The *Insite* Decision and the Case for Supervised Consumption Facilities in Ottawa

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INTRODUCTION

On September 29, 2011, the Supreme Court of Canada[1] unanimously ruled to allow a safer supervised consumption facility (SCF)[2] to remain open under a section 56 exemption of the *Controlled Drugs and Substances Act*.[3] The decision has lent additional legitimacy to SCFs as a necessary health care service that is part of a comprehensive and holistic drug and addiction strategy.

In part one of this comment, we describe the context in which Insite emerged in Vancouver, British Columbia. In part two, we discuss the legal mobilization that led

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[1] *Canada (Attorney General) v PHS Community Services Society*, 2011 SCC 244, [2011] 3 SCR 134 [*Insite SCC*].

[2] Supervised Injection Sites are "controlled health care settings where drug users can inject their own personally acquired illicit drugs under supervision and receive health care, counseling and referral to social, health and drug use treatment services:" Alan Ogborne et al, "Vancouver's INSITE service and other Supervised injection sites: What has been learned from research? Final Report of the Advisory Committee" (March 31, 2008) online: Health Canada <http://www.hc-sc.gc.ca/ahc-asc/pubs/_sites-lieux/insite/index-eng.php#ex> [*Health Canada Report*]. More recently, community groups and addiction advocates have favoured two terms in relation to such centres. The concept of Safer Injection Sites takes into account how these facilities are part of a broader health strategy intended to help people use techniques that can prevent infections and vein damage; the term safer also moves the discussion away from more libertine arguments that drugs may be implicitly safe, see: Evan Wood et al. "Rationale for evaluating North America's first medically supervised safer-injecting facility" (2004) 4 The Lancet Infectious Diseases 301-306. Safer Consumption Facility ("SCF") refers to "a legally sanctioned public health facility that offers a hygienic environment where people can inject illicit drugs under the supervision of trained staff. Some facilities also allow people to smoke illicit drugs:" Ahmed M Bayoumi & Carol Strike, et al., "Report of the Toronto and Ottawa Supervised Consumption Assessment Study, 2012" (2012) St. Michael's Hospital and the Dalla Lana School of Public Health, University of Toronto at 5 [TOSCA]. We use the two latter terms interchangeably; we take the terms to extend beyond "injection" drugs and to include services for people who smoke substances like crack cocaine.

[3] SO 1996, c 19 [*CDSA*]. Under section 56 of the *CDSA*, the Minister may grant exemptions if she or he determines that it would be necessary for medical, scientific or public policy purposes.

to the Supreme Court decision and the framework under which Insite currently operates. In part three, we explore the decision's implications for another jurisdiction – Ottawa, Ontario.

Our starting assumption is that many of Ottawa's vulnerable, and certainly marginalized, people could also benefit from access to a SCF. With a sizeable number of people who inject or inhale illicit drugs under dangerous circumstances,[4] there is need for harm reduction strategies[5] and additional primary care facilities in Ottawa.[6] While there remain challenges to fostering harm reduction strategies in the city, we maintain that these are not insurmountable.

[4] While injection drug use is often the focus of discussions around harm reduction, drug use, like other compulsive behaviours, is a complex phenomenon that may fall on a continuum of behaviours from complete abstinence to more chronic dependence and people's drug use may wax and wane with contexts and lived experiences. See generally: "Harm Reduction Training Manual: A Manual for Frontline Staff Involved with Harm Reduction Strategies and Services." (January 2011) online: BC Harm Reduction Strategies and Services <http://www.bccdc.ca/NR/rdonlyres/C8829750-9DEC-4AE9-8D00 84DCD0DF0716/0/CompleteHRTRAININGMANUALJanuary282011.pdf> at p. 5 [*HRSS*]. There are an estimated 3,000 injection drug users in Ottawa: Don Butler, "Mayor, police chief oppose safe injection site in Ottawa", *Ottawa Citizen* (October 1 2011) online: Ottawa Citizen www.ottawacitizen.com.

[5] Harm reduction strategies are polyvalent and context-specific; there is no universal or monolithic definition that can capture the range of diverse activities that this philosophy and approach encompasses. In the context of drug use, are strategies, policies and programs that attempt to reduce health, social, and economic costs of legal and illegal psychoactive drug use without necessarily reducing drug consumption: "Aims and Scope" (May 14 2012) online: Harm Reduction Journal <http://www.harmreductionjournal.com>. There are also a number of guidelines to harm reduction: a non-judgmental interventions (that respect people's inherent worth and ability to make decisions for themselves); pragmatism (while different modes of drug use can involve risks, consumption in some contexts may also constitute relationships); rights and responsibilities (drug users have a right to self-determination and support in making informed decisions); a range of interventions (different people benefit from different approaches; no prevention strategy can work for everyone); immediate and long-term goals (emphasis is on incremental gains over time); and empowerment (drug users must be at the centre of policy and program development; they are the most meaningful source of information about their own drug use). The final guideline if often considered the key to meaningful harm reduction strategies: the active participation of the person most affected by the harmful behaviour: HRSS, *supra* note 4 at pp.5-7. On the the benefits of fostering relationships with peer mentors in harm reduction programs, see generally: "Field of activities: Peer Helper" (2005) online: Cactus Montreal <http://www.cactusmontreal.org/fr/pair-aidants.html>.

[6] On April 11 2012, Toronto and Ottawa Supervised Consumption Assessment (TOSCA) evaluated feasibility of implementing a SCF in both those cities: TOSCA*, supra* note 2.

1. INSITE'S GENESIS

In September 2003, Insite became the first legally operating SCF in North America[7]. Insite is located on Hastings Street in Vancouver's downtown eastside (DTES), a collage of working-class and working poor, activists, migrant workers, young families, artists and students. Approximately 40 percent of residents receive income assistance, there is a high unemployment rate, and the lion's share of the city's affordable housing is located within its boundaries.[8] While it is a heterogeneous community of over 17,000 residents, its notoriety stems from its street-involved and street-entrenched community.[9] Most members of this community do not have access to basic health care and have experienced discrimination in health care facilities,[10] often because the DTES has, in the popular imagination, become a metonym for off-reserve Aboriginal poverty, sex work, crime and homelessness.[11]

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[7] *Insite SCC, supra* note 1 at 17.

[8] The City of Vancouver, "2005/06 Downtown Eastside Community Monitoring Report" (2006) <http://vancouver.ca/commsvcs/planning/dtes/pdf/2006mr.pdf>.

[9] Street-involved people are members of an amorphous and heterogeneous group that nonetheless shares similar socio-cultural and economic challenges: extreme poverty, unemployment or lack of a living wage, debt, little or insufficient access to required social programs, and unstable housing. Street-involved people are not necessarily "homeless." Some live in shared rental arrangements (that may or may not meet health and safety standards); others may squat or couch-surf, stay in temporary or transitional housing (such as hostels, rooming houses and emergency shelters); these conditions often render street-involved people more vulnerable to long term health concerns (high rates of tuberculosis); illness from mattresses with mould and bed bugs; scrutiny and judgment by staff and volunteers for consumption of alcohol or drug use (often for men); patronizing and controlling practices by staff and volunteers (often for women); and general annoyances with other shelter users. That said, there remain significant number of street-involved people who are without permanent shelter and who "rough sleep" (on benches, in alley ways) or who erect temporary shelters (out of cardboard and other material). In *Victoria (City) v. Adams*, (2008) B.C.L.R. 4th 116 (B.C.S.C.) at para. 148, Justice Ross held that the municipal prohibition against erecting a temporary abode was overbroad and arbitrary and violated homeless people's right to life, liberty and security of the person (and violated section 7 of the *Charter*). For a detailed discussion of the variegated features of street-involvement and homelessness, see generally: Suzanne Bouclin, *Street Law's Sites, Sights and Media* (McGill University, Faculty of Law, unpublished PhD Thesis, 2011).

[10] Dan Small, Anita Palepu & Mark W Tyndall, "The Establishment of North America's First State Sanctioned Supervised Injection Facility: A Case Study in Culture Change" (2005) 17 Intl Drug Policy J 73-82.

[11] Research indicates that 20% of DTES residents are of Aboriginal descent, 20% are homeless or street-involved, 80% have been incarcerated, 59% reported a non-fatal overdose in their lifetime, and 38% are involved in the sex trade: Wood et al, "Summary of findings from the evaluation of a pilot medically supervised safer injecting facility" (2006) 175 Can Med Assoc J 1399-1404. See

Insite's emergence has been referred to as "a complex and interconnected series of events brought about by the activities of advocates, peers, community agencies, politicians, journalists and academics."[12] In 1997, the Vancouver-Richmond Health Board declared a public health emergency for Hepatitis A and B, Hepatitis C Virus (HCV), Syphilis and Human Immunodeficiency Virus (HIV) in the DTES.[13] Bud Obsorn founded the Vancouver Area Network of Drug Users (VANDU) within an ethos that drug users are political and social agents who are instrumental to any comprehensive drug strategy.[14] Underground safer injection sites, such as the Back Alley, soon followed[15] and allies were recruited: Larry Campbell (Chief Coroner of British Columbia), John Millar (Public Health Officer), Phillip Owen (Former Mayor), and Libby Davies (Member of Parliament).[16]

Insite began as an outreach centre aimed at preventing accidental overdose deaths[17] and the spread of blood-borne diseases.[18] As it became more explicitly

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also: Hester Lessard, "Jurisdictional Justice, Democracy and the Story of Insite." (2011) 19 Constitutional Forum 93.

[12] Small *supra* note 10. See also Susan C. Boyd, Donald MacPherson & Bud Osborn, Raise Shit!: Social Action Saving Lives (Halifax: Fernwood Publishing, 2009).

[13] At least since the 1970s, the neighborhood has witnessed health concerns related to drug consumption. In the 1980s, John Turvey began a needle exchange program. Yet, despite broad community efforts over the years, health issues exacerbated in the 1990s: Larry Campbell, Neil Boyd & Lori Culbert, A Thousand Dreams: Vancouver's Downtown Eastside and the Fight for Its Future (Vancouver: Greystone Books, 2009) at 51, 127. In 2000, approximately 25 percent of injection drug users were diagnosed with HIV and approximately 88 percent had Hepatitis C: Richard Elliott, Ian Malkin & Jennifer Gold, "Establishing Safe Injection Facilities in Canada: Legal and Ethical Issues" (2002) Canadian HIV/AIDS Legal Network. According to a 2008 survey of 1,000 drug users living in the DTES, 87% are infected with HCV, 17% with HIV, 18%: See also: Our Location online: Vancouver Coastal Health Authority- Supervised Injection Site <http://supervisedinjection.vch.ca/our_location/> [*Insite Website*]; Wood et al, "Summary of findings from the evaluation of a pilot medically supervised safer injecting facility" (2006) 175 Can Med Assoc J 1399-1404. The presence of such blood-borne infections in the DTES suggests how the transmission is located in a complex nexus of individual, social, cultural and structural patterns and flows: See generally: K.E. Poundstone, S.A. Strathdee & D.D. Celentano, "The social epidemiology of human immunodeficiency virus/acquired immunodeficiency syndrome" (2004) 26 Epidemiol Rev 22-35.

[14] Vancouver Area Network of Drug Users, online: VANDU <http://www.vandu.org> [VANDU].

[15] "Timeline: Insite" *CBC* online at <http://www.cbc.ca/fifth/2008-2009/staying_alive/timeline.html>.

[16] Lessard, *supra* note 11 at 99.

[17] The British Columbia Coroner's service found that between 1988 and 1998, 2,413 people died in the DTES of heroin overdose: British Columbia's Coroner's Service *Annual Report* (1998).

[18] Insite Website, *supra* note 13.

geared toward safer injection, its goals began to include: reducing accidental overdose death and the spread of diseases; increased interactions among users, health professionals, social workers, and peer supports; and navigating neighbourhood problems related to illicit drug use.[19] In order to operate legally, however, it still required an exemption from the prohibitions on possession of controlled substances and trafficking under sections 4(1) and 5(1) of the *CDSA*. [20] Vancouver Coastal Health applied to the Minister of Health for a three-year exemption to these provisions in order to conduct a pilot research project at Insite; the exemption was granted to them in September 2003.[21]

Since then, researchers across disciplines and constituencies attest to Insite's effectiveness.[22] It has been associated with reduced injecting in public spaces,[23] safer needle disposal,[24] lower numbers of new cases of blood-borne infections – especially HCV and HIV.[25] It has also reduced overdose fatalities in the DTES.[26] Cost-benefit analyses demonstrated that Insite has lead to "an incremental net

[19] *Ibid.*

[20] Subsection 4(1) provides that: "Except as authorized under the regulations, no person shall possess a substance included in Schedule I, II or III." Subsection 5(1) provides that: "No person shall traffic in a substance included in Schedule I, II, III or IV or in any substance represented or held out by that person to be such a substance:" *CDSA, supra* note 3.

[21] Wood*, supra* note 2.

[22] For a summary of such research, see: "Findings From the Evaluation of Vancouver's Pilot Medically Supervised Safer Injecting Facility-Insite" (2009) British Columbia Centre for Excellence in HIV/AIDS. For a detailed examination of the data before and after Insite's opening shows that the rate of syringe sharing also decreased, a practice that is associated with HIV infections see Deborah Jones, "Injection Site Gets 16-month Extension" (2006) 175 Can Med Assoc J 859. See also *Health Canada Report, supra* note 1.

[23] Evan Wood et al. "Changes in Public Order After the Opening of Medically Supervised Safer injecting Facility for Illicit Injection Drug Users" (2004) 171 Can Med Assoc J. 731-734 (on the decrease in public disorder such as public injections and ill-discarded syringes after the opening of the facility).

[24] There was no evidence of increase in drug-related loitering, drug dealing or petty crime in neighbourhood: *ibid.*

[25] *Health Canada Report*, *supra* note 2; Wood, *supra* note 1*,* Insite Website, *supra* note 13.

[26] According to Health Canada, Insite has "successfully intervened in over 336 events since 2006 and no overdose deaths have occurred at the service. Mathematical modeling suggests that Insite saves about one life a year as a result of intervening in overdose events.": *Health Canada Report*, *ibid*.

savings of almost $14 million and 920 life-years gained over 10 years";[27] helped prevent 35 new cases of HIV and 3 deaths per year; and generated a societal benefit of over $6 million per annum in public health care costs. [28] Interviews with 25 women who use Insite suggest that its controlled and safe environment provided refuge from street violence and facilitated conditions for the exercise of agency over during the process of drug consumption.[29]

Nevertheless, Insite remains inadequately tailored to address the specific needs of the Aboriginal illicit drug user population[30] – in part because Aboriginal people are less likely to enroll in mainstream addiction treatment models that do not take into consideration the impact of colonial projects and the State's violent intervention into the everyday lives and social structures of Indigenous peoples.[31]

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[27] Insite's 2010-2011 operation budget was $2,969,4400; Insite Website *supra* note 13; Ahmed M. Bayoumi & Gregory S. Zaric, "The Cost-effectiveness of Vancouver's Supervised Injection Facility" (2008) 179 Can Med Assoc J 1143-1151. The Expert Advisory Committee on Supervised Injection Site Research found a cost to benefit ratio ranging from 1.5 to 4.02: *Health Canada Report*, *ibid*.

[28] More conservative estimates suggest a reduction of 5-6 infections per year: Martin A. Andresen and Neil Boyd, "A Cost-Benefit and Cost-Effectiveness Analysis of Vancouver's Supervised Injection Facility." (2010) 21 Int J Drug Policy 70-76. But see: Steven D. Pinkerton, "Is Vancouver Canada's Supervised Injection Facility Cost-Saving?" (2010) 105 Addiction J 1429-1436; Evan Wood et al. "Burden of HIV Infection Among Aboriginal Injection Drug Users in Vancouver, British Columbia." (2008) 98 Am J Public Health 515-519; Mark Tyndall et al "Attendance, Drug Use Patterns, and Referrals Made From North America's First Supervised Injection Facility" (2006) 83 Drug and Alcohol Dependence 193-98.

[29] Nadia Fairbairn et al, "Seeking refuge from violence in street-based drug scenes: Women's experiences in North America's first supervised injection facility" (2008) 67 Soc Sci Med 817-823. See also: Kora DeBeck et al, "Injection drug use cessation and use of North America's first medically supervised safer injecting facility" (2011) 113 Drug Alcohol Depend 172.

[30] See generally: Bajju R. Shah, Nadia Gunraj and Janet E. Hux, "Markers of Access to and Quality of Primary Care for Aboriginal People in Ontario, Canada." (2003) 93 American Journal of Public Health 798-802 (Aboriginal residents have insufficient or ineffective primary care); Kathi Wilson & Nicolette Cardwell, "Urban Aboriginal health: Examining inequalities between Aboriginal and non-Aboriginal Populations in Canada" (2012) Canadian Geographer 98-116 (discusses cultural factors shaping health in Aboriginal population); and Sannie Y. Tang & Annette J Browne, "'Race' Matters: Racialization and Egalitarian Discourses Involving Aboriginal People in the Canadian Health Care Context" (2008) 13 Ethnicity & Health 109-127 (on the ways in which progressive sounding discourse masks more subtle forms of racism in health care provision).

[31] Evan Wood et al, "Sociodemographic disparities in access to addiction treatment among a cohort of Vancouver injection drug users" (2005) 40 Subst Use Misuse 1153. On the broader relational repercussions of colonial treatment models see: Deviant Constructions: Sarah de Leeuw & Margo Greenwood & Emilie Cameron, "How Governments Preserve Colonial Narratives of Addictions and Poor Mental Health to Intervene into the Lives of Indigenous Children and Families in Canada" (2010) 8 Int J Ment Health Addiction 282-295. On the rich potential of harm reduction strategies

2. LEGAL MOBILIZATION AND THE CURRENT REGULATORY FRAMEWORK

After its initial three-year exemption, Insite received a prolongation until December 31, 2007 and subsequently until June 30, 2008.[32] As the deadline for the renewal approached, however, the Minister of Health alluded to the fact that the government may not renew again[33]. The Portland Hotel Society Community Services (PHS) and two of its constituents as well as VANDU commenced two separate legal actions in order to keep Insite from being forced to shut its doors.[34]

Before the British Columbia Supreme Court, PHS organized its arguments around the concept of interjurisdictional immunity.[35] As a health care service "within a very local community,"[36] Insite was a provincial undertaking; the federal government's power to legislate with respect to criminal law ought not to interfere with the provincial power over the creation and administration of health care facilities.[37] In

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which are constituted for and through Aboriginal communities, see generally: Colleen Anne Dell & Tara Lyons, "Harm Reduction for Special Populations in Canada" (2007) online: Canadian Centre on Substance Abuse. <http://www.ccsa.ca/2007%20CCSA%20Documents/ccsa-011515-2007.pdf>.

[32] *PHS Community Services v. Attorney General of Canada* (2008) BCSC 661 293 DLR (4th) [*Insite Trial Level*].

[33]Tony Clement at the House of Commons and in the media continued to assert that harm reduction was an unfavourable mandate. At the XVII International AIDS conference Mr. Clement stated that "[a]llowing and/or encouraging people to inject heroin into their veins is not harm reduction, it is the opposite ... it is a form of harm addition:" Andre Picard, "Clement's Insite attack leaves WHO red-faced" *The Globe and Mail* (August 6, 2008) online: The Globe and Mail <http://www.theglobeandmail.com/life/article701599.ece>. Mr. Clement also told the CMA that "[h]arm reduction, in a sense, takes many forms. To me, prevention is harm reduction. Treatment is harm reduction. Enforcement is harm reduction:" Solomon, Sam "Minister's mind made up on safe injection site, warn experts" National Review of Medicine: Policy and Politics (September 15, 2007) online: National Review of Medicine <www.nationalreviewofmedicine.com>. Compare the cooperative approach and guiding principles adopted by harm reduction advocates which indicate just how different (yet interrelated) harm reduction is from these other 'pillars:' HRSS, *supra* note 4.

[34],*Insite Trial Level*, *supra* note 32.

[35] They argued that because health care falls within the provincial jurisdiction and because Insite is a health care facility offering health care services, its actions were protected from federal interference by the doctrine of interjurisdictional immunity—the idea that there "is a "basic, minimum and unassailable content" to the heads of powers in ss. 91 and 92 of the *Constitution Act, 1867* that must be protected from impairment by other levels of government:" *Insite Trial level, supra* note 32 at para. 58.

[36] *Ibid.* at para 115.

[37] *Ibid.* at para 5.

the alternative, PHS claimed that subsections 4(1) and 5(1) of the *CDSA* were unconstitutional and should be struck down: they deprived persons addicted to controlled substances access to necessary and life-saving health services and violated section 7 of the *Charter.*[38] First, Insite staff, engaging in ordinary business without the commission of any offense at law could nevertheless be charged with trafficking or possession for handling equipment contaminated with controlled substances; this amounted to a violation of their right to liberty.[39] Second, people who accessed Insite's services – under the threat of criminal sanction – would be denied access to health care that could reduce or eliminate the risk of death from overdose and infectious diseases thereby violating their right to life, liberty and security of the person.[40] VANDU further sought a declaration that the offence of the possession of all addictive drugs[41] violated the *Charter* rights of all drug users because it impinges their right to the security of the person through the constant threat of criminalization.[42]

Justice Pitfield held that subsections 4(1) and 5(1) were arbitrary and amounted to blanket prohibitions "contributing to the very harm" they were intended to prevent.[43]

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[38] Section 7 of the *Charter* provides that "Everyone has the right to live, liberty and security of the person and the right not to be deprived thereof except in accordance with the principles of fundamental justice." It has been a key component of recent health law litigation in Canada and Quebec. For instance, in *Rodriguez v British Columbia (Attorney General)*, [1993] 3 SCR 519, 10 DLR (4th) 342, 7 WWR 641 the appellant felt that section 241(b) of the *Criminal Code*, which prohibits assisted suicide, violated her liberty and security of person interests. Within the same year the Supreme Court ruled on the case of *R. v. Morgentaler* (*R. v. Morgentaler*, [1993] 1 SCR 462, 1993 CanLII 158 (SCC); *R. v. Morgentaler*, [1988] 1 SCR 30, 63 OR (2d) 281, 37 CCC (3d) 449)) which dealt with the regulation of abortion in Canada and the violation of a woman's right to security of the person under section 7. Most recently in 2005 the case *of R. v. Chaoulli* (*R. v. Chaoulli (Attorney General)*, [2005] 1 SCR 791, 2005 SCC 35) dealt with whether the long wait times for health/medical services violated the security of a person under section 7. See also *Insite Trial Level, supra* note 32, *supra* at para. 5. For scholarly writing on the question of the court's relationship to health care accountability, see generally Martha Jackman, "Charter Review as Health Care Accountability Mechanism in Canada" (2010) 18 Health L J (on the *Charter* as a mechanism for health care accountability). See also Christopher P. Manfredi and Antonia Maioni, "Courts and Health Policy: Judicial Policy Making and Publicly Funded Health Care in Canada" (2002) 27 Journal of Health Politics, Policy and Law 213-240.

[39] *Insite Trial Level, supra* note 32 at para 153.

[40] *Ibid*. at para. 124.

[41] These are set out in schedules I, II, III of the *CDSA*, *supra* note 1.

[42] *Insite Trial Level, supra* note 32 at para. 134.

[43] *Ibid.* at para. 152. This finding is nothing new to critical criminologists who have been arguing for years that the criminalization of drugs constitutes rather than alleviates social harms. See for

They offended the principles of fundamental justice as arbitrary through the prohibition of addiction management.[44] He noted that as a general rule, the principles of fundamental justice are primordial in Western society and that "any law that offends them will not ordinarily be saved" by section 1 of the *Charter.*[45] Fundamental to his judgment was his finding of fact that there was inconvertible evidence that existed:

- Addiction is an illness not a choice; its central feature is impaired control over the use of an addictive substance;
- Narcotics themselves do not cause illnesses such as HCV and HIV; rather, health risks are usually caused by unsanitary practices, techniques and equipment;
- The risk of death is ameliorated when injecting occurs in the presence of qualified health professionals;
- Since Insite opened, there has been a reduction in the number of people injecting in public; there has been no evidence of increased drug-related loitering, drug dealing, or petty crime in the area around Insite; instead, police data shows no change in the DTES crime rate since Insite began operations.[46]

Justice Pitfield dismissed VANDU's application on the basis that Insite members' actions were fact-dependent and the declaration would not serve a useful purpose in the future where circumstances of the clinic could change.[47]

Regarding the question of division of powers, the trial judge determined that Insite was not protected from the *CDSA*'s provisions by virtue of the interjurisdictional immunity doctrine. Rather, the doctrines of double aspect and paramountcy – where two areas of law are governing the same matter, here the federal criminal law and the provincial health care law, and a conflict ensues, the federal law prevails – meant that the province had "no capacity to override the criminal law."[48]

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instance: Line Beauchesne, "De la Criminalisation a la légalisation des drogues: de Charybde en Scylla?" (1989) XXII Criminologie 67.

[44] *Insite Trial Level, supra* note 32 at para. 114.

[45] *Ibid.* at para. 157.

[46] *Ibid.* at para. 87.

[47] *Ibid.* at para. 98.

[48] *Ibid.* at paras. 113 and 119.

Justice Pitfield then suspended the application of invalidity until June 30, 2009 in order to give the government an opportunity to respond appropriately.[49] In accordance with established precedent,[50] he granted Insite patrons and staff a constitutional exemption from the application of impugned sections of the *CDSA.*

The British Columbia Court of Appeal upheld the trial decision: Insite should continue to operate free from federal drug prohibitions and that the application of subsections 4(1) and 5(1) of the *CDSA* were in violation of the *Charter*[51] and did not meet the minimal impairment test of the section 1 analysis[52]. Yet contrary to the trial judge, Justice Huddart (with Justice Rowles concurring), the Court of Appeal determined that the federal drug laws were inapplicable to Insite under the doctrine of interjursidictional immunity.[53] Insite was a provincial health care facility which did not undermine the federal government's objectives of protecting health and safety and eliminating the underground market which encouraged particular drug-related offences such as the importation, production or trafficking of illicit substances.[54]

The Supreme Court of Canada revisited the issues raised at trial level: the division of powers, the application of subsections 4(1) and 5(1) of the *CDSA* and whether their application to Insite infringed the *Charter*. On the question of division of powers, the Court examined the dominant purpose of the *CDSA*: to maintain, promote and balance public health and safety. The provisions were, the Court held, a valid exercise of the federal government's power over criminal matters. It unanimously upheld Justice Pitifield's judgment, clarifying that jurisprudence around interjurisdictional immunity has tended to confine the use of the doctrine.[55]

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[49] *Ibid.* at para. 158.

[50] *R. v. Ferguson*, 2008 SCC 6, 228 C.C.C. (3d) 385 at para. 46.

[51] The Attorney General of Canada appealed the order granting Insite an ongoing, constitutional exemption to permit its operation; PHS cross-appealed the dismissal of its application for a declaration that the impugned sections of the *CDSA* did not apply to Insite because of the doctrine of inter-jurisdictional immunity: *PHS Community Services Society v Canada (Attorney General)*, 2010 BCCA 15, 314 DLR (4th) 209 [*Insite Appeal Court*].

[52] *Ibid.* at para. 77, citing *R.* v. *Heywood* at paras. 802-803.

[53] According to Gillian Calder, the result obtained by Madam Justice Huddart was correct but her strict textual reading hindered "a more dynamic understanding of the role of law" which would have opened up more interesting possibilities for social justice: "Insite: Right Answer, Wrong Question" (2011) 19 Constitutional Law Forum 113 at p. 114.

[54] *Insite Appeal Court, supra* note 52 at para. 169.

[55] *Insite SCC, supra* note 1 at paras. 57-72.

In this context, health services were not a "core" aspect of the provincial purview over health care as articulated under subsections 92(7), (13) and (16) of the *Constitution Act, 1867.*[56] In any event, this case would not, the Court specified, extend the immunity to the realm of health care: while the *CDSA* provisions regulated provincial health facilities incidentally, the federal provisions were a constitutionally valid exercise of criminal law powers.[57]

While the Court took no position on the inherent worth of harm reduction programs generally, it heard from several interveners including a coalition of harm reduction advocates and activists who advanced evidence of its effectiveness internationally in addressing the harms associated with addiction management. [58] Regarding subsection 5(1), the Court found the activities of neither the clients nor the staff could constitute trafficking[59]; the provision, therefore, was a valid and constitutional deprivation of the claimants' section 7 rights.[60]

In assessing whether subsection 4(1) of the *CDSA* passed *Charter* scrutiny, the Court found that but for an exemption on drug possession, Insite staff would be vulnerable to imprisonment and would be unable to offer life-saving medical support to people who made use of supervised services.[61] Their liberty interests under section 7 of the *Charter* were engaged.[62] Moreover, by depriving Insite's constituents of such necessary and life-saving services, and by threatening them with charges of possession, the provisions engaged their rights to life and security of the person.[63]

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[56] *The Constitution Act, 1867*.

[57] *Insite SCC, supra* note 1 at paras. 66-70.

[58] Groups intervening in support of Insite and harm reduction more broadly include: Dr Peter AIDS Foundation, Canadian HIV/AIDS Legal Network, International Harm Reduction Association, CACTUS Montreal, Canadian Nurses Association, Registered Nurses' Association of Ontario, Association of Registered Nurses' of British Columbia, Canadian Public Health Association, Canadian Medical Association, British Columbia Civil Liberties Association, British Columbia Nurses' Union: *ibid.*

[59] Clients cannot purchase or otherwise obtain drugs from Insite and the facility has prohibitions against activities that might be construed as trafficking while they are on the premises: *ibid.* at paras. 95-96.

[60] *Insite SCC, supra* note 1 at para. 96.

[61] *Ibid.* at para. 92.

[62] *Ibid.* at para. 94.

[63] *Ibid.* at para. 92.

Subsection 4(1) did not, however, violate section 7 of the *Charter*. [64] The exemption provision under section 56 of the *CDSA* was intended to prevent the arbitrary application of the law, its application in a manner which was overbroad or grossly disproportionate in its effects.[65] Consequently, the Minister's power to grant or refuse exemptions must be exercised be in accordance with the principles of fundamental justice. The Court found that the Minister's failure to grant an exemption violated Insite's staff and constituents' section 7 rights[66] prevented injection drug users from accessing life-sustaining health services[67] and ignored the vast evidence founded in scientific research that showed that Insite was "effective in reducing death and disease."[68] The Minister's decision was arbitrary:[69] it undermined the very purposes of the *CDSA*, the protection of health and public safety; and its negative effects were disproportionate to any benefit that might derive from a uniform stance on the possession of narcotics.[70] The Minister's exercise of discretionary power was a violation of staff and constituents' section 7 rights. [71] The Court nonetheless denied PHS's request for a permanent constitutional exemption because it deemed it to be an inappropriate remedy for a State action, which infringed the *Charter*.[72]

The Current Framework

While Insite currently operates legally, the Supreme Court decision does not bind the Minister of Health to future exemptions.[73] A spokesperson for Health Canada recently commented that the decision "did not clear the way for additional

[64] *Ibid.* at para. 117.

[65] *Ibid.* at paras. 114-5.

[66] The Attorney General argued the Minister had not violated section 7 because he had not made a decision whether or not to grant an exemption. The Court determined, however, that the Minister had in fact made a decision to refuse the exemption: *ibid.* at paras. 119-120.

[67] *Ibid.* at para. 136.

[68] *Ibid.* at para. 140.

[69] *Ibid.* at para. 135.

[70] *Ibid.* at para. 133.

[71] *Ibid.* at para. 150.

[72] *Ibid.* at para. 148. Compare the recent British Columbia Supreme Court's decision to grant a permanent constitutional to *Criminal Code* provisions on physician-assisted dying in specific contexts: *Carter v. Canada (Attorney General)*, 2012 BCSC 886.

[73] *Ibid.* at para. 151.

supervised injection sites to be opened"[74] and that requests for exemptions "would be reviewed and given proper, careful consideration on a case-by-case basis."[75]

Chief Justice McLachlin elaborated the factors considered in making a decision on an exemption in the future.[76] The Court reaffirmed the Minister's discretion to "withdraw an exemption to Insite" should circumstances so require.[77] The framework from which the Minister must consider her or his decision to granting an exemption is the following:

1) The Minister's discretion must comply with *Charter* values, and especially if denial would amount to an unjustifiable violation of section 7;[78]
2) In determining whether such a violation exists, the minister must balance public health and safety concerns;[79]
3) Consequently, should evidence indicates that a SCF will "decrease the risk of death and disease", and, correspondingly, there is "little or no evidence that will have a negative impact on public safety", the Minister ought to grant an exemption.[80]

The legal terrain in Canada and Quebec remains that no federal, provincial or municipal government explicitly legislates for SCFs. However, the Supreme Court decision makes plain that provinces do have the right to open and operate Insite-like facilities. Yet, because of the doctrine of paramountcy, the *CDSA* remains valid and applies to any safe injection site as long it is effects or application does not violate the *Charter*. Consequently, when seeking to operate a legal SCF, an applicant must still obtain an exemption from Health Canada for *research* involving

[74] Robert Matas, "Health authority weights adding more supervised injection site." *The Globe and Mail* (January 9, 2012) online: The Globe and Mail <www.theglobeandmail.com>.

[75] *Ibid.*

[76] *Insite SCC, supra* note 1 at para. 152.

[77] *Ibid.* at para. 149.

[78] *Ibid.* at para. 153.

[79] *Ibid.* at para. 152.

[80] *Ibid.*

the use of controlled drugs and substances.[81] Following the Supreme Court's ruling, an applicant should be able to speak to the following factors:

1) Local conditions indicate a need for harm reduction strategies;
2) There is and established positive impact on public health and safety;
3) Regulatory structure and available resources to support its maintenance;
4) Expression of community support. [82]

We are of the view that there exists sufficient empirical evidence that harm reduction programs, and SCFs in particular, reduce harms such as transmission of infections, associated drug use and unintentional overdose; that it can help (re)constitute liveable and inclusive communities; and improve the quality of the life, health and wellbeing of many marginalized and vulnerable people through education, skills, and supports.[83] We attempt now to establish how Ottawa can also meet the remaining three criteria to be granted a section 56 exemption, namely: demonstrated need, necessary infrastructure, and community support.

3. INSITE'S REACH: THE CASE FOR SCF IN OTTAWA

On September 30, 2011, hundreds gathered outside of Insite to wait for the Supreme Court's ruling.[84] The court's unanimous judgment was an enormous victory for the community and, as in Member of Parliament Libby Davis' words, it

[81] "Implementation of Section 56 of the Controlled Drugs and Substances Act Requirements" online: Canadian Institutes of Health Research <http://www.cihr.ca/e/42873.html>; and online: Health Canada <http://www.hc-sc.gc.ca/hc-ps/substancontrol/exemptions/index-eng.php>.

[82] *Insite SCC*, *supra* note 1 at para. 153.

[83] See the literature cited *supra* notes 2 and 26. See also S. Carruthers, "The organization of a community: community-based prevention of injecting drug use-related health problems" (2007) 42 *Substance Use and Misuse* 1971-7 (on the value of peer-based, community-organized prevention and harm reduction initiatives); D. Bigg, "Substance Use Management: A Harm Reduction-Principled Approach to Assisting the Relief of Drug-Related Problems" (2001) 33 Journal of Psychoactive drugs 33-38 (abstinence-based programs alone cannot address the social and economic issues often at the root of addiction); Christiane Poulin, "Harm reduction policies and program for youth." (2006) online: Canadian Centre on Substance Abuse <http://www.ccsa.ca/2006%20CCSA%20Documents/ccsa-11340-2006.pdf>; Don Des Jarlais et al. "Evaluating Vancouver's supervised injection facility: data and dollars, symbols and ethics." (2008) 179 Can Med Assoc J 1106; David Keepnews, "Canada's Insite Decisions: A Victory for Public Health" (2011) 12 Policy, Politics & Nursing Practice 131.

[84] Kirk Makin, Sunny Dhillon & Ingrid Pereitz "Supreme Court ruling opens doors to drug injection clinics across Canada" (September 30, 2011) online: The Globe and Mail <http://www.theglobeandmail.com>.

"validated … years of struggle and work to show that Insite is a very important resource and service and [that] it saves lives."[85] A coalition of nurses from across the country hailed the decision as a "great victory for harm reduction and for the clients who rely on the facility for help and support."[86]

Reactions, however, were mixed.[87] Leona Aglukkaq, federal Minister of Health, expressed her disappointment, conceding, nonetheless that government would nevertheless "comply" with the ruling.[88]

The decision has fanned two on-going debates around the value of harm reduction strategies[89] the division of powers,[90] co-operative federalism, and the 'dialogic' relationships between courts and governments on the interpretation of *Charter* rights.[91]

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[85] *Ibid*.

[86] "Nurses praise supreme court ruling: Insite saves lives and improves health" (September 20, 2011) online: Canadian Nurses Association <http://www.cna-aiic.ca/en/nurses-praise-supreme-court-ruling-insite-saves-lives-and-improves-health/>.

[87] For example, groups like the Drug Prevention Network of Canada voiced their opposition to the decision stating that the Supreme Court decision was "based only on the flawed evidence of the activist researchers who had a conflict of interest in that they were also lobbyists for the establishment of the site a decade ago": Gwen Landolt (DPNC President), "A Drug Addict's Destiny" (October 3, 2011) (Posted Media Release), online: Drug Prevention Network of Canada <http://dpnoc.ca/news/page/2/>. The REAL Women of Canada who stated that the Supreme Court had "arrogantly decided that it [was] more capable of determining Canada's national drug policy than the elected government": "Supreme Court of Canada Decides Canada's National Policy on Drugs Re: Vancouver Drug Injection Site", (September 30, 2011) (Media Release), online: REAL Women of Canada <http://www.realwomenca.com/page/mediareleases.html>. Prominent groups such as the Canadian Medical Association came out in support of the decision stating that they were "very pleased that the Supreme Court ruled in favour of allowing Insite to continue to carry out its work": Canadian Medical Association, "Canada's Doctors Welcome Supreme Court Ruling on Insite" (September 30, 2011), online: Canada Newswire <http://www.newswire.ca/en/story/850989/canada-s-doctors-welcome-supreme-court-ruling-on-insite>. Even politicians chimed in such as Member of Parliament Libby Davies stated that it was a "great victory legally": "Libby Davies, "In Support of Insite" (September 30, 2011) (Blog entry), online: Libby Davies <http://www.libbydavies.ca/blog/2011/9/30/support-insite#.T62uB1I1aSo>.

[88] House of Commons Debate 41st parl 1st sess September 30, 2011: "although we are disappointed…, we will comply [with the decision]."

[89] See Wood*, supra* note 1. See also: Patricia G. Erickson & Andrew D Hathaway, "Normalization and Harm Reduction: Research Avenues and Policy Agendas" (2010) 21 Intl J Drug Pol 137-139.

[90] Lessard, *supra* note 11 at 103.

[91] Jeremy Webber, "Section 7, Insite and the Competence of the Courts" (2011) 19 Constitutional Forum 125 (the relationships between the judiciary, the executive and the legislature regarding the

Our interest in the decision is because of the potential legitimacy it helps provide organizations and rights' advocates who have mobilized to create conditions in which the dignity of Ottawa-based drug users may be protected.

i) Needs Assessment and Established Impact

Substance abuse takes a devastating human toll (premature death and physical and mental deterioration[92]), financial toll (lost productivity, expenditures on crime control rather than rehabilitation), and community toll (breakdown of informal networks and relationships and the increased formal policing and enforcement).[93] Canadian jurisdictions outside of Vancouver's DTES face similar, albeit arguably less widespread health crises related to drug addiction.

There is, for instance, a clear need in Ottawa for a SCF as a necessary component to harm reduction strategies geared at promoting public health and safety. Two major studies, one conducted by researchers at the University of Ottawa[94] and another by the Toronto and Ottawa Supervised Consumption Assessment (TOSCA)[95] recently came to the same conclusion: Ottawa ought to establish safe injection sites as the city faces very real addiction concerns and there is a need for more holistic intervention.[96]

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application of section 7). See generally: Peter Hogg and Alison Bushell, "The *Charter* Dialogue Between Courts and Legislatures (Or Perhaps the *Charter* of Rights Isn't Such a Bad Thing After All)" (1997) 35 Osgoode H L J 75; Kent Roach, The Supreme Court on Trial: Judicial Activism or Democratic Dialogue? (Toronto: Irwin Law, 2001).

[92] On the social, economic, health and identity effects of Hepatitis C on IDUs, see: L. Copeland "The Drug User's Identity and How it Relates to Being Hepatitis C Antibody Positive" (2004) Drugs, Education, Prevention, and Policy, 11(2), 129-147.

[93] On the effects of street level policing on IDUs see: Daniel Werb et al, "Effects of Police Confiscation of Illicit Drugs and Syringes Among Injection Drug Users in Vancouver" (2008) 19 Int J Drug Policy 332-338; for a review of the interplay between policing and overdose mortality see: Amy Bohner et al, "Policing and Risk of Overdose Mortality in Urban Neighborhoods" (2011) 113 Drug and Alcohol Dependence 62-68. On the geo-political repercussions of North America's war on drugs, see: Beauchesne, *supra* note 43.

[94] Lynne Leonard & Emily DeRubeis, "Needs Assessment for Safer Injecting Facility in Ottawa, Canada" (2008) HIV Prevention Research Team, Department of Epidemiology and Community Medicine, University of Ottawa.

[95] We limit our discussion to Ottawa but note that TOSCA made its recommendation for Toronto because, together, these cities "account for approximately half of all people who inject drugs in Ontario:"*supra* note 1 at 19.

[96] *Ibid.* at 14.

There are over 30,000 people in Ottawa who struggle with substance abuse, of which only 12 percent have accessed treatment;[97] counseling and referrals are made for around 200 members of this population per year – a small fraction of the drug user population in the city;[98] and between 3,000 and 5,000 people are currently on waiting lists for addiction "treatment."[99] Approximately 3,500 individuals use injection drugs in Ottawa,[100] of which, one in five had overdosed in the past six months.[101]

People who inject drugs in Ottawa suffer the same risks related to the transmission of blood-borne infections in other jurisdictions: it is estimated that between 11 and 20 percent of the injection drug community in Ottawa are HIV positive[102] and 60 percent have HCV.[103] In fact, between 1992 and 2000, the risk of HIV infection was nine times higher in Ottawa than it was in Toronto.[104] Research indicates that meaningful access to SCFs in Ottawa can avert between 6 to 10 HIV infections and 20 to 35 cases of HCV[105] per year.[106] Moreover, despite Ottawa's SITE work to distribute and collect 100,000 needles annually, there remain documented "public order problems" such as inappropriate disposal.[107] Needle and other

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[97] David Salisbury, "Community Network for the Integrated Drugs and Addiction Strategy" (June 7, 2006) Health, Recreation and Social Services Committee [City Report]. For an international perspective on the social exclusion of injection drug users, see: J.C. March, E. Oviedo-Joekes & M. Romero, "Drugs and social exclusion in ten European Cities" (2006) 12 European Addiction Research 33.

[98] 3,000 estimated drug users: Butler*, supra* note 4.

[99] Kelly Egan, "Cracking open Ottawa's drug problem" The Ottawa Citizen (April 23, 2008) online: The Ottawa Citizen <www.the ottawacitizen.com >.

[100] "Need Exchange FAQs" (2012) Ontario Hard Reduction Distribution Program online: <http://www.ohrdp.ca/resources/needle-exchange-faqs/>. The most common drugs injected by people who inject drugs in Ottawa: crack or cocaine and then opiates (53% and 46% respectively) TOSCA, *supra* note 2 at 31.

[101] TOSCA*, ibid.* at 217.

[102] *Ibid.* at 217.

[103] *Ibid.*

[104] "The Issues" The Ottawa Integrated Drugs and Addiction Strategy Initiative, The City of Ottawa online: <http://ottawa.ca/public_consult/drug_addict/issues_en.shtml>[*Ottawa Drug Strategy*].

[105] TOSCA, supra note 2 at 218.

[106] In crass monetary terms, this means between $66, 358 and $18,591 for every case averted: TOSCA, *supra* note 2 at 217.

[107] *Ibid.* at 5 (regarding the proper disposal of needles).

paraphernalia sharing remains a common practice in Ottawa with a staggering 40 percent of respondents reporting that they injected with used needles in the past 6 months;[108] 14 percent said they felt compelled to re-use needles (often used by someone else);[109] and nearly a quarter of respondents were using non-sterile water to prepare drugs or rinse needles.[110]

Particular populations in Ottawa are at risk of developing life-threatening health issues related to the use of injection drugs, especially street-involved and homeless people. These already marginalized people are often victims of crime themselves[111] and face additional criminalization as a result of being forced to use drugs publically.[112] Over half of the injection drug use community reported living in unstable housing and 34 percent of participants were denied housing or a place to stay because of their drug use. A staggering 62 percent of research participants reported losing their housing because of their drug use. Currently, one in four members of the injection drug use community in Ottawa most commonly inject outside – whether on the street, in alleyway or in another public place.[113] Yet, injecting publicly is less hygienic[114] and more dangerous because of the threat of being arrested.[115] In addition to providing safer conditions in which to inject, from a

[108] Leonard & DeRubeis, *supra* note 94 at 40.

[109] 65% of respondents reported that they most commonly inject with a close friend, 30% reported with a regular sex partner and 9% with people they did not know well. 14% said they used needles used by someone else: *ibid.* at 23.

[110] Almost a quarter "reported using non-sterile water for drug preparation or to rinse their needles." The study reflects that one fifth of all participants report reusing and experiencing trouble accessing clean injection equipment and other paraphernalia: *ibid.* at xi.

[111]See for instance: Ben Roebbuck, "Homelessness, Victimization and Crime: Knowledge and Actionable Recommendations" (2008) Institute for the Prevention of Crime University of Ottawa (describing crimes committed against and victimization experienced by street-involved people).

[112] TOSCA, *supra* note 2 at 5, 11.

[113] 25% of people reported injecting in a public place such as a washroom or stairwell and 29% report to injecting on the street or alley: TOSCA, *supra* note 2 at 24. See also: *Canada (Attorney General) v. Bedford* 2012 ONCA 186 (where, in finding the criminal regulation of certain *Criminal Code* provisions relating to prostitution to be unconstitutional, the trial judge drew a parallel between the criminal regulation of injection drug users and that of sex workers who are forced into less safe zones of the city and make more rapid evaluations of clients). For a discussion of the nuances between the trial level and the appeal level decision in *Bedford*, see generally: Suzanne Bouclin, "Regulating Sex Work in Canada" (2012) July *Public Law* 387.

[114] TOSCA, *ibid.* at 55.

[115] Almost half of participants reported a fear being arrested when they or someone they know overdosed: Leonard & DeRubeis, *supra* note 94 at p. xi.

public acceptance point of view, “making drug use less visible” by implementing a safer consumption facility, “may be desirable for neighbourhoods where there is a high level of public use"[116] Finally, the majority of active injection drug users in Ottawa have indicated their desire to access SCF were one to open in Ottawa,[117] especially their potential for help and care when overdosing occurs.[118]

People in Ottawa who use drugs and who struggle with harms associated with addiction management have identified that the following services are an integral part of holistic treatment: nursing care, food, clean toilets, counseling, detoxification beds, access to social workers, drug use information and education, accidental overdose prevention services and education, equipment distribution and disposal, referrals for drug treatment, peer support, mental health services, basic medical care, first aid, wound care, medical testing. In the next section, we explore whether the city has the infrastructure to offer such treatment options.

ii) Infrastructure and Resources

According to a now familiar story, it was the declaration of an epidemic in the specific zone of the DTES that triggered the demand of a safer injection site in Vancouver.[119] Similarly, the Kings Cross area of Sydney, Australia, which has been operating a SCF since the 1990s, has been called the “epicenter” of drug use in Australia.[120] Evidence from these jurisdictions indicates the importance of SCFs to holistic and effective drug addiction management. Unlike these cities, in Ottawa, injection drug use is dispersed and decentralized even though there exist “pockets”

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[116] *Ibid.* at 55.

[117] Half of those interviewed would use the facility "always or usually." There were no substantial differences between male and female respondents on this question: TOSCA, *supra* note 2 at 155.

[118] According to Leonard & DeRubeis, 86% of Ottawa-based injection drug users would use an SCF it was established in a convenient location and would also be willing to walk or use public transportation in order to access Insite-like services and supports: *supra* note 94 at 185. TOSCA found that 75% of people who use drugs said they would use a supervised injection facility: *TOSCA*, *ibid.* at 152.

[119] *Insite SCC*, *supra* note 1 at para. 11.

[120] In Sydney, a bill was passed in 2010 allowing a Medically Supervised Injection Site (MSIC) to function as any other health care service without being required to seek out Parliamentary approval every four years. The basis for passing the bill was that the precarious position of having to obtain government approval lead to “ongoing and unnecessary politicization of the services and uncertainty around the center’s future and uncertainty for the local community and for the people who use the service:” “Background and Evaluation” online: Sydney Medically Supervised Injecting Centre <http://www.sydneymsic.com/background-and-evaluation>.

of injection drug users (IDUs) in particular neighbourhoods:[121] the downtown core (especially the Market and lower town and Sandy Hill). The highest concentration of IDUs remains in the East Ottawa area (Vanier and Overbrook).[122]

Location is a critical component of creating a SCF that is a meaningful part of holistic care models. A SCF must be in an area familiar, visible and accessible to the IDU community.[123] TOSCA has found that people who consume drugs and other stakeholders prefer variegated, smaller supervised consumption facilities over a centralized facility.[124] Similarly, in Montreal, drug addiction maintenance activists and their allies have proposed to open several smaller SCF across the city.[125] According to TOSCA, a fixed or concentrated "mega" facility offering a gamut of services would likely be less expensive in the short term and more easily integrated into an existing organization.[126] There are, however, other incentives which favour a more diffuse model of SCFs. Drug users, according to the TOSCA study, felt that a mega clinic could be the focus of vociferous opposition; similarly, neighbourhood associations and local businesses – even when in favour of harm-reduction strategies – feared that a centralized site would have adverse impacts on their neighbourhoods. Given that SCFs generally offer primary health care services, information and education (regarding the use and disposal of equipment), social services (counseling and peer mentoring), and "life skills" infrastructure (laundry facilities and toiletries), and referrals for drug substitution therapy,[127] a number of smaller locations may be more easily adapted to Ottawa's already

[121] TOSCA, *supra* note 2 at 208.

[122] Approximately 30% of Ottawa's low-income community live in the Vanier region. See*:* Dave Rogers, "City must invest in Rideau-Vanier to reduce poverty, all-candidates meeting told," (October 6, 2010) *The Ottawa Citizen* online: <www.ottawacitizen.com> See also: David Gordon, "From Noblesse Oblige to Nationalism: Elite Involvement in Planning Canada's Capital" (2008) 28 Journal of Urban History 3-34.

[123] TOSCA, *supra* note 2 at 184 and 186.

[124] *Ibid.* at 207.

[125] "Quebec Primed for Safe Injection Sites" CBC News (October 11 2011) online: CBC <www.cbc.ca>.

[126] TOSCA*, supra* note 2 at 208.

[127] *Ibid.* at 8.

dispersed harm reduction programs, such as its Safer Inhalation Program[128] and opioid substitution program.[129]

While in 2005, the city set out a number of priority issues for its Drug and Addiction Strategy, today, some of these concerns are now refutable. For instance, despite fears that drug use and supply crimes are on the rise,[130] evidence has consistently shown that crime rates across the country are decreasing.[131] Other issues remain, however: the continued lack of user-specific spaces (for women, elderly people, and people of Aboriginal descent); access to secure and affordable social housing; the paucity of detox services; the need for information-sharing among health care providers regarding the safe disposal of drug paraphernalia; and more integrated service-provision for people dealing with addiction as well as supports for their families. These can be addressed through a holistic addiction maintenance model and are part of the spectrum of services that include safer consumption facilities.

iii) Community Support

An integral aspect to Insite's success was broad-based and multi-level support from community residence, local politicians, the Vancouver Police Department, the British Columbia Health Care Authority and the federal government at the time.[132]

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[128] See generally, Somerset West Community Health Centre, online: <http://www.swchc.on.ca/ourprograms?field_program_categories_tid=All&field_program_day_value=All&populate=inhalation>.

[129] However, under the new *Narcotics Safety and Awareness Act* (2011) people who request methadone treatment must now present patient identification on each prescription; this reduces the likelihood of the most vulnerable groups – street-involved drug users without identification for instance – from accessing this necessary service.

[130] http://www.ottawa.ca/public_consult/drug_addict/issues_en.shtml.

[131] http://www.statcan.gc.ca/pub/85-002-x/2011001/article/11523-eng.htm.

[132]See: "Support grows for Vancouver's safe-injection site" CTV News (July 18, 2006) Canadian Press http://www.ctv.ca. Additionally, the *Final Report of the Expert Advisory Committee* found that (n=852) 63% of the residents are in favor of extending Insite's exemption. See also: Mike Mickleburgh, "Vancouver ex-mayors speak up for injection site" *The Globe and Mail* (August 22, 2006). Jamie Graham, the former Chief Constable of the Vancouver Police, has publically stated that his goal is to continue working with VCHA "in the spirit of cooperation to create a more safe and healthy community": letter from Jamie H. Graham to Ms. Beth Pieterson Director General of Drug Strategy & Controlled Substances Program (April 21, 2006) available on the Insite for Community Safety website: <http://www.communityInSite.ca/pdf/jgraham-letter.pdf>.

Internationally, the effectiveness of the "war on drugs" approach to halting the illegal drug trade is increasingly under scrutiny and governments across the globe are seeking innovative and meaningful strategies as alternatives to fruitless "tough on crime" tactics.[133] Yet in Canada, we face a regressive federal climate: an Omnibus crime bill that targets poor, racialized, and street-involved people throughout the country in an ethos that favours mandatory minimums,[134] "broken windows" approaches to community, and enforcement measures over holistic, humane models of care.

Since 2007, the federal Conservative government has been explicit in its opposition to harm reduction programs[135] and continues to spend billions on enforcing largely drug laws, which have raised incarceration rates but have done little to address drug trafficking and violence associated with the organized drug trade.[136] The Conservative government has ignored research and pilot projects that demonstrate how prohibitionist measures stigmatize and criminalize addiction

[133] http://www.theglobeandmail.com/news/national/time-to-lead/canadas-youth-crime-plans-bewilder-international-observers/article592992. See generally: Amnesty International, "The Global Movement Against the Death Penalty": http://asiapacific.amnesty.org/apro/aproweb.nsf/pages/dp_taiwanoped. For years, proponents of participatory and distributive justice have been presenting similar arguments.

[134] "Mandatory sentences staying in crime bill, Nicholson says" CBC (February 22, 2012) online: CBC <http://www.cbc.ca>: US group warns against costs associated with keeping individuals in federal prisons and burden on the judicial system; Evan Wood et al, "Improving community health and safety in Canada through evidence-based policies on illegal drugs" (2012) 6 Open Med 35-40; http://www.cpa.ca/docs/file/Government%20Relations/SenateCommitteeSubmission_January302012.pdf; Clayton J Mosher, "Convergence or Divergence? Recent Developments in Drug Policies in Canada and the United States" (2011) 41 American Review of Canadian Studies.

[135] With the National Anti-Drug Strategy, the federal government eliminated funding for harm-reduction and increased resources for enforcement, prevention and treatment: See: Government of Canada, National Anti-Drug Strategy: http://www.nationalantidrugstrategy.gc.ca/index.html. See also: "Harper said harm reduction is not a "distinct pillar" of the Conservative strategy": PM wants mandatory sentences for 'serious' drug crimes" (October 4 2007) online: CBC <http://www.cbc.ca/news/canada/story/2007/10/04/drug-strategy.html>.

[136] Canada spends an estimated $2.3 billion a year on enforcement of drug laws alone: J. Rehm, D. Baliunas, S. Brochu, B. Fischer, W. Gnam, J. Patra, et al. The Costs of Substance Abuse in Canada 2002. Canadian Center of Substance Abuse. 2006. See also: Bill C-10, Controlled Drugs and Substances Act 1st Sess 41st Park, 2011 (assented to 13 March 2012). According to Louise Arbour, our drug policy is a "public health disaster:" Kathleen Harris, "War on drugs 'unsustainable,' ex-justice Louise Arbour says" (June 26, 2012) online: CBC news <http://www.cbc.ca/news/world/story/2012/06/26/drug-war-hiv-aids-policy.html

management strategies.[137] Its discourse of prevention and treatment[138] further ignores the social, cultural and economic determinants of addiction: poverty, systemic racism, colonialism, gender, the breakdown of relationships, trauma, exclusion and marginalization, mental health issues, incarceration, etc., in addition to the overwhelming evidence that harm-reduction strategies aim to address these social determinants directly and indirectly.[139]

At the provincial level, the Ontario Liberal government may have indicated some ambivalence regarding the Insite decision;[140] however, it has supported other harm reduction strategies in the past: it saved a controversial crack-pipe exchange program based on evidence that it reduced the sharing of used pipes and the spread of blood-borne diseases;[141] and needle exchange programs have been entrenched as mandatory where injection drug use is an established public health

[137] Thomas Kerr et al, "The Public Health and Social Impacts of Drug Market Enforcement: A review of the evidence" (2005) 16 Int J Drug Policy 210-220.

[138] According to Minister Aglukkaq, the government believes "that the system should be focused on preventing people from becoming drug addicts:" *Wherry, Aaron, "The Insite Ruling." Beyond the Commons* (September 30, 2011) *Maclean's* <www2.macleans.ca>.

[139] See: Sandro Galea & David Vlahov, "Social determinants and the health of drug users: socioeconomic status, homelessness, and incarceration." (2002) 117 Public Health Rep 135-145; Alex Wodak, "Harm Reduction is now the Mainstream Global Drug Policy" (2009) Addiction 343-345; Eugene J McCann, "Expertise, Truth, and Urban Policy Mobilities: global circuits of knowledge in the development of Vancouver, Canada's 'four pillar' drug strategy" (2008) 40 Environment and Planning 885-904; John Strang, "Drug Policy and the Public Good: Evidence for Effective Interventions" (2012) 379 The Lancet 71-83.

[140] Premier Dalton McGuinty has stated he will examine the Insite decision but that it is not the province's intention to support safer injection sites: Don Peat, "Injection sites not in province's plans" *The Toronto Sun* (September 30, 2011) online: The Toronto Sun <www.torontosun.com>. The provincial Minister of Health states that: "experts continue to be divided on the value of the sites. We have no plans to pursue supervised sites at this time:" Anna Mehler Paperny, "Ottawa, Toronto Resist Call for Supervised Injection Sites" *The Globe and Mail* (April 12 2012) online: <www.theglobeandmail.com>.

[141] Lynn Leonard et al, "I inject less as I have easier access to pipes: Injecting, and Sharing of Crack-Smoking Materials, Decline as Safer Crack-Smoking Resources are Distributed" (2008) 19 Int J Drug Policy 255-264; "Ontario saves Ottawa's crack pipe program" (December 21 2007) online: CBC <www.cbc.ca> See generally: L. Leonard, E. DeRubeis & N. Birkett, (2006). *City of Ottawa Public Health. Safer crack use initiative. Evaluation report* (retrieved August 26, 2007 from http://www.ohrdp.ca/Final%20Crack%20Report%20ES%20f.pdf .

concern.[142] Moreover, research indicates that Ontario is considered to be a leader in the area of harm reduction and drug policies.[143]

At the municipal level, the City of Ottawa has explicitly included harm-reduction as a part of a continuum of health services[144] of its drug and addiction strategy.[145] However, Mayor Jim Watson has publically stated that he prefers to invest "scarce public health dollars for these drug treatment centers" (geared toward youth)[146] rather than on harm-reduction holistic models of care. He reiterated this view within hours of the publication of TOSCA's report: treatment centres are a "better use of tax dollars" than "safe injection sites."[147]

Interestingly, the city zone with the highest concentration of relevant social services for street-involved people [148] is also the city's most important tourist area (the "Market").[149] This reality has resulted in the harassment of panhandlers requesting spare change – whether or not it is to purchase drugs. [150] Despite the Mayor's ideological stance, and despite Ottawa's urban aesthetics having been associated

[142] Ontario Ministry of Health and Long Term Care: http://www.search.gov.on.ca/FSS/ProcessSearch.do? (1997).

[143] Maija Tiesmaki, "Harm Reduction in Atlantic Canada: A Scan of Provincial Policies" (2011) online: Harm Reduction Atlantic <www.harmreductionatlantic.ca>.

[144] "The Ottawa Integrated Drugs and Addictions Strategy Initiative" online: City of Ottawa <http://ottawa.ca/public_consult/drug_addict/index_en.html >.

[145] In 2005, the Integrated Drugs and Addictions Strategy was launched in Ottawa; its mandate centred around four areas which include harm reduction (as well as prevention, treatment, and enforcement): *Ottawa Drug Strategy*, *supra* note 104.

[146] Butler, *supra* note 4.

[147] *Ibid.*

[148] TOSCA, *supra* note 2 at xii.

[149] *Ibid.* at 187.

[150] Ottawa's Ticket Defence Program (TDP) - an affiliation of community members, students, and street-involved activists – has been documenting harassment and social profiling of panhandlers and has provided necessary information and supports for defending tickets issued under Ontario's *Safe Streets Act* (1999) S.O. 1999 c. 8 and municipal regulations related to camping and the use of public spaces. It merits mention that the Law Society of Upper Canada (which has the authority to regulate paralegals) has recently determined that TDP must obtain paralegal licensing in order to continue its service. Given TDP's mandate and structure, the decision has effectively forced the affiliation to stop providing a vital service to street-involved people in Ottawa. The group has challenged the Law Society of Upper Canada's decision: Ticket Defence Program, "The LSUC Denies Access to Justice for Ottawa's Homeless", online: (2008) <http://www.flora.org/legal/tickets/TDP_Press_Release_2008-11-17.pdf>.

with those of the "revanchist" variety,[151] the Nation's capital has nonetheless held itself up as a "role model in breaking down the myths about poverty and taking action to reduce it."[152]

Moreover, for those who advocate for smaller more dispersed SCFs across Ottawa, the city has already acknowledged its willingness to find "constructive solutions" to "ensure that drug-related issues are dealt with across the city."[153] Ottawa is well-positioned to follow Vancouver and Montreal [154] to generate conditions for a legal SCF, which could amount to an indictment of the federal government's retrograde policies toward the urban poor, and toward street-level drug users especially [155] and become a national model for non-judgmental, pragmatic, tolerant, empowering and caring models of addressing the harms associated with addiction. [156]

In terms of less officially political actors, there are two opposing trends, one vertical (the police's deliberate and formal response to SCFs) and the other horizontal (civil society's heterogeneous and complex negotiations around SCFs).[157] On the one

[151] Neil Smith has coined the term "revanchist city" in *The New Urban Frontier: Gentrification and the Revanchist City* (London: Routledge, 1996). He uses the term to refer to the shifts in political, economic and social practices in the United States from redistribution policies (from the wealthy to the less affluent) to revanchist policies against minority groups including the poor, the working poor, immigrants, feminists, environmentalists, anti-war activists and racialized groups on behalf of the elite. See for instance: Kevin Walby & Randy Lippert, "Spatial Regulation, Dispersal, and the Aesthetics of the City: Conservation Officer Policing of Homeless People in Ottawa, Canada" (2011) Antipode: A Radical Journal of Geography.

[152] "Ottawa's Poverty Reduction Strategy" online: City of Ottawa <http://ottawa.ca/doc_repository/reports/prs_en.pdf>.

[153] *Ibid*.

[154] Ken MacQueen & Martin Patriquin "Are we ready to subsidize heroin?" (October 7, 2011) online: Macleans <www2.macleans.ca>.

[155] "Ottawa's drug policy under fire from health providers" CTV News (March 28, 2012) online: CTV <www.ctv.ca>: Prominent public health figures have been speaking out against the government's drug policy and calling on the government to shift the focus of its drug strategy from law enforcement to health and harm reduction.

[156]The downtown core of Ottawa is of mixed demographics, and despite generally leftist and centralist political leanings. One interpretation or gauge of the political climate in the city of Ottawa is to examine the electoral map to examine the political leanings of the citizens of Ottawa. See: http://www.cbc.ca/news/politics/canadavotes2011/map/fullscreen.html#/169.

[157] On the difference between changing law's rules (formal) and changing culture (informal), see generally: Thomas Stoddard, "Bleeding Heart: Reflections on Using the Law to Make Social Change" (1997) 72 NYU L Rev 967.

hand, law enforcement agents are empowered to address a situation in which possession or trafficking is suspected, and while some officers use that discretion in a way that respects drug users' dignity, others deploy policing strategies, which may "interrupt health service use by injection drug users."[158] Over the years, the Vancouver police and Insite have developed a "cooperative"[159] relationship that has promoted public safety and public order initiatives.[160] Contrary to this approach, Ottawa's former police chief has preferred to fear-monger and promote NYMBY-type warnings: "such a facility would have an extreme negative impact on nearby residents, including heightened risk to public safety."[161] He also said "I certainly didn't feel as safe in that area of Vancouver as I did in other areas of

[158] DeBeck et al. "Police and Public Health Partnerships: Evidence from the evaluation of Vancouver's supervised injection facility." (2008) 3 Substance Abuse Treatment, Prevention and Policy 1-5; Will Small et al, "Impacts of intensified police activity on injection drug users: Evidence from an ethnographic investigation" (2006) 17 Int J Drug Policy 85-95; Hannah Cooper et al, "The Impact of a Police Drug Crackdown on Drug Injectors' Ability to Practice Harm Reduction: A Qualitative Study" (2005) 61 Social Science & Medicine 673-684.

[159] *Ibid*. In 2008, Inspector Scott Thompson on behalf of the chief constable and Vancouver Police Department (VPD) addressed in front of parliament the VPD's view on the site and commented that "When the supervised injection site opened, the VPD position was that we were in favour of any legal measure that might have a chance of reducing the drug problem in Vancouver's downtown eastside. We're on record as supporting the SIS as a research project." (Standing Committee on Health, House of Commons 39th Parl 2nd Sess Thursday May 29, 2008). Currently the VPD is in partnership with Insite and there is a working cooperative relationship. Despite public endorsement and continued support of Insite from the Vancouver Police Department there is a lack of public support from the RCMP (John Geddes, "RCMP and the truth about safe injection sites" (August 20, 2010) online: Macleans http://www2.macleans.ca/2010/08/20/injecting-truth/) and the Canadian Police Association (CPA) have both made statements against keeping Insite open. (Canadian Police Association: 2007 CPA Political Agenda. In Express Issue 69 Spring; 2007). CPA's media release alluded to Insite's ineffectiveness whereas studies have shown the contrary. The Expert Advisory Committee's report to the federal Minister of Health with respect to Insite reported a "reduction in the number of people injecting in public; no evidence of increases in drug-related loitering, drug dealing or petty crime in the area around Insite; reduction in crime in the Chinese business district outside the DTES; no changes in rates of crime in the DTES.": *Insite SCC, supra* note 1 at para. 28.

[160] *Insite SCC, ibid.* at para. 185. Policing on the street level have been found to complicate harm reduction initiatives, however, the Vancouver Police Department supported the opening of Insite and "subsequently adopted the strategy of actively encouraging individuals found injecting in public to attend the local SIF."

[161] *Ibid.* at para 178.

Vancouver."[162] Nevertheless, at least one former upper level Ottawa police officer has outwardly supported harm reduction strategies in Ottawa. [163]

Anecdotal information and informal conversations with street-level "beat" police officers, however, indicate that police officers' are not monolithic, that there can be dissent within the ranks and that not everyone in the force shared the Mayor's opinion.[164] Nevertheless, TOSCA's report has not changed Ottawa police's official position: "as long as the criminal element [exists]" the police chief recently stated, "we will have issues around the current form of safe injection sites." [165] His comments, of course, beg the question of whether drug use should be treated as a public health question rather than a moral one which engages the criminal law.

On the other hand, as with Insite, there is strong support for a SCF in the Ottawa community. The Campaign for Safer Consumption sites (CSCS) is an unfunded, non-partisan collation of health professionals, drug users, activists, members of the Canadian Students for Sensible Drug Policy and broader community allies that advocate for the development of a SCF in Ottawa. [166] While CSCS accepts complexity and contradiction in their members' understandings of drug use, there are a number of shared immediate goals: advocate for a SCF in Ottawa and raise awareness about the on-going marginalization of people who use drugs – which is intricately linked to serious health issues and chronic street-involvement.[167] More aspirational aims are to promote the dignity and worth of anyone who uses drugs,

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[162] *Ibid.*

[163] On police ambivalence regarding charging people with syringes, see: Tim Rhodes et al, "Street Policing, Injecting Drug Use and Harm Reduction in a Russian City: A Qualitative Study of Police Perspective" (2006) 83 Journal of Urban Health. Conformity, however, still pervades police culture: Eugene A Paoline III, "Shedding Light on Police Culture: An Examination of Officer's Occupational Attitudes." (2004) 7 Police Quarterly 205-236.

[164] <http://blogs.ottawacitizen.com/2011/10/03/dark-ages-thinking-on-harm-reduction/>.

[165] Ottawa police officials have recently expressed "firm, clear and unanimous" opposition to such sites: Douglas Quan, "Police clearly sceptical of safe injection sites, study finds' *The Montreal Gazette* (January 12, 2012) online: The Montreal Gazette <www.montrealgazette.com>.

[166] Online: Campaign for Safer Consumption Sites in Ottawa <http://cscsottawa.ca>. The CSCS has the support of other local organizations such as the Canadian AIDS Society, Power Ottawa and the Drug Users Advocacy League (DUAL) and University professors in medicine, health sciences, and law. Their inaugural panel discussion in November 2011 after the release of the Supreme Court decision was a packed event and a recent screening of *Bevel Up* attracted similar numbers.

[167] "About CSCS" (2012) online: Campaign for Safer Consumption Sites Ottawa <http://cscsottawa.ca/about>.

and to promote holistic services and care facilities for those who require such supports.

True, there has, in the past, been NIMBY-type opposition to a SCF in Ottawa. [168] Since 2003, however, public support for SCFs across Ontario has steadily increased.[169] The TOSCA research indicates that two out of five Ontario residents "strongly support" SCFs as part of public health initiatives. [170] In the public imagination, it is increasingly accepted that SCFs can, and ought to be, part of solid health initiatives (because they help decrease the harms associated with using drugs outdoors) and public safety policies (because they reduce harm related to unsafe disposal of paraphernalia).

CONCLUSIONS

We acknowledge the specificities and heterogeneity of urban spaces, yet argue that Ottawa can learn from movements in Montreal[171] and Victoria[172] who will likely attempt to implement legal SCFs. Montreal, whose drug user population is also diffuse, has eight needle exchange programs in which may be converted into small SCFs.[173] In British Columbia, health authorities have attempted to normalize harm reduction strategies and services broadly.[174] In the interim, Ottawa SCF advocates continue to raise awareness about the benefits of holistic models, conduct empirical studies to substantiate such claims, solidify existing support from the

[168] TOSCA*, supra* note 2 at 185 and 208.

[169] TOSCA*, supra* note 2 at 68.

[170] A minority of residents interviewed (3 out of 10) were concerned that the existence SCF might encourage drug use and make it more visible: TOSCA*, supra* note 2 at 77 and 80. However, in response to fears that Insite would generate "new" drug users in Vancouver, researchers found that its pragmatic and humanistic model did not promote or increase illicit drug injection in the neighbourhood: Kerr et al, "Circumstances of First Injection Among Illicit Drug Users Accessing a Medically Supervised Safer Injecting Facility" American Journal of Public Health (2007) 97 1228-20.

[171]Since the Insite decision, at least one other organization – CACTUS in Montreal, which already implements peer-based harm-reduction strategies, has announced its intention to apply for a ministerial exemption under the *CDSA*: "Quebec to open supervised-injection clinics" (Oct 12 2011) online: *The Globe and Mail* <www.theglobeandmail.com>.

[172] MacQueen*, supra* note 154.

[173] "Quebec to open supervised-injection clinics" (Oct 12 2011) online: *The Globe and Mail* <www.theglobeandmail.com>.

[174] Robert Matas, "Health authority weights adding more supervised injection site."(January 9, 2012) online: The Globe and Mail <www.theglobeandmail.com>.

health-care practitioners, and develop a strategic implementation plan and secure funding for a safer injection facility.

The development of SFC and broader harm reduction strategies intersect larger questions that concern poverty law practitioners and other anti-poverty activists. Critical lawyering can play a crucial role in addressing the social determinants of drug addiction such as the criminalization [175] or judicialization [176] of prohibited income-generation and survival tactics on and through the "street." These tactics span a broad range including entertaining and busking, asking for change, transactioning around the sale of sex, squeegeeing car windows, collecting empty cans and bottles, creating pavement art, engaging in unlicensed street trading and vending, and selling prescription and illegal drugs. Such work may be their only source of income but more often than not, it is an additional source of income (as paid employment or receipt of some form of social assistance is generally insufficient to cover their basic needs). Others – usually people most in need of explicit and formal interventions by care workers because of addiction or other health concerns – engage in petty theft.

There remains work to be done in advocating for more meaningful access to social housing, the precariousness of which remains one of the most direct lines to drug addiction.[177] We require conditions of greater legal empowerment of the poor and

[175]While the federal provisions regulating vagrancy were struck down in 1972, loitering remains an offence under the *Criminal Code*. Several jurisdictions (Calgary, Edmonton, Halifax, Hamilton, Kingston, Oshawa, Ottawa, Saskatoon, Sudbury, Quebec City, Winnipeg, Vancouver and Victoria, for instance) have implemented by-laws against panhandling on or near city streets and especially "obstructive" solicitation. Ontario (*Safe Streets Act*, (1999) S.O. 1999 c. 8*)* and British Columbia (*Safe Streets Act,* (2004) S.B.C 2004 c. 75) have also enacted similar provincial legislation, both have been challenged as *ultra vires*; both have been upheld as constitutional: *R.* v. *Banks* (2005), 248 DLR 4th (OCA) (panhandling was considered valid "expression" under section 2 of the *Charter* but the infringement of that freedom justified under section 1); and *Federated Anti-Poverty Groups of BC* v. *Vancouver (City)*, 2002 BCSC 105 (non-obstructive panhandling is a means of providing basic sustenance and falls under the ambit of section 7 of the *Charter*, however, the by-law targeted the consequences of panhandling rather than the conduct under its valid jurisdiction over the regulation of movement and traffic on the streets).

[176] The term refers to the processes through which they are brought into the penal system but not necessarily by way of criminal regulation, but through provincial legislation regulating "safe streets" and by-laws regulating the solicitation of alms. See for instance: Nick Blomley, "How to Turn a Beggar into a Bus Stop: Law, Traffic and the 'Function of Place'" (2007)44 Urban Studies 1697 (for a rights-based critique of what he calls the "traffic code" approach to regulating the solicitation of spare change).

[177] Libby Davis' Private Members' Bill, C-304 [(2nd Session, 40th Parliament) 57-58 Elizabeth II, 2009] was defeated on a Motion of Non-Confidence on March 25, 2011:

otherwise marginalized who face significant barriers in access to justice and have disproportionately high levels of unresolved legal concerns spanning various areas of law.[178] We must challenge federal fiscal and policy decisions related to health impact income distribution[179] and, of course, continue to fight to have the social condition of poverty recognized as an analogous ground of discrimination.[180]

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http://www.parl.gc.ca/HousePublications/Publication.aspx?DocId=3660878&File=33&Language=e&Mode=1. It was reintroduced in February 2012 as Bill C-400, *An Act to Ensure Secure, Adequate, Accessible and Affordable* by the New Democratic Party's Housing Critic, Marie-Claude Morin. The Bill includes timelines for the elimination of homelessness, a complaints process for addressing violations of housing rights, and financial assistance for people who cannot otherwise afford adequate housing: <http://www.parl.gc.ca/HousePublications/Publication.aspx?Docid=5391884&file=4>.

[178] On the relationship among formal legal change, civil society and the ways in which non-profit organizations "fill the void" in the legal realm generally to facilitate marginalized populations' legal empowerment to increase critical awareness about rights and the capacity to mobilize for formal legal changes, see: Mary McClymont & Stephen Golub, Many Roads to Justice: The Law Work of Ford Foundation Grantees Around the World (New York: Ford Foundation, 2000).

[179] For a feminist reading of the ways in which technical discourse and cost-benefit analyses can occlude the "normative content" of fiscal law and policy decisions, see: Lisa Philipps, "Discursive Deficits: A Feminist Perspective on the Power of Technical Knowledge in Fiscal Law and Policy" (1996) Can J L & Soc 141-176

[180] See generally: Martha Jackman <http://www.escr-net.org/usr_doc/Martha_Jackman_-_Constitutional_Contact.pdf>.