Dalhousie Law Journal

Volume 38 | Issue 2 Article 6

10-1-2015

# Criminal Law and the Counter-Hegemonic Potential of Harm Reduction

Alana Klein
*McGill University*

Alana Klein*

# Criminal Law and the Counter-Hegemonic Potential of Harm Reduction

*Harm reduction approaches to drug use have been lauded for saving lives, being cost-effective, elevating pragmatism over prohibitionist ideology, being flexible in tailoring responses to the problem, and for their counter-hegemonic potential to empower people who use drugs. This article examines the legal system's engagement with harm reduction, and, in particular, recent cases that incorporate harm reduction's focus on empirical evidence in policy making into Canadian constitutional rights jurisprudence. It argues that harm reduction approaches in this venue may hold promise as a bulwark against some of the marginalizing features of traditional criminal justice approaches. However, the article also warns of a risk of inadvertently reinforcing the dominant discourse of criminalization and stigmatization as harm reduction's features are embodied within the institutional frameworks of the state.*

*Les approches visant à réduire les effets nocifs de l'utilisation de stupéfiants ont été vantées comme sauvant des vies, comme étant des solutions de rechange économiques qui placent le pragmatisme au-dessus de l'idéologie prohibitionniste, comme adoptant une attitude souple et offrant des réponses adaptées au problème des stupéfiants. Elles ont aussi été vantées pour leur potentiel antihégémonique à donner des moyens aux utilisateurs de stupéfiants. L'article examine l'engagement du système juridique par rapport à la réduction des effets nocifs, en particulier les cas récents qui intègrent l'accent mis par cette approche sur les preuves empiriques dans l'élaboration de politiques à la jurisprudence constitutionnelle canadienne en matière de droits. L'auteure avance que les approches de réduction des effets nocifs dans ce forum constituent peut-être un rempart contre certains des risques de marginalisation que présentent les approches de la justice pénale traditionnelle. Elle met cependant en garde contre le risque de renforcer, par inadvertance, le discours dominant qui affirme que la criminalisation et la stigmatisation comme caractéristiques de la réduction des effets nocifs sont inhérentes aux cadres institutionnels de l'État.*

* Assistant Professor, Faculty of Law, McGill University.

## *Introduction*

Canada's increasingly punitive criminal justice policy has attracted criticism for its human costs in terms of health and well-being, for acting as a politically marginalizing force, and for its ineffectiveness at reducing crime.[1] It has also met with judicial resistance.[2] In the area of drug use, both in Canada and internationally, harm reduction has emerged as the main alternative to the prevailing approaches of criminal law enforcement and abstinence-oriented medical treatment.[3] This paper considers whether recent judicial engagement with the concepts of harm reduction might offer a partial response to the marginalizing consequences of expansive criminal justice in Canada.

---

1. See, e.g., Paula Mallea, *The Fear Factor: Stephen Harper's "Tough on Crime" Agenda* (Ottawa: Canadian Centre for Policy Alternatives, 2010); Justin Piché, "Le régime de sanctions de Harper" (2013) 9 Nouveaux Cahiers du Socialisme 119; Alana N Cook & Ronald Roesch, "'Tough on Crime' Reforms: What Psychology Has to Say About the Recent and Proposed Justice Policy in Canada" (2013) 53:3 Canadian Psychology 217.

2. *R v Hill*, 2012 ONSC 5050, 291 CCC (3d) 321; *R v Lewis*, 2012 ONCJ 413, 264 CRR (2d) 122; *R v Smickle*, 2013 ONCA 678, 304 CCC (3d) 37; *R v Nur*, 2015 SCC 15; *Canada (AG) v Whaling*, 2014 SCC 20, [2014] 1 SCR 392; *R v MacDonald*, 2014 NSCA 102, 117 WCB (2d) 235; *R v Cloud*, 2014 QCCQ 464, 300 CRR (2d) 349; *R v Safarzadeh-Markhali*, 2014 ONCA 627, 122 OR (3d) 97; *R v Summers*, 2014 SCC 26, [2014] 1 SCR 575; *R v Michael*, 2014 ONCJ 360, 121 OR (3d) 244. See also Debra Parkes, "The Punishment Agenda in the Courts" (2014) 67 SCLR (2d) 589 at 590, 614; Kent Roach, "The *Charter* versus the Government's Crime Agenda" (2012) 58 SCLR (2d) 211; Don Stuart, "The *Charter* Balance against Unscrupulous Law and Order Politics" (2012) 57 SCLR (2d) 13 at 13-18.

3. Patricia G Erickson et al, eds, *Harm Reduction: A New Direction for Drug Policies and Programs* (Toronto: University of Toronto Press, 1997) at 4-6 [Erickson et al, *New Direction*]; G Alan Marlatt, *Harm Reduction: Pragmatic Strategies for Managing High Risk Behaviors* (New York: Guilford Press, 1998) at 50-51 [Marlatt, *Pragmatic Strategies*].

Although the definition of the term "harm reduction" is contested,[4] it is generally used to refer to policies, programs, interventions or practices designed to minimize negative health and social consequences associated with drug use without requiring the cessation of drug use itself.[5] Needle exchange, safe injection sites, and prescription of opiates to addicts are among the best-known examples.[6] As a response to the use of illicit drugs, harm reduction has been lauded for saving lives,[7] for its cost-effectiveness,[8] for elevating pragmatism over prohibitionist ideology, for its flexibility in fitting the response to the problem,[9] and also, particularly in contrast with traditional criminal law approaches, for its counter-hegemonic potential to empower people who use drugs.[10]

Although it has at times formed an important part of federal and provincial criminal and health policy in Canada,[11] the law's relationship with harm reduction has been ambivalent. While harm reduction

4. See *infra* notes 55-64 and accompanying text.

5. Douglas J Beirness et al, *Harm Reduction: What's in a Name?* (Ottawa: Canadian Centre on Substance Abuse, 2008) at 3; Patricia G Erickson, "Harm Reduction: What It Is and Is Not" (1995) 14:3 Drug & Alcohol Rev 283 at 284 [Erickson, "What It Is and Is Not"]; Harm Reduction International, "What is Harm Reduction," online: <www.ihra.net/what-is-harm-reduction>.

6. Dan Small, Anita Palepu & Mark W Tyndall, "The Establishment of North America's First State Sanctioned Supervised Injection Facility: A Case Study in Culture Change" (2006) 17:2 Intl J Drug Policy 73 at 74-76; Thomas Kerr, Megan Oleson & Evan Wood, "Harm-Reduction Activism: A Case Study of an Unsanctioned User-Run Safe Injection Site" (2004) 9:2 Can HIV/AIDS Pol'y & L Rev at 13; Samuel R Friedman et al, "Harm Reduction Theory: Users' Culture, Micro-Social Indigenous Harm Reduction, and the Self-Organization and Outside-Organizing of Users' Groups" (2007) 18:2 Intl J Drug Policy 107 at 115-116; Tom Carnwath, "Prescribing Heroin" (2005) 14 Am J on Addiction 311 at 315-316.

7. See, e.g., Don C des Jarlais et al, "HIV Incidence among Injecting Drug Users in New York City Syringe Exchange Programmes" (1996) 348:9033 The Lancet 987.

8. See, e.g., Peter Anderson, Dan Chisholm & Daniela C Fuhr, "Effectiveness and Cost-Effectiveness of Policies and Programmes to Reduce the Harm Caused by Alcohol" (2009) 373:9682 The Lancet 2234; Philip Jacobs et al, "Cost Effectiveness of Streetworks' Needle Exchange Program of Edmonton" (1999) 90:3 Can J Public Health 168 at 168.

9. Erickson, "What It Is and Is Not," *supra* note 5 at 284.

10. See, e.g., Aileen O'Goreman et al, "Peer, Professional, and Public: An Analysis of the Drugs Policy Advocacy Community in Europe" (2014) 25:5 Intl J Drug Policy 1001 at 1004; Friedman et al, *supra* note 6 at 108-110; Neil Wieloch, "Collective Mobilization and Identity from the Underground: The Deployment of Oppositional Capital in the Harm Reduction Movement" (2002) 43:1 Sociological Q 45 at 48-50; PM Spittal et al, "How Otherwise Dedicated AIDS Prevention Workers Come to Support State-Sponsored Shortage of Clean Syringes in Vancouver, Canada" (2003) 15:1 Intl J Drug Policy 36 at 37.

11. For a review of the role of harm reduction in Canadian drug policy, see Walter Cavalieri & Diane Riley, "Harm Reduction in Canada: The Many Faces of Regression" in Richard Pates & Diane Riley, eds, *Harm Reduction in Substance Use and High-Risk Behaviour: International Policy and Practice* (London: Wiley-Blackwell, 2012) 382.

increasingly finds support in international human rights law,[12] domestic criminal law enforcement has tended to interfere with harm reduction efforts.[13] Domestic courts, for their part, have engaged with harm reduction relatively little.[14]

Recently, however, judges, policymakers, and scholars have begun to explicitly and implicitly reflect and support aspects of harm reduction in legal approaches to socially contested or contestable behaviours, both within and beyond the drug use context. In particular, some judicial decisions,[15] legislative projects,[16] and pieces of legal scholarship[17] have approached issues such as sex work, illegal migration, and assisted death with a shift in focus away from moral judgment and a rejection of punitive approaches in favour of pragmatic, public health-oriented interventions geared toward mitigating measurable harms and empowering marginalized actors to attend to their own well-being.

This paper focuses on the growing emphasis in Canadian constitutional rights jurisprudence on evidence-based policy, on the health and well-being of the legal subject, and implicitly on the subject's participation in shaping the norms that affect it. It argues that this emphasis is oriented toward harm reduction, and may hold promise as a bulwark against some of the marginalizing features of traditional criminal justice approaches that punish based on contestable majoritarian views at the expense of the health and well-being of marginalized groups. Lessons from critical public health literature on harm reduction, however, suggest a risk of

12. See, e.g., Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, *Report to the General Assembly*, UNGAOR, 65th Sess, UN Doc A/65/255 (2010) at 16-24; *Political Declaration on HIV/AIDS*, UNGAOR, 60th Sess, Annex, Agenda Item 45, UN Doc A/RES/60/262 (2006) at 4; World Health Organization, "Injecting Drug Use," online: <www.who.int/hiv/topics/idu/en/>; High Commissioner for Human Rights, Press Release, "High Commissioner Calls for Focus on Human Rights and Harm Reduction in International Drug Policy," (10 March 2009), online: UN Human Rights—Office of the HCHR Media Center <www.ohchr.org/documents/Press/HC_human_rights_and_harm_reduction_drug_policy.pdf>.

13. See *infra* notes 65-66 and accompanying text.

14. See *infra* notes 67-68 and accompanying text.

15. *See infra* notes 69, 92.

16. Bill 52, *An Act Respecting End-of-Life Care*, 1st sess, 41th Leg, Quebec, 2014 (assented to June 10, 2014, SQ 2014, c 2) [Bill 52].

17. See, e.g., Erickson et al, *New Direction*, *supra* note 3; Joanne Csete & Jonathan Cohen, "Human Rights in Vancouver: Do Injection Drug Users Have a Friend in City Hall?" (2003) 8:2 Can HIV/AIDS Policy & L Rev 1; Margaretha Järvinen, "Approaches to Methadone Treatment: Harm Reduction in Theory and Practice" (2008) 30:7 Sociology Health & Illness 975; Desmond Manderson, "From Zero Tolerance to Harm Reduction: 'The Asylum Problem Problem'" (2013) 32:4 Refugee Survey Q 1; Mark Parts, "Disease Prevention as Drug Policy: A Historical Perspective on the Case for Legal Access to Sterile Syringes as a Means of Reducing Drug-Related Harm" (1996) 24 Fordham Urban LJ 475; Linda Cusick, "Widening the Harm Reduction Agenda: From Drug Use to Sex Work" (2006) 17:1 Intl J Drug Policy 3.

inadvertent reinforcement of the dominant discourse of criminalization and stigmatization as harm reduction's features are embodied within state institutional frameworks. For example, the commitment to non-judgmentalism and to value neutrality vis-à-vis drug use itself, which has been a key feature of harm reduction, is compromised in various ways as it moves from grassroots movement to state-based public health intervention. Similarly, though all versions of harm reduction emphasize their effectiveness at protecting the health and well-being of subjects, the evidentiary methods by which, and the standard against which, interventions are assessed in public health iterations of harm reduction become more stringent and less open to the participation of people who use drugs. These difficulties are likely to be reproduced and exacerbated in the judicial iteration. Consequently, as harm reduction moves from grassroots movement to public health intervention and finally to a legal device, the subject is constructed less as a worthy citizen whose knowledge deserves equal respect, but rather as deviant or helpless.

Part I sets out the history and key features of harm reduction, describing its roots in both public health and community activism. Part II argues that Canadian constitutional limits on the scope of the criminal law are beginning to reflect key features of harm reduction and that this development may help mitigate some alleged excesses of criminal justice. Part III interrogates the elements of harm reduction as they appear in each context, showing how the identity of the subject is understood differently in each. It describes how harm reduction was drained of its potential to reconstruct the agency of the drug user in its shift from grassroots to state-based public health intervention, and warns that adopting the language and concepts of harm reduction within constitutional discourse likewise risks reinforcing rather than undermining hegemonies perpetuated through law.

## I. *Origins and definition of harm reduction*

Harm reduction is known today primarily as a social policy response to the spread of HIV/AIDS among injection drug users. The term itself began to gain currency after the First International Conference on the Reduction of Drug-Related Harm in Liverpool in 1990,[18] which brought together drug users, public health officials, front-line workers, health professionals, and police officers around a project aiming at reducing risky behaviours associated with drug use rather than at reducing drug

18. See Erickson et al, *New Direction*, *supra* note 3 at 3.

use itself.[19] This conference formed the basis of the contemporary international harm reduction movement, which has resulted in a number of international advocacy networks and international nongovernmental organizations supporting harm reduction.[20] The practice and philosophy of harm reduction, however, find their roots in both public health policy and grassroots community activism.

1. *Public health*

Harm reduction, with its focus on "what works," in many ways reflects traditional public health principles rooted in nineteenth-century utilitarian thought. Public health is characterized by its emphasis on the health and well-being of the general population as well as (and often over) that of the individual. As such, it focuses on community-level interventions through broad laws and policies aimed at the prevention of disease rather than individual curative medical treatment.[21] It is frequently observed that harm reduction is not really new in this regard. Among health professionals, the idea of accepting the reality of drug use while minimizing harmful social and individual consequences dates at least as far back as 1920s Britain, when an expert committee of physicians chaired by Sir Humphry Rolleston, then President of the Royal College of Physicians, supported prescribing heroin to addicts in order that they may live "a fairly normal and useful life."[22] The concept is likewise reflected in the 1970s and 1980s public health policies on alcohol and tobacco, which urged minimization and moderation at the individual level in recognition that abstinence was not always realistic.[23]

In relation to illicit drugs, however, any public health-based calls to include minimization of harm as a drug policy goal failed to gain purchase in the context of the "war on drugs" that escalated in the United States

19. See Pat O'Hare, "Merseyside, the First Harm Reduction Conferences, and the Early History of Harm Reduction" (2007) 18:2 Intl J Drug Policy 141; Neil Hunt et al, *A Review of the Evidence Base for Harm Reduction Approaches to Drug Use* (London: Forward Thinking on Drugs, 2003).

20. See Patricia G Erickson, "Introduction: The Three Phases of Harm Reduction. An Examination of Emerging Concepts, Methodologies, and Critiques" (1999) 34:1 Substance Use & Misuse 1 at 2 [Erickson, "Three Phases"]; Tuukka Tammi, "The Harm-Reduction School of Thought: Three Fractions" (2004) 31:3 Contemporary Drug Problems 381 at 383.

21. See Lawrence O Gostin, *Public Health Law: Power, Duty, Restraint*, 2nd ed (Berkeley: University of California Press, 2008) at 6-8. See also AJ McMichael & R Beaglehole, "The Changing Global Context of Public Health" (2000) 356:9228 The Lancet 495 at 495.

22. Report of the Departmental Committee on Morphine and Heroin Addiction, HMSO, 1926, excerpts reproduced in Mike Ashton, "The Rolleston Legacy" (2006) 15 Drug & Alcohol Findings 4 at 7. See also Virginia Berridge, "Harm Minimisation and Public Health: An Historical Perspective" in Nick Heather et al, eds, *Psychoactive Drugs and Harm Reduction: From Faith to Science* 55 (London: Whurr, 1993), which outlines the history of minimization of drug-related harm.

23. Erickson, "What It Is and Is Not," *supra* note 5 at 284.

and spread globally through the 1970s and the early 1980s. At that time, drug use came to be understood less as a social behaviour with potential individual and societal-level harmful consequences, and more as a "socially infectious disease" in and of itself.[24] It was only following the AIDS crisis that the prevention of harms incidental to drug use and the prioritization of immediate health concerns over longer-term abstention goals became politically palatable.[25]

The public health embrace of harm reduction for illicit drugs also coincides with the growing influence of the "new public health,"[26] a philosophy that has played an important role in shaping harm reduction's key features. The new public health maintains public health's collectivist philosophy and focus on environmental factors that drive disease, but criticizes the traditional emphasis on biomedical models of harms. Instead, it views disease as a profoundly social phenomenon, embracing cultural and psychological factors that shape health and health interventions' outcomes. It also reconceives the actor as an agent engaging with those physical, psychological, cultural and environmental forces, rather than as

24. Virginia Berridge, "Histories of Harm Reduction: Illicit Drugs, Tobacco, and Nicotine" (1999) 34:1 Substance Use & Misuse 35 at 36 [Berridge, "Histories"]; G Alan Marlatt, "Harm Reduction: Come as You Are" (1996) 21:6 Addictive Behaviours 779 at 783-784 [Marlatt, "Come as You Are"]; Cavalieri & Riley, *supra* note 11; Erickson, "Three Phases," *supra* note 20 at 2; Benedikt Fischer, "The Battle for a New Canadian Drug Law: A Legal Basis for Harm Reduction or a New Rhetoric for Prohibition? A Chronology" in Erickson et al, *supra* note 3, 47 at 47-49 [Fischer, "The Battle"] (outlining the development of Canada's prohibitionist approach to drug use). However, see Friedman et al, *supra* note 6 at 110, who note that one exception to this trend is Dutch drug policy, which as early as the 1970s had integrated some aspects of harm reduction by prioritizing the well-being of drug users over goals of eradicating drug use.

25. See Berridge, "Histories," *supra* note 24 at 36; Fischer, "The Battle," *supra* note 24 at 49. See also John R Ashton & Howard Seymour, "Public Health and the Origins of the Mersey Model of Harm Reduction" (2010) 21:2 Intl J Drug Policy 94 at 95 [Ashton & Seymour, "Origins of the Mersey Model"], which quotes the 1988 Report of the UK Advisory Council on the Misuse of Drugs as follows: "[t]he spread of HIV is a greater danger to individual and public health than drug misuse. Accordingly, services which aim to minimize HIV behaviour by all available means should take precedence in development plans." *Contra* W Anderson, "The New York Needle Trial: The Politics of Public Health in the Age of AIDS" in Virginia Berridge & Philip Strong, eds, *AIDS and Contemporary History* (Cambridge: Cambridge University Press, 1993), describing how the public health effort to bring harm reduction to New York failed due to lack of political support.

26. See Erickson, "Three Phases," *supra* note 20 at 2; Tim Rhodes, "The 'Risk Environment': A Framework for Understanding and Reducing Drug-Related Harm" (2002) 13:2 Intl J Drug Policy 85 at 86: "[h]arm reduction in the time of AIDS is arguably one of the best documented examples of a new public health movement." See also O'Hare, *supra* note 19 at 141, explaining how Mersey state public health actors became the first to embrace harm reduction by bringing together traditional public health ideas around environmental change, prevention, and therapeutic interventions with a focus on "social aspects of health problems which are caused by lifestyles," citing John R Ashton & Howard Seymour, *The New Public Health: The Liverpool Experience* (Milton Keynes, UK: Open University Press, 1988) at 21 [Ashton & Seymour, *New Public Health*].

a passive recipient of services.[27] Finally, it seeks to avoid a victim-blaming mentality, which is said to be typical of traditional public health services in that they tend to view those who fail to take up reasonable suggestions as intransigent or difficult patients.[28] Instead, the new public health tries to shift health interventions toward "user-friendly and non-judgmental services".[29] This combination of features has made for mutual hospitability between the new public health and harm reduction approaches as both developed.[30] The conceptual and practical elements of harm reduction, particularly as they appear within state public health institutions, draw on and are guided by the principles of the new public health.[31]

2. *Community activism*

Harm reduction likewise has roots in community activism.[32] Riley and colleagues observe that harm reduction, in the form of social rituals and codes that enable peers to help one another use psychoactive substances safely, has likely existed for thousands of years.[33] In contemporary society, public health actors took up harm reduction in the era of HIV/AIDS in part after observing the success of grassroots, peer-to-peer organization among drug users themselves.[34]

In 1981, for example, a group of drug users from Rotterdam formed the first such recognized group, the "Junkiebond," which has been described as a "kind of trade union for concerned hard-drug users."[35] The Junkiebond's philosophy was based on the idea that drug users are the best placed to know what their problems are, and its mandate was to "improve the housing and general situation of the addict."[36] This included both political action—

27. *Ibid*; Jonathan Mann, "Human Rights and the New Public Health" (1995) 1:3 Health & Human Rights 229.

28. Tuukka Tammi & Toivo Hurme, "How the Harm Reduction Movement Contrasts Itself Against Punitive Prohibition" (2007) 18:2 Intl J Drug Policy 84 at 87.

29. Ashton & Seymour, "Origins of the Mersey Model," *supra* note 25 at 95; see also Ashton & Seymour, New Public Health, *supra* note 26 at 21.

30. Rhodes, *supra* note 26.

31. Ashton & Seymour, "Origins of the Mersey Model," *supra* note 25 at 95, describing how the authors, early proponents of the new public health, developed their model in part through engagement with harm reduction and HIV.

32. See Friedman et al, *supra* note 6; Christopher BR Smith, "Harm Reduction as Anarchist Practice: A User's Guide to Capitalism and Addiction in North America" (2012) 22:2 Critical Public Health 209; Gordon Roe, "Harm Reduction as Paradigm: Is Better than Bad Good Enough? The Origins of Harm Reduction" (2005) 15:3 Critical Public Health 243.

33. See Diane Riley et al, "A Brief History of Harm Reduction" in Pates & Riley, *supra* note 11, 5 at 5.

34. See Marlatt, "Come as You Are," *supra* note 24; Ashton & Seymour, "Origins of the Mersey Model," *supra* note 25; Roe, *supra* note 32.

35. See Marlatt, "Come as You Are," *supra* note 24.

36. GF van de Wijngaart, *Competing Perspectives on Drug Use: The Dutch Experience* (Amsterdam: Swets & Zeitlinger, 1991) cited in Marlatt, "Come as You Are," *ibid* at 784.

consulting with government officials, including police and lawmakers, on matters like housing policy and methadone treatment availability—as well as providing peer-based health information and services. The Junkiebond ultimately led to the development of Amsterdam's first needle exchange program, as well as to a policy of "normalization" of the drug problem in Holland. This meant "produc[ing] a context where the addict more resembles an unemployed Dutch citizen than a monster endangering society."[37] The Junkiebond's success in influencing state policy is credited in part to the fact that, even before the HIV epidemic, Dutch drug policy was already oriented toward harm reduction—for example, by favouring methadone maintenance over abstinence-oriented treatments.[38]

The Dutch model, in turn, inspired actors in places like Merseyside, U.K., to pioneer their own state-facilitated public health harm reduction efforts.[39] So did the experience in San Francisco, where the massive impact of HIV on the gay community led health authorities to emphasize how the most effective actions to address diseases usually included the direct involvement of people at risk.[40] In other places, such as New York, harm reduction operated for some time solely as a grassroots effort, since public health authorities were slow to endorse harm reduction in response to the epidemic, due to the massive demonization of drug users.[41] By 1990, activists from the non-governmental organization ACT UP and state public health researchers acting "on their 'free time'" had created underground needle exchanges in New York City, which have been credited with facilitating later state action to fund them and make them legal.[42]

In Canada, politicized street-based outreach workers from Toronto started the first harm reduction programs—including bleach programs for cleaning syringes and syringe exchanges—in 1987–1988. These were adopted by the city's public health authorities in 1989.[43] Later, harm reduction programs, including methadone maintenance and syringe programs, proliferated in many urban and even some rural communities across the country.[44] Though these were put in place primarily under

37. EM Engelsman, "Dutch Policy on the Management of Drug-Related Problems" (1989) 84 British J Addiction 211.
38. *Ibid*; Friedman et al, *supra* note 6 at 110.
39. See O'Hare, *supra* note 19 at 142.
40. See Ashton & Seymour, "Origins of the Mersey Model," *supra* note 25 at 94-95.
41. See Friedman et al, *supra* note 6 at 108.
42. *Ibid* at 110.
43. See Cavalieri & Riley, *supra* note 11 at 383.
44. *Ibid.*

municipal and provincial jurisdictions over health,[45] they were also practiced clandestinely by peer user groups in various stages of organization. Support at the federal level varied. Canada's 1987 Drug Strategy was framed in terms of reducing drug-related harm, and the Canadian Centre for Substance Abuse, founded under this strategy, promoted harm reduction and researched alternatives to prohibition.[46] From 1998 to 2007, Canada's federal drug strategy included harm reduction as one of its four "pillars,"[47] but this inclusion was criticized as hollow, since harm reduction efforts were defunded over that period and funds were increasingly directed into law enforcement.[48] After coming into power in 2006, the Conservative government excised any mention of harm reduction, and needle exchange in particular, from its National Anti-Drug Strategy.

The Vancouver Area Network of Drug Users (VANDU), established in 1998, was formed in the context of this federal-level regression from harm reduction.[49] Modeled after the Dutch Junkiebond, this first Canadian drug users union was established in response to rising rates of HIV, hepatitis C and overdose deaths among people using drugs in Vancouver's Downtown Eastside and to government inaction.[50] VANDU is run entirely by current or former users,[51] and its activities include advocating for human rights of drug users, opposing punitive drug policies, and providing support, harm reduction supplies and peer education.[52] It also operated an unsanctioned safe injection site,[53] and has played a key role with municipal and provincial authorities to establish Insite, Canada's first legally recognized safe injection site.[54]

45. See Alana Klein, *Sticking Points: Barriers to Access to Needle and Syringe Programs in Canada* (Toronto: Canadian HIV/AIDS Legal Network, 2007) at 5.

46. See Cavalieri & Riley, *supra* note 11 at 383.

47. See Library of Parliament, "Substance Abuse Issues and Public Policy in Canada: I. Canada's Federal Drug Strategy," by Chantal Collin, No PRB-06-15E (Ottawa: Library of Parliament, 13 April 2006) at 2, online: <www.parl.gc.ca/Content/LOP/ResearchPublications/prb0615-e.pdf>.

48. See Cavalieri & Riley, *supra* note 11 at 383; E Oscapella & DM Riley, "Canada's New Drug Law: Some Implications for HIV/AIDS Prevention in Canada" (1987) 7:3 Intl J on Drug Policy 180.

49. See Cavalieri & Riley, *supra* note 11 at 383.

50. See Jade Boyd & Susan Boyd, "Women's Activism in a Drug User Union in the Downtown Eastside" (2014) 17:3 Contemporary Justice Rev 313.

51. See Thomas Kerr et al, *Responding to an Emergency: Education, Advocacy and Community Care by a Peer-Driven Organization of Drug Users: A Case Study of Vancouver Area Network of Drug Users* (Ottawa: Health Canada, 2001) at 17.

52. *Ibid* at 6.

53. See Kerr, Oleson & Wood, *supra* note 6.

54. See Vancouver Area Network of Drug Users, "VANDU History: Civil Disobedience Necessary in Fight for Safer Injection Site" (6 November 2010), online: VANDU <www.vandu.org/vandu-history-civil-disobedience-necessary-in-fight-for-safer-injection-site/>.

3. *Common key features*

Despite many attempts to define "harm reduction," there is no agreed-upon definition of "harm reduction."[55] This is unsurprising, given the multiple roles that harm reduction plays: as a grassroots identity-based social movement for people who use drugs,[56] as a method for street-based outreach,[57] as an international human rights movement,[58] and as a state institutional response to drug use. The most encompassing definitions, (e.g. "interventions that address adverse consequences of drug use") obscure important epistemic differences. Most scholars and actors reject definition of harm reduction as a *goal*, since all approaches to drug use, even the most oppressive criminalization models, share the goal of reducing harms associated with drug use.[59] Instead, harm reduction is generally conceived as a method for reducing harm. Beyond this, differences persist. For some, harm reduction is a "set of policies and programs," while others contest such a formulation on the basis that drug users themselves are the primary practitioners of harm reduction, and that state policies and programs merely play a supporting role.[60] Some say that harm reduction "does not preclude abstinence as a worthy goal,"[61] whereas others say that it "recognizes abstinence as an ideal outcome but accepts alternatives that reduce harm."[62]

Because harm reduction may fairly mean different things to different people, it is more appropriate to frame the approach in terms of commonly shared themes or features.[63] These include (1) value neutrality as to the underlying behaviour (e.g., drug use, sex work), (2) elevating pragmatism and scientism over dogmatism and belief, (3) dismissal of punitive and authoritarian approaches, and (4) construction of the subject as a worthy citizen with full responsibilities and participation rights.[64] Part II will argue that recent decisions of the Supreme Court of Canada have integrated

55. See e.g. Diane Riley et al, "Harm Reduction: Concepts and Practice. A Policy Discussion Paper"(1999) 34:1 Substance Use & Misuse 9 at 11-12 [Riley et al, "Concepts and Practice"]; Hunt, *supra* note 19 at 2, surveying a number of proposed definitions. See also Friedman et al, *supra* note 6 at 107; Simon Lenton & Eric Single, "The Definition of Harm Reduction" (1998) 17 Drug & Alcohol Rev 213.

56. See Tammi & Hurme *supra* note 28 at 87; Roe, *supra* note 32.

57. See Marlatt, *Pragmatic Strategies*, *supra* note 3 at 54.

58. See Richard Elliott et al, "Harm Reduction, HIV/AIDS, and the Human Rights Challenge to Global Drug Control Policy" (2005) 8:2 Health & Human Rights 104 at 104.

59. See Alex Wodak & Bill Saunders, "Harm Reduction Means What I Choose It to Mean" (1995) 14:3 Drug & Alcohol Rev 269 at 269.

60. See Friedman et al, *supra* note 6 at 107.

61. See Elliott et al, *supra* note 58 at 110.

62. See Marlatt, "Come as You Are," *supra* note 24 at 50.

63. See Tammi, *supra* note 20 at 384; Erickson et al, *New Directions*, *supra* note 3 at 7-10.

64. See Kerr et al, *supra* note 51.

and promoted these features in constitutional jurisprudence setting limits on the substantive reach of criminal law. Part III will interrogate these features as they appear within each institutional context and draw some conclusions about how it constructs the identity of the legal subject.

## II. *Legal engagement with harm reduction*

Until recently, the law engaged with harm reduction relatively little in determinations about the reach of criminal sanctions. In many cases, the criminal law has undermined harm reduction efforts, for example through police enforcement of criminal law[65] and through sentencing decisions that required offenders to stay clear of areas where harm reduction services are offered.[66] Occasionally, courts have viewed harm reduction favourably as a way of managing future risky behaviour. For example, in one child protection case, participation in a harm reduction program was treated as a potential factor in favour of fitness for a mother who used drugs.[67] Similarly, sentencing judges have occasionally treated participation in harm reduction programs as mitigating the risk of reoffending and serving rehabilitative purposes.[68]

The Supreme Court of Canada mentioned harm reduction for the first time in the 2011 decision in *Canada (AG) v PHS Community Services*.[69] This decision engaged with harm reduction on a number of levels. Most obviously, it had the effect of supporting a particular harm reduction initiative. It also reflected some of harm reduction's premises in its reasoning. Finally, it incorporated, in a limited way, some elements of harm reduction's reasoning into legal doctrine.

The case concerned the survival of Insite, a safe injection site in Vancouver's Downtown Eastside that had been operating since 2003 under a medical/scientific exemption from the criminal prohibition on drug possession granted under section 56 of the *Controlled Drugs and*

65. See Csete & Cohen, *supra* note 16 at 7-8; Kerr, Oleson & Wood, *supra* note 6 at 15-17; Klein, *supra* note 45 at 16-19; 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; Evan Wood et al, "Displacement of Canada's Largest Public Illicit Drug Market in Response to a Police Crackdown" (2004) 170:10 Can Medical Association J 1551.

66. Marie-Ève Sylvestre, Dominique Bernier & Céline Bellot, "Zone Restrictions Orders in Canadian Courts and the Reproduction of Socio-Economic Inequality" (2015) 5:1 Oñati Socio-Legal Series 280.

67. See e.g. *Children's Aid Society of Halifax v S (V)*, [1996] WDFL 724 at para 44, 60 ACWS (3d) 316.

68. *R v Lukas*, 2012 ABPC 134 at para 10, 26, [2012] AJ No 706 (QL). See also *R v Lee*, 2003 BCSC 2066 at para 14, [2003] BCJ No 3284 (QL), which accepted that the objective of harm reduction was relevant in the sentencing of an addicted offender.

69. 2011 SCC 44 at para 131, [2011] 3 SCR 134 [*PHS*].

*Substances Act*.[70] In 2008, Insite's operators applied for a new exemption to replace one that was set to expire. The federal Minister of Health, consistent with the federal drug policy that was hostile to harm reduction,[71] denied the application. According to the Court, the Minister's initial failure to grant the exemption violated Insite's clients' rights to life, liberty and security in a manner incompatible with the principles of fundamental justice,[72] notably the principles that state decisions engaging with section 7 rights must not be arbitrary or have effects grossly disproportionate to their purposes.[73] The Court ruled that denying the exemption in the context of Vancouver's Downtown Eastside had the perverse effect of undermining, rather than promoting, the *Controlled Drugs and Substances Act*'s goal of protecting public health and safety. Relevant contextual factors in the determination that the law was arbitrary and grossly disproportionate included: (1) that criminal law prohibitions were not working to reduce drug use in the Downtown Eastside of Vancouver where Insite operated; (2) Insite's demonstrated success at reducing death and disease; and (3) Insite's demonstrated failure to contribute to increasing crime rates, rates of public injection or relapse rates in the area.[74] As such, the Minister's decision was both arbitrary, in that it failed to serve its intended purposes, and grossly disproportionate, in that it compromised the lives and safety of Insite's clients without any corresponding benefit.[75]

The Court explicitly stated that it was not pronouncing on whether abstinence-based approaches were generally better than harm reduction,[76] and its decision did not touch the continuing constitutional validity of drug possession laws more broadly.[77] It did, however, have the effect of insulating the particular harm reduction initiative at issue from interference with criminal drug possession laws on the basis that the harm reduction intervention had proven more effective than criminal enforcement alone at protecting the health and well-being of the community in Vancouver's Downtown Eastside.[78]

---

70. SC 1996, c 19, s 56.
71. See *PHS*, *supra* note 69 at paras 114, 122.
72. *Canadian Charter of Rights and Freedoms*, s 7, Part I of the *Constitution Act, 1982*, being Schedule B to the *Canada Act 1982* (UK), 1982, c 11.
73. See Peter W Hogg, "The Brilliant Career of Section 7 of the Charter" (2012) 58 SCLR (2d) 195 at 209.
74. *PHS*, *supra* note 69 at paras 129, 131-132.
75. *Ibid* at paras 132-133.
76. *PHS*, *supra* note 69 at para 105.
77. *Ibid* at para 114.
78. *Ibid.*

Beyond its practical effect, the decision also reflected a number of harm reduction's starting premises at various points in the reasoning, albeit in a limited way and often in deference to findings of fact from the trial judge. In determining that the rights to life and security of the person were engaged, the Supreme Court accepted that many health risks of injection drug use do not come from the drug itself but from unsanitary practices and conditions.[79] Further, it rejected the federal government's argument that drug addicts choose to assume those risks and that "those who commit crimes should be made to suffer the consequences."[80] Instead, it acknowledged that state conduct—in this case, preventing access to an existing health intervention via a criminal prohibition—could act as a systemic factor making drug use more dangerous, particularly given that loss of control over the need to consume is characteristic of drug addiction.[81] It also recognized the safe injection site, created under provincial health jurisdiction and through the cooperation of federal, provincial, municipal and community efforts, as a health care service addressing the vulnerability and the negative consequences of drug use.[82] Finally, it acknowledged that at least in the Downtown Eastside, prohibitionist policies were failing to achieve their desired goals.[83]

Perhaps less obviously, the Court also developed section 7 of the *Charter* in a manner that favours harm reduction's methodological commitment to empirical effects on health over moral or ideological considerations. First, it de-emphasized moral disapprobation as a legitimate basis for criminalization in favour of empirical examination of both the damage that the criminal law can do and its effectiveness in serving its purposes. Of course, *PHS* does not represent the first time that the Supreme Court of Canada has emphasized empirical demonstrations of harm in setting out the limits of the criminal law. In its interpretation of what constitutes obscenity in Canadian criminal law, for example, the Court has moved from a community standards test to a harm-based test.[84] It remains, however, that prior to *PHS,* the doctrines of arbitrariness and

79. *Ibid* at para 93.
80. *Ibid* at para 102.
81. *Ibid* at paras 97-106.
82. *Ibid* at para 93.
83. *Ibid* at para 131.
84. *R v Labaye*, 2005 SCC 80, [2005] 3 SCR 728, strengthening the suggestion in *R v Butler*, [1992] 1 SCR 452, 89 DLR (4th) 449, that obscenity requires more than just apprehension of moral harm.

gross disproportionality did relatively little to limit the substantive scope of the criminal law.[85]

The Supreme Court of Canada's 2003 decision in *R v Malmo-Levine* provides a useful counterpoint. In that decision, a majority of the Supreme Court of Canada upheld the criminal prohibition of marijuana possession challenged under section 7 of the *Charter* as non-arbitrary, on the basis that it expressed society's collective disapproval of marijuana use and responded to a *reasonable apprehension* of harm to society.[86] The same law was not found to be grossly disproportionate because adverse effects including stigma were viewed as "inherent" costs that inevitably result whenever Parliament exercises its criminal law power and someone chooses to break the law.[87] The Court tersely rejected an argument that the marijuana prohibition was disproportionate because it was ineffective at preventing marijuana use, expressing a skepticism that its role was to closely examine the effectiveness of any legislative measure.[88] Finally, the Court declined to balance the law's salutary and deleterious effects as part of its gross disproportionality analysis on the basis that this was a function for section 1 justification of *Charter* violations, rather than for section 7 violations themselves.[89]

In *PHS*, by contrast, rather than deferring to the Minister on the basis that a uniform stance on the possession of narcotics might *reasonably be expected* to deter their use in its arbitrariness analysis, the Court mandated and engaged in close scrutiny of the impact of both criminal prohibitions and Insite's impacts on health and safety in Vancouver's Downtown Eastside.[90] Similarly, in its analysis on gross disproportionality, the Court explicitly balanced salutary and deleterious effects of Insite and uniform drug prohibition in the Downtown Eastside.[91] Thus, while *PHS* did not overrule *Malmo-Levine*'s holding that Parliament may legislate criminality based on society's collective disapproval, the closer scrutiny of whether the law is achieving its ends and of collateral negative effects of the drug law in *PHS* has the effect of limiting the extent to which the state

85. This leaves aside constitutional constraints in s 7 of the *Charter* related to, for example, procedural rights in the context of criminal justice (e.g. *R v Stinchcombe*, [1991] 3 SCR 326, [1992] 1 WWR 97; *R v Seaboyer*, [1991] 2 SCR 577, 83 DLR (4th) 193; *R v Hebert*, [1990] 2 SCR 151, [1990] 5 WWR 1) and the level of fault required for particular criminal offences (e.g. *R v Vaillancourt*, [1987] 2 SCR 636, 47 DLR (4th) 399; *R v Martineau*, [1990] 2 SCR 633, [1990] 6 WWR 97).

86. *R v Malmo-Levine*, 2003 SCC 74, [2003] 3 SCR 571 at para 136.

87. *Ibid* at para 174.

88. *Ibid* at paras 176-178.

89. *Ibid* at paras 179-182.

90. See *supra* note 74 and accompanying text.

91. *Ibid* at para 133.

may rely on disapproval to ground policies that are causing harm without commensurate benefit.

Applying this standard in *Canada (AG) v Bedford*,[92] the Court similarly reflected harm reduction's pragmatic focus on minimizing discernible harm when it struck down criminal prohibitions on activities surrounding prostitution for the risks they created to the lives and safety of sex workers.[93] Here, the Court found that the *Criminal Code* provisions on keeping a brothel, on communicating for the purposes of prostitution, and on living on the avails of prostitution were overbroad and grossly disproportionate to their purposes of targeting exploitation through pimping and preventing nuisance associated with brothels and the street-based sale of sex because of the dangers they presented to the lives and safety of sex workers. Again, there was close scrutiny of the extent to which criminal prohibitions served their purpose and of unintended negative health and social repercussions. Of course, to the extent that the purposes of new legislation might be understood differently, the proportionality analysis in section 7 might not yield the same result.[94]

Through these cases, the Supreme Court of Canada thus crystallized[95] a constitutional requirement that state conduct in criminal law must actually serve its intended purposes, and that the extent to which it does so must be weighed against any harm created by the law itself. In other words, the government is "constitutionally barred from ignoring evidence in making policy, at least where life, liberty and security of the person are at stake."[96] In considering relative harm in this way, cases like *PHS* and *Bedford* incorporate into *Charter* analysis harm reduction's emphasis on empirical

92. 2013 SCC 72 at paras 123, 159, [2013] 3 SCR 1101 [*Bedford*].

93. Emily van der Meulen, Elya M Durisin & Victoria Love, *Selling Sex: Experience, Advocacy, Research on Sex Work in Canada* (Vancouver: UBC Press, 2013) at 202, claiming that the criminalization of sex work and drugs deny full citizenship.

94. After the Supreme Court struck down the provisions as unconstitutional, the legislature passed a new law substantially reproducing many of the provisions declared unconstitutional, but specifying new purposes in its preamble, including responding to "concerns about the exploitation that is inherent in prostitution" and "protect[ing] human dignity and equality of all Canadians by discouraging prostitution" and Bill C-36, *An Act to amend the Criminal Code in response to the Supreme Court of Canada decision in Attorney General of Canada v. Bedford and to make consequential amendments to other Acts*, 2nd Sess, 41st Parl, 2014.

95. The doctrines of arbitrariness, overbreadth and gross disproportionality have roots in early cases like *R v Morgentaler*, [1988] 1 SCR 30, 44 DLR (4th) 385, but have come into focus in the more recent decisions of *Chaoulli v Quebec (AG)*, 2005 SCC 35, [2005] 1 SCR 79, *PHS* and *Bedford*. On that subject, see Hamish Stewart, *Fundamental Justice: Section 7 of the Canadian Charter of Rights and Freedoms* (Toronto: Irwin Law, 2012) at 140. See also Hogg, *supra* note 73; *R v Carter*, 2015 SCC 5 at para 46.

96. Vanessa MacDonnell, "Developments in Constitutional Law: The 2011–2012 Term" (2012) 59 SCLR (2d) 51 at 85.

evidence of state interventions' effects (what works) over the traditional conception of the criminal law's role of setting a moral compass.[97]

Beyond the doctrinal point, cases decided under the new conception of section 7 may also have the effect of re-aligning political discussion around shorter term, measurable, and more immediate consequences of criminal prohibitions as opposed to long-term goals such as the complete elimination of markets in illegal drugs or the eradication of prostitution. In this vein, the pragmatic aspect of the harm reduction approach can arguably be observed in Quebec's new law on assisted suicide.[98] Despite the criminal prohibition on assisted suicide that remained in force at the time the law was adopted,[99] Quebec's law regulates assisted suicide with a public health-oriented approach that focuses on mitigating and balancing the risk of the vulnerable being induced to end their lives against their will against the autonomy of the person who may be unable to end his or her life as desired without assistance.[100] This law was motivated in part by a recognition that the practice of assisted dying continues without any institutional safeguards even where it is prohibited,[101] and that these harms cannot be mitigated by an absolute prohibition.

In terms of constructing the identity of the subject, however, the congruence with the principles and philosophy of harm reduction and its legal turn are less clear. For marginalized groups and individuals whose interests are ignored by majoritarian politics,[102] these developments may provide a "powerful tool," particularly in a "climate in which the government appears determined to make political choices regardless of their logic."[103] This new direction takes risks to the health and safety of drug users (or sex workers, or those facing end-of-life decision-making) seriously, recognizing them as citizens whose well-being deserves protection through pragmatic and empirically-supported means. In this regard, these developments would seem to reflect the subject as a worthy citizen. This potential to construct and recognize the identity of the drug user or sex worker differently, however, may be limited, particularly

97. See *Reference re Validity of Section 5(a) of the Dairy Industry Act*, [1949] SCR 1 at 50, [1949] 1 DLR 433, setting out the purposes of the criminal law as including "public peace, order, security, health, morality".

98. Bill 52, *supra* note 16.

99. Note that after the Quebec law was passed, the Supreme Court of Canada struck down the criminal prohibition for being overbroad in relation to its object of "protecting vulnerable people from being induced to commit suicide at a moment of weakness" in *R v Carter*, *supra* note 95 at para 86.

100. See Udo Schüklenk et al, "End-of-life Decision-Making in Canada: the Report by the Royal Society of Canada Expert Panel on End-of-Life Decision Making" (2011) 25:s1 Bioethics 1.

101. *Ibid* at 48.

102. See Hogg, *supra* note 73 at 209.

103. See MacDonnell, *supra* note 96 at 85.

when compared with harm reduction's ambitions as a social movement. Exploring this question, the next section will trace the key features of harm reduction as it is reflected within social movements, in public health interventions, and within legal doctrine.

## III. *Identity and harm reduction's key features in context*

Critical public health scholars have observed how pragmatism and scientism in state public health iterations of harm reduction have systematically obscured other features and values of harm reduction, undermining its potential to reconstruct and de-marginalize the subject. This section tracks the features of harm reduction as they appear in grassroots, public health, and legal contexts and argues that from each setting to the next, the standards and methods for demonstrating interventions' effectiveness become more exacting and exclusionary, mitigating harm reduction's counter-hegemonic promise.

### 1. *From grassroots movement to public health institution*

Harm reduction proponents generally claim to treat drug use itself as a morally neutral behaviour. That is, the methods of harm reduction are said to make no moralistic judgment either to condemn or to support use of any drug by any method.[104] As one early harm reduction scholar evocatively put it, "[b]oth the hedonist and the puritan can apply harm reduction."[105]

This claim to value neutrality looks different at the level of public health institutions than it does at the grassroots. One ethnography demonstrates how the Santa Cruz Needle exchange program, an initially illegal program started by drug users and AIDS activists, rejects the notion that abstinence should in any way be part of the harm reduction discussion, unless a program participant explicitly raises the issue.[106] In fact, the program explicitly celebrates drug use in various ways in order to resist the stigma of drug use as immoral, pathological, and illegal.[107] As one participant was quoted to have said in *Junkphood*, the program's 'zine, "[w]e should fight the feeling that there is something wrong with us because we like to get high."[108] Similarly, VANDU's *Manifesto for a Drug User Liberation Movement* describes its movement as advocating "the right to obtain, prepare, and ingest drugs, according to our own personal decisions without criminalization or unsought interference from other

104. Riley et al, "Concepts and practice," *supra* note 55 at 12.
105. John Strang, "Drug Use and Harm Reduction: Responding to the Challenge" in Heather et al, *supra* note 22, 3 at 15.
106. Wieloch, *supra* note 10 at 50.
107. *Ibid* at 52.
108. *Ibid* at 59.

individuals or organizations, as long as our drug use does not directly harm other people."[109] Grassroots movements tend to view dangers associated with drug use as by-products of colonization and of socioeconomic, racial, gender, and political inequalities.[110] The grassroots harm reduction movement is in this way *aggressively* value neutral as to drug use. It urges that there is nothing wrong with using drugs or with people who use drugs.

In contrast, the value neutrality vis-à-vis drug use reflected in the professionalized public health context shifts subtly to something more like, "We promise not to judge you for doing drugs,"[111] a stance which may ultimately reinforce the perception of the harms of drug use as inherent rather than societally produced. Harm reduction in public health has been said to occupy a middle ground between prohibition and legalization.[112] For tactical reasons[113] and because of its disciplinary relationship to evidence-based medicine,[114] professional public health places greater emphasis on the pragmatic, outcome-oriented aspects of harm reduction over any profound ideological commitment to value neutrality vis-à-vis drug use itself. Value neutrality—meeting the 'client' where he or she is, without judgment—is presented as an instrumental practice, subservient to pragmatic objectives, rather than a reflection of commitment to humanistic values such as individual agency. Further, perhaps out of fear of being perceived as supporting illegal drug use, public health harm reduction has extended its pragmatic focus beyond reducing mortality and morbidity of drug users to include, even if only as a secondary purpose, the reduction of public order or nuisance problems.[115] In doing so, it has been argued, it tacitly accepts temperance as a harm reduction goal to the extent that this may reduce harm to the *public*.[116]

---

109. Vancouver Area Network of Drug Users, *VANDU Manifesto for a Drug User Liberation Movement* (Vancouver: VANDU, 2010), online: *<www.vandu.org/documents/VANDU-manifesto-july-2010.doc> [VANDU Manifesto]*.

110. Roe, *supra* note 32 at 245; Boyd & Boyd, *supra* note 50.

111. See e.g. Clive L Morrison & Sue M Ruben, "The Development of Healthcare Services for Drug Misusers and Prostitutes" (1995) 71:840 Postgraduate Medical J 593 at 594 (describing the harm-reduction philosophy of two state-based harm reduction services as follows: "Drug misusers are encouraged to progress through a hierarchy of goals to limit the health consequences of their action... Abstinence is the ultimate aim but a non-judgemental approach can encourage interim steps toward this end, through activities that involve less risk or harm.").

112. Erickson, "What It Is and Is Not," *supra* note 5 at 284.

113. Andrew D Hathaway & Patricia G Erickson, "Drug Reform Principles and Policy Debates: Harm Reduction Prospects for Cannabis in Canada" (2003) 33:2 J Drug Issues 465 at 484.

114. Tammi, *supra* note 20 at 387.

115. Benedikt Fischer et al, "Drug Use, Risk, and Urban Order: Examining Supervised Injection Sites (SISs) as 'Governmentality'" (2004) 15:5-6 Intl J Drug Policy 357 at 360.

116. Andrew D Hathaway, "Shortcomings of Harm Reduction: Toward a Morally Invested Drug Reform Strategy" (2001) 12:2 Intl J Drug Policy 125 at 126, 127.

In a context where politics are aligned against the drug user by legal prohibition, social marginalization, and a general discourse that is unfavourable to (hard) drug users, the heavy focus on behaviour modification and the narrow pragmatics of risk reduction may reinforce the notion that drug use is inherently and necessarily dangerous.[117] Indeed, as Foucauldian critics argue, by operating alongside prohibition, harm reduction risks becoming an apologist for dominant discourses around punitive drug laws. According to Roe, the problem is the selective deployment of harm reduction. To win the support of mainstream political bodies, institutionalized harm reduction willingly restricts itself to the mere mitigation of the harms caused by prohibition and abstinence based treatments.[118]

Further, the depoliticized, institutional version of harm reduction lacks the grassroots movement's potential to reconstruct the subject as a citizen with full participation rights, as opposed to a deviant person or helpless victim.[119] These latter constructions of the drug user have been and continue to be relied upon in traditional medical and criminal models of addiction to legitimize coercion[120] and to exclude users from normative categories of citizenship, such as "the general public."[121] One of harm reduction's promises is to reconceive otherwise marginalized populations as "active citizens capable, as individuals and communities, of managing their own risk."[122] However, state and political resistance may set in around harm reduction programs that are not yet supported by sufficient scientific study, even when widely supported by experiential knowledge of front line workers and drug users themselves. The failure of public health actors to facilitate the introduction of safer crack smoking kits is a good example. Grassroots organizations in several Canadian cities had noted a risk of disease transmission as a result of sharing crack pipes and other makeshift smoking equipment and began distributing kits including pyrex stems, lip balm, alcohol wipes, and other items. The kits were supported by some public health authorities, but resisted by others who claimed the intervention lacked a sufficient evidence base.[123] Subsequent scientific

117. *Ibid* at 126.
118. Roe, *supra* note 32 at 247.
119. See Tammi, *supra* note 20 at 385; Wieloch, *supra* note 10.
120. Marlatt, "Come as You Are," *supra* note 24 at 786.
121. Helen Keane, "Critiques of Harm Reduction, Morality and the Promise of Human Rights" (2003) 14:3 Intl J Drug Policy 227 at 229.
122. Mitchell Dean, *Governmentality: Power and Rule in Modern Society*, 2nd ed (London: Sage, 2010) at 197.
123. Emma Haydon & Benedikt Fischer, "Crack Use as a Public Health Problem in Canada: Call for an Evaluation of 'Safer Crack Use Kits'" (2005) 96:3 Can J Pub Health 185 at 185-188.

research has supported the introduction of such interventions, and yet they have not been widely introduced.[124] Claims that public health iterations of harm reduction are truly user-centred lose persuasiveness in this context.[125]

Instead, critical public health scholars argue that in the hands of the state, harm reduction can become a form of "surveillance medicine", increasing state control of drug users, objectifying their bodies and creating a moralistic duty on citizens to be healthy, without challenging the dominant social, economic, medical, and legal conditions and discourses that drive criminalization and health risks in the first place.[126] It reflects a neoliberal notion of individual responsibilization disguised as a progressive practice.[127] Equal moral citizenship becomes illusory as the users are divided into the responsible and the irresponsible. The claim that harm reduction represents a turn away from punitive and non-authoritarian approaches to drug use is diminished, as authority is merely shifted from the criminological to the biomedical.[128] That is, good citizenship is constructed as adherence to the expectations of public health authorities. Meanwhile, the threat of criminal sanction still looms.

Grassroots, peer-to-peer organizations provide services that may be similar to state public health institutions, but they do so within a broader agenda of promoting users' rights as citizens.[129] Beyond mutual help and self-help, peer-based grassroots groups amount to a political identity-based social movement.[130] Tammi describes this "identity work" as both "reflexive and empowering": users become conscious of their ability to shape their social selves and to participate in political action as they engage with the drivers of their marginalization beyond the means and conditions in which they use drugs.[131]

One response to the concerns expressed above has been to ensure that harm reduction in all its iterations includes a commitment to use human

124. Andrew Ivsins et al, "Uptake, Benefits of and Barriers to Safer Crack Use Kit (SCUK) Distribution Programmes in Victoria, Canada—A Qualitative Exploration" (2011) 22:4 Intl J Drug Policy 292.

125. See also PM Spittal et al, "How Otherwise Dedicated AIDS Prevention Workers Come to Support State-Sponsored Shortage of Clean Syringes in Vancouver, Canada" (2004) 15:1 Intl J Drug Policy 36.

126. Peter Miller, "A Critical Review of the Harm Minimization Ideology in Australia" (2001) 11:2 Critical Public Health 167; Fischer et al, *supra* note 115; Nadine Ezard, "Public Health, Human Rights, and the Harm Reduction Paradigm: From Risk Reduction to Vulnerability Reduction" (2001) 12:3 Intl J Drug Policy 207.

127. Smith, *supra* note 32 at 214.

128. *Ibid* at 213; Keane, *supra* note 121; Roe, *supra* note 32.

129. Tammi, *supra* note 20 at 389; *VANDU Manifesto*, *supra* note 109.

130. Wieloch, *supra* note 10.

131. Tammi, *supra* note 20 at 390.

rights frameworks in order to understand what drives vulnerability to drug-related harm in the first place.[132] Others seek a more radical re-politicized future for public health iterations of harm reduction where, for example, addiction professionals recognize the role of capitalism in producing both addiction and its consequences in their research and their practice.[133]

2. *Identity construction and harm reduction in law*

As discussed, the legal integration of harm reduction approaches has the potential to construct the subject as worthy of health protection as it elevates immediate health needs of subjects over longer term and arguably unachievable goals like the elimination of drug markets and prostitution altogether. It may also have the effect of putting tools in the hands of the marginalized to respond to governments that make harmful and illogical political choices. However, many of the identity-construction critiques of institutionalized harm reduction canvassed in the previous subsection apply with equal or greater force to harm reduction as a legal device.

First, to the extent that the underlying behaviour remains criminal, the subject is still constructed as deviant or helpless. In *PHS*, for example, the Court refused to find that the possession law itself endangered the health of drug users, grounding its decision instead on the minister of health's failure to exercise his discretion to grant an exemption to Insite, as contemplated in section 56 of the *Controlled Drugs and Substances Act*.[134] This reinforces the notion that there are "good" drug users, who consume in the manner and under the circumstances prescribed by state institutions, and "bad" drug users who remain the proper subject of criminal sanction.[135] Moreover, the "good" drug users who use Insite do so because they have no choice: the Court relied heavily on an addiction justification in response to the government's argument that a person's choice to use drugs, not the law, was the cause of death and disease that Insite prevents.[136] The broader role of the criminal law in perpetuating risks of harm is thus ignored, as is the legitimacy of criminalization in the first place. In *Bedford*, by contrast, where the Court was able to rely on the fact that prostitution itself was not illegal,[137] the activity of sex work was constructed far more neutrally. It was acknowledged as a potentially risky activity, but the state was found

132. See Ezard, *supra* note 126; Elliott et al, *supra* note 58.
133. Smith, *supra* note 32 at 217. See similarly Roe, *supra* note 32.
134. *PHS*, *supra* note 69 at para 109.
135. Fischer et al, *supra* note 115.
136. *PHS*, *supra* note 69 at para 99-101.
137. *Bedford*, *supra* note 92 at para 5.

to be imposing dangerous conditions on it, depriving people of the ability to protect themselves.[138]

Second, the Court in *PHS* constructs its good user with primary reference to scientific, medicalized standards, leaving even less space for community-level knowledge to be translated into policy than public health harm reduction does. In holding that the minister of health was constitutionally required to grant an exemption from the drug laws to Insite, the Court cited an extensive body of publicly supported research specific to Insite itself, demonstrating its established track record of providing health benefits to its clients and its lack of neighbourhood disruption.[139] Of course, this track record could only be established because Insite had operated legally with a federal exemption for years before the minister of health declined to issue a new one. Some authors have expressed doubt that only local evidence of effectiveness could meet the standard for new section 56 exemptions for harm reduction facilities. Instead, they argue, generic evidence of a particular harm reduction intervention's effectiveness—including evidence from other jurisdictions or animal models—should suffice to gain an exemption from the operation of the enforcement of drug laws.[140] Either way, the judicial iteration of harm reduction doubles down on the notion that only interventions that meet scientific thresholds of reliability may be deemed licit, maintaining the criminal backdrop to "surveillance medicine."[141]

Third, harm reduction within legal doctrine may be even more vulnerable to colonization by community expectations than public health harm reduction. In *PHS*, for example, the minister's refusal to grant Insite an exemption was assessed in relation to the legislator's objectives of protecting public health and safety.[142] As such, the claimants' right to obtain access to safe injection depended not only on Insite's proven capacity to prevent overdoses and serve the health needs of people using drugs, but also to do so without disrupting the community. The Court cited with favour the report of a local business association report that Insite had reduced crime in the area.[143] In *Bedford*, similarly, the impugned

138. *Bedford*, *supra* note 92 at para 60, 89.
139. *PHS*, *supra* note 69 at para 131, 152.
140. Elaine Hyshka, Tania Bubela & T Cameron Wild, "Prospects for Scaling-Up Supervised Injection Facilities in Canada: The Role of Evidence in Legal and Political Decision-Making" (2013) 108:3 Addiction 468 at 471.
141. Consider, for example, a court's refusal to consider an Aboriginal offender's argument that he dealt marijuana to his community members to help them abstain from more destructive alcohol consumption as a mitigating factor at sentencing: *R v Smith*, 2011 YKTC 62, 98 WCB (2d) 251.
142. *PHS*, *supra* note 68 at para 136.
143. *Ibid.*

legislation's effects were found perverse because they failed to correspond with the legislator's own goals.[144] The Conservative government has responded with new legislation in both cases. Bill C-2, the *Respect for Communities Act*, amended the *Controlled Drugs and Substances Act* to require that any new safe injection site obtain a letter from, among others, local government and police outlining their "opinion on the proposed activities at the site, including any concerns with respect to public safety and security."[145] In addition to increasing the administrative hurdles any proposed new safe injection sites would face, it represents a legislative expression of the importance of community views in shaping harm reduction policy. In relation to prostitution, the *Protection of Communities and Exploited Persons Act* largely reproduces and adds to the criminal prohibitions struck down in *Bedford*, this time recharacterizing the purpose of legislation related to prostitution as recognizing the inherent wrongs of sex work itself.[146]

Finally, in its construction of the subject as a citizen with full participation rights, the legal iteration of harm reduction falls short. As suggested earlier, harm reduction in legal doctrine takes seriously the health risks faced by sex workers and people who use drugs and recognizes the state role in constructing risk through criminal law. However, it does so with great limitations. First, both *PHS*[147]and *Bedford*[148] rely on a negative rights interpretation of section 7 of the *Charter*, essentially precluding government from enacting laws that interfere with health-seeking behaviours in a way that is perverse to the purposes of those laws. Courts in Canada have been unwilling to recognize that section 7 might impose positive obligations on government in relation to such basic needs as health care, housing, income and the like.[149] As such, the turn to harm reduction in law fails to acknowledge the many forms of state action and neglect that drive vulnerability to the negative consequences of drug use.[150] Citizenship here is understood narrowly as freedom from government interference backed by rights-based recourses in courts. This is a thin rights paradigm compared with that of the human rights

144. *Bedford*, *supra* note 92 at paras 134, 142, 159.
145. Bill C-2, *An Act to Amend the Controlled Drugs and Substances Act*, 2nd Sess, 41th Parl, 2014, cl 5 (as passed by the House of Commons 23 March 2015), ss 56.1(3)(c), 56.1(3)(e).
146. SC 2014, c 25, preamble.
147. *PHS, supra* note 69 at para 93 (describing the state action as "preventing access" to existing state services).
148. *Bedford*, supra note 92 at para 88.
149. See e.g. *Gosselin v Quebec (AG)*, 2002 SCC 84, [2002] 4 SCR 429; *Tanudjaja v Canada (AG)*, 2013 ONSC 1878, 227 ACWS (3d) 364.
150. See Ezard, *supra* note 126.

movement, informed by the full range of substantive and participatory rights, including civil, political, economic, social and cultural, which harm reduction's proponents are increasingly urging.[151]

*Conclusion*

This paper is not intended to deny that harm reduction can inform meaningful, effective responses to hegemonic criminal law, particularly in a climate where criminal policies are enacted in a way that lacks an evidence base. On the contrary, harm reduction's numerous features—its humanistic focus, its orientation toward self-determination of marginalized individuals and groups, its recognition of the perverse consequences of dominant drug paradigms—make it suited to this task. Rather, this paper seeks to draw attention to the gap between promise and practice that results when harm reduction is embedded within particular institutional contexts. Harm reduction proponents should welcome the law's integration of aspects of the philosophy. However, lessons from the adoption of harm reduction by public health institutions recommend reflexivity about how institutionally-embedded conceptions of harm reduction may construct subjects as undeserving and may obscure the ways in which state social, economic and criminal policy creates and perpetuates risk.

151. *Ibid*; Elliott et al, *supra* note 58; Keane, *supra* note 121.