THE OPIOID CRISIS AND SECTION 7: *CHARTER* IMPLICATIONS OF SAFE SUPPLY AND SIMPLE POSSESSION

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INTRODUCTION

Canada has grappled for many years with a high mortality rate among people overdosing on illicit substances or engaging in unsafe injection practices. British Columbia ("BC") and other provinces have sought to address part of the problem by providing safe injection sites, with some success.[1] But, in the past decade, BC, Ontario, Quebec, and New Brunswick have witnessed a sharp increase in the quantity of fentanyl found in the street supply of illicit drugs, causing fatality rates to soar.[2] BC declared

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1 See *Canada (Attorney General) v PHS Community Services Society*, 2011 SCC 44 at paras 11–15 [Insite]. Since the opening of Canada's first site in Vancouver in 2003, further safe injection sites have opened in Alberta, Saskatchewan, Ontario, and Quebec. See Health Canada, "Supervised consumption sites and services: Explained" (last modified 22 July 2021), online: *Government of Canada* <www.canada.ca/en/health-canada/services/substance-use/supervised-consumption-sites/explained.html>.

2 See Andrea Woo, "As Canada's Overdose Deaths Soar, the Safe-Supply Debate Enters a New and Urgent Phase", *The Globe and Mail* (18 February 2021) [Woo, "Canada's Overdose Deaths"].

a public emergency in 2016 and launched a series of initiatives.[3] By early 2019, BC's Provincial Health Officer estimated that measures employed since 2016 had saved as many as 60% of potential deaths by overdose, but found the mortality rate was still rising.[4] The crisis has since become more severe, with recent reports finding that 20 people were dying from drug overdose every day in Canada and 6.2 people every day in BC.[5] The COVID-19 pandemic has disrupted efforts to connect vulnerable persons with effective supports, and fentanyl continues to appear in the street supply in ever higher concentrations.[6] Many stakeholders point to the criminalization of simple possession as a further

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3 See British Columbia Ministry of Health, Office of the Provincial Health Officer, *Registered Nurse and Registered Psychiatric Nurse Public Health Pharmacotherapy*, (Victoria: Office of the Provincial Health Officer, 16 September 2020) [September 2020 PHO]; British Columbia Ministry of Health, Office of the Provincial Health Officer, *Stopping the Harm: Decriminalization of People Who Use Drugs in BC*, (Provincial Health Officer's Special Report) by Dr. Bonnie Henry (Victoria: Office of the Provincial Health Officer, 2019) at 3 [PHO Report].

4 See PHO Report, *supra* note 3 at 3.

5 See Special Advisory Committee on the Epidemic of Opioid Overdoses, "Opioid- and Stimulant-related Harms in Canada" (last modified 22 March 2022), online: *Government of Canada* < health-infobase.canada.ca/substance-related-harms/opioids-stimulants> [Health Canada Infobase] (1,828 apparent opioid toxicity deaths occurred between January and March 2021 (approximately 20 deaths per day), representing a 65% increase compared to January to March 2020 (1,087 deaths)). The British Columbia reports that "In February 2022, there were 174 suspected illicit drug toxicity deaths. This is the second highest number of deaths ever recorded in the month of February"; "The number of illicit drug toxicity deaths in February 2022 equates to about 6.2 deaths per day": British Columbia Ministry of Public Safety & Solicitor General, *Illicit Drug Toxicity Deaths in BC January 1, 2012–February 28, 2022* (British Columbia: Coroners Service, 12 April 2022) at 1, online (pdf): <www2.gov.bc.ca/assets/gov/birth-adoption-death-marriage-and-divorce/deaths/coroners-service/statistical/illicit-drug.pdf> [BC Coroner Report 2022].

6 See Woo, "Canada's Overdose Deaths", *supra* note 2; September 2020 PHO, *supra* note 3; Vancouver Police Department, "The Opioid Crisis: The Need for Treatment on Demand, Review and Recommendations" (May 2017), online (pdf): <vpd.ca/wp-content/uploads/2021/06/opioid-crisis.pdf> [VPD Opioid Crisis Report].

accelerant, by raising concerns that such criminalization leads to solitary and dangerous consumption patterns or impedes access to life-saving supports.[7]

BC and other provinces are presently attempting to address the crisis in two ways: (1) by continuing to provide a safe supply of narcotics, and (2) by lobbying for decriminalization of simple possession so as to encourage vulnerable persons to work with, rather than avoid, authorities.[8] Some doctors are skeptical of the merits of safe supply, but there is ample evidence demonstrating that it has been effective in saving lives.[9] A change in government at the provincial or federal level could jeopardise the program.[10] The Trudeau government has rejected calls to decriminalize simple possession, opting instead to table Bill C-22 in February 2021.[11] The bill codifies a policy that encourages police to consider diversion in cases where possession appears to relate to addiction rather than trafficking.[12] But some suggest that

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7 See City of Vancouver, "Preliminary Submission to Health Canada: Exemption Request" (1 March 2021) at 5–6, online (pdf): <vancouver.ca/files/cov/cdsa-preliminary-exemption-request.pdf> ["Preliminary Submission"]; PHO Report, *supra* note 3; PIVOT Legal Society, Canadian HIV/AIDS Legal Network and Canadian Drug Policy Coalition, "Drug Decriminalization: A Necessary Response to Covid-19" (14 May 2020), online (blog): <pivot legal.org/drug_decriminalization_response_covid-19#_ednref23> [PIVOT letter]; VPD Opioid Crisis Report, *supra* note 6; Special Purpose Committee on the Decriminalization of Illicit Drugs, "Decriminalization for Simple Possession of Illicit Drugs: Exploring Impacts on Public Safety and Policing" (July 2020), online (pdf): *Canadian Association of Chiefs of Police* <cacp.ca/index.html?asst_id=2189 > [Report of the Canadian Association of Chiefs of Police].

8 See September 2020 PHO, *supra* note 3; PHO Report, *supra* note 3 at 22–24.

9 See Woo, "Canada's Overdose Deaths", *supra* note 2.

10 The legal mechanisms for the exemption and supply program are discussed in Part 1 below.

11 See Bill C-22, *An Act to Amend the Criminal Code and the Controlled Drugs and Substances Act*, 2nd Session, 43rd Parl, 2021 (first reading 18 February 2021) [Bill C-22].

12 See *ibid* at s 10.2(1):

> A peace officer shall, instead of laying an information against an individual alleged to have committed an offence under subsection 4(1), consider whether it would be

police discretion is not enough. Addicted persons will still fear police involvement, which will contribute to dangerous consumption patterns.[13] At the time of writing, the City of Vancouver and the Province of British Columbia have formally applied to the federal Health Minister to exempt Vancouver and/or all of BC from the application of the offence of simple possession in the *Controlled Drugs and Substances Act* ("*CDSA*").[14]

We undertake in this paper to assess the constitutional validity of a decision to suspend the safe supply program and to refuse to issue a limited exemption from the offence of simple possession, as well as the validity of a new government's decision to suspend either exemption while the opioid crisis continues. Does Canada's *Charter of Rights and Freedoms* ("*Charter*") guarantee a right to safe supply if a province is willing to provide it?[15] Does evidence about the impact of criminalization on consumption patterns, in areas most affected by the opioid crisis, give rise to a *Charter* right to an exemption from prohibition in those areas? Is *Charter* litigation an appropriate tool for policy making in this context?

The Supreme Court's decision in *Canada (Attorney General) v PHS Community Services Society*, involving *Charter* rights in the context of safe injection sites, has direct implications for the future of the safe supply program and for decriminalization.[16] We

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preferable, having regard to the principles set out in section 10.1, to take no further action, to warn the individual or, with the consent of the individual, to refer the individual to a program or to an agency or other service provider in the community that may assist the individual.

13 See Richard Elliot, "Bill C-22 Introduces Welcome Drug Policy Amendments But Falls Short, Advocates Say" (18 February 2021), online: *HIV Legal Network* <hivlegalnetwork.ca/site/statement-bill-c-22-introduces-welcome-drug-policy-amendments-but-falls-short-advocates-say/>; Bridgette Watson, "B.C. mayors say Ottawa's plan to relax drug possession penalties not enough to help opioid crisis", CBC News (22 February 2021), online: <cbc.ca/news/canada/british-columbia/c22-bc-reaction-1.5923084>.

14 See *Controlled Drugs and Substances Act*, SC 1996, c 19 [*CDSA*]. Details of the exemption applications are canvassed in Part 1 below.

15 See *Canadian Charter of Rights and Freedoms, 1982*, being Schedule B to the *Canada Act 1982 (*UK), 1982, c 11 [*Charter*].

16 See Insite, *supra* note 1.

argue that a case can be made for the continued right to a safe supply of controlled substances that is analogous to the arguments set out in Insite for safe injection. We contend that a ministerial decision to deny a continued exemption for safe supply would be arbitrary and grossly disproportionate in its effects in light of the evidence showing that it saves lives, does not result in a rise in crime rates, and that suspending it would cause more fatalities. With respect to decriminalization, the Court in Insite refused to find the offence of simple possession as it applied to *anyone* (not just clients of Insite) contrary to section 7, due to a lack of evidence at trial that it hindered access to health care. We suggest that the current crisis presents a new and substantially different evidentiary basis for making this case with respect to users in affected regions.

The continuation of the safe supply program or an exemption from prohibition for Vancouver or BC—should it be granted in the near term—would not render the assessment in this paper moot. By examining the validity of both potential *Charter* challenges in some detail, we hope to provide law scholars and policy makers alike a better sense of the legal boundaries of the viable policy options. Safe supply and exemption from prohibition may or may not be good policy, but if a clear case can be made that denying either would be unlawful, the debate proceeds on a different footing.

We begin by providing a brief overview of the empirical facts relevant to the possible *Charter* challenges we examine, with a focus on BC. In Part 2, we summarize the trial and Supreme Court of Canada ("SCC") holdings in the Insite case, highlighting findings of fact and aspects of the Court's ruling on section 7 relevant in the present context. In Part 3, we set out arguments for a *Charter* right to a continued exemption under the *CDSA* to facilitate safe supply and a right to a geographically limited exemption from simple possession. We conclude by considering the merits of using the *Charter* as a tool for policy making in this context.

I. CONTEXT

The potential *Charter* challenges we explore in this paper should be grounded upon a larger factual and evidentiary matrix. These facts include the nature and severity of the opioid crisis in BC and other parts of Canada, the operation and effects of the safe supply program, and the role that the criminalization of simple possession plays in exacerbating the opioid crisis. We canvas each of these points briefly to lend context to what follows.

Overdose deaths from illicit drug use in BC and other parts of Canada have long been a concern, but in the past decade, the scale of the problem has vastly increased. From 2005 to 2009, 815 people died in Canada from drug overdoses.[17] An extensive report published in 2019 by BC's Provincial Health Officer, Dr. Bonnie Henry, notes that deaths due to drug overdoses have risen in BC since 2012 and "accelerated exponentially since 2015."[18] Dr. Henry describes a "significant increase both in number and in geographic spread of overdose deaths that has continued to impact every corner of the province."[19] In April 2016, BC declared a public health emergency under the *Public Health Act*, enabling the Provincial Health Officer to marshal additional resources.[20] Despite various efforts, by 2019 over 3700 people had died in the province from illicit drug overdose, as many as 4 deaths per day.[21] The deceased included persons of various socio-economic backgrounds, including a disproportionate number of men between ages 30 to 59 and Indigenous persons.[22] The "vast

17 See VPD Opioid Crisis Report, *supra* note 6 at 7.

18 PHO Report, *supra* note 3 at 6.

19 *Ibid*.

20 See *Public Health Act*, SBC 2008, c 28, s 52; PHO Report, *supra* note 3 at 6.

21 See PHO Report, *supra* note 3 at 7. See also VPD Opioid Crisis Report, *supra* note 6 at 12 (noting the opening during this period of five overdose prevention sites in Vancouver and the use of Vancouver Coastal Health's mobile medical unit in the Downtown Eastside).

22 See PHO Report, *supra* note 3 at 7.

majority" of overdose deaths involved people "using drugs alone and indoors."[23]

COVID-19 has exacerbated the opioid crisis in BC. In 2020, the number of emergency medical service responses to suspected overdoses leapt from 2,927 between January and March to 4,356 between April and June.[24] Some 1,767 people died of overdose in 2020, and 2,232 in 2021.[25] The number of people dying per day has risen from 4.8 in 2020 to 6.2 in 2021.[26] COVID-19 has complicated or diminished access to health services by causing harm reduction sites to close or provide fewer services, placing drug users at increased risk of contracting HIV or Hepatitis C, overdosing, contracting infection, or experiencing other harms.[27] The pandemic has also exacerbated a tendency among most illicit drug users to consume in solitude, making life-saving intervention less likely.[28]

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[23] *Ibid*. The BC Coroners Service reports that "[i]n 2021, 83% of illicit drug toxicity deaths occurred inside (55% in private residences and 28% in other residences including social and supportive housing, SROs, shelters, and hotels and other indoor locations) and 15% occurred outside in vehicles, sidewalks, streets, parks, etc.": BC Coroner Report 2021, *supra* note 5 at 2.

[24] See Substance-related Overdose and Mortality Surveillance Task Group of the Special Advisory Committee on the Epidemic of Opioid Overdoses, "Suspected Opioid-related Overdoses Based on Emergency Medical Services" (December 2020) at 14, online (pdf*): Government of Canada* <health-info base.canada.ca/src/doc/SRHD/UpdateEMSDec2021.pdf>.

[25] See BC Coroner Report 2022, *supra* note 5 at 4.

[26] *Ibid* at 1, noting 6.2 deaths per day in 2021; we arrive at the figure for 2020 by dividing the total number of deaths in 2020 (noted on p 2) by 365 days.

[27] See PIVOT Letter, *supra* note 7; September 2020 PHO *supra* note 3, s 3:

> 3. The number of deaths due to overdose in British Columbia has worsened with the onset of COVID-19 due to a combination of factors including: . . . .
>
> (b) decreased access to harm reduction services, supervised consumption services and overdose prevention services;
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> (c) barriers in accessing treatment and social services by people who use drugs and who require these services to consume drugs safely
>
> (d) health risks due to withdrawal for persons who must self-isolate or quarantine to prevent the spread of COVID-19.

[28] A report of the BC Coroner in 2018 surveyed data from illicit overdose deaths in BC from 2016 to 2017 involving 872 cases (comprising an

The numbers nationally show a similar surge in overdose deaths in recent years, under similar conditions.[29] The federal government's Public Health Infobase reports "24,626 apparent opioid toxicity deaths" from January 2016 to March 2021, with 90% in between January and June 2021 occurring in BC, Alberta, and Ontario.[30] While 90% of deaths in the first half of 2021 "involved a non-pharmaceutical opioid," 87% of deaths involved fentanyl.[31] A 2019 study by the Public Health Agency of Canada found that "[c]haracteristics more frequently observed among those who died: included. . . . being alone at the time of overdose".[32]

The chief cause of the opioid crisis is the increasing amount and toxicity of fentanyl in the street supply of opioids. Fentanyl is a synthetic opioid analogous to morphine in its neurochemical

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estimated 35% of total suspected overdose deaths), and among these, the survey found that "[t]he majority of people had used their drugs alone (69%, or 603/872). This was true across all health authorities, health service delivery areas, and age groups. Note that these individuals may have resided with others, but were unaccompanied at the time of consumption.": British Columbia Ministry of Public Safety and Solicitor General, "Illicit Drug Overdose Deaths in BC: Findings of Coroners' Investigations" (27 September 2018) at 4–5, online (pdf): <www2.gov.bc.ca/assets/gov/birth-adoption-death-marriage-and-divorce/deaths/coroners-service/statistical/illicitdrugoverdosedeathsinbc-findingsofcoronersinvestigations-final.pdf > [BC Coroner Report 2018]. See also Kristi Papamihali et al, "Convenience and Comfort: Reasons Reported for Using Drugs Alone Among Clients of Harm Reduction Sites in British Columbia, Canada" (2020) 17:1 Harm Reduction J 90; Benjamin Perrin, *Overdose: Heartbreak and Hope in Canada's Opioid Crisis* (Canada: Viking, 2020) at 33–49, 160–178 (on factors contributing to solitary consumption).

29 See Health Canada Infobase, *supra* note 5. See also Special Advisory Committee on the Epidemic of Opioid Overdoses, "Highlights from phase one of the national study on opioid- and other drug-related overdose deaths: Insights from coroners and medical examiners" (last modified 23 November 2021), online: <canada.ca/en/public-health/services/publications/healthy-living/highlights-phase-one-national-study-opioid-illegal-substance-related-overdose-deaths.html> [Highlights].

30 Health Canada Infobase, *supra* note 5.

31 *Ibid*.

32 Highlights, *supra* note 29.

effects, but roughly 50 to 100 times more powerful.[33] Initially prescribed in clinical settings to relieve pain, it came to be produced in underground labs and introduced into the street supply by being laced with various other drugs to render them more powerful in smaller doses and more profitable.[34] As Dr. Henry's report indicates, in 2012 fentanyl was found in only 5% of illicit drug overdose deaths, whereas by 2018, it was found in 85% of cases.[35] Buyers tend to be unaware of the fentanyl content in the heroin, cocaine, or methamphetamine they purchase on the street, and even a two milligram dose of fentanyl is considered lethal.[36] The lack of quality control, the amount of fentanyl in general circulation, and the ease of inadvertent consumption of lethal amounts have all contributed to a death rate that continues to grow.

In 2019, the federal government began funding various safe supply pilot projects, often involving the use of hydromorphone, a legal alternative to fentanyl.[37] Safe supply programs are lawful through the federal Minister of Health's passage of an exemption under subsection 56(1) of the *CDSA*, which permits the Minister to issue an exemption from the operation of any provision of the Act "if, in the opinion of the Minister, the exemption is necessary for a medical or scientific purpose or is otherwise in the public

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33 See VPD Opioid Crisis Report, *supra* note 6 at 7. See also Canadian Public Health Association, "The Opioid Crisis in Canada" (December 2016), online (pdf): <cpha.ca/sites/default/files/uploads/policy/positionstatements/opioid-positionstatement-e.pdf>; and Srinivasan Govindaraj, "Fentanyl's Path of Death and Destruction" (3 August 2016), online (blog): *Canadian Public Health Association* <cpha.ca/fentanyls-path-death-and-destruction>.

34 See VPD Opioid Crisis Report, *supra* note 6 at 7. See also Perrin, *supra* note 28 at 24–32 (on conditions that contributed to fentanyl becoming pervasive in Vancouver).

35 See PHO Report, *supra* note 3 at 7.

36 See VPD Opioid Crisis Report, *supra* note 6 at 8.

37 Magnus Nowell, "Safe Supply: What is it and What is Happening in Canada?" (9 February 2021), online: *Canadian AIDS Treatment Information Exchange* <catie.ca/prevention-in-focus/safe-supply-what-is-it-and-what-is-happening-in-canada>.

interest."[38] BC has issued guidelines to pharmacists and care teams for the direct supply of medication to patients and for conducting clinical assessments remotely.[39] In September 2020, BC's Provincial Health Officer expanded the province's safe supply program to authorize nurses to carry out diagnostic tests for substance use disorders and to prescribe controlled substances.[40]

Demand for the program has been strong. When it launched in March 2020, 677 people began receiving hydromorphone—a pain-relief drug—a number which rose to 3348 by December 2020.[41] The province seeks to expand the scope of the program to include other substances, such as fentanyl and cocaine.[42] However, the program cannot meet demand nor service all affected regions of the province equitably.[43] A similar disparity

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38 See *CDSA*, *supra* note 14 (the prohibition on possession of a controlled substance appears in section 4(1) of the *Act* and the offence of trafficking in section 5(1); the latter was repealed in 2018). The current exemption order for safe supply is outlined in Health Canada and also exempts health practitioners from sections 31(1) and 37 of the *Narcotic Control Regulations*, CRC, c 1041, (2019) to enable them to sell narcotics and renew or extend a prescription: See Health Canada, "Subsection 56(1) class exemption for patients, practitioners and pharmacists prescribing and providing controlled substances in Canada" (last modified 15 November 2021), online: *Government of Canada* <canada.ca/en/health-canada/services/health-concerns/controlled-substances-precursor-chemicals/policy-regulations/policy-documents/section-56-1-class-exemption-patients-pharmacists-practitioners-controlled-substances-covid-19-pandemic.html> [Class Exemption].

39 See "New clinical guidance to reduce risk for people during dual health emergencies", *BC Government News* (26 March 2020), online: <news.gov.bc.ca/releases/2020MMHA0008-000572>.

40 See September 2020 PHO, *supra* note 3.

41 See Woo, "Canada's Overdose Deaths", *supra* note 2.

42 *Ibid*.

43 See Nick Wells, "Advocates call for national safe supply over fears overdose crisis will worsen in 2021", *National Observer* (17 December 2020), online: <nationalobserver.com/2020/12/17/news/advocates-national-safe-supply-overdose-crisis-Hadju-Ottawa-BC-Vancouver> (citing comments of Karen Ward, a "drug policy and poverty reduction consultant" with the City of Vancouver). See also Nowell, *supra* note 37 (noting the "limited clinical capacity" of safe supply programs generally).

exists nationally, due in part to politics. While the federal government has financially supported safe supply programs in BC, Ontario, Quebec, and New Brunswick—where governments were receptive—Alberta's government is reported to have "quietly shut down community-based efforts" to create a safe supply program.[44]

Researchers have begun to examine the effects of the safe supply program. While their findings are preliminary, early studies suggest promising trends. A study published in early 2021 involved 42 participants in BC's hydromorphone distribution program. The authors identified the following positive outcomes associated with program enrolment: "(1) reduced street drug use and overdose risk, (2) improvements to health and well-being, (3) improvements in co-management of pain, and (4) economic improvements."[45] An earlier study tracked a series of interventions from 2016 to 2017, including the distribution of take-home naloxone kits—a medication that can rapidly reverse the effects of an overdose—and supervised drug consumption sites.[46] It found that, in combination, the measures effectively averted an estimated 3,030 overdose deaths, but noted that "the absolute numbers of overdose deaths [had] not changed" in that period.[47] Some argue that safe supply programs have failed to curb fatality rates thus far because they have not been aggressive enough. For example, in light of the "persistent gaps in services and the limitations of available

44 Woo, "Canada's Overdose Deaths", *supra* note 2.

45 Andrew Ivsins et al, "'It's Helped Me a Lot, Just Like to Stay Alive': A Qualitative Analysis of Outcomes of a Novel Hydromorphone Tablet Distribution Program in Vancouver, Canada" (2020) 98:1 J Urban Health 59 at 59 [Ivsins et al, "It's Helped Me a Lot"]. See also Matthew Bonn et al, "COVID-19, Substance Use, and Safer Supply: Clinical Guidance to Reduce Risk of Infection and Overdose" (webinar, British Columbia Centre on Substance Use, Vancouver, BC, 4 September 2020) (made similar findings to Ivsins et al).

46 See Michael A Irvine et al, "Modelling the combined impact of interventions in averting deaths during a synthetic-opioid overdose epidemic" (2019) 114:9 Addiction 1602 at 1602–13.

47 *Ibid* at 1602.

options," a 2020 study published calls for an "immediate scale-up of low-barrier opioid distribution programs".[48]

Despite the generally persuasive evidence of the positive effects of safe supply programs, doctors have voiced concerns. Opioid tolerance levels among patients are rising in some places, requiring ever higher doses, and making substitution therapy less viable.[49] Despite evidence that assisting patients with injecting limited doses in controlled settings can be an effective risk avoidance measure, prescribing significant doses of opioids for free consumption raises other risks. Some patients sell the drugs they obtain from safe supply programs to purchase stronger street drugs.[50] But in light of the severity of the opioid crisis and the need for immediate intervention, some doctors believe the potential benefits of safe supply programs outweigh the risks.[51] Safe supply programs should be recognized for serving as a "bridging point" that brings patients into contact with other forms of much-needed care. Often what begins with a prescription for safe supply "ends with a whole myriad of other interventions that are patient-centred".[52]

BC's safe supply program is intended to continue until the emergency has passed. The Provincial Health Officer defines this as the point when an "increase in people overdosing and dying" from "highly toxic" substance use has ended.[53] However, the BC

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48 Andrew Ivsins et al, "Tackling the overdose crisis: The role of safe supply" (2020) 80 Intl J Drug Policy 1 at 1. See also Nowell, *supra* note 37 (arguing that "scaling up safe supply options and programs could significantly help to address the overdose crisis").

49 See Woo, "Canada's Overdose Deaths", *supra* note 2:

> Andrea Sereda, lead physician of the Safer Supply program at the London InterCommunity Health Centre in Ontario, says new patients coming onto her program in 2019 typically used between one-tenth and half a gram of fentanyl a day. Since early 2020, she says new intakes regularly use around 3.5 grams a day or more. . . . "[w]hen people get to a certain tolerance, it's harder to catch them with any substitution therapy – safer supply or otherwise".

50 See Woo, "Canada's Overdose Deaths", *supra* note 2 (citing Dr. Lam of the Toronto's Coderix Medical Clinic).

51 See *ibid*.

52 *Ibid* (citing Corey Ranger, clinical nurse lead at the Victoria SAFER Initiative).

53 September 2020 PHO, *supra* note 3 at 3.

program depends on a federal exemption to the operation of the *CDSA*, which is set to expire in September of 2026, with the possibility of it being renewed then or revoked at any time prior.[54]

The safe supply program is meant to address one facet of the opioid crisis. Another important facet is the effect of the criminalization of simple possession of illicit substances.[55] A number of stakeholders point to evidence suggesting that users' concerns about criminalization have contributed to the rise in overdose deaths by fostering dangerous consumption patterns and discouraging access to potentially life-saving supports.

Dr. Henry's 2019 report addresses this issue in some detail. As she notes, "[p]rohibition-based drug policies have not only failed to reduce supply or demand for illegal drugs, they have impeded public health initiatives to reduce harms related to substance use".[56] Some people in possession of illegal drugs "will not seek out supervised consumption, overdose prevention, or treatment services for fear of being arrested; instead, they will use drugs alone, increasing their risk of dying from a potential overdose".[57] In BC, this has occurred with "alarming frequency."[58] Concerns about criminalization take many forms. People on bail or probation with conditions that prohibit possession of drug paraphernalia, such as sterile needles, either "hide their use, use

54 See Class Exemption, *supra* note 38.

55 See e.g. CDSA, *supra* note 14 at s 4(1) (criminalizing possession of controlled substances).

56 PHO Report, *supra* note 3 at 19.

57 *Ibid*. See also PIVOT letter, *supra* note 7:

> [I]t is well established that continued police enforcement of simple drug possession laws and the attendant fear of arrest pushes people who use drugs to do so in isolation and compromises their ability to take critical safety precautions. This includes by deterring access to harm reduction services, to which people who use drugs cannot legally travel while in possession of the substances they wish to use there. Heightened law enforcement surveillance in the context of the pandemic further hampers their access to vital health services and ability to use drugs safely, while also increasing their risk of arrest and detention.

58 PHO Report, *supra* note 3 at 19.

unsafely, or face re-arrest for possessing harm reduction supplies."[59] Or, as Dr. Henry explains:

> [i]n situations where people living with opioid use disorder are exposed to situations where they cannot avoid withdrawal symptoms (e.g., in police holding cells, or court cells), or where they are unable to access their life-saving medication, tolerance is lost, leading to an increased risk of overdose and death when they seek out and use opioids at the same dose they would have typically taken.[60]

Dr. Henry draws further support from earlier studies, including a 2006 study conducted in Vancouver's Downtown Eastside, which found that

> an intensified police presence compromised safer injection practices, including people who inject drugs being more reluctant to carry sterile syringes due to police confiscating syringes; rushing to inject drugs (a behaviour that can increase the risk for overdose); using drugs in riskier situations and places; and discarding used syringes.[61]

Other sources support Dr. Henry's findings, including a 2020 study that sampled 414 users in 22 communities across BC, and found that 75.8% of participants reported using drugs alone within a week of being surveyed.[62] The most common reason given for using alone—provided by 44.3% respondents—was "convenience and comfort," while 14% of users identified with "not wanting others to know about drug use or facing stigma around drug use."[63] A 2012 study of the reasons users chose to use safe injection sites in BC found that "[h]aving drugs confiscated by the police also was an important form of everyday

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59 *Ibid*.

60 *Ibid*.

61 *Ibid* (citing Will Small et al, "Impacts of intensified police activity on injection drug users: Evidence from an ethnographic investigation" (2006) 17:2 Intl J Drug Policy 85).

62 See Papamihali et al, *supra* note 28 at 1. See also Perrin, *supra* note 28 (at Chapter 13, which discusses the nexus between a fear of stigmatization and solitary use).

63 Papamihali et al, *supra* note 28 at 7.

risk attributed to public injection settings in local alleys, in part because losing drugs may precipitate withdrawal symptoms in the near future".[64] A 2017 Vancouver Police Department report indicated that the force had recognized, as far back as 2006, that the "police response to overdose calls [serves] . . . as a barrier for people seeking help" since "people feared that asking for help would lead to police enforcement."[65] As a consequence, police officers have not attended to overdose calls unless they result in a fatality or occur in "suspicious" circumstances.[66] These findings about the role that users' fear of the police plays in driving solitary consumption are supported by other literature on the impact of decriminalization in countries where this has been tested.[67]

With the passage in 2017 of the *Good Samaritan Drug Overdose Act*,[68] Parliament conceded that a fear of police involvement on the part of addicted persons may impede access to life-saving measures. The *Act* amends the offence of possession in the *CDSA* to provide that in the case of an overdose, no person—including the person overdosing—who "seeks emergency medical or law enforcement assistance" can be charged with or convicted of possession of an illicit substance.[69] Nor can they be charged with or convicted of offences related to violations of bail or probation conditions prohibiting possession

64 Will Small et al, "Perceptions of Risk and Safety within Injection Settings: Injection Drug Users' Reasons for Attending a Supervised Injecting Facility in Vancouver, Canada" (2012) 14:4 Health Risk & Soc 307 at 315.

65 VPD Opioid Crisis Report, *supra* note 6 at 14.

66 PHO Report, *supra* note 3 at 7.

67 See Global Commission on Drug Policy, "Advancing Drug Policy Reform: A New Approach to Decriminalization" (2016), online (pdf): *Global Initiative Against Transnational Organized Crime* <https://globalinitiative.net/wp-content/uploads/2017/12/GCDP-Report-2016-ENGLISH.pdf> ["Advancing Drug Policy Reform"] (discussing decriminalization in Portugal, the Czech Republic, and the Netherlands, and finding that "an environment where drug use is not criminalized can reduce the stigma and fear of prosecution, leading to people feeling more able and comfortable to call on services for support should they require it" at 20).

68 SC 2017, c 4.

69 *CDSA*, *supra* note 14, s 4.1(2).

of such substances.[70] Despite this important measure, advocates of decriminalization canvassed above continue to point to evidence that drug users' fear of police involvement contributes to consumption in dangerous conditions.

The Provincial Health Officer of BC, the Canadian Association of Chiefs of Police, and other stakeholders, hold out Portugal's experience with opioid decriminalization as an example of a better approach.[71] In 2001, Portugal made simple possession of opioids a regulatory offence, rather than a criminal one, with warnings or fines and other non-custodial penalties. In combination with other harm prevention measures, Portugal's decriminalization policy has led to fewer overdose deaths but no rise in drug use.[72] A wider study of decriminalization in some 25 jurisdictions worldwide supports a similar range of benefits, including "reduced rates of HIV transmission and fewer drug-related deaths, improved education, housing, and employment opportunities for people who use drugs, and significant savings, with a negligible effect on levels of drug use."[73] Drawing upon the substantial evidence that decriminalization policies are

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70 See *ibid*, s 4.1(4).

71 See PHO Report, *supra* note 3 at 5; Report of the Canadian Association of Chiefs of Police, *supra* note 7 at 2, 13; PIVOT letter, *supra* note 7 at 3. See also Rebecca Jessman & Doris Payer, "Decriminalization: Options and Evidence" (2018), online (pdf): *Canadian Centre on Substance Use and Addiction* <www.ccsa.ca/sites/default/files/2019-04/CCSA-Decriminalization-Controlled-Substances-Policy-Brief-2018-en.pdf>. Despite criminal law falling under federal jurisdiction in Canada, BC's Provincial Health Officer has recommended that the province take measures consistent with decriminalization. Specifically, the report notes that the Minister of Public Safety should set priorities under the provincial *Police Act* to "guide law enforcement" by providing "pathways for police to link people to health and social services" and by "the use of administrative penalties rather than criminal charges for simple possession." A second step noted would be to mandate, pursuant to the provincial *Police Act*, that no police force may "[expend] resources on the enforcement of simple possession offences under Section 4(1) of the CDSA": PHO Report, *supra* note 3 at 5.

72 See PHO Report, *supra* note 3 at 5.

73 PIVOT letter, *supra* note 7 at 3 (summarizing the findings of a report of the UK advocacy group Release). See also Advancing Drug Policy Reform, *supra* note 67 at 20.

successful, a consensus has emerged across Canada's health regulation community in support of the measure, including support from Canada's Chief Provincial Health Officer, Dr. Teresa Tam.[74]

In his 2019 election campaign, Prime Minister Justin Trudeau committed to no further decriminalization of illicit substances, after possession of small amounts of cannabis was legalized in 2018.[75] Trudeau appears to have made the commitment in response to speculation by Conservative Party candidates that he would likely decriminalize more drugs in his second term.[76] Trudeau has kept his promise not to do so. In July 2020, BC Premier John Horgan wrote a letter imploring Trudeau to make "necessary changes" to subsection 4(1) of the *CDSA* to "decriminalize possession of illegal drugs for personal use".[77] He suggested that by doing so, the federal government would "support people to access the services that they need to stay safe".[78] The City of Vancouver followed in November 2020,

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74 PIVOT letter, *supra* note 7, at 2–3 (noting the support for decriminalization of simple possession among health stakeholders across Canada, including the Canadian Public Health Association, the Canadian Mental Health Association, the Canadian Nurses Association, the Toronto Board of Health, Toronto's Medical Officer of Health, Montreal Public Health, and Winnipeg Regional Health). Further afield, the United Nation's Special Rapporteur for the right to health has suggested that to "prevent unnecessary intake of prisoners and unsafe drug consumption practices, moratoria should be considered on enforcement of laws criminalising drug use and possession": United Nations Office of the High Commissioner, "Statement by the UN expert on the right to health, on the protection of people who use drugs during the COVID-19 pandemic" (16 April 2020), online: *UNHCR* <ohchr.org/en/NewsEvents/Pages/DisplayNews.aspx?NewsID=25797&LangID=E>.

75 See Mike Hager, "Police chiefs call on Ottawa to decriminalize simple drug possession", *The Globe and Mail* (9 July 2020), online: <theglobeandmail.com/canada/article-police-chiefs-call-on-ottawa-to-decriminalize-simple-drug-possession/>.

76 *Ibid*.

77 Richard Zussman, "B.C. Premier Formally Asks Federal Government to Decriminalize Illegal Drugs", *Global News* (20 July 2020), online: <globalnews.ca/news/7199147/horgan-decriminalize-illegal-drugs/> (citing the text of Horgan's letter).

78 *Ibid*.

resolving to seek an exemption from the federal Minister of Health under section 56 of the *CDSA* from the offence of possession in Vancouver.[79] In February 2021, the BC Minister of Mental Health and Addictions initiated talks with the federal minister to obtain an exemption for all of BC.[80] In March 2021, the City of Vancouver submitted a formal request for a city-wide exemption, but this appeared to be superseded in October 2021 by BC's formal application for a province-wide exemption—which is still under review as of April 2022—permitting adults to possess quantities of fentanyl, heroin, cocaine, and methamphetamine.[81]

Instead of decriminalizing simple possession altogether, in February 2021, the federal government tabled Bill C-22, which would codify a set of guidelines for police and prosecutors to approach simple possession "primarily as a health and social issue".[82] The bill would amend the *CDSA* to direct officers to "consider whether it would be preferable . . . to take no further action, to warn the individual . . . or to refer the individual to a program or to an agency or other service provider in the community that may assist the individual."[83] Similarly, the bill

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79 See Andrea Woo, "Vancouver proposes decriminalizing possession of small amounts of drugs", *The Globe and Mail* (18 November 2020), online: <theglobeandmail.com/canada/article-vancouver-proposes-decriminalizing-possession-of-small-amounts-of/>.

80 See Andrea Woo, "B.C. seeks exemption to decriminalize drug possession", *The Globe and Mail* (11 February 2021), online: <theglobeandmail.com/canada/british-columbia/article-bc-asks-ottawa-to-discuss-decriminalizing-drug-possession-across/>.

81 See "Preliminary Submission", *supra* note 7. Vancouver has since provided Health Canada with a further submission on thresholds. See City of Vancouver, "Submission on Thresholds" (8 April 2021), online (pdf): <vancouver.ca/files/cov/vancouver-proposed-threshold-submission.pdf>. British Columbia's proposal was published by the Ministry of Mental Health and Addictions. See British Columbia Ministry of Health and Addictions, "Decriminalization in BC: S. 56(1) Exemption" (2021), online (pdf): *BC Government News* <news.gov.bc.ca/files/DecrimSubmission.pdf>.

82 Bill C-22, *supra* note 11 (proposing a new s 10.1 of the *CDSA*).

83 *Ibid* (proposing a new s 10.2(1) of the *CDSA*).

would direct prosecutors to consider diverting possession cases launched by police to "alternative measures".[84]

These measures do little more than codify the approach that police and prosecutors in BC—and elsewhere in Canada—currently take in relation to simple possession.[85] The changes in the bill may lead to fewer arrests or prosecutions—whether or not they functioned in tandem with the measures that Dr. Henry has recommended—which would prevent police from expending resources on prosecuting simple possession. However, some suggest that, so long as police and Crown retain only the *discretion* not to initiate or continue with prosecution, the proposed amendments to the *CDSA* are largely symbolic.[86] Vulnerable persons, in this view, would still seek to avoid contact with police in significant numbers, or would remain incentivized to continue consuming illicit substances in solitary and dangerous conditions. As a result, Bill C-22 would be an ineffective response to the role that criminalization plays in fueling the opioid crisis.

II. *CANADA (ATTORNEY GENERAL) V PHS COMMUNITY SERVICES SOCIETY*

Our focus in this paper is on the merits of two possible challenges under section 7 of the *Charter* to a ministerial decision to decline to grant an exemption under the *CDSA*—one pertaining to the safe supply program, and the other to a temporal or geographical exemption from the offence of simple possession. A challenge of either nature would largely draw upon the precedent set by the SCC in the Insite decision, in light of the many parallels between

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84 *Ibid* (proposing a new s 10.3 of the *CDSA*).

85 See Watson, *supra* note 13.

86 See Gary Mason, "In the Face of a Different Pandemic, Ottawa is Again Refusing to Listen to the Science", *The Globe and Mail* (12 February 2021), online: <theglobeandmail.com/opinion/article-in-the-face-of-a-different-pandemic-ottawa-is-again-refusing-to-listen/>; S Monty Ghosh, Sarah Griffiths & Erin Lurie, "Bill C-22 Doesn't Go Far Enough to Decriminalize Drug Possession and Use", *iPolitics* (5 March 2021), online: <ipolitics.ca/2021/03/05/bill-c-22-doesnt-go-far-enough-to-decriminalize-drug-possession-and-use/>.

the facts and issues in that case and concerns arising from the current crisis.[87] For this reason, our discussion in Part 3 will build on the overview we provide here of the relevant factual findings in the Insite case and the Court's reasoning on section 7 of the *Charter*.

A. The Factual Foundation in Insite

The unanimous decision of the Court, delivered by McLachlin CJC, began with a factual summary drawing from the evidence at trial. Insite involved a challenge under section 7 of the *Charter* to the Minister of Health's refusal to renew an exemption under section 56 of the *CDSA*, which permitted a safe injection site to operate in Vancouver's Downtown Eastside ("DTES"). The DTES had, for many years, been home to a high concentration of intravenous drug users, due in part to the cluster of cheap single occupancy hotel rooms, the "deinstitutionalization of the mentally ill", and the availability of drugs on the street.[88] Many, if not most, drug users in the area consumed not for recreational purposes, but as a result of chronic addiction due to a combination of severe poverty and family histories of violence and substance abuse.[89] A 2008 survey, tendered at trial, found:

- users had been injecting hard drugs for an average of 15 years;
- the majority were injecting heroin and a third cocaine;
- a fifth were homeless;
- 80% had been incarcerated;
- 38% were involved in the sex trade; and,
- 59% percent had experienced a prior overdose.[90]

Despite many campaigns to raise awareness about safe injection practices, the evidence indicated that "the need for an immediate

87 See Insite, *supra* note 1.

88 *Ibid* at paras 4–7.

89 See *ibid* at para 7–9.

90 See *ibid* at para 9.

fix or the fear of police discovering and confiscating drugs can override even ingrained safety habits."[91] Common practices emerged: "addicts share needles, inject hurriedly in alleyways and dissolve heroin in dirty puddle water before injecting it into their veins."[92] Sharing needles caused a high rate of HIV and Hepatitis C transmission.[93] Hasty injection often caused overdose as a result of users' failure to properly measure doses. All these dangers were "exacerbated by the fact that injection drug users are a historically marginalized population that has been difficult to bring within the reach of health care providers."[94] Between 1987 and 1997, overdose deaths and the spread of HIV and Hepatitis increased exponentially, causing the province to declare a public health emergency in the DTES in 1997.[95]

As a result, health officials began formulating plans for a safe injection site, given the success of similar sites in Europe and Australia.[96] In 2003, the Vancouver Coastal Health Authority sought an exemption from Health Canada under section 56 of the *CDSA* to open a site, and Health Canada granted it in September of that year.[97] As McLachlin CJC noted, North America's first safe injection site

> was launched as an experiment. The experiment has proven successful. Insite has saved lives and improved health. And it did those things without increasing the incidence of drug use and crime in the surrounding area. The Vancouver police support Insite. The city and provincial government want it to stay open. But continuing the Insite project will be impossible without a federal government exemption from the laws criminalizing possession of prohibited substances at Insite.[98]

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91 *Ibid* at para 10.

92 *Ibid*.

93 See *ibid*.

94 *Ibid*.

95 See *ibid* at para 11.

96 See *ibid* at para 15.

97 See *ibid* at para 16.

98 *Ibid* at para 19.

The initial exemption that made Insite possible expired in 2008. In response to the Minister's reluctance to renew the exemption, the claimants filed the challenge.[99]

The applicants were two individual clients of Insite, PHS Community Services Society—the entity overseeing the site itself—and an advocacy group called the Vancouver Area Network of Drug Users ("VANDU").[100] The challenge was brought on both federalism and *Charter* grounds.[101] At trial, the applicants argued that the prohibition on simple possession under the *CDSA*, as it applied to clients *at the site itself*, was contrary to section 7—or in the alternative, the Court should declare the Minister's refusal to renew the exemption to be a violation of section 7.[102] Justice Pitfield made a series of more specific factual findings, which McLachlin CJC quoted at length.[103] They include the findings that (1) "[a]ddiction is an illness" giving rise to a "continuing need or craving to consume the substance to which the addition relates"; (2) the heroin or cocaine that users inject does not cause Hepatitis or HIV, but rather, using and sharing "unsanitary" equipment and methods between individuals does so; and (3) the "risk of morbidity and mortality associated with addiction and injection is ameliorated by injection in the presence of qualified health professionals."[104] Justice Pitfield also found that Insite led to a "reduction in the number of people injecting in public"; that "there was no evidence of increases in drug-related loitering, drug dealing or petty crime in the area around Insite"; "police data showed no changes in rates of crime recorded in the DTES"; and, "there was

99 See *ibid* at para 20.

100 See *ibid* at para 21.

101 We omit entirely the federalism aspect of the challenge, given the focus of this paper.

102 See Insite, *supra* note 1 at para 24. At the SCC, VANDU sought a declaration that the offence of simple possession violates section 7 altogether: Insite, *supra* note 1 at para 25.

103 See *ibid* at para 27.

104 *Ibid* at para 27 (citing *PHS Community Services Society v Canada (Attorney General)*, 2008 BCSC 661 at para 87 [*PHS 2008*]).

no evidence that Insite increased the relapse rate among injection drug users".[105]

Justice Pitfield held that the offences of possession and trafficking under the *CDSA* as they applied to users *at Insite itself* violated section 7, because they "arbitrarily prohibited the management of addiction and its associated risks."[106] The arbitrariness was not, in Pitfield J's view, avoided by the availability of an exemption under section 56, because the discretion to grant one was unfettered.[107] The violation was not saved under section 1.[108] Justices Rowles and Huddart, for the British Columbia Court of Appeal, upheld the trial judge's *Charter* rulings, finding that the application of simple possession and trafficking offences to Insite clients was grossly disproportionate because it impeded health care with no benefit to either drug users or society.[109]

B. The Supreme Court of Canada's Holdings on Section 7

At the SCC, the claimants advanced three arguments under section 7. The individual claimants, alongside PHS, argued that the prohibitions on possession and trafficking under subsections 4(1) and 5(1) of the *CDSA* violated section 7 as they applied at Insite. Alternatively, the Minister's decision to refuse to extend the exemption under section 56 of the Act violated section 7. VANDU argued that the prohibition on simple possession violated section 7 for "all addicted drug users everywhere, not just at Insite."[110]

Chief Justice McLachlin held that the possession offence, as it applied to Insite, engaged the liberty interests of staff who had knowledge and control over the presence of illicit substances on the premises, and were thus subject to a jail sentence without the

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105 *PHS 2008*, *supra* note 104 at paras 87–89.

106 *Ibid* at para 152.

107 See *ibid* at para 155.

108 See *ibid* at para 157.

109 See *PHS Community Services Society v Canada (Attorney General)*, 2010 BCCA 15 at paras 75–76.

110 Insite, *supra* note 1 at para 77.

exemption.[111] Without provision of the service by staff, clients of the site would be deprived of "potentially lifesaving medical care, . . . [which engaged] their rights to life and security of the person."[112] The prohibition on possession also engaged client interests directly. Prohibiting drugs at Insite would hinder access to "lifesaving and health-protecting services", and more broadly, prohibiting possession "by drug users anywhere engage[d] their liberty interests."[113] All of these holdings were supported by the trial judge's findings that many of the health risks at issue were caused by unsafe injection practices and were "ameliorated" by access to Insite's services.[114] As McLachlin CJC noted, "[w]here a law creates a risk to health by preventing access to health care, a deprivation of the right to security of the person is made out. Where the law creates a risk not just to the health but also to the lives of the claimants, the deprivation is even clearer."[115]

Canada had argued that any health risks claimants would suffer if Insite were not available were not caused by the *CDSA* prohibition but were instead the result of users' choice to consume illicit substances. The Chief Justice rejected this argument, pointing first to the trial judge's finding that "addiction is an illness, characterized by a loss of control over the need to consume the substance to which the addiction relates".[116] McLachlin CJC also surmised that another dimension of Canada's argument about choice was that the decision to permit a safe injection site "is a policy question, and thus immune from *Charter* review."[117] But policy considerations belong to the section 1 stage of the analysis, not to the question of whether "a law or state action limits a *Charter* right."[118]

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111 See *ibid* at para 89–90.

112 *Ibid* at para 91.

113 *Ibid* at para 92. By contrast, the trafficking offence did not engage the section 7 interests of the claimants since neither clients nor staff are engaged in what amounts to trafficking: *ibid* at paras 95–96.

114 *Ibid* at para 93 (citing *PHS* 2008, *supra* note 104 at para 87).

115 *Ibid* [citations omitted].

116 *Ibid* at para 99 (citing *PHS* 2008, *supra* note 104 at para 87).

117 *Ibid* at para 103.

118 *Ibid* at para 104.

The claimants had argued the deprivations of liberty and security of the person caused by the prohibition on possession were arbitrary, disproportionate, and overbroad. The *CDSA*'s objectives were undermined by prohibiting possession at Insite. Further, applying the prohibition at Insite would cause significant harm with no "commensurate benefit", and applying it was not necessary to meet the objectives of the *CDSA*.[119] The Court rejected this submission on the basis that it excluded consideration of the availability of the exemption mechanism in section 56 of the *CDSA*.[120] The exclusion provision effectively balances the *Act*'s two purposes, "the protection of public health and the maintenance of public safety."[121] The fact that an exemption can be granted, where in the Minister's opinion it is "necessary for a medical or scientific purpose or is otherwise in the public interest",[122] prevents the prohibition in subsection 4(1) of the *CDSA* from being contrary to section 7.

The Court then turned to whether the Minister had exercised the discretion to exempt in a manner consistent with the principles of fundamental justice. The Minister is required to exercise his or her discretion in conformity with the *Charter*.[123] A preliminary consideration was whether the Minister had in fact decided to deny an extension. A formal application was made in May 2008. The Minister demurred from formally rejecting it while the litigation was pending. Surveying ministerial communications in the wake of the application, McLachlin CJC held that the record established a de facto refusal.[124] The Chief Justice then asserted that the Minister's refusal engaged the claimants' rights under section 7 because, without the exemption, the prohibition on simple possession would apply to Insite. Notably, she did not comment on whether the decision to

119 *Ibid* at paras 108–109.

120 See *ibid* at para 109.

121 *Ibid* at para 110.

122 *Ibid* at paras 112–14 (citing *CDSA*, *supra* note 14 at s 56).

123 See *ibid* at para 117.

124 See *ibid* at paras 120, 121–22.

refuse an exemption would engage the rights of drug users elsewhere.[125]

The Court held that the decision to refuse a further exemption was arbitrary and grossly disproportionate in its effects. The first step in the analysis of arbitrariness is to identify the law's objectives. The Minister's discretion under section 56 must be exercised in a manner consistent with those objectives. The *CDSA*'s purposes were identified in *R v Malmo-Levine* as "the protection of health and public safety."[126] The second step is to identify the connection between the state interest and the law or ministerial decision at issue.[127] The relationship between the prohibition on possession and the state objective was also articulated in *Malmo-Levine* with respect to marijuana—to reduce the harm of illicit drug use and eliminate the market for those drugs.[128] The question here is whether the refusal to exempt Insite "bears the same relationship to the state objective."[129] The findings at trial suggested that exempting Insite supported, rather than undermined, the health and public safety objectives of the *Act*. The criminal prohibition on possession did not reduce drug use in the DTES, access to supervised injection reduced health risks to users, and Insite did not lead to an increase in crime or a rise in relapse rates among drug users.[130] In fact, Insite had the opposite effect: the public supported it, evidence suggested it reduced crime, and it "encouraged clients to seek counselling, detoxification and treatment."[131] Not only had staff intervened in some 336 overdoses since 2006, but no client had died of an overdose at the site.[132] At the time, the jurisprudence was unclear as to what arbitrariness required, i.e., whether a limit was unnecessary to advance a state objective or

125 See *ibid* at para 126.

126 *Ibid* at para 129 (citing *R v Malmo-Levine*, 2003 SCC 74 [*Malmo-Levine*]).

127 See *ibid* at para 130.

128 See *Malmo-Levine*, *supra* note 126 at para 136.

129 Insite, *supra* note 1 at para 130.

130 See *ibid* at para 131.

131 *Ibid*.

132 See *ibid*.

simply inconsistent. On either test, the refusal to exempt here was arbitrary as it was unnecessary or inconsistent with state objectives.[133]

The Chief Justice addressed gross disproportionality briefly. The principle protects against deprivations of life, liberty, or security of the person where the effects of a state action or law are "so extreme as to be disproportionate to any legitimate government interest".[134] Insite has proven to save lives, with "no discernable negative impact on the public safety and health objectives of Canada during its eight years of operation."[135] Denying the service Insite provides would be grossly disproportionate to "any benefit that Canada might derive from presenting a uniform stance on the possession of narcotics."[136]

In light of the Court's holdings on these two principles, it was unnecessary to consider overbreadth. Canada did not advance an argument under section 1, but McLachlin CJC indicated that "no s. 1 justification could succeed" since the Minister's decision to refuse an exemption bears no connection to the *CDSA*'s goals of promoting health and public safety.[137] The appropriate remedy was one that would "vindicate" rights in a "responsive and effective manner."[138] Since the infringement was "ongoing", it would not suffice to merely issue a declaration that the Minister had erred in refusing to extend the exemption and to remit the matter for reconsideration.[139] Yet the exemption should be temporary, with the Minister retaining the discretion to rescind it "should changed circumstances at Insite so require."[140]

At the conclusion of Insite, the Chief Justice also indicated that future decisions on exemptions would be subject to the *Charter*

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133 See *ibid* at para 132 (discussing differing opinions on arbitrariness in *Chaoulli v Quebec (Attorney General)*, 2005 SCC 35).

134 *Malmo-Levine*, *supra* note 126 at para 143.

135 Insite, *supra* note 1 at para 133.

136 *Ibid*.

137 *Ibid* at para 137.

138 *Ibid* at para 142.

139 *Ibid* at paras 143–47.

140 *Ibid* at para 149.

and that when deciding whether a decision to refuse an exemption would be in accordance with fundamental justice, the Minister should consider a series of factors including: "evidence, if any, on the impact of such a facility on crime rates, the local conditions indicating a need for such a supervised injection site, the regulatory structure in place to support the facility, the resources available to support its maintenance, and expressions of community support or opposition."[141] In 2017, Parliament codified this direction, by adding section 56.1 to the *CDSA*. In addition to including the factors set out by McLachlin CJC almost verbatim, the new provision formalizes a process for applying for an exemption for a "supervised consumption site".[142] The new provision assists the Minister in deciding on exemption applications only for supervised consumption sites. However, it suggests that applications for exemptions for initiatives related to overdose deaths also consider a similar set of factors.

III. CHARTER ARGUMENTS FOR SAFE SUPPLY AND AN EXEMPTION

We now consider two potential challenges that the SCC holdings in Insite would support in the context of the opioid crisis. The first involves a challenge to a decision by the Minister of Health to refuse an extension of the current exemption under section 56 of the *CDSA* for safe supply programs. The second challenge involves the Minister's decision to refuse to grant an exemption that would decriminalize simple possession, or a refusal to renew the exemption. To reiterate, the purpose of exploring the possibility of these challenges is to articulate the constitutional boundaries of policy options open to the government in confronting the crisis. If a clear case can be made that issuing a refusal in either context would violate section 7, an approval in both cases might be understood as constitutionally required—under specific conditions of the crisis and in limited ways we explore in what follows.

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141 *Ibid* at para 153.

142 *Ibid*.

A. A Potential Challenge to a Decision to End Safe Supply

In the future, a Minister of Health may decide to withdraw the exemption for safe supply programs across Canada. An evidentiary record could likely be assembled that closely resembles the one in Insite, which served as a basis for findings of arbitrariness and gross disproportionality. As noted earlier, BC's safe supply program has served over 3,300 clients, likely avoiding dozens, if not hundreds, of potential overdose deaths.[143] It is too early to assess the impact of the program on rates of crime in BC or elsewhere in Canada—and it may be more difficult to measure this given that, unlike Insite, the safe supply program is geographically dispersed. The crime rate may also be affected by the economic impact of COVID-19, among other variables. Yet, it would seem likely that an evidentiary foundation could be created to support the assertion that safe supply programs currently operating in Canada significantly improve health without causing undue harm to public safety.[144]

If evidence were gathered to this effect, the Insite decision would serve as a direct precedent for a challenge under section 7 to refuse a further exemption for safe supply programs. As McLachlin CJC held in Insite: "[w]here a law creates a risk to health by preventing access to health care, a deprivation of the right to security of the person is made out. Where the law creates a risk not just to the health but also to the lives of the claimants, the deprivation is even clearer."[145] Refusing an exemption for safe supply would hinder access to health care and thus engage users' security of the person. The deprivation of that security would be arbitrary or grossly disproportionate, and thus fail to accord with the principles of fundamental justice.

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143 See Woo, "Canada's Overdose Deaths", *supra* note 2.

144 A four-year pilot program for safe supply at the London Ontario InterCommunity Health Centre that began in 2016 resulted in increased engagement with primary care, a reduction in homelessness from 62% to 38%, a 48% reduction in survival sex work among women, and a 36% reduction in crime committed to pay for drugs. The program also had a reported 90% retention rate and zero fatal overdoses among 118 participants. See Bonn et al, *supra* note 45.

145 Insite, *supra* note 1 at para 93 [citations omitted].

Arbitrariness requires identifying the connection between the state interest and the law or ministerial decision at issue. The Court in the Insite case affirmed its earlier holding in *Malmo-Levine* that the *CDSA*'s purpose is "the protection of health and public safety."[146] The Court also held that the Minister's refusal to extend an exemption of the prohibition on simple possession as it applied to the safe injection site was arbitrary. More specifically, as the Court in *Bedford* characterized its holding in Insite, "the effect of not extending the exemption—that is, prohibiting the safe injection site from operating—was contrary to the objectives of the drug possession laws."[147] The question in the present context is whether the Minister's decision to refuse an exemption for safe supply would also be contrary to the *CDSA*'s object of protecting health and public safety.

In *Bedford*, decided after Insite, the Court provided further clarity on the test for arbitrariness. The applicant must show:

> a direct connection between the purpose of the law and the impugned effect on the individual, in the sense that the effect on the individual bears some relation to the law's purpose. There must be a rational connection between the object of the measure that causes the s. 7 deprivation, and the limits it imposes on life, liberty, or security of the person. A law that imposes limits on these interests in a way that bears no connection to its objective arbitrarily impinges on those interests.[148]

In cases where there might be some connection, the Court sought to clarify "how significant the lack of correspondence between the objective of the infringing provision and its effects must be" in order to establish arbitrariness.[149] In *Chaoulli v Quebec (Attorney General)*, the Court was divided as to whether "a law is arbitrary or overbroad when its effects are inconsistent with its objective, or whether, more broadly, a law is arbitrary or overbroad whenever its effects are unnecessary for its

146 See Insite, *supra* note 1 at para 129.

147 *Bedford v Canada (Attorney General)*, 2013 SCC 72 at para 100 [*Bedford*].

148 *Ibid* at para 111 [emphasis removed, citation omitted].

149 *Ibid* at para 118.

objective".[150] Resolving this dispute, the Court held in *Bedford* that the standard of "no connection" between a law's effects and its purposes is too high, preferring instead a test that permits a finding of arbitrariness where a law's purposes are "inconsistent" with its effects—or one where there is no connection, in which case the effects are "unnecessary".[151]

A court applying this reasoning to a ministerial decision to refuse an exemption for safe supply should find such a decision arbitrary for likely resulting in effects inconsistent with the purposes of the *Act*. The evidence to support this would include the fact that fentanyl continues to be found in high quantities in the street supply of drugs across Canada and in overdose deaths in BC and elsewhere.[152] It would also include evidence that terminating safe supply programs would lead directly to an increase in overdose deaths. A refusal to exempt would thus have an effect on health and public safety that is not inconsistent with Parliament's goal of improving both, but directly contradictory.

Gross disproportionality involves an assessment of whether the effects of a state action or law are "so extreme as to be disproportionate to any legitimate government interest".[153] In contrast to the Insite case, the Minister of Health may have legitimate, health-related concerns for refusing to grant a further exemption for safe supply. Yet, as the Court indicated in *Bedford*, gross disproportionality assessed at the section 7 stage of the analysis, "does *not* consider the beneficial effects of the law for society. It balances the negative effect on the individual against the purpose of the law, *not* against societal benefit that might flow from the law."[154] Moreover, as McLachlin CJC held, "gross disproportionality is not concerned with the number of people who experience grossly disproportionate effects; a grossly disproportionate effect on one person is sufficient to violate the

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150 *Ibid* [emphasis removed] (summarizing treatment of arbitrariness in *Chaoulli v Quebec (Attorney General)*, 2005 SCC 35 at paras 131–32, 232).

151 *Ibid* at para 119 [emphasis removed].

152 See Part 1, *above*.

153 Insite, *supra* note 1 at para 133.

154 *Ibid* at para 121 [emphasis in original].

norm."[155] Questions of proportionality that weigh the effects of a measure against legitimate government interests are reserved for section 1.[156]

At the section 7 stage, a trial court presented with the evidence canvassed above, in relation to arbitrariness, should find the refusal to exempt grossly disproportionate. Closing safe supply programs in BC and elsewhere in Canada would likely result in an immediate and significant increase in the number of deaths, vastly outweighing whatever legitimate health goals a government might have for their decision to refuse.

If either arbitrariness or gross disproportionality were established in relation to a refusal to extend the safe supply exemption, the violation of section 7 would likely not survive a section 1 analysis, but for slightly different reasons than in the Insite case. The test under section 1 of the *Charter* for whether a law or measure constitutes a reasonable limit on a right requires the party seeking to uphold the limit to demonstrate that the law or measure has "a pressing and substantial object and that the means chosen are proportional to that object."[157] A law or measure will be proportionate if "the means adopted are rationally connected to that objective; . . . it is minimally impairing of the right in question; and . . . there is proportionality between the deleterious and salutary effects of the law".[158] In Insite, the denial of an exemption failed the rational connection stage of the section 1 test, because the Minister's refusal bore *no* connection to the *CDSA*'s goals of promoting health and public safety. Here, the government might make out a connection by amplifying concerns voiced by some of the physicians involved in the safe supply program, namely the risk that some users may resell the clean drugs they obtain by prescription for more powerful street drugs and, in some cases, safe supply may result

155 *Ibid* at para 122.

156 See *ibid* at para 125.

157 *Carter v Canada (Attorney General)*, 2015 SCC 5 at para 94.

158 *Ibid* at para 94.

in increased doses, which would raise tolerance levels and make substitution therapy less likely to succeed.[159]

This evidence may suffice to establish a rational connection between the decision to refuse an exemption and the *CDSA*'s object to protect health and public safety. But the refusal to exempt should not survive the proportionality test under section 1, specifically the requirement that the law's deleterious effects on a right not outweigh its potential benefits. Again, terminating a safe supply program would likely result in users reverting to a highly toxic street supply and thus result in an increase in fatalities. This would far outweigh the benefit that would flow from avoiding resale or rising tolerance among some users.[160]

B. A Challenge to the Decision to Not Exempt from Simple Possession

In this section we consider the merits of a nuanced claim that the Minister's decision to refuse to grant or extend an exemption from the application of the possession offence in the *CDSA* in regions currently experiencing a high rate of overdose fatalities (i.e., Vancouver's DTES, if not all of BC) would violate section 7 on the basis of arbitrariness and gross disproportionality. In assessing this claim, a court would need to consider, as a threshold issue, whether the Minister of Health has in fact refused such a request. As noted earlier, both Vancouver and BC are seeking an exemption from the federal Minister of Health. As the Court held in the Insite case, a section 7 challenge to an exemption or extension refusal would require a formal request and at least a de facto refusal.[161]

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159 See Woo, "Canada's Overdose Deaths", *supra* note 2.

160 Another possibility would be for the Minister to grant an exemption on a new set of conditions designed to address concerns about resale or rising tolerance levels. Doing so might help avoid a violation of rights under s 7, or serve as a means of establishing, under s 1, a solution that would impair the rights at issue to a lesser degree.

161 See Insite, *supra* note 1 at para 119 (the CJ draws upon public statements of the Minister, in the period following a formal request for an extension of Insite's exemption, to find that the Minister had made a de facto decision to refuse it).

Assuming the Minister has refused to grant a geographically restricted exemption or has chosen not to renew one while the opioid crisis continues, the *Charter* challenge we contemplate here would involve distinct evidentiary issues from those canvassed earlier for safe supply or safe injection. Comments made at the end of the Insite case highlight issues unique to this context.

At the SCC in the Insite case, VANDU argued that the possession offence in subsection 4(1) of the *CDSA* violated section 7 for *all* illicit drug users, not just those at Insite. VANDU submitted that "because addicted persons have no control over the urge to consume addictive substances, they are forced by fear of arrest and prosecution to procure and consume drugs in a manner that threatens their lives and health, and which causes them a high level of psychological stress."[162] In response, McLachlin CJ held:

> VANDU's contention lacks an adequate basis in the record. The evidence at trial and the factual findings of the trial judge related to the nature of addiction and its attendant dangers, and how Insite responds to those dangers. There is nothing in Pitfield J.'s reasons which would permit this Court to conclude that there is a causal connection between the prohibition on possession and the deprivation of all addicts' s. 7 rights.[163]

The Chief Justice cannot be taken literally in this final sentence, given her assertion in the decision that "[t]o prohibit possession by drug users *anywhere* engages their liberty interests; to prohibit possession at Insite engages their rights to life and to security of the person."[164] In the concluding paragraph, when speaking of the absence of findings at trial that would support a causal connection between prohibition and "the deprivation of all addict's s. 7 rights", the Chief Justice must have meant interests in life and security of the person (i.e., the rights at issue in VANDU's submission).[165]

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[162] *Ibid* at para 154.

[163] *Ibid* at para 155.

[164] *Ibid* at para 92 [emphasis in original].

[165] *Ibid* at para 155

It is important to clarify the Court's precise holding here. There was a lack of evidence to establish that the prohibition on possession *anywhere* in Canada gives rise to a fear of police that *causes* users to consume in a life-threatening manner and causes significant psychological stress. The Court was not asked about a ministerial decision to refuse to exempt the prohibition offence to address such concerns, or about the possibility that prohibition and fear of police may impact users *in specific regions* differently from others. In the passage cited above, the Chief Justice finds only that the record at trial in Insite did not support the broad proposition VANDU sought to advance—i.e., that criminalization of possession instills a fear of police that causes stress and life-threatening consumption methods for *addicted users anywhere in Canada.*

The challenge we contemplate would advance a more discrete claim. A body of evidence can be gathered to support a finding that in some places in Canada with high overdose fatality rates, the possession offence has the effect of impeding access to life-saving supports, or contributes to a significant degree to life-threatening consumption patterns and psychological stress. The Minister's refusal to exempt those regions from the application of the possession offence thus engages rights to life and security of the person.

To be clear, it is not necessary to establish that more than one protected interest in section 7 is engaged to proceed with a challenge under that provision.[166] The challenge we contemplate would proceed past this threshold issue, because the offence of possession in the *CDSA* engages the liberty interest in section 7 by carrying a custodial sentence. However, to establish whether a deprivation of rights protected in section 7 is in accordance with the principles of fundamental justice, a court would need to decide whether the prohibition on possession in hotspots of the

[166] Section 7 guarantees "the right to life, liberty, and security of the person and the right not to be deprived thereof except in accordance with the principles of fundamental justice": see *Charter*, *supra* note 15. Given the wording of the section, a deprivation of life, liberty, or security of the person in a manner not in accord with the principles of fundamental justice would suffice to establish a violation of the section. See e.g. *Bedford*, *supra* note 147.

opioid crisis also engages rights to life and security of the person. Which principles are violated depends on which protected interests are engaged. The persuasive burden of establishing that a protected right or interest is violated contrary to a principle of fundamental justice falls upon the applicant, on the standard of a balance of probabilities.[167]

Is there sufficient evidence that criminalization of possession *causes* significant stress and life-threatening consumption patterns among at least some users in the opioid crisis? The SCC in *Bedford* clarified the causation test in this context. In that case, the government asked the Court to adopt a test involving evidence that a state law or measure be an "active, foreseeable, and a 'necessary link'" to the deprivation of a claimant's security interest.[168] The Court affirmed the more flexible and less onerous standard applied in earlier cases involving a "sufficient causal connection".[169] This standard "does not require that the impugned government action or law be the only or the dominant cause of the prejudice suffered by the claimant, and is satisfied by a reasonable inference, drawn on a balance of probabilities".[170] A sufficient causal connection is one that is "sensitive to the context of the particular case and insists on a real, as opposed to a speculative, link."[171] Can the causation test be made out here? Are concerns about police contact—or criminalization more broadly—among addicted users more likely than not to be a contributing factor to those users resorting to life-threatening consumption patterns that cause overdose, or is this merely a speculative link?

In Part 1, we noted at least four pieces of evidence that could be adduced to support a reasonable inference that concerns about police involvement among addicted persons do contribute to dangerous consumption patterns. Considered in isolation, none of the pieces of evidence we point to here is dispositive.

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167 See *Bedford*, *supra* note 147 at para 76.

168 *Ibid* at para 77.

169 *Ibid* at para 75.

170 *Bedford*, *supra* note 147 at para 76.

171 *Ibid*.

However, considered as a whole, they support a finding of a sufficient causal connection on a balance of probabilities.

First, in BC the "vast majority" of overdose deaths occur by people "using drugs alone and indoors",[172] and solitary use is common elsewhere in Canada.[173] At least two studies of drug use in Vancouver point to concerns about police involvement making drug use in public less desirable.[174] Solitary use places a person overdosing at greater risk of dying because it makes intervention less likely. Second, as far back as 2006, the VPD recognized that police response to overdose calls dissuades people from seeking assistance, leading the VPD to minimize their involvement in such calls.[175] The *possibility* of police involvement in response to a distress call functions, therefore, at least to some degree as an impediment to access to potentially life-saving measures. Thirdly, as Dr. Henry's report notes, "[p]rohibition drives manufacturers of illegal drugs to synthesize more potent drugs to be able to export these substances in smaller quantities to avoid detection."[176] Fear of police contact thus causes, at least indirectly, some users to consume drugs of higher toxicity. Finally, research on Portugal and other countries indicates that access to health care on the part of addicted users improved in response to

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172 PHO Report, *supra* note 3 at 21. See also BC Coroner Report, 2021, *supra* note 5 at 2.

173 See Highlights, *supra* note 29.

174 See Ivsins et al, "Barriers and Facilitators to a Novel Low-Barrier Hydromorphone Distribution Program in Vancouver, Canada: A Qualitative Study" (2020) 216 Drug and Alcohol Dependence at 3, noting:

> Participants expressed relief about having easy access to a safe supply that minimized their overdose risk while also insulating them from forms of structural and everyday violence (e.g., encounters with police, drug scene violence) associated with having to purchase and use drugs on the street[.]

See also "Perceptions of Risk and Safety", *supra* note 64 at 315, noting:

> Potential for arrest or encounters with police within other types of injection settings was a major concern, and many participants emphasised that Insite represented a unique type of injection setting because consumption activities were permitted under the law[.]

175 See VPD Opioid Crisis Report, *supra* note 6 at 14.

176 PHO Report, *supra* note 3 at 21.

decriminalization, a finding which suggests that prohibition had impeded such access.[177]

Still, one might argue that the connection here between prohibition, perceptions, and concerns about police and dangerous consumption remains speculative, based on at least two arguments. Users might fear police involvement when they use dangerous substances, but the connection between the fear and harmful conduct—solitary, indoor use; failing to avail oneself of health care supports, such as supervised injection or safe supply—remains hypothetical. The majority of users may use drugs in dangerous conditions and fail to seek out consumption assistance for reasons that have little or nothing to do with a desire to avoid the police. Conversely, it is not clear that if simple possession was decriminalized users would consume in a safer manner or would avail themselves of safe supply or other health care supports in greater numbers. The experience in other jurisdictions suggests that decriminalization led to a reduction in overdose deaths and to improved health outcomes for addicted users, but only when advanced together with a host of other measures (such as improved access, counseling, and other programing).[178]

These are important concerns, but an evidentiary record containing the four kinds of evidence canvassed above should suffice to establish that concerns about criminalization or police involvement are a sufficient contributing cause of at least some of the fatalities or near fatalities in regions with high overdose-related mortality rates. Prohibition thus engages rights to life, liberty, and security of the person. The question then is whether

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[177] See *ibid* at 29–30; Niamh Eastwood, Edward Fox & Ari Rosmarin, "A Quiet Revolution: Drug Decriminalisation Across the Globe" (March 2016) at 7, online (pdf): <governancejustice.org/s/Release-A-Quiet-Revolution-2016.pdf>. See also Advancing Drug Policy Reform, *supra* note 67 at 20.

[178] In relation to Portugal, the Czech Republic, and the Netherlands, "[t]he impact of decriminalization alone, . . . should not be overstated in terms of its impact on public health; it is only with substantial investments in harm reduction and treatment services that the health problems primarily associated with problematic use can be mitigated.": Advancing Drug Policy Reform, *supra* note 67 at 20. See also Eastwood, Fox & Rosmarin, *supra* note 177 at 7.

the deprivation of these rights from a Ministerial refusal to grant or extend a geographic exemption from simple possession accords with the principles of fundamental justice. We suggest that if a court were to accept that prohibition engages interests in addicts' right to life and security of the person, the refusal to exempt would be arbitrary and grossly disproportionate.

As noted above, the Court in *Bedford* clarified that arbitrariness will be made out under section 7 where the law's purposes are inconsistent with its effects.[179] The Court held in the Insite case that the *CDSA*'s purpose is "the protection of health and public safety".[180] Refusing to grant a geographic exemption of the application of the possession offence would be arbitrary if the effects of doing so are inconsistent with the *CDSA*'s purposes.[181] The court would need to rely at this juncture on its threshold finding that the possession offence raises concerns about criminalization that causes addicted users to consume in a life-threatening manner or to experience significant stress. This would support a finding that, in those regions and for those users, the refusal to grant an exemption endangers health and public safety.

An additional concern under the arbitrariness analysis is whether granting an exemption from the possession offence in certain areas would affect crime rates, including a rise in drug consumption itself. If the Minister was able to adduce evidence that an exemption would (or has) increase crime, the court would have to engage in a consideration of whether, on balance, the decision not to grant an exemption is more consistent than inconsistent with protecting health and public safety.[182] Three

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179 See *Bedford*, *supra* note 147 at para 119.

180 Insite, *supra* note 1 at para 129.

181 This would reflect the Court's characterization of Insite in *Bedford* where the CJ held that "the effect of not extending the exemption—that is, prohibiting the safe injection site from operating—was contrary to the objectives of the drug possession laws.": *Bedford*, *supra* note 147 at para 100.

182 See e.g. Report of the Canadian Association of Chiefs of Police, *supra* note 7 at 7 noting that:

kinds of evidence could be adduced to counter concerns that crime would rise in regions over which an exemption would be granted. Similar fears were raised in relation to Insite when it was first proposed, but crime in the neighbourhood in which Insite was situated did not rise significantly in the period the SCC considered in Insite.[183] A second source of evidence could be studies of Portugal, Australia, and other jurisdictions which indicate that drug-related offences did not rise notably in response to the decriminalization of possession.[184] Thirdly, the court might consider Canada's own experience with decriminalizing small amounts of marijuana possession and evidence of its correlation, if any, with crime rates.[185]

The test for gross disproportionality is whether the effects of a law or measure are "so extreme as to be disproportionate to any legitimate government interest".[186] As noted in the previous section of this paper, any legitimate concerns the Minister may have for refusing to grant an exemption should be considered

> the area around Dundas, Jarvis and Sherbourne Streets, which houses the former Moss Park [Supervised Injection Site] and which is close to other SIS facilities, has seen an increase in the number of people using drugs or traffickers frequenting the area, and erratic or threatening public behavior by some of these individuals or clients of the [Supervised Consumption Site]. It has also reportedly seen an increase in publicly discarded drug-related paraphernalia and litter, as well as decreased clientele for local businesses. Neighbourhood residents are cited as feeling fearful and expressing criticism towards the police for failing to act to prevent the social disorder and neighbourhood degradation perceived by local residents and business people as stemming from the presence of the SCS.

183 See Insite, *supra* note 1 at para 131.

184 See e.g. Advancing Drug Policy Reform, *supra* note 67 at 21 (considering a fall in drug-related offences in Portugal, Australia, Jamaica, and California following decriminalization).

185 We recognize that an absence of evidence in this area should not be mistaken for evidence of an absence. However, studies of low correlations between decriminalization of cannabis and crime rates may be of some assistance to the court. See e.g. Michelle Rotermann, "What Has Changed Since Cannabis Was Legalized" (2020) 31:2 Health Reports 11 (a limited study noting no change after 2018 in the reported rate of driving within 2 hours of cannabis use and an 11% drop in the portion of people purchasing cannabis from illegal sources).

186 Insite, *supra* note 1 at para 133.

during the section 1 analysis.[187] Under section 7, if the court finds a causal connection between prohibition and a deprivation of life and security of the person, a refusal to grant an exemption should be found to be grossly disproportionate. More specifically, if fear of police involvement due to prohibition contributes significantly to the high rate of overdose deaths that continue to occur, the failure to grant a geographic exemption is "so extreme as to be disproportionate"[188] to any other concerns about crime or public health the Minister may have.

The violation of section 7 outlined here could not be justified under section 1. We assume that the only legitimate interests the Minister could invoke for refusing to issue a geographic exemption to prohibition would be a concern to avoid an increase in crime rates, including a rise in illicit drug consumption. These interests would enable the government to meet the rational connection portion of the test because the Minister's refusal would bear a connection to the goal of protecting health and public safety. However, refusal on these grounds would fail the proportionality test since the deleterious effects on the right to life and security of the person would outweigh the benefits to health and public safety. If a court found that a fear of police involvement due to prohibition contributes to overdose deaths, no other public benefits—short of evidence of a likely significant increase in crime or a decrease in health—would suffice to avoid this conclusion.

The SCC has granted an appeal involving a *Charter* challenge to a minister's refusal to grant an exemption from a legislative scheme in at least one other context.[189] After finding that a refusal to grant an exemption violated a *Charter* right and was not justified under section 1, the remedy in *Loyala High School v Quebec (Attorney General)* was to remit the decision to the

187 See *Bedford*, *supra* note 147 at 122.

188 Insite, *supra* note 1 at para 133.

189 See *Loyala High School v Quebec (Attorney General)*, 2015 SCC 12 (finding that the Minister's refusal to exempt a school program from a curriculum mandating neutrality in its coverage of religion was contrary to the freedom of religion in s 2(a) of the *Charter*).

Minister for reconsideration in light of the Court's decision.[190] In Insite, the Court relied on the holding in *Doucet-Boudreau v Nova Scotia* in requiring a remedy that "vindicates the respondents' *Charter* rights in a responsive and effective manner".[191] The Court rejected the possibility of remitting the matter to the Minister for reconsideration because "[t]he infringement at stake is serious; it threatens the health, indeed the lives, of the claimants and others like them."[192] Reconsideration would take too long, with potentially "grave consequences."[193] For this reason, "an order in the nature of mandamus" was warranted here, but a temporary order.[194] In the potential challenge we contemplate above, the appropriate remedy would depend on the specific basis of a refusal to issue an exemption, but the order of mandamus issued in the Insite case is a possibility, for the reasons noted here.

C. Is the Charter an Appropriate Tool for Policy Making in this Context?

The evidence we canvassed in Part 1 above suggests that government policy on drug prohibition has had a profound impact on a vulnerable minority, one that cannot be justified in terms of health or public safety. Yet, governments in Canada hold fast to these policies in the face of this evidence. The federal government has resisted recent calls to decriminalize simple possession despite evidence that prohibition contributes to overdose deaths, and Alberta's government has resisted supporting safe supply, despite evidence of lifesaving effects.[195] There may indeed be sound reasons for each of these positions beyond those canvassed in this paper. But when governments

190 See *ibid* at para 81.

191 Insite, *supra* note 1 at para 142.

192 *Ibid* at para 148.

193 *Ibid*.

194 The Minister "should not be precluded from withdrawing an exemption to Insite should changed circumstances at Insite so require.": *Ibid* at paras 149–50.

195 On Canada's resistance to decriminalization, see the discussion in Part 1, *above*. See also Woo, "Canada's Overdose Deaths" *supra* note 2 (discusses Alberta's reluctance to support safe supply).

make policy choices, they do so partly in reliance on empirical evidence and partly for political expediency. The merits of using *Charter* litigation to intervene in these policy debates cannot be assessed outside of this context.

Political realities constrain the choices on which governments can act, in ways that shape the course of the opioid crisis. We noted in Part 1 Prime Minister Trudeau's commitment to avoid further decriminalization of drug possession. In early 2021, rejecting calls by BC Premier John Horgan and others to decriminalize simple possession, the federal government tabled Bill C-22.[196] The bill implies that giving law enforcement the option, in some cases, to treat simple possession as a health issue—and divert rather than arrest—strikes an appropriate balance between minority and majority interests in this case. Correct or not, the Liberal government has perceived a reluctance on the part of a plurality of voters in Canada to embrace further decriminalization. The bill thus represents not necessarily the most prudent health and public safety policy on drug possession, but rather one believed to be the most responsive to the crisis that is politically palatable to a plurality of Canadians. The *Charter* challenges we explore in this paper are not meant to supplant this larger assessment. The *Charter* is an appropriate tool not for compelling the government to craft policies thought to be best for the majority, but rather, a tool for making adjustments to a law or policy when it has clear, harmful effects on a minority group.[197]

The opioid crisis remains dire, lending urgency to the measures canvassed in this paper. As noted earlier, Health Canada's most recent data indicates that some 1,828 lives were lost due to overdose death in the first quarter of 2021,

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196 Bill C-22, *supra* note 11.

197 See *Reference re Secession of Quebec*, [1998] 2 SCR 217, SCJ No 61 at paras 80–81:

> the protection of minority rights is itself an independent principle underlying our constitutional order. . . . The concern of our courts and governments to protect minorities has been prominent in recent years, particularly following the enactment of the *Charter*. Undoubtedly, one of the key considerations motivating the enactment of the *Charter*, and the process of constitutional judicial review that it entails, is the protection of minorities.

representing a 65% increase from deaths in the first quarter of 2020, an average of 20 deaths per day in early 2021.[198] The crisis has been most acute in BC, where the BC Coroners Service has reported 2,232 deaths in 2021, or 6.1 deaths per day.[199] Over the course of 2020, during the height of the pandemic, according to Statistics Canada, there were 901 "COVID-19-related deaths" in BC, or an average of 2.4 per day.[200] In 2020, in all of Canada, there were 15,650 "COVID-19-related deaths", an average of 42.8 deaths per day.[201]

In the absence of political will to protect minority interests, *Charter* litigation may be the only recourse to achieve such protection. The opioid crisis in BC remains a peripheral issue, despite its severity. It generates more fatalities than the pandemic, but the latter garners more attention for affecting a wider swath of the population. The opioid crisis also affects a far wider, more diffuse constituency—a group of people that spans demographic, economic, social, racial, and regional categories. People from all walks of life become addicted and overdose for many reasons.[202] The victims of the opioid crisis are not a group easily categorized. Their dispersion adds to their disenfranchisement. Current governments in Vancouver and British Columbia have prioritized the crisis through initiatives canvassed in Part 1 above, but change on this front could occur in short order with an election.

Bringing the issue to a court offers a relatively stable and neutral forum in which to evaluate the effects of a policy shaped by democratic majorities on vulnerable minorities. The aim would be to shape policy to a limited degree. The *Charter*

198 See Health Canada Infobase, *supra* note 5.

199 See BC Coroner Report 2022, *supra* note 5 at 3, reaching the figure of 6.1 per day by dividing total deaths for 2021 (2,232) by 365.

200 See Statistics Canada, "Provisional Death Counts and Excess Mortality, January to November 2020," *The Daily* (8 February 2021), online: <www150.statcan.gc.ca/n1/daily-quotidien/210208/dq210208c-eng.htm>.

201 See *ibid*.

202 See e.g. PHO Report, *supra* note 3 at 7. See also BC Coroner Report 2018, *supra* note 28 at 6.

challenge we contemplate here is not meant to advance a substantial revision of Canada's drug policy, but to set outer boundaries of the harm done by present law and policy that the government can no longer ignore in favour of majority interests.

CONCLUSION

In Insite, the SCC made clear that the Minister's discretion to grant an exemption under the *CDSA* is subject to section 7 of the *Charter* and set out a host of factors courts should consider when assessing whether refusal to grant an exemption accords with the principles of fundamental justice.[203] For decisions involving supervised consumption sites, the factors involve a range of considerations, including impact on crime, local conditions, and other available supports for the program.[204] Yet the Court's direction in the Insite case can be read more broadly as a mandate to future courts on a section 7 exemption challenge to assess the decision in light of a constellation of factors, such as how users are affected in a given time and place by a host of conditions, access to supports, drug supply, and the effects of police involvement.

A constellation of factors has come to pass in BC and other regions of Canada at present that should lead a court to find that a minister's decision to refuse an exemption to continue safe supply would violate section 7. The street supply in these places contains concentrations of highly toxic substances, resulting in a continuously increasing overdose fatality rate. Safe supply programs are making a dent in the rate at which these fatalities are rising, but it is not enough. A decision to terminate the program would likely result in an even greater rise in fatalities, as addicted users turn back to the toxic street supply.

Similarly, a constellation of conditions has come to pass in BC and other hotspots of the opioid crisis to support the claim that refusing to grant or extend an exemption from the prohibition of simple possession in the *CDSA* over those regions, for the duration of the crisis, would violate section 7. Addicted users

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203 See Insite, *supra* note 1 at para 153.

204 See *ibid*.

frequently consume dangerous substances alone and indoors at least partly because of concerns about police involvement, or criminalization more broadly. Consuming drugs when sequestered and alone makes life-saving intervention less likely and increases the risk of a fatal overdose. At this time and in those places, a minister's decision to refuse to grant an exemption contributes to addicted users being deprived of life-saving measures. It does so in a manner that is both inconsistent with the *CDSA*'s goals of protecting health and public safety and grossly disproportionate in its effects on these aims.

Charter litigation is a last resort, and a slow and cumbersome tool for shaping policy in this area. However, it is an appropriate and necessary tool to defend the rights of a vulnerable minority. Our aim in this paper was to articulate the *Charter* ramifications of a potential challenge, based on evidence that could be readily marshalled—given the current crisis—to demonstrate that current policy debates about how intervention is bounded by law. Provinces are willing to fund safe supply and to defund police involvement in prohibition enforcement in light of concerns about its effects. The *Charter* compels the Minister to go a step further and grant an exemption to assist on both fronts.