedented overdose crisis, including nearly 4000 deaths in 2017³ and at least 1036 more deaths in just the first three months of 2018.⁴ This tragic situation has shed light on the consequences of Canada's harmful approach to drug policy, which remains primarily focused on the enforcement of criminal prohibitions instead of prevention, treatment and harm reduction responses. This includes the continued criminal prohibition of simple possession of drugs for personal use under the *Controlled Drugs and Substances Act* (CDSA).

A CHANGING LEGAL AND POLITICAL LANDSCAPE

Between 2006 and 2015, the federal government actively prevented the implementation of SCS. However, support for scaling up more evidence-based, health-oriented measures, including SCS, has increased in recent years. As of October 2018, 26 sites in Canada are offering SCS under an exemption (from criminal prosecution under the CDSA) issued by the federal Minister of Health,⁵ marking a significant increase from the two exempted sites that offered SCS in 2016, both in Vancouver. In addition, supervised consumption is also available in a number of “overdose prevention sites” (OPS) in Alberta, British Columbia and Ontario.⁶ The expansion of SCS in Canada has been led by the relentless efforts of people who use drugs, service providers, health professionals, researchers and activists

who have advocated at many levels, including in the courts, to open these life-saving services.⁷

More recently, these efforts have been paralleled by increased political will and pressure from the ongoing overdose crisis and from the emergence of “pop-up” services in Vancouver, Toronto and Ottawa operating, at first, without official authorization (or funding support) from any level of government. The election of a new federal government in late 2015 marked a turning point in efforts to scale up SCS across Canada. The federal government restored harm reduction as a key pillar of Canada's drug strategy and removed some of the legislative barriers to SCS that had been imposed by the previous government. Efforts were made to increase

transparency and to streamline the process to apply for an SCS exemption, including dedicating staff for the work associated with SCS applications, for example. Ongoing barriers at all levels of government, however, continue to limit Canada's ability to adequately respond to the overdose crisis and other harms sometimes associated with drug use.

In Canada, unauthorized *possession* of a controlled substance is a crime under section 4 of the CDSA. Given that SCS are services where people can use illegal substances, both clients and staff are at risk of prosecution for possession when accessing or providing SCS. Clients and staff may also be at risk of prosecution for *trafficking* under section 5 in relation to some activities such as assisted injection or drug sharing, given the broad definition of this offence in the CDSA.

As it currently reads, three sections in the CDSA offer the government of Canada the possibility of providing exemptions from the application of the Act and thereby protect SCS users and staff from criminal liability:

- » **SCS-specific ministerial exemption:** Section 56.1 of the CDSA establishes a specific legal regime allowing the federal Ministry of Health to authorize certain activities to take place at “a supervised consumption site” if necessary “for a medical purpose.”
- » **General ministerial exemption:** Section 56 of the CDSA says that the federal Minister of Health can exempt any person (or class of persons) or any controlled substance (or class of controlled substances) from the application of all or any of the provisions of the CDSA or its regulations if it is the Minister's opinion that this is “necessary for a medical or scientific purpose or is otherwise in the public interest.” This is true unless the exemption is granted specifically for a “medical purpose” to allow activities in relation to controlled substances obtained illegally to take place at a “supervised consumption site” (to which scenario section 56.1, described above, applies).⁸
- » **Regulations by Cabinet:** Section 55(1)(z) of the CDSA provides that the “Governor in Council” (i.e. the federal Cabinet) may make regulations exempting any person (or class of persons) or any controlled substance (or class of controlled substances) from the application of the CDSA or its regulations.

In June 2015, the then federal government enacted section 56.1 through the *Respect for Communities Act* (RCA) (commonly known as Bill C-2 at the time) to establish a specific, restrictive regime for issuing an exemption for a “supervised consumption site.” The subsequent government, elected in late 2015 and supportive of harm reduction, amended the CDSA again in May 2017, repealing the *Respect for Communities Act* and streamlining the exemption process under section 56.1, which continues to apply to an exemption issued “for a medical purpose” to permit the operation of a “supervised consumption site.” Since then, more than 26 individual sites have received an exemption to offer SCS under section 56.1 of the CDSA.

The legislative reforms also restored the possibility of the government using other legal avenues to grant an exemption authorizing SCS (i.e. general ministerial exemptions under section 56 and Cabinet regulations under section 55).⁹ As of October 2018, Cabinet had not yet used its authority under section 55 to adopt regulations creating exemptions from the CDSA for SCS.

In 2016 and 2017, in response to the growing crisis of opioid overdose-related deaths, community volunteers and activists began operating a number of “pop-up” sites labelled “overdose prevention sites” (OPS), without seeking federal exemptions. In December 2017, Health Canada announced that it would exempt, as a temporary response, OPS for those provinces and territories that request them.¹⁰ Class exemptions for OPS (which offer supervised consumption) were granted to Ontario and Alberta under section 56 of the CDSA on the basis that such sites were “in the public interest.”¹¹ Meanwhile, in December 2016, the British Columbia Minister of Health issued a ministerial order to support the implementation of OPS across the province. The order was issued under the province's *Health Emergency Services Act* and *Health Authorities Act* in the face of a provincial public health emergency the Minister had previously declared in April of that year.¹²

SCALING UP SCS IN CANADA: THE RESEARCH PROJECT

In 2018, with support from the Public Health Agency of Canada, the Canadian HIV/AIDS Legal Network undertook a research project to explore the current state of SCS in Canada, to monitor legal and policy changes affecting SCS, and to identify facilitators and barriers faced by current and future SCS providers. The project involved a literature review and 15 interviews with key informants from British Columbia, Alberta, Ontario and Quebec, including researchers, SCS managers, CDSA exemption applicants, policymakers and people who use drugs. Interviews were conducted between March and June 2018, either in person or by phone, and audio-recorded to ensure accuracy. Questions focused on experiences applying for a federal exemption and on implementing SCS in communities across Canada, with particular attention to the impact of policy and legal requirements at a federal level. A four-member advisory committee reviewed the work plan and provided input throughout the research project.

FACILITATORS AND ONGOING BARRIERS TO SCS: KEY FINDINGS

FACILITATORS

As noted above, between 2006 and 2015, the federal government strongly and explicitly opposed harm reduction, prompting many organizations across the country to shelve their planned SCS projects given the legislative hurdles added to the CDSA for securing an exemption and the minimal likelihood that any exemption would be granted. Respondents described a “climate of distrust” between service providers and Health Canada during this time. In late 2015, with the election of a new federal government that was explicitly supportive of harm reduction, including SCS, informants noted a striking change in Health Canada’s responsiveness.

Communication between Health Canada and applicants has improved tremendously, with government staff responding promptly to inquiries and maintaining engagement throughout the application process. Respondents noted that Health Canada began to exhibit more transparency in their communication with

applicants and demonstrated some openness to novel SCS models including supervised inhalation of drugs or SCS within hospital. Informants indicated that the application process has been streamlined to some extent, application turnaround time has been reduced, and the handling of applications has become less opaque and “at arm’s length.” Scale-up of SCS has also been facilitated by collaboration, knowledge exchange and partnerships between sites, and depending on the local context, by the support of elected officials, law enforcement authorities and regulatory health professionals. Community activists, particularly people with lived experience of using drugs, have consistently pushed the agenda forward across the country, demanding that elected officials respond more urgently to the overdose crisis.

REMAINING BARRIERS

Despite important legal reforms and policy changes, respondents maintained that the exemption application process is overly burdensome and that many of the criteria and requirements in the law or policies are problematic or irrelevant, such as mandatory community consultations and the provision of data on the expected impact of the proposed site on crime rates.¹³ Preparing exemption applications creates a hurdle for organizations without the capacity to undergo the resource-intensive process and does not allow for rapid and adaptable public health responses during a health emergency. Respondents stressed that decisions about health services should be made on the basis of need, and organizations seeking to provide supervision of drug consumption to reduce harms and save lives should not be required to pass a series of unnecessary bureaucratic hurdles or garner public support before opening. Moreover, exemptions for new SCS are generally granted for one year only and they do not necessarily allow for sufficient flexibility in implementation to adapt to clients' needs. In some cases, the federal government has imposed additional, unreasonable reporting requirements.

Respondents were unanimous: there is a strong need for a continuum of SCS to be made available in Canada, from peer-run low-threshold services to comprehensive health services offering primary care, mental health care, treatment and/or social services.¹⁴ Respondents urged Health Canada to take greater leadership in permitting and supporting diverse and innovative models of SCS. In particular, they called for a wider range of activities and services to be allowed where needed, including assisted injection and drug sharing. Failure to authorize assisted injection — either by peers, staff or nurses — bars particularly vulnerable populations of people who use drugs from accessing services, including women and individuals with physical limitations who disproportionately require assistance injecting.¹⁵ Prohibiting drug sharing on the premises may also discourage some clients from accessing services, according to respondents. Respondents also discussed the need for greater access to alternative options for people at risk to address the critical issue of unsafe drug supply (e.g. through opioid prescription). Better support is also needed from all levels of government to facilitate the involvement of people who use drugs in the design and delivery of SCS.

Finally, disparities between provinces and municipalities in their approaches to SCS continue to pose barriers to implementing these services. In Ontario, for example, the provincial government elected in June 2018 imposed a moratorium on support for new OPS sites while undertaking another “review of the evidence” for SCS. Two months later, they announced a new “Consumption and Treatment Services” model for SCS and OPS in the province, requiring all SCS, including those already authorized, to undergo a new and more burdensome funding application process (and also capping the total number of sites across the province that can provide SCS).¹⁶ The new model has raised serious concerns that it will effectively preclude the continued operation of lower-threshold OPS, unnecessarily and harmfully limiting the range of services that are needed to address the harms, including overdose, experienced by people who use drugs.

CONCLUSIONS

While efforts have been made to facilitate the scale-up of SCS across the country, the fact remains that service providers cannot confidently and sustainably offer SCS without a specific exemption protecting staff and clients from criminal prosecution under the CDSA. Such an exceptional regime for an evidence-based health service constitutes a significant barrier to the rapid implementation of these services and a great source of vulnerability. The history of SCS in Canada demonstrates that relying on the discretion of the federal Minister of Health to obtain an exemption makes SCS highly vulnerable to the changing views of successive ministers and on the political context (even if the Supreme Court of Canada has set some parameters to limit the exercise of ministerial discretion).¹⁷ The current approach to SCS is limited by providing exemptions only on a case-by-case basis, and perpetuates the politicization of a health issue by leaving the decision to open sites offering SCS in the hands of an elected government. The current legal regime also gives the federal government significant power to control, restrict and oversee the implementation and operation of SCS.

Our report identifies a number of priorities, focusing on the federal government's role and responsibilities, to improve Canada's approach to SCS in order to better facilitate the scale-up of these vital health services. Measures need to be taken to normalize and integrate SCS seamlessly into a comprehensive set of services for people who use drugs.

As a fundamental start, we propose a legal framework in which decisions about authorizing SCS are no longer solely at the discretion of the federal government and the conditions that must be satisfied before opening SCS are eased. Recognizing differences in local contexts, with provincial and municipal authorities also sometimes presenting significant obstacles to the implementation of SCS, *we recommend a legal framework wherein a specific exemption would no longer be required to provide SCS if a certain number of minimal conditions are met.*

Such further legal measures are important, but not sufficient. **Other concrete measures, including increased funding, should also be taken by all levels of government to support community organizations and health care providers to establish a wide variety of services adapted to the needs of people who use drugs.** The federal government must take a leadership role and work with provinces for greater access to life-saving, health-promoting SCS across the country.

RECOMMENDATIONS TO THE FEDERAL GOVERNMENT

1. DECRIMINALIZATION

The federal government should decriminalize activities related to personal drug use.

It is well established that drug prohibition does not protect public health or public safety. In particular, the criminalization of possession for personal use puts people who use drugs at increased risk of harm, including by impeding their access to much-needed services and emergency care in the event of an overdose. More generally, criminalization perpetuates stigma, discrimination and the over-incarceration of people who use drugs.¹⁸ Successive measures of criminal prohibition targeting various substances also have a displacement effect, contributing to the increasing toxicity of the illegal drug market in Canada and the ongoing overdose crisis. Decriminalization would effectively end SCS exceptionalism as there would be no need for an exemption from criminal prosecution to protect SCS clients and staff. It would allow these services to open and operate in a similar fashion to other harm reduction services and help remove SCS decision-making from the political realm. Calls for decriminalization of possession are mounting in Canada, including among health professionals who have been calling for a public health approach to problematic drug use.¹⁹

2. CLASS EXEMPTION FOR SCS CLIENTS AND PROVIDERS

In the interim, before necessary decriminalization, the federal government should grant a class exemption protecting clients and staff, including volunteers, from prosecution for drug possession or for activities (such as drug sharing or assisted injection) that may amount to “trafficking” when accessing or providing SCS that meet minimum required conditions.

As outlined above, under the current law, the federal Minister of Health could grant a class exemption, *in the public interest*, under section 56 of the CDSA. Alternatively, under section 55, the federal Cabinet could adopt a regulation granting such an exemption under certain conditions. A further alternative would be for Parliament to amend the CDSA to create a standing exemption in the statute itself for SCS clients and staff under certain conditions.

A class exemption that automatically provides protection against prosecution to SCS, for any service meeting the defined conditions, would remove a significant administrative burden from SCS operators who would no longer have to apply for case-by-case exemptions from Health Canada. Such an approach is particularly important in the context of an ongoing public health emergency requiring a rapid response and for small harm reduction organizations with limited capacity. Moreover, it would be entirely consistent with the federal government’s recognition that SCS are life-saving services that improve health, are cost-effective, do not increase drug use or crime, and are an entry point to treatment and social services for people who wish to stop or reduce their use of substances — as demonstrated by research conducted both in Canada and internationally.²⁰

Whether it takes the form of a ministerial exemption, a Cabinet regulation or a statutory provision in the CDSA itself, the class exemption would have to be broad enough to offer flexibility for the implementation of a continuum of SCS models across the country, from peer-run, low-threshold services to comprehensive health services. The wording of the exemption would set out certain minimum conditions to protect the safety and wellbeing of clients, staffs and the surrounding community. It is important to underscore that these minimum conditions for supervised consumption would be developed *for the purpose of defining when the criminal law does not apply*, and would not replace

best practices that may guide the implementation of different models of SCS of different scale.

Minimum conditions would be designed in consultation with service providers and people who use drugs, following experiences in other countries and within Canada including with OPS. They would focus on structural aspects of services related to personnel, procedures and protocols, equipment and health and safety requirements. Minimal conditions should not be excessive or onerous, as that would maintain or recreate barriers to the scale-up of much-needed services. Based on the OPS experience in Canada, minimum conditions for being covered by the class exemption from CDSA prosecution might include the following:

- » A reasonable minimum number of people with training in administering naloxone and CPR on site at all times as well as a “designated person” responsible for overseeing all operations of the SCS, including guaranteeing that minimum standards, procedures and protocols are respected, and for liaising with the local community.
- » Availability of appropriate equipment to ensure the immediate provision of evidence-based emergency interventions in the event of an overdose (e.g. naloxone, administration of oxygen) and to provide SCS, including harm reduction supplies such as sterile needles, syringes and other safer drug use equipment, as well as basic equipment for the safe disposal of used equipment.
- » Basic health and safety protocols and procedures related to: the roles and responsibilities of staff; response in the event of an overdose; disposal of used drug equipment and substances left behind; and preventing any activity that amounts to “trafficking” of substances (other than as may be permitted by the terms of the class exemption, such as the sharing of limited quantities of a substance between service users).
- » Satisfying reasonable provincial and municipal requirements of general application (e.g. to meet health and safety requirements such as fire safety regulations).
- » A notification to Health Canada within five days of beginning to offer services in a given venue.

3. A STREAMLINED PROCESS FOR SCS EXEMPTION APPLICATIONS

If the federal government insists on unnecessarily maintaining a case-by-case SCS exemption process, it should take measures to further streamline the current application requirements and process.

Changes in Health Canada’s policies and practices or through regulations²¹ should be made to address the following:

- » **Additional pathways are necessary** to allow expedited exemptions issued either by provincial/territorial or local health authorities, or by the federal minister simply on the basis of such a request from such authorities.
- » **Health Canada should not demand more information from applicants than is legally required** by CDSA section 56.1 or impose additional hurdles for prospective service providers. Decisions about the implementation of health services should be based on evidence of need and the potential for benefit in addressing that need. In particular:
 - **Community consultation should not be required to provide an exemption.** Instead, it should be left up to organizations to determine appropriate methods and time to engage with local community. The purpose of such engagement is to facilitate effective operation of the site; it is not something on which potential criminal liability of site users or staff should depend.
 - **Securing funding should not be a precondition for federal exemption.** It should be feasible to secure an exemption that removes any legal uncertainty about the operation of the service, and then secure the funding for operations. In fact, federal funds should be made available to support SCS including in provinces where local governments are reluctant to fund these life-saving services.
- » **Organizations should be permitted to submit joint applications and to open satellite sites without having to apply for a new exemption.** This would ease the administrative burden associated with exemption applications and facilitate coordination of service implementation within municipalities.

- » **To better accommodate the needs of individual communities, greater flexibility is needed to encourage and authorize a wide range of service models and an ability to adapt to changing contexts.** Services should be expanded where needed to accommodate not only supervised injection, oral and intranasal consumption, but also inhalation, assisted injection, drug checking, drug sharing, and interventions to address the critical issue of the unsafe drug supply leading to fatal overdoses (e.g. prescription of controlled substances).
- » **Exemptions should be granted for more than one year** so that communities are not required to repeatedly go through a burdensome reporting and approval process.

4. OTHER MEASURES THE FEDERAL GOVERNMENT SHOULD ADOPT TO SUPPORT SCS EXPANSION

As noted above, federal funds should be made available to support SCS, including in provinces and territories where authorities are reluctant to fund these life-saving services.

The federal government should work with provincial, territorial and municipal governments to ensure they commit to facilitate the scale-up of SCS where needed, including through immediate and sustained operational funding for SCS.

Greater support should be made available to service providers, especially grassroots, peer-led organizations who are well positioned to provide SCS but may not have the financial or human resources necessary to apply for an exemption or implement SCS meeting the minimum criteria. For instance, community organizations may need support to undertake renovation or build consumption rooms that respond to safety requirements.

The federal government should be convening dialogue between law enforcement, health care officials, social workers, people who use drugs and community organizations to increase understanding and accessibility of SCS across the country.

5. RECOMMENDATIONS TO PROVINCIAL, TERRITORIAL AND MUNICIPAL AUTHORITIES:

Implementation of SCS in Canada is contingent not only on the federal government's approach to exemptions from potential criminal liability under the CDSA, but also on the willingness of provincial, territorial, and municipal authorities to support the services including through funding and by not imposing unnecessary regulation. Efforts must thus be made at and by all levels of government to scale up SCS across the country.

- » **Provincial and territorial authorities should provide immediate and sustained operational funding for SCS in their province or territory.**
- » **Provincial and territorial authorities should not impose conditions for SCS implementation that are not required for other health services.** In particular, provincial and territorial authorities should not create exceptional hurdles for service providers to receive funding to provide a wide range of supervised consumption services. Provincial guidance related to SCS should be amended accordingly.
- » **Municipal authorities should not impede the establishment of SCS through the enactment of by-laws.**

OVERDUE FOR A CHANGE: SCALING UP SUPERVISED CONSUMPTION SERVICES IN CANADA

¹ SCS are also known as “supervised injection sites,” “drug consumption rooms” or “medically supervised injection centres,” depending on the jurisdiction and scope of services offered.

² SCS are operating in Australia, Canada, Denmark, Germany, Luxembourg, the Netherlands, Norway, Spain, France and Switzerland. Efforts to implement SCS are ongoing in the U.S., the United Kingdom (Scotland), Belgium, Ireland and Portugal.

See: European Monitoring Centre for Drugs and Drug Addiction (EMCDDA), *Perspective on drugs. Drug consumption rooms: an overview of provision and evidence*, 2018; Drug Policy Alliance, *Supervised Consumption Services*, March 2017.

³ Government of Canada. “Apparent opioid-related deaths” (2018). Available at www.canada.ca/en/health-canada/services/substance-abuse/prescription-drug-abuse/opioids/apparent-opioid-related-deaths.html

⁴ Public Health Agency of Canada. “Statement from the Co-Chairs of the Special Advisory Committee on the Epidemic of Opioid Overdoses Regarding Updated Data on Canada’s Opioid Crisis (September 18, 2018). Available at www.canada.ca/en/public-health/news/2018/09/statement-from-the-co-chairs-of-the-special-advisory-committee-on-the-epidemic-of-opioid-overdoses-regarding-updated-data-on-canadas-opioid-crisis.html

⁵ See www.canada.ca/en/health-canada/services/substance-use/supervised-consumption-sites/status-application.html#app for information on approved sites and current applications.

⁶ Overdose prevention sites are seen by the federal government as “temporary” locations, often set up by volunteers, sometimes with a limited structure and often not providing the ancillary services that most SCS provide. See Health Canada, “Supervised consumption sites explained,” available at www.canada.ca/en/health-canada/services/substance-use/supervised-consumption-sites/explained.html#a5. More than 20 OPS have opened in BC; for more information, see www2.gov.bc.ca/gov/content/overdose/what-you-need-to-know/overdose-prevention. By the end of September 2018, there were 8 OPS operating in Ontario under a class exemption issued by Health Canada to Ontario (per private communication with Health Canada) and one operating in Alberta.

⁷ In 2011, the Supreme Court of Canada ordered the Ministry of Health to grant an exemption so Insite (the first-known SCS to operate under a federal exemption in Canada) could continue to operate without risk of staff or clients being criminally prosecuted for possession under the CDSA. The ruling was based on the recognition that denying the exemption, thereby exposing people to this risk, would be an unconstitutional over-extension of the CDSA’s criminal prohibition on possession, infringing the constitutional rights of people who use drugs to access SCS. See *Canada (Attorney General) v. PHIS Community Services Society*, 2011 SCC 44.

⁸ CDSA, s. 56(2).

⁹ Bill C-2 (*Respect for Communities Act*) had introduced a provision preventing the Ministry of Health to grant an exemption under section 56 in relation to controlled substances obtained in a manner not authorized by the Act. As a result, the federal government could no longer grant an exemption with respect to SCS (where people use drugs obtained illegally) under section 56. But this provision was removed when Bill C-37 (*An Act to amend the Controlled Drugs and Substance Act and to make related amendments to other Acts*) was passed. The federal government can now grant an exemption in relation to SCS under section 56 if in the public interest (see section 56(2)). The federal government used this flexibility to respond to the current overdose crisis by issuing section 56 class exemptions to provinces for temporary OPS in the public interest. In approving OPS, the Federal government clearly recognized the need to step beyond the confines of the current legislative regime of section 56.1 and use all its power to expand access to supervised consumption services in response to the opioid overdose crisis.

¹⁰ Health Canada, “Statement from the Minister of Health Regarding the Opioid Crisis,” (December 7, 2017). OPS are essentially low-threshold supervised consumption sites but the shift in language and the temporary nature of the services have proved crucial to the rapid roll-out of these life-saving interventions, facilitating the bypass of the burdensome section 56.1 application process required to establish supervised consumption sites for a medical purpose.

¹¹ As confirmed in personal communication with Health Canada.

¹² Province of British Columbia, Order of the Minister of Health, Ministerial Order No. M 488, December 9, 2016.

¹³ Section 56.1 of the CDSA. See www.canada.ca/en/health-canada/services/substance-use/supervised-consumption-sites/apply.html for Health Canada’s latest guidance on section 56.1 exemption applications.

¹⁴ See also A. Scheim and D. Werb, “Integrating supervised consumption into a continuum of care for people who use drugs,” *CMAJ* August 07, 2018 190 (31) E921-E922; DOI: <https://doi.org/10.1503/cmaj.180824>.

¹⁵ R. Pearhouse and R. Elliott, *A Helping Hand: Legal Issues Related to Assisted Injection at Supervised Injection Facilities*. Toronto: Canadian HIV/AIDS Legal Network, 2007. M. Gagnon, “It is time to allow assisted injection in supervised injection sites,” *CMAJ* 189(34) (2017): E.1083-1084. doi: 10.1503/cmaj.170659.

¹⁶ F. Merali, “PCs ‘playing politics with people’s lives’ on injection sites, drug policy expert warns,” *CBC News*, August 4, 2018. Available at: www.cbc.ca/news/canada/toronto/supervised-injection-sites-waiting-1.4771143. Ministry of Health and Long-Term Care, “Ontario Government Connecting People with Addictions to Treatment and Rehabilitation,” news release, October 22, 2018. Consumption and Treatment Services would replace the former Supervised Consumption Services and Overdose Prevention Site models. Existing sites would have to apply to continue operating under the planned new model. As of the end of October 2018, details of the new Consumption and Treatment Services model were still emerging, but so, too, were concerns that it will likely create additional barriers to the implementation of SCS in the province by effectively terminating low-threshold OPS and imposing additional administrative hurdles for service providers to operate (or even continue to operate) SCS. See also Canadian HIV/AIDS Legal Network, “Open Letter to the Ontario Minister of Health About the Newly Proposed ‘Consumption and Treatment Services Model’”, October 31, 2018, available at <http://www.aidslaw.ca/site/minister-elliott-open-letter/?lang=en>. And see Toronto Overdose Prevention Society and Toronto Harm Reduction Alliance, “New CTS Model,” news release, Toronto, November 5, 2018.

¹⁷ *Canada (Attorney General) v. PHIS Community Services Society*, supra note 7.

¹⁸ See, for instance, Global Commission on Drug Policy, *Advancing Drug Policy Reform: a new approach to decriminalization*, 2016, and J. Csete et al., “Public health and international drug policy,” *The Lancet*, The Lancet Commissions 387(10026) (2016): pp. 1427-1480.

¹⁹ N. Thompson, “Toronto board of health to urge federal government to decriminalize drug use,” *The Globe and Mail*, July 16, 2018. Available at www.theglobeandmail.com/canada/toronto/article-toronto-board-of-health-to-consider-report-recommending-drug/; Canadian Public Health Association, *Decriminalization of personal use of psychoactive substances*, October 2017.

²⁰ See www.canada.ca/en/health-canada/services/substance-use/supervised-consumption-sites/explained.html

²¹ Section 55(1.2) of the CDSA.

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The Canadian HIV/AIDS Legal Network promotes the human rights of people living with and vulnerable to HIV/AIDS, in Canada and internationally, through research, legal and policy analysis, education and community mobilization. The Legal Network is one of the world's leading advocacy organizations working on the legal and human rights issues raised by HIV/AIDS.

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