

The obstacles to implementing supervised injection services in Ottawa, Ontario

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Abstract

The current opioid crisis has, among other things, resulted in soaring rates of fatal overdose across Canada, prompting officials to turn to harm reduction in hopes of combatting the epidemic. The Coroners Service of British Columbia issued a statement in March 2017 reporting an 80% increase in the number of deaths resulting from illicit drug use in 2016 from 2015 (Coroners Service of British Columbia, 2017). Despite the abundance of evidence demonstrating the effectiveness of supervised injection services (SIS) in Canada and world-wide, the implementation of this intervention has remained highly controversial, particularly in Ottawa. Guided by Michel Foucault's theory of governmentality, this thesis explores the obstacles hindering the implementation of supervised injection services in Ottawa, Ontario. Through eight qualitative semi-structured interviews with front-line workers of harm reduction programs, this thesis identifies and explores several obstacles to the implementation of SIS, primarily bureaucratic obstacles stemming from the enactment of the *Respect for Communities Act* (2015).

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List of Acronyms

AIDS: Acquired Immune Deficiency Syndrome

BC: British Columbia

CDPC: Canadian Drug Policy Coalition

CDS: *Canada's Drug Strategy*

CDSA: *Controlled Drugs and Substances Act*

CHC: Community Health Centre

CMA: Canadian Medical Association

CNA: Canadian Nurses Association

CPR: Canadian Pacific Railway

DTES: Downtown Eastside (of Vancouver)

HCV: Hepatitis C Virus

HIV: Human Immunodeficiency Virus

HR: Harm Reduction

IDU: Injection Drug Use

IHRA: International Harm Reduction Association

NADS: *National Anti-Drug Strategy*

NGO: Non-Government Organization

NIMBY: "Not-in-my-Backyard"

NSP: Needle and Syringe Program

OPH: Ottawa Public Health

OST: Opioid Substitution Therapy

PHS: Portland Hotel Society

PWUD: People Who Use Drugs

RFCA: Respect for Communities Act

SCC: Supreme Court of Canada

SCS: Supervised Consumption Services

SIS: Supervised Injection Services

STI: Sexually Transmitted Infection

TPH: Toronto Public Health

WHO: World Health Organization

A human rights-based approach to drug control must be adopted as a matter of priority to prevent the continuing violations of rights stemming from the current approaches to curtailing supply and demand, and to move towards the creation of a humane system that meets its own health-related objectives (United Nations General Assembly, 2010: 16).

If the idea of providing hard-drug users a place to shoot up sounds radical, consider this: we're already doing it. We have consumption spaces now; it's called the library. It's called the bathroom at McD's. It's called the bathroom at Cal Anderson Park. The issue is where do we want those consumption spaces to be? (Nyrop, 2016).

“...The thing about spaces where people inject is uh most times you're not seeing...there are you know. But it's the bathrooms at Loblaws, the parking at the mall, the University of Ottawa...where people are injecting in bathrooms constantly you know, I know 'cause I used to do it” (Participant, 2016).

“These aren't just Vancouver problems...they're definitely Ottawa problems too” (Participant, 2016).

CHAPTER ONE: INTRODUCTION

“Nothing for us without us.”

This is a quote from an interview with a front-line worker of an Ottawa based harm reduction advocacy group interviewed for this study. It was a moment that stuck with me; this interview was particularly significant because the participant has overcome an addiction to opiates and now spends their life advocating for people who use drugs (PWUD). This participant alleged that harm reduction strategies targeted at combatting the opioid crisis are often implemented without the inclusion of people who use drugs, highlighting their marginalized status in society.

Illicit drug use remains a major public health concern worldwide and the recent rise in the number of fatal overdoses, coupled with increasing rates of Hepatitis C and HIV reported by Ottawa Public Health (2016), has sparked meaningful conversations among key stakeholders, various health care associations, and the general public regarding the need to combat the opioid crisis. The current opioid crisis underscores the need to examine the obstacles to expanding existing harm reduction programming to include supervised injection services in Ottawa.

Injection drug use (IDU) is associated with a range of adverse health outcomes, including both fatal and non-fatal overdose, blood-borne infections, and abscesses (Fischer, Turnbull, Poland and Haydon, 2004). The harm reduction movement emerged as a response to the two contrasting models of drug use: the medical/disease model and the moral/criminal model, and encompasses a broad range of interventions, programs and policies that seek to reduce the health, social, and economic consequences of illicit drug use for PWUD and their communities (Rhodes & Hedrich, 2010). An extensive literature has emerged researching

and evaluating harm reduction policy and practice, and there is evidence of its success in reducing the harms stemming from the prohibitionist regime (Boyd, 2013; Canadian Nurses Association, 2011; Marshall, Milloy, Wood, Montaner & Kerr, 2011; Moore & Fraser, 2006; Verner, 2003). Harm reduction is a compassionate response to illicit drug use that focuses on meeting people where they are, regardless of whether they use drugs once or multiple times a day, and understands that a one-size-fits-all abstinence approach to treatment is not always realistic nor sustainable. The harm reduction movement in Canada has been successful, despite numerous political obstacles, and Canada is now home to two supervised injection services and countless needle and syringe programs (NSP).

It is well recognized that traditional enforcement-based drug-control strategies are not sufficient for reducing the availability of, and access to, illicit drugs (Dias, 2003; Levine, 2002; Riley, 1998; Packer, 2004). High overdose mortality rates in the Downtown Eastside (DTES) community of Vancouver during the 1990s resulted in a public health crisis, with records indicating one overdose death per day alongside many more non-fatal overdoses (Wood, Kerr, Montaner, Strathdee, Wodak, Hankins, Schechter & Tyndall, 2004). The crisis led to the creation of a federal task force appointed to examine the feasibility of implementing a supervised injection service in the DTES. In December 2002, the task force recommended that Health Canada proceed with exempting a SIS from the trafficking and possession subsections of the *Controlled Drugs and Substances Act* (CDSA), leading to the opening of Canada's first SIS, Insite, in Vancouver's DTES in September 2003. Over 30 peer-reviewed studies have demonstrated that Insite has successfully reduced rates of infectious disease, the number of publically discarded needles, and fatal overdose, making drug use safer for both drug users and the community (DeBeck, 2011; Jozaghi, Reid, Andresen & Juneau, 2014).

Many services and programs exist in Ottawa for people who use drugs, ranging from treatment services like abstinence programs and opioid substitution therapy (OST) to harm reduction services such as distribution programs that dispense sterile injecting and inhalation equipment. Other services exist to connect the drug using population to primary health care and counselling services, case management services, education programming, and various other social services. Although evidence suggests that existing harm reduction programs have successfully reduced rates of infectious disease in Ottawa, needle and syringe programs may not be sufficient for overcoming all drug-related harms like public drug use and overdose (Bayoumi, Strike, Jairam, Watson, Enns & Kolla, 2012; Wood et al., 2004).

In Canada, drug policy is a multijurisdictional matter. In a 2013 report, the Canadian Drug Policy Coalition (CDPC) outlined recommendations at the municipal, provincial, and federal levels of government for drug policy reform. Among these recommendations were suggestions to modernize Canada's legislative and policy frameworks that address psychoactive substances, to eliminate the National Drug Strategy and replace it with a public health approach to illicit drug use, and to repeal bylaws that restrict the implementation of harm reduction programs (Canadian Drug Policy Coalition, 2013: 8). Despite the mass allocation of resources towards supply-reduction, Canada's drug strategy has failed to achieve what it set out to do (i.e., creating a "drug-free Canada"), while further marginalizing and stigmatizing the drug using population (Packer, 2004). Despite the evident success of supervised injection services worldwide and the urgent need for community-based strategies in response to the ongoing opioid crisis, the implementation of additional supervised injection services has been met with resistance from the Mayor, the Chief of Police, and other key stakeholders in Ottawa.

Through eight semi-structured qualitative interviews with front-line workers of harm reduction services, the fundamental purpose of this thesis is to gain a better understanding of the obstacles to the implementation of harm reduction programming, specifically supervised injection services, in Ottawa from the perspectives of those who are working directly with people who use drugs. The research question guiding this thesis is: *What are the main obstacles to the implementation of supervised injection services in Ottawa according to front-line workers of harm reduction programs?*

Chapter Two summarizes the current research literature, exploring harm reduction on a global scale and then in a Canadian context. In the third chapter I outline the theoretical framework employed for this thesis, which is Michel Foucault's governmentality. Next, Chapter Four outlines the methodological framework applied to this research project, providing an overview of the sampling strategy and the data collection process. Methodological limitations of this study are also presented in this chapter. Chapter Five presents and discusses the findings of this research project, shedding light on the perspectives of eight front-line harm reduction workers about the obstacles to the implementation of supervised injection services in Ottawa. The concluding chapter revisits the research question and summarizes the key findings of this research project. Contributions to the field of criminology and the limitations of this thesis are discussed, followed by suggestions for future research.

CHAPTER TWO: LITERATURE REVIEW

This thesis examines the obstacles to the implementation of harm reduction services in Ottawa, particularly supervised injection services (SIS). This chapter begins by delving into Canadian drug policy, specifically the history of drug prohibition and the way drug use has been defined as a social problem, and presents how harm reduction was implemented as a response to the harms stemming from drug prohibition. Then, an overview of supervised injection services is provided, including the origin of SIS, the history of Insite, and a summary of the existing models. Next, scientific evaluations of Insite will be examined, with a focus on the reduction of fatal overdose, disease transmission, and public injection, as well as the impacts on public safety and disorder, followed by the likelihood of PWUD seeking treatment services. The final section of this chapter will discuss the obstacles to the implementation of harm reduction services cited in the research literature, followed by a summary of the *Respect for Communities Act* (2015).

2.1 Canadian Drug Policy

The way politicians and policy-makers problematize drug use affects the types of policies created. There are two prevailing, contrasting discourses surrounding illicit drug use: the medical/disease model and the criminal/moral model (Boyd, 1991; Haden, 2006; Wodak, 2008). The medical/disease model views drug users as victims of their addiction, which is a disease caused, in part, by biological, genetic, and/or environmental factors. This model removes the blame from the individual by insisting that drug use is out of their control and should be viewed as the result of a biological flaw. Problematizing drug use through a medical/disease lens leads to the creation and implementation of drug policies that focus on treatment rather than criminalization. In contrast, the criminal/moral model portrays drug users

as individuals who freely choose to abuse drugs, despite their illegal status and perceived risks. Critics argue that the criminal/moral model frames addiction as a flaw in character and fails to recognize the biological, environmental, and genetic components of addiction (Ball, 2007; Haden, 2006; Lenton & Single, 1998). This model proposes that harms stemming from illicit drug use are the user's own fault and that drug use should be punished by the state. This model proposes that the criminal justice system is the best institution to deal with those who violate drug laws, which adherents of the medical/disease would argue perpetuates social inequalities and contributes to the stigma surrounding drug use and addiction. In an unrealistic pursuit of a drug-free society, legislation implementing mandatory minimum sentences and increased criminal sanctions has resulted in, among other things, overcrowded correctional facilities and the social marginalization of drug users (Packer, 2004). The following section will provide a brief overview of prohibition in Canada and will shed light on why drugs are socially constructed the way they are, as either beneficial to the advancement of medicine and the treatment of disease and illness, or as being inherently bad and responsible for societal ills.

2.1.1. Prohibition in Canada

This section examines at what point drug use became *legally* problematized in Canada, and the implications of this for the way we develop, implement, and amend drug policies. According to Foucault (1997), problematization occurs at the moment when a given situation develops into an issue (p. 118). It can be argued that drugs have always been an integral part of human existence and have been present throughout history in the form of herbal remedies, medicines, and recreational or spiritual aids (Verner, 2003). Attempting to detect the exact historical moment when drugs were first *identified* as a problem is beyond

the scope of this research. This section will instead focus on when drugs became *legally* problematized in Canada.

Before the beginning of the 20th century, drug use in Canada was not regulated by legal norms. At the end of the 19th century, the practice of medicine was in its infancy in North America, and many causes of illness and effective treatments were unknown (Blocker, 1989: 8). Without the availability of the treatments we have today, those suffering from disease or illness had to rely on the use of opiates and alcohol for symptomatic relief (Blocker, 1989). The construction of the Canadian Pacific Railway (CPR) in the 1880s employed thousands of Chinese immigrants who provided cheap labour to Canadian employers. During this time, opium was used recreationally in China, and Chinese immigrants established opium dens in British Columbia upon their arrival. Drug use was not considered problematic during this time. However, the end of the railway construction in the early 1900s brought about labour disputes and anti-Chinese sentiment, leading to protests and riots on Canada's west coast. Then-Deputy Minister of Labour William Lyon MacKenzie King, pressured by anti-Chinese sentiment in Canada and by other countries in their fight for a global prohibition of opium, released a report titled "*The Report on the Need for the Suppression of the Opium Traffic in Canada*", which recommended the prohibition of opium. The *Opium Act* was passed into law in 1908, marking the beginning of drug prohibition in Canada and the basis of the current prohibitionist system. The *Opium Act* made it a criminal offence to import, manufacture, or sell opium, and was the first attempt to regulate, control, and prohibit drugs in Canada (Cavaliere & Riley, 2012; MacDonald, 2011). In 1911, the *Act* was amended to criminalize additional substances like morphine and cocaine, and to create harsher penalties for drug offences (Dias, 2003). The *Act* was further revised in 1920 to reflect an evolving

punitive-based stance towards drug use, expanding enforcement powers and increase penalties for drug use (MacDonald, 2011).

Between 1969 and 1973, the *Commission of Inquiry in the Non-Medical Use of Drugs* (also known as the *Le Dain Commission*) issued a report recommending the gradual withdrawal of the criminalization of illicit drugs. But despite these recommendations, Canada's drug policies remained unchanged (Bennett, 1974; Dias, 2003; Erickson & Smart, 1988). The final¹ amendment to the *Controlled Drugs and Substances Act* (CDSA) was introduced in 1997 with the reinstatement of a zero tolerance national drug policy (MacDonald, 2011). The CDSA outlines the legal status of drugs and other substances, as well as the penalties they carry for their misuse. All substances outlined in the CDSA are considered to be illicit, with very few exceptions for medical and scientific use. Further, the CDSA is comprised of eight schedules that encompass all illicit substances, with Schedule I containing substances that have the highest potential for abuse like opium, Codein, morphine, and Fentanyl.

The prohibitionist discourses surrounding drug use maintain that the only way to reduce both the direct and indirect harms stemming from illicit drug use is to increase treatment and prevention efforts while keeping drugs illegal and imposing criminal sanctions for possession and trafficking. This thesis will argue that the way prohibitionist discourse problematizes drug use as being inherently bad or "criminal" ensures that harm reduction strategies cannot be easily supported. The following section will outline the critiques of prohibition within the criminological literature.

2.1.2. Critiques of Prohibition

¹ In April 2017, the Federal government introduced legislation that would legalize and regulate the sale and use of marijuana on or before July 1st, 2018.

Lyman and Potter (1998) argue that modern drug control policy is “earmarked by a number of policy strategies, each designed to address a specific aspect of the nation’s drug problem” (p. 438). These strategies include supply and demand reduction, prohibition, education, and treatment (Lyman & Potter, 1998). However, many researchers claim that none of these strategies have significantly reduced the prevalence of illicit drug use (Andresen & Boyd, 2009; Broadhead, Kerr, Grund & Altice, 2002; Enns, Zaric, Strike, Jairam, Kolla & Bayoumi, 2015; Haden, 2006; Ottawa Public Health, 2016b). It can be argued that drug policy reform has been hindered by the current dominance of prohibitionist discourse, despite overwhelming evidence suggesting that punitive sanctions have little to no effect on the eradication of drug use (DeBeck, 2011; Tupper, 2012). The war on drugs, declared in the United States during the 1980s, has been a primary contributor to the immense growth of the prison system in the United States, and drug-related offences have accounted for more than one-third of the growth in the incarcerated population in Canada since the 1970s (Grant, 2009; Riley 1998).

The criminalization of drugs has been deemed ineffective and counter-productive, with prohibitionist laws failing to control illicit drug use and instead disproportionately targeting disadvantaged people of colour and other minority groups (Grant, 2012). Beauchesne (1997) notes that, although Canada has previously “distanced itself somewhat from repressive American drug policies” (p. 32), recently established Canadian drug policies (such as the removal of harm reduction from Canada’s drug strategy and the introduction of the *Respect for Communities Act* by the previous federal government) represent a “reversion back to a U.S.-style war on drugs that threatens Canada’s harm reduction progress” (Wodak, 2008: 226). There is consensus among researchers that prohibitionist approaches to drug use (i.e.,

implementing mandatory minimum sentences and increased criminal sanctions) have been wholly ineffective in “curbing illicit drug consumption and availability” (Erickson, Riley, Cheung & O’Hare, 1997: 4; see also Lenton & Single, 1998). According to the Canadian Drug Policy Coalition (CDPC), the previous Conservative government allocated \$527.8 million for the National Anti-Drug strategy (NADS) for 2012-2017 (CDPC, 2013: 6). In December 2016, the Liberal government announced the Canadian Drugs and Substances Strategy, which replaces the NADS and restores harm reduction as an integral pillar of Canada’s drug policy (Canadian Drugs and Substance Strategy, 2016). Enforcement remains the most common response to the “drug problem” across the globe, and in the early 2000s Canada had the second highest number of drug arrests per capita of any nation, following the United States (Motiuk & Vuong, 2002). According to Statistics Canada, approximately 109,000 CDSA violations were reported by police forces in 2013, accounting for around 5% of overall criminal incidents recorded by police (Cotter, Greenland & Karam, 2015).

In contrast to the prohibitionist approach to drug use, the evolving harm reduction movement seeks to minimize the harms associated with drug use, and raises the question of whether it is necessary to criminalize illicit drug use to reduce its prevalence. The following section will trace the genealogy of the harm-reduction paradigm in Canada.

2.1.3. The Introduction of Harm Reduction

Despite the obstacles created as a result of the prohibitionist regime, some harm reduction strategies have been gradually introduced in Canada. Harm reduction can be thought of as an alternative to the two dominant, contrasting discourses surrounding drug use: the moral/criminal model which depicts illicit drug users as individuals who freely choose to

abuse substances and who deserve to be punished, and the medical/disease model which views illicit drug users as victims of addiction who require treatment (Erickson et al., 1997).

Since harm reduction in Canada is a relatively new concept emerging as a response to the negative effects of the “zero tolerance” prohibitionist approach to illicit drug use, current definitions and policies do not provide clear guidelines as to what is considered to be harm reduction relative to illicit drug use. In a general sense, harm reduction is simply the act of engaging in certain practices to reduce the potential harms of risk-taking behaviours. For example, using a seatbelt while in a car, wearing a helmet while riding a bike, or even using condoms when engaging in sexual intercourse are all examples of harm reduction. In the context of illicit drug use, general definitions of harm reduction are overly broad and fail to distinguish between treatment and harm reduction programming. For example, abstinence-based drug policies or programs that attempt to reduce drug-related harm through the elimination of drug use could be described as harm reduction in line with current definitions (Lenton & Single, 1998; Single, 1995). Thus, a more conceptually distinct definition of harm reduction is needed when discussing effective intervention programming surrounding drug use. For the purpose of this thesis, *harm reduction will encompass all policies and programs that prioritize the reduction of health, social, and economic harms stemming from illicit drug use while presuming that abstinence is not the primary goal* (Single, 1995: 289). The primary goal of harm reduction programming is to reduce the harms associated with illicit drug use; this intervention is not focused on determining the origin of drug use, nor does it demand abstinence from an individual in order to be eligible for treatment. Rather, these programs promote the importance of harm-minimization among those who are either unwilling or un-

able to curb their drug use (Kerr, Tyndall, Li, Montaner & Wood, 2005). In 1987, the Canadian government introduced harm reduction policy as part of the framework for its National Drug Strategy, but this was later removed by the Conservative government in 2007 when it was replaced with the NADS (Canadian Drug Policy Coalition, 2013; Zilkowsky, 2001). The NADS is a \$527.8 million effort to combat illicit drug use, allocating the majority of funding to drug law enforcement rather than health-focused initiatives (Canadian Drug Policy Coalition, 2013; DeBeck, Wood, Montaner & Kerr, 2009; Office of the Prime Minister, 2007).

The evolution of harm reduction in Canada has been controversial, especially with respect to services for injection drug users, but such resistance has not been encountered worldwide. According to the International Harm Reduction Association (IHRA), 93 countries provided support for harm reduction in policy or practice in 2016 (Harm Reduction International, 2016). As of 2016, approximately 90 countries have needle and syringe programs (NSP), 80 countries have opioid substitution therapy (OST), and ten are home to supervised injection services (Ibid). As cited in a joint position statement put forward by the Canadian Nurses Association (CNA) and the Canadian Association of Nurses in AIDS Care, harm reduction is “part of a comprehensive health-care response to the health and social harms experienced by people who use substances that complements abstinence, prevention and treatment strategies for substance use” (CNA and CANAC, 2012). Studies have found that harm reduction programs like supervised injection services are able to offer a safe and supportive space for hard to access, vulnerable populations, while connecting them to other health and social services like primary health care, counselling services, referrals to drug treatment, and housing support programs (Ottawa Public Health, 2016; Small, Van Borek,

Fairbairn, Wood & Kerr, 2009). The following section will expand on the origin and services offered by a specific harm reduction strategy: supervised injection services.

2.2 The Origin of Supervised Injection Services

Non-authorized injection spaces already exist in alleyways, parking lots, bathrooms, parks, and other unsupervised places. Supervised injection services (SIS) are legally sanctioned and medically supervised spaces that provide people who use drugs with a safe and hygienic environment to inject pre-obtained drugs (Andresen & Boyd, 2009; Boyd, 2013). Upon entering the site, drug users are supplied with clean injection equipment such as syringes, cookers, filters, water, and tourniquets. Health care services such as wound care and immunizations are also available, as well as access to addictions counsellors, mental health workers, and community resources like housing support (Vancouver Coastal Health, 2016). In theory, all that is needed to provide a supervised injection service is a registered nurse, a person who uses drugs, a safe, hygienic space, and access to sterile injecting equipment. In 2010, there were more than 90 identified supervised injection services worldwide (Semaan, Fleming, Worrell, Stolp, Baack & Miller, 2011). Canada is home to two supervised injection services: Insite and the Dr. Peter Centre, both of which are located in Vancouver, British Columbia.

Bern, Switzerland is home to the first supervised injecting room. Initially a café for drug users, the supervised injecting room was established in 1986 as a means of responding to the emerging HIV and Hepatitis C (HCV) epidemics, the drug-related litter stemming from public injection, and overdose-related deaths. Supervised injection services have been operating in Germany since the mid-1990s after it became apparent that prohibitionist policies had failed to combat the growing drug epidemic. Reports have indicated that people who use

drugs are consistent in their use of these facilities, showing usage rates upwards of six times per week for the majority of PWUD (Anoro, Ilundain & Santisteban, 2003; Hedrich, 2004).

Table 1. Number of SIS in Europe (2014):

Country	Number of Supervised Injection Services
Switzerland	13
Netherlands	30
Germany	24
Spain	13
Luxembourg	1
Norway	1
Denmark	5

Source: European Harm Reduction Network. (2014). Drug Consumption Rooms in Europe Models, Best Practices and Challenges. Retrieved from: http://www.eurohrn.eu/images/stories/pdf/publications/dcr_europe.pdf

Supervised injection services are part of a broader harm reduction approach to substance use promoting “patient-first” care, alongside community safety and health. Harm reduction advocates argue that supervised injection services are only one aspect of what should be a comprehensive approach to drug use; these services are complementary to drug treatment programs for individuals who are unable or unwilling to curb their drug use (Kazatchkine, Elliott & MacPherson, 2014; Kerr et al., 2005; Skirrow, 2001; Wood, Kerr, Small, Li, Marsh & Montaner, 2004). Supervised injection services remain controversial despite an abundance of scientific evidence supporting their effectiveness as a vital component of an integrated health system. The process of expanding SIS into communities is influenced as much, if not more, by political ideology and decision-making and community support as it is by evidence-based research (Wodak, Symonds & Richmond, 2003; Kerr et al., 2005).

The following sections will review the three models of SIS, explore the history of Insite and its legal battleground, examine the evidence surrounding SIS, and discuss the future implementation of additional supervised injection services in the province of Ontario.

2.3 The Three Main Models of Supervised Injection Services

There are three main models of supervised injection services described in the current harm reduction literature: integrated, stand-alone, and mobile (Ottawa Public Health, 2016c). This section will review each model, its benefits and considerations, and their respective documented successes and costs.

The integrated model is the most common model of SIS and is offered alongside a variety of other health and social services like primary health care, drug treatment and housing support (European Harm Reduction Network, 2014). Integrated supervised injection services benefit from pre-established relationships with PWUD who are already accessing other resources in the same space and are therefore more likely to feel comfortable with, and accepted by, the front-line staff. Stigma and discrimination have been identified as barriers to accessing health and social services for vulnerable populations, especially for PWUD (Ahern, Stuber & Galea, 2007; Ojeda & McGuire, 2006; Reif, Golin & Smith, 2005). A significant consideration prior to the implementation of supervised injection services is the location of these spaces. Research has shown that harm reduction services should exist in places where drug use and high-risk behaviours are known to be present, like downtown community health centres and homeless shelters (Bayoumi et al., 2012; Boyd, 2013; Hathaway & Tousaw, 2008). However, critics of the integrated model argue that the coexistence of supervised injection services and opioid substitution therapy (Methadone and Suboxone treatment) could act as a potential trigger for relapse for people in recovery (European Harm

Reduction Network, 2014). There have been several documented successes of this model, including a reduction in overdose deaths, a reduced risk of HIV and HCV infection stemming from the shared use of injecting equipment, a reduction in public injecting, a reduction in the number of publically discarded needles, and an increase in referrals to treatment programs (Ottawa Public Health, 2016b). According to the *Report of the Toronto and Ottawa Supervised Consumption Assessment Study (TOSCA)*, the implementation of one supervised injection service in Ottawa could prevent up to 358 HIV infections and 323 HCV infections over 20 years, saving upwards of 32.3 million dollars in health care costs (Bayoumi et al., 2012). In sum, the integrated model is often seen as best practice because clients can access a wide range of health and social services in one location (European Harm Reduction Network, 2014).

The second model is the stand-alone SIS. Usually located near open drug scenes, stand-alone models primarily focus on providing a supervised and hygienic space for people to inject drugs (European Harm Reduction Network, 2014). Although this model does not provide direct access to other health and social services on site, staff members are able to refer drug users to services like drug treatment programs, primary health care, and housing services (European Harm Reduction Network, 2014). A notable advantage of this model is the likelihood that people accessing this service are actively using drugs, meaning that this service is less likely to be a trigger for those who are in treatment and/or recovery (Ottawa Public Health, 2016c). One limitation of this model is that the services are centered on supervised injection and rely on referrals to other community service providers to access health and social services, augmenting the risk that people will get “lost in transition” (i.e., wanting to access a service at another location but never making it there). With consideration to the

annual operating costs of Insite in Vancouver, Ottawa Public Health estimates that the cost of opening a stand-alone supervised injection service in Ottawa would be around 1.5 million dollars per year (Ottawa Public Health, 2016c). Existing figures from Insite estimate that an average of 2.85 to 8.55 million dollars are saved annually due to the number of prevented HIV cases at Insite alone (Bayoumi et al., 2012). Stand-alone supervised injection services provide the same overall public health benefits as the integrated model, including a reduction in overdose-related deaths and blood-borne infections (European Harm Reduction Network, 2014).

Mobile supervised injection services are the third and final SIS model, and operate together with fixed services in the same city (European Harm Reduction Network, 2014). This model exists in three European countries: Spain (Barcelona), Germany (Berlin), and Denmark (Copenhagen). A mobile SIS is a van consisting of 1-3 injection booths that drives through the city and typically offers a variety of harm reduction services like needle and syringe distribution services, testing for blood-borne infections, and providing referral services to other health and social services (Ottawa Public Health, 2016c). This model increases the accessibility of supervised injection services, and has the potential to reach more hidden populations, including those who do not want to travel to a fixed facility (Bayoumi et al., 2012). However, there are drawbacks to this model such as not having the resources available to provide as much basic medical care as other models and the potentially long wait times as a result of having only 1-3 booths (Bayoumi et al., 2012). According to Ottawa Public Health (2016c), there is little evidence documenting the costs and successes of mobile supervised injection services due to the limited number of them worldwide. The following section will outline the history of Canada's first supervised injection service, Insite, including the legal

battle that once threatened its existence.

2.4 Insite: Canada's First Supervised Injection Service

Arguably the most significant advancement in Canadian harm reduction policy was the founding of the country's first supervised injection service, Insite, in Vancouver. The Portland Hotel Society (PHS Community Services Society, herein the PHS) was founded in 1991 as the result of an ongoing drug-related public health crisis in the Downtown Eastside (DTES) Community of Vancouver (PHS Community Services Society, 2016). The DTES is a unique community, and is perhaps best described as a "post-industrial neighbourhood with an established drug market and widespread illicit drug use, poverty, poor housing conditions, and infectious diseases, such as HIV and HCV" (Voon, Ti, Dong, Milloy, Wood, Kerr & Hayashi, 2016: 476). Estimated to be home to approximately 4,600 injection drug users, the DTES faces many complex challenges relating to social determinants of health (City of Vancouver Community Services, 2013). More recently, after declaring the opioid crisis a public health emergency in April 2016, the province of British Columbia has taken measures to address the drug problem, such as increasing the availability of the overdose-reversing drug Naloxone. In March 2016, Health Canada announced a decision to make Naloxone more readily available by allowing the drug to be obtained over the counter without a prescription (Health Canada, 2016). The social and structural problems faced by the DTES, such as high rates of drug use and homelessness, highlight the inherent need for the adoption of broader strategies to reduce the effects of the opioid crisis.

In 1997, the PHS hosted a conference where experts in the substance use and addictions field gathered to discuss alternative approaches to the "status quo" surrounding drug use and addiction, and served as the beginning of a founding place for more pragmatic alternatives

(PHS Community Services Society, 2016). In September 2003, the federal government granted Canada's first supervised injection service a limited three-year exemption from the trafficking and possession subsections of the CDSA on the condition that the program undergo rigorous scientific evaluation. Insite is deemed to be a part of Vancouver's "Four-Pillar" drug strategy that highlights prevention, treatment, enforcement, and harm reduction as equal in weight (Skirrow, 2001). The then-Federal Minister of Health, under the newly elected Conservative government, renewed Insite's exemption in 2006 for another fifteen months, allowing Insite to legally operate until the end of 2007. After realizing the possibility that the federal government would not renew the exemption and that Insite would be forced to shut down, the PHS filed a constitutional claim in the B.C. Supreme Court in August 2007, alongside two clients of Insite, Dean Wilson and Shelley Tomic (PHS Community Services Society, 2016). Legal counsel for the PHS argued that healthcare falls under provincial jurisdiction and that interference from the federal government in the regulation of Insite (a health care facility) is inappropriate. The second argument referred to section 7 of the Canadian Charter of Rights and Freedoms, which states that, "everyone has the right to life, liberty and security of the person and the right not to be deprived thereof except in accordance with the principles of fundamental justice" (*The Constitution Act*, 1982). Counsel for the PHS argued that denying injection drug users access to critical health care services is an infringement of their section 7 Charter rights. In May 2008, the B.C. Supreme Court ruled in favor of Insite, asserting that sections 4(1) and 5(1) of the CDSA (the provisions that prohibit possession and trafficking of controlled substances) are constitutionally invalid and violate drug users' rights to life, liberty and the security of the person according to section 7 of the Canadian Charter of Rights and Freedoms (PHS Community Services Society, 2016). The federal government

appealed the decision before the B.C. Court of Appeal in January 2010, but the appeal was dismissed. The federal government then applied to the Supreme Court of Canada (SCC) and in September 2011, the SCC ruled in favor of the PHS, maintaining that refusing to grant Insite an exemption from the trafficking and possession subsections of the CDSA is not in accordance with the principles of fundamental justice. According to the decision, “denying health services to clients of Insite is grossly disproportionate to any benefit that Canada might derive from presenting a uniform stance on the possession of narcotics” (*Canada v. PHS Community Services Society*).

The following section will outline the evidence in support of harm reduction in the form of supervised injection services, including reduction of fatal overdoses, disease transmission, public injecting, the impact on public disorder and safety, and the likelihood of seeking treatment.

2.5 Evidence in Support of Supervised Injection Services

There has been an abundance of research conducted by scientists and researchers on the need for supervised injection services in Ottawa (Enns et al., 2015; Jozaghi et al., 2014; Sandy Hill Community Health Centre, 2016; Shaw, Lazarus, Pantalone, LeBlanc, Lin, Stanley, Chepesiuk, Patel & Tyndall, 2015; Small et al., 2009), as well as scientific studies evaluating Insite in Vancouver (Andresen & Jozaghi, 2012; Boyd, 2013; British Columbia Centre for Excellence in HIV/AIDS, 2009; MacDonald, 2011) and SIS in other countries.

The primary goals of supervised injection services are: (1) to connect marginalized drug users with health and social services; (2) to reduce the prevalence of dangerous injection practices like needle and syringe sharing; (3) to reduce the risk of infectious disease like HIV and HCV; and, (4) to reduce the rate of both fatal and non-fatal overdose. Other goals of SIS

include reducing public injection, providing referrals to treatment and detoxification, and educating the public on the benefits of these life-saving interventions (Small, 2010). In countries outside North America where health related crises similar to Canada's have emerged, SIS have proven effective in reducing the community, public health and economic impacts of injection drug use (Kerr, Wood, Small, Palepu & Tyndall, 2003).

Insite has been the subject of over 30 Canadian peer-reviewed studies since its inception in 2003. Evaluators have sought to determine how the facility affects injection drug users and rates of overdose in the DTES, as well as the effectiveness of Insite in connecting people who use drugs to health care services (Wood et al., 2004). Overall findings demonstrate that not only is Insite effective in reducing HIV/HCV prevalence rates, preventing overdose deaths, and reducing the frequency of public injecting, but the intervention also helps to promote safer drug using practices (Boyd, 2013; Jozaghi et al., 2014; Small et al., 2009). The following subsections elaborate the latest findings on the effectiveness of supervised injection services with a focus on Insite in Vancouver.

2.5.1. Fatal Overdose

Overdose is one of the leading causes of mortality among injection drug users (Andresen & Boyd, 2009; Fischer, Popova, Rehm & Ivsins, 2006). According to the B.C. Ministry of Health and the B.C. Coroners Service, there were 914 overdose deaths in 2016 in British Columbia directly linked to the recent Fentanyl crisis, compared to 510 in 2015 (Global News, 2017). Further, there were 142 overdose deaths in December 2016 — the highest number ever recorded in a single month in the province of British Columbia (Ibid). Although the most appropriate intervention would be to call 911 in the case of an overdose, drug users are typically hesitant to do so, often citing fear of police involvement (Pollini,

McCall, Mehta, Celentano, Vlahov & Strathdee, 2006). Injection drug users also often use alone in isolated places where the risks of overdose are exacerbated. Overdose is a fairly common occurrence at Insite, with estimates suggesting that there are 13 overdoses for every 10,000 injections (Milloy, Kerr, Tyndall, Montaner & Wood, 2008). Over the 18-month study period implemented by Insite's evaluators (March 2004 to August 2005), the facility reported 336 overdoses and zero deaths (British Columbia Centre for Excellence in HIV/AIDS, 2013; Kerr, Tyndall, Lai, Montaner & Wood, 2006).

At Insite, drug users are able to inject their pre-obtained illicit drugs while under the supervision of health-care professionals who are trained to intervene in the event of overdose. Insite's staff are trained to recognize the first signs of overdose and are equipped to respond quickly without having to wait for first responders to arrive on the scene. Providing emergency care (i.e., oxygen and Naloxone administration) reduces the risk of fatal overdose, and also reduces the risk of brain damage in cases of non-fatal overdose (Marshall et al., 2011: 1430).

Kerr, Small, Moore, and Wood (2007) found that supervised injection services could effectively “address many of the micro-environmental factors that drive overdose risk and [enhance] individual ability to employ overdose prevention practices” (p. 34). Since Health Canada's decision to make Naloxone more accessible, drug users have been advised to carry it. Naloxone is a drug that reverses the effects of overdose immediately if used within a short period following an opioid overdose, and has saved many lives in the DTES since the beginning of the current opioid crisis. Not only do SISs appear to be effective in reducing the number of fatal overdoses, but they have also been proven to teach and embed safer injecting practices, thereby helping to minimize high-risk injecting behaviour.

2.5.2. Disease Transmission

Blood serum is easily transferable from person to person via shared injecting equipment, and so the sharing of used syringes and needles poses a high risk of HIV and Hepatitis C (HCV) transmission for intravenous drug users (British Columbia Centre for Excellence in HIV/AIDS, 2013). In addition to the serious health complications stemming from HIV and HCV, injection drug users are also at risk of developing other serious and potentially life-threatening health problems, including abscesses, injection related vein damage, cellulitis, and subcutaneous endocarditis (Kerr et al., 2005). Research has estimated that the annual number of injections per drug user in Ottawa is approximately 675, with 4.5% of these injections involving shared injecting equipment (Enns et al., 2015: 478). The prevalence of injection drug use is highly influenced by drug culture; this mode of consumption is both efficient and cost effective due to its ability to produce the desired effect as soon as the drug enters the bloodstream. This makes it a popular route of administration despite the variable high risk of HIV and HCV transmission stemming from the shared use of injecting equipment among users (Kerr et al., 2005). DeBeck (2011) found that HIV prevalence among PWUD in Ontario is somewhere between 17% and 30%. More relevant to this thesis, a study conducted by Bayoumi and colleagues indicated that approximately 1 in 10 injection drug users in Ottawa are infected with HIV, and around 6 in 10 have contracted the hepatitis C virus (Bayoumi et al., 2012). Similarly, a study by the Ontario Ministry of Health and Long-Term Care (2004) found that the highest prevalence of HIV infections attributed to injection drug use was reported in Toronto (32% of HIV-infected drug users in Ontario), while the highest overall infection rate is in Ottawa (18%). HIV and HCV seropositivity are strongly correlated with frequency of injection, suggesting that each individual injection poses a variably high

risk of transmission (DeBeck, 2011). Milloy and Wood (2009) analyzed data from a study of SIS in Spain and concluded that regular SIS clients have reduced their likelihood of sharing needles and syringes by 69%. Interventions that are successful in reducing the rate of needle and syringe sharing among PWUD are fundamental in helping prevent new cases of HIV and HCV.

2.5.3. Public Injection

Although harm reduction strategies like NSPs exist in Ottawa, these services only dispense sterile injecting equipment and do not provide drug users with a safe space to inject drugs. Research has suggested that the likelihood of using unsterile or shared injecting equipment is influenced by the injection space. Marginalized populations, like injection drug users, are often physically and socially driven into environments like abandoned buildings and alleyways where the risks of overdose and infection transmission are exacerbated (Wood et al., 2004). Koester, Glanz, and Baron (2005) found that drug users who inject in what is deemed an “unsafe injecting location” (i.e., alleyways, public parks, and abandoned houses) are twice as likely to inject with previously used injecting equipment than a drug user who injects in a “safer injecting location” (defined as locations like a SIS, their home or a friend’s home). A 2004 study by Navarro and Leonard found that 65% of participants reported injecting in a public place in the six months preceding the interview (N=506). The participants, recruited from the Point Study through the City of Ottawa’s Needle and Syringe Program, shared that they had previously injected in public washrooms, parking lots, streets and alleyways, abandoned buildings, and parks or school yards (Navarro & Leonard, 2004: 279). In support of this, findings show that consistent use of Insite is associated with less risky injecting behaviours (Stoltz, Wood, Small, Li, Tyndall, Montaner & Kerr, 2007). Stoltz et al. (2007) found

that participants who reported using Insite frequently were less likely to report rushed injections² and were more likely to report safe needle disposal (p. 37).

High-risk injecting practices, like public and semipublic injection, have been associated with an elevated risk of contracting HIV and HCV due to a sense of urgency stemming from the fear of violence or police interference (Rhodes, Kimber, Small, Fitzgerald, Kerr, Hickman & Holloway, 2006). Supervised injection services enable off-street injection by providing people who use drugs with a safe location to inject, along with sterile injecting equipment and overdose intervention (Rhodes et al., 2006). McKnight and Colleagues (2007) sought to understand why some clients of Insite continue to publicly inject drugs despite the availability of supervised injection services. The research findings indicate that Insite clients who continue to inject in public are 3 times more likely to be homeless, 5 times more likely to lend used syringes, and 1.6 times more likely to require help injecting (p. 322). Key findings from this study highlight the concerns from drug users about wait times at Insite, demonstrating the need for additional SISs in Vancouver, as well as the current restriction against assisting with injections at Insite.

2.5.4. Public Safety and Disorder

Visible signs of drug-related disorder like public injection scenes are often regarded as a “nuisance” or a “threat” to communities facing high levels of drug use (Small, Rhodes, Wood & Kerr, 2007). Research conducted by Wood et al. (2004) evaluated the effect of Insite on levels of public order in the local vicinity by comparing levels of public drug use, publicly discarded syringes, and injection-related litter six weeks before and twelve weeks after

² Rushed injections have been associated with an increased risk of overdose, likelihood of sharing injecting equipment, and a decrease in swabbing the injection site prior to injection which may lead to infections and abscesses (Stoltz et al., 2007).

the SIS' opening. The study found that public order in the area surrounding the facility had improved and there were significant decreases in the number of publicly discarded needles and syringes.

The establishment of Insite led to concerns about the migration of PWUD into the neighborhood where Insite is located. Known as the “honeypot effect”, opponents of SIS fear that harm reduction programs lead to an increase in the level of drug-related crime. Evaluators examined the impact of Insite on levels of drug-related crime in the DTES by comparing crime rates from before and after Insite opened, and found that there were no statistically significant changes in rates of drug trafficking, assaults or robberies (Wood, Tyndall, Lai, Montaner & Kerr, 2006). These findings suggest that supervised injection sites do not lead to significant disruptions in public order or public safety in their surrounding neighbourhoods (Bell, 2014).

2.5.5. Seeking Treatment

One public concern prior to the opening of Insite was that a SIS would enable illicit drug use while undermining drug treatment efforts (Ontario Association of Chiefs of Police, 2012). It has been argued that SISs encourage drug use by providing PWUD with a comfortable space to inject, thereby making it easier for people to use drugs (Kerr, Stoltz, Tyndall, Li, Zhang, Montaner & Wood, 2006). However, Hedrich (2004) asserts that supervised injection services provide protection to even the most marginalized members of society whose social, physical, and mental health-related needs are rarely met. Kerr et al (2006) studied the rates of relapse into injection drug use among former users after the establishment of Insite, as well as the cessation of injection drug use among current users, and found that there was neither a substantial increase in the rate of relapse into injection drug use nor a decrease in

the number of PWUD seeking treatment options. Concerns about supervised injection services promoting illicit drug use have been dismissed, with research showing that the average Insite user has been injecting for 16 years and that these services attract marginalized individuals with long histories of injection drug use (Kerr et al., 2007).

Opponents of SIS have also argued that the availability of supervised injection services may discourage drug users from seeking treatment for their substance use. A study by Wood et al. (2006) examined the effect of Insite on the use of detoxification services in Vancouver. The researchers found that 185 out of 1,000 Insite users (18%) began a detoxification program at some point during the two-year study period. According to the research results, Insite clients who accessed the facility at least once a week were 1.7 times more likely to enroll in a detoxification program than those who visited the facility less frequently. In addition to providing people who use drugs with a safe, hygienic space to inject pre-obtained drugs, Insite's staff can refer clients to the OnSite Detox and Transitional Housing Program located above Insite. OnSite, established in September 2007, offers a twelve-bed detox floor in addition to an eighteen-bed transitional housing floor for some of the city's most marginalized drug users. Researchers have found that there has been a 30% increase in detoxification service use associated with the opening of Insite in 2003 (Wood, Tyndall, Zhang, Montaner & Kerr, 2007).

In sum, research demonstrates that Insite successfully reduces rates of infectious disease and overdose, and reduces the visibility of drug use in the DTES by minimizing the prevalence of public injecting and drug-related paraphernalia (DeBeck, 2011). Perhaps most significantly, Insite has been found to attract the highest risk users who are hard to reach through conventional public health programs, such as those who are more likely to be HIV

or HCV positive, who are more likely to overdose, and who engage in public drug use and unsafe needle and syringe disposal (British Columbia Centre for Excellence in HIV/AIDS, 2009; Wood, Tyndall, Montaner & Kerr, 2006). It can be concluded that Insite is associated with a wide range of community and public health benefits with very little adverse impact. However, despite the abundance of evidence in favour of SIS worldwide, there has been resistance against implementing SIS in other Canadian cities affected by the opioid crisis. The following sections will document the recent progress of Toronto and Ottawa in their respective efforts towards obtaining approval to implement their own supervised injection services.

2.6 Implementing Supervised Injection Services in Ontario

The fundamental aim of this thesis is to gain a better understanding of the obstacles to the implementation of harm reduction programming in Ottawa, Ontario. This section will discuss the viability of implementing the intervention in the two Ontario cities of Ottawa and Toronto. Although Ottawa is the site of this research, literature from Toronto is included since research has been conducted jointly on the two cities.

The 2012 *Report of the Toronto and Ottawa Supervised Consumption Assessment Study* (TOSCA) was conducted by the University of Toronto in collaboration with St. Michael's Hospital to investigate the demand for the expansion of an intervention like Insite to the cities of Toronto and Ottawa. Surveying inner city drug users in both cities, projected use of the facility was similar in both Toronto and Ottawa: almost 75% reported that they would use the facility if it were available to them (Bayoumi et al., 2012). The findings also suggest that the sites would attract drug users who are part of a vulnerable population, such as those

who live on the street, are unaware of how to access sterile injecting equipment, and who had previously shared injecting equipment with somebody they did not know.

Supervised injection services are usually located in areas of concentrated and highly visible drug use, like the Downtown Eastside (DTES) of Vancouver where Insite and the Dr. Peter Centre are located (Kazatchkine et al., 2014). However, research determining the efficacy of expanding SIS to Toronto and Ottawa found that the geographical distribution of drug use in these two cities is very different to the highly concentrated amount of drug use in the DTES (Bayoumi et al., 2012; Enns et al., 2015). TOSCA concluded that Toronto would benefit from multiple supervised injection sites integrated into existing health services serving people who inject drugs. In March 2016, Toronto's Medical Officer of Health released a report addressed to the Board of Health outlining the next steps for implementing three supervised injection sites in Toronto. All three proposed Toronto sites (as of March 2016) would be integrated into existing clinical services for people who inject drugs. These organizations are well established in their communities and have experience in serving clients with high rates of injection drug use and associated high-risk behaviours (ex. incidence of overdose, public injection, and sharing injecting equipment). The three locations are dispersed across the city to address the geographical distribution of drug use in Toronto, which, like in Ottawa, is decentralized. The immediate need for supervised injection services in Toronto is supported by overwhelming evidence indicating that there is high demand for these services among the city's most vulnerable and high-risk populations (Bayoumi et al., 2012; Enns et al., 2015; Public Health Agency of Canada, 2006).

The report by the Medical Officer of Health in 2016 demonstrated the high demand by stating that Toronto Public Health (TPH) and 47 community agencies provide harm reduction supply access at over 80 service locations across the City of Toronto. In 2015, there were 104,952 client visits to these programs, and almost 1.9 million needles were distributed along with other sterile injection supplies (Minister of Health, 2016). A 2015 report by the Medical Officer of Health indicated that city officials recognize that drug overdose is a significant public health issue in Toronto, as it is across North America. Between 2004 and 2013 there was a 41% increase in the reported number of fatal overdoses in Toronto, rising from 146 in 2004 to 206 in 2013 (Medical Officer of Health, 2015). More recent statistics estimate that the rate of fatal overdose in Toronto had risen to 252 in 2014, a 22% increase from 2013 (Toronto Sun, 2015). According to the results of a study conducted by the Public Health Agency of Canada (2006), approximately 8 in 10 surveyed injection drug users in Toronto reported injecting alone, and 29% had overdosed in the six months prior to the study.

The City of Toronto has implemented its own municipal drug strategy, titled the Toronto Drug Strategy (TDS), to address the needs of the city's drug using population. The TDS identifies four integral parts that must all be present to effectively reduce the harms associated with alcohol and other drugs: prevention, harm reduction, treatment, and enforcement (City of Toronto, 2016). This municipal drug strategy mirrors the former drug strategy (CDS) that emphasized harm reduction as being an essential part of the federal drug strategy.

Recent statistics estimate that there are 1,200 to 5,600 people living in Ottawa who inject drugs, and approximately 40 Ottawa residents die from illicit drug overdoses each year (Ottawa Public Health, 2016). In addition, emergency room visits for overdoses have increased by more than 80 percent in the last seven years (Ottawa Public Health, 2016). In

April 2016, Ottawa’s Medical Officer of Health, Dr. Isra Levy, voiced his support to the Ottawa Board of Health for a more comprehensive and modern approach to drug treatment, noting that integrating supervised injection services into already existing harm reduction programming would represent a “logical extension” of current addiction and treatment services (Ottawa Board of Health, 2016). However, agencies wishing to integrate a supervised injection program into their already existing services still have to submit the onerous information required by the *Respect for Communities Act* (elaborated in the next section). Like Toronto, drug use in Ottawa is not as centralized as the DTES, with high concentrations of drug use in the ByWard Market, Centretown, Little Italy, and Sandy Hill. On July 26, 2017 Health Canada announced their decision to approve Ottawa’s first supervised injection service at the Sandy Hill Community Health Centre. The following section outlines the Federal *Respect for Communities Act*, with a focus on how this legislation creates obstacles for proposed supervised injection services.

2.7 The Respect for Communities Act

In response to the 2011 Supreme Court of Canada (SCC) decision, the Conservative government first brought forth Bill C-2 in June 2013. Originally introduced as Bill C-65, the *Respect for Communities Act* proposed an amendment to section 56 of the CDSA to change the application process for organizations wishing to obtain an exemption to legally operate a supervised injection site. The bill at this stage did not gain the support required for passage and was withdrawn. However, the bill was reintroduced in October 2013 as Bill C-2, and was eventually passed in the Senate on June 10, 2015. Researchers, health care providers, and scientists have argued that the bill threatens the survival of Canada’s current supervised

injection services, as well as the implementation of additional ones (Canadian Drug Policy Coalition, 2015; Zlotorzynska, Wood, Montaner & Kerr, 2013).

Since drug laws fall under federal jurisdiction, prospective supervised injection services in Canada must first obtain an exemption under section 56 of the CDSA to legally operate and to protect their staff and clients from criminal prosecution. Section 56 allows the federal Minister of Health to exempt a service from provisions of the CDSA when deemed necessary for medical or scientific purposes (Kazatchkine et al., 2014); however, the *Act* did increase the administrative burden for obtaining the exemption, stating that an exemption should only be granted in “exceptional circumstances and after the applicant has addressed rigorous criteria” (the *Respect for Communities Act*, 2015). These “rigorous criteria” amount to an onerous amount of information that applicants are now required to submit to the federal Minister of Health before they are able to consider an application for an exemption (Kazatchkine et al., 2014).

In sum, the requirements outlined in the *Respect for Communities Act* create obstacles for health authorities and community agencies hoping to offer supervised injection services for people who use drugs by setting out what Kazatchkine et al. describe as “an excessive and unreasonable” process for applying for an exemption under section 56 of the CDSA (Kazatchkine et al., 2014). It is also argued that the *Act* fuels misinformation about supervised injection services by failing to acknowledge the scientific evidence demonstrating that these services have successfully reduced rates of fatal overdose and disease transmission (Kazatchkine et al., 2014). Among the 26 criteria outlined in the *Act*, applicants must submit numerous letters from various officials, including the head of the police force, the lead health professional of the government of the province in which the site would be located, the provincial

Minister responsible for health, the provincial Minister responsible for public safety, and the municipal government, all outlining his or her opinion on the proposed activities at the site, including any concerns with respect to public safety and security. Resistance from these officials can be an obstacle to the implementation of these services. Ottawa Police chief Charles Bordeleau has publically opposed supervised injection services, citing a fear of the possibility of the site to become a congregating area for drug users and drug dealers (Ottawa Sun, February 6, 2017). With regard to funding, the amount of detailed information that a potential supervised injection service must provide in order to submit an application is time-consuming and can be costly to a not-for-profit organization. Once a SIS is granted an exemption from the CDSA, the feasibility and sustainability of operating the site can also constitute a barrier to offering the service.

In addition, applicants must provide information about the expected impact on public crime rates, data on the number of persons who consume illicit substances in the vicinity of the proposed site, treatment options, and reports of various consultations held with the community, among other documentation (see *Appendix G* for full legislation).

2.8 Other Obstacles to the Implementation of Supervised Injection Services

It should be noted that there are other obstacles beside the ones from the *Act*, which is why the categories were identified from both the legislation and the literature. This section will explore the two other categories of obstacles identified in the most current and relevant literature on supervised injection services, besides the delays created by the *Respect for Communities Act*.

The first, and broadest, category identified is *obstacles to the implementation of supervised injection services*, in the form of funding, and public perceptions. In addition, the

amount of time that it can take from submitting an application to being granted an exemption can also be problematic for cities that are experiencing public health emergencies and need the exemption quickly. The Dr. Peter Centre, located in Vancouver, British Columbia, received an exemption in 2016, two years after submitting an official application to Health Canada. The Dr. Peter Centre has been operating since 2002; the urgent need for another supervised injection service led to the creation of an agreement between the police and the Centre, thereby allowing the Centre to operate despite absence of an exemption from the provisions of the CDSA relating to trafficking and possession (PHS Community Society Services, 2016). This amendment makes the process of acquiring an exemption under section 56 of the CDSA more difficult, creating barriers to the expansion of supervised injection services to other parts of Canada.

With consideration to the annual operating costs of Insite in Vancouver, it is estimated that the cost of opening a stand-alone supervised injection service in Ottawa would be around 1.5 million dollars annually (Ottawa Public Health, 2016c). Among others, this money is necessary to renovate existing buildings to make them suitable for supervised injection spaces, to provide SIS users with clean injecting supplies, and to extend hours of operation for SIS that are housed in the same building as other programs (Bayoumi et al., 2012). Funding for supervised injection services is primarily obtained through the provincial health ministry, which can be difficult if there is resistance from the municipal mayor or the provincial government in power. In January 2017, the provincial government of Ontario committed to funding three supervised injection sites in Toronto and one in Ottawa (Jones, 2017).

Public perceptions can also create barriers to the implementation of supervised injection services. “Not In My Back Yard” (NIMBY) is a phrase characterizing the opposition by

residents to a controversial or perceivably dangerous new development (i.e., a homeless shelter, a supervised injection service, a marijuana dispensary, a group home, etc.). Public consultations provide the opportunity for residents in the catchment area of a new development to have their voice heard about any concerns they may have. In spite of the evidence supporting supervised injection sites, these services sometimes face NIMBY opposition that can result in limitations on the delivery and location of services (Tempalski, Friedman, Keem, Cooper & Friedman, 2007). According to Strike et al. (2015), some opponents of harm reduction programming believe that supervised injection services promote initiation of injection drug use, endorse continued drug use, and encourage the congregation of PWUD in one area which could lead to an increase of crime. In their study, Strike and colleagues conducted 26 one-on-one interviews and focus group discussions (n=115) with community stakeholders and found that while most participants agreed that there might be a “right place” for SIS, they excluded locations near their homes and businesses. “Not in My Back Yard” opposition can hinder accessibility to harm reduction services, often affecting their location (Tempalski et al., 2007).

The second category is *obstacles to using supervised injection services once they have been implemented*, including the willingness to use a SIS, police presence, and the accessibility of the site. Shaw et al. (2015) examine the willingness of drug users in Ottawa’s By-Ward Market neighbourhood to using a supervised injection service should it be available in Ottawa. In this study, 270 participants reported injecting drugs in the previous 12 months, and 75.2% reported a willingness to use a SIS in Ottawa (p. 1). Those who reported that they would not use a SIS in Ottawa were more likely to report not injecting in public and not injecting with other people (Shaw et al., 2015: 7). A similar study conducted by Reddon,

Wood, Tyndall, Lai, Hogg, and Montaner (2011) examining the willingness of drug users to use SIS services in Vancouver identified injection at home, already having a safe place, and willingness to inject in private as the main reasons not to use a supervised injection service.

In a report outlining best practices and recommendations for the implementation of needle and syringe programs in Ontario, Strike et al. (2006) stress the importance of establishing positive relationships with law enforcement in the development phases of a NSP. Literature indicates that injection drug users may be reluctant to use harm reduction services out of fear of police crackdowns or arrest (Kerr et al., 2006; Rhodes et al., 2006; Small et al., 2007). Police officers who are not familiar with the evidence surrounding harm reduction programming may not be supportive of these programs, especially if there is a strong perception that providing injection drug users with clean injecting equipment and a safe space to use drugs encourages and endorses illegal activities (Strike et al., 2006: 227). Strike et al. (2006) recommend that municipalities train their law enforcement agents on the purpose and goals of harm reduction programs, the evidence about the effectiveness of these programs, and the health and social concerns of injection drug users (p. 65). Agreements with law enforcement agents can be negotiated to ensure that clients are not harassed when entering or leaving the site, that clean equipment is not confiscated, and that protocol will be established to resolve conflicts between law enforcement agents and harm reduction services (Strike et al., 2006: 66).

With regard to the accessibility, Hathaway and Tousaw (2008) note that determining the location of sites is an important factor in the development of effective supervised injection services. Welton, Adelberger, Patterson and Gilbert (2004) studied the distance injection drug users are willing to travel to obtain harm reduction services. Using complex statistical

techniques to determine optimal locations for needle and syringe programs, Welton et al. (2004) found that there are several vital factors that influence harm reduction site selection, including spatial distribution of drug use, ease of transportation and proximity to public transportation, proximity to police stations, and the walking distance from areas heavily concentrated with drug use (p. 269). Research has shown that harm reduction services should exist in places where drug use and high-risk behaviours are known to be present, like downtown community health centres and homeless shelters (Bayoumi et al., 2012; Boyd, 2013; Hathaway & Tousaw, 2008). Barriers to SIS use (i.e., long waiting times, limited number of injecting booths, and travel distances to the facility) could be addressed by increasing the number of SIS available to PWUD (Marshall et al., 2011; Petrar, Kerr, Tyndall, Zhang, Montaner & Wood, 2007).

2.9 Chapter Summary

This chapter outlined the current academic literature surrounding the health and social aspects of injection drug use, including the different types of harm reduction programming available worldwide, and the scientific research conducted on existing supervised injection services. This chapter also examined the evolution of Canadian drug policy and introduced the *Respect for Communities Act*, the legislation that represents one of the main forms of resistance in regard to the implementation of supervised injection services. The *Act* was introduced by the previous federal government in 2015 and requires organizations applying to Health Canada for an exemption from the CDSA to fulfill 26 criteria before their application will be considered. This thesis will examine the obstacles to implementing supervised injection services in Ottawa. The following chapter will outline the theoretical framework for this

thesis. Drawing on Michel Foucault's governmentality, the chapter will develop a theoretical framework that will outline the shift from prohibition to harm reduction.

CHAPTER THREE: THEORETICAL FRAMEWORK

The preceding chapter reviewed the current academic literature surrounding injection drug use and harm reduction programming worldwide. Central to this thesis is the *Respect for Communities Act* (formerly Bill C-2) that became law in 2015. Given its recent enactment, there is a dearth of research examining the obstacles to harm reduction programming resulting from both political and public resistance. The purpose of this chapter is to develop a theoretical framework to encompass the shift from prohibition to harm reduction, and the implications of this shift with regards to the regulation of drug use in contemporary societies.

Levine (2002) maintains that harm reduction is a “movement within drug prohibition that shifts drug policies from the criminalized and punitive end to the more decriminalized and openly regulated end of the drug policy continuum” (p. 173). The primary goal of prohibition is the elimination of drugs, whereas harm reduction is concerned with reducing the negative consequences of drug use without requiring abstinence. This shift towards harm minimization (as opposed to drug elimination) confronts a strong contemporary practice of governing illicit drug use through discourses of addiction and abuse (O’Malley, 1991a: 191). This discursive transformation allows us to think of drug use as being subject to new techniques of governance. Using the Foucauldian theoretical framework of governmentality, it is argued that the technologies employed within the harm reduction movement delegate responsibility for safer drug consumption onto the individual, thereby positioning drug users as autonomous individuals responsible for their own conduct. Governmentality is a useful framework for examining the rationalities and practices surrounding the regulation of drug use and the forms that “power” can take in attempts to regulate drug use. The governance of drug use entails processes concerned not just with relations of the state and to sovereignty,

but also with tactics and techniques of governmental interventions such as the family, schools, and the self (Dean, 1999b). There are a number of studies from diverse disciplines that are guided by the governmentality framework (Ferlie, Mcgivern & Fitzgerald, 2012; Rasmussen, 2011; Wilson, 2011), including drug use and regulation (Fischer et al., 2004).

Beginning with an overview of critical criminology, this chapter sets out to explore the emerging discourse of governing drug use through the harm reduction paradigm. Critical criminology takes the position that the construction of laws are ingrained in social and structural inequalities, and that laws are created to benefit those with economic and social power while targeting those who belong to socially or economically disadvantaged groups. These laws are formulated in response to phenomena that were defined as social ‘problems’ by certain groups, like drug use and poverty. Section 3.2 provides an overview of Michel Foucault’s governmentality and explores how the neoliberal state governs ‘at a distance’ through various spheres of power as well as through the self-regulation of its citizens. Section 3.3 explores the ways in which drug use has been problematized, reproduced, and made governable. According to Walmsley (2012), the emergence of drug use as a governmental problem can be traced back to the latter half of the 19th century. Little else is found on the topic prior to this, demonstrating that problems are not “pre-given and lying there waiting to be revealed... they have to be constructed and made visible” (Rose & Miller, 2008: 14). Next, section 3.4 will explore how the limits of state governance have shifted over time, separated into three distinct phases: classical liberalism, welfare liberalism, and neo-liberalism. The way that drug use is problematized affects the way it is regulated, and section 3.5 will examine how drug use has been problematized during all three phases of liberalism. These shifts in state governance represent what Foucault refers to as governmentality: “a rationality of

government *specific* to liberal democracies which incorporates detailed practices so governed individuals can exist as acting subjects” (Foucault, 1991 as cited in Zibbell, 2004: 58). The genealogy of liberalism illustrates how the exercise of power has changed over time, and helps us better understand the shift from prohibition to harm reduction.

3.1 Critical Criminology and Foucault

The field of criminology underwent rapid and significant change during the 20th century as a result of epistemological disagreements pertaining to the object of study and its production of knowledge (Carrington & Hogg, 2002). The dominance of the positivist school during the 1950s, which understood crime as a factual behaviour, gave way to the more critical formulation of crime as process (MacLean, 1986). This important shift marked the emergence of critical criminology. While traditional criminology seeks to understand and explain criminal behavior, critical criminology is oriented towards understanding how individuals are identified (or labeled) criminals or delinquents (DeKeseredy & Dragiewicz, 2012). Critical criminology also emphasizes the negative effects of the criminal justice system on individuals who have been labeled as “criminal”. Through a critical criminology lens, crime is not the result of a fault in individual character or the symptom of weakness, but a political-judicial construction that is played out through relations of power in society, enabling the criminal justice system to target and penalize certain groups and social classes over others. In other words, critical criminology defines crime through the concept of oppression: certain groups suffer oppressive social relations based on their class, sex, and/or race (Hopkins, 2001: 173). Epistemologically, critical criminology is characterized by the way it challenges traditional understandings of crime and criminal justice, and the ontology of the institutional construction that is crime and the criminal, and denounces the way they are regulated and

controlled (Carrington & Hogg, 2002; DeKeseredy, 2011). Critical criminology is a particularly important theoretical framework for this thesis as it guides our thinking about what perpetuates social inequalities, as well as what contributes to the reproduction of social order. In addition, it examines how certain types of laws and policies, such as those influenced by drug prohibition, are created to maintain the status quo by preserving and masking inequalities.

During the 1970s, developments in other areas of criminological theory (i.e., feminist criminology, cultural criminology, and left realism) led to claims that the creation of laws and the administration of justice do not only target individuals from lower social classes, but also those belonging to any other socially disadvantaged group like women, youth, members of minority groups, and drug users (DeKeseredy, 2011; Godfrey, 2012; Messerschmidt & Tomsen, 2012; Renzetti, 2012). Critical criminological thought has advanced since the 1980s and 1990s and, regardless of the theoretical approach or perspective (i.e., Marxism, feminism, left realism, etc.), these approaches share the idea that crime and the process of criminalization is deeply rooted in the socio-political and economical structures of society (DeKeseredy, 2011; DeKeseredy and Perry, 2006; Scranton, 2002). The creation of laws and the administration of justice may be used to persuade the population that the greatest threats to maintaining social order and prosperity of the state are small crimes carried out mostly by those from underprivileged social classes (i.e., drug users), thereby diverting attention from other behaviours and acts that are actually more harmful (i.e., corporate crime). This strengthens the belief that individuals from lower social classes, or members of minority groups, are more likely to commit crime than members of the affluent class, leading to the acceptance of laws that unfairly target these individuals while characterizing them as appropriate targets

for state responses to crime. The idea of the justice system as a socio-political tool for preserving social order and ensuring prosperity of the state is an important facet to this thesis. It has much to do about the way power is exerted in contemporary societies, in particular over vulnerable groups such as drug users.

Rooted in what was once called radical or Marxist criminology, critical criminology takes the position that the construction of laws and the administration of justice are ingrained in social and structural inequalities (Matthews, 2012; Milovanovic, 2012; Scantron, 2002). Arguably one of the more fundamental developments in Marxist criminology has been theorizing about the role of the state in maintaining social order, leading to the idea that the criminal justice system and its institutions are merely tools used by the state to advance the interests of the ruling class (Matthews, 2012) and maintain its dominance (DeKeseredy & Perry, 2006; Neocleous, 2000; Quinney, 1974; Scranton, 2002). According to Marx, power is used to dominate one class over another, mainly through the intervention of the state and of criminal law. Critical criminology has been evolving towards a Foucauldian approach to power whereby power transcends the state. According to Rose and Miller (1992), the common philosophical and constitutional concepts of the sovereign state are distorted. The modern state does not 'rule' exclusively by itself, but instead with an ensemble of institutions and apparatuses that form it, as well as state and non-state institutions (p. 176).

Michel Foucault has been extremely influential in shaping the understanding of power, primarily the idea that power is diffused and embodied in discourse, knowledge, and "regimes of truth" (Foucault, 1991; Rabinow, 1997). Unlike Marx, Foucault's works recognize that power can be a productive and positive force in society that is necessary to the success of the exercise of government, rather than being exclusively coercive (Gaventa,

2003: 2) and that it can be a source of social discipline and conformity. In his works, Foucault explores the development of ‘disciplinary power’, which is created through administrative systems and institutions like prisons, schools and hospitals. An example of disciplinary power can be found in the realm of addiction treatment, which is oriented towards transforming drug users into active citizens who are capable of self-regulation and responsabilization. The following section will introduce Michel Foucault’s concept of governmentality.

3.2. Governmentality

Governmentality is a term that was introduced by Michel Foucault during the 1970s. Put simply, it is a theoretical concept that describes the various “techniques, practices, rationalities and institutions for the exercise of power over populations and subjects” (Walmsley, 2012: 92). A fundamental tenet of governmentality is that governmental power is not concentrated exclusively in the state, but is dispersed throughout society in spheres such as schools, hospitals, and the family, with each sphere acting as a centre of governance (Barry, Osborne & Rose, 1996; Dean, 1997; Miller & Rose, 1990). As Foucault explained in his 1977-1978 course titled “Security, Territory and Population”, government is “an *activity* that undertakes to conduct individuals throughout their lives by placing them under the authority of a guide responsible for what they do and for what happens to them” (Foucault, 1997: 68). Neoliberalism indicates a gradual shift from disciplinary-based societies towards societies of control, meaning that power shifts across different “realms” in society, ultimately producing subjects who behave as they ought to (Jazeel, 2009). This shift in power, termed *government at a distance*, allows the state to distance itself from direct involvement in the government of its citizens while extending the reach of governmental programs (Rose, 1996:

350). In his 1978-1979 course “On the Government of the Living”, Foucault explains governmentality as being the “*conduct of conduct*”; that is the rationalities and technologies used to govern human conduct, with human conduct being something that can be regulated, controlled, and turned to specific ends (Foucault, 1997; Gordon, 1991; Nadesan, 2008).

An important component of governmentality is the self-regulation of subjects. Referred to as *self-governing*, Foucault argues that individuals are able to “operate” upon themselves through techniques of self-improvement, thereby achieving governmental ends through their own self-interest (Foucault, 1988: 18). According to Cruikshank (1999), the production of self-esteem and empowerment act as a social vaccine capable of providing protection against many kinds of social ills, like poverty, homelessness, teen pregnancy, drug use, etc. Through the process of self-governing, subjects internalize the belief that they are engaging in self-improvement to better themselves, usually blind to the reality that the state is fostering its own success, since the real basis of state power lies in the strength and productivity of its population. Sokhi-Bulley (2013) maintains that “governmentality has, contrary to being lessened, been increased by becoming more deeply ingrained in the structures and processes relating to rights, and by becoming less visible because it manifests itself in forms of authority less detectable than hierarchical forms of government” (p. 231). In other words, citizens may not realize that they are being governed through spheres other than the state.

Governmentality offers a powerful framework for analyzing how drug use is problematized in neoliberal societies by revealing the ways in which drug users who are deemed to be “high-risk” are governed. According to Fischer et al. (2004), the implementation of supervised injection services illustrates a shift from the punitive repression of PWUD to the

governance of drug use as a form of regulated risk consumption (p. 357). Fischer and colleagues (2004: 358) describe supervised injection services as “factories of health”, whereby drug users are responsabilized through disciplinary technologies as agents of risk. Of key interest is how the harm reduction paradigm, unlike the prohibition paradigm, delegates responsibility for safer drug use onto the user. Responsibilization is closely aligned with the neo-liberal principle of risk management, as well as governmentality. As O’Malley (1996) writes, the governmentality paradigm:

Constitute[s] their subjects not as members of an overarching social whole, shaped by social conditions and to be governed through social interventions, but as autonomous individuals, responsible for their own fate, invested with personal agency and thus with personal responsibility for their actions (p. 28).

To become, as Dean (1999a) says, “active citizens capable of managing their own risk” (p. 35), subjects who use drugs are governed through the choices they make as consumers, leading them to play an active role in reducing the risks associated with their drug use, rather than being policed into doing so.

Roe (2005) suggests that the creation of specific interventions and policies are the latest strategies in the historic efforts to minimize risk from and maximize control over high-risk populations like injection drug users. Fischer et al. (2004: 360) claim that supervised injection services are appealing as an effective measure against the “dangerization” of urban space by drug users who disturb the safety and aesthetics of the state, and that the prosperity of the state is the real goal of these interventions, not the at-risk user.

Foucault introduced the theoretical concept of problematization as an important element of governmentality, exploring “how and why certain things (i.e., behaviour, phenom-

ena, processes) become a problem”, and how they are shaped as “objects” that must be regulated or governed (Foucault, 1985: 115). The following section will discuss the concept of problematization and illustrate how it can be applied to illicit drug use.

3.3. Problematization: The Rise of the ‘Drug Problem’

In part, critical criminology involves ‘problematizing’ crime and the criminalization process by focusing on the way power is exerted and on the way issues are defined as social problems (McLaughlin, 2010). This section traces the shift from prohibition to harm reduction, illustrating how the problematization of drug use has changed over time.

Problematization, a term introduced by philosopher Michel Foucault in *Discipline and Punish* (1975), is the act of transforming something into requiring action at the level of the state, and beyond, by identifying it as a problem. As noted by Rabinow and Rose (2003), the concept of problematization, like many of Foucault’s concepts, was never clearly defined and explained by Foucault himself, but instead left to the interpretation of others. The most explicit presentation of problematization by Foucault was during a discussion at Berkeley in 1983, where Foucault raised the question of whether it was possible to separate the history of thought from the history of ideas (i.e., the analysis of systems of representation). He later argued that the one element capable of describing the history of thought was the element of problems, or, more precisely, problematizations (Rabinow, 1984; Rabinow & Rose, 2003). According to Foucault, a problematization does not represent an already existing process nor does it represent the creation of an object through discourse; instead, it is “the ensemble of discursive and non-discursive practices that make something enter into the play of true and false and constitute it as an object of thought” (Rabinow & Rose, 2003: 12). Simply put, problematization is the practice of taking something that was not initially considered to be a

problem and then transforming it into a problem that requires political action. For a problematization to form, something has to happen to change the way in which a situation is apprehended; to make something uncertain and to create a number of difficulties around it (Rabinow & Rose, 2003).

Relevant to this thesis is the problematization of drug use. According to O'Malley and Mugford (1991a), there are four prevailing discourses in regard to the problematization of drug use: the discourses of *pathology*, *profit*, *pleasure*, and the *state* (p. 50). *Pathology*, the dominant discourse in the "War on Drugs"³ rhetoric, shares the same objectives as the medical model of drug use with an emphasis on the complete elimination of illicit drug use. This discourse highlights the psychological and social deficiencies that drive people to use illicit drugs as an escape from reality. Next, the *profit* discourse is rooted in political economy and emphasizes the economic principles of supply and demand, arguing that the enormous profits made from the illicit drug trade are what keep it thriving. This discourse does not provide an answer to the question of *why* people use drugs, but might provide insight about how to reduce drug use. The third discourse, *pleasure*, revolves around the idea that people engage in illicit drug use because of the pleasure they derive from the substances. O'Malley and Mugford (1991a) claim that, unlike the pathology discourse which fixates on problematic drug use, the pleasure discourse insists on the idea that drug use is not deviant and can be enjoyable. Finally, the *state* discourse is the most relevant to this thesis and centres on notions of governance and power. Based on the idea that drug use is a natural part of society, this discourse questions the distinction between illicit and licit drugs as well as the role of the

³ The War on Drugs originates with the United States government under President Richard Nixon that produces criminal justice policies criminalizing and imprisoning millions of Americans, disproportionately African American. They have since recognized it as a failure, mostly due to the economic costs of incarceration.

state in defining which substances are prohibited and which are regulated. According to O'Malley and Mugford (1991b), the distinction between illicit and licit drugs does not reflect the separation of the harmful from the harmless, but rather “the historically contingent separation of drugs to reflect the interests or power of some groups over others” (p. 29). Similarly, Mugford (1993) argues that the governance of drug use has little to do with the actual drugs and their biochemical properties, but more to do with changes in society and systems of social control. This idea that drugs are classified as either licit or illicit because of their social “status”, rather than their pharmacological properties, questions the objectives of Canada’s current drug policy. The question of when, and why, substances were later classified as being either licit or illicit is important since drug laws did not exist until after the creation of the “drug problem”.

Since the rise of liberalism has an important impact on the way drug use has been problematized and regulated over the past two centuries, it is now time to explore this particular form of political regime. The following section will then discuss liberalism and how it has evolved over time, beginning with very limited state governance during classical liberalism, to the creation of very powerful states during welfare liberalism, and finishing with the current phase of neo-liberalism with its emphasis on individual autonomy.

3.4 Liberalism

The birth of capitalism during the 18th century was accompanied by the emergence of a new framework of government, liberalism, which remains central to contemporary forms of governance (Seddon, 2010: 9). Liberalism, as characterized by Rose and Miller (1992), is “a political philosophy defined by the limits it places on the legitimate exercise of power by

political authorities” (p. 179). One of the hallmarks of liberalism is the way it stresses individual freedom by placing limits on the power of the state. In essence, governmentality is a theoretical framework that can be used to understand liberalism and the way drug use is regulated in contemporary societies. Michel Foucault believed that liberalism should not be thought of as an ideology, but instead as a set of techniques for governing human conduct (Seddon, 2010: 10).

Seddon (2010) explores the genealogy of the drug problem since its emergence, along with how it relates to liberalism and liberal ideology, and concludes that the drug problem is a recent creation that was constructed for specific governmental purposes (p. 10). This section will outline the transformations liberalism has undergone in the past 200 years, divided into three distinct phases: classical liberalism, welfare liberalism, and neoliberalism.

The first phase, classical liberalism, took place from the late eighteenth century until the late nineteenth century, and was centered on the free market, free trade, and limiting interference from state governments (Seddon, 2010: 11). Individual freedom and autonomy were the main tenets of this period, and this focus on individual responsibility was mirrored in the way drug use was regulated. As Seddon (2007) argues, before legislative changes prohibited the use of some substances, societies operated on the principle of free markets, and drugs were seen simply as commodities in the market economy.

From the end of the nineteenth century until the 1970s, the state was transformed from limited and constrained central apparatuses to an entity that ruled over its citizens (Rose, 1999: 176). Termed welfare (or social) liberalism, this regime involved a shift to a more “interventionist” state with a focus on citizen security and rights (Seddon, 2010: 11). Welfare liberalism is based on the idea that the free market creates inequalities, and that the state is

responsible for intervening to compensate for those inequalities. According to Rose and Miller (1992), a key tenet of welfare liberalism was the relation between political rationalities and the formation of networks of government. With regard to political rationality, welfarism was structured to “encourage economic growth and well-being through the promotion of social responsibility and the mutuality of social risk” (p.192). Strategies of welfarism sought to govern through networks of government and shift the burden of risk management onto the state (Rose & Miller, 1992: 193). According to Rose (1996), the production of social norms in the welfare state “transformed the state into a focal point that could then shape, judge and govern individuals through a nexus of professionals that were invested by the state with the authority to act as experts in the technologies of social governance” (p. 43).

Neoliberal practices of government stemmed from a critique of welfare liberalism and its creation of over-powerful states during the 1980s. This new style of liberalism reverts back to classical liberalism with emphasis on the need for individual autonomy and responsibility in managing one’s own conduct (Bell, 1993: 395). Whereas the welfare state focused heavily on state-centered governance, neoliberalism questions whether it is possible to govern through the regulated choices of autonomous individuals (Miller & Rose, 1990; O’Malley, 2009; Rose, 1996). There has been a notable shift from what Rose (1999) terms “governing through the social” under welfare liberalism, to “governing through community” in neoliberalism (p.176). Thomas and colleagues (2016) suggest that neoliberal rationalities are “underpinned by the assumption that the governance of advanced liberal societies cannot be accomplished by the state alone” (p.39); power is no longer exercised primarily through the state but through a *plurality of mechanisms*, which include authorities, institutions, and practices (Thomas et al., 2016: 39). The emergence and development of various forms of non-

state governance has been referred to as “*governing at a distance*”, a term that illustrates the shift in the exercise of power by downplaying the importance of the state in governing modern societies (Hunt & Wickham, 1994).

Nadesan (2008) asserts that the diffusion of governmental power is achieved by the neoliberal responsabilization of every citizen and their everyday conduct. Subjects are granted responsibility, rationality, and the freedom to make their own choices because this “free subject” is to be repurposed as a tool for effective government (Dean, 1999a: 155). It is necessary that the subject believes themselves to be “free”, as power is only power when addressed to individuals who are free to act in one way or another (Gordon, 1991: 5). This process of responsabilization creates subjects that make decisions in accordance with the neoliberal ideal of reducing risk and increasing rewards, fashioning productive and responsible individuals that facilitate the success of the state (Gordon, 1991). Since responsabilization is founded on the premise that citizens are governed through their own choices, those who are unable to assume responsibility, or violate established societal norms, face social and/or political exclusion (Rose, 1999). This exclusion is attributed to their own actions (i.e., deviating from the established norms) or lack of action (i.e., failing to responsabilize), thus illustrating the shift of risk and empowerment from the state on to its subjects (Nadesan, 2008: 3). Populations who are deemed high risk become the target of programs to transform their status and shape them into active subjects capable of managing their own risk (Dean, 1999a: 168).

The emphasis on risk management is another important facet of neoliberalism ideology and is an element that can be easily applied to harm reduction. The concept of risk evolved alongside positivist methodologies, with emphasis placed on being able to observe, quantify and predict social phenomena, particularly through actuarial assessment of risk

(Lupton, 1993). Risk is equal to the likelihood or probability of an event occurring given a number of known factors. With respect to the governmentality framework, Dean (1999b) characterizes risk as a calculative rationality that is tied to different techniques for the regulation, management, and shaping of human conduct. The problematization of drug use at the turn of the 20th century was accompanied by the notion of risk, particularly the management of risk across the drug using population (Seddon, 2016: 417).

Neoliberalism stresses the need to concentrate on collectively managing the risks manifested in society, rather than on eliminating them. O'Malley (1999) identifies neoliberalism risk management discourses as the basis of the new and alternative technologies of governance aimed at regulating the conduct of drug users. Both scientific and popular discourses have “shaped and reinforced the identity of the injection drug user as a ‘site’ of extensive and omnipresent risk” due to lack of access to hygiene or stable housing, death, and disease (Fischer et al., 2004: 361). There is an expectation that SIS users will secure “healthy bodies [by way of] healthy choices” by avoiding overdose and the transmission of infectious disease, among other risk management practices (Peterson & Lupton, 1996, p. ix).

Collaboration between government and non-government organizations (NGOs) stems back to the development of neoliberal policies in the 1980s, and has become important in shaping modern drug policy discourse amid the increasing demand for ‘evidence-based’ policies (Thomas, Bull, Dioso-Villa & Smith, 2016). In parallel, the emergence of experiential knowledge in the development of evidence-based policies and practices highlights a challenge to the traditional dominance of scientific “experts” and policy-makers in the drug policy arena (Duke & Thom, 2014). Knowledge gained through lived experience is increasingly recognized as a legitimate form of knowledge, challenging the past dominance of traditional

authoritative knowledge (Lang, 2005: 115). Harm reduction is based primarily on evidence-based medicine, case studies, and epidemiology. Practices and programs are often established in alliance with drug user groups and advocates who have personal experience with drugs and can help make informed policy decisions. The channelling of power through non-state organizations allows for the collaboration of governmental and non-governmental groups on various state issues, like drug use, producing better forms of knowledge on which to base policies.

3.5. The Regulation of Drug Use

The shift through the different phases of liberalism has had important implications on the way drug use was regulated in contemporary societies. Governmentality is a framework that can be used to understand this shift. For the purpose of this thesis, the concept of regulation will be adopted from what Crawford (2006) defines as any attempt to “control, direct or influence behaviour and the flow of events in desired directions” (p. 422). Seddon (2010) notes that this definition of regulation is very similar to the Foucauldian concept of government as the ‘conduct of conduct’ (Seddon, 2010: 6).

3.5.1. Classical Liberalism

The emergence of drug use as a governmental problem can be traced back to a little over a century ago (Seddon, 2016: 395). Berridge (1999) notes that the “drug problem” did not exist in nineteenth-century Britain; the use of opium-based “pick-me-ups” and elixirs were so common during this period that it was largely viewed as a part of everyday life (see Berridge, 1977). Derivatives of opium were used in cough syrups and soothing syrups for children and babies (*Godfrey’s Cordial* and *Mrs. Winslow’s Soothing Syrup* were among the

most popular), as well as to treat varying common ailments like toothache and diarrhea (Berridge, 1982: 2). This stance on drug use aligns well with the classical liberal notion of individuals as free and responsible actors and with the limitation in state intervention (Seddon, 2010: 27).

During the first decade of the nineteenth century, the issue of excessive consumption of alcohol started to be defined as a social problem due to its increased visibility in urban settings as a result of industrialization (Seddon, 2010: 61). The idea of the ‘free subject’ being ‘addicted’ to alcohol and engaging in irresponsible and out of control behaviour was highly problematic to the liberal mode of government, and contributed to the call for the total prohibition of alcohol during the 1900s. It was during this period that a ‘problem’ framework was also beginning to be applied to opium and opiates, as well as the idea that the legislative regulation of opium supply could be a solution to dealing with the ‘problem’ (Seddon, 2010: 65).

3.5.2. Welfare Liberalism

The notion of addiction and drug use shifted at the turn of the 20th century with the transition to welfare liberalism. Instead of viewing drug use as a choice of free will, it came to be viewed as an example of a character defect requiring intervention and correction. Seddon (2010) notes that the scope of addiction was expanded during the welfare liberalism period, being applied not only to alcohol but to opium and opiates as well (p. 26). This period marked the emergence of the prohibitionist regime in Canada, notably the introduction of the *Opium Act* in 1908.

During this period, drug users were viewed as defective characters that did not have the capacity to exercise control and choice (Dean, 1999b: 20). As such, drug users became

objects for state interventions targeted at transforming them into capable citizens. Within the welfare state, drug users are policed by “experts” who stress the importance of abstinence-based addictions treatment while pushing for prohibitionist drug policies (Seddon, 2010). Seddon (2010) describes the genealogical significance of the welfare liberal period by outlining two main points: first, this period marked the beginning of the concept of ‘dangerous drugs’ and can be considered the origin of the contemporary ‘drug problem’; and second, it marked the emergence of the use of a criminal law framework for the regulation of drugs (p. 88). However, there was a shift away from the liberal governance of the welfare state with the emergence of a ‘risk society’ to what Rose (1996) terms ‘advanced liberalism’ or neoliberalism. Zibbell (2004) notes that health crises have often been moments for the reconfiguration of the role of the liberal state (p. 56).

3.5.3. Neoliberalism

The shift from welfare liberalism to neoliberalism was marked by the rise of the HIV/AIDS epidemic during the 1980s. This new form of governance is characterized by its emphasis on risk management and on “*governing at a distance*”. Populations that manifest high risk (i.e., drug users) are subject to rationalities and technologies that will transform them into active citizens capable of managing their own risk (Dean, 1999b: 26).

The increased popularity of substances like heroin and Cocaine during the 1970s and 1980s led to the development of a public-health problematization of drug use (Seddon, 2010: 94). Instead of being considered a danger to one’s own health and well-being, as it was during welfare liberalism, the drug user was reformulated as posing a threat to the community, namely as a potential carrier of HIV and other blood-borne viruses. The rise of the HIV/AIDS epidemic led to the development of a public health approach to drug use and was a catalyst

of the harm reduction movement. The shift from prohibition to harm reduction is characterized by the emergence of the ‘risk society’ and the threats posed by illicit drug use. Through “*governing at a distance*”, neoliberalism urges drug users to make responsible choices about their consumption practices.

3.6. Chapter Summary

The purpose of this chapter was to establish a well-grounded theoretical framework that would outline the theoretical perspective employed in this thesis. By analyzing the shift from a punitive prohibitionist outlook on drug use to the harm reduction paradigm, we are able to understand the governance of drug use as a form of regulated risk consumption. The following chapter discusses the methodological approaches employed in this thesis.

CHAPTER FOUR: METHODOLOGY

The aim of this thesis is to better understand the obstacles to implementing supervised injection services in Ottawa from the perspective of frontline service providers. Exploring the perceptions of harm reduction workers about the obstacles is important because these individuals work on the front line with drug users and many have direct experience with difficulties related to expanding current harm reduction services. This chapter describes the method that was used during the course of this research.

This chapter begins with a discussion of the ontological and epistemological assumptions that underpin this research project, followed by an outline of research objectives and questions, the method used to recruit research participants and the eligibility criteria. Techniques used in the data collection process are then reviewed, as well as the coding procedures implemented to analyze the data. The chapter concludes with a discussion of the reliability and validity of this research, including the ethical considerations undertaken in order to ensure that this research project was aligned with the ethical principles outlined by the University of Ottawa Research Ethics Board (REB). Finally, the methodological limitations of this study are discussed.

4.1. Paradigmatic Reflections: Ontology and Epistemology

According to Tracy (2013), paradigms represent ways of understanding reality and gathering information about the world (p. 38). There are four dominant paradigms in the social sciences: positivist/post-positivist, interpretative, critical, and post modern/post structural (Howitt, 2010; Walliman, 2011). A researcher's paradigm is made up of a combination of ontological, epistemological, and methodological dimensions.

Ontology can be defined as “the science or study of being” and refers to the researcher’s view of the nature of reality or being (Blaikie, 2010: 138). There are two main ontological stances: objectivism and subjectivism (constructivism). Objectivism is “an ontological position that asserts that social phenomena and their meanings have an existence that is independent of social actors” (Bryman, 2012: 29) whereas constructivism, on the contrary, argues that reality is based on perceptions created from lived experiences and interactions with others in our individual social worlds (Howitt, 2010: 426). Social constructivism stresses the importance of the role perceptions play in informing one’s social construction of reality, and argues that our opinions about truth are based on these perceptions. This research was conducted from a constructionist perspective.

Epistemology refers to the nature of knowledge within this ontological reality, and asks questions about knowledge, beliefs and truth (Sullivan, 1990 as cited in Forrester, 2010: 17). Stemming from epistemology are the questions of what truth is and how knowledge is produced. During the course of this research project, it was expected that the beliefs and perceptions of participants would vary as a result of differing worldviews formed from lived experiences and interactions with the social world, and it was likely that there would be differences among participants with respect to the value of additional harm reduction services in Ottawa. It can be argued that participants, while discussing their own experiences working in front line services, were creating their own truths about the challenges of implementing harm reduction programming. However, even if the perceptions of participants are socially constructed, their opinions are based on their own experiences working front-line and are valuable to the object of inquiry, which is identifying the obstacles to implementing supervised injection services in Ottawa.

4.2. Research Question and Design

The fundamental aim of this thesis is to gain a better understanding of the obstacles to the implementation of harm reduction programming, specifically supervised injection services, in Ottawa, Ontario. This thesis explores, in part, the obstacles that are created by prohibitionist drug policies in regard to the implementation of additional harm reduction services in Ottawa.

As Erickson et al. (1997) explain, the harm reduction movement can be viewed as an effort to address the shortcomings of current drug laws and policies while providing policymakers with an alternative framework for addressing issues related to illicit drug use like poverty, homelessness, and disease. It is important to study the obstacles that harm reduction advocates face in regards to the establishment of supervised injection services and in turn to assess the possible future of harm reduction programming in Ottawa. Thus, the research question guiding this study is: *What are the main obstacles to the implementation of supervised injection services in Ottawa according to front-line workers of harm reduction programs?*

The research design for this thesis is qualitative in nature and relies on data collected through semi-structured interviews with eight front-line workers of Ottawa harm reduction organizations in October and November, 2016. At the outset of the project, it was not clear which data collection strategy would be most appropriate for this study. I weighed the interview strategy against other possible methods, including a qualitative content analysis of the *Respect for Communities Act* or surveying current injection drug users about the practicality of supervised injection services in Ottawa. I decided that conducting a qualitative content analysis would allow me to examine how legislators construct drug use and its harms and solutions, but would not allow me to understand how the *Act* has actually created barriers to

implementing supervised injection services. After several discussions with my peers and supervisors, I decided against surveying current injection drug users. The reasoning for this decision was twofold. First, ethics approval would be more difficult to obtain and I was limited in the length of time I could allocate to the ethics process. Second, it would not provide me with information relevant to the object of inquiry, which are the obstacles to the implementation of harm reduction programming. It is with these reservations in mind that I decided that interviewing front-line harm reduction workers would be the most appropriate method for this particular project. Interviewing front-line workers about their opinions on the perceived obstacles to expanding harm reduction services in Ottawa provided me with several advantages. Most notably, interviews are one of the best ways to collect data rich in detail, allowing me to build a more informed analysis. Additionally, front-line workers are often involved in harm reduction advocacy outside of their work duties. Although this was not an essential criterion for participation, all participants were very passionate and knowledgeable about the effects of prohibitionist legislation on harm reduction programming. Speaking with these individuals provided me with the opportunity to learn more about my own object of research and more about how harm reduction services operate in practice, not just in theory.

4.3. Sampling Strategy

The research design was developed in such a way that data could be generated from a range of harm reduction organizations. The sampling frame consisted of several organizations in Ottawa that are identified as offering harm reduction services, specifically those that offer needle and syringe programs (NSP). The City of Ottawa website⁴ provides the locations

⁴ The City of Ottawa webpage on the needle and syringe services offered throughout the city can be found at: <http://ottawa.ca/en/residents/public-health/healthy-living/clean-needle-syringe-program>

of various sites offering needle and syringe programs within the city of Ottawa borders, and this list of programs was the basis of the sampling frame used in the research project. Ottawa's Clean Needle Syringe Program (located at 179 Clarence Street) is a health program that has been in operation since 1991 (City of Ottawa, 2015). In partnership with this program are 15 agencies that deliver needle and syringe services and supply information about other harm reduction initiatives, like how to access and dispense Naloxone in the event of an overdose. I specifically chose to sample front-line workers because they are likely to be knowledgeable about the challenges faced when advocating for the implementation of supervised injection services as a result of their involvement in the harm reduction community. In addition, this population has direct experience working with those who are primarily affected by prohibitionist drug policies.

The sample for this research is purposive in nature and is comprised of front-line workers of harm reduction programs offering needle and syringe distribution services in Ottawa. Purposive sampling is a form of non-probability sampling used when the researcher wishes to access a particular subset of people that fit certain criteria (Palys & Atchison, 2008). I employed a fairly flexible approach to data collection, deciding to interview between six and twelve participants and to quit recruiting when I achieved data saturation. The resulting sample size was eight interviews. According to Bloor and Wood (2011), many researchers follow this approach, ending data collection and analysis when it seems that the data is becoming repetitive and additional data gathering would be fruitless (p.165). With regard to the inclusion criteria, participants had to be working in Ottawa, have experience providing harm reduction services to people who use drugs, and have been an employee or volunteer at a harm reduction organization for at least six months prior to the interview.

4.4. Data Collection Process: Recruitment Strategy

In order to be granted ethics approval from the University of Ottawa Research Ethics Board, I was required to obtain letters of support from all organizations I intended to sample from. I originally contacted ten organizations from my sampling frame and received letters of support from eight stating that they would be willing to pass on my contact information, along with a recruitment letter outlining the purpose of the research study, to their employees (see *Appendix C* for the organization recruitment letter). Once I was ready to begin the data collection process, I contacted the individuals who had granted me the letters of support and asked them to forward the recruitment letter explaining the research project to employees who work front-line and have experience working with people who use drugs (see *Appendix D* for the participant recruitment letter). Six out of the eight organizations quickly responded saying that they had passed along the recruitment letter. I was contacted by front-line workers over the phone and by email, and then organized a mutually convenient interview time and location. Qualitative interviews can be lengthy and the location of the interview can be a significant factor in the type of information an interviewer receives. For example, the risk of being overheard could be inhibiting and may influence the material participants are willing to share (Noaks & Wincup, 2004). With one exception, interviews were conducted in a private office. One participant did not have office space to conduct the interview so we had to speak in a corner of a loud room. I asked the participant several times if he/she felt comfortable conducting the interview in an open space and he/she said yes.

4.4.1. Research Participants

All of the participants were front-line workers of harm reduction programs in Ottawa. Four participants identified themselves as harm reduction workers, three as case managers, and one as a program director. The length of time working in their current position ranged from 1 year to 22 years.

Table 2. Participant Demographics

Research Participant	Type of Organization	Job Title of Participant	Length of Time in Current Position	Length of Interview
A	Advocacy group offering NSP	Chairperson and Founder	6 years	32 minutes
B	Community Health Centre	Harm reduction worker	2 ½ years	39 minutes
C	Community Health Centre	Program director	15 years	89 minutes
D	Community Health Centre	Harm reduction worker	22 years	70 minutes
E	Methadone Clinic	Case manager	4 years	45 minutes
F	Homeless Shelter	Case manager	5 years	48 minutes
G	Community Health Centre	Harm reduction worker	5 years	62 minutes
H	Homeless Shelter	Case manager	1 year	52 minutes

4.4.2. Interview Process

I conducted the first interview on October 21, 2016 and allowed myself some time in between this interview and the next to transcribe the audio recording, make necessary adjustments to the interview guide, and receive feedback from my thesis supervisors. Doody and Noonan (2013) suggest that listening to and transcribing an interview before conducting the next one provides the opportunity to reflect on the data and identify where improvements can be made. The average interview length was approximately 50 minutes and ranged between

32 and 89 minutes. All participants agreed to be audio-recorded. Audio-recording the interviews is a methodological decision that helps ensure the quality of the resulting transcriptions and enables the interviewer to focus on actively listening to the respondent instead of trying to write everything down. Notes were also taken during the interviews to supplement the audio-recordings and were manually transcribed immediately following the completion of the each interview. The audio recordings were transcribed within one week. The interviews were audio-recorded on two iPhones, one of which was a backup to account for any technical difficulties, and both iPhones were password protected. In terms of storing information, I downloaded all of the audio recordings from the two cell phones on to a USB stick and external hard drive as soon as possible, and then deleted all audio recordings from the iPhones. My laptop and external hard drive were also both password protected. Upon completion of this thesis, the interview transcripts will be stored in a locked filing cabinet in Dr. Bastien Quirion's office for a period of five years.

One challenge that I encountered during the data collection process was the length of time between contacting the organizations for letters of support for my ethics application and contacting the organizations to distribute the participant recruitment letters. As previously mentioned, I received letters of support from eight organizations in August 2015 but, due to delays, I only re-contacted the organizations to begin participant recruitment in October 2016. I received responses from six of the eight organizations stating that they would pass along the recruitment letters meaning that I had lost two of the organizations that I could recruit from. I did not encounter any further challenges in recruiting participants from the six organizations.

4.5. Semi Structured Interviewing

The interview is a form of social interaction whereby participants discuss and share information about an experience, event, or particular issue (Coghlan & Brydon-Miller, 2014). Rowley (2012) defines interviews as “face-to-face verbal exchanges in which one person, the interviewer, attempts to acquire information from and gain an understanding of another person, the interviewee” (p. 260). Interviews can be conducted on a one-to-one basis or follow a group format. Interviews range from highly structured to unstructured depending on the type of research project and its theoretical orientation, with each type dictating the level of participation from the interviewee (Hugh-Jones, 2010 as cited in Forrester, 2010: 77). According to Doody and Noonan (2013), semi-structured interviews are the most commonly used type of interview in qualitative research for its flexible design and exploratory nature (p.30). Aided by the use of an interview guide, researchers can ask a series of predetermined questions but are able to also seek clarification and elaboration on the answers given, usually through probing, providing an opportunity to enter into a dialogue with the interviewee (Rowley, 2012). Howitt (2010) notes that the qualitative interview is highly dependent on the researcher’s ability to quickly absorb the information and make choices on the spot about what to ask and how (p. 75).

It is due to the flexible nature and opportunity for dialogue with participants that I chose to use semi-structured interviews as my data collection method. The opportunity to explore issues as they arose spontaneously was central to my research project and it was fundamental that I allow the participants to voice their opinions and share their experiences rather than limit them.

4.6. Interview Guide

Howitt (2010) notes that, for semi-structured interviews, a skeletal outline of the interview should be prepared prior to beginning the data collection phase (p. 67). An interview guide can simply list the topics to be covered or may instead list some of the questions to be used during the interview. According to Van Den Hoonaard (2012), qualitative interviewers most often use the term *guide* rather than script, questionnaire, or schedule when referring to the document containing the interview questions for the reason that *guide* better reflects the flexibility of the approach (p. 85). Interviewers using an interview guide are able to rearrange, add, or even omit particular questions depending on the flow of the interview.

The final version of the interview transcript was comprised of 20 open-ended questions, divided into two parts. In the first part, participants were asked general questions about the organization, their role in the organization, and how they personally understand the term ‘harm reduction’. Participants were also asked questions about their opinions towards supervised injection services, any foreseeable obstacles to implementing such a service in Ottawa, and about the support or resistance they think a supervised injection site in Ottawa would receive (see *Appendix A* for the full interview guide). The interview guide provided me with some structure but also allowed me to skip questions or change the order depending on the participant’s responses. For instance, participants were asked some general questions pertaining to the *Respect for Communities Act*, but I was able to move on to other questions if they were not familiar with the legislation.

4.7. Data Analysis

Qualitative interviews can generate a vast amount of rich and detailed data, and this can be overwhelming for the researcher at the beginning of the coding and analysis processes

(Noaks & Wincup, 2011: 123). During the course of this research project, the interview transcripts were analyzed using a deductive thematic analysis with inductive possibilities. A thematic analysis identifies and describes broad themes that summarize the content of a data set, with illustrative quotes or excerpts from the transcripts supporting these themes (Howitt, 2010: 164).

Some researchers describe thematic analysis as a “poorly branded” qualitative analytic method, rarely acknowledged but widely used in the social sciences (Braun & Clarke, 2006: 79). This method has been criticized for lacking a consistent and transparent structure (Howitt, 2010: 163). Perhaps in an attempt to make it more structured, Braun and Clarke (2006) outline five separate stages of conducting a thematic analysis: data familiarization, initial coding generation, searching for themes based on initial coding, review of themes, and theme definition and labelling.

First, I transcribed the interviews. Transcription is the process of turning audio recordings into written text prior to the further analysis of the material (Howitt, 2010: 139). For this project, the transcription process included listening to each audio file multiple times while pausing and rewinding until I had produced the interview transcripts. Transcripts vary in the level of detail they contain; some researchers believe in transcribing the whole interview verbatim and including all of the ‘um’s, ‘ah’s, laughter, and long pauses, whereas others only transcribe what seems applicable to their research study (Van Den Hoonaard, 2012). Howitt (2010) suggests that the researcher should only transcribe the portions of the recording that are relevant to their study because of how time-consuming the transcription process is. Despite time limitations, I chose to transcribe the audio-recordings verbatim because I did not know what would be relevant prior to analyzing the data.

After the transcripts were complete, I carried out the first step in Braun and Clarke's (2006) outline for conducting a thematic analysis, which is "data familiarization". I submerged myself in the data by reading and re-reading the interview transcripts. Tracy (2013) calls this stage the "data immersion stage" and suggests that the researcher should "absorb" and "marinate" the data, jotting down reflections and noting things of immediate importance in the right-hand margin (p. 188). At this stage, I started to think about what was emerging in the data and began to identify patterns; this phase was the inductive part of the analysis.

The second step of the analytic process involved identifying and generating initial codes. Coding is the process of identifying, categorizing, and assigning an essence-capturing word or short phrase to key concepts drawn from raw data to "locate key themes, patterns, ideas, and concepts that may exist" (Hesse-Biber & Leavy, 2006: 349). In other words, the coding process involves attributing interpreted meaning to individual datum in order to later organize and group similarly coded data, and has been described as the critical link between data collection and data analysis (Charmaz, 2006; Saldaña, 2013). Padgett (2014) claims that coding both sets the stage *for* interpretation and *is* interpretation; coding *is* a form of analysis (p. 172). There are many things that influence and affect how the researcher codes their data, such as their approach to qualitative inquiry, the ontological, epistemological and methodological decisions employed throughout the research project, and even the types of questions asked during the interview along with the researcher's own subjectivities (Kvale & Brinkmann, 2009; Saldaña, 2013). Some researchers suggest that coding should be seen initially as a reductive process that facilitates data manipulation as "a preamble to going beyond the data, thinking creatively with the data, asking the data questions, and generating theories and frameworks" (Coffey & Atkinson, 1996: 30). Rubin and Rubin (2012) posit that the decisions

a researcher makes during the coding process largely shapes what they will be able to conclude during the stages of analysis (p. 209).

There are two different approaches to coding depending on whether the data are theory-led (deductive) or data-led (inductive). An inductive approach does not use a pre-existing coding model or frame, but instead allows themes to emerge naturally from the data (Floersch, Longhofer & Derrik, 2010). In contrast, a deductive approach is theory-driven and is limited to predetermined themes derived from pre-existing studies or literature reviews. Zhang and Wildemuth (2009) note that coding categories used in a deductive approach are usually formed through three components: the data collected, the theories employed, and the coding categories used in related studies. This project employed a deductive thematic analysis with inductive possibilities. When coding the interview transcripts, I was guided by a coding scheme created from broad themes that were presented at the end of the literature review, as well as from an examination of the *Act*. However, I was also open to identifying themes that were not explicit in the coding scheme (see *Appendix F* for the coding scheme).

Prior to the analysis, I consulted the scientific literature on supervised injection services to devise the interview questions. I also read through the text of the *Respect for Communities Act* several times but I decided against using the legislation to formulate the interview questions because I was interested in exploring all of the obstacles to implementing SIS, not just those stemming from the *Act*. Like all Canadian legislation, the *Act* is accessible to the public online through the Parliament of Canada website under “Parliamentary Business”⁵. The webpage provides information about the *Act*, including its sponsors and committee, the status of the Bill, and the various stages that the Bill went through in both the House

⁵ The direct link to the *Respect for Communities Act* is: <http://www.parl.gc.ca/LegisInfo/BillDetails.aspx?Language=E&Mode=1&Bill=C2&Parl=41&Ses=2>

of Commons and the Senate before receiving Royal Assent on June 18, 2015. The latest publication of the Bill, as well as all preceding drafts, can be accessed through the “Text of the Bill: Latest Publication” hyperlink.

The initial coding involved systematically working through the interview transcripts and assigning short codes to quotes that struck me as being typical or interesting. Some datum was double and triple coded if several codes related to it. According to Auerbach and Silverstein (2003), the coding process is not a linear movement; the codes themselves are progressively defined and refined several times during multiple rounds of coding (p. 43). This research project involved multiple rounds of coding that consisted of going back and forth between the various stages of research and continuously refining codes and concepts. Charmaz (2006) advises the researcher not to narrow down their initial search to themes that are perceived as being important but instead uses the first round of coding as a way to trigger creativity. In general, initial coding is descriptive and requires little interpretation; the first cycle usually answers the ‘what’ questions relating to the data (Tracy, 2013: 189).

The third step in conducting a thematic analysis is searching for themes based on the initial coding. This is the stage where I began to critically examine the codes identified during the initial coding by organizing and categorizing them into broader themes. According to Tracy (2013), themes are used to explain, theorize, and synthesize the data; themes are not merely a reflection of the data, but go beyond comparing and contrasting the codes to instead analyzing their meanings (p. 194). I used different coloured “highlighters” on Microsoft Word to organize and categorize the codes, and then grouped codes together based on their commonalities. Sub-themes were also grouped together. Each theme was stored in a separate Microsoft Word document on my laptop.

Once tentative themes had been developed, I examined them against the original data set. Howitt (2010) outlines the importance of reviewing the themes when progressing through the analytic process. First, it is possible that there may be very little in the data to support a theme that was previously regarded as being important. Second, two themes may overlap, in which case they should be combined to ensure that themes are conceptually distinguishable. Finally, some data may no longer fit the theme that it was originally assigned to, and may need to be revised (p. 178). The final step in Braun and Clarke's (2006) guide to thematic analysis is labelling and defining the themes. This stage included refining all of the themes and assigning an essence-capturing phrase to each. During the analytical process, I refined and collapsed the original six themes in to four themes: the necessity of harm reduction services, bureaucratic barriers, forms of resistance and choice of location. Each theme, with the exception of bureaucratic barriers, consisted of two sub-themes. One of the benefits of thematic analysis is its flexibility. This analytic method is compatible with a range of theoretical and epistemological approaches, as opposed to being restrictive to a particular theoretical or epistemological position like grounded theory (Glaser, 1992) or discourse analysis (Willig, 2003). I chose to employ this analytic method because it allowed me to critically examine the meanings behind the themes that emerged throughout the data analysis process, and enabled me to easily highlight similarities and differences across the data set.

Reliability is an often-cited concern in thematic analysis due to its ability to produce a wide variety of interpretations from multiple researchers (Krippendorff, 2004; Tracy, 2013). The following section will discuss the validity and reliability of this project.

4.8. Validity and Reliability

Whereas quantitative researchers evaluate the quality of their research based on quantitative markers like validity, objectivity, and generalizability, qualitative researchers believe that “good” research should be assessed on its ability to achieve criteria like being meaningful, rich in rigour, sincere, and credible (Tracy, 2010: 837). Tracy (2010) outlines eight hallmarks for high quality in qualitative research. This section will present the most relevant of these key criteria and will explore how they were implemented in this research project.

The first hallmark of high quality research is the **relevance, timeliness and significance** of the topic. Tracy (2010) notes that current political climates or controversies can spark research (p. 840). At the time of writing, many Canadian cities are facing an opioid crisis and there is increasing pressure on politicians to adopt effective strategies for addressing the crisis. The current government is under pressure from harm reduction advocates and provincial governments to reverse or modify legislation enacted by the previous government and adopt evidence-based harm reduction strategies. Analyzing the obstacles to the implementation of harm reduction programming, specifically supervised injection services, is critical at this point in time as many Canadian cities are faced with an overdose epidemic stemming primarily from the use of opioids like Fentanyl and Carfentanil.

Rich **rigour** is the second criteria of good qualitative research that Tracy (2010) discusses. In contrast to quantitative research that is focused on precision, qualitative research is marked by rich descriptions and explanations of phenomena (Winter, 2000 as cited in Tracy, 2010: 841). Demonstrations of rigour during the interview process include the number and length of interviews, the appropriateness and diversity of the sample, the types of questions asked, and verbatim transcriptions of the interviews (Tracy, 2010: 841). I conducted

eight semi-structured interviews with front-line workers of various harm reduction organizations in Ottawa because that is when I reached the saturation point. I was satisfied that I had generated the maximum amount of new and relevant information, and that any additional interviews likely would have provided similar data. In terms of the interview questions, I created a set of questions that would yield rich data by ensuring that they were open-ended and clear. I conducted semi-structured interviews where the questions were subject to elaboration or omission and were not read word-for-word from the interview guide, while ensuring that each participant derived the same contextual meaning from the interview questions. I made sure that the same question yielded comparable results. Padgett (2014) notes that human error can occur as early as the transcription phase in the research process. Encountering unfamiliar terminology may lead to the researcher to ‘fill in the blanks’ when speech is muffled (p. 157). To ensure the validity of the transcription process, I listened to each audio recording at least twice while transcribing and also checked the transcripts against the recording whenever necessary to confirm their accuracy.

The third hallmark of high quality qualitative research is **sincerity**, which is achieved through self-reflexivity, transparency, and honesty (Tracy, 2010: 841). Examining the way one’s own subjectivity can influence the research process is known as reflexivity, and is paramount in the process of generating knowledge by means of qualitative research (Auerbach & Silverstein, 2003; Berger, 2015; Hammersley & Atkinson, 2002; Koch & Harrington, 1998). The worldview and background of the researcher influences the way in which he/she constructs the world, potentially affecting the information gathered from participants which, in turn, shapes the findings and conclusions of the study (Kacem & Chaitin, 2006 as cited in Berger, 2015: 220). As such, Sword (1999) maintains that no research is “free of the biases,

assumptions, and personality of the researcher, and we cannot separate self from those activities in which we are intimately involved” (p. 277). Reflecting upon potential assumptions or biases made during the course of the research process allows the researcher to consider the implications of such assumptions or biases on their analysis and findings (Dowling, 2006; Lincoln, 2002). Essentially, the exercise of self-reflection provides an opportunity for the researcher to formally acknowledge how their prior values, perceptions, and beliefs may have influenced the research process, thereby increasing the rigour and credibility of the findings (Howitt, 2010: 330). Lincoln (2002) writes that “a text that displays honesty or authenticity ‘comes clean’ about its own stance and about the position of the author” (p. 333). First and foremost, I acknowledge that I am passionate about the formulation of drug policies based on evidence and not ideology. The *Respect for Communities Act* (originally Bill C-2) was introduced in 2015 by the Harper Conservative government and, like many, I was disappointed with the passing of this Act amid research evidence demonstrating that supervised injection sites save both lives and money. I must also acknowledge that I am a white, female, middle class university student pursuing a Master’s degree and shared similar demographics to the participants interviewed for this thesis. This may have made me seem more relatable, allowing me to build a rapport with my participants which could have potentially affected the type of information they shared with me.

The fourth criterion of high quality research is **credibility**, which refers to the trustworthiness and plausibility of the research findings (Tracy, 2010: 842). In contrast to quantitative research where credibility is achieved through reliability, replicability, and accuracy, credibility in qualitative research is earned through practices such as multivocality (Tracy, 2010: 843). The credibility of this research project was enhanced by including the voices of

eight individuals who worked for different types of harm reduction organizations (see section 4.3.) and who shared different viewpoints. Not putting words in participants' mouths, but instead allowing participants to share their viewpoints even if they diverged from my own or my expectations of their views, also increased the credibility of this study. There needs to be a balance between respecting the participants by staying as close to the true meaning of their words as possible, and capturing these meanings at a level of abstraction necessary in qualitative research.

The fifth, and final, relevant hallmark of high quality research relevant to this project is **adherence to ethical considerations**. The *Tri-Council Policy Statement: Ethical Conduct for Research Involving Humans* maintains that a Research Ethics Board (REB) must approve all university research involving human participants. At the University of Ottawa, strict adherence to ethical standards when conducting research is mandatory for all research projects associated with the University. Of particular importance is the way individuals are treated before, during, and after their participation in research. According to the REB, a minimal risk review is intended for research that poses minimal risk to participants and complies with standards relating to matters of free and informed consent, anonymity and confidentiality, as well as an appropriate balance of risks and benefits (University of Ottawa Research Ethics Board). This research was not foreseen to cause any psychological, emotional, or physiological harm to participants. Nonetheless, in an attempt to minimize any potential discomfort, the consent form provided participants with information for counselling services in Ottawa should they be required.

The participant recruitment letters, consent forms, letters of support, and the interview guide were submitted and approved. Full ethics approval for this study was granted on

October 15, 2015 (File Number: 08-15-32). A request to extend the expiry date of the ethics certificate was submitted in September 2016 due to a delay in data collection, and was approved in October 2016 (see *Appendix B* for research ethics approval notice).

4.9. Chapter Summary

This research project used a qualitative thematic analysis to analyze the transcripts of eight semi-structured interviews conducted with front-line workers of Ottawa-based harm reduction agencies offering needle and syringe distribution programs. The interviews were conducted to gain a better understanding of the obstacles to the implementation of harm reduction programming in Ontario. This chapter explored the methodological techniques employed during this research project, including the particularities of the interview and coding processes. The following chapter will present the findings of this study.

CHAPTER FIVE: FINDINGS AND ANALYSIS

In this chapter, the results from eight qualitative semi-structured interviews conducted with front-line workers of harm reduction programs are presented and analyzed in detail. These interviews aim to address the research question guiding this thesis: *What are the main obstacles to the implementation of supervised injection services in Ottawa according to front-line workers of harm reduction programs?*

This chapter highlights the four dominant themes that emerged from the interviews that shed light on the main obstacles to the implementation and viability of supervised injection services, and also demonstrate the demand for these services in Ottawa. These are: 1) the necessity of harm reduction services; 2) bureaucratic barriers; 3) forms of resistance; and 4) choice of location. Integrated into each section is analysis and discussion of the research findings, situating them within the context of the current literature. Before examining the themes, a few general observations about the participants are presented.

Although they share similar core elements of harm reduction, the organizations to which participants were affiliated operate for a variety of reasons, and no two organizations are the same. For example, some offer needle and syringe services under a mandate of improving community health care, whereas other agencies provide these programs in collaboration with other services because of the characteristics of the population they serve (i.e., homeless persons or those living with HIV/AIDS). It also should be noted that because the mission statements of these organizations differ, so may their perspectives on the necessity of harm reduction programming in Ottawa and on the obstacles to its implementation. For example, a front-line worker at a homeless shelter may have less experience in providing harm reduction services to people who use drugs than a front-line worker at an organization

whose primary objective is providing clean injecting equipment to their clients. During the data collection phase, I interviewed eight harm reduction workers, including four from community health centres, two from homeless shelters, one from a Methadone clinic, and one who works as an advocate for people who use drugs. In this chapter, I explore in detail the four main themes that arose from the interviews and their sub-themes, considering the ways in which they provide harm reduction workers with a lens through which to think about the obstacles to implementing supervised injection services in Ottawa.

5.1. Theme #1: The Necessity of Harm Reduction Services

“Harm reduction is in place to counter bad drug policy, that’s why we do harm reduction – it’s not really about the drugs themselves, it’s about drug policy”
(Participant C).

The most common theme to emerge from the interviews centred on the necessity of harm reduction services in Ottawa. Participants shared the same stance towards harm reduction, noting it as “an important part of the treatment spectrum, especially for [drug] users who can’t or don’t want to stop using [drugs]” (Participant H). The two sub-themes revolve around the necessity of harm reduction programming for drug treatment in general, and the demand for supervised injection services in Ottawa.

5.1.1 Harm reduction as an essential component of drug treatment

Since the interviews focused primarily on the current demand for supervised injection services in Ottawa, there was a lot of discussion surrounding the benefits and drawbacks of harm reduction services in general and whether these services are a necessary component of

drug treatment. When asked to describe the term ‘harm reduction’, the majority of participants defined it as a way of working with people who use drugs to improve their health without assuming that they will abstain from drug use:

Harm reduction is an orientation towards working with people that accepts people for where they are right now and encourages them to take control and responsibility and to begin to minimize the harms associated with their drug use. I think it's really really important when talking about harm reduction to recognize that most of the harms associated with drug use are not caused by the drugs themselves, they're caused by drug policy (Participant C)

Harm reduction is meeting people where they are at um so taking uh kind of removing the disease model or the moral model and really kind of really looking at ways of reducing people's harms and leading to better, a better...helping people live healthier lives regardless of their decision. If they choose to continue using that is their prerogative, I'll just ensure that they do that in the safest way possible, so reducing those risks no matter what, without judgment (Participant G)

Harm reduction is meeting people where they are without pressuring them to stop using drugs. It's a form of treatment... you're just not demanding that they stop using and instead understand that some people don't wanna stop using or at least not right now (Participant H)

These quotes demonstrate the role of individual responsibility and the move towards mobilizing self-governance strategies that reflect a more neoliberal ethos. This shift away from strict policing and prohibitionist attitudes towards drug use challenges assumptions regarding the role of the state in governing its subjects (i.e., PWUD). Participant A shared why harm reduction was particularly important to him/her, mentioning that it kept him/her alive:

Harm reduction for drug users uh I guess to put it in a sentence, harm reduction kept me alive, you know, it kept me from getting uh a really bad disease or overdosing, uh it taught me how to treat my body the best as I could while I was using drugs and uh you know I'm a really happy man right now and uh it's only because of harm reduction, the people who taught me elements of that, that I'm still existing (Participant A)

Likewise, a number of participants discussed how harm reduction programming connects some of the most marginalized drug users to health and social services:

[Harm reduction] gives people access to treatment. I was only able to get better by accessing clean needles and harm reduction supplies, going to Public Health and having a talk with the nurse that was there just about my day. I was able to start making some changes. It's that engagement with people, it brings in the most marginalized people that aren't accessing services into a place where they are accessing services (Participant A)

We really wanted to emphasize the range of services that were available here and that people who would be coming in to use the service would at the same time have access to physical health services, case management services, Methadone and Suboxone programming (Participant C)

For someone who is a heavy drug user, who's HIV positive or potentially HIV positive, who's a sex worker they're going to get really shitty service from an Apple Tree [a medical centre in Ottawa] or trying to get a doctor or even the hospital. Having the nurses in the building really takes away from that gigantic barrier that's there because the nurses aren't expecting abstinence, they're not going to give a lecture on why using drugs is bad (Participant F)

As discussed in Chapter 2, there is consensus among researchers that a prohibitionist approach to drug use has not been effective in reducing the prevalence of drug use in society (Enns et al., 2015; Erickson et al., 1997; Haden, 2006; Lenton & Single, 1998). Emerging as an alternative discourse to the two main models of drug use (the medical/disease model and the criminal/moral model), harm reduction programs promote safer injecting behaviours among drug users, with a focus on reducing the harms from drug use and drug laws (Kerr et al., 2005). This is similar to what Participant C discussed when he spoke about harm reduction programming: he emphasized that harm reduction “is in place to counter bad drug policy”, again reiterating that the main target of this orientation is “not really about the drugs themselves, it's about drug policy.”

There was consensus among participants that harm reduction programming connects otherwise hard-to-access drug users with health services. The findings support the idea that adopting a harm reduction perspective when providing front-line services for this population is necessary, as stigma towards drug users within the health-care system was mentioned by six of the eight participants. For example, Participant F notes that harm reduction nurses are going to be less judgmental than Apple Tree nurses because of their experience of working with PWUD. Adopting a harm reduction approach towards health care is often the first step in developing positive relationships with PWUD, and is extremely important for further engaging this population to promote other health and social services such as housing support and detox programs. Further, an important premise of governmentality is the responsabilization of subjects and the expectation that citizens will regulate their conduct to become productive members of society who are capable of managing their own risk (Dean, 1999a: 35). By participating in harm reduction programming, PWUD are reducing the risks of transmitting HIV and HCV and also reducing the risk of fatal overdose.

5.1.2 The need for supervised injection services in Ottawa

*“It’s a complex problem and it could be one solution but it’s not **the** [emphasis added] solution” (Participant D)*

When asked why Ottawa would benefit from the expansion of current harm reduction services to include supervised injection services, participants often spoke about the evidence in support of current supervised injection services worldwide, particularly the reduction in fatal overdose, public injecting, and blood-borne diseases. Even though all participants expressed their appreciation for harm reduction services in general, opinions surrounding the

implementation of supervised injection services in Ottawa differed slightly. The majority of participants stated that Ottawa needs a SIS, and shared reasons why they believe so:

So why does Ottawa need one? It's a good question because we spent a lot of time building a case for it. Ottawa has about a 10-13% rate of HIV among people who inject drugs which is one of the highest measured in the entire province, 3 or 4 times higher than Toronto. We have a person die from overdose every 10 days in Ottawa, uh we don't know how many of those people are injection drug users – the data just isn't there. Um but we do know the overdose, we do know that in this population overdose is a very common experience – about 20% of people surveyed had experienced an overdose I think in the last 6 months or the last 12 months. The average lifetime number of overdoses was 5 – this is based on the TOSCA study so this is pre-Fentanyl and pre powdered Fentanyl numbers (Participant C)

We've got people using in dangerous places, really undervalued members of our community, I was one of those people for years, like I could've dropped dead in countless public bathrooms (Participant A)

We also know that there is quite a bit of public consumption that happens in Ottawa, we don't have the situations like the Downtown East Side in Vancouver where it's happening in parks, but it's happening in bathrooms, it's happening in parking garages, it's happening in stairwells. And so it does happen in public space as well but one of the problems I think in the way that this has been conceptualized is that people have this idea that there has to be a certain threshold that needs to be crossed to justify a supervised injection site and so we have to really change that type of thinking as well (Participant C)

Most notably, preventing overdose was identified as the primary driver of the intervention, with all eight participants discussing the skyrocketing increase in overdose since the introduction of Fentanyl on the streets of Ottawa in 2015. Researchers find that using drugs alone in hidden places is associated with an increased risk of overdose (Green et al., 2009; Kerr et al., 2007; Marshall et al., 2011).

Participant A discussed how many injection spaces go unnoticed but “the bathrooms at Loblaws, the parking lot at the mall, the University of Ottawa” are common spaces for drug users to inject alone. Both Participants A and C spoke to the amount of public drug

consumption in Ottawa, with Participant C insinuating that Ottawa does not have the same open drug scene as the DTES in Vancouver. However, the two locations have drastically different climates, with Ottawa's extreme weather making it difficult for PWUD in Ottawa to consume drugs outside during the winter months, while the temperature in Vancouver is milder year round. Further, Participant C mentioned that there needs to be a "certain threshold" that is surpassed to justify implementing SIS, reflecting the opinion that a public health crisis must occur to initiate any real change.

Participant G shared a recent encounter they had with a drug user and how having access to a SIS could have made the intervention more positive by allowing him/her to provide a safe space for the drug user:

Not having a supervised injection site really gets to me because to use an example, yesterday there was a young woman outside of our centre injecting quite publically. I had to go tell her that she couldn't inject there, but at the same time I couldn't offer her a safe space to go. So at the end of that intervention I felt shitty because I put her at risk, I put her at harm. She's gonna have to essentially go find some unsafe alley to go use which she risks violence, overdose, contamination because it's dirty. So telling someone that they have to move along while not being able to offer her something like we have a space here but I can't do it (Participant G)

The impact on service delivery resulting from the RFCA was a common narrative. When asked about obstacles resulting from the legislation, Participant G expressed his concerns about the apparent disconnect between the principles guiding harm reduction and the services that he is currently able to deliver. Within the prohibitionist regime, if a harm reduction worker were asked by a drug user to supervise their injection, he/she would not be able to honour this request. This view was shared by other participants who expressed guilt about dispensing clean equipment and then directing drug users away from the building to inject.

On the other hand, Participant D expressed his/her concerns about the population these services are catered to:

One of my concerns, because I know that vintaged users don't actually access our services, so I question who is the target population that will? And what can we do to bring services to those who use indoors. A lot of increase in drug use and injection drug use in university students – they're not gonna come here for that. You know they'll pick up occasionally here or they might get the van but they're not going to use it. So who is the target population? I understand it's the homeless and the folks at the shelter but it's a small percentage. That's my interpretation, it doesn't necessarily mean I'm correct, and so the frustration is that we have to do it this slowly to get everybody else ready. In the meantime, the true and immediate needs of the people that we're providing services to is not being met (Participant D)

Participant D also noted that a SIS in Ottawa would be very different from Insite in Vancouver:

We're not going to be like Insite, we don't have the manpower, we don't have the space, we don't have the ok to be 24 hours, we're gonna have pockets of availability because it's a trial and a research thing as my understanding. That does not cater to the drug user, right? So but I understand it's the first step (Participant D)

Arguing that “vintaged⁶ drug users don't actually access our [current] services,” Participant D brings up an interesting point: who are the targeted clients of SIS? According to Wood et al. (2005), one of the primary successes identified in Insite's evaluation was the intervention's ability to attract drug users who exhibit higher-risk characteristics (i.e., those at higher risk for overdose and HIV infection, and those who share injecting equipment), and those who belong to more marginalized sub-groups (i.e., women and homeless persons). Similarly, German researchers evaluating the effects of SIS on drug use patterns found that people who use drugs tend to be consistent in their use of these services, with the majority of PWUD

⁶ The term “vintaged” refers here to people who have been using drugs for an extended period of time. It should be noted that the participant did not give an exact definition of what they meant by this term.

reporting usage rates of up to six times per week (Anoro et al., 2003; Hedrich, 2004). Research demonstrating high usage patterns among injection drug users indicates that these services are able to attract and retain high-risk drug users by providing them with a safe space to inject. Indeed, with the emergence of Fentanyl, the identity of the drug user has changed substantially. The opioid crisis is not only affecting people who use drugs on a regular basis who are exposed to various environmental and situational risks (i.e., homeless individuals who consume drugs in an alleyway because they don't have anywhere else to go, etc.), but also youth at house parties who are consuming drugs containing traces of Fentanyl or Carfentanyl. This raises the question of whether SIS are an adequate response to the opioid crisis since university students and people with apartments or houses are not likely to use a SIS. However, the value of this intervention for vulnerable groups in society (i.e., those living in a shelter or on the street) cannot be understated.

Based on the interviews, the harm reduction workers seem to have differing opinions on the suitability of supervised injection services in Ottawa. The majority of participants expressed their support for SIS, endorsing the service as the next step in developing a more progressive drug strategy that mitigates the harms resulting from current drug policy as well as those stemming from drug use. Meanwhile, Participant D struggled with whether SIS was an appropriate response to the current opioid crisis, emphasizing that what works for Vancouver may not necessarily work for Ottawa. This concern shows that there may even be resistance towards SIS within the harm reduction community.

5.2. Theme #2: Bureaucratic Barriers

Another theme that emerged from the interviews centred on the numerous obstacles to the implementation of supervised injection services, predominantly bureaucratic barriers

imposed by the *Respect for Communities Act*. Indeed, participants provided several concrete examples that demonstrate how bureaucratic barriers are significant obstacles to the implementation of supervised injection services.

Each participant spoke about the legislation to the best of their knowledge, discussing obstacles that it has (or would have) created. At the time of the interview, two of the eight participants were actively involved in preparing an exemption application and were the most knowledgeable about the obstacles stemming directly from the legislation. However, it is interesting to note that the majority of participants did not know a lot about the legislation itself, although they did see first-hand the negative impacts that the *RFCA* has had on service delivery to people who use drugs. Participants explicitly stated that the legislation had created barriers for harm reduction programs that are hoping to expand their current services to include supervised injection services. To quote one participant:

The Act has definitely created obstacles for us cause we would have opened our supervised injection site already. Our board of directors approved it, everyone in the building has approved it, we are moving forward, but because of the actual legislation we have to spend like 2 or 3 years, it slows down the service delivery (Participant G)

Other participants echoed this perspective. For example:

It's putting barriers up in terms of taking us a step backwards towards providing harm reduction services. So if you're asking organizations to jump through 100,000 hoops to be able to offer safe injection sites it's challenging to do that (Participant H)

The amount of detailed information required to submit the application was identified as the biggest obstacle stemming from the legislation:

When we initially met with Health Canada back in 2012 to indicate that we were moving forward on this, um what they told us that they were looking for from us was binders full of information. That's how they explained it and that they wanted as much information as possible and uh so there was really a strong sense that the government was basically trying to paper over us

and the basic message was “don’t bother” and that was before the Respect for Communities Act came in (Participant C)

We still haven’t applied, we’re still doing the paperwork [laughs] it’s such a burden, like it’s so... there are so many steps that it just takes forever to complete it, meanwhile Ottawa’s overdose rates are sky rocketing so, yeah it’s definitely affecting how we can deliver our services (Participant G)

The amount of information you’ve gotta provide is just ridiculous too. You hear every day about people dying from overdoses, especially with Fentanyl and we can’t monitor people and help stop them from dying because of this law. The amount of time it would take to get all of the documents they ask for... people are dying everyday (Participant E)

The amount of documentation is a huge strain on resources, resources that smaller organizations may not even have to begin with because, you know, we don’t get a lot of funding really (Participant H)

Similarly, Participant C noted that the amount of documentation required by the *Act* creates barriers for smaller towns and cities that may not have the statistics to justify implementing supervised injection services if they are just now experiencing the effects of the overdose epidemic:

We were fortunate to have a lot of research that put us ahead of other cities in the province in terms of establishing supervised injection sites, so a lot of other communities are currently doing catch-up in terms of trying to establish the epidemiological numbers to justify opening a service, and it’s completely bogus – there’s no reason why we should have to justify the service based on these numbers. We know that injection drug use is a behaviour that increases the risk of overdose, of HIV, uh and incarceration. And so we should be doing something to minimize those harms associated with it (Participant C)

I mean even if you have 10 injection drug users and observe 5 injections a day, you have to meet all those 26 conditions the same as Insite does that is basically moving towards being open 24/7 and having 12 injection booths and tens of thousands of injections a year – it’s exactly the same process and that’s just really not fair (Participant C)

The *Act* explicitly states that an exemption should only be granted in “exceptional circumstances and only after the applicant has addressed rigorous criteria” (the *Respect for Communities Act*, 2015), constituting what Kazatchkine et al. (2014) describe as “an onerous amount of information”. The problem with the *RFCA* is that it is quite obviously based on political ideology rather than on the wealth of scientific evidence demonstrating the effectiveness of SIS on saving lives, reducing the transmission of blood-borne diseases, and connecting drug users to health and social services. Implementing legislation that makes it increasingly difficult to obtain an exemption from the CDSA demonstrates the previous government’s prohibitionist stance on illicit drug use and indicates a disregard for the lives of PWUD. In addition to the amount of information required, several participants shared their concern over the type of documentation required under the *Act*. Six out of eight participants expressed their frustration about requiring letters from political figures who they believe are “*not qualified*” (Participant E) to be consulted about the implementation of supervised injection services:

Um the fact that some of that criteria still requiring a letter from the mayor and chief of police, I think that’s just foolishness too...they’re not experts, you know, they wouldn’t come to me to ask for a letter to pull in some new criminal law or some municipal election law or something, you know, they’re experts in their field, we’re experts in ours, they should just frankly butt out (Participant A)

I mean I would never have to go ask someone, the Chief of Police, can I treat this person for cancer? Why would I have to ask the police, you know? It just implies that these people are criminals. To me, that’s how I interpret it, that the fact that you’re making the assumption that the people who would use this service are criminals, so public safety is at risk (Participant G)

Harm reduction workers work directly with people who use drugs and are perhaps best suited to determine whether SIS is a necessary component of harm reduction program-

ming in Ottawa. Prohibition-based legislation is a reversion to welfare liberal forms of governance, with the drug user portrayed as a criminal who does not hold the capacity to govern his own behaviour. The *RFCA* promotes this negative image of the drug user and perpetuates the stigma around illicit drug use by depicting the drug user as somebody from whom society needs to be protected. Participant G notes that “*the title implies many things, that the individuals who would use such services are not safe, it criminalizes people even before it starts.*” As Seddon (2010) notes, this mentality leads to state targeted interventions with drug users being policed by “experts” who stress the importance of abstinence-based addictions treatment while pushing for prohibitionist drug policies. Another concern was that the legislation gives political officials the power to delay the submission of the application by withholding the letters:

From what I gather is they've indicated that they've received the letter but it's going to be worded, I'm sure it's going to be read and reread and proof-read and triple read [laughs] and sent around so I'm not sure. Giving the benefit of the doubt and hoping it won't be too long but people are dying (Participant G)

The problem somebody who doesn't want a safer injection site could halt the process by taking their time to give us the documents. I hope they wouldn't do that given the crisis we are going through but I don't know (Participant H)

Two participants raised a very interesting point relating to the fact that even if all of the documentation is submitted and the need for a service is demonstrated, the federal Minister of Health ultimately decides whether or not supervised injection services will be added to the current harm reduction services:

And even if you do meet all of the requirements you still risk the Minister saying no. It just puts a whole lotta power in one person's hands and I don't think that's how it should be. It should be a board of some sort so that one person's beliefs aren't the deciding factor (Participant H)

Yeah, they can turn around and say no and dismiss everything we've done. Yep, it's a lot of money spent/invested in creating this application and it could be just as easily...I think we're going to be on year 3 of creating this and we still haven't submitted but we're very close, very very close. We're waiting on a letter from the police and the city right now (Participant G)

Similar to the comments about requiring letters from various political officials, several participants expressed their frustration for having to consult the community as part of the application process:

We didn't consult the community about whether we are going to start providing HIV care or whether we're going to start a diabetes program, we didn't consult our community about our addictions and mental health services being onsite, so why this particular intervention does it require a community consultation? (Participant C)

Like, why do we have to do all of this? Why do we have to ask permission from our neighbour to do this? I get consultations and that's fine, getting people's input I'm always for that; I think people's voices should be heard but shouldn't be relied on; it shouldn't be the deciding factor. Luckily for us [our community] said yes, from our consultations. But if they had said no, would that be the end of the road for us, you know? (Participant G)

Although there was a general consensus that community consultations provided an opportunity to educate the general public on the scientific evidence surrounding supervised injection services, participants noted that the consultations did not provide the organization with a learning opportunity. As participant C puts it:

It was a great opportunity to get them to know us a little bit better but we didn't learn an awful lot from our community and nor would I expect to because they're not experts on this (Participant C)

Instead, participants brought up the point that the drug using community should be the ones providing their input since they are perceived as the experts in this field:

Interesting is that the Respect for Communities Act doesn't require us to consult with the drug using population which you'd think is an obvious group that should be consulted – in fact, their needs should be prioritized (Participant C)

There's been a lot of things in politics lately with regard to Fentanyl overdoses, supervised injection sites, and despite being well intentioned a lot of these decisions are being made without our inclusion. Yeah so for us to be involved in that ...when anytime a decision basically affects us. That's the dream. Any decision that involves people who use drugs has to involve people who use drugs (Participant A)

Different forms of problematization call for different strategies of governance, and the *Respect for Communities Act* is an explicit illustration of how prohibition-based legislation ensures that harm reduction strategies cannot be easily supported, while justifying the creation of prohibitionist drug policies. When asked about the effect of prohibitionist drug policies on harm reduction programming, Participant C replied that politicians and policy makers have “taken drug use from a mild public health problem and completely multiplied the harms by applying a prohibitionist lens to it.” It can be argued that the *RFCA* promotes a prohibitionist approach as a suitable response to drug use, which is revealed through the increasing number of bureaucratic barriers to implementing supervised injection services. Indeed, one of the most common narratives throughout the interviews is that the *Respect for Communities Act* has caused more harm than good, and is based more on political ideology than it is on evidence from scientific evaluations of SIS across the world. This perspective is aligned with what Mugford (1993) says when referring to the problematization of drugs: the governance of drugs has little to do with the actual drugs but more to do with systems of social control and managing high-risk behaviours.

5.3. Theme #3: Forms of Resistance

“Once you're addicted the mentality is that you're weak, you're a burden on society” (Participant D)

Another obstacle to the implementation of supervised injection services that emerged from the interviews relates to forms of resistance. Political and community resistance were

the most commonly acknowledged forms of resistance associated with extending harm reduction services to include supervised injection services.

5.3.1 Political resistance

Several participants highlighted the obstacles resulting from a lack of support from local politicians and police officials. They commented on the fact that the Ottawa Chief of Police and the Mayor of Ottawa do not support the implementation of supervised injection services in Ottawa:

Mayoral resistance, political resistance...he [Jim Watson] certainly hasn't been an ally, that's for sure (Participant B)

It's scary that they don't publically support it. For me, I think it's more that political aspect and people will stand behind their mayor and their police chiefs (Participant H)

When it was announced quite a while ago that our manager was going to put forward an application for a supervised injection site, we were told the police aren't for it, the mayor isn't for it. As an example we have a spot here for distribution like needles, right? And a couple of cop cars would be sitting here in front of the building, they'd be on the side of the road, or even coming with their bicycles, just intimidating people from coming in, and this has nothing to do with us just distributing cause we've been doing that since we've been down at [location]... it was because a stand was taken that we were going to try and open up a safe injection site (Participant D)

I think there's a lot of fear around supervised injection sites and if the big honchos don't agree with it, even though the agencies will do their best to get around them, I think those who voted will agree cause they share the same values (Participant D)

I saw no way to get any support; we did not have a federal ally, the government was actively opposed to it, the mayor in his election campaign stated he was opposed to it, the police were opposed to it (Participant C)

Participant G discussed the lack of support for harm reduction strategies from city counsellors:

On overdose awareness day I try hard to get counsellors to come because people are dying; there are more people in Ottawa dying of overdose than

dying from accidents, yet a city councillor come open this new traffic light to reduce accidents and take the picture or whatever, but when it's about harm reduction they run (Participant G)

In sum, political resistance might be justified by ideological positions, by fear or by lack of information about supervised injection services.

5.3.2 Community resistance

“Someone’s ideology is killing people, it’s preventing services from being accessible” (Participant G)

Wodak et al. (2003) argue that the process of implementing SIS is as strongly influenced by discourses surrounding drug use, as well as political ideology and community support, as it is by evidence-based research. As part of the application criteria outlined in the *RFCA*, the community of the proposed SIS must be consulted about the implementation of the service. Although it is not clearly outlined in the legislation whether negative feedback would actually influence the application decision, participants acknowledged the importance of having a positive relationship with the community. A source of community resistance identified by participants was public fears and misconceptions about drug use and harm reduction, namely the perception that harm reduction services condone drug use instead of promoting treatment options:

So, a lot people, like my uncle for example, just thinks that it should be abstinence based only and they don’t understand how I could work somewhere where you’re essentially [laughs] an illegal drug dealer and you’re distributing medication to people who can get it by other means. But to me, I think that’s a better option than say a woman selling her body to earn money to support her habit, or somebody injecting in an alley and then contracting something or putting themselves in harm’s way (Participant E)

In response to arguments about harm reduction services promoting and encouraging drug use, participants state that harm reduction services should not be considered the only solution

to the opioid crisis, but are instead part of a range of interventions targeted towards those who do not want to be abstinent. In fact, a study by Kerr et al. (2006) observed the drug use behaviours of 871 drug users in the one-year period before the opening of Insite and in the one-year period after. The researchers found that there was no substantial increase in the rate of relapse into IDU among former users (17% prior to Insite's opening and 20% after), and there was no impact on the number of PWUD seeking treatment (17% prior to Insite's opening and 15% after).

A few participants pointed out how isolated incidents involving drug use and crime are exaggerated by politicians and the general public remains fearful of the drug using population:

Even the name of the Act insinuates that we need to be afraid of drug users, they'll break in to your car, they'll take your 52 inch TV that you're still paying for, they'll rob the old lady... you know? They leave a needle in the park where your kids are playing... I mean they take those isolated incidents and they play on your emotions (Participant D)

Participant C shared this belief, commenting on how they think that the nature of the legislation is perpetuating the stigma surrounding drug use and supervised injection services:

Well the Act actually perpetuates stigma about supervised injection sites as scary things. It promotes the stigma if you read the Act, it gives people the idea that drug use is scary and dangerous, and that people who use them are, and that people who use these services are. This service has been promoted by politicians as a scary thing that we should be avoiding at all costs and uh making ill-informed statements like "shouldn't we spend our money on treatment and not this?" (Participant C)

In fact, stigma and discrimination towards people who use drugs was identified in the literature as a barrier to accessing health care (Ahern et al., 2007; Ojeda et al., 2006; Reif et al., 2005). In addition to the misinformation surrounding drug use and harm reduction, several participants highlighted the obstacles resulting from the attitudes of community members

who attend the consultations. They held mixed opinions about the fairness of the consultations, with some sharing their concerns about the polarized nature of these gatherings:

I think 9 times out of 10 those public consultations won't go well because you'll get people who are uneducated about substance use and are just more concerned about what a site might mean for that area of a community. You'd get people who are totally against supervised injection sites disputing one (Participant E)

Other participants shared this perspective. For example:

People who usually go to public consultations are usually either very for it or very very against it. It's polarized and it's usually unfair because most of the people attending are probably trying to engage in an argument about how we are allowing people to use illegal drugs. At that point is it really fair (Participant H)

It's much harder and unfair for our local politicians and our local community to pass any judgment on supervised injection sites because they've got no experience of it, they've only got what has been filtered through community leaders that is in many cases not accurate (Participant C)

In contrast, a number of participants described their experiences with the community at the consultations as being very positive. As Participant G puts it:

I must say that the public consultations, as much as I thought they were going to be terrible, were so [emphasis added] positive. I was very surprised. I had this group of lovely women who were like in their 70s and in my head I was thinking oh they're going to be very...but no, the most sweetest things came out of them like "oh these people are part of our community and they live here and this is unsafe for them and it's already happening so if you guys could provide this..." they know it's already happening, they accept the fact that it's happening as opposed to this utopia view that if we open it, it is going to happen (Participant G)

This perspective was shared by Participant A who pointed out the shifting attitudes towards drug use within the general public:

Uh I remember the very first articles coming out and we were just getting roasted uh both by the media and the community at large. I think it has really changed, there's been a lot of great groups that have educated the community and we're seeing this at the consultations. Uh I think we've done a really good job and people have been listening you know, it's taken a while

and there's still a lot of naysayers out there and we're never gonna please everybody but I think it'd be uh not as hard now as it would've been a few years ago (Participant A)

This is aligned with the findings from a recent study by Strike et al. (2014) in that many Canadians still hold mixed opinions towards the implementation of supervised injection services, although the authors did find that there appears to be an increase in support in 2009 from 2003.

In sum, participants identified community and political resistance as potential obstacles to the implementation of SIS in Ottawa, noting that the lack of support from political officials could accentuate the stigma toward this intervention. The idea that SIS condones drug use was identified as a common misconception among community members. The community consultations were recognized as a way of educating the community on the importance of this intervention, as well as a place to disseminate the evidence surrounding the benefits of SIS. Participants also noted that perceptions towards SIS appear to be changing and becoming more positive, perhaps a result of the news coverage of the current opioid crisis.

5.4. Theme #4: Choice of Location for Implementing SIS

The final theme that emerged from the data related to the location of supervised injection services should they be made available to drug users. Participants frequently reiterated the importance of location when asked about potential obstacles, including accessibility to the SIS and police presence around the SIS. In this section, I identify the sub-themes that emerged from the interviews: accessibility and police presence.

5.4.1 Accessibility

Accessibility was identified as the primary obstacle to using a SIS should one be granted in Ottawa. Participants mentioned that accessibility to the site was of utmost importance when predicting whether drug users would use a SIS, noting that the demographics of drug use are substantially different in Ottawa compared to Vancouver (in reference to Insite):

Ottawa isn't like Vancouver, our drug use isn't centralized and that's the thing with harm reduction – it's very personalized. I mean we can take the philosophy but not every strategy will work. So larger cities like Toronto, Montreal you know they're stronger in advocacy, they have more concentrated areas of drug users, more of the population. Good for them that they take a model so similar to Insite. Here, we're such a political little town; we have to almost be doing these things gingerly (Participant D)

I'm a bit biased because I'm beside the shelters so we're the closest community health centre to the shelters so I see a very condensed kind of ... Salvation Army to the Sheps [the Shepherds of Good Hope shelter] to the Mission, that kind of triangle. But no, there are different pockets all over and now with painkillers how it's not necessarily just affecting the homeless community but people in Barrhaven, people in... it's just exploding and the demographics of the use is changing also (Participant G)

I would suggest having it close to the three shelters nearby...Shepherds, Salvation Army, and the Mission because I think that's where the majority of homeless drug users are (Participant F)

Participant E echoed this perspective, adding that people may not be willing to travel far to use the service:

I definitely think that some people may not be as willing to go out of their way to access that service. And you can't just still access it closer to you, with supervised injection services you have to go there to access that service. So I don't know if people would generally want to or can't for whatever reason because they don't have bus fare. I heard that quite often...people couldn't come in to our facilities because they didn't have bus fare (Participant E)

This perspective is aligned with Bardwell et al. (2017), who identify public transportation as a potential barrier to accessing harm reduction services. Perhaps other participants did not

consider the lack of accessibility to public transportation as an obstacle to using a SIS because the majority of homeless shelters are located nearby the ByWard market. Harm reduction services must be easily accessible in order to attract and retain clients.

Some participants raised the idea that Ottawa would need multiple SIS because drug use is so decentralized:

We absolutely need multiple locations. It's because we're not like Vancouver, we're not centralized, we're just decentralized which is good, because ghettoizing one location, putting everyone in one location is not good either. But no, definitely immediately would be downtown. Like the Market area; the market building is a big injection place (Participant G)

We have to stop thinking about how many sites do we need as well... we need to think about access that it's geographically accessible to people and we should really be thinking about well with the size of the drug using community, how many supervised injections should be happening regardless of where they are in order to see a change. So Insite measured a change – out of the people who used it, only 5% did all of their injecting at Insite. So you can see a big benefit with even a small amount of onsite injecting (Participant C)

This suggestion was echoed in the *Report of the Toronto and Ottawa Supervised Consumption Assessment Study (TOSCA)*, which found that Ottawa would benefit from up to three supervised injection sites that would be spread out across the city. In addition, the report also recommended that SIS be integrated into already existing harm reduction services since some drug users are already accessing other resources in the same space and are likely to feel comfortable with, and accepted by, front-line staff. Further, Participant G uses the term “ghettoizing one location” which suggests that the mere presence of PWUD has negative outcomes for the community, perhaps in terms of safety. This language reflects the government rhetoric set out in the *Act*. Finally, in addition to the actual physical location of the

site, Participant G also noted that considering the hours of operation of a potential SIS is very important:

If you look at opiate addiction as what it is; as soon as you wake up in the morning you need to do your hit. So that's like 6-7 in the morning so people will need access to services at that point. 9-5 is not realistic in terms of substance use (Participant G)

In sum, participants noted that PWUD may not be willing to travel far to use a SIS meaning that the location and accessibility of the site is an important factor to consider. Participants mentioned the idea of opening multiple SIS in Ottawa, which would address concerns about accessibility and would also help avoid the ghettoization of one area.

5.4.2 Police presence

It is acknowledged throughout the research literature that the relationship between drug users and the police is often strained, with much of drug users' interactions with police characterized by violence or abuse of power (MacPherson, 2001: 32; see also Burris & Strathdee, 2006). Thus, it is not surprising that increased police presence and monitoring of public spaces has been found to exacerbate risky injection practices among people who use drugs (Cooper et al., 2005). In the interviews, harm reduction workers express their concerns about police presence having the potential to undermine public health interventions. As Cohen and Csete (2006) write, the fear of contracting HIV and HCV is a sufficient reason for the average drug user to access harm reduction programs. However, the authors recognize that this reason "is rarely as powerful as the fear of arrest or incarceration represented by law enforcement officials, even if those officials act within the bounds of professional conduct" (Cohen & Csete, 2006: 102). While acknowledging that accessing harm reduction services is in the best interest of PWUD, participants noted that drug users might be hesitant to use a SIS:

A problem I can definitely see is people won't use it if there are cops around. Just look at the history between addicts and cops, they don't trust them to help them and I don't blame them (Participant H)

It'd have to be who is running the sites, how they're run, when they're open, whether or not there's police by them, cause no one's gonna go to a site if the police are parked half a block away writing down names and taking pictures, so if it's done right and done with the inclusion of people who use drugs then I'm hopeful (Participant A)

I wish I could tell my clients "oh you can trust the police, they're there to help" but I can't do that because there's that long history (Participant G)

Mistrust between PWUD and the police was a common narrative in the interviews, with participants stressing the history of mistreatment in the contacts between the police and drug users. Participants identified the abuse of power when interacting with PWUD as the main reason for drug users' mistrust of the police. Participant D exemplifies this abuse of power:

The problem is that once they move out of our boundaries they can't use anywhere – we had a poor fella OD in Pizza Pizza. And you know they pick up and they've quickly got to find an alley or something – they're well known by the cops so the cops will try to follow them. They'll take their shit from them and break their pipes and all that kind of stuff so people then go in to back alleys and backyards (Participant D)

Finally, Participant C shared that the presence of police nearby existing services can affect access to health care and harm reduction:

It happened just yesterday where there was a cruiser that was parked just outside of the centre and our staff went up to them and said that we're a health care centre and if you're parked here it actually interferes with people being able to access health care and generally speaking they move along when we say that (Participant C)

This concern is supported by DeBeck et al. (2008), who write that police crackdowns have been found to displace drug users away from needle exchange programs and other harm reduction services. These findings highlight the need for a partnership between policing and

public health initiatives like supervised injection services. Furthermore, DeBeck et al. argue that the police should acknowledge their role in shaping the risk-environment for people who use drugs by adopting a harm reduction approach when interacting with this population.

Evaluations of supervised injection services indicate that police support plays an important role in the successful operation of these services (Hedrich, 2004; Wood et al., 2006). Insite in Vancouver benefits from a partnership with the Vancouver Police Department, with police officers actively encouraging those found injecting in public to attend the SIS (DeBeck et al., 2008). Rethinking the relationship between policing and public health is the first step in resolving some of the existing tensions between the police and drug users, as well as ensuring that harm reduction services in Ottawa are accessible to all people who use drugs.

5.5. Summary

These interviews demonstrate the importance of harm reduction programming for the drug using community, as well as the necessity of the implementation of supervised injection services in Ottawa through the perspectives of eight front-line harm reduction workers. All participants shared a similar stance on the importance of harm reduction programming and the ability of these services to help combat the opioid crisis. However, the degree to which the participants believed that SIS would benefit drug users in Ottawa differed somewhat. Overdose was identified as the primary driver of the harm reduction movement and participants recognized supervised injection services as an effective intervention in reducing the prevalence of fatal overdose. Ottawa Public Health (2016) estimates that approximately 40 Ottawa drug users die from illicit drug overdoses each year and, based on statistics from

Insite, researchers have identified SIS as part of the solution to curbing fatal overdose (Andresen & Boyd, 2009; Kerr et al., 2007; Milloy et al., 2008). All of the participants voiced their concerns about how the *Respect for Communities Act* has created obstacles to the implementation of SIS in Ottawa. It can be argued that prohibitionist-based legislation is a reversion to welfare liberalism, with drug treatment and law enforcement being the primary responses to illicit drug use. In addition, participants identified a need for police and public health to work in partnership pointing to the strained relationship between PWUD and the police as a barrier to accessing existing (and future) harm reduction services.

CHAPTER SIX: CONCLUSION

This study explored the obstacles to the implementation of supervised injection services in Ottawa, Ontario. Eight semi-structured interviews with front-line workers of harm reduction programs offering needle exchange services were subject to a qualitative thematic analysis. The principle research question guiding this thesis was: *What are the main obstacles to the implementation of supervised injection services in Ottawa according to front-line workers of harm reduction programs?* This thesis also sought to determine the need and demand for supervised injection services in Ottawa, along with any foreseeable obstacles to the use of the service.

6.1 Contribution to the field of Criminology

This thesis makes a valuable contribution to the field of criminology in several ways. First, although there is substantial Canadian literature on Vancouver's supervised injection service, Insite (Andresen & Boyd, 2009; Andresen & Jozaghi, 2012; Boyd, 2013; British Columbia Centre for Excellence in HIV/AIDS, 2009; Hathaway & Tousaw, 2008; Kerr et al., 2003; Kerr et al., 2007; Marshall et al., 2011; McKnight et al., 2007; Wood et al., 2006), very little research has been conducted on the suitability and viability of a SIS in Ottawa and the barriers to its implementation (Bayoumi et al., 2012; Enns et al., 2015; Jozaghi et al., 2014; Navarro & Leonard, 2004; Shaw et al., 2015). Of the research that has been conducted, most findings revolve around the feasibility of a SIS in Ottawa. Also, these studies were conducted before the current opioid crisis and do not reflect potential obstacles resulting from the *Respect for Communities Act*.

Similarly, research on drug policy and harm reduction in a Canadian context is sparse (Broadhead et al., 2002; Dias, 2003; Riley, 1998), and what has been done is out-dated. This

research fills the gap that was created by the enactment of the *Respect for Communities Act* in 2015 by exploring the impact of this legislation, among other obstacles, on expanding current harm reduction programming to include SIS.

Finally, much of the available literature is quantitative in nature and examines the benefit of Insite in Vancouver. The present study is the first to use qualitative semi-structured interviews to engage with harm reduction workers about their opinions about the obstacles to opening supervised injection services in Ottawa.

6.2 Limitations

This study has several limitations. First and foremost, as Ball et al. (2011) write, policy is “always contested and changing (unstable) – always ‘becoming’” (p. 10-11). There have been significant changes made to the *Respect for Communities Act* during the writing of this thesis. In December 2016, the federal government introduced Bill C-37, an amendment to the *Controlled Drugs and Substances Act*, to “reduce the harms associated with drug and substance use in Canada” (Bill C-37, 2017). In essence, Bill C-37 simplifies the process of applying for an exemption to open a supervised injection service by reducing the application criteria from 26 to 8, aligned with the 5 factors outlined in *Canada v. PHS Community Services Society* (2011). According to the legislative summary presented in the Bill, the amendment was sparked by the significant increase in the number of illicit drug overdoses in British Columbia in 2016 (Bill C-37, 2017). The Coroners Service of British Columbia issued a report on March 17 2017 stating that there was an 80% increase in the total number of deaths stemming from illicit drug use, increasing from 513 deaths in 2015 to 922 deaths in 2016 (Coroners Service of British Columbia, 2017). Montreal was the first city to receive an exemption on February 6 2017, followed by Toronto on June 2 2017, allowing the two cities

to proceed with opening supervised injection services (3 in Montreal and 3 in Toronto). On July 26 2017, Health Canada announced a decision to approve a supervised injection service at the Sandy Hill Community Health Centre in Ottawa. Applications have also been submitted by Vancouver (2), Surrey (2), and Victoria (1) (CBC, 2017).

Due to the rapid changes in drug policy over the last year, I decided to exclude research in the literature review after October 21st 2016 – the date of the first interview. The reasons behind this were two-fold. First, all of the interviews were conducted before the amendment of the *Controlled Drugs and Substances Act*, meaning that the research findings would not reflect the new legislation. Second, this research was conducted to examine the obstacles to the implementation of supervised injection services in Ottawa, including bureaucratic obstacles like the *Respect for Communities Act*. The interviews were conducted at a point in time where the viability of harm reduction programming, particularly supervised injection services, was unknown, and the findings of this thesis shed light on the obstacles to the implementation of SIS in Ottawa including and apart from the *Act*.

Moreover, participants were asked to speak about the benefits of SIS and whether they believe that Ottawa needs one when they do not have direct experience with one. Participants were able to speculate about the importance of supervised injection services based on the success of current harm reduction programs, and appeared to be well-versed in the literature on existing SIS. Similarly, only one of the organizations was in the process of applying for an exemption and so it was the only organization that had direct experience with the *Respect for Communities Act*. Despite this, all participants were able to speculate about the obstacles to implementing supervised injection services in Ottawa.

6.3 Avenues for future research

Moving forward, there are other avenues for research that could be conducted in this area. For instance, the present study could be replicated with a focus on the new legislation, Bill C-37, with a focus on whether there are still obstacles to implementing SIS. Another potential research project could centre on sampling members of the Ottawa drug using community and exploring their willingness to use supervised injection services. This type of research may be more suitable for doctorate students rather than master's students because of the time-constraints on obtaining ethics approval. As one participant said, interventions that target the drug using population should be developed alongside the input and involvement of this group. Lastly, it will be important to evaluate the recently granted SIS once it opens, as well as exploring stigma and whether the implementation of a SIS has changed public attitudes towards drug use and people who use drugs.

6.4 Conclusion

Research findings have been overwhelmingly favourable of the implementation of SIS, with scientific evidence demonstrating the intervention's effectiveness in reducing the transmission of blood-borne infections like HIV and HCV, reducing the prevalence of fatal overdose (there have been no deaths at Insite since its opening in 2003), reducing public injecting, and connecting drug users to primary health care and counselling services (Andresen & Jozaghi, 2012; Boyd, 2013; British Columbia Centre for Excellence in HIV/AIDS, 2009; MacDonald, 2011).

The emergence of Fentanyl and Carfentanil has drastically changed the drug scene over the last year, supporting the need for additional SIS. The number of opiate overdoses across Canada is shocking – Vancouver's officials attributed 374 fatalities to Fentanyl alone from January to October 2016. These deaths are preventable by increasing access to safe

injecting spaces, like supervised injection services, where drug users can be monitored for early signs of overdose. The need for SIS in Ottawa is well-established throughout the literature (Enns et al., 2015; Jozaghi et al., 2014; Sandy Hill Community Health Centre, 2016; Shaw et al., 2015; Small et al., 2009), and this thesis also demonstrates that the demand for this service is growing in Ottawa, and the biggest obstacles appear to be bureaucratic in nature, most stemming from the recently enacted *Respect for Communities Act*. Since the enactment of the *Opium Act* (1908), the “drug problem” has been framed as being homologous to crime and criminality, with prohibitionist discourses maintaining that the only way to reduce the harms stemming from illicit drug use is to impose criminal sanctions for possession and trafficking. Researchers, doctors, and scientists have disputed the *RFCA*, cautioning that it threatens the survival of Canada’s current supervised injection services, as well as the implementation of additional ones (Canadian Drug Policy Coalition, 2015; Zlotorzynska et al., 2013).

In August 2017, President Donald Trump declared the opioid crisis a national emergency in the United States, a designation that offers more resources and power to combat the epidemic (CNN, August 10 2017). Acknowledging the opioid crisis as a public health epidemic that warrants emergency status demonstrates the seriousness of the drug problem worldwide. It is becoming more critical that supervised injection services and other harm reduction measures are thoroughly investigated and are based on evidence rather than on ideology.

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Appendices

Appendix A: Interview Guide

Interview Guide

Part One:

1. Could you tell me about the organization you work for?
2. How long have you worked as a front-line worker for this organization?
3. What is your position in the organization?
4. What are your day-to-day activities as a front-line worker?
5. What is your understanding of the term “harm reduction”?
6. Based on your understanding of harm reduction, in which kind of harm reduction strategies is your organization involved?
7. What are the goals of your organization with regard to harm reduction programming?
8. Do you think these strategies effectively respond to drug users’ needs?
9. What more could be done to support the reduction of harm for drug users in Ottawa?
10. Does your organization promote harm reduction in the community?

Part Two:

1. What are your personal opinions about supervised injection sites?
2. Do you think that supervised injection services would benefit Ottawa?
3. Where in the city of Ottawa do you think would benefit from a supervised injection site?
4. Do you think drug users would use supervised injection sites if they were available?
5. Could you tell me what you know about the *Respect for Communities Act*?
6. In general, how do you feel about the role of the federal and provincial governments in promoting or discouraging harm reduction?
7. Has/will the *Respect for Communities Act* affect how your organization functions?
8. Do you think the *Respect for Communities Act* will affect or has affected the services available to drug users in Ottawa?
9. What are some foreseeable obstacles of implementing a supervised injection site in Ottawa?
10. Based on your own experience, what kind of support or resistance do you think a supervised injection site would receive in Ottawa?

Appendix B: Ethics Approval

File Number: 08-15-32

Date (mm/dd/yyyy): 10/15/2015



Université d'Ottawa **University of Ottawa**
 Bureau d'éthique et d'intégrité de la recherche Office of Research Ethics and Integrity

Ethics Approval Notice

Social Sciences and Humanities REB

Principal Investigator / Supervisor / Co-investigator(s) / Student(s)

<u>First Name</u>	<u>Last Name</u>	<u>Affiliation</u>	<u>Role</u>
Bastien	Quirion	Social Sciences / Criminology	Supervisor
Laura	Simpson	Social Sciences / Criminology	Student Researcher

File Number: 08-15-32

Type of Project: Master's Thesis

Title: The Needs and Challenges of a Supervised Injection Site in Ottawa, Ontario

Approval Date (mm/dd/yyyy)	Expiry Date (mm/dd/yyyy)	Approval Type
10/15/2015	10/14/2016	Ia

(Ia: Approval, Ib: Approval for initial stage only)

Special Conditions / Comments:

N/A

File Number: 08-15-32

Date (mm/dd/yyyy): 10/03/2016



Université d'Ottawa **University of Ottawa**
 Bureau d'éthique et d'intégrité de la recherche Office of Research Ethics and Integrity

Ethics Approval Notice

Social Sciences and Humanities REB

Principal Investigator / Supervisor / Co-investigator(s) / Student(s)

<u>First Name</u>	<u>Last Name</u>	<u>Affiliation</u>	<u>Role</u>
Bastien	Quirion	Social Sciences / Criminology	Supervisor
Holly	Johnson	Social Sciences / Criminology	Co-Supervisor
Laura	Simpson	Social Sciences / Criminology	Student Researcher

File Number: 08-15-32

Type of Project: Master's Thesis

Title: The Needs and Challenges of a Supervised Injection Site in Ottawa, Ontario

Renewal Date (mm/dd/yyyy)	Expiry Date (mm/dd/yyyy)	Approval Type
10/15/2016	10/14/2017	Approved

Special Conditions / Comments:

N/A

Appendix C: Recruitment Letter (Organization)



Université d'Ottawa | University of Ottawa

Département de criminologie | Department of Criminology

120 Université, FSS14002 / 120 University, FSS14002, Ottawa, ON K1N 6N5

Hello,

My name is Laura Simpson and I am currently enrolled as a Master of Criminology student at the University of Ottawa. As part of the requirements for this degree, I am writing a thesis that aims to examine the obstacles that harm reduction advocates face when assessing the implementation of additional harm reduction services in Ottawa, and was hoping that your organization could be involved by helping me to recruit participants among your employees.

Throughout my first year in the master's program I looked at the existing literature on harm reduction and drug policy, and noticed that there are numerous harm reduction organizations in Ottawa that are fighting for an Ottawa-based supervised injection site. As I am sure you are aware, Ottawa is a city that would greatly benefit from additional harm reduction services, and I am passionate about researching the effects of anti-harm reduction legislation on these efforts. In order to do so, I am interested in conducting semi-structured interviews with 8-12 front-line workers of different organizations that describe themselves as harm reduction agencies, specifically those that offer needle exchange services. This study involves one 60 minute interview that will take place in a mutually convenient, safe location. Interviews will be audio-recorded. There are no restrictions on the gender or age of the front-line workers being sampled, only that they must have been an employee (excluding volunteers of the organization) for a minimum of six months prior to the interview.

I found that there is an abundance of literature surrounding the benefits of supervised injection sites, as well as research evaluating the viability of implementing one here in Ottawa. However, none of the existing research has examined what additional obstacles Ottawa will face now that Bill C-2 has been passed. I hope that my research will contribute to the harm reduction discourse by providing support for both the continued operation of Canada's only supervised injection site, Insite, and the implementation of additional facilities.

Do you think that this is a project that would be of interest to your organization? I am in the process of applying for my ethics approval and aim to begin my data collection at the end of this year. Should you agree to participate, I will need a letter of support from your organization for my ethics application.

I look forward to hearing from you and meeting you.

Laura Simpson
MA Candidate
University of Ottawa

Appendix D: Recruitment Letter (Participants)



Université d'Ottawa | University of Ottawa

Département de criminologie | Department of Criminology

120 Université, FSS14002 / 120 University, FSS14002, Ottawa, ON K1N 6N5

Hello,

My name is Laura Simpson and I am currently enrolled as a Master of Criminology student at the University of Ottawa. As part of the requirements for this degree, I am writing a thesis that aims to examine the obstacles that harm reduction advocates face when assessing the implementation of additional harm reduction services in Ottawa. This study is not associated with the organization for which you work, and there is no obligation to participate.

Throughout my first year in the master's program I looked at the existing literature on harm reduction and drug policy, and noticed that there are numerous harm reduction organizations in Ottawa that are fighting for an Ottawa-based supervised injection site. As I am sure you are aware, Ottawa is a city that would greatly benefit from additional harm reduction services, and I am passionate about researching the effects of anti-harm reduction legislation on these efforts. In order to do so, I am interested in conducting semi-structured interviews with 8-12 front-line workers of different organizations that describe themselves as harm reduction agencies, specifically those that offer needle exchange services. This study involves one 60-minute interview that will take place in a mutually convenient, safe location. Interviews will be audio-recorded. There are no restrictions on the gender or age of the front-line workers being sampled, only that they must have been an employee (excluding volunteers of the organization) for a minimum of six months prior to the interview. For those who wish to participate and meet the criteria, I will select participants on a first come first served basis.

I found that there is an abundance of literature surrounding the benefits of supervised injection sites, as well as research evaluating the viability of implementing one here in Ottawa. However, none of the existing research has examined what additional obstacles Ottawa will face now that Bill C-2 has been passed. I hope that my research will contribute to the harm reduction discourse by providing support for both the continued operation of Canada's only supervised injection site, Insite, and the implementation of additional facilities.

Thank you

Appendix E: Consent Form



Université d'Ottawa | University of Ottawa

Département de criminologie | Department of Criminology

120-Université, FSS14002 / 120-University, FSS14002, Ottawa, ON K1N 6N5

Consent Form

The Needs and Challenges of a Supervised Injection Site in Ottawa, Ontario

Researcher:

Laura L. Simpson

Department of Criminology

120-University Private

University of Ottawa

Ottawa, Ontario

K1N 6N5

Dr. Bastien Quirion

Associate Professor

Department of Criminology

120-University Private

University of Ottawa

Ottawa, Ontario

K1N 6N5

Dr. Holly Johnson

Associate Professor

Department of Criminology

120-University Private

University of Ottawa

Ottawa, Ontario

K1N 6N5

Invitation to participate: I have been invited to participate in the above-mentioned research study conducted by Laura Simpson (principal investigator) under the supervision of Dr. Bastien Quirion, of the Department of Criminology, University of Ottawa. This study is a master's research thesis and is part of the requirements for completing the Master of Arts in Criminology degree. As the principal investigator, Laura Simpson will be responsible for data collection, data transcription, and data analysis. As the supervisor, Dr. Bastien Quirion will be responsible for overseeing the research project and helping with the analysis of data.

Purpose of the study: The purpose of the study is to shed light on what obstacles are faced when assessing the viability of an Ottawa-based supervised injection site.

Participation: My participation will consist of a one-hour semi-structured interview during which I will be asked to answer a series of questions related to both my experiences as a front-line worker and my opinions on the obstacles to harm reduction efforts in Ottawa. The interview will be audio recorded for accuracy, but I understand that all material will be kept confidential and will be safely conserved by the use of password protection.

Purpose of the Study: The purpose of the study is to shed light on what obstacles are faced when assessing the viability of an Ottawa-based supervised injection site.

Participation: My participation will consist of a one hour semi-structured interview during which I will be asked to answer a series of questions related to both my experiences as a front-line worker and my opinions on the obstacles to harm reduction efforts in Ottawa. The interview will be audio recorded for accuracy, but I understand that all material will be kept confidential and will be safely conserved by the use of password protection.

Risks: My participation in this study will entail that I discuss my experiences as a front-line worker of a harm reduction agency, and this may cause me some emotional discomfort. I have received assurance from the researcher that every effort will be made to minimize these risks, and have been given the following information for counselling services should I need them:

Ottawa Distress Centre: (613) 238-3311
Mental Health Crisis Line: (613) 722-6914

Benefits: My participation in this study will offer me the chance to discuss the issue of harm reduction in Ottawa. By engaging in a conversation about the obstacles Ottawa faces in regard to implementing a supervised injection site, I will help increase the knowledge about this topic. My participation in this study will help contribute to the existing literature on the obstacles faced by harm reduction agencies. My participation will also help address the problems caused by certain policies that make accessing harm reduction services more difficult.

Confidentiality and anonymity: I have received assurance from the researcher that the information I will share will remain strictly confidential. I understand that the contents will be used only for the purpose of this research study, and that my confidentiality will be protected. I will be provided with a pseudonym for any material that may be quoted in the research study. No identifying factors of myself will be disclosed.

Conservation of data: The tape recordings of the interviews and the transcripts will be kept in a secure manner. The research project is hoped to be completed by August 2016. All data will be stored in the supervisor's locked office and on a password protected USB key for 5 years from completion of the thesis (August 2021) and will then be safely destroyed.

Voluntary Participation: This study is an independent research project and is not associated with the organization. I am under no obligation to participate and, if I choose to participate, I can withdraw from the study at any time and/or refuse to answer any questions, without suffering any negative consequences. If I choose to withdraw, all data gathered until the time of withdrawal will be destroyed.

Acceptance: I, _____, agree to participate in the above research study conducted by Laura Simpson of the Department of Criminology, which research is under Professor Bastien Quirion.

If I have any questions about the study, I may contact the researcher or her supervisor.

If I have any questions regarding the ethical conduct of this study, I may contact the Protocol Officer for Ethics in Research, University of Ottawa, Tabaret Hall, 550 Cumberland Street, Room 154, Ottawa, ON K1N 6N5
Tel.: (613) 562-5387
Email: ethics@uottawa.ca

There are two copies of the consent form, one of which is mine to keep.

Participant's signature: *(Signature)* Date: *(Date)*

Researcher's signature: *(Signature)* Date: *(Date)*

Appendix F: Coding Scheme

Coding Scheme

Theme #1: Obstacles to the implementation of SIS

- a) Political Resistance
 - i. Legislation (*RFCA*)
 - ii. Lack of local political support
 - iii. Public officials publically opposing SIS
- b) Funding
 - i. Federal/Provincial/Municipal
 - ii. Cost-effectiveness
 - iii. Lack of funding
- c) Public Perceptions
 - i. Community resistance/opposition
 - ii. Not-In-My-Backyard
 - iii. Attitudes towards drug use
 - iv. Seen as promoting continued and new drug use

Theme #2: Obstacles to using a SIS

- a) Willingness to use
 - i. Model of SIS (stand-alone versus integrated model)
 - ii. Already have a place to inject
- b) Police Presence
 - i. Arrest/incarceration (waiting for drug users to be far enough away from the site and then arresting for drug possession)
 - ii. Searching users – warrants on known-users
 - iii. Intimidation
 - iv. Relationship with client and site
 - v. Protocol
 - vi. Education and support (educated on benefits of SIS)
- c) Accessibility
 - i. Location (close to shelters?)
 - ii. Decentralized drug use
 - iii. Hours of operation
 - iv. Transportation
 - v. Proximity to police stations

Appendix G: *Respect for Communities Act*

Respect for Communities Act

S.C. 2015, c. 22

Assented to 2015-06-18

An Act to amend the Controlled Drugs and Substances Act

SUMMARY

This enactment amends the [*Controlled Drugs and Substances Act*](#) to, among other things,

- (a) create a separate exemption regime for activities involving the use of a controlled substance or precursor that is obtained in a manner not authorized under this Act;
- (b) specify the purposes for which an exemption may be granted for those activities; and
- (c) set out the information that must be submitted to the Minister of Health before the Minister may consider an application for an exemption in relation to a supervised consumption site.

Preamble

Whereas Parliament recognizes that the objectives of the [*Controlled Drugs and Substances Act*](#) (“the Act”) are the protection of public health and the protection of public safety;

Whereas the Act and its regulations have a dual role of prohibiting certain activities associated with harmful substances and allowing access to those substances for legitimate medical, scientific and industrial purposes;

Whereas the diversion of controlled substances and precursors, as those terms are defined in the Act, which are frequently used in the production of illicit drugs, is a worldwide problem with significant impacts on Canada;

Whereas the money that is used to purchase controlled substances that are obtained from illicit sources often originates from criminal activity such as theft, and that money, in turn, often funds organized crime in our communities;

Whereas the substances that are subject to the Act may pose serious risks to the health of individuals and those risks are exacerbated when those substances are unregulated, untested and obtained from illicit sources;

Whereas the negative consequences associated with the use of illicit substances can have significant impacts on vulnerable subsets of the Canadian population;

And whereas an exemption from the application of the Act and its regulations for certain activities in relation to controlled substances that are obtained from illicit sources should only be granted in exceptional circumstances and after the applicant has addressed rigorous criteria;

Now, therefore, Her Majesty, by and with the advice and consent of the Senate and House of Commons of Canada, enacts as follows:

SHORT TITLE

Marginal note:Short title

1. This Act may be cited as the *Respect for Communities Act*.

1996, c. 19 *CONTROLLED DRUGS AND SUBSTANCES ACT*

2. Subsection 30(2) of the *Controlled Drugs and Substances Act* is replaced by the following:

- Marginal note:Certificate of designation

(2) An inspector shall be provided with a prescribed certificate of designation and, on entering any place under subsection 31(1) or a supervised consumption site under subsection 31(1.1) or (1.2), shall, on request, produce the certificate to the person in charge of the place.

• 3. (1) Section 31 of the Act is amended by adding the following after subsection (1):

- Marginal note:Powers of inspectors — inspection of supervised consumption sites

(1.1) In order to confirm any information in relation to an application submitted to the Minister for an exemption for a medical purpose under subsection 56.1(2) to allow certain activities to take place at a supervised consumption site, as defined in subsection 56.1(1), an inspector may, at any reasonable time, enter the site and may for that purpose exercise any of the powers set out in paragraphs (1)(a) to (i).

- Marginal note:Powers of inspectors — inspection of supervised consumption sites

(1.2) In order to verify compliance or to prevent non-compliance with the provisions of this Act or the regulations, or with any terms and conditions specified by the Minister in an exemption granted under subsection 56.1(2), an inspector may, at any reasonable time, enter any supervised consumption site, as defined in subsection 56.1(1), and may for those purposes exercise any of the powers set out in paragraphs (1)(a) to (i).

• (2) Subsection 31(2) of the English version of the Act is replaced by the following:

- Marginal note:Warrant required to enter dwelling-place

(2) In the case of a dwelling-place, an inspector may enter it only with the consent of an occupant or under the authority of a warrant issued under subsection (3).

- **(3) Paragraph 31(3)(a) of the Act is replaced by the following:**

- o (a) a place referred to in subsection (1) or (1.2) is a dwelling-place but otherwise meets the conditions for entry described in that subsection,

- **(4) Subsection 31(5) of the English version of the Act is replaced by the following:**

- o Marginal note:Assistance to inspector

(5) The owner or other person in charge of a place entered by an inspector under subsection (1), (1.1) or (1.2) and every person found there shall give the inspector all reasonable assistance in that person's power and provide the inspector with any information that the inspector may reasonably require.

- **(5) Subsection 31(8) of the Act is replaced by the following:**

- o Marginal note:Return by inspector

(8) If an inspector determines that to ensure compliance with the regulations or with any terms and conditions specified by the Minister in an exemption granted under subsection 56.1(2) it is no longer necessary to detain a controlled substance or a precursor seized by the inspector under paragraph (1)(i), the inspector shall notify in writing the owner or other person in charge of the place where the seizure occurred of that determination and, on being issued a receipt for it, shall return the controlled substance or precursor to that person.

- **4. (1) Paragraph 55(1)(n) of the Act is replaced by the following:**

- o (n) respecting the qualifications for inspectors and their powers and duties in relation to the enforcement of, and compliance with, the regulations or any terms and conditions specified by the Minister in an exemption granted under subsection 56.1(2);

- **(2) Section 55 of the Act is amended by adding the following after subsection (1):**

- o Marginal note:Exception related to paragraph (1)(z)

(1.1) A regulation made under paragraph (1)(z) shall not exempt from the application of all or any of the provisions of this Act or the regulations

- (a) any person or class of persons in relation to a controlled substance or precursor that is obtained in a manner not authorized under this Act; or

- (b) any controlled substance or precursor or any class of either of them that is obtained in a manner not authorized under this Act.

- o Marginal note:Regulations

(1.2) The Governor in Council may make regulations for carrying out the purposes of section 56.1, including

- (a) defining terms for the purposes of that section;
- (b) amending the definitions that are set out in subsection 56.1(1);
- (c) respecting any information to be submitted to the Minister under paragraph 56.1(3)(z.1) and the manner in which it is to be submitted;
- (d) respecting the circumstances in which an exemption may be granted for a medical or law enforcement purpose;
- (e) respecting requirements in relation to an application for an exemption made under subsection 56.1(2), including the information to be submitted with the application; and
- (f) respecting terms and conditions in relation to an exemption granted under subsection 56.1(2).

5. Section 56 of the Act is replaced by the following:

Marginal note:Exemption by Minister

- **56.** (1) 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.
- Marginal note:Exception

(2) The Minister is not authorized under subsection (1) to exempt from the application of all or any of the provisions of this Act or the regulations

- o (a) any person or class of persons in relation to a controlled substance or precursor that is obtained in a manner not authorized under this Act; or
- o (b) any controlled substance or precursor or any class of either of them that is obtained in a manner not authorized under this Act.

Marginal note:Interpretation

- **56.1** (1) The following definitions apply in this section.

“alternate person in charge”
« *personne responsable suppléante* »

“alternate person in charge” means any person designated by the applicant who is responsible, when the responsible person in charge is absent from the supervised consumption site, for ensuring that every person or class of persons who is exempted for a medical purpose under subsection (2) from the application of all or any of the provisions of this Act or the regulations complies with any terms and conditions specified by the Minister in the exemption when they are at the site.

“designated criminal offence”
« *infraction désignée en matière criminelle* »

“designated criminal offence” means

- o (a) an offence involving the financing of terrorism against any of sections 83.02 to 83.04 of the [Criminal Code](#);
- o (b) an offence involving fraud against any of sections 380 to 382 of the [Criminal Code](#);
- o (c) the offence of laundering proceeds of crime against section 462.31 of the [Criminal Code](#);
- o (d) an offence involving a criminal organization against any of sections 467.11 to 467.13 of the [Criminal Code](#); or
- o (e) a conspiracy or an attempt to commit, being an accessory after the fact in relation to, or any counselling in relation to, an offence referred to in any of paragraphs (a) to (d).

“designated drug offence”
« *infraction désignée en matière de drogue* »

“designated drug offence” means

- o (a) an offence against section 39, 44.2, 44.3, 48, 50.2 or 50.3 of the [Food and Drugs Act](#), as those provisions read immediately before May 14, 1997;
- o (b) an offence against section 4, 5, 6, 19.1 or 19.2 of the [Narcotic Control Act](#), as those provisions read immediately before May 14, 1997;
- o (c) an offence under Part I of this Act, except subsection 4(1); or
- o (d) a conspiracy or an attempt to commit, being an accessory after the fact in relation to, or any counselling in relation to, an offence referred to in any of paragraphs (a) to (c).

“illicit substance”
« *substance illicite* »

“illicit substance” means a controlled substance that is obtained in a manner not authorized under this Act.

“key staff members”
« *principaux membres du personnel* »

“key staff members” means the persons designated by the applicant who are responsible for the direct supervision, at the supervised consumption site, of the consumption of an illicit substance by every person or class of persons who is exempted for a medical purpose under subsection (2) from the application of all or any of the provisions of this Act or the regulations.

“local government”
« *administration locale* »

“local government” includes

- o (a) a council of an incorporated city, metropolitan area, town, village or other municipality;
- o (b) an authority responsible for delivering municipal services to an unincorporated city, metropolitan area, town, village or other municipality;
- o (c) a council of the band, as that term is defined in subsection 2(1) of the [Indian Act](#); and
- o (d) a government of a band that is a party to a comprehensive self-government agreement that is given effect by an Act of Parliament.

“municipality”

« *municipalité* »

“municipality” includes

- o (a) the geographical area of an incorporated or unincorporated city, metropolitan area, town, village or other municipality;
- o (b) a reserve and designated lands, as those terms are defined in subsection 2(1) of the [Indian Act](#); and
- o (c) lands that are subject to a comprehensive self-government agreement that is given effect by an Act of Parliament.

“responsible person in charge”

« *personne responsable* »

“responsible person in charge” means the person, designated by the applicant, who is responsible, when the person is at the supervised consumption site, for ensuring that every person or class of persons who is exempted for a medical purpose under subsection (2) from the application of all or any of the provisions of this Act or the regulations complies with the terms and conditions specified by the Minister in the exemption when they are at the site.

“supervised consumption site”

« *site de consommation supervisée* »

“supervised consumption site” means a location specified in the terms and conditions of an exemption, granted by the Minister under subsection (2) for a medical purpose, that allows any person or class of persons described in the exemption to engage in certain activities in relation to an illicit substance within a supervised and controlled environment.

- Marginal note: Exemption by Minister

(2) 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, other than this section, if, in the opinion of the Minister, the exemption is necessary for a medical, law enforcement or prescribed purpose

- o (a) any person or class of persons in relation to a controlled substance or precursor that is obtained in a manner not authorized under this Act; or
 - o (b) any controlled substance or precursor or any class of either of them that is obtained in a manner not authorized under this Act.
 - Marginal note: Information to accompany application
- (3) The Minister may consider an application for an exemption for a medical purpose under subsection (2) that would allow certain activities to take place at a supervised consumption site only after the following have been submitted:
- o (a) scientific evidence demonstrating that there is a medical benefit to individual or public health associated with access to activities undertaken at supervised consumption sites;
 - o (b) a letter from the provincial minister who is responsible for health in the province in which the site would be located that
 - (i) outlines his or her opinion on the proposed activities at the site,
 - (ii) describes how those activities are integrated within the provincial health care system, and
 - (iii) provides information about access to drug treatment services, if any, that are available in the province for persons who would use the site;
 - o (c) a letter from the local government of the municipality in which the site would be located that outlines its opinion on the proposed activities at the site, including any concerns with respect to public health or safety;
 - o (d) a description by the applicant of the measures that have been taken or will be taken to address any relevant concerns outlined in the letter referred to in paragraph (c);
 - o (e) a letter from the head of the police force that is responsible for providing policing services to the municipality in which the site would be located that outlines his or her opinion on the proposed activities at the site, including any concerns with respect to public safety and security;
 - o (f) a description by the applicant of the proposed measures, if any, to address any relevant concerns outlined in the letter referred to in paragraph (e);
 - o (g) a letter from the lead health professional, in relation to public health, of the government of the province in which the site would be located that outlines their opinion on the proposed activities at the site;
 - o (h) a letter from the provincial minister responsible for public safety in the province in which the site would be located that outlines his or her opinion on the proposed activities at the site;

- o (i) a description of the potential impacts of the proposed activities at the site on public safety, including the following:
 - (i) information, if any, on crime and public nuisance in the vicinity of the site and information on crime and public nuisance in the municipalities in which supervised consumption sites are located,
 - (ii) information, if any, on the public consumption of illicit substances in the vicinity of the site and information on the public consumption of illicit substances in the municipalities in which supervised consumption sites are located, and
 - (iii) information, if any, on the presence of inappropriately discarded drug-related litter in the vicinity of the site and information on the presence of inappropriately discarded drug-related litter in the municipalities in which supervised consumption sites are located;
- o (j) law enforcement research or statistics, if any, in relation to the information required under subparagraphs (i)(i) to (iii);
- o (k) relevant information, including trends, if any, on the number of persons who consume illicit substances in the vicinity of the site and in the municipality in which the site would be located;
- o (l) relevant information, including trends, if any, on the number of persons with infectious diseases that may be in relation to the consumption of illicit substances in the vicinity of the site and in the municipality in which the site would be located;
- o (m) relevant information, including trends, if any, on the number of deaths, if any, due to overdose — in relation to activities that would take place at the site — that have occurred in the vicinity of the site and in the municipality in which the site would be located;
- o (n) official reports, if any, relevant to the establishment of a supervised consumption site, including any coroner's reports;
- o (o) a report of the consultations held with the professional licensing authorities for physicians and for nurses for the province in which the site would be located that contains each authority's opinion on the proposed activities at the site;
- o (p) a report of the consultations held with a broad range of community groups from the municipality in which the site would be located that includes
 - (i) a summary of the opinions of those groups on the proposed activities at the site,
 - (ii) copies of all written submissions received, and

- (iii) a description of the steps that will be taken to address any relevant concerns that were raised during the consultations;
- o (q) a financing plan that demonstrates the feasibility and sustainability of operating the site;
- o (r) a description of the drug treatment services available at the site, if any, for persons who would use the site and the information that would be made available to those persons in relation to drug treatment services available elsewhere;
- o (s) relevant information, including trends, on loitering in a public place that may be related to certain activities involving illicit substances, on trafficking of controlled substances and on minor offence rates in the vicinity of the site, if any;
- o (t) information on any public health emergency in the vicinity of the site or in the municipality in which the site would be located that may be in relation to activities involving illicit substances as declared by a competent authority with respect to public health, if any;
- o (u) a description of the measures that will be taken to minimize the diversion of controlled substances or precursors and the risks to the health and the safety and security of persons at the site, or in the vicinity of the site, including staff members, which measures must include the establishment of procedures
 - (i) to dispose of controlled substances, precursors, and any thing that facilitates their consumption, including how to transfer them to a police officer,
 - (ii) to control access to the site, and
 - (iii) to prevent the loss or theft of controlled substances and precursors;
- o (v) a description of record keeping procedures for the disposal, loss, theft and transfer of controlled substances and precursors — and any thing that facilitates their consumption — left at the site;
- o (w) the name, title and resumé, including relevant education and training, of the proposed responsible person in charge, of each of their proposed alternate responsible persons, and of each of the other proposed key staff members;
- o (x) a document issued by a Canadian police force in relation to each person referred to in paragraph (w), stating whether, in the 10 years before the day on which the application is made, in respect of a designated drug offence or a designated criminal offence, the person was
 - (i) convicted as an adult,

- (ii) convicted as a young person in ordinary court, as those terms were defined in subsection 2(1) of the *Young Offenders Act*, chapter Y-1 of the Revised Statutes of Canada, 1985, immediately before that Act was repealed, or
 - (iii) a young person who received an adult sentence, as those terms are defined in subsection 2(1) of the *Youth Criminal Justice Act*;
 - o (y) if any of the persons referred to in paragraph (w) has ordinarily resided in a country other than Canada in the 10 years before the day on which the application is made, a document issued by a police force of that country stating whether in that period that person
 - (i) was convicted as an adult for an offence committed in that country that, if committed in Canada, would have constituted a designated drug offence or a designated criminal offence, or
 - (ii) received a sentence — for an offence they committed in that country when they were at least 14 years old but less than 18 years old that, if committed in Canada, would have constituted a designated drug offence or a designated criminal offence — that was longer than the maximum youth sentence that could have been imposed under the *Youth Criminal Justice Act* for such an offence;
 - o (z) any other information that the Minister considers relevant to the consideration of the application; and
 - o (z.1) any prescribed information that is submitted in the prescribed manner.

- Marginal note:Information to accompany subsequent application

(4) The Minister may consider an application for an exemption for a medical purpose under subsection (2) that would allow certain activities to continue to take place at an existing supervised consumption site only after, in addition to the information referred to in paragraphs (3)(a) to (z.1), the following have been submitted:

- o (a) evidence, if any, of any variation in crime rates in the vicinity of the site during the period beginning on the day on which the first exemption was granted under subsection (2) in relation to the site and ending on the day on which the application is submitted; and
- o (b) evidence, if any, of any impacts of the activities at the site on individual or public health during that period.

- Marginal note:Principles

(5) The Minister may only grant an exemption for a medical purpose under subsection (2) to allow certain activities to take place at a supervised consumption site in exceptional circumstances and after having considered the following principles:

- o (a) illicit substances may have serious health effects;
- o (b) adulterated controlled substances may pose health risks;
- o (c) the risks of overdose are inherent to the use of certain illicit substances;
- o (d) strict controls are required, given the inherent health risks associated with controlled substances that may alter mental processes;
- o (e) organized crime profits from the use of illicit substances; and
- o (f) criminal activity often results from the use of illicit substances.

- Marginal note:Notice

(6) The Minister may give notice of any application, in the form and manner determined by the Minister, for an exemption for a medical purpose under subsection (2) to allow certain activities to take place at a supervised consumption site. Members of the public have 90 days after the day on which the notice is given to provide the Minister with comments.

COMING INTO FORCE

Marginal note:Order in council

6. The provisions of this Act come into force on a day or days to be fixed by order of the Governor in Council.