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Harm Reduction and Human Rights: Emphasizing the Dignity and Capabilities of People Who Use Drugs

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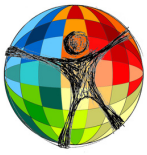

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ABSTRACT

This paper aims to draw a link between harm reductions practices and human rights that ought to remain immune from political persuasions.

After outlining harm reduction's definition, history, and guiding principles, I argue that harm reduction is compatible with two dominant theories of human rights: human dignity and the capabilities approach, as articulated by Amartya Sen and Martha Nussbaum. I then outline the critical approach to harm reduction, which stipulates that institutionalizing a practice with grassroots origins may ultimately reify state violence rather than serving as a source of liberation for marginalized individuals. To combat such nefarious effects, I argue that harm reduction policies ought to focus on individual vulnerabilities from external circumstance, that at times harm reduction's articulation ought to be modified, and that informal and grassroots policies should be retained where possible. I argue that harm reduction practices must incorporate the perspectives of people who use drugs as they are best positioned to understand the nuances of the laws and policies that affect their lives, while such incorporation also emphasizes their autonomy and dignity.

I argue that articulating harm reduction within a framework of human dignity and capabilities can offer a solid normative basis for critiquing the Supreme Court of Canada's 2011 *Insite* decision and offering avenues forward to better emphasize the autonomy and dignity of people who use drugs through harm reduction practices.

CONTENTS

Frequently Used Acronyms

ART = Anti-Retroviral Therapy

CDSA = *Controlled Drugs and Substances Act*

NSP = Needle and Syringe Programmes

OST = Opioid Substitution Therapy

PWUD = People Who Use Drugs

SCS = Supervised Consumption Sites

I. Introduction

Between January 2016 and March 2021, nearly 23,000 Canadians died from drug overdose.[1] While numerous factors have enabled this tragedy, the criminalization of drug use by the Canadian government is one source of blame. The HIV Legal Network contends that such criminalization "has led to more potent and dangerous drugs, hampered efforts to scale up safe supply programs, and contributed to a drug poisoning crisis."[2] The fact of such a crisis necessitates a widespread and effective response. The practice of harm reduction, which aims to reduce harm from "risky" behaviour like drug use, is one possible answer. At the 2019 UN Harm Reduction International Conference, the UN High Commissioner for Human Rights, Michelle Bachelet, indicated that harm reduction programs—when existent and adequately funded—are "markedly successful in reducing harm and to the health and wellbeing of people who use drugs."[3]

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[1] See Government of Canada, "Opioid- and Stimulant-related Harms in Canada", (last modified 22 September 2021), online: <health-infobase.canada.ca/substance-related-harms/opioids-stimulants/>.

[2] See HIV Legal Network, "Decriminalization Done Right: A Rights-Based Path for Drug Policy" (9 December 2021) at 6, online: <www.hivlegalnetwork.ca/site/decriminalization-done-right-a-rights-based-path-for-drug-policy/?lang=en> [HIV Legal Network, "Decriminalization"].

[3] See UN Human Rights Office of the High Commissioner, "Statement by UN High Commissioner for Human Rights Michelle Bachelet", *Harm Reduction*

However, since its Canadian origins in the 1980s, harm reduction has been subject to widespread controversy surrounding the practice's efficacy and underlying normative claims. This requires advocates of harm reduction to consistently re-prove its scientific basis and normative ethical value.[4] Repeatedly re-evaluating harm reduction's merits creates barriers against its implementation and, unsurprisingly, leads to increased harm to some of Canada's most vulnerable populations, all of whom have elevated rates of HIV: women, Indigenous persons, transgender persons, and people in prison.[5] Women, and in particular sex workers, are vulnerable to attacks on harm reduction because they often rely on intimate partners to inject drugs into them, and can thus be vulnerable to unsafe injection practices if their intimate partners are not present.[6] Transgender individuals are severely marginalized and are at high risk of drug-related harms, including HIV and Hepatitis C.[7] Prisoners often lack access to adequate programming to reduce infection transmission, including services available outside like needle exchange programs.[8] Finally, Indigenous individuals have elevated rates of HIV, Hepatitis C, poverty, suicide, and incarceration, and many cannot benefit from urban harm reduction programming while living in rural areas.[9] These four groups remain vulnerable to human rights violations from government action that undermines harm reduction's normative foundation.

Furthermore, international law entitles individuals to harm reduction methods as a human right, as the universality of rights is not conditional on abstinence from drug use. People who use drugs are entitled to the "highest attainable standard of health, to

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International Conference 2019 (28 April 2019), online: <www.ohchr.org/EN/NewsEvents/Pages/DisplayNews.aspx?NewsID=24529&LangID=E>.

[4] See Walter Cavalieri & Diane Riley, "Harm Reduction in Canada: The Many Faces of Regression" in Richard Paters & Diane Riley, eds, *Harm Reduction in Substance Use and High-Risk Behaviour: International Policy and Practice* (London: Wiley-Blackwell, 2012) 382 at 384–85.

[5] See *ibid* at 391.

[6] See *ibid*.

[7] See *ibid*.

[8] See *ibid* at 392.

[9] See *ibid*.

social services, to work, to benefit from scientific progress, to freedom from arbitrary detention and freedom from cruel inhuman and degrading treatment."[10] Despite this entitlement, an articulation of harm reduction's link with human rights is lacking. This paper attempts to fill this void by analyzing how harm reduction interacts with human rights, whether it can be conceptualized as falling under the paradigm of human rights, and if such a goal is desirable. Despite certain difficulties stemming from formalizing harm reduction—a practice with grassroots origins and the critical involvement of people who use drugs—I argue that harm reduction is compatible with the human rights framework and that harm reduction practices ought to be a human right. However, there are limitations to the normative reach of this alignment, and to the best of its abilities, harm reduction ought to retain its fundamental underlying principle of non-judgmentalism towards what is perceived as "risky behaviour", continue to implement the perspectives of people who use drugs ("PWUD"), and not ignore other structural factors that contribute to individual vulnerability. I note here that while harm reduction practices can be applied to a variety of settings—including sex work and medical assistance in dying—this paper predominantly focuses on harm reduction measures related to drug use. Nonetheless, and in my view, harm reduction and its articulation within the human rights framework ought to continue its application in a wide variety of settings given the normatively desirable principles underpinning the practice.

This paper proceeds as follows: Part II asks *what* harm reduction is, offering a definition of the practice and a brief historical overview, and a summary of harm reduction's underlying principles and goals. Part III asks whether harm reduction *can* fit within the human rights paradigm, normatively evaluating the practice against human rights as encapsulated by human dignity and the capabilities approach to human rights. Part IV asks whether harm reduction *should* fit within the human rights paradigm, offering both a summary and response to the critical perspective on harm reduction. Part V asks *how* harm reduction ought to be defined, assessing *who* ought to define the practice and *when* it should be applied, and whether outer limits ought to

[10] Harm Reduction International, "What is harm reduction?" (last visited 6 July 2022), online: <www.hri.global/what-is-harm-reduction>.

be drawn. Finally, Part VI provides a brief analysis regarding supervised consumption sites and how articulating harm reduction as a human right can broaden accessibility to such sites to uphold the human rights of those who access them.

II. *What* is harm reduction?

This section begins by defining harm reduction and offering some underlying bases for the practice. It also provides a brief historical overview of the practice within Canada, and then outlines harm reduction's principles and goals.

i. Definition and Application

While harm reduction has no universal definition,[11] it generally describes policies and practices that aim to reduce harmful consequences from risky behaviour, most often drug use.[12] Harm Reduction International defines harm reductions as the "policies, programmes and practices that aim to minimise negative health, social and legal impacts associated with drug use, drug policies and drug laws."[13] It focuses on "working with people without judgement, coercion, discrimination, or requiring that they stop using drugs as a precondition of support."[14] Some examples of harm reduction programmes and services for drug use include supervised consumption sites ("SCS"), needle and syringe exchange programs ("NSP"), drug checking, overdose prevention through naloxone kits, opioid substitute therapy ("OST"), "safe supply" opioid programs, and information on safer drug use.[15] In addition to drug use, scholars, judges, and legislators have also approached sex work, illegal migration, and

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[11] See *ibid*.

[12] See Alana Klein, "Criminal Law and the Counter-Hegemonic Potential of Harm Reduction" (2015) 38:2 Dalhousie LJ 447 [See Klein, "Counter-Hegemonic"] at 449.

[13] See Harm Reduction International, *supra* note 10.

[14] *Ibid*.

[15] See *ibid;* HIV Legal Network, "Decriminalization", *supra* note 1 at 10.

medical assistance in dying with a harm reduction lens.[16] The practice's reach is continuing to expand horizontally, with discussions of harm reduction being present in difficult medical and ethical issues like female genital mutilation, domestic violence, and COVID-19 behaviours.[17]

One common underlying feature between most potential applications of harm reduction is a general oppositional framework surrounding the normative and ethical value of allowing or disallowing certain practices. Drug use, for instance, might have one side advocating for individual autonomy to use drugs, while the other may hold a normative assessment that drug use is more harmful than helpful to society and should thus be discouraged.[18] Harm reduction can offer a bridge between such opposing views. Instead of being required to pick a side regarding whether a behaviour is morally acceptable or not, harm reduction contends that the state ought to strive to reduce the risks of harm flowing from such practices; it accepts that certain practices involve an irreconcilable contest of personal values, and therefore "changes the subject" toward reducing the risk of societal harm.[19]

Harm reduction is most often contrasted with a prohibitionist or coercive response to harm flowing from drug use,[20] which has led to "widespread human rights violations against people who use drugs."[21] Some of these violations include increased risk of overdose and disease transmission, engagement with more harmful drug use practices if supply or time to consume is limited by reason of threat of arrest, undermined access to health care services, deterrence against individuals using sterile syringe programs, and deterrence from seeking assistance in the event of

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[16] See Klein, "Counter-Hegemonic", *supra* note 12 at 450.

[17] See Daniel M Weinstock, "Disagreement, Unenforceability, and Harm Reduction" (2020) 28 Health Care Analysis 314 [Weinstock, "Disagreement"] at 315.

[18] See *ibid* at 316.

[19] *Ibid* at 316–18.

[20] See Alana Klein, "Harm Reduction Works: Evidence and Inclusion in Drug Policy and Advocacy" (2020) 28 Health Care Analysis 404 at 405 [Klein, "Harm Reduction Works"].

[21] Harm Reduction International, *supra* note 10.

an overdose for fear of police prosecution.[22] Incarceration also significantly increases societal harms; individuals often begin using drugs in prison to cope with being in an overcrowded and violent environment. Injection equipment is likely to be shared, and sexual violence between inmates can increase HIV and other STI transmission.[23] Furthermore, access to generally accepted harm reduction measures—like needle and syringe exchange programs, opioid substitution therapy, and anti-retroviral therapy—is generally limited in prison.[24]

The contrast between prohibition and harm reduction provides another justificatory basis for the latter. For most of the practices that harm reduction programs engage with, complete enforcement of prohibitions against the practice would likely come with immense costs of enforcement at both the economic and human rights level.[25] For instance, adequately catching and enforcing all forms of illicit drug use or sex work would come at such a high cost of surveillance that it may conflict with a liberal society that values the individual rights of its citizens.[26] Because of such costs, harm reduction stipulates that the preferred course of action ought to be regulating a given practice rather than expending resources on outlawing it.[27] This conceptualization of harm reduction, however, may be prone to criticisms that it is not sufficiently critical of the normative desirability of prohibitive enforcement; this criticism will be returned to in Part IV.

ii. History

Harm reduction has been practiced in varying forms for several centuries, though the modern definition and practice did not rise to prominence until late in the second half of the 20th

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[22] See Richard See Elliott et al, "Harm Reduction, HIV/AIDS, and the Human Rights Challenge to Global Drug Policy" (2005) 8:2 Emerging Issues in HIV/AIDS 104 at 109.

[23] See Ralf Jürgens et al, "People who use drugs, HIV, and human rights", *The Lancet* (20 July 2010) 475 at 477.

[24] See *ibid*.

[25] See Weinstock, "Disagreement", *supra* note 17 at 317.

[26] See *ibid*.

[27] See *ibid* at 318.

century.[28] Canada's harm reduction orientation in its policies was borne out of the heavy increase in economic and social costs resulting from drug criminalization in the 1960s and 70s.[29] The Canadian Government, after becoming cognizant of such costs, commissioned an inquiry into drug use in a non-medical context and how society ought to respond to this problem.[30] The Commission concluded that drug criminalization's high costs outweighed its benefits, and recommended that criminal sanctions against drug use be removed.[31] Nonetheless, the recommendations of the commission were never implemented and its conclusions widely faded from the public eye.[32] In the 1990s, and in opposition to the report's recommendations, Canada introduced its new drug legislation–the *Controlled Drugs and Substances Act* ("*CDSA*")–which touted a prohibitionist model on drug use. The legislation widened the criminal net to capture more people who use drugs despite the social and economic costs highlighted twenty years prior.[33] The legislation and its criminalization of drug use led to the denial of fundamental human rights of PWUD, including the right to life, health, and bodily integrity.[34]

Nonetheless, Canada was a pioneer in the 1980s in implementing harm reduction measures in response to the HIV/AIDS epidemic among PWUD.[35] In 1987, as a result of increased HIV infections, Toronto community members began sterilizing syringes at a public park with bleach.[36] This quickly

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[28] See Cavalieri & Riley, *supra* note 4 at 384.

[29] See *ibid* at 382.

[30] See *ibid*.

[31] See *ibid*.

[32] See *ibid* at 383.

[33] See *ibid* at 383–84.

[34] See Health and Human Rights Resource Guide, "How is Harm Reduction a Human Rights Issue" (12 March 2014), online: <www.hhrguide.org/2014/03/12/how-is-harm-reduction-a-human-rights-issue/>.

[35] See Elaine Hyshka et al, "Principles, practice, and policy vacuums: Policy actor views on provincial/territorial harm reduction policy in Canada" (2019) 71 Intl J of Drug Policy 142 at 143.

[36] See Cavalieri & Riley, *supra* note 4 at 384.

turned into a needle exchange program by 1988, with the City of Toronto managing the program by 1989; Vancouver and Montreal quickly implemented similar needle exchange programs.[37] Harm reduction practices continued to rise in prominence in the 1990s as a response to the continuous rise of HIV infection among injection drug users.[38] In 1998, harm reduction became one of four pillars of Canada's drug policy, alongside prevention, treatment, and enforcement.[39] Despite such practices and influenced by an increasing model of criminalization, by 1998, approximately 25 to 35 percent of people who use drugs in the Vancouver Downtown East Side were HIV-positive; at the time this represented the highest level of HIV prevalence among injection drug users in the Western world.[40]

Despite its promising origins, harm reduction has suffered numerous drawbacks since its origins in Canada. Notably, during Stephen Harper's tenure as Canadian Prime Minister, the practice regressed as a result of 2007's National Anti-Drug Strategy that aimed its focus toward prevention, treatment, and enforcement against drug use in Canada,[41] thereby eliminating harm reduction as a pillar of the government's strategy for drug policy. The Canadian Centre for Addiction and Mental Health criticized the Strategy shortly after its release for ignoring harm reduction efforts that succeed in providing care to people who use drugs that are either unable or unwilling to halt their use.[42] Also highlighted was that this marked a shift in Canada's drug policy toward abstinence, deterrence, and the use of the criminal justice system to resolve what may be better conceptualized as a public health problem. This shift was particularly concerning when comparing Canada's policy to the USA's efforts in addressing drug use through punitive law and the resulting increases in incarcerated individuals and a quadrupling of drug-related

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[37] See *ibid*.

[38] See *ibid* at 385.

[39] See Hyshka, supra note 35 at 143.

[40] See *ibid*.

[41] See Centre for Addiction and Mental Health, "The National Anti-Drug Strategy: A CAMH Response" (September 2008) at 1, online (pdf): <www.camh.ca/-/media/files/pdfs--public-policy-submissions/nads-response-final-2008-pdf.pdf>.

[42] See *ibid* at 3.

deaths.[43] Harper's plan introduced a "law and order" approach to drug use in Canada and his government implemented mandatory minimum prison sentences and large fines were implemented for drug offenders while also increasing law enforcement funding and restricting the rights of incarcerated people.[44]

Harm reduction, even since the end of Harper's tenure, has been subject to opposition from provincial and municipal governments. Until 2016, Vancouver was the only city in which SCS and OST were available, and naloxone distribution was only available in Alberta, Ontario, and British Columbia. [45] In Coquitlam, BC, the city banned methadone clinics to make the city more "family friendly." [46] After Alberta centralized its health services, its government ended the Non-Prescription Needle Use Initiative, a harm reduction needle exchange program.[47] In the Quebec legislative assembly, an opposition party leader claimed that a cocaine harm reduction information card promoted drug use.[48] Most recently, Alberta has "unjust[ly] assault[ed]" SCS by closing them without adequate community consultation.[49] Harm reduction practice thus remain vulnerable to the particularities of whomever currently holds political power, emphasizing the importance of interrogating the relationship between such practices and human rights that ought to be immune from political persuasions.

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[43] See *ibid* at 4.

[44] See Cavalieri & Riley, *supra* note 4 at 389.

[45] See Hyshka, supra note 35 at 143.

[46] Cavalieri & Riley, *supra* note 4 at 390.

[47] See *ibid*.

[48] See *ibid* at 392.

[49] Anna Junker, "Alberta harm reduction advocates call on province to stop 'unjust assault' on supervised consumption sites", *Edmonton Journal* (30 August 2021), online: <edmontonjournal.com/news/local-news/alberta-harm-reduction-advocates-call-on-province-to-stop-unjust-assault-on-supervised-consumption-sites>.

iii. Principles of Harm Reduction

Harm reduction efforts are generally grounded in several principles. First, harm reduction exemplifies a value neutral approach regarding the underlying behaviour it seeks to address;[50] second, it uses evidence-based science to guide its arguments (instead of political belief); third, it dismisses punitive criminalization models; fourth, it upholds the belief that those who engage in "risky" practices remain worthy of human rights;[51] fifth, it addresses underlying causes of drug-related harm; finally, it involves PWUD in decision-making processes to tailor the practices' needs to the population's needs.[52]

The principle of non-judgmentalism toward risky behaviour is generally thought to be a key feature of harm reduction,[53] particularly when considering the practice's grassroots origins between community members that used harm reduction as a response to state criminalization of personal drug use.[54] Harm Reduction International also underlines the importance of not stigmatizing individuals who use drugs or arbitrary line-drawing on what constitutes "good" or "bad" drug use, commonly referred to as "meeting people where they are."[55] While abstinence can be a goal for certain PWUD, harm reduction need not necessarily concern itself with such goal and instead focuses on "the negative consequences of drug use to the user and others."[56]

Related to harm reduction's basis in science and not partisan political beliefs, the Supreme Court of Canada has developed its interpretation of Section 7 of the *Charter*—the right to life, liberty,

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[50] See Weinstock, "Disagreement", *supra* note 17 at 318–19.

[51] See Klein, "Counter-Hegemonic", *supra* note 12 at 457; Daniel M Weinstock, "A Harm Reduction Approach to the Ethical Management of the COVID-19 Pandemic" (2020) 13:2 Public Health Ethics 166 [Weinstock, "COVID-19"] at 167.

[52] See Hyshka, supra note 35 at 143.

[53] See Klein, "Counter-Hegemonic", *supra* note 12 at 451.

[54] See *ibid*.

[55] Harm Reduction International, *supra* note 10.

[56] British Columbia Ministry of Health, "Harm Reduction: A British Columbia Community Guide" (last visited 6 July 2022) at 5, online (pdf): <www.health.gov.bc.ca/prevent/pdf/hrcommunityguide.pdf>.

and security of the person—along the lines of harm reduction, emphasizing the need for the government to take into account scientific evidence instead of relying on dogmatic political beliefs about the moral perils of certain actions when crafting policy that affects individuals' right to life and liberty.[57] Furthermore, joining human rights law with public health evidence can shift society away from a prohibitionist model towards one based on principled pragmatism.[58]

Harm reductionists can be seen as human rights advocates, with an underlying aim of ensuring respect for the fundamental human rights of individuals who use drugs, regardless of whether the practice is legal or not.[59] Harm Reduction International, for instance, emphasizes the need to respect the human rights of people who use drugs by treating them with compassion and dignity and making their rights to life, health, privacy, social services, and freedom against arbitrary detention not conditional on abstinence from drug use.[60] In many ways, harm reduction has elevated the political standing of individuals traditionally cast aside by the political process, including people who use drugs and sex workers.[61] The practice thus aims to ensure the highest attainable standard of physical and mental health for all of society, cognizant of the human rights harms that may flow from health care denial and subjecting individuals to cruel and unusual punishment from a prohibitive drug policy.[62]

One grounding principle of harm reduction is its alignment with the philosophy of "new public health", which aims to focus on environmental factors that drive disease instead of the bio-medical model of health that regards disease as a medical condition with little attention to the societal factors that cause it.[63]

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[57] See Klein, "Counter-Hegemonic", *supra* note 12 at 460–61.

[58] See Elliott et al, *supra* note 22 at 106–107.

[59] See *ibid* at 106.

[60] See Harm Reduction International, *supra* note 10.

[61] See Klein, "Counter-Hegemonic", *supra* note 12 at 463.

[62] See Elliott et al, *supra* note 22 at 115–16.

[63] See Nadine Ezard, "Public health, human rights and the harm reduction paradigm: from risk reduction to vulnerability reduction" (2001) 12:1 Intl J of Drug Policy 207 at 207; Klein, "Counter-Hegemonic", *supra* note 12 at 453–54.

The new public health is in effect a social model of health, emphasizing the agency of individual subjects who engage with an environment created by structural factors.[64] Harm reduction can be seen as reflective of such a model; it presumes substance dependence not as a treatable individual condition but an amalgamation of social factors that effectively contribute to dependence. As such, it can be seen as advocating for the removal of barriers that needlessly restrict or worsen the individual health of PWUD, emphasizing social and economic rights like security of the person, the right to remuneration and social security, and the right to an adequate standard of living.[65]

Finally, the participation of PWUD is central to harm reduction, as they are "the best source of information about their own drug use and are empowered to join with service providers to determine the best interventions to reduce harm from drug use."[66] Harm reduction thus emphasizes the autonomy and dignity of PWUD and enables them to make choices that can alter their habits and allow them to reduce the risk of harm from certain behaviours.[67]

iv. Goals of Harm Reduction

Harm reduction is generally not thought to be an end in and of itself, but rather a process of amelioration of the health of PWUD.[68] While protecting the life and health of PWUD is a general underlying goal of harm reduction, the practice's goals are broader than this.[69] Drug laws and policies that exacerbate the risks of drug use—such as criminalizing personal drug use, denying medical treatment to PWUD, and restricting access to sterile drug injection equipment—are also areas of oppositional focus for the project at the political and legal level.[70] Furthermore,

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[64] See Ezard, *supra* note 63 at 207.

[65] See Elliott et al, *supra* note 22 at 118–19; Health and Human Rights Resource Guide, *supra* note 34.

[66] British Columbia Ministry of Health, *supra* note 56 at 5.

[67] See *ibid*.

[68] See Klein, "Counter-Hegemonic", *supra* note 12 at 457.

[69] See Harm Reduction International, *supra* note 10.

[70] See *ibid*.

relying on incarceration to address drug use often exacerbates human rights violations due to prison conditions like "unsanitary facilities, overcrowding, inadequate food, violence, sexual assault, inadequate medical attention," possibility of blood-borne disease like HIV and Hepatitis C due to non-sterile drug injection equipment, and lack of access to antiretroviral therapy.[71]

Whether abstinence from drug use is or ought to be a goal of harm reduction remains a contentious question. It could be contended that one benefit of SCS is the capacity for drug treatment programs to be recommended to individuals who use such facilities. To be sure, some do advocate for abstinence as a worthy goal.[72] Harm Reduction International stipulates that access to treatment *is* important for some individuals but should not be a requirement of access to harm reduction programs and services.[73] Abstinence can be a valid goal for some PWUD, but it likely should not be imposed and instead offered as a choice to individuals,[74] respecting their agency and capacity to make decisions regarding their own health.

III. *Can* harm reduction fit within the human rights paradigm?

This section analyzes whether harm reduction fits within the human rights paradigm. It outlines two theoretical approaches to human rights—human dignity and the capabilities approach—and assesses harm reduction's compatibility with them.

i. Human dignity

Human dignity plays a central role in human rights. Both the *International Covenant on Economic, Social and Cultural Rights* and the *International Covenant on Civil and Political Rights* state

[71] Health and Human Rights Resource Guide, *supra* note 34.

[72] See Klein, "Counter-Hegemonic", *supra* note 12 at 457.

[73] See Harm Reduction International, *supra* note 10.

[74] See *ibid*.

"that all human rights derive from the inherent dignity of the human person."[75] While dignity is a concept with multiple definitions, its "minimum core" is thought to be that every human possesses an intrinsic worth by virtue of being human, that this worth ought to be respected by others, and that the state's role is to realize the dignity of the individual human and not the other way around.[76] Immanuel Kant used the concept in his work *Metaphysics of Morals*, which stipulated that as its basis, dignity requires that individuals be treated as ends in themselves and not simply as means.[77] Kant is thought to closely associate the concept of dignity with *autonomy*—that dignity requires individuals be treated as autonomous to choose their own paths.[78] Dignity thus emphasizes that humans are agents in themselves and can make their own moral choices, shape their identities, and participate in the shaping of society.[79] This conceptualization continues into the present day; the 1993 Vienna World Conference on Human Rights adopted *dignity* into several provisions dealing with particular focuses for human rights, including issues of biomedical ethics and the right to health.[80] Human dignity can provide a theoretical basis for human rights because of its non-ideological basis and humanistic orientation that can evolve alongside human rights discourse progresses.[81]

Dignity is often thought to be associated with *negative* liberties—a limitation on the state's interference over individual choice and autonomy.[82] Yet in ensuring such liberties, the state may be required to create social conditions that enable individuals to lead the life of their choosing—a *positive* onus on the state.[83] Dignity can be used to claim that a person who lacks basic

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[75] Christopher McCrudden, "Human Dignity and Judicial Interpretation of Human Rights" (2008) 19:4 Eur J Intl L 655 at 656.

[76] *ibid* at 679.

[77] See *ibid* at 659.

[78] See *ibid* at 659–60.

[79] See Sandra Leidenberg, "The Value of Human Dignity in Interpreting Socio-Economic Rights" (2005) 21:1 SAJHR 1 at 7.

[80] See McCrudden, *supra* note 75 at 670.

[81] See *ibid* at 677.

[82] See Leidenberg, *supra* note 79 at 9.

[83] See *ibid*.

material necessities ought to be granted them in order to enable their survival and development as a community member.[84] In a South African case, the government was asked to provide an antiretroviral drug to a mother to limit the possibility of HIV transmission to her child; the Court held that the government *did* have an obligation to extend distribution of the drug because to not do so would "indicate a lack of respect for [the mother's] dignity as [a] human bein[g] entitled to be treated as worthy of respect and concern."[85] Conditions of marginalization can thus be seen as a societal failure to uphold the dignity of each individual rather than any sort of moral failing for individuals who must rely on the state for their dignity to be upheld.[86] Dignity can thus serve as a challenge to the stigmatization that characterizes marginalized individuals as societal dependents who are undeserving of the state's support

ii. Harm Reduction's Compatibility with Human Dignity

Dignity and harm reduction appear to be mutually compatible concepts, and both can be seen to reinforce the other. Prohibitionist drug control strategies often focus on isolating, controlling, and containing PWUD—similar to how the state responds to drugs themselves—marking them for arrest through their use of drugs and incarcerating them to limit their potential to re-offend.[87] In contrast, harm reduction strategies emphasize the inherent dignity of PWUD; it acknowledges that leaving aside whether abstinence is the best strategy to be pursued in drug policy, harm reduction operates on the notion that all individuals are worthy of protection by public health measures, including PWUD, irrespective of their decision to use drugs.[88] It emphasizes their agency and autonomy, giving them the opportunity to reduce the risks of their consumption on their own accord without relying on detention, forced treatment, or stigmatization to deter

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[84] See *ibid* at 12.

[85] *Ibid* at 13.

[86] See *ibid* at 14.

[87] See Jonathan Cohen & Daniel Wolfe, "Harm reduction and human rights: finding common cause" (2008) 22 AIDS 593 at 594.

[88] See *ibid*.

individuals,[89] while also relying on PWUD to assist in the creation of harm reduction strategies.[90] This emphasizes their autonomy and dignity, emphasizing that the individuals most affected by criminal policies are best positioned to understand "their own well-being [over] state-based entities."[91] In contrast, a prohibitionist drug control strategy revokes the autonomy of PWUD, determining their drug use as harmful and imprisoning individuals, a clear violation of freedom. As such, harm reduction and dignity are compatible in seeking to uphold PWUD's autonomy and freedom from state coercion that denies its citizens their right to the highest attainable standard of health.[92]

Another benefit of conceptualizing harm reduction through the lens of human dignity is that it offers a theoretical layer of protection in instances where individuals who benefit from harm reduction practices—people who use drugs, for instance—are scapegoated by the government as a threat to public health and the economy.[93] In situations of economic crisis when resentment flows from government austerity measures and increasing inequality, societal elites often redirect such resentment toward certain populations to gain support from the middle and working class.[94] Harm reduction measures can thus be rendered (falsely) oppositional to the attainment of economic prosperity if governments are believed to be "distributing drugs" or sanctioning "drug use facilities" in working class neighbourhoods.[95] Human dignity and the human rights of PWUD can offer an alternative conceptualization upon which harm reduction practices can be grounded, and harm reduction can affirm the dignity of PWUD to protect them against political scapegoating.

Human dignity can also frame the interpretation and application of socio-economic rights, which certain harm reduction

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[89] See *ibid*.

[90] British Columbia Ministry of Health, *supra* note 56 at 3.

[91] Klein, "Harm Reduction Works", *supra* note 20 at 407.

[92] See *ibid* at 409.

[93] See Samuel R Friedman et al, "Harm reduction — a historical view from the left" (2001) 12:1 Intl J of Drug Policy 3 at 7–8.

[94] See *ibid* at 7.

[95] *Ibid* at 10.

measures advocate for. Despite socio-economic rights not being enshrined in the Canadian *Charter*, the Canadian Supreme Court has left open the possibility of Section 7 supporting a positive obligation on the state to guarantee living standards.[96] Harm reduction and its emphasis on human dignity could, in theory, open the door to some forms of positive obligation. For example, in response to the increasing toxicity of "street supply" opioids as a result of the COVID-19 pandemic, the BC Government recently committed $22.6 million worth of funding toward "safe supply" opioids over the next three years, which are non-toxic government-distributed opioids that aim to reduce harm from illicit consumption.[97] If the government were to discontinue the program and a high level of toxicity in street supply opioids were to return, human dignity as articulated under Section 7 of the *Charter* might support a legal obligation on the government to re-impose such a program.

This obligation, however, could also be interpreted as a negative one; once the government begins such a program, arbitrarily terminating it might infringe PWUDs' Section 7 rights, but there might be no positive obligation on the government to begin such a program. This characterization is arguably more in line with the Supreme Court's reasoning in the 2011 *Insite* decision, where the decision to deny Insite the necessary exemption from the *CDSA* to continue operating unconstitutionally infringed Insite staff and clients' Section 7 rights.[98] This finding supports only a negative obligation on the government and thus limits the possibility of socio-economic rights being guaranteed under Section 7 of the *Charter*. Furthermore, the Supreme Court may be unwilling to open the door to a positive governmental obligation if it leaves no limiting principle on Section 7's scope. Despite the benefits that would flow to PWUD from an interpretation that imposes a positive governmental obligation to provide its citizens with, for instance, housing,[99] such an

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[96] See *Gosselin v Quebec (Attorney General)*, 2002 SCC 84 at paras 81–83.

[97] See British Columbia Government News, "B.C. introduces new prescribed safer supply policy, a Canadian first" (15 July 2021), online: <news.gov.bc.ca/releases/2021MMHA0035-001375>.

[98] See *Canada (Attorney General) v PHS Community Services Society*, 2011 SCC 44 at paras 85–94 [*Insite*].

[99] See British Columbia Ministry of Health, *supra* note 56 at 3.

interpretation appears out of reach within the current framework. Furthermore, judicial deference is often granted toward the legislature on policy decisions, thereby limiting the possibility of courts positively obligating the government to enact certain policies.[100] Nonetheless, harm reduction and its compatibility with dignity can breathe new life into the potential for positive governmental obligations, and perhaps an argument in support of imposing such obligations could succeed if it were tightly circumscribed to specific harm reduction measures.

iii. Capabilities

Indian philosopher Amartya Sen and American philosopher Martha Nussbaum developed the capabilities approach to human rights, a normative framework that describes human rights as the "rights to certain specific freedoms": capabilities. [101] The capabilities approach relies on a distinction between the freedom to *choose to do* something and holding the *means, instruments, or permissions* to make this choice.[102] The capabilities approach aims to provide all individuals with the former: freedom of choice, regardless of means. [103] This conceptualization allows us to understand individual rights as a threshold level of capabilities, where each individual may require particularized assistance in reaching the basic level of capabilities accorded to them by virtue of being human.[104] As such, it adequately accounts for a diverse society of individuals with different needs and starting points in their ability to convert resources into functionings.[105] Capabilities, however, are not to be conflated with functionings, or actual end results; for instance, the right to health under the capabilities approach does not require visits to a doctor to ensure the highest standard of health imaginable, but rather the *freedom or*

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[100] See e.g. *Cooper v Hobart*, 2001 SCC 79 at para 53.

[101] Amartya Sen, "Human Rights and Capabilities" (2005) 6:2 J of Human Development 151 at 152.

[102] See *ibid* at 153.

[103] See *ibid* at 153–54.

[104] See *ibid* at 154.

[105] See Caroline Harnacke, "Disability and Capability: Exploring the Usefulness of Martha Nussbaum's Capabilities Approach for the UN Disability Rights Convention" (2013) 41:4 JL Med & Ethics 768 at 770.

opportunity to access such a standard if they so choose.[106] Capabilities, in Marx's words, thus involve a need to replace "the domination of circumstances and chance over individuals by the domination of individuals over chances and circumstances."[107] Capabilities thus represent a minimum theory of justice that the state must respect in order for a society to be considered just.[108] While the capabilities approach interacts with human dignity—Nussbaum, for instance, stipulates that capabilities represent the "bare minimum of what respect for human dignity requires"[109]—the capabilities approach offers some theoretical considerations that dignity may inadequately capture, as will be discussed in the next section.

Sen and Nussbaum differ in whether capabilities ought to be listed. Sen contends that the creation of a universal list of capabilities would "displac[e] the need for continued public reasoning" regarding what a state ought to provide to its citizens for a society to be considered just",[110] whereas Nussbaum lists ten capabilities that she describes as universal for the framework, including life, bodily health and integrity, and control over one's environment.[111] Regardless of the approach a state takes, both theorists agree that capabilities include the freedom to "live disease-free lives", "move around", and "participate in public life."[112] The state is thereafter left to weigh such freedoms and how they believe they should go about their obtainment for their subjects, dependent on whether any one particular freedom is particularly deficient in comparison to another.[113] One advantage of this approach is that it does not require an ethical evaluation of whether one capability is universally more important than another; instead, the state has the onus to ensure all capabilities

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[106] See Sen, *supra* note 101 at 154–55.

[107] *Ibid* at 155.

[108] See Harnacke, *supra* note 105 at 771.

[109] *Ibid* at 770.

[110] Sen, *supra* note 101 at 157.

[111] See Harnacke, *supra* note 105 at 770.

[112] Sen, *supra* note 101 at 158 (these three freedoms correspond to three capabilities listed by Nussbaum (bodily health, control over one's environment, and affiliation)).

[113] See *ibid* at 159.

are obtained, with of course the freedom to choose which should be worked towards at any particular moment.[114] A state with a low incidence of disease but high incidence of institutionalization that restricts mobility is thus likely better served by focusing on remedying mobility restrictions than further decreasing disease incidence. The process of public reasoning serves as a critical element in determining how such capabilities are to be obtained and subjecting each one to scrutiny provides individuals with the opportunity to make a defence for its importance.[115]

iv. Harm Reduction's Compatibility with Capabilities

Like dignity, the capabilities approach is in line with many principles of harm reduction, including that all individuals ought to live healthful lives and participate in public life. The approach's focus on capabilities over functioning is also in line with harm reduction's de-emphasis on abstinence as a necessary goal for drug policy. The capabilities approach adequately accounts for the possibility of abstinence as a goal for certain PWUD but does not require it; individuals thus ought to have the capability to choose to abstain from using drugs if they so choose, without necessarily requiring the state to choose whether abstinence is a worthy normative goal.

One advantage that the capabilities approach has over human dignity is that it may allow us to more easily account for intersecting forms of discrimination that flow from marginalization, contrasted with an approach to human dignity that arguably accounts for dignity more broadly and thus might ignore individual circumstances that may require differential treatment. Harm reduction theorized through the capabilities approach provides a normative basis for addressing these differences. Women, for example, often experience severe forms of discrimination as a result of prohibitionist policies: drug use is used as grounds for custodial denial; women are often initiated into drug abuse by sexual partners, which limits their autonomy in modifying drug use behaviours; women also often require assistance injecting drugs, increasing their subordination in

[114] See *ibid*.

[115] See *ibid* at 160–61.

relationships where sex and drugs are intertwined.[116] As a result, harm reduction approaches that inadequately uphold the capabilities of all societal members may be inadequate in upholding human rights. In the context of, for instance, SCS, women may require assistance injecting because they traditionally rely on an intimate partner to do so yet receiving assistance from staff remains illegal at SCS.[117] Theorizing harm reduction through the capabilities approach can offer a structural form of analysis that can help ensure that states implement harm reduction measures to adequately ensure accessibility for all PWUD. Furthermore, it may highlight the advantages of a harm reduction approach to drug policy over a prohibitionist one, particularly when considering the widely documented human rights violations against Black and Indigenous persons of colour flowing from a prohibitionist drug policy.[118]

IV. *Should* harm reduction fit within the human rights paradigm?

i. Foucauldian critique

In approaching harm reduction at the human rights level, a clash becomes apparent with the project of legalizing a practice that has its origins in community and grassroots-level activism. Harm reduction originated as a bottom-up approach to rectifying the harms brought on by a punitive drug criminalization model and a state ignorant of drug users' claims to being worthy of

[116] See Jürgens, *supra* note 23 at 479.

[117] See HIV Legal Network, "Overdue for a Change: Scaling Up Supervised Consumption Services in Canada, Key Findings + Recommendations", (11 December 2018) at 5, online: <www.hivlegalnetwork.ca/site/overdue-for-a-change-scaling-up-supervised-consumption-services-in-canada/?lang=en> [HIV Legal Network, "Scaling Up"].

[118] See Health and Human Resources Guide, *supra* note 34. See generally Eva Nilsen, "Decency, Dignity, and Desert: Restoring Ideals of Humane Punishment to Constitutional Discourse" (2007) 41:1 UC Davis L Rev 111; Akwasi Owusu-Bempah & Shaun L Gabbidon, *Race, ethnicity, crime, and justice: an international dilemma* (New York: Routledge, 2021).

dignity and autonomy.[119] While such individuals thereby presume the project to act as an instrument for structural societal change against a harmful and punitive model of criminalization, others approach the practice more pragmatically in emphasizing its capacity to promote health and reduce harm without necessarily decriminalizing drug use.[120] The "activist orientation" sees harm reduction as a first step in reducing social, economic, racial, and political inequalities, with the "public health orientation" aiming to remedy the harms of drug use "without necessarily re-orienting the system which produces them."[121] While introducing harm reduction as part of the "system"—mainstream organizations, academia, and public policy—is not necessarily a negative, it opens the door to harm reduction perpetuating structures of domination that emphasize social control and the creation of a normative subject instead of social welfare that is responsive to human needs and the state's deficiencies in adequately upholding the rights of its citizens.[122] Harm reduction can then become a form of risk management by the state, where individual prudentialism is reified, distracting from external economic and social factors toward an individual behavioural modification to reduce the risks flowing from harmful conduct.[123] The most marginalized of PWUD, who are the ones who most apparently ought to benefit from harm reduction practices, are thus neglected in the state setting a normative standard of who a client can be and on what conditions they may be granted relief from harm.[124]

The internal tension between harm reduction's fundamental orientation was somewhat settled in the 1980s at the height of the HIV/AIDS crisis, where the medicalization model of harm reduction became the project's predominant discursive basis.[125] Departing from the practice's somewhat anarchist origins that

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[119] See Klein, "Harm Reduction Works", *supra* note 20 at 407.

[120] See Gordon Roe, "Harm reduction as paradigm: Is better than bad good enough? The origins of harm reduction" (2005) 15:3 Critical Public Health 243 at 244.

[121] *Ibid* at 245.

[122] See Cavalieri & Riley, *supra* note 4 at 394.

[123] See Ezard, *supra* note 63 at 211–12.

[124] See *ibid*.

[125] See Roe, *supra* note 120 at 245.

aimed to create resistance separate from the state's reach,[126] harm reduction may now be perceived to attract "reformers rather than revolutionaries, technologists rather than activists."[127] As argued by many critics, harm reduction's emphasis on biomedically remedying the risks associated with drug use may divert attention from the risks' underlying causes and continue the stigma that drug use is inherently dangerous.[128] The function of such a practice becomes not liberation but a form of "surveillance medicine", where the state's apparatus of criminalization relies instead of public health to create a normative subject and induce internalized compliance among those who are deviant, lest they be subject to the criminal sanction typically enacted against those who engage in illicit drug use.[129] Harm reduction becomes not a liberationist project of escaping the state's reach into matters that, arguably, ought not to be the focus of criminal law, but an extension of the state's regulatory apparatus. This shifts the onus of risk management onto individuals who engage in risky practices. [130] The practice's procedural orientation—reducing harm—thus simultaneously ameliorates the most dastardly impacts of criminalization while reducing the state's incentive to alter such policies, [131] perhaps even supporting and strengthening prohibitionist laws.

ii. Response

Such criticisms are not to be taken lightly. In implementing harm reduction within the human rights framework, such criticisms require constant evaluation to analyze the risks of the practice being co-opted by biomedical models of normativity. However, I propose that such criticisms, though they can never be fully ignored, can be at least attenuated as to not render harm reduction incompatible with human rights and formal implementation. Three bases exist for such an attenuation: the

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[126] See Klein, "Harm Reduction Works", supra note 20 at 407.

[127] Roe, *supra* note 120 at 247.

[128] See Klein, "Counter-Hegemonic", *supra* note 12 at 466.

[129] See *ibid* at 467.

[130] See Roe, *supra* note 120 at 246.

[131] See *ibid* at 247.

vulnerability model for risk assessment; a change in the discursive method by which harm reduction is articulated; and maintaining grassroots and informal policies where possible.

To minimize the risk of negative consequences flowing from linking harm reduction with human rights, a third dimension—in addition to harm and risk—ought to be added to harm reduction: *vulnerability*. Harm reduction traditionally utilizes risk of harm to delineate its approach of behaviour to regulate, yet reliance on risk as a policy-making factor has been argued to reinforce individual behaviour modification.[132] Vulnerability, on the other hand, refers to a "restriction of individual capacity to effect control over one's life with factors, such as youth, gender and poverty influencing vulnerability."[133] While distinct from risk, vulnerability partly *determines* risk, and treatment of individual vulnerability—through, for instance, mental health initiatives to improve depression—and structural vulnerability—through, for instance, educational opportunities—can succeed in reducing overall vulnerability to drug-related harms.[134] This approach contextually assesses risk, encompassing not just the moment when, for instance, an individual prepares to inject with a contaminated needle, but when the police confiscates a sterile syringe or when an evicted individual injects on the street.[135] Vulnerability analysis de-centres the subject as the focal point of harm reduction's capacity to modify behaviour, enjoining it with an approach to public health that analyzes multiple causes of illness, including poverty, racism, and sexism.[136] Vulnerability analysis shifts the focus from individual responsibility onto the state, ensuring that harm reduction adequately accounts for not just individual actions, but the broader context in which they take place.[137]

Modifying the discursive basis by which harm reduction is spoken about can also assist in overcoming problems relating to the formalization of harm reduction. This could be done by simply adjusting the words used to describe harm reduction. For instance,

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[132] See Ezard, *supra* note 63 at 211–12.

[133] *Ibid* at 212–13.

[134] See *ibid* at 214.

[135] See Jürgens, *supra* note 23 at 481.

[136] See Ezard, *supra* note 63 at 217.

[137] See *ibid*.

as harm reduction is a politically polarizing topic, the terminology could be adjusted to use terms like "risk mitigation" instead of "harm reduction", as the former has been shown to remain popular among governments who are generally unaccepting of harm reduction practices.[138] Regarding the normative articulation of the practice, it may be more desirable to conceptualize the practice as one that "changes the subject" from irreconcilable debates about whether drug use is morally acceptable or not, over accepting that drug use is wrong but inevitable.[139] The former abstains from questions surrounding whether abstinence is a normative goal for harm reduction to be achieved, in line with harm reduction's principles.[140] Furthermore, "changing the subject" holds that both sides of the debate may have reasonable yet irreconcilable points of view regarding the values that underlie the debate around drug prohibition, including those who believe that drug use does not signify a moral failure.[141] This allows harm reduction to maintain its non-judgmental stance against substance use while also emphasizing the inherent dignity in its advocates and PWUD.

Finally, states can refrain from formally articulating harm reduction policies unless necessary. In Canada, harm reduction implementations are generally not driven by a principled approach but rather respond to crises as needed.[142] Harm reduction was, in essence, born out of the HIV/AIDS crisis, and now predominantly aims at combatting the harmful consequences from the opioid overdose crisis.[143] While some advocate for a permanent stream of harm reduction funding, others contend that engaging with harm reduction at this level may bureaucratize the practice and disincentivize PWUD to develop bottom-up harm reduction initiatives to resolve on-the-ground crises.[144] Harm reduction successes have largely been based on the ingenuity and resourcefulness of PWUD; needle cleaning and exchange

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[138] See Hyshka, supra note 35 at 146.

[139] Weinstock, "Disagreement", *supra* note 17 at 318–19.

[140] See *ibid* at 319.

[141] See *ibid*.

[142] See Hyshka, supra note 35 at 146.

[143] See *ibid*.

[144] See *ibid* at 146–47.

programs and SCS were initially developed by PWUD and later overtaken and sanctioned by the state, and it is perhaps this "policy vacuum" that enables such creative solutions to pressing social problems.[145] It should be clarified that there remains a desirability for the state to acknowledge and aid in implementing PWUD-created harm reduction practices; however, it is through a non-formal articulation of harm reduction practices that may enable on-the-ground solutions to flourish.

V. *How* should *harm reduction* be defined?

i. Who *gets to define* harm reduction?

What constitutes harm reduction and how its measures ought to be implemented are critical questions to answer in locating harm reduction within the human rights framework. Traditionally, PWUD have "rarely been included in discussions of issues that affect their lives."[146] However, there are "ethical and human rights imperatives" to adequately include the perspectives of PWUD within the harm reduction framework.[147] As PWUD are best positioned to identify effective harm reduction measures within their given community, they ought to be able to participate in decisions regarding their health.[148] Relying on PWUD to structure public policy construes them as responsible citizens and emphasizes their autonomy and dignity.[149] To adequately ensure their perspectives are included in conversations about harm reduction, the government ought to explicitly recognize the value

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[145] *Ibid* at 147.

[146] HIV Legal Network, "'Nothing About Us Without Us': Greater, Meaningful Involvement of People Who Use Illegal Drugs: A Public Health, Ethical, and Human Rights Imperative", (1 December 2005) at ii, online: <www.hivlegalnetwork.ca/site/nothing-about-us-without-us-greater-meaningful-involvement-of-people-who-use-illegal-drugs-a-public-health-ethical-and-human-rights-imperative/?lang=en> [HIV Legal Network, "Nothing"].

[147] *Ibid* at iii; Klein, "Harm Reduction Works", *supra* note 20 at 410.

[148] See Jürgens, *supra* note 23 at 480; Friedman, *supra* note 93 at 12.

[149] See Klein, "Harm Reduction Works", *supra* note 20 at 408.

of including PWUD in harm reductions consultations while also dedicating funding to pay PWUD for offering their perspectives.[150]

Important to note is that while harm reduction policy efficacies ought the validity in certain harm reduction measures ought not to be entirely derived from traditional forms of evidence-based medicine. Such a restriction may bar evidence that cannot be slotted into traditional forms of policy evidence and thus inappropriately privilege "the voices of researchers and clinicians while marginalizing and delegitimizing others." [151] Instead, evidence pertaining to the value of harm reduction measures could be considered valid through ethnographic data drawn from the lived experiences of PWUD which could inform public policy.[152]

ii. When *should harm reduction practices apply?*

Another important question in defining *harm reduction* is how to assess when it should be applied and what its outer limits are. In terms of the former question, it could be contended that harm reduction ought to be applied whenever there is a risk of harm that can reasonably be reduced. The contentious aspect in this definition is, of course, what is reasonable in the circumstances.

What is reasonable could be defined legally—in terms of what constitutes a crime or not. However, this definition is somewhat circular and does not make room for harm reduction efforts that are *de jure* illegal but reasonable in the circumstances. One potential limitation could come from the aforementioned grounding that harm reduction's normative basis is an acknowledgment of the reasonable basis of both sides of the argument as related to contentious moral issues like drug use or sex work. Harm reduction's function of "changing the subject" to reducing harm is premised on the basis that both sides are reasonable in their articulation of their values and positions. If this premise were to be undermined—if one side were to begin to make unreasonable moral claims that while perhaps reducing harm, would compromise society's moral integrity—then an outer limit to

[150] See HIV Legal Network, "Nothing", *supra* note 146 at iii–iv.

[151] Klein, "Harm Reduction Works", *supra* note 20 at 406–407

[152] See *ibid*.

harm reduction's reach could be articulated.[153] However, this quantification of harm reduction's limit could be deficient in being subject to insecure definitions of societal moral integrity that are subject to varying interpretations dependent on who currently occupies a given political office. Nonetheless, in terms of defining harm reduction's limits, it remains clear that such evaluations ought not to be made without the involvement of individuals affected by the policy. Furthermore, it could be beneficial to make such evaluations on a less partisan basis, perhaps through the judiciary.

VI. *Where* do we go with harm reduction?

Harm reduction in Canada has seen a proliferation of application in the past 10 years. Three Canadian Supreme Court decisions—all surrounding Section 7 of the *Charter*—have relied on harm reduction principles to realize the rights of individuals as it pertains to drug use, sex work, and medical assistance in dying.[154] This section will narrow in on supervised consumption sites to assess what progress still needs to be made to fully realize the human rights of PWUD and whether a human rights approach to harm reduction can assist in realizing such goals.

Having initially been opened as a pilot scientific project to determine the efficacy of SCS in reducing harm, Insite currently operates under an exemption from Section 4 of the *CDSA*, which criminalizes drug possession.[155] As of December 2021, 38 sites in Canada offer SCS.[156] However, this number has exponentially grown in recent years. Despite Insite being opened in 2003, only two sites were operational until 2016, where the government

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[153] See Weinstock, "Disagreement", *supra* note 17 at 320.

[154] See generally *Insite*, supra note 98; *Canada (Attorney General) v Bedford*, 2013 SCC 72; *Carter v Canada (Attorney General)*, 2015 SCC 5.

[155] See British Columbia Ministry of Health, *supra* note 56 at 10.

[156] See Government of Canada, "Supervised consumption sites: Status of applications", (last modified 9 December 2021), online: <www.canada.ca/en/health-canada/services/substance-use/supervised-consumption-sites/status-application.html>.

began approving SCS exemptions again.[157] Harper's Conservative government actively prevented the implementation of SCS during its reign, and it was the Minister of Health's decision to not renew Insite's exemption that the Supreme Court of Canada held to be a decision that unconstitutionally violated Insite staff and clients' Section 7 *Charter* rights.[158] This decision effectively places harm reduction within the human rights framework. The Supreme Court endorsed SCS in the decision, indicating that "Insite saves lives" and that its "benefits have been proven" and denying Insite its exemption to continue operating would be grossly disproportionate to the objectives of the *CDSA*.[159] Nonetheless, the Court rejected a challenge to Section 4 of the *CDSA*—criminalizing drug possession—brought by the Vancouver Area Network of Drug Users ("VANDU"), holding that a causal basis was lacking between the prohibition and the Section 7 *Charter* rights of *all* PWUD.[160]

The dismissal of VANDU's claim demonstrates an unwillingness by judges and policymakers to listen to those most deleteriously affected by legislation. The continued prohibition on personal drug possession creates numerous hurdles in implementing harm reduction measures for PWUD, particularly as it surrounds SCS.[161] For example, the prohibition precludes staff from assisting with injections,[162] which is problematic when considering that it is often women who require assistance and thus the restriction may enact needless accessibility barriers for women to use SCS. The restriction also precludes the practice of "splitting and sharing" drugs, which while a common practice between PWUD when entering SCS, is precluded by government laws.[163] The result of such a prohibition is that it opens PWUD who leave SCS to split on the streets, often leaving such individuals in a vulnerable position from police arrest or increased likelihood of

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[157] See HIV Legal Network, "Scaling Up", *supra* note 117 at 2.

[158] *Insite*, *supra* note 98 at paras 85–94.

[159] *Ibid* at para 133.

[160] See *ibid* at paras 154–55.

[161] See HIV Legal Network, "Scaling Up", *supra* note 117 at 5.

[162] See *ibid*.

[163] *Ibid*.

injecting on the streets without overdose prevention services like naloxone nearby.[164]

A human rights approach to harm reduction can offer clarity into the above issues that currently plague SCS. First, it would indicate that the voices of PWUD ought to be listened to in designing and implementing harm reduction policies. PWUD have indicated that current criminal prohibitions on drug possession *do* create unnecessary barriers to SCS access. Their voices ought to be amplified and legislation that limits accessibility should be tightly circumscribed. Second, the capabilities approach enables us to assess intersecting forms of discrimination that can offer areas of inquiry to ensure all PWUD can access SCS. While women were identified as having accessibility barriers for SCS, people with disabilities or other vulnerable populations might have similar barriers; such barriers ought to be accounted for in devising accessibility improvements for SCS. Finally, grounding harm reduction in human rights creates a basis for SCS that is not amenable to political persuasions. The opposition SCS faced from prior governments should not affect the rights of PWUD, and access to harm reduction services like SCS should thus remain a human right.

VII. Conclusion

This paper has aimed to analyze the extent to which harm reduction fits within the human rights framework. Articulating this connection may prove helpful as harm reduction continues to be subject to political machinations, as it may more stably ground the practice and its normative bases. After outlining harm reduction's definition, history, principles, and goals, this paper outlined its compatibility with two dominant bases of human rights—dignity and capabilities—and concluded that harm reduction adequately fits within these two domains. However, this paper noted that approaching harm reduction at the human rights level might risk

[164] See Nick Pineau et al, "Splitting and sharing at overdose prevention and supervised consumption sites: What we learned", *CATIE Blog* (29 July 2021), online (blog): <blog.catie.ca/2021/07/29/splitting-and-sharing-at-overdose-prevention-and-supervised-consumption-sites-what-we-learned/>.

formalizing a practice that has its origins in a grassroots and bottom-up approach; nonetheless, these risks can be attenuated by looking to other structural factors that increase individual vulnerability, being ready to modify the discursive basis by which harm reduction is articulated, and not formally implementing harm reduction policies until PWUD have had the chance to enact their own informal policies. This paper also discussed the importance of centreing the voices of PWUD in our approaches to harm reduction, but also noted that defining the outer limits of harm reduction remains an area of further research. Finally, this paper looked to the operation of supervised consumption sites and noted how a human rights approach to harm reduction can enable the articulation of recommendations to the government in adequately ensuring such sites are accessible to all PWUD.

Harm reduction remains a novel and progressive manner by which the human rights of marginalized individuals can be advanced, empowering them to create their own solutions and thereby emphasizing their dignity and autonomy. Including harm reduction practices within the human rights framework will continue to improve the lives of Canadians and grant them authority to be involved in policy decisions that can significantly impede human rights.

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