

A Utilitarian Argument for the Operation of Safe Injection Sites

Ozan Gurcan

Major Research Paper (MRP) submitted to the
Faculty of Philosophy, Saint Paul University, in partial fulfillment
of the requirements for the degree of Master of Arts in Public Ethics

© Ozan Gurcan, Ottawa, Canada, July, 2016

Table of Contents

Part 1: Introduction	2
1.1- Brief history and current state of safe injection sites in Canada.....	2
1.2- Research problem.....	4
1.3- Thesis	7
Part 2: A defense of utilitarianism in the context of drug policy	8
2.1- Utilitarianism in harm reduction	8
2.2- Kantian ethics in abstinence.....	13
2.3- Kantian ethics and drug policy	15
2.4- Utilitarianism and drug policy	20
Part 3: An evaluation of the values underlying the harm reduction and abstinence model outcomes	23
3.1-Theoretical relationship between safe injection sites and the encouragement of drug injection.....	25
3.2- Which model's sought consequences are better and why?	26
3.3- Anticipated criticisms of the values underlying the harm reduction model outcomes	28
Part 4: Conclusion	31
Appendix 1- Key terms and phrases	33
Appendix 2- Relevant facts and statistics	34
Bibliography	36

Part 1: Introduction

1.1- Brief history and current state of safe injection sites in Canada

Safe injection sites are facilities where illicit drug users can come to self-inject their self-acquired drugs using site-provided sterile equipment under the supervision of medical personnel (Vancouver Coastal Health- Insite Services, 2011, p. 1) (Elliott, Malkin and Gold, 2002, p. 1). These facilities help drug users avoid the possible ramifications of public drug injection such as overdose and the transmission of blood-borne viruses and bacteria (Vancouver Coastal Health- Insite Services, 2011, p. 1) (Elliott, Malkin and Gold, 2002, p. 2). Safe injection sites are not only injection facilities, however, as they “...also help direct drug users to treatment and rehabilitation programs, and can operate as a primary healthcare unit.” (Elliott, Malkin and Gold, 2002, p. 1). There are currently two legally approved safe injection sites in Canada. These are Insite and the Dr. Peter Centre, both located in Vancouver, British Columbia (CBC News, 2016, p. 1). Both Insite and the Dr. Peter Centre serve areas where rates of HIV, Hepatitis C and overdose deaths are very high. For example, in 2002 (the year before Insite was opened), researchers reported that:

The city’s [Vancouver] Downtown Eastside is Canada’s poorest neighbourhood. Street-based drug use is rampant in this area, and HIV prevalence among injection drug users was estimated to be between 23 to 30 percent in 2000. The prevalence of HCV [Hepatitis C Virus] was even higher, at approximately 88 percent in the same year. While fatal overdoses and other health concerns related to drug use have been observed in the area since the 1970s, they have increased dramatically. There have been more than 2000 overdose deaths in British Columbia since 1992, and it has been the leading cause of

death among people aged 30 to 49 for five years in a row (Elliott, Malkin and Gold, 2002, p. 2).

In Canada, supervised injections sites require an exemption from the law that criminalizes the possession and injection of drugs (Eggertson, 2015, p. 225). This exemption is noted under section 56.1 of the *Controlled Drugs and Substances Act*. The legislation states that:

The Minister may, on any terms and conditions that the Minister considers necessary, exempt from the application of all or any of the provisions of this Act or the regulations any person or class of persons or any controlled substance or precursor or any class of either of them if, in the opinion of the Minister, the exemption is necessary for a medical or scientific purpose or is otherwise in the public interest.” (Government of Canada- Controlled Drugs and Substances Act, 2016, p. 10).

Insite began operating as a safe injection facility in 2003 after feasibility data suggested that it had the potential to reduce public drug use, overdose deaths, transmission of HIV and Hepatitis C, and public disorder (Wood, Kerr and Spittal, 2003, p. 2-3) (Kerr, Wood and Small, 2003, p. 759). In 2008, however, when Insite applied for re-exemption, the Minister of Health (Tony Clement) declined their application (Popovich, 2008, p. 1). Tony Clement had already spoken out against Insite during the 2008 Canadian Medical Association’s Conference where he “... outlined funding cuts for the safe injection services at the facility in favour of detox and classical rehab expansion.” (Popovich, 2008, p. 1). Nevertheless, in 2011, after the case went all the way up to the Supreme Court of Canada, Insite was re-granted the exemption that it required on the basis that it aided drug users access health services, saved lives, and protected public health (Kerr and Montaner, 2013, p. 1) (Canada (Attorney General) v. PHS Community Services

Society, 2011, p. 1). Nonetheless, in 2015, the House of Commons passed Bill C-2, *An Act to Amend the Controlled Drugs and Substances Act*, which is likely to create major obstacles for organizations that are planning to establish supervised injection facilities in the future (Eggertson, 2015, p. 225). For example, organizations now have to gather support at many different levels in order to offer safe injection site services (Eggertson, 2015, p. 225). After the 2015 federal elections in Canada, the Liberal government decided to "... stick to the existing set of rules for approving safe-injection sites in Canada [Bill C2] for the time being, in spite of criticisms that those rules are overly onerous." (Muise, 2016, p. 1). However, the government "...will continue to assess the effectiveness of the legislation as applications are received and reviewed." (Muise, 2016, p. 1)

In the meantime, there is a steadily growing interest in opening safe injection sites in other parts of Canada; the push has been increased as "...the city [Toronto] is facing a record number of fatal overdoses — 206 in 2013 — that have jumped in the last decade." (Campbell, 2016, p. 1). In Ottawa, Rob Boyd, the director of the Sandy Hill Community Health Centre, has already applied to begin offering supervised injection services (Duffy, 2016, p. 1). In Quebec "...community groups have spoken out against the decision to halt plans for the safe injection sites...denouncing the Quebec Health Ministry's [2008] stance." (Popovich, 2011, p. 1).

1.2- Research problem

The focus of this research paper is the moral standing of safe injection sites in Canada. As such, this paper will attempt to answer the question of whether safe injection sites should continue to operate. Although this is particularly a public health issue, ethics also has a major role to play, which is why this topic is well-suited for research in applied ethics, particularly

bioethics and public policy ethics. In fact, it is essential that a moral theory grounds a drug policy model, so that a sound and conclusive argument for or against the operation of safe injection sites can be made. Just because science can demonstrate whether safe injection sites are effective or not does not mean that they ought or ought not to operate.

The moral debate on safe injection sites is one based on the conflict between the abstinence model and the harm reduction model. Those who are against safe injection sites prescribe the abstinence model of drug policy-making (Mangham, 2006, p. 1-2) (Christie, Groarke and Sweet, 2008, p. 52). This model aims to decrease the total number of illicit drug users in society by criminalizing drug use and implementing demand and supply reduction strategies (Mangham, 2006, p. 1-2) (Elliott, Malkin and Gold, 2002, p. 3). Those who support the operation of safe injection sites, on the other hand, prescribe the harm reduction model (Elliott, Malkin and Gold, 2002, p. 5-6) (Christie, Groarke and Sweet, 2008, p. 52). This model mainly aims to decrease the negative outcomes associated with drug use, while not requiring abstinence from drug users (Elliott, Malkin and Gold, 2002, 6).

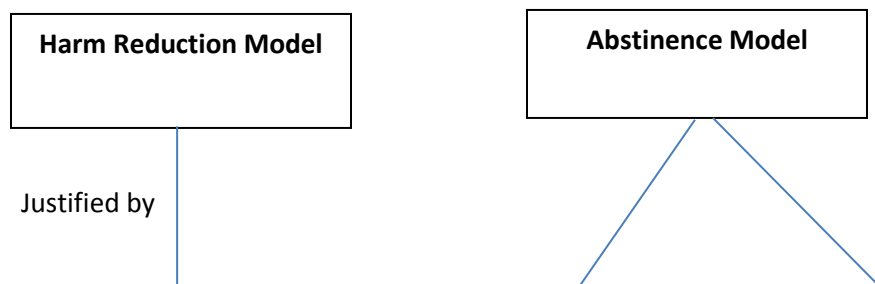
As demonstrated by Christie, Groarke and Sweet, the harm reduction model is best justified by utilitarianism (2008, p. 54). This model does not require abstinence from illicit drug users because, even though engaging in illicit drug use may be immoral (in the Kantian sense), the operation of safe injection sites has good consequences on drug users and society-at-large, including the healthcare system (i.e. “everyone involved”). Those who favour the abstinence model, on the other hand, have a problem with there being such an emphasis placed on reducing negative outcomes associated with drug use when it is apparently possible to reduce the number of illicit drug users in society by absolutely criminalizing the practise and implementing demand and supply reduction. (Christie, Groarke and Sweet, 2008, p. 52) (Elliott, Malkin and Gold,

2002, p. 5-6). This model, like the harm reduction model, can be justified by utilitarianism but it can also be justified by Kantian ethics. On the one hand, supporters can use utilitarian reasoning to argue that their model should be implemented over the harm reduction model because their model leads to “better” consequences (call this the Utilitarian Abstinence Model). If this route is taken, then the following questions need to be answered:

- Which model’s sought consequences are better (in theory) and why?
- What are the consequences of the two models in real life (i.e. which model *actually* achieves their sought consequences)?

These questions will be the topic of discussion in Part Three.

As indicated by Christie, Groarke and Sweet, however, supporters of the abstinence model can also argue against safe injection sites using Kantian ethics (call this the Kantian Abstinence Model) (2008, p. 56). To this end, critics could argue that the harm reduction model is not moral and that drug policies should be based on the abstinence policy regardless of the negative consequences that it may give rise to (Christie, Groarke and Sweet, 2008, p. 56). Whether this is an appropriate moral justification to adhere to in the context of drug policymaking will be the topic of discussion in Part Two. Please refer to *figure 1* (below) for a graphic representation of the moral justifications that ground the two drug policy models. Note that these moral theories will be explained and discussed in much greater detail in the following Part.



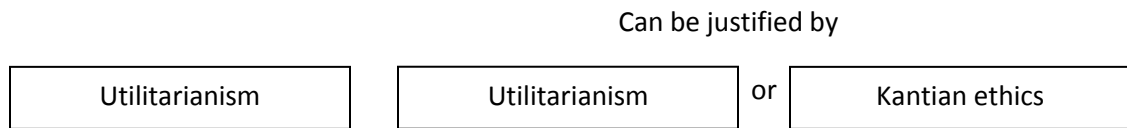


Figure 1: Ethical theories justifying the two drug policy models.

1.3- Thesis

Public discussion on the standing of safe injection sites in Canada is on the rise (Duffy, 2016, p. 1) (Mehler Paperny, 2013, p. 1). Although commentators maintain that the issue at hand is a moral one, there is still a lack of contribution from philosophical ethics to inform drug policy on this matter (Bayoumi, 2013, p. 31-36). One of the main objectives of this research paper, then, is to explicate the philosophical underpinnings of the safe injection site debate. Filling in this gap will strengthen the arguments put forth in favour of and against the operation of safe injection sites at the public level, so as to facilitate action at the policy level. After the philosophical foundations are established, I will argue for the continuing operation of safe injection sites in Canada. The following utilitarian justification will be offered and defended:

Premise 1: Drug policies should be based on the model that will lead to the best possible consequences for everyone involved.

Premise 2: The harm reduction model, giving rise to the policy allowing for the operation of safe injection sites, has better consequences for everyone involved (drug users, and society) than the absolute criminalization policy derived from the abstinence model.

Conclusion: Safe injection sites should continue to operate.

My purpose in Part One was only to introduce the research topic. To this end, I provided a history of safe injection sites in Canada and explained the current state of affairs. I then laid out the research problem where I briefly outlined the conflicting philosophical justifications of the two drug policy models – a topic which will be expanded on in Part Two. I ended by displaying my main argument in standard, simplified form. This argument is formally valid in that both a moral and non-moral premise (which are themselves the conclusions of other arguments in this paper) is present. If both premises are accepted as true, the conclusion necessarily follows. Now, in the following parts of this MRP, I will take a stance – in support of safe injection sites – and defend my position based on utilitarianism.

Part 2: A defense of utilitarianism in the context of drug policy

2.1- Utilitarianism in harm reduction

The ethical theory underlying the harm reduction model is utilitarianism. Utilitarianism is a consequentialist moral theory that claims that what makes an action right or wrong is defined by the good or bad consequences that result from the proposed action (Mill, 1861, p. 90). In this way, the good, however defined, comes before the right (Heimir and Holmgren, 2010, p. 83). As a normative ethical theory, then, utilitarianism tells one to maximize utility, regardless of how it is to be achieved. The good or utility in classical utilitarianism, for example, often attributed to philosophers like Jeremy Bentham and John Stuart Mill, is happiness (the overall balance of intrinsic good over intrinsic evil) (Regan, 1992, p. 41) (Mill, 1861, p. 90). Happiness, it is argued, is the only thing that is intrinsically valuable which is the reason why the good

consequences of an action can make that action right (Mill, 1861, p. 90). Different utilitarian philosophers have had different conceptions of happiness. For example, Bentham viewed happiness only quantitatively, whereas, Mill also understood happiness qualitatively, referring to the superiority of intellectual pleasures over base pleasures (Mill, 1861, p. 91). In this MRP, I will also view pains and pleasures qualitatively. The challenge in this will be in evaluating the different drug policy model outcomes. Nevertheless, this will be my aim in Part Three.

What makes utilitarianism different from other teleological, foundational theories is that it considers all moral agents that are likely to be affected by a given decision, as opposed to ethical egoism which only considers the self, and ethical altruism which considers everyone but the self (Regan, 1992, p. 39-40). So, in drug policy, this would mean that the happiness of both drug users as well as society at-large are relevant considerations. Moreover, in this MRP, the utility that is sought will be related to health, public safety, and money saved—that is, lower number of deaths from overdosing, lower rates of viral infection transmission from needle sharing (including HIV and HCV), increased referrals to drug treatment programs, cost effectiveness on the healthcare system, and public order. These are all outcomes which empirical studies on Insite have studied and outcomes that are commensurable with Mill's principle of utility. Even though Mill argues that happiness is the only thing that is valuable for its own sake, he acknowledges that these types of health and safety related goods are, "...besides being means... are a part of the end [happiness]." (Mill, 1861, p. 96). Much more will be said about Mill in Part Two but before continuing, it is important to understand the scope of the specific utilitarian position I intend to defend.

The particular utilitarian argument I intend to use and develop in this research paper is the "regulating wrongdoing" argument proposed by Frowe and Shue. Forming the central point

of the harm reduction principle, the regulating wrongdoing argument posits that, “Given that people are going to engage in...[a] wrongful act, we must focus our efforts on minimising the harm they cause, even if the best way to do this is to grant that they may legally cause some harms, but not others.” (Frowe, 2011, p. 46). When specifically applied to drug policy, the following argument is generated: since there will be people in society who misuse drugs, the law should allow for them to engage in drug injection on the condition that they do it in safe injection sites. The reason for this being that allowing drug injection in safe injection sites reduces overall harms. In other words, by opening safe injection sites, we ensure that injection drug users do not, on top of inflicting the harm of ingesting heroin into the body, inflict other harms such as overdosing, getting infected with HIV through using dirty needles, disrupting public order and causing significant and unnecessary costs on the healthcare system. As I pointed out, however, this non-moral premise alone does not form a conclusive argument for the operation of safe injection sites. A moral theory is needed to ground such a conclusion. This theory is utilitarianism—that is, we should focus on reducing overall harms *because* consequences (harm reduction) matter to morality.

Given the position of the harm reduction principle, it now becomes important to determine the scope of its use. After all, without setting any boundaries it may be suggested that this regulating wrongdoing argument can be incorrectly used to sanction any and all acts that seems to be inevitable. Frowe looks to tackle this problem by considering the act of rape. She states that if the regulating wrongdoing argument is applied to rape, one can make the assertion that, “...what we must deal with is the reality that some people will think that their act of rape is an act of consensual sex..., and will act accordingly.” (Frowe, 2011, p. 46). Therefore, if we want to reduce overall harms, instead of outright banning rape, “...we might have a law that

unmarried couples may engage in consensual sex only if it is protected sex.” (Frowe, 2011, p. 46). In this way, Frowe continues, we reduce overall harms because “...he [the rapist] ensures that he won’t in addition to inflicting the harm of rape upon his victim, inflict the further harm of sexually transmitted diseases and unwanted pregnancy.” (Frowe, 2011, p. 46).

I agree with Frowe that, unfortunately, rape (or rapists thinking that their act of rape is an act of consensual sex) is one of those acts that will continue to happen in parts of the world regardless of different intervention and education programs. However, I do not think that the regulating wrongdoing argument can be used to deal with rape. This is because “inevitability” is not the only criterion that needs to be met for the appropriate application of the harm reduction principle. There are further classifications. For example, the reason why safe injection sites can be justified by this argument is that, not only is injection drug use inevitable, but safe injection sites are actually effective in reducing harms, a necessary component of utilitarianism. Nonetheless, even with regards to rape, Frowe seems to think that the aforementioned “using protection” rule would in fact reduce harms by ensuring that committed rapes are protected rapes (Frowe, 2011, p. 46). The justification she uses for this is that in the absence of the “using protection” rule, there is still an equal number of rapes, with the downside being that they are unprotected rapes (Frowe, 2011, p. 46). However, I do not agree with Frowe that there would be an equal number of rapes if such a law existed and if the law did not exist. If the permissibility of ‘consensual sex only when using protection’ becomes a written legislation, this *may* actually encourage some misguided people to partake or be less deterred from not partaking in a supposed consensual sexual activity, as opposed to ensuring that a rapist uses protection (which is the aim of such a rule).

This “encouraging” type of side-effect is also a criticism brought forward against safe injection sites. Some, for example, can claim that allowing injection drug users to inject heroin on the condition that they do it in safe injection sites would lead some people who do not normally inject drugs to try heroin (Popovich, 2008, p. 1). However, it has already been empirically proven that safe injection sites do not have such a side effect. For example, with respect to Insite, “...most users of the safer injecting facility were long-time injection drug users, and... found no evidence to suggest that the safer injecting facility prompted elevated rates of initiation into injection drug use in the community.” (Kerr, Tyndall and Zhang, 2007, p. 1229). Regarding rape, on the other hand, we can never be certain that the committed rapes would in fact be protected rapes, as Frowe suggests, until there is empirical evidence. Nonetheless, even at a theoretical level, one can realize that the “using protection” law would not be successful because such a policy assumes that a person who would commit rape would actually abide by the “using protection” rule. If a person is already committing the immoral act of rape, I am not certain that this person would do the moral act of using protection. It is true that such a law is attempting to view the possible rape from the perspective of the victim (by trying to minimize the harms that could be inflicted on the victim), but this does not mean that the rapist has the same point of view. A rapist, whose aim is to seek self-pleasure or to inflict suffering, would not have an interest in not transmitting a potential STD onto the victim. Contrarily, injection drug users do have an interest in attending safe injection facilities as there are many health and safety benefits that they can take advantage of.

Overall, since the “using protection” policy would only be effective if the rapist actually follows the given rule, which is not likely, utilitarianism would not be able to justify it. Thus, on top of drawing the limits of the regulating wrongdoing argument to acts that are inevitable, the

suggested policy must, (a) actually achieve its goals, and (b) not encourage the act proposed by the policy for those who are not targeted by the policy. Criterion (a) and (b) are necessary components of what Tom Regan calls “information” in reaching an ideal moral judgement (Regan, 1992, p. 34). Regan reminds us that, “Moral questions come up in the real world, and a knowledge of the real-world setting in which they arise is essential if we are seriously to seek rational answers to them.” (Regan, 1992, p. 34-35).

2.2- Kantian ethics in abstinence

The greatest philosophical challenge to the harm reduction model comes from Kantian ethics. According to Kant, one has to do something duty requires because duty requires it, not because of inclinations or because of the good consequences (such as happiness) that are likely to result from performing such an action (Kant, 1786, p. 152). This is because only actions done from duty have moral worth and this action derives its moral worth from the maxim (principle of the will) by which it is determined (Kant, 1785, p. 153). Accordingly, “...nothing...determine[s] the will except objectively the law and subjectively pure respect for this practical law...” (Kant, 1785, p. 153). From this, Kant concludes that one should follow this law regardless of all inclinations and regardless of the desire to achieve good consequences (Kant, 1785, p. 153). But Kant asks what sort of law can be something that determines the will, such a will that is considered good without qualification (Kant, 1785, p. 154). To this, he answers the following: “Never act otherwise than so that I could also will that my maxim should become a universal

law.” (Kant, 1785, p. 154). He says that this must serve the will as principle, if duty is not to be an error or delusion (Kant, 1785, p. 154).

Kant holds that everything in nature works according to laws, the physical world according to physical laws and the moral world according to moral laws (Kant, 1785, p. 154). To this he adds that humans have a will (because we can act according to principles) and that the deduction of actions from principles requires reason (Kant, 1785, p. 154). However, because reason is not infallible, since it can be led astray by inclinations (as it usually does with humans, according to Kant), “...actions which are objectively recognized as necessary become subjectively contingent and reason itself does not sufficiently determine the will.” (Kant, 1785, p. 154-155). Therefore, “...the determination of will according to objective laws is an obligation.” (Kant, 1785, p. 155).

This categorical imperative is a test to determine a moral agent’s duty, which tells one that the action in question is good in itself, and not good instrumentally (Christie, Groarke and Sweet, 2008, p. 55). Even though there are three formulations of the categorical imperative, I will only focus on the “universalizability” rule as it is the one that is most relevant—that is, (i) *can* the proposed action be universalized? and (ii) even if it *can* be universalized, can one *will* that it *should* be universalized? (Kant, 1785, p. 158-159). As explained above, for Kant, ethics is about doing the right thing because it is the right thing to do (duty), not because performing this action will benefit the person or for any other instrumental reason. It is because of this that the harm reduction model giving rise to safe injection sites can never be moral according to Kant. Remember that the regulating wrongdoing argument accepts that engaging in illicit drug use may be immoral (in the Kantian sense), but says that safe injection sites should still operate because it leads to certain goods in health, healthcare and public order. Kant would find that this

instrumental reasoning deserves praise and encouragement but not esteem, because an appeal to consequences does not have any moral worth (Kant, 1785, p. 152). The abstinence model, on the other hand, is in line with Kantian reasoning, because it passes the universalizability rule: we can certainly will that the maxim, ‘no one should engage in illicit drug use’ be universalized (Christie, Groarke and Sweet, 2008, p. 56).

2.3- Kantian ethics and drug policy

To identify the adequateness of a moral theory in an applied-ethics field, such as bioethics or drug policy ethics, Lewis Vaughn identifies three criteria for evaluation. These are, (a) consistency with our considered moral judgements, (b) resourcefulness in moral problem solving, and (c) consistency with the facts of the moral life (Vaughn, 2013, p. 47). In this paper, I will only focus on the first two because both utilitarianism and Kantian ethics are consistent with the facts of the moral life—that is, moral judgements are truth apt (cognitivism), people can disagree, be mistaken and have the ability to provide supporting reasons for their moral conclusions (Vaughn, 2013, p. 48-49). The application of first two criteria to an applied-ethics field, on the other hand, will yield different conclusions if one uses utilitarianism than if one uses Kantian ethics. Moreover, it must be noted that these two criteria do not say anything about the truth of either theory. Rather they focus on the instrumental value of utilitarianism and Kantian ethics. Because this research topic is within the field of applied ethics, however, using Vaughn’s criteria will suffice in answering which moral theory is more appropriate in drug policy making. Nevertheless, since Kant’s main focus is precisely the point about the irrelevancy of consequences and resourcefulness (utility) in moral decision making, I am compelled to say more about Mill’s utilitarianism first.

First of all, it is evident that the application of Kant's deontology is sometimes inconsistent with our considered moral judgements (Vaughn, 2013, p. 37). As noted earlier, according to Kant, right actions do not depend on consequences, happiness or the maximization of utility. But public policy decisions need to take account of these to some degree. After all, if a policy decision leads to chaos, it does not matter what the intention behind the policy is. As Mill explains in his work entitled *Utilitarianism*, consequences do matter to morality (Mill, 1861, p. 95). In his own words, "Happiness has made out its title as one of the ends of conduct and, consequently, one of the criteria of morality." (Mill, 1861, p. 95-96). He admits, however, that this does not prove that consequences are the only criterion of morality (Mill, 1861, p. 96). For example, humans also "...desire...virtue and the absence of vice no less really than pleasure and the absence of pain." (Mill, 1861, p. 96). But what is fundamental to his point is that this position does not contradict utilitarianism because a virtuous action is "virtuous" *because* it produces desirable consequences (Mill, 1861, p. 96). In talking about health, power or fame, for example, Mill says that, "In being desired for its own sake it is, however, desired as part of happiness...The desire of it is not a different thing from the desire of happiness any more than...the desire of health. They are included in happiness" (Mill, 1861, p. 96). So with regards to safe injection sites, Mill would argue that the health and safety goods that result from their operation may be desired for their own sake, but they are at the same time desired as part of happiness.

Kant, on the other hand, is only too clear about the irrelevancy of consequences in morality. He says that, "A categorical imperative concerns not the matter of the action, or its intended result, but its form and the principle of which it is itself a result; and what is essentially good in it consists in the mental disposition, let the consequence be what it may." (Kant, 1785, p.

157) As noted earlier, Kant believes that, “Nothing can possibly be conceived in the world, or even out of it, which can be called good without qualification, except a good will.” (Kant, 1785, p. 150). There is already a contrast with Mill’s utilitarianism here where the only thing that is valuable for its own sake is happiness (Mill, 1861, p. 90). On the contrary, Kant says that ethics cannot be about happiness because,

...the promotion of the happiness of others could have also been brought about by other causes, so that for this there would have been no need of the will of a rational being; whereas it is in the this alone that the supreme and unconditional good can be found. The pre-eminent good which we call moral can therefore consist in nothing else than the conception and not the expected effect, determines the will” (Kant, 1785, p. 154).

Given the theoretical meta-ethics conflict between Kant’s ‘good will’ and Mill’s ‘happiness’, it becomes important to find the correct balance between obeying unconditional moral rules and achieving good consequences when making laws and policies. In the context for drug policy, for example, Kantian ethics is not very resourceful. Its strictness leads to otherwise avoidable overdose deaths, an increase in HIV transmission in the population, and an increase in the cost of healthcare delivery (Wood, Tyndall and Montaner, 2006, p. 1399-1400). As it does in this case, sometimes our considered judgements actually suggest that the “...consequences of our actions do matter more than adherence to the letter of the law, even if the law is generally worthy of our respect and obedience” (Vaughn, 2013, p. 49). Helping drug addicts and making society a more peaceful place certainly seems more morally important than obeying Kant’s universalizability rule.

Of course, this notion of “our considered moral judgements” raises questions about whether we can reach an agreement as to what our considered moral judgements or common sense actually entails. After all, different people may have different considered moral judgements. Culture certainly plays a significant role in the development of moral judgements. For example, a devoted religious person may have different common sense about active euthanasia than an atheist. Moreover, the West is generally more individualistic than the East, where groups and family values are more cherished (Gorodnichenko and Roland, 2011, p. 27-28). This is certainly not necessarily true: with the growth of feminism, ethics of care and communitarianism, there are many doctrines in the West that are not individual-oriented. Psychological studies tend to make such generalizations, but exceptions exist. Nevertheless, a person from the West may have the common sense view that the most basic human rights (life, liberty, property), which tend to be atomistic, are more important than group rights (right to be heard as a group, right to form interest groups) or personal relationships that are valued by persons from the East. In the context of drug policy, then, a person from the East may have the view that safe injection sites are morally permissible because they serve the interests of a group as a whole (for example, because it reduces HIV and other disease transmission within the drug injecting population), whereas a person from the West may have the common sense view that the operation of a safe injection site necessarily infringes on the right of another to not have to live near an injection facility. So it may be difficult to determine who is right here based on common sense per say.

Bioethicists Beauchamp and Childress try to work out of this problem of (un)common considered judgement(s) by referring to what they call ‘common morality’ (2013, p. 2-3). According to them there are certain moral and immoral actions that can be agreed upon by

almost everyone, whether one lives in the East or West (Beauchamp and Childress, 2013, p. 3).

The authors claim that,

We learn about morality as we grow up, and we learn to distinguish part of morality that holds for everyone from moral norms that bind only members of specific communities or special groups such as physicians, nurses, or public health officials. There are core tenets in every acceptable particular morality that are not relative to cultures, groups, or individuals.” (Beauchamp and Childress, 2013, p. 3).

Examples of acts that fall under this common morality proposed by Beauchamp and Childress include not lying, not stealing others’ property, keeping promises, respecting the rights of others, not harming or causing pain on others, saving persons in danger, taking care of the young and the elderly, not punishing the innocent, and obeying just laws (2013, p. 3). There are other philosophers as well, such as James Griffin, a non-reductive ethical naturalist, who believe that there are basic human interests that all humans share (and that should be protected) (Griffin, 2010, p. 114). Some examples he gives are avoiding pain and anxiety and caring about the fulfillment of our goals (Griffin, 2010, p. 116). Common morality for Griffin, then, is similar to the theory of common morality proposed by Beauchamp and Childress, which is expected if it truly is a “common morality”. All of this being said, I am critical of the notion of common morality only in that it does not allow us to solve specific problems that come up in the real world. But this is also the perspective of Beauchamp and Childress, and they do not intend to use common morality to solve specific problems, but only as a starting point (Beauchamp and Childress, 2013, p. 4-5). Thus, if we are broad enough, I agree with the aforementioned philosophers that there are actions that would be deemed immoral or moral by all.

2.4- Utilitarianism and drug policy

In the previous section I argued that Kantian deontology is not an adequate moral theory to deal with drug policies concerning safe injection sites. Part of this discussion included Mill's point about the relevancy of happiness in morality. In this section, I will now evaluate how utilitarianism performs in moral problem solving and in being consistent with our considered moral judgements when it comes to drug policy making.

Primarily, utilitarianism has generally been accused of not being useful in moral problem solving because it is said that it demands too much from moral agents and ignores the difference between obligatory actions, such as saving one's life when it is easily possible, and supererogatory actions such as donating most of our possessions to charity (Vaughn, 2013, p. 48). Another common criticism is that, "It just seems wrong to say that we are constantly under an obligation to do whatever would produce the best overall results as judged from an impartial perspective." (Heimir and Holmgren, 2010, p. 88-89). Thus, under this critical framework, utilitarianism can be accused of leading us to the position that we ought to open safe injection sites anywhere, and any time that this act is likely to lead to more good than bad. For example, there are currently serious talks about opening safe injection sites in Ottawa and Toronto, and the Report of the Toronto and Ottawa Supervised Consumption Assessment Study (TOSCA) has predicted that safe injection sites here would have a number of benefits on the community, ranging from less overdose deaths to more money being saved (Bayoumi, Strike and Brandeau, 2012, p. 11). Researchers:

...used mathematical modeling to project potential health benefits related to establishment of supervised injection facilities... [They] projected that the number of

HIV infections averted by the first three facilities in Toronto was about 2 to 3 per facility per year and that the number of hepatitis C virus infections averted was about 15 to 20 per facility over 20 years...[They] projected that the number of HIV infections averted by the first two facilities in Ottawa was 6 to 10 per facility per year and the number of hepatitis C virus infections averted was 20 to 35 per facility per year...The cost per HIV infection averted with the first supervised injection facility in Toronto is \$323,496 and with the first supervised injection facility in Ottawa is \$66,358. The cost per hepatitis C infection averted with the first supervised injection facility in Toronto is \$47,489 and with the first supervised injection facility in Ottawa is \$18,591. The greatest cost savings in the Toronto and Ottawa models come from averting hepatitis C virus infections (Bayoumi, Strike and Brandeau, 2012, p. 11)

Given these benefits, the utilitarian position would argue that safe injection sites should certainly be opened in Ottawa and Toronto. Although this may not be such a bad thing in theory, it can still be posited that having to be in a position where we must work towards opening safe injection sites anywhere and anytime that they are likely to do more good than bad demands too much from individuals. However, this criticism is not fully appropriate with respect to safe injection sites. Individuals are not the main actors in this case as it is the state's responsibility to fund safe injection sites; they are not privately funded. Thus, the two ways in which individuals become directly involved are primarily, through the tax that they pay, and secondly, by potentially living close to a facility. With regards to tax payment, the operation of safe injection sites would not require an increased financial assistance from citizens because, as explained above, the healthcare system actually saves more money from their operation. With regards to potential location issues, safe injection facilities are actually associated with an increase in public

order in the areas in which they are located. For instance, Insite has led to a decrease in the presence of suspected drug dealers, publicly discarded syringes, public injection drug use, and injection-related litter in Vancouver Eastside (Wood, Tyndall and Montaner, 2006, p. 1400-1401). All of this being said, there is not much that individuals have to be concerned about—that is, the utilitarian position here does not ask too much from individuals who are directly involved. On the contrary, it provides health and safety benefits to individuals (drug user and non drug user) and society.

Secondly, with respect to its consistency with our considered moral judgements, utilitarianism has been accused of overriding concerns over individual rights and justice (Heimir and Holmgren, 2010, p. 88) (Vaughn, 2013, p. 48). A common example to demonstrate this problem is the alleged justification utilitarianism offers in allowing a doctor to kill one patient to save five other ones (Heimir and Holmgren, 2010, p. 87). This clearly seems wrong as the patient has a right not to be killed, even if it will save five others. However, once again, this criticism does not necessarily apply to the regulating wrongdoing argument of the harm reduction principle. In this case, the wrongdoing that the harm reduction principle is allowing (illicit drug use) has good consequences on the individual drug user and society. On the other hand, saying that ‘killing a patient to save five other ones leads to good consequences’ is short-sighted. It may lead to good consequences in the short run, but in the long run this action will have many detrimental consequences, ranging from damage to public health to collapse of the healthcare system. As I mentioned in the beginning of the MRP, like Mill, I am viewing happiness qualitatively. Thus, it is evident that the long term benefit here outweighs any short terms benefits. Overall, scenarios like the murdering doctor case, used to argue against utilitarianism, are unrealistic and misleading and do not take anything away from the harm reduction principle.

If we carefully analyze all possible consequences, including long term ones, we would find that most actions that utilitarianism justifies does not actually go against our considered moral judgements (Heimir and Holmgren, 2010, p. 89) (Vaughn, 2013, p. 49).

Part 3: An evaluation of the values underlying the harm reduction and abstinence model outcomes

In the previous part, I argued that the utilitarian harm reduction model is a better way to approach drug policy than the deontological abstinence model. Nonetheless, critics of safe injection sites can continue to prescribe the abstinence model, not because they believe it is right thing to do, in the Kantian sense, but because they believe that the abstinence model leads to better consequences. In this section, I will argue that the harm reduction model, giving rise to the policy allowing for the operation of safe injection sites, has better consequences for everyone involved (in reality) than the absolute criminalization policy arising from the abstinence model.

One of the relevant criticisms of utilitarianism is that it is sometimes difficult to predict consequences. Fortunately, this is not the case in Canada as there are dozens of peer-reviewed, empirical studies that demonstrate the positive outcomes of safe injection sites. Primarily, Insite is associated with a significant reduction in overdose deaths (Marshall, Milloy and Wood, 2011, p. 1429). In terms of public related goods, Insite has been utilized by frequent drug users, has not been associated with an increase in the rates of initiation into injection drug use, and has led to an increase in the number of injection drug users seeking detoxification services (Kerr, Stoltz and Tyndall, 2006, p. 1400) (Kerr, Tyndall and Zhang, 2007, p. 1228) (Wood, Tyndall and Zhang, 2006, p. 2512-2513). Moreover, after the opening of Insite, (a) there was a significant

reduction of public injection drug use and publicly discarded syringes, (b) there was a significantly reduced rate of syringe sharing among Insite clients (this practice is the primary mode of HIV transmission in this community), (c) there was an increased likelihood of entering addiction treatment services among Insite clients, and (d) there was not an increase in drug-dealing or drug related crimes in the area where the facility is located (Wood, Tyndall and Montaner, 2006, p. 1400-1403). In terms of monetary consequences, the treatment of the ramifications of illicit drug injection is very costly. These are costs that safe injection sites can help avoid. For example,

The cost for every untreated opiate user is estimated to be over \$45,000 (Cdn) per year, the lifetime cost of treating a person with HIV exceeds \$250,000 (Cdn)...and Emergency Department utilization is significantly higher among those with problematic substance use than those without (Christie, Groarke and Sweet, 2008, p. 55) (Wall, Rehm and Fischer, 2000, p. 688) (Kuyper, Montaner and Schechter, 2004, p. 655) (Palepu, Tyndall and Leon, 2001, p. 415-416)

Since the empirical evidence is vast and mostly accepted by the academic community, I will not take the time to re-iterate these findings more than I already have. The real issue, "... which has largely been overlooked, is about ethics." (Christie, Groarke and Sweet, 2008, p. 54). More so, "The opposition to supervised injection in Canada ultimately comes down to a question of values." (Zlotorzynska, Wood and Montaner, 2013, p. 1304). Thus, to complete my argument and conclude that Insite has better consequences, the following two questions will be answered: (1) which model's sought consequences are better and why, and (2) which model actually achieves their sought consequences in real life? Remember that while the abstinence model seeks to decrease the total number of illicit drug users through criminalization and supply/demand

reduction, the harm reduction model initially seeks to decrease deaths, infections, costs, and increase public order.

3.1-Theoretical relationship between safe injection sites and the encouragement of drug injection

Before going on to question 1, however, I would like to take some time to discuss one very common, consequentialist argument against safe injection sites. This is the argument that safe injection sites encourage drug use and lead to an increase in the number of illicit drug users. Even though empirical research has demonstrated that this does not actually happen, theoretically it still seems as though a “illicit drug use is okay” message is delivered to the general public through the standing of safe injection sites. Ken Gallinger intelligently responds to this criticism by making a comparison to food banks. He explains how food banks, which were established to feed the hungry and ultimately reduce the number of hungry people in society, actually led to an increase in the number of people using food banks. This phenomenon led some to argue that food banks were “...perpetuating the problem of hunger – making people dependent, taking government off the hook for real solutions.” (Gallinger, 2012, p. 1). Similarly, it is argued that safe injection sites do not solve the real problem behind drug misuse and that they encourage drug injection. Sticking to his comparison of safe injection sites to food banks, Gallinger responds by stating that, “...I never met a single person who chose to be hungry simply because they could get free food. Can anyone seriously argue that someone would choose to be addicted to crack, just because there was a place where they could get clean needles free?” (Gallinger, 2012, p. 1).

One question that can be raised is: why has there been an increase in the number of food bank users throughout time? One pessimistic but possible reason is that the existence of food

banks has de-motivated those in poverty from making lifestyle changes in order to get out of poverty. But it is also possible that this outcome is the result of food banks being (more) successful in their mission to reach out to the (perhaps growing number of) vulnerable and hungry persons in society. As Gallinger points out, it certainly does not seem logical for anyone to give up work, or purposely enter into poverty, just to be able to get free food. However, logic is not always the only factor influencing a person's behaviour as inclinations, among other things, can also play a role. Thus, just like the safe injection site debate, empirical evidence would be required to convincingly settle this ambiguity.

3.2- Which model's sought consequences are better and why?

In beginning to answer question 1, I think that the aspiration of the abstinence model - decreasing the total number of illicit drug users - is a great outcome. What is peculiar is that the harm reduction approach does not disagree. The reason for this is that if there are fewer injection drug users, there will automatically be fewer deaths and infections, better public safety, and large amounts of money saved by the healthcare system. These are the particular elements that the harm reduction model also attempts to minimize, but directly. A potential reason for why the abstinence model may be viewed as a theoretically better outcome, however, is that the harm reduction model may actually be exacerbating certain harms while minimizing other ones. For example, safe injection sites may play a role in keeping substance users addicted for longer (Popovich, 2008, p. 1). The "ideal" abstinence model, on the other hand, does not fall prey to this criticism outlined by Popovich because it eliminates drug use as soon as possible, thereby cutting off the chances of there being long-term addiction problems for individuals.

The problem with the abstinence model, however, is not that it has bad goals but that these goals are not achievable. In other words, abstinence based policies have not been successful in minimizing injection drug use. For example,

With regard to drug use patterns, intensified police presence prompted 'rushed' injections, injecting in riskier environments, discouraged safer injection practices, and increased unsafe disposal of syringes. Service providers indicated that the CET [a large scale police initiative called Citywide Enforcement Team] negatively impacted contact between health services and IDUs [injection drug user], as outreach was compromised due to the displacement of IDUs. Police activities also negatively influenced IDUs' access to syringes and their willingness to carry syringes, and syringe confiscation was reported. The intensification of police activities led to less drug related activity in the area where the drug market was traditionally concentrated, but widespread displacement of drug use activities to other locations also occurred (Small, Kerr and Charette, 2006, p. 85).

The theoretical reasons for why abstinence based strategies, such as increased police surveillance, do not work will be discussed shortly.

Secondly, saying that the harm reduction model necessarily feeds addiction is short-sighted and misleading. This alleged limitation of the harm reduction model is actually dealt with by facilities like Insite because, on top of aiming to reduce harms, safe injection sites also have, "... addictions counsellors, mental health workers, and peer staff who connect clients to community resources such as housing, addictions treatment, and other supportive services." (Vancouver Coastal Health- Insite Services, 2011, p. 1). They even note that:

Insite was not designed to be a stand-alone facility. It's part of a continuum of care for people with addiction, mental illness and HIV/AIDS. It was designed to be accessible to injection drug users who are not well connected to health care services. For people with chronic drug addiction, InSite is the first rung on the ladder from chronic drug addiction to possible recovery; from being ill to becoming well (Vancouver Coastal Health- Insite Services, 2011, p. 1).

For example, when Insite clients are ready to access withdrawal management, they can move to the upper floor of the same building, Onsite (Vancouver Coastal Health- Insite Services, 2011, p. 1). At OnSite clients can detox and work with mental health workers, counsellors, nurses and doctors to stabilize and plan their next steps (Vancouver Coastal Health- Insite Services, 2011, p. 1). From there they can "...move up to the 3rd floor transitional recovery housing for further stabilization and connection to community support, treatment programs and housing" (Vancouver Coastal Health- Insite Services, 2011, p. 1).

3.3- Anticipated criticisms of the values underlying the harm reduction model outcomes

As stressed throughout this MRP, the regulating wrongdoing argument posits that it is better to reduce overall harms instead of trying to stop drug users from injecting drugs because consequences matter to morality. The point that could be made against this argument in the context of drug policy is that we should not have to care about reducing the negative consequences of illicit drug injection. The reason for this being that injection drug users are self-responsible for the position that they are in life and that it is more plausible for the general public to expect them to stop using drugs altogether. To respond to this criticism, I must explain why

the reduction of overdose deaths, lower rates of public drug use and lower rates of HIV infections within the drug injecting community, among other things, are important. In other words, this section will explain why the happiness caused by increased health and safety from the operation of safe injection sites should concern us.

As I have already mentioned a couple times, one response is that criminalization does not work. Even if the law usually has an enforcing/detering effect on citizens, it is clear that in this case the law does not deter most injection drug users from using drugs. Apart from psychological non-deterrence, perhaps one reason why the abstinence model does not work in reducing the number of illicit drug users is because the system is not in place. By this I mean that maybe the police turn a blind eye to what marginalized, homeless illicit drug users do, as long as they do not affect others. This, then, allows injection drug users to continue to inject. However, if this is the reason why it does not work, critics of safe injection sites should not be upset with those who say that criminalization does not work, but rather be upset with the system that is supposed to be responsible for arresting those who engage in criminal activities. Maybe if the system was intact and the state had the capacity and the desire to put all injection drug users in jail, then maybe the abstinence model would be effective. Nonetheless, even if the system was in place, it still seems unjust to put all injection drug users to jail. One obvious reason for this is that these people are addicted and did not (do not) choose to be injection drug users. In other words, it may be that an abstinence based policy requires unreasonable characteristic traits from drug misusers which are not found in drug addicts.

This notion of addiction is a second reason why we should care about reducing the negative outcomes of drug use. However, this comes with its own theoretical problem, such as what it means to be free. Can we, with confidence, say that injection drug users are not free and

that they are not responsible for the state that they are in? To briefly answer this question, I will compare two opposing theories of liberty; negative and positive liberty. Negative liberty states that one is free when no others are coercing that person from doing things s/he would like to do (Berlin, 1958, p. 2-3). Positive liberty, on the other hand, states that one is free when s/he is provided with the support s/he needs to be able to do the things s/he would like to do (Berlin, 1958, p. 7-8). For example, a handicapped person in a wheelchair is free, in the negative sense, to go up the stairs, but is not physically able to do so without an elevator or a ramp. So, positive freedom would assert that this person needs to be provided with the necessary means for him/her to be able to get up to the top floor if s/he is to be called “free”. Another example is that of a drug addict. The addict, whose real intention is to quit, is too absorbed by his/her inclinations that s/he cannot abstain from drug injection on his/her own. In the positive sense, then, freedom means having the ability to accomplish one’s true intention (against one’s immediate desire to inject), which may require help from others. It does not mean to be left untouched. The medical aspects of addiction are not disputed. It is defined as a “... chronic, often relapsing brain disease that causes compulsive drug seeking and use, despite harmful consequences to the addicted individual and to those around him or her” (National Institute on Drug Abuse, 2012, p. 1). In other words, it is a serious condition and usually requires assistance to beat. Safe injection sites are sensitive towards this concern, which is the reason why they do not require immediate abstinence from drug users. On the other hand, the criminalization policy assumes that all drug users are free and have a choice to quit, thereby making it apparent that it values negative liberty over positive liberty. According to the criminalization model, then, the state needs to treat everyone equally, thereby not having to take into account the special circumstances of injection drugs users. The theory of positive liberty responds to this weakness, first by recognizing the

reality of addiction/dependence, and secondly by considering the living contexts of people: most drug users come from low income families that live in poverty (Hickler and Auerswald, 2009, p. 824). Thus, to treat everyone equally would mean that the state should give special permissions to these persons so that they may one day live to beat their addiction. One such special permission is the permission to engage in illicit drug use in safe injection sites, which are facilities that also offer addiction support and withdrawal management programs.

Finally, the third reason why we should care about reducing the negative outcomes of drug use is that others are affected by their actions if nothing is done: public order is disturbed in areas with high levels of illicit drug use, and more money is spent from treating overdoses than the money that would be spent to operate safe injection sites (Wood, Kerr and Small, 2004, p. 731-732) (Wood, Tyndall and Montaner, 2006, p. 1400-1401) (Bayoumi, Strike and Brandeau, 2012, p. 243-245). As highlighted by the utilitarian position, surely an increase in public order, public health and cost-effectiveness are desirable outcomes. Taking all of this into account, drug policy makers should incorporate a harm reduction approach into their overall plan to reduce illicit drug use in society. Opening safe injection sites where there are large numbers of illicit drug users is a moral and effective way to do this.

Part 4: Conclusion

The research question that this essay dealt with is whether safe injection sites ought to continue to operate. To this end, in Part One, the two opposing models to drug policy making

(the harm reduction model and the abstinence model) were discussed. The different ethical theories that can justify each model were then briefly outlined and expanded on in Part Two. In filling this gap, the aim was to form a strong, and philosophically grounded basis of the abstinence and harm reduction models. In Part Two, I defended utilitarianism (specifically the regulating wrongdoing argument) against Kantian ethics in the context of drug policy making. As such, I answered the question of why an act that is accepted to be immoral can nonetheless be permitted in the context of drug policy. Next, in order to complete the utilitarian justification offered in this research paper, Part Three outlined the findings of several empirical studies and evaluated the underlying values of the abstinence and harm reduction model outcomes. Overall, it was argued that safe injections sites ought to continue to operate.

Future public ethics research can look to further develop how a theory of positive liberty applies to the field of drug policy or to another public policy issue. This research essay talked about the philosophical aspects of addiction but did not seek to identify the possible ramifications of accepting the view that certain individuals are not actually “free”. It is important to identify the limits of such a position, however, because of the potentially dangerous powers it may confer on the state. For example, it may lead to governments controlling others for their ‘own good’ which is precisely against what one *actually* desires, justifying this act by stating that people do not always know what is for their own good. Rousseau’s social contract theory where he makes a distinction between the “will of all” and the “general will” is a good starting point to take up this research. Secondly, in philosophy there are some who argue that there is a distinction between “doing” and “letting happen”, an idea which others have challenged. In drug policy, some can hold the position that not providing the services of safe injection sites, when it is feasible, is in fact a case of “doing” harm. However, others can argue that this idea is skewed,

suggesting a clear, physical distinction between forcing one to take drugs and allowing people who already take drugs to use drugs. Thus, even if injection drug use harms drug users, it is not the state that is harming them. In light of all the evidence demonstrating the benefits to individual addicts, society at large and the healthcare system (including saved money), can one argue that the state is at fault for not offering safe injection facilities?

Appendix 1- Key terms and phrases

Safe injection sites: Medically supervised facilities where injection drug users (IDU) can come to self-inject their self-acquired drugs using site-provided sterile equipment. Safe injection sites are also referred to as Supervised Injection Sites/Facilities or Drug Consumption Rooms.

Insite: North America's first supervised injection site located in Vancouver, Canada.

Onsite: A floor connected to Insite where injection drug users can go to detox and access mental health services and counsellors.

Dr. Peter Centre: Canada's second supervised injection site, also located in Vancouver.

Harm reduction model: A model in drug policy that mainly aims to reduce the negative outcomes associated with illicit drug use without requiring abstinence from drug users. Safe injection sites operate on this model.

Abstinence model: A drug policy model that mainly aims to reduce the number of illicit drug users in society by criminalizing drug use and implementing other demand and supply reduction strategies. The abstinence model opposes the standing of safe injection sites.

Regulating wrong-doing argument: Given that an (immoral) action is practically unavoidable, we should attempt to minimise the harms caused by the action, rather than absolutely banning the practise. This will be used interchangeably with the harm reduction argument.

HIV: Human immunodeficiency virus. This virus leads to AIDS (acquired immune deficiency syndrome) and can be transmitted through needle sharing.

HCV: Hepatitis C virus. This virus leads to liver disease and can be transmitted through needle sharing.

Appendix 2- Relevant facts and statistics

- The **1st** supervised drug consumption facility was opened in Berne, **Switzerland** in June 1986 (European Monitoring Centre for Drugs and Drug Addiction, 2015, p. 2).

- Countries that have supervised injection facilities are **Canada, Switzerland, Germany, Netherlands, Spain, Norway, Luxembourg, Denmark, and Australia** (European Monitoring Centre for Drugs and Drug Addiction, 2015, p. 2).
- There are approximately **90** supervised injection facilities worldwide (European Monitoring Centre for Drugs and Drug Addiction, 2015, p. 2).
- Safe injection sites like Insite provide clients with clean syringes, cookers, rubbing alcohol, filters, water, and tourniquets (Vancouver Coastal Health- Insite Services, 2011, p. 1)
- There have been over **3 million** visits to Insite by clients since 2003 (Vancouver Coastal Health- Insite Services, 2011, p. 1).
- There are approximately **18 thousand** registered clients at Insite (Vancouver Coastal Health- Insite Services, 2011, p. 1).
- There have been approximately **5 thousand** overdose interventions at Insite (Vancouver Coastal Health- Insite Services, 2011, p. 1).
- In 2015, there have been, on average, **722** visits to Insite per day (Vancouver Coastal Health- Insite Services, 2011, p. 1).
- In 2015, approximately **25** percent of visiting clients of Insite have been women (Vancouver Coastal Health- Insite Services, 2011, p. 1).
- In 2015, approximately **29** percent of visiting clients of Insite have been Aboriginal (Vancouver Coastal Health- Insite Services, 2011, p. 1).
- In 2015, there have been approximately **5 thousand three hundred** referrals to other social and health services and **464** referrals to Onsite detox by Insite (Vancouver Coastal Health- Insite Services, 2011, p. 1).
- Insite's operational budget for the fiscal year ending March 31, 2105 was **\$2,938,665** (Vancouver Coastal Health- Insite Services, 2011, p. 1).
- Onsite's operational budget for the fiscal year ending March 31, 2015 was **\$1,454,351** (Vancouver Coastal Health- Insite Services, 2011, p. 1).

- Vancouver Coastal Health (Insite's main source of funding), spent approximately **\$231 million** during 2015/16 on *all* mental health and substance use community services (Vancouver Coastal Health- Insite Services, 2011, p. 1).

Bibliography

Bayoumi, Ahmed. *Evidence, values, and ideology in public health decision-making: The debate over supervised injection facilities*. Toronto, 26 November 2013. Web.

<https://www.publichealthontario.ca/en/LearningAndDevelopment/Events/Documents/Evidence_values_ideology_public_health_decision_making_2013.pdf>.

Bayoumi, Ahmed, et al. *Report of the Toronto and Ottawa Supervised Consumption Assessment Study*. Assessment Study. Toronto: St. Michael's Hospital and the Dalla Lana School of Public Health, 2012. Web.

<<http://www.catie.ca/sites/default/files/TOSCA%20report%202012.pdf>>.

Beauchamp, Tom and James Childress. *Principles of Biomedical Ethics*. New York: Oxford University Press, 2013. Print.

Berlin, Isiah. "Two Concepts of Liberty." Berlin, Isiah. *Four Essays on Liberty*. Oxford: Oxford University Press, 1958. 1-32. Web. <https://www.wiso.uni-hamburg.de/fileadmin/wiso_vwl/johannes/Ankuendigungen/Berlin_twoconceptsofliberty.pdf>.

Campbell, Will. "Toronto's top doctor calls for 3 safe-injection sites in city." *Global News* 14 March 2016: n.a. Web. <<http://globalnews.ca/news/2575930/board-of-health-report-to-urge-implementation-of-safe-injection-sites-in-toronto/>>.

Canada (Attorney General) v. PHS Community Services Society. No. 33556. Supreme Court of Canada. 30 September 2011. Web. <<http://scc-csc.lexum.com/scc-csc/scc-csc/en/item/7960/index.do>>.

CBC News. "Dr. Peter Centre approved to operate second supervised injection site in Canada." *CBC News* 15 January 2016: 1. Web. <<http://www.cbc.ca/news/canada/british-columbia/dr-peter-centre-approved-to-operate-second-supervised-injection-site-in-canada-1.3345252>>.

Christie, Timothy, Louis Groarke and William Sweet. "Virtue ethics as an alternative to deontological and consequential reasoning in the harm reduction debate." *International Journal of Drug Policy* (2008): 52-58. Web.

Duffy, Andrew. "Safe-injection plan will proceed with or without city support, health-centre executive says." *Ottawa Citizen* 04 April 2016: 1. Web. <<http://ottawacitizen.com/news/local-news/safe-injection-plan-will-proceed-with-or-without-city-support-health-centre-executive-says>>.

Eggertson, Laura. "Legislation jeopardizes safe injection sites." *Canadian Medical Association Journal* (2015): 225-226. Web.

Elliott, Richard, Ian Malkin and Jennifer Gold. *Establishing Safe Injection Facilities in Canada: Legal and Ethical Issues*. Research report. Toronto: Canadian HIV/AIDS Legal Network,

2002. Web. <<http://www.aidslaw.ca/site/wp-content/uploads/2013/04/Canada-SIFs-ENG.pdf>>.
- European Monitoring Centre for Drugs and Drug Addiction. *Drug Consumption Rooms: an overview of provision and evidence*. Overview Report. n.a.: European Monitoring Centre for Drugs and Drug Addiction, 2015. Web.
- Frowe, Helen. *The Ethics of War and Peace: An Introduction*. New York: Routledge, 2011. Print.
- Gallinger, Ken. "The thorny issue of safe injection sites." *Toronto Star* 13 April 2012: n.a. Web. <<http://canadianharmreduction.com/sites/default/files/The%20Thorny%20Issue%20of%20Safe%20Injection%20Sites.pdf>>.
- Gorodnichenko, Yuriy and Gerard Roland. "Berkeley Economics: Gerard Roland." n.a n.a 2011. *Understanding the Individualism-Collectivism Cleavage and its Effects: Lessons from Cultural Psychology*. Web. 05 May 2016. <<http://eml.berkeley.edu/~groland/pubs/IEA%20papervf.pdf>>.
- Government of Canada- Controlled Drugs and Substances Act. *Controlled Drugs and Substances Act*. n.a n.a 1996 (last modified in 2016). Web. 14 March 2016. <<http://laws-lois.justice.gc.ca/eng/acts/C-38.8/page-10.html#docCont>>.
- Griffin, James. *On Human Rights*. Oxford: Oxford University Press, 2010. Web.
- Heimir , Geirsson and R Margaret Holmgren. *Ethical Theory: A Concise Anthology*. Toronto: Broadview Press, 2010. Print.
- Hickler, Benjamin and Colette Auerswald. "The worlds of homeless white and African American youth in San Fransisco, California: A cultural wpidemiological comparison." *Social Science and Medicine* (2009): 824-831. Web.
- Kant, Immanuel. "The Foundations of the Metaphysics of Morals." Geirsson, Heimir and Margaret Holmgren. *Ethical Theory: A Concise Anthology*. Toronto: Broadview Press, 2010 (Originally in 1785). 150-167. Print.
- Kerr, Thomas and Julio Montaner. "Evidence trumps ideology over public health benefits of Insite." *Vancouver Sun* 23 July 2013: n.a. Web. <<http://www.vancouversun.com/health/Evidence+trumps+ideology+over+public+health+benefits+Insite/8704065/story.html>>.
- Kerr, Thomas, et al. "Circumstances of first injection among illicit drug users accessing a medically supervised safer injection facility." *American Journal of Public Health* (2007): 1228-1230. Web.

- . "Impact of a medically supervised safer injection facility on community drug use patterns: A before and after study." *British Medical Journal* (2006): 220-222. Web.
- Kerr, Thomas, Evan Wood and D Small. "Potential use of safer injecting drug users in Vancouver's Downtown Eastside." *Canadian Medical Association Journal* (2003): 759-763. Web.
- Kuyper, L, et al. "The cost of inaction on HIV transmission among injection drug users and the potential for effective interventions." *Journal of Urban Health* (2004): 655-660. Web.
- Mangham, Colin. "A Critique of Canada's INSITE Injection Site and its Parent Philosophy: Implications and Recommendation for Policy Planning." *The Journal of Global Drug Policy and Practise* (2006): 1-11. Web.
<<http://www.globaldrugpolicy.org/Issues/Vol%201%20Issue%202/A%20critique%20of%20Canada's%20INSITE.pdf>>.
- Marshall, B, et al. "Reduction in overdose mortality after the opening of North America's first medically supervised safer injecting facility: A retrospective population-based study." *Lancet* (2011): 1429-1437. Web.
- Mehler Paperny, Anna. "Toronto's Board of Health wants a supervised injection site. The province doesn't. Now what?" *Global News* 11 July 2013: 1. Web.
<<http://globalnews.ca/news/711134/torontos-board-of-health-wants-a-supervised-injection-site-the-province-doesnt-now-what/>>.
- Mill, John Stuart. "Utilitarianism." Geirsson, Heimir and Margaret Holmgren. *Ethical Theory: A Concise Anthology*. Toronto: Broadview Press, 2010 (Originally in 1861). 90-98. Print.
- Muise, Monique. "Liberals stick with existing rules to approve safe-injection sites, for now." *Global News* 14 March 2016: 1. Web. <<http://globalnews.ca/news/2577356/liberals-stick-with-existing-rules-to-approve-safe-injection-sites-for-now/>>.
- National Institute on Drug Abuse. *Drug Facts: Understanding Drug Abuse and Addiction*. n.d. November 2012. Web. 06 May 2016.
<<https://www.drugabuse.gov/publications/drugfacts/understanding-drug-abuse-addiction>>.
- Palepu, A, et al. "Hospital Utilization and costs in a cohort of injection drug users." *Canadian Medical Association Journal* (2001): 415-420. Web.
- Popovich, Nadja. "The great safe-inject debate." *McGill Daily* 04 September 2008: 1. Web.
<http://www.mcgilldaily.com/2008/09/the_great_safeinject_debate/>.

- Regan, Tom. "Introduction to Moral Reasoning." Moore, Adam. *Information Ethics: Privacy, Property and Power*. Seattle: University of Washington Press, 2005 (Originally in 1992). 30-46. Print.
- Small, W, Thomas Kerr and J Charette. "Impacts of intensified police activity on injection drug users: evidence from an ethnographic investigation." *International Journal of Drug Policy* (2006): 85-95. Web.
- Vancouver Coastal Health- Insite Services. *Services*. n.a May 2011. Print. 10 June 2016. <<http://supervisedinjection.vch.ca/services/services>>.
- Vancouver Coastal Health- User Statistics. *User Statistics*. n.a n.a 2016. Web. 12 June 2016. <<http://supervisedinjection.vch.ca/research/supporting-research/user-statistics>>.
- Vaughn, Lewis. *Bioethics: Principles, Issues, and Cases*. New York: Oxford University Press, 2013. Print.
- Wall, R, et al. "Social costs of untreated opiate dependence." *Journal of Urban Health* (2000): 688-722. Web.
- Wood, Evan, et al. "Attendance at supervised injecting facilities and use of detoxification services." *New England Journal of Medicine* (2006): 2512-2514. Web.
- . "Changes in public order after the opening of a medically supervised safer injecting facility for illicit injection drug use." *Canadian Medical Association Journal* (2004): 731-734. Web.
- . "Summary of findings from the evaluation of a pilot medically supervised safer injecting facility." *Canadian Medical Association Journal* (2006): 1399-1404. Web.
- Wood, Evan, Thomas Kerr and PM Spittal. "The potential public health and community impacts of safer injection facilities: Evidence from a cohort of injection drug users." *Journal of Acquired Immune Deficiency Syndromes* (2003): 2-8. Web.
- Zlotorzynska, Maria, et al. "Supervised injection sites: Prejudice should not trump evidence of benefit." *Canadian Medical Association Journal* (2013): 1303-1304. Web.