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Response

Adrift from the moorings of good public policy: Ignoring evidence and human rights

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The approach of Canada's Government to Insite, North America's first safer injecting facility (SIF) (Wood, Kerr, Tyndall, & Montaner, 2008), is one manifestation of what appears to be the government's broader hostility to both evidence and human rights in public policy, at least insofar as that policy involves the health of people who use illicit drugs. A number of observations are warranted in this regard.

As noted in the Commentary by Wood et al. (2008), while refusing to grant Insite anything more than a 6-month extension of the legal exemption from Canada's drug laws, the federal health minister also stated that he would not entertain any applications for exemptions to establish additional safer injection sites. Setting aside the legal question of whether he thereby impermissibly fettered his discretion *a priori*, contrary to basic administrative law principles of procedural fairness, this is an astonishing stance — a health minister declaring that he would not facilitate the delivery of health services to some of those who are most marginalized and suffer disproportionately from morbidity and mortality, notwithstanding what the evidence of need and of efficacy might be in support of a given proposal to address local health needs. That this declaration was made in the face of an extensive body of peer-reviewed scientific evidence indicating significant benefits for both individual and public health makes it all the more troubling.

While the minister (paradoxically) declares the need for more evidence before making decisions about the future of Insite or other such facilities, the government also appears to be illegitimately moving the goal posts. Among the new areas of research of interest to the government is whether SIFs lead to reductions in crime. The underlying suggestion, implicit as well in numerous public comments by government representatives, has been that failure to show a link between Insite and a reduction in crime will be a basis on which to discontinue its legal exemption. SIFs are health facilities aimed at achieving individual and public health benefits; they do not seek to reduce crime, although this could be a welcome side benefit in some cases. To deem SIFs a failure if they do not reduce crime is akin to concluding that a hospital emergency room should be closed for failing to prevent injuries caused by drunk driving. As an aside, it should be noted that the existing evaluation of Insite addressed this question to some degree, showing that there had been no increase in crime in the neighbourhood (Wood, Tyndall, Lai, Montaner, & Kerr, 2006). However, the question itself subordinates health policy to criminal justice objectives unjustifiably and unnecessarily.

This dynamic appears to be at play in the Canadian Government's policy more generally, with Insite serving as one high-profile flashpoint. Previously, Canada's Drug Strategy had as its stated central aim "to ensure that Canadians can live in a society increasingly free of the harms associated with problematic substance use" (Government of Canada, 2005). That strategy incorporated "four pillars": prevention of problematic drug use, treatment of drug dependence, law enforcement to reduce the supply of drugs, and harm reduction measures "to limit possible secondary effects of substance use, such as the spread of HIV/AIDS and Hepatitis C." In addition, a national, multi-year, multi-stakeholder consultative process led by Health Canada and the Canadian Centre on Substance Abuse developed a new national framework for reducing the drug-related harms, released in 2005, underscoring the importance of harm reduction measures in Canada's strategy to deal with drugs (Health Canada & CCSA, 2005). Yet in 2007, the Government of Canada

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replaced this approach with a new "National Anti-Drug Strategy", committing almost CAN$64 million over two years to a strategy that consists of only three of these pillars, completely omitting any support for harm reduction (Government of Canada, 2007). A third of that funding is dedicated directly to law enforcement, and some of the funds allocated under the rubric of "treatment" are to be directed as well to law enforcement actors such as the Royal Canadian Mounted Police (RCMP).

This short shrift given to basing public policy on sound scientific evidence raises at least two human rights concerns. First, under the *International Covenant on Economic, Social and Cultural Rights*, Canada has a legal obligation, commensurate with available resources, to take steps to realise over time the right of everyone to the "highest attainable standard of physical and mental health", including those steps "necessary for . . . the prevention, treatment and control" of epidemics (such as HIV and hepatitis C virus), and the steps necessary to "assure to all medical service and medical attention the event of sickness" (United Nations, 1966). The Public Health Agency of Canada estimates that, in the mid-1990s, over one third of new HIV infections were among people who inject drugs. Likely in part because of harm reduction initiatives, this has declined to an estimated 14% of new infections in 2005 (PHAC, 2006). Hepatitis C is transmitted primarily through the sharing of needles and other drug equipment (Health Canada, 2006). Hence the importance of health services, such as SIFs, that evidence indicates reach some of those most in need of accessible medical services and reduce the harms associated with unsafe drug injection such as infection with these blood-borne viruses. In addition to the obligation "to move as expeditiously and effectively as possible" toward the goal of realising the highest attainable standard of health, international law also contains a presumption against "any deliberately retrogressive measures in that regard", which "would require the most careful consideration" (United Nations, 1990). Policies that "are likely to result in bodily harm, unnecessary morbidity and preventable mortality" are in breach of the obligation to realise the highest attainable standard of health (United Nations, 2000). Deliberate decisions by Canada's Government to abandon financial or policy support for proven health-protecting measures – or worse, to impede the delivery of such services by withdrawing a legal framework that facilitates them – run counter to Canada's international human rights obligations.

Second, the government's pattern of conduct disregarding the evidence about effective health services for people who use illicit drugs raises a *prima facie* case of discrimination. Stigma against "drug abusers" is widespread and pervasive. The principle of non-discrimination is central in international human rights law, underpinning and running through the enjoyment of all other human rights. Under Canadian law, specifically, discrimination based on drug dependence is prohibited as a form of discrimination based on disability (Pearshouse, Elliott, & Csete, 2006). To the extent that the government refuses to take the necessary steps to facilitate ongoing and expanded access to evidence-based health services that protect and promote the health of people with addictions (e.g., SIFs), favouring instead a criminal prohibition on drug possession that impedes access to health services, it not only hinders the realisation of the right to health but does so in a discriminatory fashion, disadvantaging those who are already most vulnerable.

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