

# Legislating for Health and Human Rights: Model Law on Drug Use and HIV/AIDS

Supervised drug consumption facilities



# 4

This model law resource consists of eight modules, addressing the following issues:

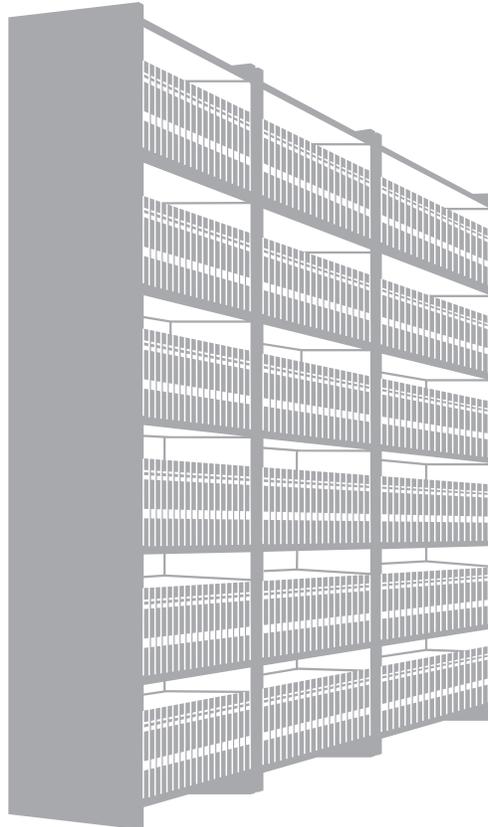
1. Criminal law issues
2. Treatment for drug dependence
3. Sterile syringe programs
4. Supervised drug consumption facilities
5. Prisons
6. Outreach and information
7. Stigma and discrimination
8. Heroin prescription programs

This module, and the other modules, are available in multiple languages on the website of the Canadian HIV/AIDS Legal Network at [www.aidslaw.ca/drugpolicy](http://www.aidslaw.ca/drugpolicy).



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# Legislating for Health and Human Rights: Model Law on Drug Use and HIV/AIDS

Supervised drug consumption facilities



# **Legislating on Health and Human Rights: Model Law on Drug Use and HIV/AIDS Module 4: Supervised drug consumption facilities**

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## **About the Canadian HIV/AIDS Legal Network**

The Canadian HIV/AIDS Legal Network ([www.aidslaw.ca](http://www.aidslaw.ca)) 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 Canada's leading advocacy organization working on the legal and human rights issues raised by HIV/AIDS.

## Introduction

UNAIDS (the Joint United Nations Programme on HIV/AIDS) suggests that approximately 30 percent of new HIV infections outside sub-Saharan Africa are due to contaminated injection equipment.<sup>1</sup> In eastern Europe and Central Asia, the use of contaminated injection equipment accounts for more than 80 percent of all HIV cases.<sup>2</sup> Yet, globally, less than five percent of people who inject drugs are estimated to have access to HIV prevention services,<sup>3</sup> and even in regions where they account for the majority of HIV infections, people who use drugs are routinely excluded from HIV/AIDS care and treatment.

Many countries with injection-driven HIV/AIDS epidemics continue to emphasize criminal enforcement of drug laws over public health approaches, thereby missing or even hindering effective responses to HIV/AIDS. There is considerable evidence that numerous interventions to prevent HIV transmission and reduce other harms associated with injection drug use are feasible, effective as public health measures and cost-effective.<sup>4</sup> Despite such evidence, millions of people around the world who use drugs do not have access to such services because of legal and social barriers.

International human rights law establishes an obligation on states to respect, protect and fulfill the right to the highest attainable standard of health of all persons, including those who use drugs. Other human rights are equally relevant in the context of the HIV/AIDS epidemic. When human rights are not promoted and protected, it is harder to prevent HIV transmission, and the impact of the epidemic on individuals and communities is worse. Consequently, UN member states have committed to

enact, strengthen or enforce, as appropriate, legislation, regulations and other measures to eliminate all forms of discrimination against and to ensure the full enjoyment of all human rights and fundamental freedoms by people living with HIV/AIDS and members of vulnerable groups ....<sup>5</sup>

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<sup>1</sup> UNAIDS, *2006 Report on the Global AIDS Epidemic*, May 2006, p. 114. At [www.unaids.org/en/HIV\\_data/2006GlobalReport/default.asp](http://www.unaids.org/en/HIV_data/2006GlobalReport/default.asp).

<sup>2</sup> UNAIDS, *2006 Report on the Global AIDS Epidemic*, p. 114.

<sup>3</sup> United States Agency for International Development et al, *Coverage of selected services for HIV/AIDS prevention, care and support in low and middle income countries in 2003*, June 2004. At [www.futuresgroup.com/Documents/CoverageSurveyReport.pdf](http://www.futuresgroup.com/Documents/CoverageSurveyReport.pdf).

<sup>4</sup> See, for example, N. Hunt, *A review of the evidence-base for harm reduction approaches to drug use*, Forward Thinking on Drugs, 2003. At [www.forward-thinking-on-drugs.org/review2-print.html](http://www.forward-thinking-on-drugs.org/review2-print.html).

<sup>5</sup> *Declaration of Commitment on HIV/AIDS*, UN General Assembly, Res/S-26/2, 27 June 2001, para. 58. At [www.un.org/ga/aids/docs/aress262.pdf](http://www.un.org/ga/aids/docs/aress262.pdf).

UN member states have also committed to ensuring that a wide range of HIV prevention programs is available, including the provision of sterile injecting equipment and harm reduction efforts related to drug use.<sup>6</sup>

The widespread legal, social and political ramifications of the HIV/AIDS epidemic make it necessary to review and reform a broad range of laws. Some countries have adopted national HIV/AIDS laws, but these laws often ignore crucial policy issues, as well as human rights abuses that perpetuate the HIV epidemic. This is particularly true with respect to illegal drug use. HIV prevention, care and treatment services operate best within a clear legal framework that specifically protects the human rights of people who use drugs and enables harm reduction measures to mitigate the impact of HIV. A legislative framework can provide clarity and sustainability for such services. This is particularly important, given the often dominant approach of criminalizing illegal drug use and people who use drugs, which creates additional barriers to delivering health services. Law reform is not a complete solution to effectively addressing the HIV epidemic among people who use illegal drugs, but it is a necessary and often neglected step.

## **The model law project**

In early 2005, the Legal Network established a project advisory committee and, in consultation with the committee, developed a plan to produce model law that would assist states in more effectively addressing the HIV epidemic (and other harms) among people who use drugs, based on evidence of proven health protection and promotion measures, and in accordance with states' human rights obligations.

Comprehensive consultations were conducted during the drafting of the model law. A draft version of the model law was reviewed by a group of legal experts, harm reduction advocates and government representatives from central and eastern Europe, and countries of the former Soviet Union, during a meeting in Vilnius, Lithuania (7–8 November 2005). The document was modified in line with this feedback and recommendations. In early 2006, the model law was circulated in electronic form to a large number of people and organizations, providing a further opportunity to modify and strengthen the resource. This final document has, therefore, benefited from the thinking of a wide range of experts in the fields of HIV/AIDS, human rights and drug policy.

## **About this resource**

This model law resource is a detailed framework of legal provisions and accompanying commentary. It makes reference to examples of law from those jurisdictions that have attempted to establish a clear legal framework for addressing HIV/AIDS issues among people who use drugs.<sup>7</sup> This resource also incorporates human rights principles and

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<sup>6</sup> *Declaration of Commitment on HIV/AIDS*, para. 52.

<sup>7</sup> References to national legal instruments are included in order to demonstrate the feasibility of establishing progressive legal frameworks so that law reform in other jurisdictions can be informed by such examples.

obligations of states throughout the document. It is annotated in order to highlight critical issues and evidence that supports the measures proposed.

This model law resource is designed to inform and assist policy-makers and advocates as they approach the task of reforming or making laws to meet the legal challenges posed by the HIV epidemic among people who use drugs. The model law resource is not intended for any one country or set of countries. Rather, it is designed to be adaptable to the needs of any of a wide number of jurisdictions. In some instances, the model law presents different legislative options for implementing states' human rights obligations. It is hoped that this resource can be most useful for those countries where injection drug use is a significant factor driving the HIV epidemic, and particularly for developing countries and countries in transition where legislative drafting resources may be scarce.

The model law resource consists of eight modules, addressing the following issues:

- (1) Criminal law issues
- (2) Treatment for drug dependence
- (3) Sterile syringe programs
- (4) Supervised drug consumption facilities
- (5) Prisons
- (6) Outreach and information
- (7) Stigma and discrimination
- (8) Heroin prescription programs

Each of the eight modules in this series is a stand-alone document. Each module begins with the introduction that you are reading now; the text of the introduction is identical in all of the modules.

Following the introduction, each model provides a prefatory note, model statutory provisions and a list of selected resources. (Taken together, the model statutory provisions in all eight modules would form a model law addressing HIV/AIDS and drug use.)

The prefatory note presents a rationale for reforming laws and policies in the area covered by the module. This is followed by a discussion of the relevant UN conventions on drug control, and of states' human rights obligations in this area.

The section on model statutory provisions contains provisions that could be included in a model law on HIV/AIDS and drug use. The provisions are divided into chapters, articles, sections and subsections. The first chapter ("General Provisions") describes the purpose of that Part of the model law, and provides definitions for many of the terms included in the provisions.

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These references do not imply that the actual practice in the jurisdictions cited represents "best practice." There is often a long way to go in ensuring that actual practice conforms to these legal undertakings.

Some of the provisions are accompanied by a commentary. The commentary provides additional information on, or rationale for, the provision in question. For some model statutory provisions, two options are presented; a note inserted into the text indicates either (a) that one or the other option should be selected, but not both; or (b) that one or the other option, or both options, can be selected. As well, some of the provisions have been labelled as “optional.” This means that these provisions may or may not be applicable, depending on the situation in the country.

The section on selected resources contains a short list of resources which the Legal Network considers to be particularly useful. There are two subsections: one on articles, reports and policy documents, and one on legal documents.

The model law resource is heavily footnoted. The notes provide additional information on the issues being addressed, as well as full references. If the same source is cited more than once in a module, the second and subsequent references to that source are somewhat abbreviated (usually just the name of the author, or organization, and the title of the article or report).

# Module 4:

## Supervised Drug Consumption Facilities

*Module 4 contains a prefatory note which outlines the rationale for and benefits of supervised drug consumption facilities and which describes relevant international laws and policies, including human rights obligations. Module 4 provides model law that can be put in place to make such facilities effective interventions in protecting the health and well-being of individuals who use drugs, advancing public health more generally, and benefiting communities affected by public drug use. Module 4 concludes with a list of recommended resources.*

### Prefatory Note

#### Rationale for reform

Supervised drug consumption facilities (SDCFs) have been established in a growing number of countries, in response to the escalating epidemics of HIV and hepatitis C among people who use drugs, the fact that large numbers of people who use drugs were not being reached by existing services, and the health and public order challenges associated with the use of illegal drugs, especially in public places.

SDCFs — also called “safe injection sites,” “supervised injection centres,” “safe consumption centres,” and variants thereof — are legally sanctioned health and social welfare facilities that enable the consumption of pre-obtained drugs with sterile equipment under supervision of health professionals.<sup>8</sup> SDCFs constitute a specialized health intervention within a wider network of services for people who use drugs.

By providing a facility that other services cannot offer, SDCFs play an important role in establishing and maintaining contact with high-risk groups of people using drugs.<sup>9</sup> A particularly important group is people who inject drugs in public, who tend to be characterized by social exclusion, poor health and homelessness, and who often lack

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<sup>8</sup> K. Dolan, “Drug consumption facilities in Europe and the establishment of supervised injecting centres in Australia,” *Drug and Alcohol Review* 19 (2000): 337–346; W. Schneider, *Guidelines for the Operation and Use of Consumption Rooms* (materialien Nr.4), Akzept e. V and C von Ossietzky Universitat Oldenburg, 2000.

<sup>9</sup> European Monitoring Centre for Drugs and Drug Addiction (EMCDDA), *European report on drug consumption rooms — executive summary*, Office for Official Publications of the European Communities, 2004, p. 4. A review of evaluations conducted in several European countries indicated that these facilities tend to attract hard-to-reach and marginalized drug users — including those living on the street and many who have never been in treatment — who are likely to be a high-risk population for overdose.

access to health care services.<sup>10</sup> People who use drugs in public areas are also more vulnerable to public hostility and intensive law enforcement that may increase the harms related to drug use.<sup>11</sup>

SDCFs aim to reduce the risk of transmission of blood-borne infections, in particular HIV and hepatitis; to reduce the likelihood of illness and death resulting from overdose; and to help people who use drugs avoid other harms associated with drug consumption under unhygienic or unsafe conditions. At the community level, SDCFs seek to address public order and safety concerns associated with public drug use.<sup>12</sup> More specifically, SDCFs provide individuals and communities with the following short-term and long-term advantages:

Health benefits:

- SDCFs reduce risks of death and illness due to overdose.<sup>13</sup>
- SDCFs facilitate lower-risk, more hygienic consumption of drugs.<sup>14</sup>

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<sup>10</sup> H. Klee and J. Morris, “Factors that characterize street injectors,” *Addiction* 90 (1995): 837–841; D. Best et al, “Overdosing on opiates: thematic review— part 1: causes,” *Drug and Alcohol Findings* 4 (2000): 4–20.

<sup>11</sup> T. Rhodes et al, “The social structural production of HIV risk,” *Social Science and Medicine* 61 (2005):1026–1044; T. Rhodes, “The ‘risk environment’: a framework for understanding and reducing drug-related harm,” *International Journal of Drug Policy* 13 (2002): 85–94; T. Kerr et al, “The public health and social impacts of drug market enforcement: a review of the evidence,” *International Journal of Drug Policy* 16 (2005): 210–220, p. 211; L. Maher and D. Dixon, “The cost of crackdowns: policing Cabramatta’s heroin market,” *Current Issues in Criminal Justice* 13(1) (2001): 522, pp. 5–6.

<sup>12</sup> H. Renn et al, *Urban Districts and Drug Scenes: A comparative study on nuisance by ‘open’ drug scenes in major European cities*, European Commission, 1996.

<sup>13</sup> Medically Supervised Injecting Centre (MSIC) Evaluation Committee, *Final report on the evaluation of the Sydney Medically Supervised Injecting Centre*, Sydney, 2003. The final report of the evaluation of the MSIC demonstrated good management of overdoses by the centre and a reduction in risky injection as well as a very high number of referrals to treatment for addiction.

<sup>14</sup> “Staff of consumption rooms report that a majority of clients consistently adopt hygienic practices after information about basic hygiene rules had been provided repeatedly over a period of several months. In particular, tailor-made advice, based on direct observation of individual drug use behaviour and risks, helps clients to improve their injecting techniques and to reduce the direct harms of injecting”; see D. Hedrich, *European report on drug consumption rooms*, European Monitoring Centre for Drugs and Drug Addiction, February 2004, p. 50; E. Wood et al, “Safer injecting education for HIV prevention within a medically supervised safer injecting facility,” *International Journal of Drug Policy* 16(4) (2005): 281–284; T. Kerr et al, “Safer injection facility use and syringe sharing in injection drug users,” *Lancet* 366(9482) (2005): 316–318; F. Benninghoff et al, *Résultats de l’étude de la clientèle du Cactus BIEL/BIENNE 2001*, Institut universitaire de médecine sociale et préventive, 2002; F. Benninghoff et al, *Evaluation de Quai 9 ‘Espace d’accueil et d’injection’ à Genève: période 12/2001–12/2000*, Institut universitaire de médecine sociale et préventive, 2003; S. Poschadel et al, *Evaluation der Arbeit der Drogenkonsumräume in der Bundesrepublik Deutschland: Endbericht im Auftrag des Bundesministeriums für Gesundheit*, Das Bundesministerium für Gesundheit und Soziale Sicherung (Schriftenreihe Bd 149), Nomos-Verlags-Gesellschaft, 2003.

- SDCFs bring people who use drugs into contact with health care services, such as counselling, drug treatment and physical and mental health practitioners services.<sup>15</sup>
- SDCFs provide education concerning HIV/AIDS and drug dependency.
- SDCFs stabilize and promote the health of clients.

Social benefits:

- SDCFs reduce public drug use and associated disturbances.<sup>16</sup>
- SDCFs help prevent crime in the neighbourhoods around the facilities.<sup>17</sup>
- SDCFs reduce costs to the health and law enforcement systems.<sup>18</sup>
- SDCFs promote community integration and improved quality of life of people who use drugs.

The operational model of SDCFs, the services offered, and the populations they target vary according to the local needs and regulations. Depending on local conditions, SDCFs may operate out of a fixed location or they may be mobile.<sup>19</sup> SDCFs are in place in

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<sup>15</sup> Findings from the BC Centre for Excellence in HIV/AIDS indicate that Vancouver's SDCF, Insite, is leading to increased uptake into detoxification programs and addiction treatment; see E. Wood et al, "Attendance at supervised injecting facilities and use of detoxification services," *New England Journal of Medicine* 354(23) (2006): 2512–2514; BC Centre for Excellence in HIV/AIDS, *Evaluation of the Supervised Injection Site: One Year Summary*, 17 September 2004, p. 5. See, also, J. Kimber et al, "Drug consumption facilities: an update since 2000," *Drug and Alcohol Review* 22 (2003): 227–233. This evaluation found that European SDCFs have succeeded in reducing the worst consequences of overdose and reducing risky injection as well as bringing people who use drugs into contact with a wide range of health and social services, including addiction treatment. See, also, MSIC Evaluation Committee, *Final report on the evaluation of the Sydney Medically Supervised Injecting Centre*.

<sup>16</sup> E. Wood et al, "Changes in public order after the opening of a medically supervised safer injecting facility for illicit injection drug users," *Canadian Medical Association Journal* 171 (2004): 731–734. See, also, D. Hedrich, *European report on drug consumption rooms*, pp. 61–64; MSIC Evaluation Committee, *Final report on the evaluation of the Sydney Medically Supervised Injecting Centre*.

<sup>17</sup> E. Wood et al, "Impact of a medically supervised safer injecting facility on drug dealing and other drug-related crime," *Substance Abuse Treatment, Prevention, and Policy* 1 (8 May 2006): 13.

<sup>18</sup> See D. Hedrich, *European report on drug consumption rooms*, p. 48: "Trained staff respond quickly to emergencies, which can usually be managed at the service level without hospitalisation. Some evidence suggests that outcomes of emergencies occurring within consumption rooms are less severe than those taking place outside. Immediate medical emergency care reduces overdose morbidity and possibly also hospital admissions and therefore costs." See, also, D. MacPherson, *A framework for action: A four-pillar approach to drug problems in Vancouver*, City of Vancouver, April 2001, pp. 20–21. Available at [www.city.vancouver.bc.ca/fourpillars/](http://www.city.vancouver.bc.ca/fourpillars/). See, also, MSIC Evaluation Committee, *Final report on the evaluation of the Sydney Medically Supervised Injecting Centre*. This report recognizes the costs of ambulance and police callouts that are avoided as a result of the services offered by the MSIC (pp. 192–193).

<sup>19</sup> N. Hunt, *An overview of models of delivery of drug consumption room*, Independent Working Group on Drug Consumption Rooms, Joseph Rowntree Foundation, 2006.

Switzerland, the Netherlands, Germany, Spain, Norway, Canada and Australia.<sup>20</sup> The legal framework for SDCFs has been established in Portugal and Luxembourg, though the facilities are not yet operational.<sup>21</sup> Facilities are usually set up in the vicinity of other drug services and located near important illegal drug markets with concentrated open drug scenes.

An SDCF may operate as part of an integrated facility offering a range of additional treatment, health, and welfare services directly, or it may operate independently as a specialized facility that only provides consumption facilities and makes referrals to other services. Increasingly, SDCFs are providing for consumption of drugs by inhalation as well as injection, with the goal of preventing the spread of blood-borne diseases associated with the sharing of equipment for drugs that are ingested by inhalation.<sup>22</sup>

SDCFs usually have primary health care professionals, trained in emergency procedures, on site to respond to overdose and other health emergencies, as well as social workers. They also provide sterile injecting equipment and, sometimes, sterile equipment for consumption of drugs that are ingested by inhalation. Education and general health promotion services are offered to increase knowledge and awareness of risks among clients and minimize risk-taking behaviour within and outside the facility.

It is also important to note that certain populations may face unique challenges in using drug consumption rooms. For example, in many settings, women who are dependent on illegal drugs are reliant on other people to inject them. Others may have physical or mental disabilities that prevent them from consuming drugs independently. Efforts

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<sup>20</sup> As of 2004, Switzerland had 12 SDCFs in seven cities, Germany had 25 SDCFs in 14 cities, the Netherlands had 22 SDCFs across 12 cities, and Spain had three SDCFs in three cities. Canada, Norway and Australia had one SDCF. Consumption rooms vary in size, providing between four and 30 places for clients to consume. The larger rooms supervise 500–2000 consumptions per week, while smaller facilities may supervise fewer than 100 per week. See J. Kimber et al, “Drug consumption facilities: an update since 2000,” *Drug and Alcohol Review* 21, 22 (2003): 227–233; D. Hedrich, *European report on drug consumption rooms*, p. 71.

<sup>21</sup> Council of Ministers Resolution 39/2001 of 9 April 2001, para. 11.4 [Portugal]; *Loi du 27 avril 2001 modifiant la loi modifiée du 19 février 1973 concernant la vente de substances médicamenteuses et la lutte contre la toxicomanie*, art. 2 [Luxembourg].

<sup>22</sup> A facility permitting supervised inhalation would be based in the same public health rationale as that advanced for facilities limited to safe injection: reducing the spread of blood-borne viruses, increasing access for users to health care services and education, and improving public order; see K. Shannon et al, “Potential community and public health impacts of medically supervised safer smoking facilities for crack cocaine users,” *Harm Reduction Journal* 3(2006): 1. The primary mode of drug consumption in Dutch consumption rooms is smoking or inhaling, which is becoming permitted in an increasing number of rooms in Germany and Switzerland, while in all other countries injecting is predominant. For an example of legislative enablement of harm reduction programs aimed at the distribution of material for the inhalation or smoking of cocaine, crack or heroin, see Article 3(1) of *Référentielle nationale de réduction des risques pour usagers de drogue mentionné à l'article D.3121-33* (National Framework on Harm Reduction for Drug Users Provided by Article D. 3121-33), France, 14 April 2005. (Article D. 3121-33 inserted an annex [31-2] into the *Code de la santé publique* [Public Health Code].)

should be made to ensure SDCFs remain as accessible as possible to the broadest spectrum of people who use drugs.

## International law and policy

### UN conventions on drug control

SDCFs were not foreseen by the UN conventions of 1961, 1971 and 1988 on drug control. Indeed, these treaties were formulated before the extent to which the HIV epidemic would be fuelled by injection drug use was fully appreciated and before the rapid increase in illegal drug use of the 1990s.

The International Narcotics Control Board (INCB), which oversees the implementation of the conventions, but which does not have the authority to issue binding legal interpretations of them, has expressed concern about SDCFs. Even though the INCB has misguidedly equated SDCFs with “shooting galleries,” SDCFs are indeed permissible under the UN conventions on drug control.<sup>23</sup>

The 1961 *Single Convention on Narcotic Drugs* and the 1971 *Convention on Psychotropic Substances* expressly allow states to permit the use and possession of drugs in the pursuit of medical and scientific purposes<sup>24</sup> and, further, require signatory states to “take all practicable measures to provide treatment, education, aftercare, rehabilitation and social reintegration of drug users.”<sup>25</sup> It is exactly such services that SDCFs aim to provide people who use drugs, in particular for high-risk populations. Established with a clear scientific and medical mandate, SDCFs come well within the scope of what is permitted by these two conventions.

Further, the UN Drug Control Program (UNDCP), located within the UN Office on Drugs and Crime, has recognized that the purpose of treatment includes not only a cure for illness but also the reduction of suffering associated with it.<sup>26</sup> Several studies have shown that SDCFs reduce unsafe injection practices among people who use drugs, thus

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<sup>23</sup> “Shooting galleries” refer to places where illegal drugs may be obtained, prepared, and taken by injection, often with equipment provided on the premises. In contrast to SDCFs, shooting galleries generally have no safeguards in place, may well involve the re-use or sharing of injection equipment, and provide no access to health services. The very purpose of SDCFs is to provide a health facility where the safer consumption of drugs is facilitated, sterile equipment is provided, and access to health and emergency services are available.

<sup>24</sup> *Single Convention on Narcotic Drugs*, 1961, UN, 520 UNTS 204, art. 4(c); *Convention on Psychotropic Substances*, 1971, UN, 1019 UNTS 175, art. 7(a).

<sup>25</sup> *Single Convention on Narcotic Drugs*, 1961, art. 38; *Convention on Psychotropic Substances*, 1971, art. 20.

<sup>26</sup> UNDCP, *Flexibility of treaty provisions as regards harm reduction approaches*, UN document E/INCB/2002/W.13/SS.5, 30 September 2002, para. 23.

helping to prevent the transmission of blood-borne diseases such as HIV and hepatitis.<sup>27</sup> Given the available evidence, an increasing number of countries are recognizing that SDCFs represent a practicable measure aimed at protecting and promoting the health of those who use illegal drugs.

Contrary to the views expressed by the INCB, there is nothing in the 1988 *United Nations Convention Against Illicit Traffic in Narcotic Drugs and Psychotropic Substances* that prevents states from establishing SDCFs. Article 3(2) of the 1988 Convention is often misinterpreted as requiring the blanket criminalization of possession for personal use. However, the 1988 Convention only requires signatory states to criminalize possession for personal consumption that is “contrary to the provisions” of the 1961 and 1971 conventions.

The view expressed by the INCB that SDCFs might be regarded as aiding, abetting, facilitating or counselling the illegal use of drugs for personal use, contrary to Article 3 paragraph 1(c)(iv) of the 1988 Convention, is incorrect for reasons concerning the intention of the parties. The Legal Affairs Office of the UNDCP recognized in 2002 that the health objectives of “drug-injection rooms” demonstrated an intent that could be seen to be consistent with the spirit of the conventions. The relevant report states:

It would be difficult to assert that, in establishing drug injection rooms, it is the intent of parties to actually incite or induce the illicit use of drugs, or even more so, to associate with, aid, abet or facilitate the possession of drugs. On the contrary, it seems clear that in such cases the intention of governments is to provide healthier conditions for IV drug [users], thereby reducing risk of infections with grave transmittable diseases and, at least in some cases, reaching out to them with counseling and other therapeutic options.<sup>28</sup>

There is, therefore, latitude for states to interpret and apply even the provisions of the 1988 Convention, which is often considered harsher than the earlier 1961 and 1971 conventions, in a manner that legally exempts people from prosecution when they possess and consume otherwise illegal drugs within an SDCF.

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<sup>27</sup> F. Zobel, *Short appraisal of the role and usefulness of drug consumption facilities (DCF) in the reduction of drug-related problems in Switzerland*, produced at the request of the Swiss Federal Office of Public Health, (Lausanne: University Institute of Social and Preventive Medicine, 2004), p. 27; S. Broadhead et al, “Safer injection facilities in North America: their place in public policy and health initiatives,” *Journal of Drug Issues* 32(1) (Winter 2002) , pp. 347–348; MSIC Evaluation Committee, *Final report on the evaluation of the Sydney Medically Supervised Injecting Centre*; D. Hedrich, *European report on drug consumption rooms*; E. Wood et al, “Safer injecting education for HIV prevention within a medically supervised safer injecting facility,” *International Journal of Drug Policy* 16(4) (2005): 281–284.

<sup>28</sup> UNDCP, *Flexibility of treaty provisions as regards harm reduction approaches*, UN document E/INCB/2002/W.13/SS.5, 30 September 2002, at paras. 23–28. At [www.tni.org/drugsreform-docs/un300902.pdf](http://www.tni.org/drugsreform-docs/un300902.pdf).

When establishing SDCFs, national and regional governments have often relied on various legal analyses from national public prosecutors offices or academic institutes stating that SDCFs are indeed consistent with the conventions' intent to enable rehabilitation and treatment of people who use drugs without promoting drug use.<sup>29</sup>

## Human rights obligations

There is an urgent need to recognize that the right to health under international law should be viewed as “an inclusive right extending not only to timely and appropriate health care but also to the underlying determinants of health ... and access to health-related education and information.”<sup>30</sup> As experience in numerous countries demonstrates, the implementation of SDCFs is an effective harm-reduction measure that reaches out to certain groups of people who use drugs and provides them with education, health care and information about drug treatment programs. The obligation to provide all persons in the community with the highest attainable standard of health is clearly infringed when deliberate policies thwart the establishment of these potentially life-saving, disease-preventing measures. Given the seriousness of the dangers associated with unsafe injection drug use, it can be argued that the obligation to establish SDCFs meets even the most core, fundamental description of the right to health: “The right to health imposes a duty on a state to intervene or act, to the extent of its available resources, to reduce or

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<sup>29</sup> The legal analysis for Germany is found in H. Körner, *Penal Law Report on the admissibility of health care centres for hygienic and stress-free consumption by opiate addicts*, Chief Public Prosecutor, Frankfurt am Main Regional Court, ZfB (Headquarters of the Campaign against Drug Abuse), 17 May 1993. Here, the Chief Public Prosecutor concluded that such facilities were not contrary to the UN conventions nor German narcotics law provided that the sites are not used for the sale or acquisition of drugs, and that hygienic and risk-reduced drug consumption is ensured. The legal analysis for Switzerland can be found in Swiss Institute of Comparative Law, *Use of Narcotic Drugs in Public Injection Rooms under Public International Law*, Avis 99-121c, 7 January 2000. This analysis found that “[t]he texts of the relevant international conventions do not provide any guidance on the essential question of whether or not public injecting rooms are in fact conducive to the rehabilitation and social integration of drug addicts in the short term and to the elimination of financial incentives for illegal traffic in the long term. The actual practice of States Parties in this respect could provide some guidance, if it is substantially uniform. If not, it must be concluded that States Parties retain the freedom to make their own policy choices on the tolerance of *Fixer-Stübli* [drug consumption rooms]” (p 7). The legal analysis for the Netherlands is found at College van Procureur-general, *Richtlijnen voor het opsporings- en strafvorderingsbeleid inzake strafbare feiten van de Opiumwet*: vastgesteld op 11.09.96 in werking tredend op 1.10.96, Ministry of Justice, 1996. The document provided official support for the possession of drugs in drug consumption facilities from the Public Prosecutor’s Office of the Ministry of Justice, in accordance with the document’s guidelines. Although a safe drug consumption room is not operational in Slovenia, a legal opinion on the legality of such facilities was undertaken by Professor Damjan Korosec, *Possibilities for Establishment of the Room for Safe Injecting in the Republic of Slovenia - Criminal Justice perspective*, Faculty of Law, University of Ljubljana, May 2005.

<sup>30</sup> UN Committee on Economic, Social and Cultural Rights, General Comment No. 14: The right to the highest attainable standard of health: Article 12, E/C.12/2000/4, 11 August 2000, para. 11. See, also, Article 25 of the *Universal Declaration of Human Rights*, which provides for the right to “a standard of living adequate for the health and well-being of himself” including “medical care and necessary social services.” Article 35 of the *Charter of Fundamental Rights of European Union* states: “Everyone has the right to access preventive health care and the right to benefit from medical treatment under the conditions established by national laws and practices.”

address serious threats to the health of individuals or the population.”<sup>31</sup> States have the obligation to ameliorate or prevent the negative health consequences of injection drug use, such as the spread of infectious disease.

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<sup>31</sup> S. Jamar, "The international human right to health," *Southern University Law Review* (1994) at 61.

# Model Statutory Provisions

## Chapter I. General Provisions

### Article 1. Purpose of this Part

The purpose of this Part is to:

- (a) enable the establishment of supervised drug consumption facilities;
- (b) improve individual and public health;
- (c) increase public safety and public order; and
- (d) to fulfill, in part, the human rights of the people who use drugs and of the staff of these facilities, including the right to the highest achievable standard of physical and mental health.

### Article 2. Definitions

For the purposes of this Part, the following definitions are used:

“Client of a facility” means any individual using a supervised drug consumption facility in accordance with the rules of conduct to be observed by such persons.

“Controlled substance” means a substance included in the Schedules of the [applicable drug legislation].

“Exempt quantity of a controlled substance,” in relation to a supervised drug consumption facility, shall be an amount established by Regulations.

“Health practitioner” means a person entitled under the [relevant health law] to provide health services. Health practitioners include accredited physicians, registered nurses and other trained medical staff.

“Internal management protocol”, in relation to a supervised drug consumption facility, means the protocol established by the [relevant public health authority] for the operation of the facility.

“Operator” of the supervised drug consumption facility, means a person who is approved by the [responsible public health authority] as the operator of the facility, where such approval is required by this Part.

“Supervised drug consumption facility” means premises approved as facilities for the consumption of controlled substances, where such approval is required by this Part.

“Staff” of the supervised drug consumption facility, includes the following persons:

- (a) the operator or manager of the facility;
- (b) a person engaged by the operator or manager of the facility to provide services at the facility, whether under a contract of employment or otherwise; and
- (c) a person engaged by the operator or manager of the facility to provide voluntary assistance at the facility.

“Use” means, in respect of a substance included in the Schedules of the [applicable drug legislation], to introduce a controlled substance into the body of a person, including smoking or inhaling fumes caused by heating or burning the substance.

## Chapter II. Establishing Supervised Drug Consumption Facilities

### Article 3. Legal basis for establishing supervised drug consumption facilities

[Two options for Article 3 are provided below (3a and 3b). One or the other should be selected, but not both.]

#### Option 1: Article 3(a). Licence to operate supervised drug consumption facilities

- (1) The [responsible public health authority] may issue a licence to a specified person or specified organisation to operate a supervised drug consumption facility.<sup>32</sup>
- (2) A licence issued under this article shall require the licence holder to provide:
  - (a) a supervised and hygienic environment for the use of controlled substances;
  - (b) sterile equipment for such use, and facilities for safely disposing of the equipment after use; and
  - (c) an opportunity for clients of the facility to be referred to counselling, medical treatment, addiction treatment and other services.<sup>33</sup>

<sup>32</sup> Various legislative approaches to SDCF exist in various countries. In Australia, several legislative instruments provide for the establishment of such facilities. The Sydney Medically Supervised Injecting Centre (MSIC) was established by the *Drug Summit Legislative Response Act* — Schedule 1, New South Wales (Australia), 1999. There also exists an Act and corresponding regulations in the Australian Capital Territory (although a facility has not commenced in that jurisdiction): *Supervised Injecting Place Trial Act*, A1999-90, 1999; Australian Capital Territory and Supervised Injecting Place Trial Regulation. SL2003-24, 2003. In Germany (which has 20–25 SDCF in operation), Section 10a of the federal *Narcotics Act* (which came into force 1 April 2000) sets out ten minimum standards for consumption rooms. Statutory orders at the Lander [the states or provinces of the German federation] level must meet these standards. In Switzerland (which has approximately 12 facilities operating) the operation of the facilities was declared legal after an assessment commissioned by the Swiss Federal Office for Public Health from a law professor at the University of Berne: Swiss Institute of Comparative Law, Avis 99-121c: Use of Narcotic Drugs in Public Injection Rooms under Public International Law, 7 January 2000. In the Netherlands, which has approximately 22 facilities operating, the College van Procureur-general issued legal guidelines on 1 October 1996, hence establishing general legal authority: College van Procureur-general, Richtlijnen voor het opsporings- en strafvorderingsbeleid inzake strafbare feiten van de Opiumwet: vastgesteld op 11.09.96 in werking tredend op 1.10.96, Ministry of Justice. The legal authority for the operation of specific facilities in Dutch cities is based on municipal regulations. In Spain, the facility in Madrid operates under authority of *Law 5/2002*, 27 June 2002 of the Community of Madrid, while the site in Bilbao operates pursuant to a legal opinion issued by the Basque Institute of Criminology. In Canada, the Insite facility in Vancouver operates under a ministerial exemption of liability granted pursuant to s. 56 of the *Controlled Drugs and Substances Act 1996*, which allows exemptions when “the exemption is necessary for a medical or scientific purpose or is otherwise in the public interest.” Norway also has an Act (*LOV-2004-07-02-64*) on SDCFs and relevant regulations. SDCFs are enabled (but not yet in operation) in Luxemburg: *Loi du 27 avril 2001 modifiant la loi modifiée du 19 février 1973 concernant la vente de substances*, art.7; and in Portugal: *Decreto-Lei 183/2001*, 21 June 2001, c.10.

(3) A license is subject to such other conditions as are imposed by or under this Part or the Regulations.

– OR –

### **Option 2: Article 3(b). Statutory authority to operate supervised drug consumption facilities**

Supervised drug consumption facilities may be established and may operate in accordance with this Part and corresponding Regulations on the initiative of any public body with responsibilities in the field of public health or any private organizations whose objectives include health promotion.

### **Article 4. Regulations for operating supervised drug consumption facilities**

(1) The Regulations may make provision for, or with respect to, any of the following matters:

- (a) the standards for a supervised drug consumption facility, including the elaboration of an internal management protocol for a supervised drug consumption facility;
- (b) the provisions to be observed in the operation of a supervised drug consumption facility;
- (c) the rules of conduct to be observed by persons using a supervised drug consumption facility;
- (d) the qualifications of persons engaged in the operation of a supervised drug consumption facility; and
- (e) the functions of persons engaged in the operation of a supervised drug consumption facility.<sup>34</sup>

### **Article 5. Services provided by supervised drug consumption facilities**

(1) Staff of the supervised drug consumption facilities may supply to clients of the facility the following material:

- (a) sterile syringes and other related material for safer injection drug use, including sterile water ampoules, swabs, filters, safe acid preparations, spoons and bowls and other appropriate materials;

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<sup>33</sup> This wording is derived from *Supervised Injecting Place Trial Act*, Australian Capital Territory, s. 2.

<sup>34</sup> This wording is derived from the *Drug Misuse and Trafficking Act 1985*, No 226, New South Wales (Australia), s. 36S.

- (b) material to enable safer smoking and inhalation of drugs, such as pipes, stems, metal screens, alcohol wipes and lip balm;<sup>35</sup> and
  - (c) condoms and other safer sex materials such as water-based lubricants and dental dams, as well as information about reducing the risks of HIV and other sexually transmitted infections.
- (2) Staff of the supervised drug consumption facilities may provide clients of the supervised drug consumption facility with
- (a) medical supervision of drug use; and
  - (b) emergency medical assistance, if required.
- (3) Staff of the supervised drug consumption facilities may provide clients of the supervised drug consumption facility with, or refer such clients to,
- (a) relevant health care services, including medical consultation and medical assessment services;
  - (b) drug and alcohol counselling services;
  - (c) health education services;
  - (d) drug and alcohol treatment and rehabilitation services
  - (e) the services of opioid substitution treatment providers;
  - (f) service for diagnosing and treating blood-borne and sexually transmitted diseases; and
  - (g) services of a sterile syringe program.<sup>36</sup>

## **Article 6. Operating procedures for safe drug consumption facilities**

The facility shall establish procedures:

- (a) for the disposal of controlled substances;
- (b) to account for material distributed, returned and disposed of;

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<sup>35</sup> For an example of legislative enablement of harm reduction programs distribution of material for the inhalation or smoking of cocaine, crack or heroin, see *Référentiel national de réduction des risques pour usagers de drogue mentionné à L'article D* [France], Décret No. 2005-347 du 15 Avril 2005, Annexe 31-2, art. III(1). Studies have identified crack smoking as a possible risk factor for HIV, hepatitis C and tuberculosis; infectious disease may be transmitted via the sharing of implements through which contaminated blood particles are transmitted. See A.E. Weber et al, "Risk Factors associated with HIV infection among young gay and bisexual men in Canada," *Journal of Acquired Immune Deficiency* 28 (2001): S1-S8; J. McMahon and S. Tortu, "A potential hidden source of hepatitis C infection among noninjecting drug users," *Journal of Psychoactive Drugs* 35 (2003): 523-534; S. Tortu et al, "Sharing of noninjection drug-use implements as a risk factor for hepatitis C," *Substance Use & Misuse* 39 (2004): 211-224.

<sup>36</sup> This wording is derived from the *Drug Misuse and Trafficking Act 1985*, New South Wales, s. 36L.

- (c) to ensure the proper training of staff in handling controlled substances as well as used syringes, needles and other paraphernalia;
- (d) to prevent loss and theft of any controlled substances kept on site; and
- (e) to keep records, including records related to the disposal, loss and theft of controlled substances, and any incident of non-compliance with the protocols of the supervised drug consumption facility or the terms of this Part.

## **Article 7. Location of supervised drug consumption facilities**

Supervised drug consumption facilities may be located in fixed premises or may be mobile.

### **Commentary: Article 7**

The operation of an SDCF and the delivery of services will vary among facilities depending on local circumstances and needs. An SDCF may evolve as part of a wider network of services, being integrated into existing facilities where health and welfare services are directly available, or it might specialize exclusively in consumption room services from which referrals may be made to external services. In some circumstances, a mobile SDCF may be more appropriate.<sup>37</sup> Mobile consumption rooms may be able to better meet the needs of people who use drugs by facilitating access to the SDCF, especially in rural areas or expansive cities where transportation may be a barrier to accessing fixed-location SDCFs. Not only do mobile services offer wider coverage and avoid some of the costs associated with fixed sites, but they may also be a way of reducing some of the potential problems of obtaining planning permission and of managing community concerns.

## **Article 8. Confidentiality**

- (1) The confidentiality of all health care information shall be respected. Records of any person which are created or obtained in the course of a supervised drug consumption facility operation:
  - (a) are confidential;
  - (b) are not open to public inspection or disclosure;
  - (c) shall not be shared with other individuals or agencies without the consent of the person to whom the record relates; and
  - (d) shall not be discoverable or admissible during legal proceedings.
- (2) No record referred to in Section (1) may be used to:
  - (a) initiate or substantiate any criminal charges against a client of a facility; or
  - (b) act as grounds for conducting any investigation of a client of a facility.

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<sup>37</sup> N. Hunt, *An overview of models of delivery of drug consumption rooms*, Independent Working Group on Drug Consumption Rooms, Joseph Rowntree Foundation, 2006.

- (3) Supervised drug consumption facility staff cannot be compelled under [relevant criminal procedure code] to provide evidence concerning the information that was entrusted to them or became known to them in this capacity.<sup>38</sup>
- (4) All use of personal information of clients of a facility and program staff in research and evaluation shall be undertaken in conditions guaranteeing anonymity, and any such information shall also be governed by Section (2).

### **Commentary: Article 8**

The right to confidentiality is of particular relevance in the context of drug consumption rooms. A lack of confidentiality and the possibility of discrimination or police harassment may discourage people from using SDCFs for fear that information about their health status may be released. The requirement of confidentiality respects the right to privacy articulated under several international instruments<sup>39</sup> and affords people who are drug-dependent an environment in which they can safely consume drugs and get health care without fear of social or institutional violations of their human rights.

Information regarding a person's health status should be made available to that person and, beyond him or her, only to those for whom knowledge of the person's status is absolutely necessary, such as a health practitioner where that information is relevant to the treatment being sought from that practitioner. Ensuring confidentiality of health status and all health-care information is critical to respecting the human rights of people who use drugs, including those who are dependent on drugs.

### **Article 9. Non-discrimination**

- (1) No person shall be subject to any discrimination in the operation of a supervised drug consumption facility on the basis of gender, race, religion, age, disability,<sup>40</sup> sexual orientation, nationality, political opinion or social or ethnic origin.
- (2) For greater clarity in Section (1):
  - (a) access to supervised drug consumption facilities shall extend to whoever needs the services of supervised drug consumption facilities, regardless of age, frequency of injection, controlled substance used or residence; and

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<sup>38</sup> This wording is derived from Germany's *Code of Criminal Procedure*, s.53, para. 1, no. 3b.

<sup>39</sup> See, for instance, Article 12 of the UN *Universal Declaration of Human Rights*, Article 8(1) of the *European Convention for the Protection of Human Rights and Fundamental Freedoms*, and Article 17(1) of the *International Covenant on Civil and Political Rights* (ICCPR).

<sup>40</sup> In certain jurisdictions, dependence on alcohol or a controlled substance may be considered as a disability under anti-discrimination laws, and persons dependent on drugs enjoy the corresponding protections from disability-based discrimination. See Module 7 of this model law resource (Stigma and Discrimination) for model provisions on this issue.

(b) supervised drug consumption facilities program staff may include people who currently use or have previously used controlled substances.

## Optional: Article 10. Facility oversight committee

- (1) A facility oversight committee may be established to oversee the operation of the supervised drug consumption facility.
- (2) The facility oversight committee shall include representatives from among people who use the services of the facility.<sup>41</sup>

### Commentary: Article 10

The meaningful involvement of people who use drugs is important in establishing effective and sustainable harm reduction measures such as SDCFs. The HIV and hepatitis C epidemics have highlighted the urgent need to involve people who use drugs, as well as the importance of “understand[ing] more about how the injecting drug user community function[s], in order to understand the nature of the risk and to plan interventions.”<sup>42</sup> People who use drugs have demonstrated that they are able to organize themselves and make valuable contributions to their community, expand the reach and effectiveness of HIV prevention and harm reduction services, provide much needed care and support, and advocate for their rights and dignity.<sup>43</sup> In addition to the practical benefits described above, there are human rights imperatives that require greater involvement of people who use drugs, including the right to be involved in decisions affecting their lives.<sup>44</sup> The UN *International Guidelines on HIV/AIDS and Human Rights* recommend that representatives of vulnerable groups, such as people who use drugs, be involved in consultations and in planning and delivery of services.<sup>45</sup>

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<sup>41</sup> For example, the Australian Capital Territory (ACT) legislation established an Advisory Committee, which is required to include two members of organisations of people who use drugs; see *Supervised Injecting Place Trial Act*, part 3.

<sup>42</sup> [U.K.] National Treatment Agency, *A Guide to Involving and Empowering Drug Users*, Public Draft 2, undated, s. 1.3; A. Neaigus et al, “The relevance of drug injectors’ social and risk networks for understanding and preventing HIV infection,” *Social Science and Medicine* 38(1) (1993).

<sup>43</sup> Canadian HIV/AIDS Legal Network, “*Nothing about us without us*” — *Greater, meaningful involvement of people who use illegal drugs: A public health, ethical, and human rights imperative*, 2005, p. 17. Available via [www.aidslaw.ca/drugpolicy](http://www.aidslaw.ca/drugpolicy). See also The Australian Injecting & Illicit Drug Users’ League, *Policy Position: Drug User Organisations*, undated. Available via [www.aivl.org.au/](http://www.aivl.org.au/); N. Crofts et al, “A history of peer-based drug user groups in Australia,” *Journal of Drug Issues* 25 (1993): 599–616.

<sup>44</sup> Canadian HIV/AIDS Legal Network, “*Nothing about us without us*” — *Greater, meaningful involvement of people who use illegal drugs: A public health, ethical, and human rights imperative*. p. 17. See, also, Australian Injecting & Illicit Drug Users’ League, *Policy Position: Drug User Organisations*.

<sup>45</sup> Office of the United Nations High Commissioner for Human Rights and UNAIDS, *HIV/AIDS and Human Rights: International Guidelines*, 1998, Guideline 2, para. 24.

## Optional: Article 11. Working group on law enforcement practices

- (1) The [relevant public health agency] shall be responsible for convening a working group to establish a protocol for law enforcement practices that are compatible with the effective operation of the facility. Such a protocol shall include the issue of law enforcement practices in the vicinity of the facility.<sup>46</sup>
- (2) The working group shall include representatives of
  - (a) the [relevant public health agency];
  - (b) staff of the facility;
  - (c) clients of the facility;
  - (d) law enforcement agencies; and
  - (e) local community representation.

### Commentary: Article 11

Evaluations have shown that SDCFs are more likely to meet their health objectives when they are established with the participation and agreement of local law enforcement officials and community organizations.<sup>47</sup> In developing a protocol for law enforcement practices that is compatible with the effective operation of an SDCF, the establishment of a working group that includes local law enforcement, people who currently use drugs, staff of the facility, and the relevant health authority will facilitate ongoing communication and cooperation and help to ensure that the SDCF continues to meet the needs of clientele and the local community. According to a report by the European Monitoring Centre for Drugs and Drug Addiction, SDCF staff and neighbourhood committees work in partnership with local police to minimize the need for law enforcement interventions and increase the efficacy of SDCF.<sup>48</sup> In addition, clients and

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<sup>46</sup> Law enforcement agencies need to be aware that searches and seizures conducted near or in the SDCF for the purpose of enforcing drug related offences may dissuade clients from using such services. Law enforcement protocols regarding searches and seizures for drug related offences in such locations should be modified accordingly.

<sup>47</sup> J. Kimber et al, "Drug consumption facilities: an update since 2000," *Drug and Alcohol Review* 22 (June 2003): 227–233.

<sup>48</sup> European Monitoring Centre for Drugs and Drug Addiction, *European report on drug consumption rooms*. In the Netherlands, the majority of the current facilities have originated from initiatives by neighbourhood residents and police, supported by local authorities. Other Dutch facilities have been established at the initiative of social or drugs services, often in cooperation with drug users' interest groups. See, also, J. Kimber et al, *International survey of supervised injecting centres (1999-2000)*, (Australia) National Alcohol and Drug Research Centre, Technical Report, 2001. In Australia, the New South Wales Police Service were actively involved with the planning and development of the SDCF, as well as with the evaluation of the facility, and are supportive of the role it plays as a public health initiative. See, also, D. MacPherson, *A framework for action: A four-pillar approach to drug problems in Vancouver*, City of Vancouver, April 2001. [At www.city.vancouver.bc.ca/fourpillars/](http://www.city.vancouver.bc.ca/fourpillars/). The four pillars consist of enforcement, prevention, treatment and harm reduction. The Vancouver Police Department was a partner in establishing an SDCF as part of the four-pillar integrated approach to dealing with the city's drug problem.

staff of SDCFs are familiar with the unique needs of people who use drugs and are able to offer valuable experience and insight that should inform protocol for local law enforcement practices. The involvement of local community representation is important not only to ensure local needs and concerns are addressed, but also to facilitate public education concerning the value of such interventions in terms of community public health and social integration of people who use drugs.

## Chapter III. Issues of Criminal and Civil Liability

### Article 12. Exemption from criminal liability for clients of supervised drug consumption facilities

Notwithstanding [relevant drug legislation], it is legal for a person at a supervised drug consumption facility:

- (a) to be in possession of no more than an exempt quantity of a controlled substance;
- (b) to be in possession of an item of equipment for the consumption of a controlled substance; and
- (c) to administer or attempt to administer to himself or herself no more than an exempt quantity of a controlled substance.<sup>49</sup>

### Article 13. Exemption from criminal liability for persons engaged in the operation of supervised drug consumption facilities

Notwithstanding [relevant drug legislation]:

- (a) it is lawful for a person to engage, participate or otherwise be involved in the operation of a supervised drug consumption facility;
- (b) in particular, a person who is engaged, participates or is otherwise involved in the operation of a supervised drug consumption facility does not commit an offence under [relevant criminal law], or any other offence prescribed by Regulations.<sup>50</sup>

#### Commentary: Articles 12 & 13

Under national drug legislation, the unauthorized possession, manufacture, cultivation, trafficking, export and import of controlled substances is often expressly forbidden. In addition, these laws often extend to anything containing an illegal drug — for example, injection equipment. In order to promote the social aims and effective operation of supervised drug consumption facilities, governments must ensure adequate protection from criminal liability for clients accessing supervised drug consumption facilities as well as managers and staff involved in the operation of the facilities.<sup>51</sup> This may take the form of exemptions on the part of the relevant health authority or law enforcement authority, or governments may wish to enact regulations that would have the same effect.<sup>52</sup>

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<sup>49</sup> This wording is derived from the *Drug Misuse and Trafficking Act 1985*, New South Wales, s. 36N.

<sup>50</sup> This wording is derived from the *Drug Misuse and Trafficking Act 1985*, New South Wales, s. 36O.

<sup>51</sup> R. Fortson, *Setting up a drug consumption room: Legal issues*, Independent Working Group on Drug Consumption Rooms, Joseph Rowntree Foundation, 2006.

<sup>52</sup> See *Drug Summit Legislative Response Act 1999*, (NSW) sch I, ss. 36N–36O. New South Wales [Australia] has opted for statutory changes to the criminal law. Under the NSW Act, individuals using

## **Article 14. Exemption from civil liability in connection with operation of supervised drug consumption facilities**

- (1) A civil proceeding cannot be brought against any person (including the state, the licensee and staff) in relation to any act or omission in connection with the operation of a supervised drug consumption facility, if the act or omission was in good faith for the purpose of executing this Part and was not a reckless or negligent act or omission.
- (2) For greater clarity, given the nature and objectives of a supervised drug consumption facility, permitting the use of controlled substances on the premises in accordance with facility rules does not give rise to any liability on the part of any person associated with operation of the facility.
- (3) This section does not affect any rights or obligations as between a member of the staff of a supervised drug consumption facility and his or her employer.<sup>53</sup>

### **Commentary: Article 14**

Exemption from civil liability in connection with operation of an SDCF is relevant because of the concern that operators or staff could be held civilly responsible for incidents, such as overdoses, taking place at an SDCF. In order to encourage the establishment of SDCFs, operators and staff should be exempt from any such threat of civil liability for the opportunity to consume drugs, the provision of syringes or other safer drug use material, or information about safer drug use, except in cases where the injury has resulted from the negligence or recklessness of the operators or staff. Civil liability issues associated with SDCFs are not unique or complex — indeed, they are issues that arise for the operation of any health service — and they should not act as a bar to the establishment of such programs.

## **Optional: Article 15. Health practitioner-assisted injection**

- (1) Health practitioners may instruct the clients of the supervised drug consumption facility regarding safer injection techniques where, in their opinion, this is necessary to minimize the likelihood of harm to the person who uses the facility.
- (2) Where, in the opinion of a health practitioner, and after receiving instruction regarding safer injection techniques, the person using the facility experiences difficulties in injecting him or herself, the health practitioner may assist the person in injecting. Before assisting a person with an injection, the health practitioner must obtain the person's informed consent.

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small quantities of drugs at the supervised facilities are exempt from criminal liability. Further, those responsible for the operation and management of the trial facility are granted exemption.

<sup>53</sup> See, also, *Drug Misuse and Trafficking Act 1985*, New South Wales, s. 36P; *Supervised Injecting Place Trial Act*, Australian Capital Territory.

- (3) Notwithstanding [relevant criminal provisions], a health practitioner who participates or is otherwise involved in the administration of a controlled substance in the circumstances described in Sections (1) and (2) does not commit an offence under [relevant criminal law] or any other offence prescribed by regulations.
- (4) A civil proceeding or discipline under professional regulatory codes cannot be brought against any person (including the state, the licensee and facility staff) in relation to any act or omission in connection with operation a supervised drug consumption facility, including in relation to assisted injection, if the act or omission was in good faith for the purpose of executing this Part and was not a reckless or negligent act or omission.

### Commentary: Article 15

Studies show that many people receive injections from or administer injections to other people.<sup>54</sup> In situations without medical supervision, assisted injection practices are associated with higher HIV prevalence and other unsafe injection practices, such as needle sharing.<sup>55</sup> There are many factors driving the practice of assisted injection, including gender dynamics, a lack of knowledge of and experience with injecting, loss of viable veins, preference for jugular injection, and inability to inject oneself due to the anxiety and shakiness that can accompany withdrawal. Although both men and women report needing assistance with injection, women are significantly more likely to require assistance injecting and more likely to report not knowing how to inject as the reason for requiring assistance.<sup>56</sup> The denial of assisted injection is inconsistent with the right of every person to enjoy the highest attainable standard of health.<sup>57</sup> A number of international human rights instruments promote health as a central human right, and

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<sup>54</sup> A.H. Kral et al, “Risk factors among IDUs who give injections to or receive injections from other drug users,” *Addiction* 94(5) (1999): 675–683.

<sup>55</sup> J.M. O’Connell et al, “Requiring help injecting independently predicts incident HIV infection among injection drug users,” *Journal of Acquired Immune Deficiency Syndrome* 40(1) (2005): 83–88; E. Wood et al, “Requiring help injecting as a risk factor for HIV infection in the Vancouver epidemic,” *Canadian Journal of Public Health* 94(5) (2003): 355–359; T. Kerr, “Safer injection facility use and syringe sharing in injection drug users,” *Lancet* 366 (2005): 316–318.

<sup>56</sup> J.M. O’Connell et al, “Requiring help injecting independently predicts incident HIV infection among injection drug users”. This paper shows that up to 40 percent of people who inject drugs in Vancouver report that they require assistance with illegal drug injections at certain times. It also finds that people who inject drugs in Vancouver who require assistance with injections have an HIV incidence rate that is double the rate seen in those people who inject drugs who do not report this vulnerability. See, also, E. Wood et al, “Requiring help injecting as a risk factor for HIV infection in the Vancouver epidemic: implications for HIV prevention.”

<sup>57</sup> See, particularly, Article 55 of the *Charter of the United Nations*; Article 25 of the *Universal Declaration on Human Rights*; Article 12 of the ICESCR; Article 6 of the ICPCR. For an excellent discussion of these instruments, customary international law and international drug treaties in context of the right to health and the establishment of SDCFs, see I. Malkin, R. Elliott, and R. Mcrae, “Supervised injection facilities and international law,” *Journal of Drug Issues* 33(3) (2003); and R. Elliott, I. Malkin, and J. Gold, *Establishing Safe Injection Facilities in Canada: Legal and Ethical Issues*, Canadian HIV/AIDS Legal Network, 2002, p. 24.

states that have the capacity are arguably obliged under international law to implement SDCF trials to progressively realize the rights of their citizens to the highest attainable standards of health. Because any policy against assisted injections in an SDCF would appear to have a particularly adverse effect on women and people with certain disabilities, such a policy could be considered discriminatory. Permitting medical staff to assist clients with injections at supervised consumption facilities has the potential to decrease HIV transmission, encourage safer injection practices, and promote the health and autonomy of individuals. Ensuring equitable access to SDCFs is key to reaching the most vulnerable and at risk group of people using drugs.

### **Optional: Article 16. Client-to-client assisted injection**

- (1) Where, after receiving instruction regarding safer injection techniques from a health practitioner in a supervised drug consumption facility, a person using the facility experiences difficulties in injecting himself or herself, and is unable or does not wish to inject himself or herself, the health practitioner may allow the individual to be assisted or injected by another client of the facility. Before allowing a client of the facility to be assisted or injected by another client, the health practitioner must obtain both persons' informed consent.
- (2) Notwithstanding [relevant criminal provisions], a health practitioner who allows a client of a facility to inject another client or is otherwise involved in the administration of a controlled substance in the circumstances described in Section (1) does not commit an offence under [relevant criminal law] or any other offence prescribed by Regulations.
- (3) Notwithstanding [relevant criminal provisions], a client of a facility who injects another client or is otherwise involved in the administration of a controlled substance in the circumstances described in Section (1) does not commit an offence under [relevant criminal law] or any other offence prescribed by Regulations.

### **Commentary: Article 16**

Facilitating client-to-client assisted injection may avoid liability concerns related to medical staff participating in the administration of illegal drugs while acknowledging the high prevalence of assisted injection amongst people who use drugs. The preceding provision is intended to allow an SDCF to implement a policy on client-to-client assisted injection, to remove potential concerns over liability for facility staff who would be in charge of permitting such assisted injection, and to protect those individuals taking part in client-to-client assisted injection.

## Selected Resources

*This section provides a list of resources that the Legal Network considers to be particularly relevant.*

### Articles, reports and policy documents

British Institute of International and Comparative Law. *Draft fourth framework convention on risk management*. 2003. At [www.senliscouncil.net/documents/BIICL\\_HR\\_Framework#search=%22Draft%20fourth%20framework%20convention%22](http://www.senliscouncil.net/documents/BIICL_HR_Framework#search=%22Draft%20fourth%20framework%20convention%22)

Council of the European Union. *Recommendation on the prevention and reduction of health-related harm associated with drug dependence* of 18 June 2003. 2003/488/EC.

Dolan, K. et al. “Drug consumption facilities in Europe and the establishment of supervised injecting centres in Australia.” *Drug and Alcohol Review* 19 (2000): 337–346.

Elliott, R. et al. “Supervised injection facilities and international law.” *Journal of Drug Issues* 33(3) (Summer 2003).

European Monitoring Centre for Drugs and Drug Addiction. *European report on drug consumption rooms*. Office for Official Publications of the European Communities, 2004.

Kerr, T. et al. “Impact of a medically supervised safer injection facility on community drug use patterns: a before and after study.” *British Medical Journal* 332 (2006):220–222.

Körner, H. Chief Public Prosecutor, Frankfurt am Main Regional Court. *Penal Law Report on the admissibility of health care centres for hygienic and stress-free consumption by opiate addicts*. ZfB (Headquarters of the Campaign against Drug Abuse), 17 May 1993.

Medically Supervised Injecting Centre (MSIC) Evaluation Committee. *Final report on the evaluation of the Sydney Medically Supervised Injecting Centre*, 2003.

Poschadel, S. et al. *Evaluation of the work of drug consumption rooms in the Federal Republic of Germany*. Zeus GmbH, on behalf of the Federal Ministry of Health, 2003.

Swiss Institute of Comparative Law. *Use of Narcotic Drugs in Public Injection Rooms under Public International Law*, Avis 99-121c, 7 January 2000.

Wood, E. et al. “Requiring help injecting as a risk factor for HIV infection in the Vancouver epidemic.” *Canadian Journal of Public Health* 94(5) (2003):355–359.

## Legal documents

*Act to regulate the traffic in narcotics (Narcotics Act), Section 10a.* [Germany].

*Council of Ministers Resolution 39/2001* of 9 April 2001. [Portugal].

College van Procureur-general. *Richtlijnen voor het opsporings- en strafvorderingsbeleid inzake strafbare feiten van de Opiumwet: vastgesteld op 11.09.96 in werking tredend op 1.10.96.* Ministry of Justice, 1996 [Netherlands].

*Decree-Law No. 183/2001* of 21 June 2001 [Portugal].

*Drug Misuse and Trafficking Act 1985.* Sections 36A-36T. [New South Wales, Australia].

*Loi du 27 avril 2001 modifiant la loi modifiée du 19 février 1973 concernant la vente de substances médicamenteuses et la lutte contre la toxicomanie* [Luxemburg].





Canadian  
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Legal  
Network | Réseau  
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VIH/sida

**Canadian HIV/AIDS Legal Network**  
**1240 Bay Street, Suite 600**  
**Toronto, Ontario**  
**Canada M5R 2A7**  
**Telephone: +1 416 595-1666**  
**Fax: +1 416 595-0094**  
**E-mail: [info@aidslaw.ca](mailto:info@aidslaw.ca)**  
**[www.aidslaw.ca](http://www.aidslaw.ca)**