‘No easy fix’: The Supervised Injection Site Debate in Canada

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Abstract

Supervised injection sites (SISs) have become subject to much political and social controversy in Canada since the late 1990s. Since the implementation of North America's first SIS, *Insite*, in 2003 in Vancouver, the controversy has reached new levels. Despite the increasing evidence base available regarding the effectiveness of SISs as a harm reduction strategy trans-nationally, the implementation of this intervention in Canada prevails within public and parliamentary debates. Guided by the theoretical contributions of Joel Best (2008) on claims-making and the construction of social problems, this thesis explores the SIS debate in Canada and the assertions advanced with respect to the implementation of SISs. Building on the available literature, the author identifies numerous types of claims advanced by proponents and opponents of SISs through a qualitative content analysis of 164 newspaper documents from *The Vancouver Sun*, *The Ottawa Sun* and *The Ottawa Citizen*. It was determined that claimsmakers often present the intervention as a solution to the 'drug problem' or part in parcel of the problem. Opponents in particular attempt to construct the intervention as harmful for the community in that the implementation of a SIS would exacerbate various aspects of the 'drug problem' including drug abuse and crime. Very rarely, however, claimsmakers suggest the SIS is merely one strategy to addressing public health issues related to injection drug use and that there is 'no easy fix' to this 'drug problem'. Further, the author applies the findings from this analysis to make sense of the Canadian federal government's proposed policy response, *The Respect for Communities Act*, towards the establishment of SISs.

Acronym List

AIDS Acquired Immunodeficiency Syndrome

B.C. British Columbia

CCAP Carnegie Community Action Project

CDS *Canada's Drug Strategy*

CDSA *Controlled Drugs and Substances Act*

CEO Chief Executive Officer

CIHR Canadian Institutes of Health Research

CMA Canadian Medical Association

COPE Committee of Progressive Electors

CPA Canadian Police Association

CSCS Campaign for Safer Consumption Sites

DFAF Drug Free America Foundation

DPNC Drug Prevention Network of Canada

DTES Downtown Eastside

EAC Expert Advisory Committee

FGTA From Grief to Action

HCV Hepatitis C

HIV Human Immunodeficiency Virus

IFCS *Insite for Community Safety*

INCB International Narcotics Control Board

IV Intravenous

MMT Methadone Maintenance Treatment

MP Member of Parliament

MSIC Medically Supervised Injection Centre

NADS *National Anti-Drug Strategy*

NCA *Narcotic Control Act*

NCR *Narcotic Control Regulations*

NDP New Democratic Party

NEP Needle Exchange Program

NGO Non-Governmental Organization

NIMBY "Not-in-my-backyard"

NPA Non Partisan Association

NPP Non Partisan Party

NSW New South Wales

NSWJSCSIR New South Wales Joint Select Committee into Safe Injecting Rooms

OC *Ottawa Citizen*

ODA *Opium and Drug Act*

ONDA *Opium and Narcotic Drug Act*

ONDB Opium and Narcotic Drugs Branch

OS *Ottawa Sun*

PDF Portable Document Format

PHPC Public Health Physicians of Canada

PHS Portland Hotel Society

PM Prime Minister

PWSD People Who Sell Drugs

PWUD People Who Use Injection Drugs

RCMP Royal Canadian Mounted Police

RNABC Registered Nursing Association of British Columbia

SCC Supreme Court of Canada

SHCHC Sandy Hill Community Health Centre

SIR Safe Injection Room

SIS Supervised Injection Site

SIF Supervised Injection Facility or Safe Injection Facility

SRO Single-Room Occupancy

TOSCA Toronto and Ottawa Supervised Consumption Assessment

UBC University of British Columbia

UN United Nations

U.S.A. United States of America

VANDU Vancouver Area Network of Drug Users

VCH Vancouver Coastal Health

VDPEC Victoria Drug Policy Expert Committee

VPD Vancouver Police Department

VRHB Vancouver Richmond Health Board

VS *Vancouver Sun*

WHO World Health Organization

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INTRODUCTION

In the last two decades, there has been a substantial increase in street drug use related harms, particularly morbidity related to drug use such as Human Immunodeficiency Virus (HIV), Hepatitis C (HCV) transmission and mortality, including overdose deaths (Cruz et al., 2007, p.55). Supervised injection sites[1] (SISs) were introduced as a harm reduction strategy to minimize the risks associated with injection drug use, to reach out to PWUD (people who use injection drugs[2]) with health and social services and to reduce the negative impacts of an open drug scene on the community (Elliott et al., 2002, p.53). SISs are medically supervised facilities that offer PWUD a sanitary space to consume pre-obtained illicit psychoactive substances[3] (Stover, 2000; Marshall, Milloy & Wood et al., 2011). This intervention has become subject to much political and social controversy in Canada, particularly in the city of Vancouver, British Columbia, since the late 1990s, prior to the implementation of North America's first SIS, *Insite*, in 2003 (Kerr, Montaner & Wood, 2008; Des Jarlais, Arasteh & Hagan, 2008; Milloy & Wood, 2009) and more recently in Ottawa, the nation's capital. Despite the increasing evidence base[4] available regarding the effectiveness of SISs as a harm reduction strategy trans-nationally (Hedrich, Kerr, & Dubois-Arber, 2010), the implementation of SISs in Canada still prevails in public and parliamentary debates as an object of controversy.

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[1] Supervised injection sites are also commonly referred to as safe injection sites, supervised injection facilities (SIFs), safe injection facilities, or safer consumption sites (SCSs). In Australia they are referred to as medically supervised injection centres (MSIC) and in Europe, as drug consumption rooms (DCRs) or drug consumption facilities (DCF).

[2] The term PWUD allows for a value neutral way of representing individuals who consume drugs. This term is borrowed from the Urban Health Research Initiative (2013).

[3] Psychoactive substances or drugs refer to "chemicals that alter mental functioning for the effects on mood and, or, with an altered state of subjective reality" (Health Officers Council of British Columbia, 2005, p.6). This includes alcohol, tobacco, illegal drugs and some prescription drugs. However, for the purpose of this research project, the term psychoactive substances will be used to refer to injectable illicit drugs under the *Controlled Drugs and Substances Act* (CDSA), such as heroin and cocaine.

[4] The term evidence base refers to a body of evidence from scientific research; effective public policies need to be based on scientific evidence (Sherman, Farrington, Welsh & MacKenzie, 2002).

The debates regarding the future of SISs in Canada take place within the context of dominant prohibitionist drug policies where abstinence is the preferred objective. In contrast, strategies such as the SIS constitute a harm reduction intervention that does not require abstinence from PWUD and is underscored by a specific set of principles, including pragmatism and humanistic values[5] (Riley, 1998). Harm reduction strategies are characterized as pragmatic in that the use of psychoactive substances, to some extent, is understood as an inevitable aspect of society (Riley, 1998) or "a common feature of human experience" (Hunt, 2010, p.3). From this perspective, the choice of individuals to use psychoactive substances is not subject to moral judgment either in support or condemnation of the behaviour, but rather, the choice is accepted as fact so as to respect the rights of PWUD (Hunt, 2010). Such principles oftentimes conflict with certain members of the public and "institutional spokespeople" which are, in part, the cause of disagreements in relation to the establishment of SISs (Carter & Chu, 2013). The development and preservation of *Insite* reflects this supposition in light of the Canadian federal government's demonstrable opposition to the intervention through a series of judicial proceedings[6] (Small, 2007; Kerr, Montaner & Wood, 2008; DeBeck & Kerr, 2010; Hyshka, Bubela & Wild, 2013).

There are currently a variety of harm reduction services across Canada, ranging from education about safer drug use to the distribution of supplies for drug use, to safer consumption services or facilities, to opiate substitution therapies (Riley, 2008). However, harm reduction services are not offered consistently throughout the country[7] (Carter & MacPherson, 2013). An evaluation of Canada's drug strategy, the *National Anti Drug Strategy* (NADS) in 2008 by the

[5] The following chapter will present an in depth theoretical discussion of the principles of harm reduction and the values underpinning this framework.
[6] See *PHS Community Services Society v. Attorney General of Canada (2008), PHS Community Services Society v. Canada (Attorney General)* (2010), and *Canada (Attorney General) v. PHS Community Services Society* (2011).
[7] It is important to note the division of powers in Canada is as follows, provincial and territorial governments are responsible for the provision of health care services, while the federal government is responsible for the control of illicit psychoactive substances. Thus, the implementation of certain services like SISs requires the approval from the federal government.

Department of Justice concluded that provincial drug strategies differ remarkably from the one endorsed by the federal government (Carter & MacPherson, 2013, p. 69). For example, provincial drug policies take a holistic approach to substance use, encompassing harm reduction in their strategies unlike the *NADS* (Carter & MacPherson, 2013, p.69). However, despite provincial policy frameworks that mandate the provision of harm reduction services, their implementation is not guaranteed. In Ontario and Nova Scotia for example, the provincial strategies for substance use do not refer to harm reduction although harm reduction is a part of the public health standards for both provinces (Carter & MacPherson, 2013, p.45). Another example is the SIS, which has only been established in one city across the entire nation, despite findings from feasibility studies which demonstrate a need for the implementation of SISs in cities such as Toronto and Ottawa (Bayoumi et al., 2012).

This project is largely influenced by the *Insite* scholarship that highlights the effectiveness of SISs as a harm reduction strategy as well as various commentaries[8], which call attention to the federal government's opposition to this intervention. There is also a plethora of research highlighting the prominent role of state elites in conjunction with the mass media in the construction of social problems resulting in public concern regarding those matters[9]. Thus, this is an exploratory study that examines the SIS debate using Joel Best's (2008) construction of social problems from a subjectivist outlook in order to shed light on the resistance to the implementation of this intervention in Canadian cities. Politicization is also an important concept employed in this research project, particularly because the existing literature has highlighted the way in which the SIS and the scientific evidence on the intervention has been heavily politicized.

[8] See Hwang (2007); Small (2007, 2008, 2012); Wood, Kerr, Tyndall & Montaner (2008); Webster (2008); Hathaway & Tousaw (2008); and Zlotorzynska, Wood, Montaner & Kerr (2013).
[9] See Bennett, 1980; Edelman, 1988; Hall et al., 1978; Iyengar and Kinder, 1987; Jensen, Gerber & Babcock, 1991; Nelson, 1984; Reinarman and Levine, 1989; and Beckett, 1994.

This thesis also aims to address a gap within the social science literature with respect to the SIS debate in Canada. Through a qualitative content analysis of newspaper documents, this thesis explores the SIS debate in order to better understand the continued resistance to the implementation and scale up of this harm reduction intervention. Thus, the main research question is: What is the nature of the debate regarding the implementation of SISs in Canada? The secondary research question is: What are the assertions advanced by proponents and opponents with respect to the implementation of SISs? (E.g. what are the claims and who are the claimsmakers?)

Personal & Political Context

It is important to acknowledge that in undertaking this research project, the author is also partaking in the social problems process and claims-making activities. The analysis portion of this thesis in particular may be read as a claim in its own right. The politics of the researcher will be addressed in more detail in the methodology chapter of this thesis. With respect to the politics of the research, it is also impossible to have a complete disconnect from the political since the governing body[10] ultimately decides the fate of SISs in Canada given that the intervention requires a legal exemption under the federal drug statute, the *Controlled Drugs and Substances Act* (CDSA) in order to operate. Thus, this debate is ultimately embedded within the political struggles of the issue under study.

In what follows, chapter one provides a brief historical background on the approaches to illicit drug control and a description of the existing literature on the implementation of SISs in Canada, namely the politicization of SISs and scientific evidence on *Insite* in Canada, in order to situate the research project socially, culturally and politically. In addition, chapter one provides a

[10] Applications for exemptions to operate a SIS are submitted to Health Canada, a branch of the federal government.

brief discussion on the existing literature on the SIS debate in order to establish a point of departure for this research project. The second chapter discusses the theoretical framework guiding this thesis, the social construction of social problems by Joel Best (2008) and a framework for the analysis of claims. Chapter two also explores the concept of politicization with respect to crime policies and drug issues. The methodology employed for this research project is described in the third chapter and potential limitations are discussed in detail. Subsequently, chapter four provides a description of the findings from the qualitative content analysis of newspaper documents. Finally, chapter five presents an analysis of the findings and a discussion of the results. The conclusion will provide a discussion of the introduction of *The Respect for Communities Act* as a potential response to the claims-making activities of opponents of SISs as well as discuss avenues for future research.

CHAPTER 1: HISTORICAL CONTEXT & LITERATURE REVIEW

This chapter begins with a presentation of a brief history of drug policy in Canada in order to highlight the predominant approach employed to the control of psychoactive substances. Next, the historical development of SISs as a harm reduction strategy in Vancouver and the socio-political context in which the SIS emerged will be discussed. Subsequently, two main bodies of literature will be presented: the nature of the debate regarding SISs and the politicization of scientific evidence on *Insite* in Canada.

1.1 Historical Overview of Canadian Drug Policy

1908-1929

In Canada, prior to 1908, there was an absence of legal restrictions on the consumption and distribution of psychoactive substances (Solomon & Green, 1988; Beauchesne, 2004). During the 20th century, the pharmaceutical industry was the primary buyer of opium in crude form for the purpose of producing anesthetics (Beauchesne, 2004, p.57). Several opium factories in British Columbia also purchased crude opium to manufacture opium for smoking (Beauchesne, 2004, p.57). Pharmaceutical companies advertised opiates in the newspapers as a "miracle drug," which targeted adults, in particular women, for the relief of menstrual pains and pains associated with child-birth (Beauchesne, 2004, p.58). In addition, calming syrups for children were widely used within Canadian households, where opium or morphine was employed as the primary ingredient (Collin, 1994, p.41 in Beauchesne, 2004, p.58). During this time, the use of psychoactive substances did not invoke a degree of moral stigma, which is now attributed to such conducts (Soloman & Green, 1988). In contrast, an opiate dependency was characterized as a

"personal vice" or "medical misfortune" until the emergence of anti-opium campaigns, which transformed public perception and in due course, the criminal law (Solomon & Green, 1988).

In 1908, the Canadian government passed a short piece of legislation prohibiting activities in relation to the sale and import of opium for non-medical purposes, referred to as the *Opium Act*[11] (Giffen et al., 1991; Fischer, 1997, 1998, 1999). The application of legal restrictions on the non-medical use of opiates was not a reflection of the addictive properties of the substance, rather the efforts of reformers who redefined opiate usage as immoral[12] (Solomon & Green, 1988, p.88). At this time, it was believed that opiates represented a threat to Christian values and brought to light mankind's innate licentiousness (Solomon & Green, 1988). The origins of the 1908 *Opium Act* have been explored elsewhere, most notably by Cook (1969), Comack (1985) and Giffen et al. (1991). Some authors[13] suggest the initial *Act* was utilized to target opium smoking by Chinese immigrant workers in Vancouver, British Columbia as a "political strategy to defuse a moral, social, and economic conflict" that emerged between Asian and Occident communities (Fischer, 1999, p.198).

The *Opium Act* controlled opium in crude or powdered form, and opium prepared for smoking. Five offenses became criminalized under the *Act*: the sale of; offering to sell; possession for the purpose of selling; import of; and manufacturing of opium (Giffen et al., 1991, p.78). These conducts were classified as indictable offenses, requiring a maximum prison sentence of three years or a one thousand dollar fine, or both (Giffen et al., 1991, p.79-80). The *Act* did not prohibit the consumption of opiates nor simple possession (Solomon & Green, 1988). In light of the limited scope of the *Act*, it was ineffective in eradicating opium smoking (Giffen et

[11] The bill was passed without being subject to debate in the House of Commons (Green & Solomon, 1988).
[12] Mackenzie King, Deputy Minister of Labour at the time, along with Caucasian labour spokesman were among the vocal reformers (Solomon & Green, 1988).
[13] See Giffen et al., 1991; Erickson, 1992; and Fischer, 1997, 1998, 1999.

al., 1991). As a result, in 1909, an amendment to the *Criminal Code of Canada* provided the police with powers to search "opium joints"[14] and seize substances or equipment in relation to opium consumption in such vicinities (Giffen et al., 1991, p.77).

In 1911 the federal government passed the *Opium and Drug Act* (ODA) subsequently adding cocaine, morphine, eucaine, and any of their compounds or salts to the schedule of prohibited substances (Giffen et al., 1991, p.78). In comparison to the 1908 *Act*, the ODA included thirteen more offences, however the penalties associated with the offences were less severe (Giffen et al., 1991, p.80). The legislation of the ODA marks the official commencement of the prohibition of psychoactive drugs in Canada (Giffen et al., 1991, p.78). The ODA targeted drug users, criminalizing individuals for possessing or smoking opium and for being present at an opium den (Giffen et al., 1991, p.78). The *Act* also penalized illegal drug traffickers and business owners involved in the drug trade (Giffen et al., 1991, p.78). From 1911 to 1961, the *Act* was subject to minor amendments on sixteen occasions (Giffen et al., 1991, p.3)[15].

Giffen et al. (1991) described the enforcement of drug law as a "hit-and-miss affair" until the Department of Health and the Opium and Narcotic Drugs Branch[16] (ONDB), a division within the department, were established in 1920 to implement the ODA (p.103). In addition, the Royal Canadian Mounted Police (RCMP) became tasked with the responsibility of enforcing the drug statute. In the same year, another section was added to the *Act*, outlining the criminal offence of smuggling, or the act of importing or exporting opiates or cocaine without a license

[14] Also referred to as an opium den, it is a place of business, the purpose of which to engage in the smoking of opium.
[15] For the purpose of this brief overview I will not discuss the minor amendments made to the drug statute between 1911-1961. I will focus on the major changes to the drug statute in order to highlight the dominant drug strategy in Canada. For details regarding the minor amendments to the drug statute, see Giffen et al. (1991).
[16] The ONDB was under the control of the RCMP until the 1950s.

from the Department of Health (Giffen et al., 1991, p.108)[17]. While drug law enforcement maintained a center stage during this era, the focus of enforcement targeting Chinese labourers shifted from the 1920s and onward to lower social classes (Fischer, 1999, p.198).

In 1923, cannabis and codeine were added to the schedule of prohibited substances (Giffen et al., 1991, p.2; Government of Canada, 1991). In light of the expansion of prohibited substances and offenses, the RCMP expanded the scope of drug law enforcement in the early 1920s with the establishment of RCMP drug squads (Giffen et al., 1991, p.132). Furthermore, the necessity for a warrant for the purpose of search and seizure during a drug raid was eliminated and the appointment of special prosecutors for drug related offenses established (Fischer, 1998, p.160). This era also markedly extended the severity of penalties through the application of mandatory minimum sentences, mandatory imprisonment and extradition of foreigners (Solomon & Green, 1988; Solomon & Madison, 1977).

The enactment of the *Opium and Narcotic Drug Act* (ONDA) in 1929 marks another attempt by the federal government to amend the drug statute. In the following forty years, this piece of legislation served as the "main instrument of drug policy" in Canada (Riley, 1998). The ONDA was approximately eleven pages in length, with 28 sections and multiple subsections (Giffen et al, 1991, p.1). The legislation continued to espouse prohibitionist principles and a commitment to the criminalization of drugs.

1930-1968

Commencing in 1930, opium related offenses began to dissipate, in contrast, the focus of drug law enforcement during this period shifted to users of heroin (Fischer, 1998, p.161). The number of convictions for the possession of heroin increased drastically between 1945-1960

[17] The *Opium and Narcotic Drugs Branch* became responsible for the oversight of the licensing process (Giffen et al., 1991, p.104).

accounting for one-half of all drug convictions during that period (Fischer, 1998, p.161).

The prohibitionist strategies dominating Canadian drug policy remained unchallenged until the 1950s (Giffen et al., 1991; Dias, 2003) with the emergence of the treatment movement. The movement reflected a marked shift in the conceptualization of drug use as a medical problem rather than a criminal act, thereby warranting medical rehabilitation and treatment rather than a law enforcement response (Fischer, 1998, p.161). During this period, the proposed *Narcotic Control Act* (NCA) reflected treatment principles, suggesting for the replacement of punishment with mandatory treatment in correctional institutions however, these changes were not officially adopted in the NCA (Solomon & Maddison, 1977; Fischer, 1995).

In contrast, in 1954, the penalties for trafficking became more severe and the burden of proof for the offense, possession for the purpose of trafficking, shifted from the Crown to the accused individual (Erickson, 1992, p.245), wherein the accused shouldered the responsibility for demonstrating his or her innocence of a criminal offense. By 1961, the existing international drug control treaties were integrated into one mechanism, the NCA, which continued to espouse principles of prohibition (Fischer, 1997, p.48). In addition, the criminal law aspect of drug control was separated from the regulation of legal channels for the import, export and distribution of prohibited substances listed in the drug statute (Giffen et al., 1991, p.1). In other words, the NCA strictly pertained to illicit drug use and trafficking while acts in relation to "legitimate" channels of distribution fell within the purview of the *Narcotic Control Regulations* (NCR) (Giffen et al., 1991, p.1). Individuals in violation of the NCA were subject to a maximum penalty of life imprisonment for the offenses of trafficking, possession for the purpose of trafficking and smuggling (Giffen et al., 1991, p.1)[18]. After the enactment of the NCA, law enforcement

[18] In contrast, offences under the *NCR* were classified as summary convictions and subject to a five hundred dollar fine or six months imprisonment, or both. The *Narcotics Drug Branch* may also withdraw a distributor's license to

practices intensified, targeting illicit drug users, namely, cannabis users (Fischer, 1997, p.48). The "cannabis enforcement era" began in 1965, resulting in a drastic increase in the number of convictions for drug offences by the 1970s (Fischer, 1997).

Erickson (1992) notes numerous tensions arose during the 1960s, sparking uncertainty in regard to prohibitionist drug polices and subsequent modifications (p.245). During this period an emergent trend in the criminalization of young, educated individuals from the upper or middle class generated socio-ideological disagreement about the criminalization of drug users (Erickson, 1980). Nearly half of the cases for cannabis possession during this time resulted in the imprisonment of the accused given the limited sentencing options available to trial judges (Erickson, 1992). In addition, the increasing number of drug offenses placed a tremendous strain on the judicial system (Riley, 1998). These occurrences further prompted criticism of prohibition as "an inappropriate form of social control" given its severe consequences, expressly for young individuals, and its ineffectiveness in deterring individuals from the use of cannabis (Fischer 1998, p.162). As a result, these events generated an immense level of pressure for both lawmakers and politicians to liberalize Canadian drug policies (Riley, 1998).

1969-Present

Despite the emergent criticisms regarding prohibition, few legal reforms manifested in policy (Erickson, 1992, p.245). In 1969 the federal government established the Le Dain Commission, or the Commission of Inquiry in the Non-Medical Use of Drugs, to evaluate Canadian drug policies (Solomon & Green, 1988). The Commission concluded the prohibition of drugs to be a costly endeavor for Canada, one that produces minimal benefits, thereby affirming the criticisms of prohibition at the time (Erickson & Smart, 1988; Riley, 1998). The Commission

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prescribe narcotics (Giffen et al., 1991, p.1).

also deemed certain enforcement practices during drug investigations to be an encroachment upon individual rights and freedoms (Riley, 1998)[19]. The most notable recommendation by the commission was for a gradual withdrawal from the use of criminalization in response to illicit drug use (Erickson & Smart, 1988). Among other recommendations, the Commission urged for the abolishment of prison sentences for drug possession offences (Dias, 2003). The recommendations of the Le Dain Commission alluded to the possibility of drug policy reform during this period, however it did not materialize (Erickson, 1992, p.244).

There was a subsequent reduction in drug law enforcement practices and penalties lessened in severity in 1969 with an amendment to the NCA, which added the sentencing option of a "fine only" for drug offences. In addition, in 1972, absolute and conditional discharges were included as alternative sentencing options (Erickson, 1980). During the 1980s most forms of illicit drug use and arrest rates for cannabis related offenses declined (Erickson, 1992, p.247)[20]. Consequently, political attention to drug issues and public pressures for drug policy reform subsided until the mid-1980s, when concerns arose regarding the effectiveness of law enforcement efforts on demand reduction in relation to illicit drugs[21] (Riley, 1998). In response to the public's unease, in May of 1987 the federal government attempted to redirect drug policy through the creation of *Canada's Drug Strategy* (CDS). The CDS sought to balance demand and supply reduction measures and emphasize harm reduction principles (Government of Canada, 1991).

The federal government designated 210 million dollars to the implementation of the CDS for a period of five years with the majority of the funds assigned to treatment and prevention

[19] Such practices refer to the use of undercover law enforcement agents, wiretaps, paid informants, surprise raids, strip-searches, police dogs, and providing immunity to suspects in exchange for information (Riley, 1998, p.3).
[20] With the exception of the use of cocaine experiencing a slight increase (Erickson, 1992).
[21] Illicit, or illegal drugs refer to "substances with criminal sanctions against any personal possession or use" (Health Officers Council of British Columbia, 2005, p.6). See the *Controlled Drugs and Substances Act*, Canada's federal drug statute, for a detailed list of currently illegal drugs in Canada.

strategies and 30% allocated to enforcement and control (Erickson, 1992, p.248). However, Fischer (1994) notes, in practice, less than half of the resources were allocated to treatment while the majority of funds directed towards prevention were utilized on drug education programs led by law enforcement agents[22] (p.75-76). In 1992, the federal government renewed the CDS for another five years (Erickson, 1992, p.249). Despite the federal government's stated objective to emphasize harm reduction principles, the implementation of the CDS more closely reflected prohibitionist principles with the addition of new offenses and laws (Erickson, 1992, p.249). In contrast, following obligations with the International Conventions, the federal government's attempt to rebalance the demand and supply reduction measures culminated in the creation of a federal drug control statute, the *Controlled Drugs and Substances Act* (CDSA), which continued to center on the prohibition of certain psychoactive drugs. The CDSA, adopted in June of 1996, acts as the federal law governing the control of illegal drugs in Canada (Fischer, 1997, p. 62). Fischer (1999) suggests the introduction of the CDSA, counteracts previous attempts to redirect drug policy in Canada towards a public health oriented approach and further closes the "policy reform window" of that time (p.197).

In 1998, the federal government renewed the CDS, simultaneously adding a four pillars approach to drug control, the pillars include: education and prevention; treatment and rehabilitation; enforcement and control; and harm reduction (Government of Canada, 1991). This marked the first time in Canadian history wherein the expression "harm reduction" had been formally included in the national drug strategy. The inclusion of harm reduction as a pillar within the national drug strategy can be understood as an attempt to engage in drug policy reform towards a public health approach. However, on October 7, 2007 the newly elected Conservative

[22] Despite research indicating the ineffectiveness of police led drug education programs, such as Drug Awareness Resistance Education (DARE) (DeBeck et al., 2007).

federal government replaced the CDS with the *National Anti Drug Strategy* (NADS) (Dooling & Rachlis, 2010; Hyshka, Butler-Mcphee, Elliott, Wood, & Kerr, 2012). The harm reduction pillar was removed from the national drug strategy notwithstanding support of harm reduction services from all the provinces (the NADS is discussed first with all the provinces before it is presented to the federal government), the World Health Organization (WHO)[23] and the successfulness of this approach internationally, in countries such as Australia, Switzerland and Germany (Hyshka et al., 2012, p.125). Hathaway and Tousaw (2008) suggest the removal of the harm reduction pillar from the federal drug strategy reflects the Canadian government's "commitment to the war on drugs" (p.12) through the criminalization of drug use.

As a result, despite the attempts to reshape Canadian drug policy, criminal prohibition continues to be the predominant strategy in relation to the control of psychoactive drugs (Riley, 1998). The current federal government continues to allocate the majority of funding towards drug law enforcement measures (DeBeck et al., 2009) notwithstanding recognition of the need for a balanced drug policy approach in Canada (MacPherson, 2000; Office of the Auditor General of Canada, 2001). In addition, Carter and MacPherson (2013) suggest the federal government's position towards harm reduction services has been either "hostile or indifferent" since the introduction of the NADS (p. 44). The authors argue the federal government has shifted support away from harm reduction services, instead espousing a "tough on crime" approach (Carter and MacPherson, 2013). This position is further reflected in the 2011 passage of the *Omnibus Crime Bill*, or Bill C-10, an act to amend the CDSA (Hyshka et al., 2012). Bill C-10 espouses more punitive crime control policies such as mandatory minimum prison sentences for drug related

[23] See the WHO technical guide for countries to set targets for universal access to HIV prevention, treatment, and care for injecting drug users (2013).

offences[24]. Hyshka et al. (2012) suggest mandatory minimum sentences do not deter the use of drugs nor aid in the rehabilitation of offenders (p.126). In addition, mandatory minimum sentences have proven to be ineffective in a number of jurisdictions, most notably in the United States of America (U.S.A) (Tonry, 2009; Gabor & Crutcher, 2002). The addition of this penalty reflects the prevailing spirit of prohibition within Canadian drug policy as addictions related issues continue to be treated as criminalized offenses and alternative responses to illicit drug use are overlooked. The spirit of prohibition in conjunction with the lack of harm reduction within Canada's drug strategy is a key barrier that prevents the scale up of harm reduction services across the country (Carter & MacPherson, 2013).

1.2 The Origin of Supervised Injection Sites

In 2001, the Canadian federal government established a task force to examine the feasibility of a national research-based trial of SISs, called The Federal, Territorial and Provincial Advisory Committee on Population Health in response to calls for SIS trials in Canada to address high rates of fatal overdose, and the increase in rates of HIV and HCV (Kerr & Palepu, 2001). Illicit drug overdose is the leading cause of premature death in North America as well as the leading cause of death among injection drug users (Marshall, Milloy & Wood et al., 2011, p.1429). In addition, unsafe injection practices such as the sharing of non-sterile syringes, contributes significantly to new HIV infections (Karon, Fleming, Steketee & De Cock, 2001) and the HCV epidemic worldwide (Wood, Kerr, Montaner et al., 2004; Kerr et al., 2007). In North America, one in every four incidents of HIV infection is attributed to injection drug use (Milloy & Wood, 2009, p.620). The literature suggests SISs play an integral role in reducing rates of

[24] Mandatory minimum prison sentences are applicable to "serious drug offences, such as dealing drugs for organized crime purposes or using a weapon or violence when involved in proscribed drug-related activities" (Parliament of Canada, 2012).

blood-borne infectious diseases and overdose mortality (Wood et al., 2006a). Research into the risk factors associated with incidences of drug overdose indicates the use of injection drugs in public significantly increases an individual's risks of drug overdose (Bohnert, Tracy, & Galea, 2009). Thus, the development of SISs can be understood as a public health response to concerns regarding public injection drug use despite the availability of treatment programs and other harm reduction services such as needle exchange programs (NEPs)[25].

Moreover, the health consequences related to injection drug use places a strain on emergency room services in hospitals because injection drug users tend to rely on these services rather than seek conventional health care services (Kerr, Wood & Grafstein et al., 2004; Small et al., 2009). The over-reliance on emergency care is in part due to the barriers faced by injection drug users when accessing conventional health care services (Kerr, Wood & Grafstein et al., 2004). Many individuals are unable to afford the financial costs in relation to health care such as transportation to hospitals and other treatment facilities (Drumm et al., 2003; Merril et al., 2002). Some individuals simply are not aware of the services available to them and fail to seek out such services (Neale, Sheard & Tompkins, 2007). In addition, the length of wait times associated with access to treatment and the limited hours of operation play a role in hindering this population's access to health services (Neale, Sheard & Tompkins, 2007). The stigma associated with injection drug use and the discrimination experienced by those individuals may also act as a barrier to accessing treatment and services (Drumm et al., 2003; Merril et al., 2002). In light of these barriers, it is particularly difficult to provide PWUD essential and necessary health care services (Grund et al., 1992). According to the literature, SISs play an integral role in providing

[25] Needle exchange programs provide PWUD with clean syringes and collect used ones (British Columbia Ministry of Health, 2005, p.9).

this difficult to reach population access to health care services both on-site, as in the case of *Insite*, and within the community (Broadhead et al., 2002; Small et al., 2009).

The number of SISs has increased significantly since the first legally sanctioned SIS was implemented in Switzerland (Boyd, 2013). Hedrich, Kerr and DuBois-Arber note, as of 2010, there have been approximately 90 sanctioned SISs established throughout the world, the majority of which exist in Europe, namely Switzerland, the Netherlands, Germany, Luxembourg, Norway, Spain and most recently Denmark (Boyd, 2013)[26]. Efforts to establish SISs beyond Europe have been met with varying degrees of success. While three state and territorial governments in Australia, New South Wales (NSW), Australian Capital Region and Victoria have endeavored to trial SISs (Elliott et al., 2002, p.20), only one SIS has been established. In 2001, the NSW government established a SIS in Sydney, Australia, referred to as the Medically Supervised Injection Centre (MSIC). Similarly, in North America, there is one SIS located in Vancouver, Canada known as *Insite*. A large portion of SISs in Europe have been integrated into local policies and treated as a social service, with the exception of Norway where SISs constitute pilot scientific studies that require legal exemptions or a special law in order to operate (Sznitman, Olsson & Room et al., 2008). Similarly, SISs in Australia and Canada began operations as pilot scientific studies (Sznitman, Olsson & Room et al., 2008). In 2010 the NSW government amended the *Drug Misuse and Trafficking Act* to include the MSIC as a legal public health service. This amendment excuses the facility from the requirement to obtain an "act of Parliament every four years" in order to remain in operation (Boyd, 2013, p.240).

[26] The establishment of SISs in Denmark is not included in the calculation by Hedrich, Kerr & DuBois-Arber (2010) given that the report was published prior to the implementation of such facilities in Denmark.

1.3 North America's First Sanctioned SIS: *Insite*

In contrast, the Canadian SIS operates as a scientific study despite being recognized as providing health services by the judiciary[27] (Boyd, 2013). While the possession of certain psychoactive substances remains illegal in Canada, *Insite* operates lawfully under an exemption granted by the federal Health Minister under section 56 of the *Controlled Drugs and Substances Act* (CDSA) (Small et al., 2006). Section 56 of the CDSA permits the federal Health Minister to issue exemptions from provisions relating to possession under the CDSA for scientific and research purposes (Health Canada, 2011). The federal government granted *Insite* a legal exemption on the condition that a scientific evaluation of its impacts would be conducted over the three-year trial period (Wood et al., 2006a, p.1). The exemption would also absolve the Vancouver Police Department (VPD) from adhering strictly to the *Criminal Code* in cases involving the possession of illicit psychoactive substances (Small et al., 2006, p.76). Upon approval from Health Canada, *Insite* opened on September 21, 2003 in an area of Vancouver referred to as the Downtown Eastside (DTES) (Small et al., 2006). The legal exemption was granted amid an epidemic of drug overdose deaths and HIV and HCV infections in Vancouver.

1.3.1 Snapshot of the DTES

For decades, the DTES has been the center of the sex industry and the illicit drug market (Kerr MacPherson Wood, 2008). It is the poorest urban area in Canada[28], characterized by high rates of drug use, addiction, mental illness and infectious diseases (Elliott et al., 2002; Jozaghi, 2012a; Campbell et al., 2009). The majority of residents inhabit Single-Room Occupancy (SRO) hotels about eighty square feet in size (Small, 2007). Individuals in the DTES also struggle with

[27] See *Canada (Attorney General) v. PHS Community Services Society*, 2011 SCC 44, [2011] 3 S.C.R. 134.
[28] See Statistics Canada, *Population Census of Canada*, 1996.

unemployment, crime, and homelessness (City of Vancouver, 2012, p.2). These issues intensified with the deinstitutionalization of the mentally ill, a shortage of social assisted housing, and the increased supply of powder cocaine, which culminated in the emergence of two epidemics: injection drug use and HIV infections (Wood & Kerr, 2006). In the early 2000's, there were approximately five thousand injection drug users living in the DTES (Kerr, Wood, Palepu, Wilson, Schechter, & Tyndall, 2003). In addition, researchers have documented a high level of public injection drug use, overdose deaths, and injection-related infections in this neighbourhood (Strathdee, Patrick, Currie, Cornelisse, Rekart, Montaner, Schechter, & O'Shaughnessy, 1997; Tyndall, Craib, Currie, Li, O'Shaughnessy, & Schechter, 2001). From 1992 to 2000, the DTES experienced a total of 1200 overdose deaths, with approximately 200 occurring per year (Kerr, MacPherson & Wood, 2008). Overdose fatalities attributed to injection drug use were cited as the leading cause of death in Vancouver during this time (B.C. Vital Statistics Agency, 2000). The city planned to establish a SIS in the DTES in order to address these concerns and to establish healthcare contact with a difficult to reach group (Small, Palepu, & Tyndall, 2006). The SIS was established through a joint effort between the Portland Hotel Society (PHS) Community Services Society[29], Vancouver Coastal Health (VCH)[30] and Health Canada (Small, 2008).

1.3.2 Snapshot of *Insite* Clients

The clients who frequently access the services provided by *Insite* include homeless individuals, and individuals who inject cocaine and heroin (Wood et al. 2006b; Tyndall, Kerr & Zhang, 2005). The SIS helps to combat the negative health consequences experienced by this particular group of individuals and to improve the overall health of the community (Wood et al.,

[29] The PHS Community Services Society is a non-profit organization that provides supportive housing services and transitional housing for difficult to house individuals (HealthLink B.C., 2013).
[30] VCH is the provincial health authority in British Columbia. VCH also provides funding for the operation of *Insite* (Wood et al., 2006b, p.770).

2006a; Jozaghi, 2012). Within the SIS, there are twelve individual spaces available for supervised injection. The facility remains open to the public for eighteen hours each day, between the hours of ten and four in the morning (Small et al., 2011, p.561). *Insite* clients have access to sterile injection equipment such as syringes, filters, water, and tourniquets (Vancouver Coastal Health, 2013). Most importantly, the SIS constitutes a continuum of services for individuals with addictions and HIV/AIDS as it helps to connect these individuals with health care services by providing counselors, mental health workers, and health care professionals who can facilitate access to treatment or detoxification programs (Vancouver Coastal Health, 2013). In this respect, SISs help to overcome a significant service gap in existing public health programs for a traditionally marginalized and under-serviced population (Broadhead et al., 2002, p. 348) because it breaks down some of the barriers that prevent PWUD from accessing health services.

1.4 Historical Development of *Insite*

Most SISs have been initiated after extensive consultations and debates in both public and political arenas. The literature by Small, Palepu and Tyndall (2006) and Kerr, MacPherson and Wood (2008) suggests this to be the case in the establishment of *Insite*. Harm reduction interventions remain controversial in most environments, as such the implementation of such strategies generally manifest in the wake of complex social and political processes (Kerr, MacPherson & Wood, 2008). In Vancouver, the campaign for a SIS, commenced ten years prior to the establishment of *Insite* (Kerr, MacPherson, and Wood, 2008).

Small[31] et al. (2006) provide a narrative of the plans, activities and politics resulting in the establishment of *Insite* (p.73)[32]. The account centers on the notion of culture[33] change regarding

[31] Dan Small is part of the senior management of the Portland Hotel Society (PHS) Community Services Society. Small is actively involved in the establishment, implementation and management of *Insite*.

Insite as a community initiative to address public injection drug use and the associated harms. Small et al. (2006) rely on three main theoretical concepts; habitus developed by Pierre Bourdieu (1999); the cultural construction of public problems by Joseph Gusfield (1989); and the purposeful use of symbols **(**Dyck 1985, 1991; Jhappan, 1990). The authors argue the establishment of *Insite* was a result of two cultural shifts, one in the "addiction habitus" and the other at the bureaucratic level.

First, the concept of *habitus* is applied so as to explicate the way in which individuals may engage in collective practices unaccompanied by a rigid adherence to regulations or requiring complete awareness of such engagement (Small et al., 2006). According to Bourdieu (1999) "the *habitus* – embodied history, internalized as second nature and so forgotten as history – is the active presence of the whole past of which it is the product. As such, it gives practices their relative autonomy with respect to external determinations of the immediate present" (p.54). In other words, *habitus* refers to the ways in which people accept everyday practices as a matter of common sense, conforming to such practices as if they are innately customary. Small et al. (2006) employ the term "addiction habitus" to describe long-established, common addiction narratives. According to the authors, the traditional "addiction habitus" may incorporate the following elements: addiction is a choice, thus addicts are responsible for their "corrupt lifestyles"; resources and services for addicts attract addicts and encourage addictive behaviour; "addicts should be made uncomfortable to prevent and not enable addiction"; harm reduction interventions help maintain people's addictions; "drugs promote violence"; and drugs are illegal because they are dangerous (Small et al., 2006, p.74). In 2001, the authors note the dominant

[32] The ideas and processes will be discussed in this section however a discussion regarding the politics of *Insite* will be presented in a subsequent section.
[33] Small et al. (2006) define culture as "the process of negotiating meaning with respect to constantly changing implicit and explicit values that underpin the moral fabric of social action or inaction" (p.73).

understanding of addiction as a criminal matter; however, by 2002 the notion that individuals with addictions were worthy of life, care and compassion in contrast to "punishment and death" began to overshadow the traditional narrative maintained through prohibition and law enforcement responses to addiction (Small et al., 2006, p.74). The authors refer to this shift in understandings of addiction as a challenge to the traditional "addiction habitus" (Small et al., 2006, p.74).

A second and necessary cultural shift transpired at the bureaucratic level with respect to the values of risk management (Small et al., 2006, p.75). The proposal to implement harm reduction interventions such as needle exchange programs (NEPs) and SISs spark multiple legal and political concerns such as the potential for lawsuits, negative publicity and "a political risk from negative exposure or embarrassment for politicians" (Small et al., 2006, p.75). The implementation of a SIS may reach a standstill if the perceived risks associated with such an intervention cannot be neutralized (Small et al., 2006). According to the authors, the establishment of *Insite* involved the support and efforts of numerous stakeholders (see figure 1) from both "within and outside numerous political institutional systems" (Small et al., 2006, p. 74). Several key bureaucrats at each of the three levels of government, including Health Canada and Vancouver Coastal Health (VCH), supported the implementation of *Insite* despite the risks associated with the promotion of such an intervention. Small et al. (2006) highlight the vital role these bureaucrats played in the implementation of a SIS, arguing that without their advocacy, *Insite* would cease to exist (p.75).

Both cultural shifts were brought about through the efforts of many agents of social change including the peer movement; the family movement; community agencies; law enforcement; academics; journalists; a poet activist; chief medical health officers; coroners; and

the drug user's resource centre (Small et al., 2006, p.79). Each of these forces of change helped to challenge the traditional "addiction habitus" and will be discussed in further detail below.

The peer movement comprised of PWUD (Small et al., 2006), in conjunction with civil disobedience (Kerr, MacPherson & Wood, 2008) played a key role in humanizing addiction. The Vancouver Area Network of Drug Users (VANDU), a grassroots organization of current and past drug users, together with other advocates of supervised injection, established a non-sanctioned SIS in the city in the spring of 2003, referred to as the "327 Carrall Street SIF" (Kerr, MacPherson & Wood, 2008, p.121) or the "hair salon" (Small et al., 2006, p.78). This measure was in response to an intensification of policing practices in the DTES's open drug scene and the delays in the establishment of *Insite* (Kerr, Oleson & Wood, 2004). VANDU along with community service providers feared the heightened police presence would effectively displace the drug market and subsequently people with addictions, removing them from much needed community services (Kerr, Oleson & Wood, 2004). As a result, this act of civil disobedience applied pressure to the federal government to grant an exemption for the implementation of a legally sanctioned SIS (Small et al., 2006).

In addition, the family movement challenged the traditional "addiction habitus" by reinforcing the notion of addiction as a public problem in Vancouver, one that was not bound by social class (Kerr, MacPherson & Wood, 2008, p.117). The family movement commenced with the development of From Grief to Action (FGTA), a support group, comprised of parents of individuals with addictions within the community offering support to other individuals with relatives suffering from addiction (Kerr, MacPherson & Wood, 2008). The group also advocated for the inclusion of harm reduction services for PWUD, urging all levels of government to respond to the issue of addiction. This group included middle class professionals such as professors, lawyers and public service workers, whose voices helped to shatter the image of

addiction as affecting only the most marginalized individuals living in low-income neighbourhoods (Kerr, MacPherson & Wood, 2008). The family movement succeeded in challenging the "addiction habitus" regarding individuals with addictions by highlighting "that any family, regardless of social status, can be touched by addiction" (Small et al., 2006, p.76). This movement also triggered much media coverage, which encapsulated a kinder message about the reality of drug use, thereby humanizing people with addictions (Small et al., 2006).

Community agencies also attempted to respond to the issue while the city awaited the federal Health Minister's decision regarding the legal exemption for a SIS. The Dr. Peter Centre, a medical facility for individuals with HIV/AIDS, constructed a safe injection room (SIR) for HIV-infected clients. The Dr. Peter Centre did not obtain a legal exemption to operate the SIR; rather, they consulted with the Registered Nursing Association of British Columbia (RNABC), which advised the centre that the scope of nursing practices includes supervised injection and that such practices constitute a nurse's ethical obligation given the harms associated with unsupervised injection (Wood, Zettel & Stewart, 2003). In addition, other community agencies such as the Carnegie Community Action Project (CCAP) voiced public support for SISs and the PHS worked towards implementing a SIS (Small et al., 2006).

Despite publicly voiced opposition within law enforcement, several officers from the VPD endeavored to shift the cultural understandings of addiction (Small et al., 2006). The authors note that while the traditional "addiction habitus" was strongly embedded within police culture, there were "some cautious supporters" of SISs among the VPD, namely Gill Puder, Scott Thompson, Kash Heed, Ken Doern, Ken Frail, Bob Rich, and Jamie Graham, former Police Chief of the VPD.

In addition, Small et al. (2006) suggest, the eventual inclusion of evidence-based knowledge into societal understandings of drug use served to undermine and challenge the

traditional "addiction habitus" (Small et al., 2006, p.75). Academics also advocated for drug policy reform and the establishment of NEPs, SISs and methadone maintenance treatment[34] (MMT) (Small et al., 2006). Moreover, research findings on the prevalence of HIV/AIDS in Vancouver and high rates of overdose played a crucial role in the recognition of addiction as a public problem. Researchers in HIV/AIDS and addiction combined the work from both fields, generating intense pressure to develop evidence-based policies to achieve public health goals. As a result, medical authority and academic legitimacy became incorporated into the discourse on harm reduction. The efforts of academics helped to weaken the traditional "addiction habitus" as the self-blame placed on individuals with addictions was gradually superseded by a public health understanding (Small et al., 2006, p.77). Additionally, Kerr, MacPherson and Wood (2008) note the efforts of researchers to evaluate the merits of SISs in light of the ongoing public debates (p.119). Between 2001-2003, researchers conducted a number of feasibility studies on SISs (Wood et al., 2003; Kerr, Wood & Palepu et al., 2003; Kerr, Wood & Small et al., 2003), which helped to highlight the need for such an intervention.

The work of an activist/poet Bud Osborn was also crucial to the development of the SIS (Small et al., 2006, p.77). Osborn served as the director of the Vancouver Richmond Health Board (VRHB), which was replaced by the VCH, and led numerous public education campaigns about addiction (Small et al., 2006). In June of 2001, the VRHB urged for the implementation of a SIS as its final action (Small et al., 2006, p.77). The editorial board of the *Vancouver Sun*, a daily newspaper in the city, also voiced the need for the implementation of a SIS (Small et al., 2006, p.77). Finally, local drug users worked in collaboration with municipal leaders, bureaucrats and members of the community to establish a drug user's resource center as a precursor to the

[34] Methadone maintenance treatment or therapy is used to treat individuals with a heroin dependence (British Columbia Ministry of Health, 2005, p.10).

proposed SIS. The resource center was a safe and "welcoming place" for individuals with addictions (Small et al., 2006, p.77).

In addition to the aforementioned forces of change, public scrutiny of the narratives related to the traditional "addiction habitus" also helped to break down popular conceptions regarding individuals with addictions (Small et al., 2006, p.75). The issue of addiction became entrenched in the *Vancouver Agreement* (2000), thereby transforming the matter into a public problem, for which the municipal, provincial and federal government became responsible for addressing (Small et al., 2006, p.12). Small et al. (2006) suggest the conversion of an issue into one that is understood as a public problem subsequently gives a sense of responsibility to public institutions, particularly government bodies, to devise and implement a solution (p.12). Therefore, the SIS was constructed as the appropriate response to the public problem of addiction, and more specifically injection drug use (Small et al., 2006, p.12).

Two Chief Coroners, Vince Cain and Larry Campbell, and Chief Medical Health Officers of B.C., Perry Kendall and John Millar played a critical role in legitimizing the public response to the problem of addiction in the form of a SIS (Small et al., 2006, p.77). In 1993, Cain established a task force to study the drug overdose epidemic throughout the province and the reasons for such a growth in rates of overdose death. The task force reported back to Cain, the findings of which were subsequently presented in the Cain Report (1994). Cain noted the majority of overdose deaths were preventable, and that the criminalization of heroin and cocaine were among the leading causes of the harms occurring in the community (Cain Report, 1994). As such, Cain recommended that the possession of certain illicit substances be decriminalized and for PWUD to be treated using a medical rather than criminal approach (Cain Report, 1994). Similarly, Millar's (1998) report, *Pay Now or Pay Later* identified a drug overdose epidemic in B.C. and suggested for health services to be extended for individuals with addictions, including the implementation

of harm reduction strategies. Kendall, who assumed Millar's position as Chief Medical Health Officer subsequently worked towards the implementation of a SIS.

The establishment of *Insite* not only required a great deal of activism in the community but also the use of dramatic symbols to raise awareness of and support for SISs (Small et al., 2006, p.78). The PHS initiated a campaign in 1997 called the "Killing Fields," a public demonstration where a thousand crosses were placed in a local park to mark the number of deaths due to overdose over the previous five years (Small et al., 2006). In 2000, the PHS partnered with various community organizations including the VANDU, to recreate the demonstration (Kerr, Small, Peeace, Pierre & Wood, 2006), at which time the number of deaths had doubled within two years. These community organizations continued to hold public education events to humanize individuals affected by addictions and highlight government inaction through the use of symbols of death, such as coffins, grim reapers, a war on drugs tank and needles and symbols of hope, including white carnations, music and the presence of children (Small et al., 2006).

Similarly, Kerr, MacPherson and Wood (2008) provide an insider's account regarding the establishment of *Insite*. The authors suggest the establishment of a SIS in Canada was a result of a social movement, commencing at the grassroots level and gradually securing community support. A variety of different approaches were taken, including grass roots activism, civil disobedience, research, legal analyses, public education, coalition building, and policy development (Kerr, MacPherson & Wood, 2008, p.122). The authors speculate that perhaps, these approaches carried out independent of one another may not have prompted the implementation of this contentious intervention (Kerr, MacPherson & Wood, 2008, p.122). Kerr, MacPherson and Wood (2008) note the movement involved the mobilization of numerous social actors from cross sectors and fundamentally required a shift in cultural understandings of addiction.

Adding to the analysis of *Insite*'s establishment by Small et al. (2006), Kerr, MacPherson and Wood (2008) suggest the case of *Insite* corresponds with Kingdon (1995) and Baumgartner and Jones' (1993) theories regarding the development of policy (p.123). The establishment of *Insite* was made possible through the efforts of diverse social actors and "policy entrepreneurs" who called attention to community problems, and maneuvered through relevant policies and politics in order to address the matter of addiction (Kerr, MacPherson & Wood, 2008, p.123). According to Kingdon (1995) there are three policy streams vital to the process of policy-making: the problem stream, the policy stream and the political stream. In the problem stream, social actors identify and publicize the idea that a problem exists through "focusing events" and the documentation of indicators (Kingdon, 1995). In the case of *Insite*, community activists, lobbyists and journalists first called attention to the problems related to injection drug use in the DTES, followed by local decision makers (Kerr, MacPherson & Wood, 2008, p.123). The problem of addiction was further highlighted through "focusing events" including public demonstrations and the presence of drug users from the community at policy meetings (Kerr, MacPherson & Wood, 2008, p.123).

In the policy stream, "policy entrepreneurs" develop possible solutions to the recognized problems (Kingdon, 1995). In the period leading up to the implementation of *Insite*, local policy makers in conjunction with community groups helped foster the notion of the SIS as an appropriate response to the problems in relation to injection drug use (HIV/AIDS and overdose deaths). Finally, in the political stream, a shift in public opinion manifests along with relevant changes at the bureaucratic level and interest groups apply pressure for institutional systems to take action (Kingdon, 1995). In Vancouver, a SIS was added to the policy agenda of the municipal government once a "policy window" relevant to the addiction problem emerged (Kerr,

MacPherson & Wood, 2008). The *Four Pillars Drug Strategy*[35] institutionalized the SIS while the Vancouver Agreement (2000) obligated all levels of government to respond to the issue of addiction. As such, the provincial and federal governments were compelled to express policy positions regarding SISs (Kerr, MacPherson & Wood, 2008). Public opinion in support of SISs intensified this political impetus. Finally, non-governmental organizations (NGO)[36] mapped out the necessary legal and policy structures for the implementation of SISs in Canada, thereby making the SIS a feasible endeavour (Kerr, MacPherson & Wood, 2008).

The literature by Small et al. (2006) and Kerr, MacPherson and Wood (2008) shed light on the complexity of the nature of addiction and highlight the pivotal events that contributed to the establishment of a SIS in the backdrop of prohibition. The authors highlight the cultural shift in societal understandings of addiction that became integral to the acceptance of alternative responses to drug use and PWUD. Most importantly, the authors demonstrate the necessity for social actors to work both within official institutional systems and the community in order to bring about culture change. The literature by Small et al. (2006) will be revisited in a subsequent discussion on the politicization of SISs.

Despite the steady scale-up of SISs internationally, in North America, SISs as a harm reduction strategy continue to be controversial and elicit limited political support (Milloy & Wood, 2009; Beletsky et al., 2008; Kerr, Montaner & Wood, 2008a; Des Jarlais et al., 2008). While this section revealed the historical and political context in which the debate regarding SISs in Canada occurs, the following section provides a discussion regarding the existing literature on the nature of the SIS debate and the politicization of *Insite* in Canada.

[35] The *Four Pillars Drug Strategy* will be discussed in more depth in a subsequent section.
[36] Namely the Canadian HIV/AIDS Legal Network, see Elliott, Malkin and Gold (2002).

1.5 Literature on the SIS Debate

This section presents literature on the SIS debate in Canada, with some aspects of the debate derived from the Australian context due to the paucity of literature regarding the Canadian debate. The available literature is also limited in that it reflects the debate prior to the completion of research on the impacts of the Vancouver SIS. In light of this, I incorporate the findings from the scientific evaluations of *Insite* as a means to better reflect potential arguments advanced in the current debate regarding the implementation of SISs in Canada.

1.5.1 Opposition to SISs

Elliott, Malkin and Gold (2002) provide a discussion of the nature of the debate regarding SISs. According to the authors, the main argument advanced by opponents in regard to the implementation of SISs is that it "sends out the wrong message" to the public[37]. This message is one that condones drug use and reflects "official support"[38] of these behaviours (p.9). For some, the most protested feature in relation to the implementation of a SIS is the supervision of drug using behaviour at SISs. Opponents present this program as actively authorizing illegal behaviour in comparison to other widely accepted harm reduction strategies such as needle exchange programs (NEPs) (Elliott et al., 2002, p.11).

The second objection to SISs is referred to as the "honey pot effect," wherein opponents suggest the implementation of a SIS will create a space that is overpopulated by drug dealers and PWUD (Dolan et al., 2000, p.338). More specifically, Elliott et al. (2002) suggest opponents to the establishment of SISs claim "SISs attract users and dealers from outside the area" thereby creating more nuisance and crime. This argument is often supported by businesses in order to oppose the implementation of a SIS within their neighbourhoods (Elliott et al., 2002, p.13).

[37] Dolan et al. (2000) also points out this critique.
[38] "Official support" in this sense refers to support from the ruling body of government.

A third argument advanced by opponents suggests that SISs stall PWUD from entering drug treatment programs (Dolan et al., 2000, p.338). Elliott et al. (2002) also note critics advance morality based arguments in opposition to SISs[39]. The first argument suggests drug use is morally wrong; therefore opponents express disapproval of proposals for programs that accept this practice (New South Wales Joint Select Committee into Safe Injecting Rooms[40], 1998, p.107 in Elliott et al., 2002). Additionally, opponents argue, it is "morally wrong" to encourage individuals to consume illicit psychoactive substances (NSWJSCSIR, 1998, p.108). Opponents also held the view of addiction as a "self-inflicted wound" since individuals voluntarily engage in drug use. From this perspective, the provision of a SIS is to be understood as a "reward for illegal actions" which further "encourage weak willed persons" to engage in injection drug use (NSWJSCSIR, 1998, p.108). Lastly, opponents of SISs argue there is a "lack of clear evidence demonstrating the success of SIS," describing SISs as "ineffective" or even "harmful" (Elliott et al., 2002, p.12). The literature is not specific with respect to the ways in which the SIS is deemed to be ineffective or harmful. However, this research project will attempt to address some of these gaps within the literature regarding the nature of the debate in order to provide more insight into this matter.

1.5.2 Support for SISs

In 2002, when Elliott et al. composed this article, the available evidence on the effectiveness of SISs was limited to the European experience (Elliott et al., 2002, p.12). Currently however, over a decade later, there exists more than thirty-five research papers published in leading academic journals indicating the effectiveness of this strategy in Canada as a public

[39] Elliott et al. (2002) draw from the Australian SIS debate regarding the implementation of a pilot facility in New South Wales (NSW).
[40] Henceforth referred to as the NSWJSCSIR.

health intervention (Hyshka, Bubela & Wild, 2013). The federal government of Canada commissioned a research team from the B.C. Centre for Excellence in HIV/AIDS to complete scientific evaluations of *Insite* during the pilot phase[41] of *Insite*'s implementation. These evaluations examined the impact of *Insite* on four specific areas, namely the social, health and legal costs associated with the SIS, the rate of overdose, the health rate, and the use of health and social services (Vancouver Coastal Health, 2013). Extensive and systematic evaluations of *Insite* have provided Canadians with a wealth of scientific evidence in relation to the effectiveness of SISs as a harm reduction strategy. There has been no evidence of adverse impacts from Vancouver's SIS, in contrast, *Insite* has been associated with a variety of public health and community benefits (Wood et al., 2006a). In addition, the demonstrable merits of Vancouver's SIS are consistent with several European and Australian SIS evaluations (Dolan et al. 2000; MSIC Evaluation Committee, 2003).

Proponents also claim that such facilities are an "effective public health measure" (Elliott et al., 2002). Evidence from research suggests more habitual use of the SIS is associated with the application of safer injection practices (Stoltz, Wood & Small et al., 2007). Safer injection practices help to reduce the transmission of bacterial infections and blood-borne diseases, such as HIV and HCV among PWUD. *Insite* also serves as the main setting for supervised injection education (Wood et al., 2006, p.1403). These findings are significant given the prevalence of HCV among users of *Insite* is 88% (Wood et al., 2005, p.1115)[42]. The frequent use of *Insite* is also associated with a decrease in rushed-injections, an unsafe injection practice that increases the likelihood of drug overdose (Stoltz, Wood & Small et al., 2007, p.37). Furthermore, these

[41] The pilot phase of *Insite* lasted three years.
[42] The authors found three main factors to be independently associated with HCV infection: involvement in the sex trade; syringe sharing; and a history of incarceration (Wood et al., 2005, p.1115).

findings are significant given that *Insite* successfully attracts individuals with an elevated risk of overdose, and HIV infection, and individuals who are more likely to engage in public injections (Wood, Tyndall, Li et al., 2005). Such risks are further elevated by unsafe injection practices including the reuse of syringes, and the failure to use alcohol to clean an injection site prior to injecting (Wood, Tyndall, Li et al., 2005). The positive changes in injection drug practices among individuals who utilize *Insite* also suggests SISs are effective structural interventions which may alter the physical conditions that impact injection-related harm for individuals who inject in public (Stoltz, Wood & Small et al., 2007, p.38).

Furthermore, the evidence suggests more frequent use of the SIS in Vancouver corresponds with an increased uptake of detoxification services[43] (Wood et al., 2006c). Individuals who utilize *Insite* receive referrals to other services such as addiction counselling, community clinics, housing, methadone maintenance and recovery housing (Tyndall, Kerr and Zhang et al., 2005). Tyndall, Kerr and Zhang et al. (2005) suggest the increasing number of individuals seeking out addiction counselling[44] may be a result of more frequent interaction with health professionals which allows clients and staff to develop trusting relationships (p.5). In addition, Small et al. (2009) conclude that the SIS, in comparison to traditional programs[45] is more accessible for PWUD because the facility provides "non-judgmental and integrated care" (p.341).

In addition, proponents of SISs claim such facilities aid in "preventing shooting galleries" (Elliott et al., 2002, p.14). In the absence of a regulated, safe space for injection drug use, some

[43] On the second floor of *Insite* is a detoxification facility called *Onsite*. *Onsite* contains twelve rooms, each with a private bathroom, wherein PWUD can engage in detoxification with the support of social workers, and medical professionals. The third floor of this facility contains recovery housing for individuals in transition between drug use (Vancouver Coastal Health, 2013).
[44] From 2003 to 2004, the number of individuals who sought out addiction counselling increased from 121 to 314 (Tyndall, Kerr & Zhang et al., 2005, p.4).
[45] Traditional programs in this context refer to programs that are abstinence-based.

PWUD retreat into "shooting galleries," or illegal venues where individuals pay an entrance fee to meet for the purpose of injecting drugs (Ouellet, Jimenez & Johnson, 1991). Due to the illegal nature of shooting galleries, such spaces lack the presence of health care professionals and the supply of sterile injection equipment (Elliott et al., 2002, p.14). Proponents also argue SISs are an effective harm reduction strategy in areas with high rates of drug injection related overdose. Marshall, Milloy and Wood et al. (2011) note *Insite* contributes to a reduction in overdose mortality, reducing the rate of mortality by 35% within 500 metres of the facility[46] (p.1434).

In response to opponents concerns regarding the "honey pot effect," researchers assert SISs attract a population of street based, or homeless PWUD, a cohort that already makes use of the local drug market (Elliott et al., 2002, p.13). This cohort is not particularly mobile and "will travel only a short distance between the point of purchase and the use of drugs" (Clarke (2000) in MacPherson, 2000, p.64). Furthermore, Elliott et al. (2002) suggest the experience in Frankfurt, Germany, exemplifies the establishment of a SIS does not necessitate an inundation of drug users (p.13). Evaluation research on *Insite* also indicates the establishment of a SIS increases public order, and does not contribute to an increase in crime (Wood, Kerr, Small et al., 2004). In relation to public order, after the implementation of *Insite*, Wood et al. (2006) observed a significant decrease in both public drug use and the sharing of syringes for injection purposes (p.1403). The authors also note a reduction in publicly discarded drug injection equipment (Wood et al., 2006a). The implementation of a SIS also does not correspond with an increase in drug trafficking or other drug-related crimes (Wood et al., 2006, p.15). The VPD's definition of drug trafficking includes "selling, administering, giving, transferring, transporting, sending, or delivering illicit drugs" (Wood et al., 2006, p.13). Moreover, drug related crimes include "acquisitive crimes" such as theft, robbery, vehicle break-ins, and assaults (Wood et al., 2006, p.13). While these acts

[46] The rate of overdose in other parts of Vancouver witnessed a 9% reduction.

are associated with concentrated illegal drug scenes in the DTES area[47] (Wood, Kerr, Montaner et al., 2004), the implementation of a SIS in the community was not met by an increase in such crimes[48].

Another claim advanced by proponents of SISs utilizes a cost-benefit argument, which suggests SISs are "a cost effective measure" (Elliott et al., 2002, p.14). The total operational cost of *Insite* is approximately three million dollars per year (Pinkerton, 2010). The financial cost associated with treating one individual infected with HIV for a lifetime is estimated to be 210, 555 dollars[49] (Albert et al., 1998). Pinkerton (2010) conducted a cost savings analysis of *Insite,* concluding the SIS is effective in preventing approximately 83.5 HIV infections each year, an equivalent of 17.6 million dollars in health care cost savings (Pinkerton, 2010, p.1433). The associated savings in preventable medical costs in relation to HIV effectively offsets *Insite*'s annual cost of operation; therefore the SIS is extremely cost saving (Pinkerton, 2010, p.1434). In fact, without the SIS, the DTES anticipates an increase in the annual rate of HIV infection, from 179.3 to 262.8 (Pinkerton, 2010, p.1429).

Lastly, in response to the argument that SISs facilitate illegal conduct (e.g. the use of certain psychoactive substances), Elliott et al. (2002) argue that the provision of a space to an individual for the purpose of drug consumption, is not "substantially different from providing a needle" to individuals to inject an illicit substance through NEPs given that both interventions are carried out with the knowledge of the activity that PWUD will engage in through the use of such services (p.11). Rather, the significant difference lays in the fact that SISs offer a sanitary

[47] The DTES area includes the DTES proper, Chinatown, Victory Square, Strathcona and Gastown (Wood et al., 2006).
[48] Wood et al. (2006) studied the rates of crime for drug trafficking, vehicle theft and assault and robbery, one year prior to the implementation of *Insite* and one year after its establishment. The authors found no increase in these types of crimes after the implementation of *Insite*.
[49] This is based on estimates from the Canadian Policy Research Network, and is adjusted to account for rates of inflation (Pinkerton, 2011).

environment staffed with medical professionals in addition to the provision of sterile syringes (Elliott et al., 2002, p.11). From this perspective, the authors suggest SISs are a "natural, small step beyond" NEPs[50], which have been widely accepted and implemented throughout Europe and North America[51].

The literature by Elliott et al. (2002) and Dolan et al. (2000) highlights many key arguments in the debate with regard to the implementation of SISs. However, the social, political and legal landscape has shifted drastically in Canada over the last decade and there is a dearth of knowledge regarding the nature of the current debate in relation to the establishment of additional SISs in Canada. In addition, many of the arguments are derived from the debate in Australia, in which the establishment of a SIS was the product of a government initiative (NSWJSCIR, 1998) rather than a social movement (Kerr, MacPherson & Wood, 2008). Therefore, this literature should be understood exclusively as an informative point of departure for this thesis. The subsequent section presents the literature on the politicization of SISs and scientific evidence regarding *Insite*.

1.6 The Politicization of *Insite*

Insite is an example of a harm reduction intervention that has been heavily politicized and debated in Canada[52]. Small (2007) suggests the politicization of SISs in Canada first began with the political debates in Vancouver and continued into the nation's capital, in Ottawa. In 2000, Mayor Owen launched Vancouver's new drug strategy entitled *A Framework for Action: A Four*

[50] This is not to suggest that NEPs are only limited to the provision of sterile syringes.
[51] However, this is not to suggest that NEPs and SISs serve the same objectives, while NEPs aim to reduce the spread of blood-borne infectious diseases through the distribution of sterile syringes this is merely one of the objective of SISs (Elliott et al., 2002, p.10). SISs also aim to manage incidents of overdose in relation to injection drug use through the supervision of injections by medical professionals (Elliott et al., 2002, p.11) as well as to connect drug users with health and social services.
[52] A theoretical discussion regarding politicization will be presented in the following chapter.

Pillars Approach to Drug Problems in Vancouver (MacPherson, 2000). The drug strategy espoused a public health approach to address the calamity in Vancouver, advocating for a balance between the use of enforcement, treatment, prevention and harm reduction (MacPherson, 2000). The strategy also outlined the need for a collective response between the municipal, provincial and federal government (MacPherson, 2000). Among the recommendations within the new drug strategy, the proposal to study the practicality of establishing a SIS attracted the most interest (Kerr, MacPherson & Wood, 2008, p.119). Consequently, Mayor Owen convened a public discussion regarding the potential establishment of a SIS in the following months (Kerr, MacPherson & Wood, 2008). In the same year, a citizen group comprised of local business operators and property owners called the *Community Alliance* voiced their opposition to harm reduction and SISs[53] (Small et al., 2006; Small, 2007; Dooling & Rachlis, 2010). The *Alliance* attempted to block a number of development applications for healthcare and support services for PWUD, including applications for a drug user's resource center and a SIS (Small et al., 2006). The *Alliance* was defeated at a public hearing in Vancouver and in their appeal to the Board of Variance[54]. Subsequently, the *Alliance* filed a legal injunction, which was also met with a loss (Small et al., 2006, p.78).

In May of 2001, the Vancouver City Council approved the new four pillars drug strategy (Kerr, MacPherson & Wood, 2008, p.119). While Mayor Owen and City Counselor Sam Sullivan, members of the Non Partisan Association (NPA), advocated for the implementation of a SIS, the proposal was met with much political discord by other members of the NPA (Small et al., 2006). According to Small et al. (2006) it was "politically hazardous" to support the

[53] A notable portion of the Chinatown community opposed the proposed SIS; Chinatown shares a border with the DTES in Vancouver (Boyd, 2013). However, after *Insite* opened, the attitudes of the Chinatown community shifted towards support for the facility as business operators and property owners experienced an increase in public order.
[54] The Board of Variance hears appeals to decisions in accordance to bylaws of the city of Vancouver regarding zoning and development (City of Vancouver, 2013).

establishment of SISs during this time (p.79). The SIS became subject to further politicization during the 2002 Municipal Election in Vancouver. While Mayor Owen's proposal for a SIS garnered much public support, his own political party did not maintain the same view. In the time leading up to the 2002 municipal election, Mayor Owen was forced to resign from his position by the NPA in light of his advocacy of SISs (Small et al., 2006; Kerr, MacPherson & Wood, 2008). The NPA appointed a new contender for the upcoming election, an individual who was subsequently defeated by Larry Campbell[55] of the Committee of Progressive Electors (COPE), who proposed to go forward with Owen's plans to implement a SIS (Kerr, MacPherson & Wood, 2008, p.119). The voters had hoped for the establishment of a SIS in Vancouver and in a majority vote, elected Campbell as the new mayor of Vancouver (Small et al., 2006; Small 2007). The local political landscape shifted on November 16, 2002 with the election of Campbell[56]. In contrast to the previous year, it became "politically hazardous" not to support the establishment of SISs (Small et al., 2006, p.79).

In November of that year, Mayor Campbell traveled to the nation's capital to press for the federal government and Health Canada to grant a legal exemption for a SIS upon reception of Vancouver's proposal (Kerr, MacPherson & Wood, 2008, p.121). Once Mayor Campbell returned to Vancouver, he organized a meeting between the Chief Executive Officer (CEO) of the Vancouver Coastal Health (VCH) and the Vancouver Chief of Police to construct a plan for the implementation of a SIS (Kerr, MacPherson & Wood, 2008, p.121). The police demonstrated opposition to SISs given their illegal status[57] however the VCH moved forward with plans for a SIS and submitted an application to the federal government for a legal exemption (Kerr,

[55] Campbell was a former RCMP officer and chief coroner in the city of Vancouver (Small, 2007).
[56] Prior to Campbell's election, the Non Partisan Party (NPP) had been in power since the 1980s (Boyd, 2013).
[57] In this instance, the illegal status of SISs refers to the criminalized activities that clients of a SIS and the staff engage in (e.g. possession of certain illicit psychoactive substances).

MacPherson & Wood, 2008, p.121). In the province of British Columbia the SIS debate "cut across political boundaries" as leading politicians from various parties demonstrated support for SISs (Small et al., 2006). More specifically, these key players included Libby Davis, a New Democratic Party (NDP) Member of Parliament for the Vancouver East riding, Jenny Kwan, an NDP member of the Legislative Assembly, and Heddy Fry, a Liberal Member of Parliament (Small et al., 2006).

The federal politicization of SIS commenced in 2003 with the debate to grant the VCH an exemption to implement a pilot SIS in Vancouver (Small, 2007). The Liberal government, under the leadership of former Prime Minister Jean Chrétien, assented to the initial exemption under section 56 of the CDSA (Boyd, 2013, p.236). The initial federal exemption issued in 2003 by the Health Minister at the time, Tony Clement, was valid for three years (Small et al., 2006). The exemption was granted with a stipulation, that *Insite* be subject to rigorous scientific evaluations during the first three years of its pilot phase in order to ascertain the effectiveness of the facility (Kerr, MacPherson, & Wood, 2008, p.124). Health Canada provided the funding for the evaluation research on *Insite* during this pilot phase and the VCH contracted the B.C. Centre for Excellence on HIV/AIDS to complete the studies on *Insite* (Expert Advisory Committee, 2008).

In 2005, before the 2006 federal election, the Conservative government publicly voiced their opposition to *Insite* (Small, 2010). The politicization of *Insite* continued throughout the federal election, during which time Conservative leader, Stephen Harper, expressed his view of addiction as a criminal matter (Small, 2007, p.20). Further highlighting his opposition to *Insite*, Harper also stated "[w]e as a government will not use taxpayers' money to fund drug use" (Boyd, 2013, p.236). The conflict in relation to *Insite* became even more heightened in January 2006, upon the election of Stephen Harper as the Prime Minister of Canada (Boyd, 2013, p.236). The Conservative party succeeded in obtaining a minority government for the first time in thirteen

years, prior to which time the Liberal government held power (Boyd, 2013). According to Small (2007), the political storm subsided until February of 2006 with the expiry of *Insite*'s legal exemption nearing (p.19).

Upon the end of the first three years, in 2006, *Insite* was required in accordance with the law to apply for another exemption in order to continue its operations (Small, 2008). Several months before the expiry of the exemption, *Insite* operators and evaluators applied to Health Canada for a three-and-a-half year extension for the pilot SIS (Kerr, MacPherson & Wood, 2008, p.124). To assist in the decision-making process, Health Canada contracted three international experts to review the proposal, which was inclusive of the research results from the evaluations of *Insite* (Kerr, MacPherson & Wood, 2008, p.124). Each of the reviewers provided positive assessments of the proposal (Kerr, MacPherson & Wood, 2008, p.124). However, the future of *Insite* appeared uncertain as reports in the media suggested Harper "was not supportive of harm reduction" (Small, 2007, p.20). The Prime Minister also stated to the media "he would be consulting the RCMP for advice on the SIF"[58] (Small, 2007, p.20). In response to the unfavourable political climate, in May 2006, organizations and citizens concerned for the future of *Insite* formed a coalition, *Insite for Community Safety* (IFCS), to advocate for the SIS (Small, 2007, p.23). The grassroots organization launched a public education campaign and delivered thousands of letters in support of *Insite* to Prime Minister Harper, the Health Minister, and Canadian members of parliament[59] (Small, 2007, p.21).

In July, 2006, the RCMP's Drugs and Organized Crime Awareness Service countered the grassroots organization by sending emails of encouragement to all members of the RCMP, the

[58] SIF refers to supervised injection facilities or safe injection facilities.
[59] Letters were sent by physicians, unions, nurses, police officers, the Canadian Federation of Students, business associations in Vancouver, community leaders such as the Health Minister of B.C., the Premier of B.C, the Mayor of Victoria and leaders major Chinese service organizations, leading academics, editorial boards of the *Vancouver Sun* and the *Vancouver Province*, Canadian AIDS service organizations and international medical experts (Small, 2007, p.21).

VPD and addictions health professionals, urging individuals to voice their opposition to *Insite* through letters to the PM requesting "that he not renew the exemption" (Small 2007, p. 21). Furthermore, on August 28, 2006, the RCMP issued a statement regarding *Insite* claiming the facility to be unsuccessful without providing evidence of this claim (Wood, Tyndall, & Montaner et al., 2006). On September 1, 2006, the Canadian Police Association (CPA) issued a similar statement, also calling for *Insite* to be shut down (Wood, Tyndall & Montaner et al., 2006). On the same day, hours after the CPA statement, the Health Minister, in a press release announced: [60]

> Initial research has raised new questions that must be answered before Canada's new government can make an informed decision about the future of Vancouver's drug injection site or consider requests for any new injection sites […] Do safe injection sites contribute to lowering drug use and fighting addiction? Right now the only thing the research to date has proven conclusively is drug addicts need more help to get off drugs […] Given the need for more facts, I am unable to approve the current request to extend the Vancouver site for another three and a half years (Health Canada, 2006).

Rather than grant another exemption, the Health Minister granted an eighteen-month extension to the operators of *Insite* with the stipulation that additional research be conducted on the impact of *Insite* on crime, treatment and prevention[61]. Small (2007) speculates the decision to extend the legal exemption would have provided the federal government enough time to establish a majority government, because the extension was set to expire after the next federal election, which would allow the federal Conservative party to eliminate the SIS "without chance of being defeated in the House of Commons by the Liberals, New Democrats and Block who all support *Insite*" (p.23).

[60] Later sources revealed this decision to be influenced by an opinion poll conducted by the Prime Minister's Office regarding SISs (Small, 2008; Kerr, MacPherson & Wood, 2008). The results of the opinion poll indicated majority support for SISs both in British Columbia, the province in which *Insite* operates, and in Canada (Kerr, MacPherson & Wood, 2008, p.125; Small, 2008).

[61] Several months after the Health Minister's announcement, the federal government introduced the *National Anti Drug Strategy* (NADS) (Kerr, MacPherson & Wood, 2008).

Despite the Health Minister's request for additional research, previous funding from Health Canada for evaluation research was terminated (Small, 2007, p.23)[62]. In addition, the Health Minister prohibited the search for additional information regarding SISs by placing a ban on further trial SISs throughout Canada (Wood, Kerr, Tyndall & Montaner, 2008a, p.223). Subsequently, the federal government sought out proposals for SIS research on the additional areas of crime, treatment and prevention. However, as Wood, Kerr, Tyndall and Montaner (2008) note, investigators were granted contracts for this research on the condition that they would abstain from publishing their research in any venue such as peer-reviewed academic journals, academic conferences or the media until six months after the date of completion, coincidentally, also after the expiration of the *Insite*'s legal exemption (Wood et al., 2008, p.222). The authors suggest this stipulation to be unorthodox for scientific grants and a violation of the legal and ethical research guidelines of University institutions (Wood et al., 2008, p.222). The actions of the Health Minister were subject to scrutiny and the evaluators of *Insite* criticized the federal government of "political interference" in the natural advancement of evidence-based policy (Kerr, MacPherson & Wood, 2008, p.125).

Elliott (2008) suggests the request for additional research in the areas of crime, treatment and prevention reflects the way in which the federal government is "illegitimately moving the goal posts" (p.229). In other words, the request for further research in such areas thereby obliges a public health intervention to meet criminal justice goals. Whereas the SIS offers PWUD health services, to measure the effectiveness of such an intervention in terms of a reduction in crime is to arbitrarily apply standards of evaluation. In addition, Elliott (2008) suggests the failure to demonstrate a relationship between the implementation of *Insite* and a reduction in rates of crime

[62] Subsequently, the evaluators of *Insite* submitted the same funding proposal to the Canadian Institutes of Health Research (CIHR), which was accepted (Wood et al., 2008a, p.224). The team of evaluators received funding from the CIHR for further evaluation research on *Insite*.

may serve as the justification to terminate the legal exemption (p.229). It is important to note the federal government had not yet disclosed the justification for going against the suggestions emanating from the scientific evaluations (Wood et al., 2008, p.224).

The RCMP also attempted to discredit the research conducted by the evaluation team through statements in the media criticizing "the independence and objectivity of the research" (Small, 2007, p.21). In late 2006, the RCMP discretely commissioned several researchers to complete reviews of the existing evaluations of SISs (Boyd, 2013, p.236). When the RCMP funded research resulted in positive findings in support of previous research on the effectiveness of SISs, the RCMP attempted to "distance itself" from these reports (Wood et al., 2008; Dooling & Rachlis, 2010, p.1442)[63]. Subsequently, the RCMP contracted an anti-harm reduction activist, Colin Mangham, to conduct another review of the evidence (Wood et al., 2008). The critique of *Insite* was subsequently published online in a non-academic journal, *The Journal of Global Drug Policy and Practice*, which is financed by the Drug Free America Foundation (DFAF)[64] (Hyshka, 2012, p.126)[65]. The article by Mangham did not meet scientific peer-review standards required of academic research (Wood et al., 2008), however the federal government cited this research as reason to oppose *Insite* (Hyshka et al., 2013; Wood et al., 2008; Dooling & Rachlis, 2010; Boyd, 2013). According to Hyshka et al. (2012), these occurrences reflect the way in which the current federal government has overlooked the role of evidence in determining public policy (p.125). Similarly, DeBeck and Kerr (2010) note the insignificance of scientific evidence in this policy domain as the nature of the federal government's opposition to SISs remains ideological (E168).

[63] This was kept from public knowledge until the *Pivot Legal Society*, under the freedom of information act, discovered the RCMP had tried to conceal their association with the research they commissioned (Dooling & Rachlis, 2010, p1442).
[64] The DFAF is a lobby group in support of criminal justice responses to illicit drug use (Wood, Montaner & Kerr, 2008).
[65] See Mangham (2007).

Because the existence of scientific evidence did not serve to persuade policy-makers to keep *Insite* open, the operators of the facility sought out a different approach.

1.7 *Insite* in Court: the Legal Battle to Stay Alive

On October 2, 2007, with the expiration of *Insite*'s extension nearing, Harper ordered the Health Minister to defer the decision regarding the status of the pilot SIS yet again, extending the life of the legal exemption until June 30, 2008 (Small, 2008). With the second extension about to expire, *Insite* submitted another proposal to renew the pilot status of the SIS. The Health Minister did not provide a response formally denying the application nor did he grant the VCH another extension (Small, 2008). In an effort to keep *Insite* alive, the Portland Hotel Society (PHS) Community Services Society, a co-operator of the facility, initiated legal proceedings against the Attorney General of Canada and the Health Minister[66] (DeBeck & Kerr, 2010, E168; Small, 2012). The Conservative government took an unwavering stance against *Insite* in a legal battle that spanned over three years, finally proceeding to the Supreme Court of Canada (SCC) (Small, 2012).

On May 27, 2008, the matter between the PHS and the federal government entered the B.C. Supreme Court (Dooling and Rachlis, 2010). The main argument advanced by the PHS claimed PWUD, specifically injection drugs, "have a constitutional right" to utilize the services of *Insite* in light of the provision of health care at the facility which helps to reduce the harms associated with injection drug use (DeBeck & Kerr, 2010, E168). Therefore, the claimants argued the application of the possession provision of the CDSA to both clients and staff of *Insite* to be in violation of their rights "to life, liberty and security of the person" (Hyshka et al., 2013, p.470).

[66] The VCH advised the PHS to refrain from turning to the courts and did not provide formal assistance to the PHS despite being a co-operator of the facility (Small, 2012, p.35).

Since health care falls under the purview of provincial and territorial governments in Canada, the PHS argued, the province of B.C. should have "constitutional power" over the operation of *Insite* given that the SIS provides health care services (DeBeck & Kerr, 2010, E168). While the B.C. Supreme Court Judge, Ian Pitfield dismissed the argument regarding interjurisdictional immunity in the case of *Insite* (DeBeck & Kerr, 2010), he ruled section 4 subsection 1 and section 5 subsection 1 of the CDSA[67] to be inconsistent with section 7 of the *Canadian Charter of Rights and Freedoms*[68] thereby granting *Insite* an exemption in order to continue its operation (Dooling & Rachlis, 2010).

Following the verdict of the B.C. Supreme Court, the federal government appealed Judge Pitfield's decision. The case appeared in the B.C. Court of Appeal on January 15, 2010. Justice Carol Huddart of the B.C. Court of Appeal upheld the ruling by Judge Pitfield. Justice Huddart further stated the province of B.C. had "jurisdictional immunity" over *Insite* (Dooling and Rachlis, 2010, p.1443). In other words, Justice Huddart supported the view that *Insite* provided health care services to its clients, and thereby concluded that the SIS should fall under the jurisdiction of the province, not the federal government (Dooling and Rachlis, 2010, p.1443). This decision was subsequently cross appealed by the Attorney General of Canada and brought to the SCC (Small, 2012).

On September 30, 2011 the SCC issued a decision in favour of *Insite*. However, the SCC dissented with the rulings from the previous courts, rather the SCC ruled the failure of the Health Minister to grant a legal exemption endangered the lives of those who relied on the services of

[67] In relation to possession provisions under the CDSA, section 4, subsection 1 states, "except as authorized under the regulations, no person shall possess a substance included in Schedule I, II or III. In relation to trafficking provisions under the CDSA, section 5 subsection 1 states, "no person shall traffic in a substance included in Schedule I, II, III or IV or in any substance represented or held out by that person to be such a substance".
[68] Henceforth referred to as the *Charter*. Section 7 of the *Charter* states "everyone has the right to life, liberty and security of the person and the right not to be deprived thereof in accordance with the principles of fundamental justice."

Insite and was therefore, in violation of section 7 of the *Charter* (Small, 2012; Hyshka et al., 2013). The appeal by the Attorney General was dismissed and the SCC ordered the Health Minister to grant *Insite* an exemption under the CDSA (Small, 2012)[69]. The *Charter* entrenches individual rights and freedoms with respect to the federal, provincial and territorial governments (Small, 2012, p.34-35). As such, the decision served to highlight "the rights of people with addictions to the security of their person under section 7 of the Charter" (Small, 2012, p.34). The SCC decision regarding *Insite* also reflects an instance wherein scientific evidence and constitutional rights triumphed over ideology in the courts (DeBeck & Kerr, 2010, E169).

1.8 Continued Resistance to Supervised Injection

Although the federal government failed to shut down *Insite* through a series of legal proceedings, Hyshka et al. (2013) suggest the SCC decision to allow for *Insite* to remain open does not completely dissolve the legal hurdles that impede the implementation of SISs. Some authors[70] characterize the federal government's continued resistance to SISs as an ideological opposition in light of the available scientific evidence citing the merits of the intervention and notable public support for the establishment of a facility in cities including Vancouver[71], Toronto and Ottawa[72]. This speculation is reflected in the most recent campaign against SISs initiated on June 6, 2013 by the Conservative party entitled "keep heroin out of our backyards" (Webster,

[69] In addition, the SCC decision stated the Health Minister "should generally grant an exemption" in cases where "there is little or no evidence that it will have a negative impact on public safety" and a SIS "will decrease the risk of death and disease" (*Canada (Attorney General) v. PHS Community Services Society*, 2011, p.11). The SCC ruling also instructed the Health Minister to consider "evidence, if any, on the impact of such a facility on crime rates, the local conditions indicating a need for such a supervised injection site, the regulatory structure in place to support the facility, the resources available to support its maintenance, and expressions of community support or opposition" (*Canada (Attorney General) v. PHS Community Services Society*, 2011, p.75).
[70] See Hwang, 2007; Kerr, Montaner & Wood 2008; Hathaway & Tousaw, 2008; DeBeck & Kerr, 2010; and Jozaghi, 2012.
[71] See Kerr, MacPherson & Wood, 2008; and Small et al., 2006.
[72] See Bayoumi, Strike, Brandeau et al., 2012.

2013). The campaign allows individuals to sign an electronic petition in opposition to SISs (Webster, 2013). The campaign is spearheaded by Jenni Byrne, the Prime Minister's deputy chief of staff. On the main webpage of the campaign Byrne writes to Canadians and asks:

> Do you want a supervised drug consumption site in your community? These are facilities where drug addicts get to shoot up heroin and other illicit drugs. I don't want one anywhere near my home. Yet, as I write this, special interests are trying to open up these supervised drug consumption sites in cities and towns across Canada—over the objections of local residents and law enforcement (Byrne, 2013).

According to Webster (2013), the Conservative government "seems unrelenting" as this campaign was introduced in conjunction with the *Respect for Communities Act*, which proposes an amendment to section 56 of the CDSA in order to change the application process for SISs (Health Canada, 2013). The introduction of this *Act* threatens the survival of *Insite* (Zlotorzynska, Wood, Montaner & Kerr, 2013, p.1303) and the implementation of additional SISs in Canada, in light of this, a discussion of the proposed policy will be revisited in the conclusion of this thesis.

1.9 Conclusion

The existing literature provides an appreciation of the socio-political context in which the SIS in Vancouver was established. Numerous political, social, cultural, and legal challenges had to be confronted in order for the establishment of a SIS to be realized (Kerr, MacPherson & Wood, 2008; Small et al., 2006). The literature also suggests the Canadian federal government has politicized a health issue, and demonstrated ideological opposition to the SIS[73]. In addition, the literature brings to light several of the key players involved in the debate and the politicization of *Insite,* however a missing piece within the literature is the nature of the debate on the implementation of SISs in Canada. In addition, given the current literature, it is important to

[73] See Hwang, 2007; Small, 2007, 2008; Wood, Kerr, Tyndall & Montaner, 2008; Hathaway & Tousaw, 2008; Kerr & Wood, 2008; Wood, Montaner & Kerr, 2008; Zlotorzynska et al., 2013; and Boyd, 2013.

critically analyze the opposition to SISs given that the resistance to this life saving intervention has direct implications for individuals with active addictions (Wood & Kerr, 2008). Joel Best's (2008) theoretical perspective on the construction of social problems may be valuable in an analysis of this phenomenon.

CHAPTER 2: THEORETICAL FRAMEWORK

The theoretical approach undertaken in this thesis is inspired by the work of Jensen, Gerber and Babcock (1991) and Jensen and Gerber (1993). Jensen et al. (1991) utilize a constructionist approach to analyze the 1986 war on drugs in the U.S.A. through the application of the model of social problems construction by Mauss (1975). Existing theories on the social problems process suggests some social problems are constructed by activists at the grassroots level in the form of a social movement (Mauss, 1975, 1984, 1989; Small, Palepu & Tyndall, 2006) while other studies (Chauncey, 1980; Randall & Short 1983; Jensen, Gerber & Babcock, 1991; Scheingold, 1991) suggest government officials construct social problems on their own accord. Jensen et al. (1991) and Jensen and Gerber (1993) demonstrate the socially constructed nature of the war on drugs to be a "result of political claimsmakers attempting to boost their popularity in an election season with a wholesome, safe issue to champion" (Jensen et al., 1991). Similarly, Jensen and Gerber (1993) analyze the construction of the 1986 war on drugs in Canada through the use of a social constructionist model that suggests "some social problems are created by powerful claimsmakers, to serve political self-interests" (Jensen & Gerber, 1993, p.454). In light of these findings, I have chosen to adopt a similar theoretical framework, the social construction of social problems by Joel Best (2008) in order to examine the debate on the implementation of SISs in Canada.

This chapter begins with a brief overview of the two perspectives from which the study of social problems may be approached. Thereafter, a discussion regarding the socially constructed nature of the 'drug problem'[74] and the potential responses to the condition will be presented.

[74] The 'drug problem' is presented in single quotation marks to emphasize its socially constructed nature. This is not to suggest the absence of observable conditions that qualify as the 'drug problem,' but rather that the 'drug problem'

Given the importance of the theoretical concept of politicization for this thesis, several interpretations of the term will be discussed. Furthermore, the politicization of crime issues, and politicization in relation to drug policies will subsequently be addressed. Lastly, an outline of the natural history model of the social problems process by Best (2008) will be presented, followed by an overview of the framework to analyze claims.

2.1 Objectivist vs. Subjectivist Outlook

There are two distinct perspectives on the construction of social problems, namely the objectivist outlook and the subjectivist outlook (Best, 2008)[75]. The first perspective is often called objectivist in light of its tendency to define social problems in relation to "objectively measurable characteristics of conditions" (Best, 2001, p.4). In other words, a social problem is measured according to an observable level of harm to individuals and the social structure (Jensen & Gerber, 1998, p.2). Thus, from this perspective, social problems are defined as a "societal condition that causes harm to individuals or to society as a whole" (Basis, Gelles & Levine, 1982 in Jensen & Gerber, 1998, p.2). However, the objectivist perspective falls short in this regard because not all conditions that are considered to be harmful will gain recognition as a social problem (Best, 1989, 2008). As a result, the application of this approach fails to consider such social problems that emanate through a process of social construction.

In light of this shortcoming of the objectivist outlook, various scholars (Jensen & Gerber 1993, 1998; Best, 2008; Spector & Kitsuse, 2001) have adopted the subjectivist, or

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is a product of claims-making activities which has resulted in the acknowledgement of such a matter to be problematic.

[75] The objectivist outlook parallels Jensen & Gerber's (1998) notion of the objective harm perspective. In the same way, the subjectivist outlook is equated with the social constructionist perspective.

constructionist outlook for the study of social problems[76]. From this perspective social problems must be understood as the result of an interactive process by which people respond to social conditions rather than as an independent social condition (Best, 2008, p.9-10). In other words, social problems are the result of activities people participate in, involving the construction of claims regarding a particular condition as troubling (Spector & Kitsuse, 2001). From this perspective, social problems can also be understood as attempts to stimulate interest regarding certain conditions within society (Best, 2008, p.10). It is important to highlight that the study of social problems from a subjectivist perspective is not concerned with the validity of the claims, that is, "whether or not the imputed[77] condition exists" (Spector & Kitsuse, 2001, p.76)[78]. Rather, the subjectivist outlook focuses on the definitions of social problems, or the way in which social problems are defined (Schneider, 1985).

However, the objectivist outlook cannot be fully dismissed, as all social problems are comprised of "an objective condition and its constructed definition" (Jensen, Gerber & Babcock, 1991, p.652). Even the most extreme objectivists concede that claims-making activities have an influence over the social problems process in which a particular condition is recognized as problematic (Jensen et al., 1991). Similarly, most constructionists acknowledge the existence of an observable condition that serves as the point of departure for claims-making activities (Jensen et al., 1991). The work of previous authors (Jensen et al., 1991; Jensen & Gerber, 1993) points to the notion that, in relation to drug policy, the constructed definitions of the social condition are more important. As such, the author adopts a subjectivist outlook of the social problems process in this thesis, more specifically, the social construction of social problems advanced by Best

[76] That is not to suggest the subjectivist perspective comes without limitations. For a discussion on the limitations of this perspective see Holstein and Miller (1993; 2003).
[77] Spector and Kitsuse (2001) prefer the term putative conditions in order to highlight the notion that claims are about conditions that other individuals or groups allege to exist (p.76).
[78] A challenge to this perspective is grounded in the notion that there is a "real world—out there"— wherein particular conditions do exist (Spector & Kitsuse, 2001, p.76).

(2008) in order to explore the SIS debate during a period of heightened contention regarding the implementation of such facilities[79].

2.2 Social Construction and the 'Drug Problem'

It is first necessary to clarify what I mean when I refer to the 'drug problem'. In order to do so, I will borrow from Wright and Devine (1994) who have systematically detailed this phenomenon[80]. According to Wright and Devine (1994), the use of psychoactive substances comes to be a 'drug problem' "when the consequences become problematic" (p.4). Subsequently, the 'drug problem' becomes a social problem in the event that the consequences begin to have wide-reaching impacts on society and when measures to address the problem are feasible and sought-after (p.4). In other words, the 'drug problem,' when viewed as a phenomenon that solely threatens individual values and as a consequence of "unique and limited circumstances" can be understood as a private trouble[81]. Whereas, the 'drug problem' may be defined as a public issue (Mills, 1959) when it poses a threat to societal values, results from "general circumstances" and requires "collective action" in order to address the concern. In order to specify the 'drug problem,' Wright and Devine (1994) describe a number of social consequences associated with drug use that people collectively deem problematic including: crime; the enticement of drug use for young people; the harmful effects on health/ well-being; the large number of people who now regularly consume both licit and illicit psychoactive substances; the costs associated with medical care, the criminal justice system and lost productivity; and the decline of inner city neighbourhoods.

[79] The adoption of a constructionist perspective is not to deny the lived experiences of PWUD.
[80] Although Wright and Devine's (1994) account of the 'drug problem' is specific to the American context, the work of various scholars (Jensen et al., 1991; Jensen and Gerber, 1993) suggests the American experience is rather analogous to that of Canada.
[81] See C. Wright Mills (1959).

According to Best (2008), the way in which social problems come to be defined involves social construction, which refers to the manner in which individuals "assign meaning to the world" (Best, 2008, p.11)[82]. Humans utilize language in order to assign meaning and to construct knowledge (Best, 2008, p.11). From this perspective, all knowledge is socially constructed (p.114), as are all social problems (p.16). The social constructionist perspective assumes that social problems are created by people in society through a process of definition and redefinition, wherein people define certain conditions to be problematic (Best, 1987, 2008; Gusfield, 1963, 1981; Schneider, 1985; Spector & Kitsuse, 1987; 2001). Throughout this constructive process claimsmakers may present particular conditions as troublesome while disregarding other conditions (Jensen & Gerber, 1998, p.141). Thus, researchers employing the constructionist approach attempt to "trace the history of claims making" in order to provide an explanation for how and why an issue attracts public attention (Best, 1994).

This perspective is particularly well suited for inquiries regarding illicit drugs as various authors; most notably Giffen, Endicott and Lambert (1991), Jensen et al. (1991), and Jensen and Gerber (1993; 1998) have illustrated the socially constructed nature of the 'drug problem' in nations such as the U.S.A. and Canada. The constructive process points to the possibility for a problem to manifest in different forms and meanings, "with each form and meaning implying a particular set of policy solutions" (Jensen & Gerber, 1998, p.141). In light of this, the approaches to drug policy and the various strategies that have emerged under each approach should also be understood as a product of social construction[83]. As such, I begin by providing an overview of the approaches and strategies in response to the 'drug problem,' while highlighting some shared similarities underlying several of the strategies. This is an important distinction to make given

[82] This understanding of social construction is not to be confused with the account of social construction, which "refers to imaginary, nonexistent phenomena" (Best, 2008, p.16).
[83] See Giffen et al. (1991) on the social origins of Canadian narcotic drug prohibition (p.45).

that claims-making activities center around a troubling condition, or rather a claim that a troubling condition exists. Therefore, the responses to a particular social problem may vary in instances where there is a lack of consensus regarding the nature of the troubling conditions.

2.3 Responses to the 'Drug Problem': Approaches and Strategies

In general, there are three main approaches to the control of psychoactive substances and drug use in society: the legal/moral approach; the medical approach; and the public health approach[84]. The legal/moral approach and the medical approach both emerged at the turn of the 20th century (Shiner, 2006, p.59), while the public health approach emerged in the late 20th century.

2.3.1 Legal/Moral Approach

The legal/moral approach understands drug use to be a form of deviant behaviour (Goode, 1997). More specifically, the 'drug problem' under this approach is defined as a "moral failure" (Skolnick, 1992, p.156) and the non-medical use of drugs is perceived to be "a vice to be controlled by the law" (Shiner, 2006, p.60). The criminal law is utilized to control the 'drug problem'. As previously discussed, in Canada, the legal/moral approach to drug control emerged and developed at a rapid pace during the early 1900's (Giffen et al., 1991). The first federal drug statute, the *Opium and Narcotic Drug Act,* became ratified in 1908 (Giffen et al., 1991). Prior to that time, psychoactive substances did not fall under the domain of criminal law (Giffen et al., 1991).

The legal/moral approach utilizes prohibitionist strategies in order to eliminate non-medical use of certain drugs and promote a "drug free society" (Quirion, 2003). Prohibitionist

[84] See appendix B, table 1.

strategies aim to reduce the supply of illicit drugs and to deter individuals from using such drugs (Erickson, 1993). In order to achieve this utopian objective, legislation is utilized to criminalize certain drugs targeted in the 'drug problem' and drug related behaviours such as possession and trafficking[85]. These strategies rely on both law enforcement agents to police individuals and illicit drug related activities, as well as the criminal justice system to impose criminal sanctions and punish individuals who commit drug related offences (Benoit, 2003). The strategies and policies reflect the way in which the problem is constructed, as a criminal matter.

However, prohibitionist strategies such as the war on drugs have failed to meet its stated objective (Nadelmann, 1989; Andreas & Nadelmann, 2006; Friesendorf, 2007; Greenfield & Paoli, 2012) and such strategies have produced a number of unintended consequences (Nadelmann, 1989; Elliott et al., 2002; Robelo, 2013). A strict reliance on prohibitionist drug strategies and policies produces an array of negative consequences[86] for both individual drug users and society given that drug use and PWUD "do not exist in isolation" (Erickson & Butters, 1998, p.189). Current prohibitionist drug policies reflect a zero-tolerance mentality, which generates a highly profitable black market for illicit drugs subsequently contributing to violence and crime amongst the parties involved (Riley, 1999, C4). In addition, the violence and crime negatively impacts the larger society, extending beyond individual illicit drug users and dealers to their families and communities (Riley, 1999; Erickson & Butters, 1998). Furthermore, a zero-tolerance model of drug control that criminalizes illicit drug use marginalizes and stigmatizes PWUD (Elliott et al., 2002, p. 3) rather than provide these individuals with necessary health care services. The reliance on prohibitionist drug policies reinforces a particular kind of discourse surrounding illicit drug use that fails to recognize drug users as human beings, further

[85] For details on the criminal offences of possession and trafficking of illicit drugs, see the *Controlled Drugs and Substances Act* (CDSA).
[86] For additional information on the consequences of prohibitionist policies see Riley (1999).

legitimizing the traditional law enforcement response to illicit drugs. Additionally, such policies promote anti-drug attitudes within the public, which undermines notions of community caring (Riley, 1999).

2.3.2 Medical Approach

In response to the failure of prohibitionist strategies and the war on drugs, several alternative strategies have emerged including treatment, harm reduction, and drug legalization (Elliott et al. 2002; Greenfield & Paoli, 2012). Similar to prohibitionist strategies under a legal/moral approach, the medical approach, which emerged in the 1950s, also aims to eliminate non-medical illicit drug use in society. However, the medical model solely targets the demand of drugs whereas prohibitionist strategies aim to reduce both the supply and demand of illicit psychoactive substances. In addition, from a medical perspective, PWUD are not perceived as criminals, rather as diseased individuals in need of medical treatment[87]. Since drug use is understood as a disease, the central policy objective under this approach is to manage addictions through the provision of treatment (Benoit, 2003). From this perspective, PWUD are understood to be curable, that is, treatment strategies are believed to help PWUD abstain from drug use. Much like the legal/moral approach, the fact that certain drugs are illegal is not a problem, "except for purposes identified by the medical establishment" (Benoit, 2003). While the legal/moral and medical approach utilize different drug strategies, both prohibitionist and treatment strategies aim to achieve a similar objective, that is, to eliminate illicit drug use. This highlights how one single objective may be approached through different means, further emphasizing the socially constructed nature of illicit drug strategies and policies.

[87] This is not to suggest that all medical professionals perceive addiction as a disease as some medical professionals in the 1950s viewed PWUD as criminals. However, for the purpose of this project the medical approach should be understood as one that views addiction as a disease.

2.3.3 Public Health Approach

Moreover, the public health approach can also be understood as a response to prohibitionist drug strategies. Under this approach, addiction and addiction related issues such as the risk of the spread of disease, are conceived as public health issues rather than criminal matters (Riley, 1999). This approach is concerned not only with the health of individual drug users, but also the health of the community (Compton, 2005, p.461). Health related issues come to be viewed as a shared responsibility between all citizens in light of the widespread "social impacts of drug abuse" (Compton, 2005, p.461). As such, the strategies employed are aimed at reducing the spread of disease in both the population of illicit drug users and the broader community (Riley, 1993). These strategies are referred to as harm reduction or harm minimization strategies and started in the 1980s. Harm reduction can be understood as a framework[88] for the development and implementation of programs and policies so as to minimize or reduce the harms associated with illicit drug use without requiring abstinence from drug use (Erickson & Butters, 1998, p.179). The implementation of harm reduction strategies has been proposed as an alternative to the criminalization of drug-related behaviours. Riley (1998) notes harm reduction is preoccupied with safeguarding "the quality and integrity of human life, in all its wonderful, awful complexity" (p.27). In other words, the harm reduction approach appreciates the complex nature of societal issues, in particular those related to illicit drug use and the diversity of human needs, and recognizes that the response to problematic illicit drug use and the solutions may not be immediate or well defined.

The main principles of the harm reduction framework include pragmatism, humanistic values, a focus on harms and a hierarchy of goals (Riley, 1998). Pragmatism involves the

[88] In addition, harm reduction can be understood as a goal or a strategy (Riley, 1998), in either instance, the principles of harm reduction apply.

recognition and acceptance of the use of psychoactive drugs, to a certain extent, as ineluctable and that for some PWUD, the requirement of abstinence as a prerequisite for admission into treatment is not a realistic goal. Therefore, harm reduction strategies aim to reduce the harms associated with problematic illicit drug use rather than to eliminate all use of drugs (Erickson et al., 1997). In addition, the harm reduction approach emphasizes the need to adopt humanistic values such as respecting the rights and the self-worth of PWUD. In this sense, illicit drug use is understood as an individual's choice and should not be subject to "moralistic" judgment (Riley, 1998). This approach also helps to foster caring community attitudes towards PWUD in order to reduce the stigma attached to PWUD that are reinforced by prohibitionist strategies (Elliott et al., 2002). The use of a non-judgmental approach to drug use also facilitates access to health care services for PWUD (Drumm et al., 2003; Merril et al., 2002). This framework calls for a focus on the harms associated with problematic illicit drug use rather than the level of an individual's use. In light of this principle, the indicators of success for harm reduction strategies include a decrease in harms and an increase in safety and wellness (Carter & Chu, 2013, p.2). Lastly, harm reduction strategies and interventions employ a hierarchy of goals so as to address the most critical needs first. Some examples of harm reduction strategies include needle exchange programs (NEPs), methadone maintenance treatment (MMTs), SISs, and the distribution of safer crack use kits[89]. These strategies aim to reduce the negative health, social and economic consequences related to illicit drug use without requiring PWUD to abstain from drug use (Erickson & Butters, 1998, p.179).

Moreover, drug legalization promotes the eradication of "restrictive" drug policies and targets the reduction of harms associated with problematic drug use (DuPont & Voth, 1995,

[89] Safer crack use kits include materials such as a glass stem, rubber mouthpiece, brass screens, alcohol wipes, and lip balm in order to reduce the harms associated with smoking crack (Canadian HIV/AIDS Legal Network, 2008).

p.461). Under this strategy, the production and possession of any psychoactive substance does not constitute a criminal offence nor is subject to criminal prosecution[90] (Riley, 1998, p.2). Some scholars (Beauchesne, 1997, 2006; Chiu & Burris, 2011) view drug legalization as an avenue for the successful implementation of harm reduction strategies. Specifically, Burris and Chiu (2011) note the criminal law and police practices have the effect of impeding access to harm reduction services (p.8). In this sense, harm reduction and legalization strategies may operate in conjunction as both strategies share a similar objective; to reduce the harms associated with problematic drug use (United States General Accounting Office, 1993). In light of this shared objective, it becomes possible to incorporate legalization as a strategy under the public health approach for the implementation of harm reduction strategies.

In Canada, there is a continued reliance on the criminal law as a mechanism to control certain psychoactive substances despite the unintended consequences associated with prohibitionist strategies and the availability of alternative strategies. Prohibitionist strategies are not only ineffective in eliminating drug use, but the increase in health, social, economic and legal costs are in part a result of failed prohibitionist strategies (Elliott et al., 2002, p.3). Overall, the application of prohibitionist strategies results in negative consequences that "produce more net harm to individuals and society than accepting the inevitability of some drug use" (Elliott et al., 2002, p. 3). Riley (1999) suggests the reliance on prohibition is in part because illicit drug use continues to be understood from a legal/moral perspective wherein the problem is attributed to an individual shortcoming or weakness rather than a disease or an inevitable facet of human existence.

[90] Legalization offers multiple scenarios of regulation. It can be similar to the manner in which alcohol in society is controlled, or be more characterized as a free enterprise model (Riley, 1998, p.2).

2.4 Politicization of Crime Policies

For the purpose of this thesis, politicization can be understood as a process whereby "social actors attempt to place issues on the public agenda by calling attention to them and defining them as subject to political action" (Beckett, 1994, p.426). Social actors refer to conscious thinking individuals, groups or large-scale institutions that have the capacity to influence public debate and policy[91] (Ritzer & Ryan, 2011). Examples of social actors include all claimsmakers, and the mass media. Political action in this sense refers to any actions by "the institutional order of the state" (Dallmayr, 1997 in Marchart, 2007, p.182). Some examples of these actions include, but are not limited to, claims-making, the enactment of legislation, and the introduction of social policies.

David Garland (2002) notes there has been a dramatic shift in crime control practices during the last few decades. Of particular relevance is the manner in which crime policies have become salient issues in electoral campaigns in contrast to its former characterization as bipartisan matters at the helm of professional experts (Garland, 2002, p.16). The issue of illicit psychoactive substances in particular is a highly politicized issue in Western societies such as in Canada and the U.S.A. (Reuter, 2001). Radimecký (2007) describes the process of politicization as one that involves "the generation of arguments between drug abuse experts and politicians where the latter might ignore evidence-based recommendations by professionals" (p.18). This definition also reflects Garland's (2002) assertion that crime policies tend to be formulated in ways that seemingly value political advantage and populist ideas[92] rather than evidence from research and expert recommendations (Garland, 2002, p.16). The case of *Insite* reflects this

[91] In light of the available literature on social actors, this is most appropriate definition as it pertains to this thesis.
[92] According to Garland (2002), while the term politicization often implies a difference in policy positions, during the 1980s and 1990s, the debate between political parties began to narrow, resulting in less divergent policy proposals from the major political parties.

assumption as the authors[93] discussed in the previous chapter have highlighted the way in which the federal government of Canada takes issue with the intervention despite scientific evidence of its positive impacts and recommendations from international experts[94].

Scheingold (1991) suggests the rationale to politicize an issue is related to political elections and the desire to maintain political office. That is, politicians must establish an election campaign and adopt certain matters as major election issues. Politicization, in this sense, "has more to do with gaining and retaining political office than with policy making […]" (Scheingold, 1984, p.38). In light of this suggestion, once the debate enters a political arena, there are other issues that must be taken into consideration, such as the personal and institutional agenda of social actors as well as the power dynamics prevalent in such debates. As Best (2008) notes, individuals are more likely to participate in the debate if they have something to lose given that a particular claim succeeds.

Meier (1994) argues politicization in the drug policy sphere, is unlike the politics of other policy realms in that "no one supports drug abuse; virtually everyone is opposed" (p.106). Taking into consideration this shift in the trajectory of crime control policy, I suggest politicization can be understood as an important strategy in the process of social problems construction. I will proceed to outline the natural history model of the social problems process by Best (2008).

2.5 A Natural History Model of the Social Problems Process

Social problems are created through a process that involves a temporal order of developments (Fuller & Myers, 1941, p.322). Thus, a social problem is constantly in "a dynamic

[93] See Small 2007, 2008, 2010, 2012; Hwang, 2007; Kerr, Montaner & Wood, 2008; Hathaway & Tousaw, 2008; DeBeck & Kerr, 2010; Jozaghi, 2012; Hyshka et al., 2013; and Boyd 2013.
[94] See Kerr, MacPherson & Wood, 2008, p.124.

stage of becoming" as it "passes through the natural history stages" (Fuller & Myers, 1941, p.322). This is a hypothetical model, that is, it provides a framework for researchers to approach the study of social problems. In other words, it should be understood as a preliminary template to address first cases (Spector & Kitsuse, 2001, p.141). Various scholars have also proposed natural history models most notably Fuller and Myers (1941), Blumer (1971), Spector and Kitsuse (1977, 1987, 2001) and Best (2008). I utilize the model proposed by Best (2008) because the first stage of his framework of the social problems process is not specific to a particular group of claimsmakers, leaving the process of social problem construction more open ended so as to avoid making assumptions about how the social problems process is initiated. Best's (2008) natural history model of the social problems process is composed of six stages: claims-making; media coverage; public reaction; policy making; social problems work and; policy outcomes (Best, 2008, p.18).

Stage I: Claims-making

In this stage, claimsmakers first attempt to present persuasive arguments about what they perceive to be troubling conditions[95], which may generate the attention of others to the matter and produce reactions from other participants (Best, 2008, p.15). Best refers to this process of social construction as claims-making (Best, 2008, p.15). A claim is an argument, or an attempt to convince an audience, that there is "something wrong" or a troubling condition that must be resolved (Best, 2008, p.18). There are at least two participants involved in each claim: one party presents the claim and the other is the recipient of the claim. The party on the receiving end of the claim is referred to as the audience, that is, the participants "whom the claim is meant to persuade" (Best, 2008, p.40). Any participant of the social problems process may also be part of

[95] Troubling conditions refer to "the conditions that become subjects of claims" (Best, 2008, p.15).

the audience; this includes, but is not limited to the general public, other claimsmakers, the media, and policymakers (Best, 2008, p.40). The audience is segmented in terms of race, class, gender, age and other distinguishing characteristics (Best, 2008, p.41). The audience is also composed of individuals who differ in their ideologies and values, as such claimsmakers must take into consideration the interests and ideologies of the audience when constructing their arguments (Best, 2008, p.42).

Claimsmakers can be understood as "people who make claims" (Best, 2008, p.15). Best (2008) distinguishes between "outsider" and "insider" claimsmakers, the former refers to those individuals or activists who "do not hold powerful political offices" or lack connections with individuals who do (p.64). While insider claimsmakers are individuals who have a preexisting relationship with policymakers and are able to influence the policymaking process (Best, 2008, p.65). The media is the most important audience for outsider claimsmakers (Best, 2008, p.65) as it serves as the outlet through which claims may come to the attention of policymakers. In contrast, it is less important for insider claimsmakers to gather media attention and public awareness in light of their pre-established connections to policymakers (p.65). Some examples of individuals or groups who maintain connections with policymakers include government officials, lobbyists, and interest groups (Best, 2008, p.65). Policymakers are mindful of the interests of these individuals and groups, thus they may play an influential role in the policymaking process (Best, 2008, p.65).

In addition there are other types of claimsmakers, including the expert claimsmaker, an individual who holds "especially authoritative knowledge" (Best, 2008, p.98). Experts are also presumed to be capable of understanding social problems because they possess special knowledge (Best, 2008, p.98). In light of these characteristics, experts as claimsmakers are highly influential in the claims-making process. Other participants in the social problems process,

including the media, policymakers and activists, may consult experts for information (p.98). In addition, the prestigious status of an expert may allow them privileges, such as easier access to policymakers, in turn allowing experts to form part of the "polity"[96] (Best, 2008, p.98).

More specifically, there are three types of expert claimsmakers: scientists; medical authorities; and officials. Scientists have been granted "considerable authority" in society (Best, 2008, p.105-106). The claims of scientists are well respected given that they possess "special knowledge" as well as additional evidence to support their claims (Best, 2008, p.106). This notion is at least in part an outcome of the technological and medical advancements made possible on account of science over the last two hundred years (Best, 2008, p.106). The construction of risk is a principal focus of claims-making activities (Best, 2008, p.111). Oftentimes, scientists pair "scientific evidence with warnings" regarding the risks and the critical nature of the troubling condition (Best, 2008, p.111-112).

Medical authorities constitute another type of expert claimsmaker and they can be understood as a subcategory of the scientific field (Best, 2008, p.105). Medical authorities have succeeded in defining certain conditions as medical problems[97], a process referred to as medicalization (Best, 2008, p.99). Portraying a problem as medical in nature calls for a medical solution to address the troubling condition (Best, 2008, p.99). Medicalizing a problem involves the use of medical language to frame discussions about the allegedly troubling condition (Best, 2008, p.99). This offers a "familiar frame" through which the audience is able to consider the matter (Best, 2008, p.100). Lastly, medicalization can be understood as an attempt by medical

[96] The polity refers to those who are able to influence policymaking (Useem & Zald, 1982) such as the insider claimsmakers previously mentioned. Thus, experts who become part of the polity are also considered insider claimsmakers.

[97] For example, beginning in the 19th century, problematic alcohol drinking became medicalized into a disease in need of treatment, called alcoholism (Best, 2008, p.99).

authorities to gain ownership of a social problem (Best, 2008, p.100). The advantages of owning a particular social problem will be discussed in a subsequent paragraph.

Furthermore, officials are regarded as expert claimsmakers regardless if they possess special knowledge. Officials refer to both publicly elected individuals and those who occupy positions within government agencies (Best, 2008, p.121). Elected officials, such as prime ministers and mayors, may simply take hold of an issue and engage in claims-making activities without expertise on the matter. Although some elected officials lack expertise on the issues they adopt, they are able to generate public awareness and obtain media coverage on account of the "visible positions" they maintain (Best, 2008, p.121). In contrast, the claims-making activities of officials who are employed by government agencies typically take place without the knowledge of the general public (Best, 2008, p.121). These officials generally possess a degree of expertise given their positions within government agencies. In addition, the availability of financial resources at government agencies enables official claimsmakers to gather "more and better information about troubling conditions" in comparison to unofficial claimsmakers. In turn, this enables officials to claim ownership of various social problems (Best, 2008, p.118).

While there are no limitations to who may participate in claims-making activities, not all claimsmakers and their claims will be treated equally (Jensen & Gerber, 1998). Experts hold a rather unique status that increases the credibility of their claims. The knowledge of experts is perceived "to be more likely to be accurate" in comparison to other forms of knowledge (Best, 2008, p.114). In light of this, when claims are advanced by esteemed individuals or groups, such as experts, they tend to be treated more seriously[98] (Jensen & Gerber, 1998, p.15).

Stage II: Media Coverage

[98] This will be discussed in further detail in the final section of this chapter.

It is important to call attention to the idea that the move from the first stage to the second stage is not a linear process; in contrast it reflects a feedback process (Best, 2008, p.26). In other words, while claims-making affects media coverage, claimsmakers are in turn affected by such coverage. Media involvement in the social problems process typically occurs after claimsmakers have presented their primary claims (Best, 2008, p.130). As previously stated, for outsider claimsmakers, the media is the most important audience because they anticipate the media to report on their claims in order to expose them to a wider audience and garner public awareness (Best, 2008, p.130). Media coverage allows claimsmakers to engage in contact with a much larger portion of the public than they could reach individually (Best, 2008, p.163). However, the media oftentimes transforms claimsmakers' primary claims into secondary claims, which tend to be "shorter, more dramatic and less ideological" versions of the primary claims (Best, 2008, p.130).

In addition, there are limits to the number of stories the media can cover given that each arena has a carrying capacity, or a limited space wherein claims may be presented (Best, 2008, p.131). An arena refers to a setting wherein "claims about social problems may be presented" (Best, 2008, p.131). There are multiple arenas that constitute the "social problems marketplace," such as the pages in a newspaper, the hearings in a parliamentary committee, or a talk show on television (Best, 2008, p.131). In each of these arenas, media workers select which claims will receive coverage by sorting through each of the competing claims (Best, 2008). As such, claimsmakers must package their claims strategically so as to entice the media to present their claims (Best, 2008, p.130-131). In this sense, claimsmakers contend for the attention of the media in various arenas (Best, 2008, p.131).

Moreover, Best (2008) suggests media coverage about claims-making exhibits several patterns (p.142). First, in relation to "audience segmentation," media workers tend to favour the

claims of individuals with a prestigious status, such as experts, government officials, and claimsmakers who have ownership over a particular social problem (p.143). Second, "landmark narratives" regarding a specific problem are also prevalent within news coverage (Nichols, 1997). Landmark narratives are instances of a particular social problem that are "more serious, dramatic or troubling than most cases" (Best, 2008, p.145)[99]. Third, the media uses "packages" to present landmark narratives. A package refers to a particular perspective of a social problem, one that is familiar and incorporates the causes of the problem and the proposed actions to resolve it (Best, 2008, p.145). Packages are useful as they organize the manner in which the audience thinks about social problems (Best, 2008, p.147). Packages also provide a clear framework for the secondary claims presented by the media. Lastly, packages present "condensing symbols" that bring the package to mind, such as slogans, images, and typifying examples (Best, 2008, p.145-146). Packages appeal to a variety of cultural resources such as values, symbols and worldviews (Best, 2008, p.147).

It is important to add a word of caution about the influence of the media in the social problems process. According to Best (2008), media influence should not be overstated, while the media may influence the topics that people think about, it does not determine "what exactly people think about those topics" (Best, 2008, p.169). In other words, the media plays an integral role in shaping the social problems process because it is influential in setting the public and political agenda (Beckett, 1994) in order to generate awareness about an issue. Meanwhile, individual thoughts about certain topics are determined by a variety of external and internal forces such as individual and collective values, personal experiences and ideological commitments.

[99] In this sense, landmark narratives are similar to typifying examples.

Stage III: Public Reaction

Oftentimes, the general public gains exposure to claims through the media (Best, 2008, p.21), but in some cases, the public may be exposed to claims through direct contact with primary claimsmakers such as through conversations or speeches given by a particular claimsmaker (Best, 2008, p.163). This third stage in the natural history model of the social problems process is composed of the public's response to primary or secondary claims (Best, 2008). Claimsmakers tend to modify their claims in response to the public's reaction to make their claims more persuasive. Public reaction, or public opinion can be measured through various means, including but not limited to public opinion polls, surveys, interviews, and focus groups (Best, 2008). The results of polls and surveys are useful to claimsmakers who may wish to modify their claims to appease a specific segment of the audience. The media also responds to public reaction in order to improve their ability to "capture the audience's attention" and increase readership (Best, 2008). Furthermore, public opinion also acts as a major factor influencing policymakers' responses, for example, sweeping concerns regarding particular matters may be perceived as a warning to take action in the form of a new policy (Best, 2008, p.170). Although it is important to note that public concern does not always warrant a policy response.

Stage IV: Policymaking

The fourth stage involves policymakers reacting to claimsmakers, the media and public opinion, typically in the form of policies in order to address certain troubling conditions. The aim of claimsmakers goes beyond merely highlighting certain conditions as troubling, claimsmakers also hope to create change, to ameliorate or eliminate a social problem (Best, 2008, p.194). In order to do this, claims regarding a particular troubling condition must peak the attention of policymakers, as these individuals have the resources to create modifications to existing policies

or introduce new policies to formally address the troubling condition. However, legislators and policymakers are also limited in time and financial resources, therefore they are unable to respond to all of the policy demands they receive (Best, 2008, p.197). As such, claimsmakers must also compete for the attention of policymakers, an endeavor that may continue for a long period of time (Best, 2008, p.197).

Furthermore, policymakers must also engage in claims-making to persuade the public that a particular policy is sensible and pertinent (Best, 2008, p.212). Policymakers tend to rely on rhetoric and the construction of causal stories in order to accomplish this. Causal stories allow policymakers to categorize troubling conditions in accordance to the types of cause; accidental causes; intentional causes; and inadvertent causes (Best, 2008, p.212). A causal story accompanied by an accidental cause portrays both the events that gave rise to, and the effects of, a troubling condition as unintentional (Best, 2008, p.212). While the second causal story represents troubling conditions as a product of actions which are intentional in nature (Best, 2008, p.212). Finally, an inadvertent cause suggests an individual may have acted with intent; however, the consequences of their actions were not premeditated (Best, 2008, p.213).

Moreover, the causal story attributed to a troubling condition also helps to establish the "target population" of a particular policy (Schneider & Ingram, 1993). On the one hand, policymakers are able to construct casual stories that portray a condition as troubling for victims, or "vulnerable but morally worthy people" (Best, 2008, p.213). On the other hand, causal stories may attribute a troubling condition to the misbehaviour of "villains" or individuals who need to be restrained through the enactment of a policy (Best, 2008, p.213). The use of different causal stories allows policymakers to portray the same target population as both victims and villains (Best, 2008, p.213). For example, illicit drug users have been constructed as villains, "people

who knowingly break the law" and as victims, "whose hopeless lives lead to despair that causes them to turn to drugs" (Best, 2008, p.213).

The policy response to troubling conditions serves both "instrumental" and "symbolic" purposes (Best, 2008, p.216). Instrumental policies refer to those policies aimed at resolving or ameliorating a troubling condition. In contrast, policies serve symbolic purposes such that they represent societal values and reinforce or "promote particular constructions of the world" (Best, 2008, p.216). The example of drug laws help illustrate the symbolic purpose of certain policies; history suggests there has been numerous failed attempts to eliminate the supply and use of illicit substances. In addition, controversial issues, such as illicit drugs, tend to prompt policymakers to promote a policy for its symbolic function. Therefore, it is particularly important to take into consideration the symbolic purpose that policies may serve in instances involving contentious issues (Best, 2008, p.217). For example, while prohibitionist or anti-drug laws are ineffective in eliminating drug use, such policies continue to exist given their symbolic purpose to uphold moral principles and a societal devotion to abstinence (Best, 2008, p.217). Friedman (1998) and Morgan (1990) suggest drug policies also serve instrumental purposes. Friedman (1998) attributes the continued use of policies that amplify drug-related harms to the notion that such policies "benefit the powerful and/or functional needs of the current socioeconomic order" (p.16). Similarly, Morgan (1990) interprets the reliance on prohibitionist drug laws as serving an instrumental purpose that enables "socially powerful" individuals to pursue personal interests that are political and economic in nature.

Policymaking is a gradual process wherein successful policies yield transformations over long periods of time (Best, 2008, p.218). However, as noted above, not all policies result in positive social changes, however they remain dominant given their symbolic and instrumental

functions. Finally, the way in which policies are implemented also has an impact on its success, this constitutes the next stage in the social problems process.

Stage V: Social Problems Work

Social problems work involves the application of particular constructions of policies to their current state of affairs (Holstein & Miller, 2003; Miller & Holstein, 1997). Social problems workers are individuals who implement social policies in fulfillment of their employment responsibilities, such as police officers and doctors (Best, 2008, p.227). The "subjects" of social problems workers are individuals "who in some way embody a socially constructed problem," such as offenders, PWUD, and patients (Best, 2008, p.228). Much like previous stages, social problems workers also engage in the construction and reconstruction of troubling conditions (Best, 2008, p.226). However, at this stage, the focus shifts from claims about social problems in abstract terms to the everyday interactions between social problems workers and their subjects. Social problem workers engage in an array of complex tasks where they must consider their subjects as "cases," that is instances of a particular troubling condition, rather than unique individuals (Best, 2008, p.241).

In a similar way as media workers and policymakers, social problems workers also work under various constraints, as most workers are part of institutional structures regulated by professional codes of conduct (Best, 2008, p.229). Many organizations of social problems workers are also shaped by bureaucratic hierarchies, which have additional expectations for staff. While these rules and regulations shape the actions of social problems workers, these individuals also possess a considerable amount of discretion as they interact with subjects in everyday situations (Best, 2008, p.231). The level of discretion allotted to a social problems worker however, may also be subject to scrutiny as the use of discretion may lead to "inconsistent work"

which may be “corrupt or incompetent” (Best, 2008, p.232). As such, claimsmakers often make claims against social problems workers; thereby stimulating the development of new policies so as to address reconstructed troubling conditions (Best, 2008, p.255). This is a vital stage in the social problems process given its capacity to connect the discussion of social problems from a macro-sociological perspective with individual, practical situations (Best, 2008, p.254). The next stage will address the various reactions to social problems work.

Stage VI: Policy Outcomes

While social problems workers are tasked with the implementation of policy, this final stage addresses the way in which those policies are measured. Policy outcomes refer to the responses to the way in which social problems workers implement a particular policy (Best, 2008, p.260). The possible policy outcomes are wide ranging. On the one hand, all participants could agree that a troubling condition is resolved as a result of policy implementation (Best, 2008, p.260). In contrast, a policy could be perceived as ineffective and therefore abandoned (Best, 2008, p.261). Generally, there are three types of critiques regarding social policies. The first critique claims the policy is insufficient (Best, 2008, p.262-264). If a policy is insufficient, it lacks the ability to address the troubling condition. Second, policies may be critiqued for being excessive (Best, 2008). The third critique of policies is that they are misguided, in one of two ways, either there is a flaw in the way in which the troubling conditions are constructed (Best, 2008, p.264) or the policies result in ironic consequences (Best, 2008, p.265). Social problems workers, their subjects, as well as claimsmakers can engage in policy critiques (Best, 2008, p. 272). However, critiques from these individuals may be dismissed as biased because they are perceived to have “a vested interest” in the debate (p.276). In light of this, policies are subject to

research evaluations, which set out to determine the costs, benefits and outcome of such policies (p.276).

Finally, it is important to note the cyclical nature of the social problems process, while this stage brings the natural history model to a close; a policy outcome may stimulate the construction of new claims (Best, 2008, p.286). If new claims emerge from the evaluation of a particular policy, the social problems process may continue. For example, the politicization of a social problem may in fact propel the social problems process forward, facilitating the possibility for reform (Hughes, 2009) or policy development and implementation. On the other hand, the literature alludes to the possibility where the politicization of an issue may have the effect of impeding the social problems process[100]. The move from each of the stages may reach an impasse, failing to reach past a particular stage of the social problems process or the process may continue as new claims emerge from the final stage.

2.6 Framework for the Analysis of Claims

Claims that encounter limited opposition and that are generally accepted are called valence issues (Best, 2008, p.41). On the other hand, claims attending to controversial matters that generate opposing standpoints are what Best (2008) refers to as positions issues (p.41). In most cases, claims regarding position issues will generate counterclaims, arguments against the initial claim, by other participants in the social problems process (Best, 2008, p.41). Claims are not fixed; in contrast, they evolve as participants engage in the construction and reconstruction of social problems throughout each stage of the social problems process (Best, 2008, p. 226). Even

[100] See Hwang, 2007; Small, 2007, 2008; Wood, Kerr, Tyndall & Montaner, 2008; Hathaway & Tousaw, 2008; Kerr & Wood, 2008; Wood, Montaner & Kerr, 2008; Zlotorzynska et al., 2013; and Boyd, 2013. These authors suggest the politicization of science impedes the establishment of evidence-based interventions such as the SIS.

when a particular claim is considered to be "well-established,"[101] it continues to compete for attention in the "social problems marketplace" where new claims are continuously being introduced to audiences and compete for recognition (Best, 2008, p.46). The competitive nature of claims-making prompts participants to develop arguments that are "dramatic, disturbing, [and] easily grasped" in order to obtain and maintain the attention of an audience (Best, 2008, p.46).

Moreover, an established claim can also be refined in such a way that further claims may be developed on the basis of one that has already been accepted. Best (2008) refers to this as "domain expansion" (p.47) wherein the area of a particular social problem extends to "include more and more phenomena" (Best, 2008, p.48). Similarly, claimsmakers may utilize a well-established claim as an avenue to advance new conditions that are troubling by "piggybacking" the new condition onto the foundations of the original claim (Loseke, 2003). In order to piggyback successfully onto a well-established problem, claimsmakers must also present the new troubling condition as "analogous" to the earlier claim (Best, 2008, p.48-49).

2.7 The Rhetoric of Claims

Each claim is composed of two types of statements: "those describing the condition, and those explaining why it should be considered troublesome" (Best, 2008, p.31). The former refers to what is termed, the grounds of a claim, while the latter refers to the warrants (Best, 2008). The grounds of a claim provide the audience with a sense of the nature of the alleged social problem (Best, 2008, p.31) and evidence in support of the alleged condition (p.36).

2.7.1 Grounds of a Claim

[101] The term "well-established" refers to the notion that there is "widespread agreement that this troubling condition ought to be considered a social problem" (Best, 2008, p.47).

Best (2008) suggests the grounds of a claim utilize a "basic rhetorical recipe" in order to justify that the matter at hand is troublesome. The claims often commence with a typifying example, followed by a name and a statistic (Best, 2008, p.32). A typifying example is "a description of a particular instance of the condition" (Best, 2008, p.32). Typifying examples are seldom typical; in contrast, these examples are sensationalist and exceptional cases (Best, 2008, 32). Subsequently, the problem is designated a name, such as child abuse or road rage. It is important to highlight that the attribution of a name to a problem is distinctly different from providing a specific definition of what the problem is (Best, 2008, p.32). Finally, in order to convey the magnitude of the problem, the claim incorporates a statistic, or a number. However, Best (2008) contends the statistic employed in initial claims are generally educated estimates given that such statistics involve problems which have been commonly ignored and relatively undocumented (p.33). According to Best (2008) the coalescence of these three elements produces a persuasive argument regarding the existence of a social problem (p.32).

2.7.1 (a) Additional Grounds

Claims may also include additional grounds, that is, other rhetorical devices, including, but not limited to the following: a "worsening situation"; a "familiar type of problem"; the "kind of people affected"; the "range of people affected" and; a "challenge to older interpretations" (Best, 2008, p.34-35). Claims that employ a "worsening situation" often suggest that if the problem is unaddressed, the troubling condition will become more troubling. A "familiar type of problem" refers to grounds that draw upon a similar troubling condition in order to provide the audience with a frame of reference from which to understand the condition. Grounds that employ a "kind" and "type of people affected" refer to the individuals or groups that may be impacted by the troubling condition. Lastly, some grounds "challenge older interpretations" of a social

problem, or in other words invalidate widely held beliefs about a problem (Best, 2008, p.35). Compelling grounds help to establish the basis for the warrants of a claim, which provides the justification to take action in regard to the troubling condition (Best, 2008, p.36). The warrants of a claim suggest the troubling condition conflicts with societal values and breaches commonly held perceptions of justice, equality, fairness, and the like (Best, 2008, p.36).

2.7.2 Warrants of a Claim

Best (2008) and Spector and Kitsuse (2001) highlight the role of values in claims-making activities by pointing out that the warrants of a claim invokes values. In other words, claimsmakers justify their claims by making an appeal to values (Spector & Kitsuse, 2001, p.93). Values are the linguistic tools used by individuals and groups to express and to legitimize their claims (Spector & Kitsuse, 2001, p.74). Although Spector and Kitsuse (2001) suggest values play a prominent role in claims-making activities, they offer a word of caution to constructionists adopting this theoretical approach, that values must not be examined as explanations for claims-making about a particular troubling condition (p.93).

2.7.3 Conclusions of a Claim

Lastly, the conclusions of a claim are the changes or policies proposed by claimsmakers in order to address the troubling condition (Best, 2008, p.31). The grounds and warrants of a claim set out the "nature of the conclusions" (p.31). Conclusions may be comprised of both short and long term goals, which can range from generating awareness to the development of new policies or legislation (Best, 2008).

2.8 Ownership, Interests and Stakes

A claimsmakers can gain ownership over a social problem when a claim that he or she presents is recognized as "the best way to understand a particular issue" (Best, 2008, p.92). If claimsmakers do not assume ownership of a particular social problem, it becomes difficult to move the social problems process forward (Best, 2008, p.89). In this sense, a social problem is in need of an owner to look after the topic and to ensure the claims remain current and interesting (Best, 2008, p.89). Claimsmakers who gain ownership are perceived as the "go-to authorities" regarding a particular social problem (Best, 2008, p.85-86). As the owner of a social problem, the claimsmakers may be regarded as an expert on the issue and gain more legitimacy, which allows for their claims to become more recognized (Best, 2008, p.86). Owners also tend to have more contact with the media and policymakers, enabling them to establish themselves within social networks to become insider claimsmakers (Best, 2008, p.89-90). Expert claimsmakers who gain ownership of a social problem also gain more power as a result of an increase in their social visibility (Best, 2008, p.103). Some experts may also experience fiscal gains, as increasingly more people troubled with a particular condition require their services (Best, 2008, p.103). In light of these advantages, it is important to emphasize that experts, as well as other claimsmakers, may have a personal stake in the social problems process (Best, 2008, p.103).

It is important to note claimsmakers may also be members of, or have loyalties to, organizations and parties with specific interests (Best, 2008, p.114) given that all claimsmakers are "part of the larger social order" (p.116). Much like the audience is segmented in terms of their individual identities, claimsmakers' identities are also segmented. Thus, claimsmakers' interests and ideologies will differ (Best, 2008, p.41) and their claims may be shaped by their ideological preferences (Best, 2008, p.116).

Conclusion

As previously stated, this model of the social problems process should be understood as a template from which to address first cases in the study of social problems (Spector & Kitsuse, 2001). This is not to suggest all social problems will fit this framework, but that some instances of social problem construction may be better suited for such a model. Let us keep in mind the literature thus far has highlighted the highly controversial nature of the SIS as a public health initiative, and suggested that such initiatives are subject to intense public and political discussions before coming to fruition. The literature further illustrates the establishment of a SIS to be the result of a decade long social movement, which required a shift in cultural understandings of addiction, and the construction of addiction as a public problem. Thus, the theoretical framework of the social construction of social problems may be of value in the analysis of the ongoing SIS debate. In light of the presentation on the social problems process from a constructionist perspective, the proceeding chapter will describe the methodology used to examine the claims-making activities in relation to the SIS debate in Canada.

CHAPTER 3: METHODOLOGY

Overview

The method employed for this research project is a qualitative content analysis of 164 print newspaper documents from *The Vancouver Sun*, *The Ottawa Citizen* and *The Ottawa Sun* ranging from the first of January 2002 to the thirty-first of December 2013. A qualitative content analysis can be described as "a research method for the subjective interpretation of the content of text data through the systematic classification process of coding and identifying themes or patterns" (Hseih & Shannon, 2005, p.1278). This is a suitable method for this project because it allows the researcher to systematically analyze the newspaper articles in order to explore the nature of the SIS debate. Unlike conventional content analyses, this approach relies on a qualitative approach in order to examine the meaning of the text and to draw inferences from manifest[102] content. The researcher employs a predominantly deductive approach in light of the grey literature[103] by Elliott et al. (2002), which offers a point of departure for the identification of categories (Elo & Kyngäs, 2008). However, according to Hseih and Shannon (2005), Berg (2009) and Neuendorf (2011), researchers ought to allow for the emergence of additional codes in the deductive coding process. Thus, inductive codes were also included as they emerged throughout the coding process and retained in order to re-code the data. This was essential as the legal battle between *Insite* operators and the Canadian federal government produced new themes, which were not discussed in the grey literature.

[102] Manifest content refers to "elements that are physically present and countable" (Berg, 2007, p.208).
[103] Grey literature can be understood as "information produced on all levels of government, academia, business and industry in electronic and print formats not controlled by commercial publishing" (Fourth International Conference on Grey Literature, 1999). In other words, grey literature refers to literature that is produced by persons or groups where publishing is not the primary function (Western Libraries, 2014).

In regard to the content analysis process, this project is guided by the methodological contributions of Kaid and Wadsworth (1989) who outline seven steps involved in conducting a content analysis, which includes: developing the research question(s); selecting samples for analysis; defining the categories to be applied; "outlining the coding process"; "implementing the coding process"; "determining trustworthiness"; and "analyzing the results of the coding process" (p.199).

3.1 Research Questions

The primary research question guiding this project is: What is the nature of the debate regarding the implementation of SISs in Canada? The secondary research question is: What are the assertions advanced by proponents and opponents with respect to the implementation of SISs? (E.g. what are the claims and who are the claimsmakers?)

3.2 Data Source

This research project examines one type of archival data (Payls & Atchison, 2008), newspaper documents from *The Vancouver Sun*, *The Ottawa Citizen* and *The Ottawa Sun*. *The Vancouver Sun* circulates on average 161,785 copies daily and nearly one million copies weekly (Newspapers Canada, 2013). On average, *The Ottawa Citizen* circulates 110,173 copies daily and 661,039 copies weekly (Newspapers Canada, 2013). Lastly, *The Ottawa Sun* circulates on average, 41,297 copies daily and 289,076 copies weekly (Newspapers Canada, 2013). The researcher utilized an electronic search through two online newspaper databases, *ProQuest Canadian Newsstand* for articles from *The Vancouver Sun* and *The Ottawa Citizen* and *Sun Media News Research Centre* for articles from *The Ottawa Sun*. The search parameters were narrowed in terms of the publication date range, from January 1, 2002 to December 31, 2013, and

the following keywords were employed: “Insite” or “safe injection site*” or “supervised injection site*” or “supervised injection facility*” or “safe injection facility*” or “drug injection site”. In order to remain inclusive of a broad range of claims made by a variety of claimsmakers, the sample of newspaper documents included news reports, letters to the editor, editorials and opinion articles.

Each newspaper document was subject to preliminary reading to ensure that the content was relevant to the research question regarding the nature of the SIS debate. Any duplicate documents or documents that did not present elements reflecting a discussion of the merits or disadvantages of SISs were excluded (e.g. articles that mention the SIS in passing or in reference to benefit events/concerts in support of SISs). In the case of duplicate documents, the document with a larger word count was included for analysis. All documents from the same newspaper outlet were subject to coding in chronological order, from the earliest publication date to the most recent. Documents that contained relevant content were saved as portable document format (PDF) files and assigned an alphanumeric code. For example, the first document retained from *The Vancouver Sun* is assigned the code “VS1,” documents from *The Ottawa Sun* begin with the code “OS” and documents from *The Ottawa Citizen* begin with the code “OC”. In addition, the researcher recorded the document title, the author, the publication date and the document type onto an Excel spreadsheet arranged in chronological order to facilitate sampling. The researcher employed two sampling techniques. First, the researcher employed a purposive sampling technique where only news documents that contained elements of the SIS debate were retained. At the end of this process, the sample included 515 documents from *The Vancouver Sun*, 160 from *The Ottawa Citizen* and 145 from *The Ottawa Sun*. In light of the time restraints for the completion of a Master’s thesis, the researcher employed a second sampling technique to accommodate for this large sample through the use of a random systematic sampling technique

(Kaid and Wadsworth, 1989), where every fifth document from each newspaper was included in the data set. Because the SIS debate spans over a decade this sampling technique allows the researcher to be more inclusive of the claims advanced throughout the entire debate.

The Vancouver Sun was selected because the SIS debate in Canada was the most prominent in the city of Vancouver after mayoral candidate Larry Campbell, placed the implementation of SISs on his election platform. The researcher was able to pinpoint a location where the SIS debate began to ignite in light of the Toronto and Ottawa Supervised Consumption Assessment (TOSCA) study suggesting Ottawa would benefit from the implementation of several SISs. Thus, the researcher chose newspapers that would most likely capture the development of the SIS debate in Ottawa[104]. *The Ottawa Citizen* and *The Ottawa Sun* were mainly chosen because they are owned by different parent companies, which could offer a more diverse perspective on the issue. Furthermore, the decision to employ a specific date range was influenced largely by the literature, which suggests the SIS debate in Vancouver, British Columbia began roughly around 2002, with the SIS gaining unprecedented attention during the mayoral election in that year. The first SIS was implemented in Vancouver in 2003, and since this time, the debate has continued to gain prominence in media reports as well as parliamentary debates. In 2013, the Sandy Hill Community Health Centre in Ottawa, Ontario, announced its intention to submit an application to Health Canada for an exemption to lawfully operate a SIS. Thus, the researcher has selected this time range in order to account for as much of the debate as possible.

[104] Although cities such as Toronto and Montreal have also expressed an interest in the implementation of SISs, these cities were not included in this research project because at the time of data collection, the debate had not developed to the same extent as that of Ottawa. Because the federal government has played a key role in the SIS debate since the beginning of the *Insite* controversy in the early millennium there has been more steady media coverage on this matter.

3.3 Conceptualizing Central Categories

The grey literature by Elliott et al. (2002) provides a point of departure for the conceptualization of central categories. Elliott et al. (2002) identify three categories, or objections to the implementation of SISs. Specifically, these categories are SISs send the "wrong message," SISs create a "honey pot effect" and SISs are "ineffective or even harmful" (Elliott et al., 2002). In addition, Elliott et al. (2002) identify the following categories as arguments in support of SISs: SISs are a "natural, small step beyond" needle exchange programs (NEPs), they are an "effective public health measure," they reduce public nuisance, they are cost-effective, and there is a "moral imperative to trial" SISs.

In light of the absence of literature on the nature of the debate, an inductive approach was also employed. In regard to opposition to the implementation of SISs, the following categories were identified: hostility to the harm reduction philosophy and SISs are harmful for communities. A number of sub-categories, or arguments were identified under the category hostility to the harm reduction philosophy, they include: SISs are ineffective, SISs encourage drug use, SISs divert resources from treatment, SISs send the wrong message, SISs undermine the national objective of prohibition, SISs accept defeat (in the war on drugs), there is no such thing as safe drug use and the hidden agenda argument. Sub-categories were also identified under the last category, they include: "not-in-my-backyard" (NIMBY), SISs create public nuisance, SISs enable illegal conduct, SISs threaten public safety, and SISs lead to the social deterioration of neighbourhoods. Other inductive arguments that demonstrate opposition to the implementation of SISs include SISs violate international drug control treaties, medically supervised drug injection is unethical and there is a lack of clear scientific evidence demonstrating the effectiveness of SISs. Moreover, the researcher identified inductive categories in support of the establishment of SISs, they include: SISs benefit communities and PWUD, reconciling harm reduction and treatment, SISs

save lives, SISs provide PWUD a health service, SISs do not contravene international drug control treaties, SISs are an evidence-based harm reduction intervention, the benefits of SISs outweigh potential benefits of prohibition, and there is public support for SISs. The sub-categories assigned for the first category include: SISs are an effective public health measures, SISs reduce public nuisance, SISs improve public safety, SISs enhance the aesthetics of public space, SISs provide PWUD a safer environment as well as a "therapeutic space of acceptance" [105] and SISs are cost-effective.

Furthermore, it is necessary to conceptualize the term harm for this research project. The harm reduction literature suggests harm may be experienced at the individual, community or societal level (Newcombe, 1992). The Oxford online dictionary (2014) defines harm as "physical injury, especially that which is deliberately inflicted; material damage; and actual or potential ill effects or danger". The third definition is more suitable for this research project as it is inclusive of both claims that suggest harm will ensue and claims that suggest there may be actual ill effects or dangers associated with the implementation of a SIS. According to Newcombe (1992), there are several types of harm, including health, social or economic harms. For the purpose of this study, potential ill effects or danger include crime, victimization, a reduction in property values, a disruption to businesses, or an interruption to the daily life of individuals who reside in the community.

3.4 Coding Scheme and Process

Each newspaper document was read numerous times and examined for manifest content. As discussed above, a preliminary reading was conducted in order to determine the relevance of the documents and to filter out duplicate documents. The second reading was conducted in order

[105] Quoted from Maxine Davis, executive director of the Dr. Peter AIDS Foundation (VS465).

to divide the text in terms of directionality (Kaid & Wadsworth, 1989), in other words opposition to or support for the implementation of SISs. In the third reading, the text was sorted into the categories identified within the grey literature and all remaining text that did not reflect existing categories were grouped into new, potential categories and assigned a tentative name until all documents had been read through. This was achieved by highlighting phrases and sentences within the PDF newspaper document using different colours and then employing a copy-paste technique to transfer blocks of text to a Word document. This technique was employed to facilitate re-reading and to systematically sort inductive categories. For an enumerated coding scheme, please refer to appendix C, table 2.

The researcher did not encounter all categories identified in the grey literature, namely the argument that SISs are a natural, small step beyond NEPs. This is not to suggest the category is absent from the SIS debate, rather, Best's (2008) assertion that only persuasive claims will receive media coverage may provide a possible explanation for this.

3.5 Quality and Trustworthiness

While measures of reliability and validity are important in content analytic procedures, these concepts must be re-conceptualized to correspond with qualitative research methods. In qualitative research, quality refers to the criteria by which research may be assessed (Lincoln, 1995). Specifically, the term trustworthiness[106] encompasses both reliability[107] and validity (Golafshani, 2003), where trustworthiness can be understood as "establishing confidence in the findings" (Lincoln and Guba, 1985). Trustworthiness can be achieved by providing a "systematic and careful" account of the research process (Stenbacka, 2001, p.555). This chapter of the thesis

[106] Also referred to as credibility or transferability (Guba, 1981).
[107] Stenbacka (2001) suggests the measure of reliability is irrelevant as applied to qualitative studies.

should be read as an attempt to provide a comprehensive description of the research process, in particular the decision-making process. In order to increase trustworthiness, the researcher documented each of the steps and decisions made with regard to the sampling technique, the conceptualization of key concepts and the development of the coding sheet. The text was also subject to re-reading in order to ensure the consistent application of the coding scheme and to adjust initial categories to emergent themes, which further ensures intra-coder reliability. Furthermore, Patton (2001) asserts in qualitative research "the researcher is the instrument" (p.14) thus, the trustworthiness of the research is dependent upon the effort and capability of the researcher. In light of this, the researcher took breaks between coding in order to prevent exhaustion and to reduce coding error.

3.6 Reflexivity

Moreover, trustworthiness or rigor in qualitative research requires an exploration of subjectivity and reflexivity (Davies & Dodd, 2002). Reflexivity can be understood as "a process of critical reflection both on the kind of knowledge produced from research and how that knowledge is generated" (Guillemin & Gillam, 2004, p.274). The necessity to practice reflexivity is guided by the assertion that researchers can never be completely objective in their research, and that the production of knowledge is not value-free (Guba & Lincoln, 1994, p.107). In contrast, values play an inevitable role in shaping or creating research outcomes (Guba & Lincoln, 1994, p.114). Similarly, Becker (1967) argues that it is not possible for researchers to withdraw their "personal and political sympathies" from the phenomenon under study. In particular, a qualitative content analysis is subject to a high degree of subjectivity and interpretation. Thus, it is necessary to address all potential biases of the researcher. With respect to positional reflexivity (Macbeth, 2001), it is important for the researcher to recognize her social

position as an individual who is writing from a privileged position, as well as remain cognizant of the fact that the conceptualization of this research project and the decision to employ a constructivist epistemological framework has been largely influenced by the *Insite* scholarship which is highly critical of the opposition to SISs. As such, it has been a challenge to remain non-partisan as a researcher in light of the highly politicized nature of the SIS debate. However, the researcher has, and will continue to remain mindful of potential biases throughout the research process and on the occasions in which the researcher speaks about this project as a neutralization technique to minimize the possibility of partisanship.

3.7 Strengths and Limitations

The literature suggests there are several strengths and limitations to conducting a content analysis. A primary strength of content analysis is that it allows the researcher to employ an unobtrusive[108] method to minimize reactivity and ensure reliability (Berg, 2009). Content analyses are also useful for retroactive measurement (Kaid & Wadsworth, 1989), in the context of this research project; it allows the researcher to examine information regarding claims that arise throughout time to account for the claims-making process. Specifically, a deductive content analysis also allows researchers to substantiate or enhance existing theories (Hseih & Shannon, 2005), which is particularly important in light of the absence of literature exploring the nature of the SIS debate. However, no method is without its limitations, with respect to content analyses, a key limitation is the potential for over interpretation. In order to combat this issue, the researcher has provided a detailed account of how the research findings were obtained as well as included a rigorous coding scheme for reference.

[108] Andersen (1989) describes unobtrusive methods as "research tactics that allow data collection without interference in the process being studied" (p.250).

3.7.1 Limitations of Secondary Data

Moreover, there are also several limitations in regard to the selected data source. In consideration of Best's (2008) assertion regarding the competing "social problems marketplace" where claimsmakers contend with one another to attract attention from the public, the media and policymakers, it is important to acknowledge that this analysis is only inclusive of the claims that received media coverage. According to Best (2008), outsider claimsmakers (e.g. activists) typically have fewer resources[109] than insider claimsmakers (e.g. officials) to garner media attention. In pointing to this limitation, the researcher attempts to highlight the way in which certain voices are privileged over others, and the way in which certain claims may be apportioned more consideration and credence than others.

Another limitation of using newspaper documents is such that some claims are presented as secondary claims by media workers (Best, 2008). Secondary claims are not presented in their original syntax and have been subject to interpretation by journalists and re-represented in order to fit the needs of the news outlet (Best, 2008, p.25-26). These claims are typically shortened, "more dramatic and less ideological" in comparison to the primary claim (Best, 2008, p.130). In the findings chapter, the use of two sets of quotation marks indicates that the claim is secondary in nature. This limitation is not to suggest the data is completely exclusive of primary claims, oftentimes media workers include direct quotations advanced by claimsmakers and this will be indicated through the use of one set of quotation marks.

Although the main focus of this analysis is the claims advanced with respect to SISs, Best's (2008) framework requires the researcher to also consider the grounds of a claim. It is important to note however, that the analysis of the claims' grounds in this thesis is limited in

[109] Resources may be financial in nature or take the form of power, status, education and even social contacts (Best, 2008, p.24).

scope because the project focuses on the portion of the debate that begins in 2002 despite the commencement of claims-making regarding a public health crisis in the *Downtown Eastside* (DTES) in the late 1990's. However, this limitation does not hinder the ability of the researcher to provide an analysis of the claims advanced by proponents and opponents of SISs given that the issue of implementation did not enter the debate until 2002 when the matter became subject to increasing politicization.

Lastly, a well-established critique of the mass media is such that stories and claims presented are often fashioned in an exaggerated manner in order to attract readership. However, with respect to claims-making about an alleged troubling condition, the use of sensationalized stories, or typifying examples (Best, 2008) should be understood as an attempt to persuade rather than disregarded as fictitious tales. Overall, the limitations I have made note of are acceptable in light of the exploratory nature of this study and the limited availability of sources of information in order to study this phenomenon (Franzosi, 1987).

CHAPTER 4: FINDINGS

In this chapter, I will present the findings from the qualitative content analysis of 164 articles from *The Vancouver Sun*, *The Ottawa Citizen* and *The Ottawa Sun*. The findings are organized according to the respective themes highlighted in the review of literature with the addition of several new themes derived from the data. The findings are guided by the main research question: *What is the nature of the debate regarding the implementation of SISs in Canada?* I will first present the arguments advanced by claimsmakers in opposition to the implementation of SISs, followed by the claims reflecting support for the establishment of such facilities.

4.1 Claims in Opposition to SISs

4.1.1. Hostility to the harm reduction philosophy

Tensions have long existed between crime control and harm reduction strategies with respect to illicit psychoactive substances, wherein the objectives of both strategies are often presented as two dichotomized entities (Greenfield & Paoli, 2012). Thus, opponents often claim that PWUD require treatment not harm reduction interventions such as SISs. For example, Prime Minister Stephen Harper suggests:

> The preference of this government in dealing with drug crime is obviously to prosecute those who sell drugs and create drug addiction in our population and in our youth. And when it comes to treating drug addiction, to try and do so through programs of prevention and treatment, rather than through the issues that were in front of this court in terms of so-called harm reduction (VS495).

The underlying assumption of this argument is that treatment and prevention programs allow PWUD to achieve abstinence or avert use altogether, while harm reduction enables individuals to continue to use drugs. Thus, opposition to SISs can be understood as disapproval of the principle

feature of harm reduction interventions, which does not require PWUD to abstain from drug use. For opponents, abstinence is the single tolerable state with regard to illicit drugs. This view is reflected in the following claim from an anonymous writer: "The answer to Ottawa's drug problems is to get people off drugs […] while Vancouver lives in upsidedown land, we here in Ottawa prefer law enforcement and getting people off of drugs to enabling crime and addictions" (OS80). Similarly, Chris and Lisa Grisham from *Safer Ottawa* claim: "The reality is addicts need help. They need treatment and aftercare, they need services like San Patrignano in Italy who boasts a 72% success rate in abstinence based treatment, they need housing, support, compassion and services to help them get off drugs, off the streets, not a place to inject the very poison that is killing them" (OS140). There are also a number of subcategories under this theme, they include the following: there is no such thing as safe drug use; SISs are ineffective or even harmful; SISs encourage drug use; harm reduction strategies accept defeat (in the war on drugs); SISs divert resources from treatment and prevention; SISs undermine the national objective of prohibition; and the hidden agenda argument.

4.1.1 (a) There is no such thing as safe drug use

The claim that there is no such thing as safe drug use also reflects hostility to the harm reduction philosophy given that such strategies accept some level of drug use as an inevitable feature of society (Riley, 1998). Opponents contest the notion that SISs are, in practice, safe, arguing that the word "safe," in SIS, is misleading and should be replaced. For example, a resident of Vancouver states: "While the term "safe" injection site is commonly used, a more appropriate nomenclature would be "supervised" injection sites. There is nothing "safe" about injecting heroin or cocaine into your body" (VS125). Similarly, Chief Superintendent Raf Souccar, Director General of the RCMP Drugs and Organized Crime section also suggests the

intervention "[…] should be called supervised injection sites "because it's not safe" […]" (OC5). Lastly, Conservative MP, Randy White states: "…he doesn't even like the term "safe injection site". It's really an oxymoron. Injection sites are not safe. You're allowing people to inject drugs into themselves so let's not call it that, …" (VS225).

4.1.1 (b) SISs are ineffective or even harmful

Moreover, the literature by Elliott et al. (2002) suggests opponents often advance the argument that SISs are "ineffective" or even "harmful". Opponents suggest the intervention is ineffective in addressing the public health problem (e.g. reducing rates of fatal overdose and the spread of infectious disease). For example, after the implementation of *Insite* in Vancouver, RCMP Staff Sergeant Chuck Doucette stated: "…overdose deaths in Vancouver increased from 2004 to 2005 despite a corresponding decrease in the rest of the province" (OC35). In addition, American Drug Czar, John Walters "… doesn't even buy the argument that safe-injection sites reduce the spread of disease" (VS110). More specifically, Walters states:

> Even the best sites, the usual safe-injection site argument is for the prevention of hepatitis and HIV transmission, but the rates of conversion [to illness] in the studies that have been best in these areas still have many times the number of people converting than those who get effective treatment. Again, hepatitis and HIV are deadly diseases. So is drug addiction. We want to save people from the underlying condition that is deadly (VS110).

Similarly, Prime Minister Stephen Harper voiced his concerns about the effectiveness of SISs as a harm reduction intervention, for example, he suggests: "I remain a skeptic that you can tell people we won't stop the drug trade, we won't get you off drugs, we won't even send messages to discourage drug use, but somehow we will keep you addicted and reduce the harm just the same…Even if that's effective, that has got to be a second-best strategy at best" (OC60). Opponents of SISs advance the claim that such facilities do not reduce harms associated with injection drug use, rather, they argue SISs are harmful. For example, former federal Health

Minister, Tony Clement states: "Allowing and or encouraging people to inject heroin into their veins is not harm reduction, […] It is a form of harm addition" (VS420). Thus, the underlying assumption of this argument reflects the belief that there is no such thing as safe drug use. Further, this comments reflects the charge that the implementation of SISs exemplifies an endorsement of illicit drug use, which will be discussed in more detail below.

4.1.1 (c) SISs encourage drug use

As Elliott et al. (2002) note, a prevalent argument presented by opponents of SISs claims that such facilities encourage or facilitate the use of drugs. The underlying concern is such that a SIS will "send out the wrong message" to the wider public so as to demonstrate support for the use of illicit psychoactive substances. For example, in letters to the editor of *The Ottawa Citizen*, an anonymous individual writes: "Opponents of Insite say they want to focus on prevention and rehabilitation, and they worry that allowing addicts a safe place to shoot up sends a mixed message, enabling the very behaviour the government wants to discourage" (OC105). Similarly, a resident from North Vancouver states:

> It makes me sick when I hear the academia-driven spout off their data collection of research and evidence. What on earth is Perry Kendall, chief medical officer for B.C. thinking when he says there is no evidence that supervised injection sites encourage drug use? What an asinine comment. I think it is fairly clear that giving addicts a safe site in which to use illegal drugs encourages and enables their drug use (VS75).

Andre Bigras former Executive Director of the Drug Prevention Network of Canada (DPNC) also claims: "Harm reduction measures only ensure the addictive behaviour continues and doesn't do anything to prevent it from beginning in the first place" (OC80). In addition, an *Ottawa Sun* editorialist states:

> We all know how dangerous drugs are. All you have to do is look into the hollow stares of the heroin addicted. Tombstones in their eyes. But instead of getting real help, addicts are being enabled by mindless bureaucrats. There's a growing movement underway to turn provincial governments into the biggest drug pushers of them all. Vancouver's Insite

> heroin shooting gallery started all of this, giving free syringes to junkies, along with a quiet place to inject poison into their veins (OS100).

The underlying assumption in these claims reflect the notion that once the risks associated with psychoactive substance use are diminished—a goal of harm reduction strategies—individuals may perceive such behaviour to be more enticing, and engage in use. For example, the Pacific region coordinator of the RCMP Drugs and Organized Crime Awareness program, Staff Sergeant Chuck Doucette states: "There is considerable evidence to show that when the perceived risks associated to drug use decreases, there is a corresponding increase in number of people using drugs" (OC35). Similarly, former American Drug Czar, John Walters states: "…any policy that makes life easier for drug users will only attract more drug users" (VS110).

4.1.1 (d) Harm reduction strategies accept defeat (in the war on drugs)

Opponents of SISs advance another argument that reflects disagreement with the harm reduction philosophy. As discussed in Chapter 2, harm reduction accepts that "some level of drug use is normal in a society"[110] (Riley, 1998), however opponents of SISs argue that this kind of mentality reflects an acceptance of defeat with respect to the war on drugs. For example, in reference to *Insite*, an editorialist from *The Ottawa Sun* writes: "Folks, it's not naive to ask the obvious question: If you want to help addicts, shouldn't we step up the war on drug dealers, instead of becoming one? …It's time to escalate the war on drugs to help the addicts and take those tombstones out of their eyes. It's Canadian common sense" (OS100). Similarly, The Canadian Alliance suggests harm reduction conveys a message that "essentially says, 'We give up, let's encourage use—but make it clean use'" (OC5). David Berner of the DPNC also

[110] This is not to suggest that harm reduction strategies and interventions inhibit abstinence, rather, the approach recognizes the possibility for a wide variety of strategies to be used in order to address addiction-related issues (Riley, 1998, p.26). In other words, current use of a harm reduction approach does not preclude abstinence in the future.

suggests: "… harm reduction has become so pervasive a reality, it's really part of the culture now. But it's a big giving-up. It's a big shrug of the shoulders" (VS505).

4.1.1 (e) SISs divert resources from treatment

Because critics often present harm reduction and treatment as two dichotomized strategies, opponents argue that resources should be directed towards treatment rather than harm reduction interventions. For example, Langley-Abbotsford Conservative MP, Randy White, claims: "I would rather spend my time and money and effort ... getting people off of drugs, not maintaining them on drugs, …" (VS225). More specifically, opponents argue the provision of funding to harm reduction strategies effectively diverts resources away from treatment and prevention efforts. For example, former federal Health Minister, Tony Clement, states: "A better thing to do is to treat people, to prevent people from going on the drugs in the first place, …The fact of the matter is that every dollar you spend on safe injection is a dollar that you could have used for treatment" (VS410). Similarly, David Berner of the DPNC argues: "There will never be enough for addicts because addicts always want more. So the question is, do we put our resources into harm reduction or do we put our resources to help people get clean?" (VS505). The assumption underpinning these arguments suggests treatment and prevention programs allow PWUD to discontinue the use of psychoactive substances or avert use altogether, while harm reduction enables PWUD to continue their consumption. Opponents appear to value abstinence over the interventions that aim to reduce drug related harm because such interventions are viewed as allowing the continuation of drug use. This is reflected in the following comment voiced by John Walters, American Drug Czar:

> …Vancouver's proposed safe-injection sites for drug users are a waste of resources that should go to helping addicts get clean…From my point of view, why not save people from the fatal disease of addiction and not just from the fatal opportunity for an overdose

> at some point in time? Use the resources – they're always going to be scarce –to make people well, to reintegrate them into society (VS110).

In addition to diverting resources from treatment, some opponents, such as Colin Mangham from the DPNC, argue: "Canada's preoccupation with harm reduction could divert funds from prevention, treatment and enforcement efforts" (VS355).

4.1.1 (f) SISs undermine the national objective of prohibition

Moreover, opponents of SISs advance an argument with respect to the symbolic function of prohibitionist drug laws and policies, which is to uphold moral principles and a societal devotion to abstinence (Best, 2008, p.217). The argument suggests that the establishment of SISs undermines this function and threatens the moral fabric of society. For example, a resident of Ottawa claims with respect to SISs: "This goes against the very fabric and ideals of a law-abiding society" (OS65). Similarly, the lawyers for the federal government in *PHS Community Services Society v. Attorney General of Canada* (2008) claimed: "Permitting Insite to continue its operations will create a safe haven from the criminal law and undermine its national objective and importance" (VS405). In addition, some opponents suggest this approach weakens one's confidence in the state. For example, with respect to the municipal government's interest in implementing a SIS in the DTES, a member of the Gastown Community Safety Society in Vancouver, and 30-year resident of the area claims: "I no longer have faith in the system"… (VS15). Similarly, in letters to the editor, a resident of West Vancouver asks: "Why should we fear sending our kids to college downtown or to TinselTown or to clubs in the Downtown Eastside? We cannot continue to let addicts use illegal drugs on the street without consequences. Else, why bother saying drugs are illegal?" (VS115).

4.1.1 (g) The hidden agenda argument

Beirness, Jessemen, Notarandrea and Perron (2008) suggest opponents of harm reduction argue that advocates utilize harm reduction as a facade for drug legalization[111]. In other words, critics argue harm reduction is a strategy used by proponents of drug legalization to abate public concern regarding the use of illicit psychoactive substances until all psychoactive substances are in due course legalized. With respect to the implementation of SISs, opponents advance slippery slope style arguments by suggesting that if a SIS is established, it will lead to the legalization of illegal psychoactive substances. For example, *The Ottawa Citizen* writes:

> One side says the reforms are making drug use acceptable and will inevitably become more and more extreme, ultimately leading to legalization … Hardliners pounce on statements like that. Harm reduction, they claim, is really just a smokescreen for legalization. The White House argues that even small-h harm reduction programs such as needle exchanges and safe injection sites are just the first step in a program of ever-more radical changes that will ultimately lead to corner stores selling heroin to kids (OC5)[112].

In addition, *The Ottawa Citizen* suggests Colin Mangham from the DPNC believes "the people who advocate large-H harm reduction[113] are really using programs like needle exchange and safe injection sites to soften up public opinion for more radical experiments that will culminate in legalization" (OC5). Similarly, an editorialist from *The Ottawa Sun* writes:

> When Canada's top court gave the thumbs-up to Insite's assisted suicide, we warned you that the movement would not stop until there's a franchise on every other street corner in Canada. Well, guess what? Our worst fears are coming true… And these enablers are shoving hard to send us over the edge. Step one, shooting galleries in every city in Canada, writing off a human life as being completely hopeless, so long as they don't suffer. But they wouldn't stop there. Step two in their junkie safety program is to give out free high- grade drugs. Don't believe me? Dr. Julio Montaner, clinical director of the B.C. Centre for Excellence in HIV/AIDS, is on the record with that dime bag of advice, because it's safer to use government-approved, high-grade heroin (OS100).

[111] See also DuPont (1996).
[112] "Small-h" harm reduction refers to programs that fill the gaps in existing services, such as needle exchange programs, SISs and methadone maintenance programs, which do not require modifications in drug policy.
[113] "Large-H" harm reduction refers to strategies, programs and policies that focus on the harms associated with drug use rather than the elimination of all drugs (the goal of prohibition).

4.1.2 SISs are harmful for communities

Moreover, opponents suggest SISs are particularly harmful for communities where the intervention is implemented. For example, an anonymous individual claims:

> Don't give "harm reduction" a chance to harm Ottawa. Vancouver's safe-injection site has been told by the Supreme Court of Canada it can continue its operations. But we want to make it clear that any "harm reduction" advocates in Ottawa shouldn't get any ideas out of this decision. If a similar site comes to Ottawa, we'll only see an increase in harm to our community (OS80).

Similarly, Matt Skof, president of the Ottawa Police Association suggests with respect to the implementation of SISs: "If introduced in Ottawa, it would be catastrophic for any community that would be hosting it… This is a debate about whether you want to have people injecting very dangerous products and give up a neighbourhood" (OS135). There are five subcategories within this theme, which represent the reasons advanced by claimsmakers that suggest SISs extend rather than reduce harm: SISs enable illegal conduct; SISs create public nuisance; SISs threaten public safety; SISs lead to social deterioration; and "not-in-my-backyard" (NIMBY).

4.1.2 (a) SISs enable illegal conduct

Another argument raised by opponents suggests SISs facilitate illegal conduct set forth in the *Criminal Code of Canada,* such as the possession or trafficking of certain psychoactive substances listed under the CDSA. For example, a resident of West Vancouver suggests: "…it could be viewed as promoting the continued sale of illegal drugs by criminals…" (VS425). Similarly, a resident of Ottawa states:

> In respect to safe injection sites –a crime is a crime. The law is the law. As it should be. If someone was to break into another person's home can you imagine the police saying to them, 'Oh, you did this in the wrong neighbourhood, you're only allowed to commit break and enter in specific communities.' Possession and use of crack cocaine and heroin is a crime. But now there's discussion that people committing this particular crime be told that it's OK to do this so long as you do it in a specific area (OS65).

This comment demonstrates opposition to the fact that SISs allow individuals to commit a "technical offence"[114] and be free from criminal prosecution. Moreover, critics suggest the state should not partake in the facilitation of illegal conduct. For example, *The Ottawa Citizen* writes: "News that a possible safe-injection site for drug users is to be studied for Ottawa has generated some negative reaction from people who feel government should not be enabling illegal drug use" (OC15). Similarly, a resident from Kanata, Ontario states:

> Let me get this straight: Drugs are illegal and anyone caught with illegal drugs can be charged under the Criminal Code, yet our city should seriously consider providing a safe injection site for an illegal activity? ... I'm not sure what kind of society we are fast becoming but it is my fervent hope that someone with some semblance of intelligence puts an end to this nonsense immediately. If drugs are against the law, how on Earth can it be legal for governments to provide a taxpayer funded supervised injection site along with all the necessary equipment? (OC140).

These comments suggest the notion of a state sanctioned SIS is paradoxical in light of the unlawful psychoactive substances consumed by PWUD at such facilities[115].

4.1.2 (b) SISs create public nuisance

Opponents of SISs also claim such facilities will attract an influx of PWUD and people who sell drugs (PWSD) to the neighbourhood, which is referred to as the "honey pot hypothesis" (Elliott et al., 2002). For example, Canadian Alliance MP and the vice-chair of the House of Commons Special Committee on the Non-medical Use of Drugs, Randy White, commenting on his visit to European countries where SISs operate, claims he witnessed: "…human carnage for blocks, as well as a substantial gathering of addicts and pushers in areas where trafficking and using were reluctantly permitted" (VS120).

[114] Technical offences constitute crimes because of the policies concerning drug prohibition (Wright & Devine, 1994).
[115] Clients of *Insite* also consume licit psychoactive substances such as prescription medication (Vancouver Coastal Health Authority, 2013).

4.1.2 (c) SISs threaten public safety

In addition, some opponents of SISs suggest the implementation of such facilities will increase rates of crime and jeopardize the safety of individuals who live in the neighbourhood. In order to threaten public safety, this two-part claim suggests the SIS first creates a honey pot effect. For example, Senator Vernon White writes: "Just Say No. As a former Ottawa Chief of Police and with over 20 years as an RCMP officer, I take issue with those who want to build a drug injection site in Ottawa. Building to what amounts to an illegal drugs hangout centre is detrimental to public safety. It will do nothing but maintain addicts' needs, breed drug dealers, and foster criminal behaviour" (OS130). Similarly, an *Ottawa Sun* editorialist claims: "By enabling drug users we are harming our community. We are putting pedestrians at risk of robbery. We are putting family homes at risk of being broken into" (OS80). *The Ottawa Sun* also claims: "There are concerns in Ottawa that a safe injection site would lead to more crime and would be a detriment to the downtown area" (OS40). For example, a resident of Orleans, Ontario states: "Insite locations will simply make it everyone's problem, by holding the surrounding communities hostage to the desperate and criminal behaviour that goes with drug use" (OC135). Furthermore, opponents suggest there are still high rates of crime in the area where *Insite* operates. For example, *The Vancouver Sun* writes: "Addicts may have a safe place to inject their drugs, but Vancouver still has the third-highest property crime rate in Canada, behind Abbotsford and Regina" (VS310).

Therefore, opponents argue the implementation of SISs cannot be considered solely from a public health perspective. For example, Chris and Lisa Grisham from *Safer Ottawa* suggest: "This is a very dangerous attitude to take, especially in light of the broad scope of safety issues faced by surrounding businesses and property owners; security, crime, …" (OS140). Similarly, the Executive Director of the DPNC, David Berner states:

> So needle exchanges, Insite, free crack pipe kits, shot glasses of whiskey to so-called chronic alcoholics ... those kinds of things are anathema to us…while harm reductionists would claim that the services they provide are humanitarian and meant to save lives…they don't question the consequences. They say, 'I'm going to give you a clean place to shoot up, but I'm not going to ask you where you got your drugs, or how you got the money to pay for your drugs or what you're going to do after you've shot up here.' And what they do after they've shot up is break into your car to feed their habit. The result… is that they ultimately harm everyone - themselves, since they remain addicted and continue to live in misery, the people and family members around them, and society at large, since they feed crime while draining away valuable government resources (VS505).

4.1.2 (d) SISs lead to social deterioration

This is also a two-part claim, predicated on the honey pot effect, whereby opponents suggest the public nuisance following from the implementation of a SIS will subsequently lead to social decay in the neighbourhood. Opponents appear to measure social decay both in terms of public nuisance and the rate of crime. For example, Chris and Lisa Grisham from *Safer Ottawa* argue: "If a site is opened and a four-block No-Go Zone is created for legal drug use and possession the reality is addicts will flock to this area from all over Ottawa and surrounding cities and with them come dealers and all the associated crimes to support addiction. The area will become a veritable wasteland" (OS140). Similarly, a resident from Vancouver also suggests: "Every addict knows there can never be enough drugs or supervised injection sites to appease the addiction. Evidence of this is all around us as Vancouver's social decay continues uninterrupted. If this is called success (after four years), I shudder to think what failure would have looked like" (VS380).

Elliott et al. (2002) suggest business owners commonly advance this argument in opposition to the implementation of SISs because opponents claim the establishment of a SIS in the immediate surrounding area will result in a decrease in commerce. For example, *The Vancouver Sun* writes: "Streets and alleys in the Downtown Eastside may no longer be used as shooting galleries, but aggressive beggars desperate for a fix are frightening away tourists and

conventioneers" (VS310). Similarly, Shirley Chan, a New Democratic Party (NDP) MP argues with respect to SISs: "By over-emphasizing support for those with dependencies in the Downtown Eastside, we have managed to kill off what were healthy businesses" (VS220). In addition, opponents "…complain about the number of junkies around Downtown Eastside businesses…" (VS225). For example, a member of the Gastown Community Safety Society suggests: "This is just another hook to go in the community. The community needs relief from the addicts" (VS15).

4.1.2 (e) "Not-in-my-backyard" [116]

Objections to the implementation of SISs also reflect NIMBY attitudes. The data suggests not all individuals who express concern about SISs are entirely opposed to the concept of a facility that allows PWUD to consume psychoactive substances under medical supervision, however, individuals and groups display NIMBYism toward the establishment of SISs in specific neighbourhoods. For example, Bloc Quebecois health critic, Réal Ménard states:

> […] he favours safe injection sites but only if they operate within a strict framework… injection sites should be the exception, not the rule, and should not be located near schools or on residential streets. Under those conditions, I think we should try it... The more people are in contact with health professionals, street workers and community, the better it is, […] (OC1).

Similarly, *The Vancouver Sun* writes: "And keen as Vancouverites say they are on having the drug problems disappear, few want any part of the solution in their neighbourhoods" (VS310). According to a *Vancouver Sun* survey, there were "47 per cent of poll respondents outside Vancouver who oppose the implementation of supervised injection sites in their neighbourhoods" (VS130). Additionally, an independent candidate running for Vancouver City Council, George Chow has concerns with respect to the future location of the SIS. For example, Chow states: "He

[116] Henceforth referred to as NIMBY. The Merriam-Webster online dictionary (2014a) defines NIMBY as "opposition to the locating of something considered undesirable (as a prison or incinerator) in one's neighborhood".

is campaigning against safe-injection sites because he knows damn well where the first one will be going –and that's right next door to his old neighbourhood of Chinatown" (VS80). Chow also claims: "I think it's quite unfair…for one community to have to supply all the facilities for those people of other communities whose kids have gone astray. There is no right or wrong, only victims –from those who just want to live in their neighbourhoods, to those who end up dying in them" (VS80).

The Vancouver Sun also conducted a poll regarding the level of support candidates running in the municipal election held for harm reduction. The results indicated individuals who oppose the implementation of SISs demonstrate a concern for the businesses in the surrounding area where a SIS may be located. The poll results suggest the majority of Liberal candidates support harm reduction strategies such as SISs, apart from three candidates, including Randy Hawes, a contender for the Member of the Legislative Assembly position for the Maple Ridge-Mission riding. Hawes explains his opposition: "… it was because there is nowhere in his hometown of Mission to put a needle exchange or injection site without making local businesses "evaporate quickly." It's one thing to be in a metropolitan area, where there are areas more conducive to needle exchanges and safe injection sites. The main street of Mission is not one of them, …" (VS455). Similarly, local business owners display concerns with respect to the establishment of a SIS in their neighbourhood. The literature by Small et al. (2006) highlights the active role of the *Community Alliance,* a group of landowners and business leaders from neighbouring areas such as Chinatown and Gastown, in preventing the development of a SIS (Small et al., 2006, p.77). For example, *The Vancouver Sun* writes: "Just as business' Community Alliance wants to keep safe injection sites out of the Downtown Eastside, some

community residents don't want the ordinary working poor to horn in on their Woodward's" (VS70)[117].

4.1.3 Lack of clear scientific evidence demonstrating the effectiveness of SISs

A common argument advanced in opposition to the establishment of a SIS in Vancouver centered on the lack of clear evidence of the effectiveness of SISs as a harm reduction strategy (Elliott et al., 2002). For example, *The Vancouver Sun* writes: "Since its election in 2006, the Harper government has asserted that more research is needed to test Insite's effectiveness…" (VS400). In addition, at the end of *Insite*'s three-year scientific trial period, RCMP Staff Sergeant Chuck Doucette suggested: "…there's "no evidence" to show that Insite users are going to drug treatment, and said there has been no decrease in public drug use in the area around the facility" (OC35). This argument was also employed by the former federal Health Minister, Tony Clement, as justification for denying *Insite* operators a second exemption under section 56 of the *CDSA* to lawfully operate the SIS. For example, Clement states: "Given the need for more facts, I am unable to approve the current request to extend the Vancouver site for another 3 1/2 years" (VS320). Clement further questioned: "Do safe-injection sites contribute to lowering drug use and fighting addiction? … Right now the only thing research to date has proven conclusively is drug addicts need more help to get off drugs" (VS320). This claim suggests that opponents measure the interventions effectiveness in terms of abstinence and a decrease in drug use.

4.1.4 Medically supervised drug injection is unethical

Moreover, as Elliott et al. (2002) note, for some opponents of SISs, the most contested feature of these facilities center on the supervision of individuals who inject drugs. For example,

[117] Woodward's Stores Limited is a chain department store; one Woodward's was located in the DTES (HBC Heritage, 2014).

The Vancouver Sun writes: "Clement said he would not like to see Insite shut down outright but he didn't support the supervised injection aspect…" (VS410). Tony Clement suggests: "…allowing heroin addicts to shoot up is against a health professional's code of ethics" (OC85). This attitude is reflected in Clement's comments regarding *Insite* at the annual meeting of the Canadian Medical Association (CMA) where Clement told physicians:

> I find the ethical considerations of supervised injections to be profoundly disturbing, … Is it ethical for health care professionals to support the administration of drugs that are of unknown substance or purity or potency, drugs that cannot otherwise be equally prescribed? …drug overdoses regularly occur at Insite, something that would be considered highly unprofessional in any other medical setting. In this way, the supervised injection site undercuts the ethic of medical practice and sets a debilitating example for all physicians and nurses, both present and future in Canada, who might begin to question whether it's all right to allow someone to overdose under their care (OS45).

Similarly, a resident of North Vancouver writes: "Since the medical staff does not supply the drugs, however, they have no idea what kind of poison goes into the addict's veins. How would medical professionals feel if they ended up hurting or killing their patients instead of helping them?" (VS55).

4.1.5 SISs violate international drug control treaties

Critics of SISs also claim that such facilities contravene international laws regarding illicit psychoactive substances, and argue existing SISs should be shut down. For example, *The Vancouver Sun* writes: "The International Narcotics Control Board says it does not in principle oppose harm reduction programs, but it refuses to recognize the safe-injection site, which is clearly saving lives, as a legitimate and legal approach" (VS210). More specifically, the International Narcotics Control Board (INCB) "…argues that Vancouver's safe injection site, which opened last September in the Downtown Eastside, violates the fundamental principle that

illicit drugs only be used for "medical or scientific purposes"" [118] (VS210). Additionally, in an annual report of the United Nations (UN) panel, opponents claim *Insite* facilitates "the illicit use of internationally controlled substances and violate[s] the provisions of international drug control treaties … Consequently, the board plans to advise Health Minister Tony Clement to shut down the site, possibly at the board's annual meeting next week" (VS350). The INCB further states: "By permitting injection rooms, a government could be considered to be in contravention of the international drug control treaties by facilitating, aiding and/or abetting the commission of crimes involving illegal drug possession and use, as well as other criminal offences, including drug trafficking" (VS350).

This concludes the presentation of arguments advanced in opposition to the implementation of SISs. The following section of this chapter will present the arguments that reflect support for the implementation of this intervention.

4.2 Claims in Support of SISs

4.2.1 SISs are an evidence-based harm reduction intervention

As previously discussed in the review of literature, over thirty-five studies published in peer-reviewed scholarly journals suggest *Insite* is an effective public health intervention (Hyshka, Bubela & Wild, 2013). Supporters of SISs often point to the plethora of research as evidence of the intervention's success as a harm reduction strategy. For example, Wendy Muckle, Executive Director of Ottawa Inner City Health claims:

> There are 90 (supervised injection sites) around the world, they have been studied to death, […] The evidence shows they protect the health of people who use drugs, they

[118] Article 4 of the 1961 *United Nations Single Convention on Narcotic Drugs* states: "The parties shall take such legislative and administrative measures as may be necessary […] c) Subject to the provisions of this Convention, to limit exclusively to medical and scientific purposes the ... distribution of, trade in, use and possession of drugs".

> prevent overdose deaths, prevent the transmission of disease, that they don't increase crime rates, they do reduce drug use overall and people enter addiction treatment more rapidly (OS135).

Similarly, The Public Health Physicians of Canada (PHPC) states "…research and studies document the "positive public health and public safety outcomes" of such supervised injection sites" (OS125). In addition, during a news conference, Liz Evans, a nurse and Executive Director of the Portland Hotel Society (PHS) which co-operates *Insite,* cites the mounting research on SISs as reason to maintain the operation of the facility. Evans states: "…enough research and studies have been done to prove that harm-reduction strategies, such as safe injection sites, are effective and worthwhile" (VS395). *The Vancouver Sun* also writes: "Its primary objective is "harm reduction," that is, the reduction of incidences of overdose, disease, crime, and shooting-up detritus. According to its advocates, Insite is a resounding success with peer reviewed, measurable data in all areas to support their case" (VS300). In addition, academics such as Dr. Thomas Kerr and Dr. Julio Montaner[119] state:

> Likewise, a large body of scientific evidence shows that Insite is meeting its objectives. Peer-reviewed studies involving dozens of researchers from Canada, Australia, Britain and the U.S. demonstrate clearly that Insite does not increase crime or perpetuate active drug use. More than 30 peer-reviewed studies show that Insite saves lives and health care dollars, reduces disease transmission, and promotes entry into addiction treatment (VS515).

4.2.2 SISs benefit the community and PWUD

Proponents of SISs claim such facilities not only benefit PWUD or the clients of the SIS but also the public and more specifically the community in which a SIS operates. For example, Alan Lowe, former Mayor of Victoria, B.C. states a SIS "will protect our citizens as well as the addicts – we have to realize these people are sick, …" (VS325). The underlying rationale for this

[119] Dr. Montaner is the director of the B.C. Centre for Excellence in HIV/AIDS, Head of Division of AIDS in the Faculty of Medicine at the UBC, and chair in AIDS research (B.C. Centre for Excellence in HIV/AIDS, 2014b).

argument assumes that PWUD will inject regardless of the conditions of their environment or their injection equipment, thus the establishment of an intervention to reduce the harms associated with public injection drug use would be beneficial to both PWUD and the public. This is exemplified in the following statement by *The Ottawa Citizen*:

> If someone's going to inject heroin no matter what (as good a definition of an addict as any) it's better for him to use a sterile, sharp needle than a dull one rinsed out with puddle water. More to the point, it's better for the rest of us. Using a dirty needle is one of the best ways we know to get HIV and hepatitis C. Do that and bang! – you're the health system's $100,000 problem. Spread it to another drug user and the taxpayer's on the hook for another $100,000. That's about a dozen knee replacements, at average costs, or nearly a million clean needles. Some estimates put the total social cost of one AIDS case as high as $500,000. Diseases spread beyond circles of addicts, too – to secret users' unknowing sex partners, to prostitutes' johns and their families, to police officers who get stuck during arrests (OC10).

Similarly, a resident of Ottawa states: "Lives are saved, disease spreads more slowly, crime rates go down and society at large benefits from harm reduction. This is not an opinion, it is a documented fact. Every article or report I have read that slams harm reduction ignores all of these facts" (OC30). Liz Evans, Executive Director of the PHS also claims the implementation of SISs in each region has been carried out so as to ensure the facility is beneficial for the neighbourhood and PWUD: "In every jurisdiction where harm reduction is practised, it is done so in collaboration with local police, business and residents to ensure both the individual users and the broader community equally benefit" (OC65). More specifically, Dr. Mark Tyndall[120] claims:

> Of the more than 10,000 individuals who had used drugs at Insite, nearly half had entered some form of drug treatment and all had been given the opportunity to connect with caring people. Those who were using drugs were helped to stay free of disease and connect with services that they needed. There were fewer drug overdoses, fewer HIV infections, and fewer hospital admissions. The community benefits included less crime, less drug dealing, less public drug use, happier shop owners, and higher property values" (OC150).

[120] Dr. Tyndall has been the chief and chair of the Infectious Diseases Division at The Ottawa Hospital since 2010 (Department of Medicine, 2014). Prior to this role, he was a researcher and physician at the B.C. Centre for Excellence in HIV/AIDS and a co-investigator in the impact studies on *Insite* with the Urban Health Research Initiative. (2008).

In addition, Wendy Muckle, Executive Director of Ottawa Inner City Health states: "Those who'd benefit most are the most vulnerable among the estimated 5,000 IV drug users citywide – the about 1,000 people, often mentally ill, who shoot up outside because they're homeless, […] Residents who find needles in their yards and see people wandering high can only benefit by moving some of that drug use inside, …" (OS135)[121]. Thus, supporters of SISs claim that the reduction of harms for PWUD and community members is not mutually exclusive; rather, they go hand in hand. For example, *The Vancouver Sun* writes:

> Reducing harm to the community and reducing harm to the addicted and the mentally ill are not two separate things. Whether we like it or not, people with substance use and psychiatric problems are a part of the community, and it is only by helping them that we can help ourselves. It's not a quick fix, but it's the only fix that will work in the long run (VS330).

Moreover, there are five subsections under this category, they include: SISs are an effective public health measure; SISs reduce public nuisance; SISs improve public safety; SISs enhance the aesthetics of public space; and SISs provide a safer environment for PWUD.

4.2.2 (a) SISs are an effective public health measure

As the literature by Wood, Tyndall, Spittal, Li et al. (2001) suggest, SISs may alleviate public health related problems associated with public injection drug use through the provision of an alternative setting in which drugs may be consumed. Thus, a common argument advanced in support of SISs is the claim that such facilities improve public health. Elliott et al. (2002) suggest SISs have the potential to improve public health in three major ways: through the prevention of overdose death; the prevention of the spread of disease and wounds from unsafe injecting practices; and the facilitation of access to treatment, education and rehabilitation (p.12). Proponents of SISs also suggest other measures indicate improvements in public health, these

[121] IV refers to intravenous.

include: a reduction in needle sharing; increased initiation into detoxification programs; a reduction in drug use; modification of risky injection practices; and the provision of contact with health care providers.

First, proponents claim SISs are effective in reducing rates of overdose death because the facilities are staffed with medical professionals who are able to intervene immediately in incidents of overdose at the facility, in contrast to overdoses which occur in public spaces in the absence of health care workers. In other words, proponents argue *Insite* has the capacity to save lives. For example, Mark Townsend of the PHS suggests: "If those people [who overdosed] had been on the street or in a hotel, obviously, some of them would be dead, … at least 25 per cent of them – or six people – would have died had they not been fixing under a nurse's watch" (VS205). Similarly, Executive Director of the PHS, Liz Evans states:

> While I welcome the significant improvement to my neighbourhood for both myself and my children, the primary reason I continue to support InSite is its ongoing life-saving work. More than 900 overdose interventions have happened at InSite –each someone's child who would not be with us today if InSite nurses had not been there to take immediate action (OC65).

Their argument is founded upon the scientific study of *Insite* conducted by Marshall, Milloy, Wood, Montaner, and Kerr (2011). For example, an anonymous individual states:

> No matter which way that case[122] goes, the Conservative government should drop its campaign against the facility. There is new, dramatic evidence that if Insite closes, people will die. No government can, in good conscience, ignore such evidence. It comes in the reputable medical journal The Lancet, which published a study last month regarding fatal overdoses in Vancouver between 2001 and 2005. In the city as a whole, such deaths decreased by nine per cent. Within 500 metres of Insite, such deaths decreased an impressive 35 per cent. The conclusion? Closing Insite would likely lead to unnecessary and preventable deaths due to overdose (OC105).

[122] The individual is referring to the SCC case, *Canada (Attorney General) v. PHS Community Services Society* (2011).

Second, proponents argue SISs improve public health because it allows PWUD to develop a point of contact with health care providers, to commence drug treatment programs, or to access other health and social services. For example, Peter Whiticar claims: "One of the big advantages of a safe-injection site like Vancouver's, he says, is that it draws drug-users who have been marginalized back into the public system. Once they start getting involved, they have the opportunity to avail themselves of various forms of assistance" (VS215). Similarly, Dr. Mark Tyndall suggests:

> Of the more than 10,000 individuals who had used drugs at Insite, nearly half had entered some form of drug treatment and all had been given the opportunity to connect with caring people. Those who were using drugs were helped to stay free of disease and connect with services that they needed. There were fewer drug overdoses, fewer HIV infections, and fewer hospital admissions (OC150).

Most notably, supporters suggest SISs may act as a gateway to detoxification and treatment, for example, Dr. Thomas Kerr[123], with reference to a study he co-authored in the *New England Journal of Medicine*, states: "If you use the site at least weekly, you are two times as likely than others to enter detox, …Our findings provide reassurance that supervised injection facilities are unlikely to result in reduced use of addiction-treatment services, …" (VS285). In addition, Kerr suggests: "…peer-reviewed and published scientific studies have shown that Insite users are going into detox facilities and that drug use in the area has been reduced" (OC35). More specifically, Kerr states, with reference to a study published in the *British Medical Journal*: "We showed actually that binge drug use went down" (OC35). Furthermore, *The Ottawa Sun* suggests individuals who utilize *Insite* are also "more likely to start methadone therapy and reduce their number of monthly visits to the facility, …" (OS20). These arguments are consistent with the findings of Tyndall, Kerr and Zhang et al. (2005), which suggest the increasing number of

[123] Dr. Kerr is the co-director of the Urban Health Research Initiative at the B.C. Centre for Excellence in HIV/AIDS and professor of medicine at the University of British Columbia (UBC) (B.C. Centre for Excellence in HIV/AIDS, 2014a).

individuals seeking out addiction counselling[124] may be a result of more frequent interaction with health professionals, which allows clients to develop trusting relationships with the staff (p.5).

Third, supporters of SISs claim such facilities help to educate PWUD about safer injection practices, which subsequently impacts future injection drug use practices. The literature by Kerr, Tyndall, Li, Montaner and Wood (2005) suggest individuals who utilize *Insite* engage in less "high risk injecting practices". For example, Peter Whiticar, a public-health administrator in Hawaii suggests:

> […] one of the keys to improving public health is modelling –getting people to change their behaviour to a less-destructive model. When people are injecting in that site, they're coming there, they're getting clean syringes, they're getting clean cotton, clean water, clean cookers, so they're actually learning the skills of clean, safe injection, and then they're disposing of the syringes afterward, so it's pretty good modelling (VS215).

In addition, *The Vancouver Sun* writes:

> Nurses at the site are there to oversee the injections, but are also available to educate users on safer ways to inject. Many of the women who come into the site are what [Viviana] Zanocco calls "jugular injectors," meaning they have someone else inject the needle into their neck. The site doesn't allow a second person to inject a user, so the nurses often show these women other, safer places they can inject (VS205).

Along a similar line of thought, proponents argue PWUD may reduce their risk of contracting infectious diseases through the adoption of safer injecting practices. A spokesperson for Vancouver Coastal Health Authority, Viviana Zanocco states: "It really is good, because a lot of women, when they're injected by somebody else, are second on the needle, so they're getting infected with whatever the first person has, …" (VS205). Supporters claim this argument is also grounded in scientific research on *Insite*. For example, *The Ottawa Citizen* writes: "A study centred on the Vancouver safe-injection site has shown that drug users there have been

[124] From 2003 to 2004, the number of individuals who sought out addiction counselling increased from 121 to 314 (Tyndall, Kerr & Zhang et al., 2005, p.4).

influenced by nurses' advice to follow safer practices even when they're shooting up on their own" (OC10).

4.2.2 (b) SISs reduce public nuisance

Public spaces saturated with public injection drug use are perceived to be "a nuisance and a threat" (Broadhead, Kerr & Altice, 2002). Supporters argue SISs can address issues related to public injection drug use, thus areas where an open drug market already exists serve as ideal locations to situate a SIS (Victoria Drug Policy Expert Committee[125], 2000). Fischer, Turnbull, Poland and Haydon (2004) contend SISs have the capacity to uproot PWUD in public in order to respond to community concerns with respect to public disorder in the neighbourhood. According to Elliott et al. (2002), supporters of SISs argue the "honey pot hypothesis" is an unsubstantiated claim since the public injection drug using population often tends to be homeless and "will travel only a short distance between the point of purchase and the use of drugs" (VDPEC, 2000). The data reflects this view, whereby supporters of SISs claim such facilities improve public order because it leads to reductions in public injection drug use and injection drug related litter (e.g. discarded syringes)[126]. For example, Liz Evans, Executive Director of the PHS states: "Since InSite opened in 2003, there has been a dramatic decrease in the number of public injections and injection-related litter. As a resident of the neighbourhood, I have witnessed a stark contrast in the livability of the Downtown Eastside since InSite opened its doors" (OC65). Vancouver's drug policy coordinator, Donald MacPherson also claims there is a reduction in public drug use on account of the establishment of *Insite* in the DTES. For example he states: "We hear from police and nurses that there are fewer injections going on in the back alleys. The open drug scene at Hastings and Main doesn't exist anymore in the form that it had existed" (VS225). In addition,

[125] Henceforth referred to as the VDPEC.
[126] Some claimsmakers also refer to the public order issues as "street problems".

MacPherson states: “Many of the fears of the community that it would lead to massive disorder have not come to fruition, …” (VS225).

Academics also suggest SISs play a role in contributing to public order with respect to public injection drug use. A professor of family medicine at the University of Toronto, Dr. Berger claims: “This will bring it under control. It will be on the side of more control, not less” (OC15). Dr. Lynne Leonard, a professor of epidemiology and community medicine at the University of Ottawa suggests SISs “…would get addicts out of public places, reduce needle litter and act as a check on overdoses” (OC70). In addition, Dr. Irwin Waller, a criminology professor at the University of Ottawa states: “The Vancouver experience shows that there is no “honey hive” effect around supervised injection sites…” (OS135). Some proponents also refer to evidence from international experiences to substantiate this claim. For example, Dr. Perry Kendall, provincial health officer of B.C., suggests jurisdictions in Europe that have established SISs have not experienced an increased presence of PWSD in the area. He claims:

> My answer is that you already have one of the largest open air drug markets in the Lower Mainland in the Downtown Eastside. It’s hard to imagine you’d get more drug dealers… drug users from other areas would be unlikely to migrate near a safe injection facility. That hasn’t been the experience in Europe…I doubt that would be the experience here. If there was one, I doubt that it would be noticeable given the current numbers (VS15).

Finally, a Vancouver city councilor, George Chow who “at one time opposed the city’s plan to support having a safe-injection site for drug users in the Downtown Eastside” has stated the SIS “…has improved the area” (VS250).

4.2.2 (c) SISs improve public safety

As previously mentioned, the public injection drug using population is limited in terms of mobility (VDPEC, 2000), thus, proponents reject the claim that the implementation of a SIS will attract PWUD from other areas. The data indicates proponents of SISs claim such facilities do not

create a "honey pot effect" nor do such facilities have a negative impact on crime rates in the vicinity. For example, Dr. Irwin Waller states: "Because the drugs that they're going to be injecting are illegal, there is some crime that goes along with it, but you do not increase the crime by opening a safe injection site –you just continue it, …" (OS135). A report from the Expert Advisory Committee (EAC) on SIS research appointed by the federal government also suggests: "the controversial site in the Downtown Eastside doesn't affect crime rates…" (VS395). In contrast, business owners have reported a decrease in street crime. For example, *The Ottawa Sun* writes:

> Opponents only need to look to Chinatown in Vancouver, two blocks away from the InSite location, to see that it's not all bad news. Merchants in that area were originally opposed to the site for fear of increased crime rates, but they've since changed their tune and now stand next to politicians supporting InSite. Merchants said at a press conference recently that within the first two years of InSite's operation, they noticed a decrease in street crime (OS40).

Similarly, a resident of Ottawa claims: "The InSite experiment out west has actually lowered crime in the surrounding region…" (OS145). Supporters of SISs substantiate this claim using the findings from a study on *Insite* published in the *American Journal of Preventive Medicine,* which suggests "the site is attracting young drug users who have an elevated risk of HIV infection and overdose…[who]…may otherwise pose safety risks by using drugs in public…" (VS240).

Lastly, as Elliott et al. (2002) note, supporters suggest the safety of frontline workers, in particular emergency response personnel, is enhanced through the establishment of SISs. The authors suggest it would reduce altercations between PWUD and police officers and their chances of being pricked by contaminated syringes (Elliott et al., 2002, p.8). For example, a resident of Ottawa suggests: "It seems rather mind-boggling that Ottawa's police chief opposes safe injection sites, which reduce the odds police officers will be exposed to HIV in the course of their work. This fact is recognized by many police services in the United States" (OC95).

4.2.2 (d) SISs enhance the aesthetics of public space

Proponents of SISs also advance the claim that such facilities help to improve the aesthetics of a neighbourhood. For example, Dr. Perry Kendall claims: "The evidence from Europe is that if you do this right, you can improve the ...neighbourhood and the neighbourhood looks better, …" (VS15). Similarly, Dr. Irwin Waller suggests: "If a supervised injection site goes where street drug use is already happening, odds are that in addition to public health benefits it would make streets "neater" and win support from the community around it…" (OS135). More specifically, some proponents suggest the establishment of SISs will help to clear the streets of the homeless population[127] and result in "cleaner" looking streets. For example, *The Vancouver Sun* writes: "Opening a safe-injection site is a first step in cleaning up the Downtown Eastside – which is where many of the campers come from …" (VS185).

More specifically, proponents argue the establishment of a SIS contributes to an increase in surrounding property values for land and business owners. For example, *The Vancouver Sun* writes: "The supervised injection site, health clinics, and spiffy new social housing projects built in the last five years have all helped make the area a little less scary to people…The result is that land values are going up and development applications are percolating for the Downtown Eastside, Gastown and Chinatown" (VS280).

4.2.2 (e) SISs provide a safer environment for PWUD

Proponents also argue SISs are a safer alternative to injection drug use in public environments such as the streets and alleyways. For example, Dr. Evan Wood[128], a professor of medicine at the UBC, states: "the creation of a sanctioned area for drug users prevents them from using drugs in unsafe public spaces" (VS240). Dr. Wood explains: "Essentially, there is no space

[127] Often these individuals are homeless and referred to as "campers" since some of these individuals reside in tents.
[128] Dr. Wood is also a research scientist at the B.C. Centre for Excellence in HIV/AIDS.

for drug use because it's an illicit activity, …Illicit drug use takes place in unsterile environments –behind dumpsters, in shooting galleries– in these types of hidden environments. That's an effect of our current approach to the drug problem" (VS240). Similarly, Dr. Thomas Kerr suggests: "drug injection facilities would provide sterile injection equipment and a safer place than the streets" (VS10). In addition, the literature by Fairbairn et al. (2008) suggests the "controlled environment" of SISs offer female injection drug users protection from violence on the streets. This notion is reflected in a claim from *The Vancouver Sun*: "It is making life safer for highly vulnerable female addicts living in the Downtown Eastside" (VS435).

4.2.2 (f) SISs provide PWUD a "therapeutic space of acceptance"

As outlined in the theoretical framework, harm reduction strategies are characterized by a realistic, practical and non-judgmental approach to drug use that avoids making value judgments of individuals, which helps to minimize the stigma that is often attached to drug use and drug users (Elliott et al., 2002). Similarly, Jozaghi (2012) suggests *Insite* is a therapeutic space that offers PWUD a "unique microenvironment," akin to a "refugee camp" where distressed PWUD may seek relief and support (p.1155). From this perspective, the space at *Insite* not only serves as a place to consume psychoactive substances, but also offers PWUD a sense of human dignity and social support (Jozaghi, 2012, p.1156). This notion is reflected in comments from a client of *Insite*: "…it will help many people stay healthy and, just as important, give them a place to go where they are treated like normal human beings" (VS200). In addition, the client claims: "For some people, this might be their only healthy, non-drug-related interaction" (VS200). Similarly, Liz Evans, Executive Director of the PHS suggests: "This is a space that restores some safety and dignity to the people with this problem" (VS140).

Overall, these arguments reflect the humanizing nature of SISs and community caring for PWUD. For example, Chris Buchner, manager of the Vancouver Coastal Health HIV/AIDS Harm Reduction Programs, suggests clients of *Insite* informed former federal Health Minister Tony Clement during his visit at *Insite* of the importance "of having access to this place, how it adds dignity to their lives and how it's a critical health service" (VS340). Similarly, a resident of Ottawa, suggests: "Drug users are not pieces of garbage to be discarded because they are not productive members of society…By providing clean needles in a safe space, we will be shining a ray of hope into the wreckage that is their lives. Feeling valued, they may yet live and recover to lead full and healthy lives. The first key is that they live" (OC160). In addition, an individual who uses drugs suggests: "Something like this would be a start to saying to the addicts, 'There's a facility you can go to, you don't have to be like this'" (VS160).

4.2.2 (g) SISs are cost-effective

As previously discussed in chapter one, the cost-benefit analysis conducted by Pinkerton (2010)[129] suggests the Vancouver SIS is a cost-effective harm reduction measure. Proponents of SISs suggest the implementation of such facilities are cost effective because SISs help to reduce the rate of overdose death and the spread of infectious diseases, which subsequently alleviates costs to the health care system. For example, Dr. Evan Wood states: "…making safe injection sites available would likely control health care costs by reducing infectious disease and overdoses" (VS35). Another academic, Dr. Mark Tyndall, claims: "…people would be shocked if they knew how much health-care money goes into treating addicts for infections and overdoses—problems that could be prevented if there were more harm-reduction efforts like injection sites" (VS160). Specifically, Dr. Thomas Kerr states: "…the facilities in other countries cost $300,000

[129] See also Des Jarlais, Arasteh & Hagan (2008).

to $1 million, which he said is low compared to the billion-dollar price of drug law enforcement and health care for drug-related disease" (VS10). Proponents argue the cost of treatment for persons with HIV/AIDS is much greater than the price of operating a SIS. For example, Mark Townsend of the PHS "…estimated it would cost $300,000 to $800,000 a year to staff the site his group built, depending on how many hours a day it was open. Townsend said $800,000 to operate a safe-injection site might seem like a lot of money, but it's very little compared to the cost of a life or of treating someone with HIV" (VS140). Similarly, a public health administrator in Hawaii, Peter Whiticar, states: "So the way we look at it, if you can prevent five cases of HIV each year and your program costs $1 million, you're basically breaking even on your costs" (VS215). Some proponents employ this argument in order to persuade opponents who take issue with claims asserting the life-saving capacity of SISs. For example, a resident of Burnaby, British Columbia, writes: "If saving lives does not resonate, perhaps the financial bottom line will. Fewer people going to hospital emergency departments thanks to the safe injection site saves money and reduces the strain on an already overwhelmed health-care system" (VS295).

4.2.3 SISs save lives

The literature by Jozaghi (2012) suggests the most prevalent narrative advanced by clients of *Insite* is with respect to the intervention's "life saving" capacity (p.1150). While the claim that SISs are an effective public health measure encompasses the claim that SISs save lives in terms of fatal overdose prevention, proponents also suggest *Insite* saves lives in a metaphysical sense by enabling PWUD to stay alive long enough to enter treatment and turn their lives around. For example, Dean Wilson, president of the Vancouver Area Network of Drug Users (VANDU) claims:

> As a plaintiff for Insite's Supreme Court challenge I feel it is time the media stop referring to Insite as only a supervised injection site. It is so much more. In fact, injection is only

> one of many services offered on the first floor. We also have a detox on the second floor and transitional housing on the third floor. The whole site is a comprehensive medical facility that provides addiction medicine to the people of the Downtown Eastside. The injection site saves lives; the rest of the facility changes lives (VS480).

Similarly, Dr. Perry Kendall believes "…safe injection sites are the best option for dealing with Vancouver's drug problem and keeping addicts alive until they decide to seek treatment" (VS15). This argument reflects the assumption that SISs save PWUD from fatal overdose, for example, Greg Riehl, president of the Canadian Association for Nurses in AIDS Care also argues: "If we don't have harm reduction, if we don't have Insite, those people will be dead. Dead people cannot enter into treatment, …" (VS395).

The literature by Elliott et al. (2002) suggests proponents also advance arguments that assert there is a moral imperative to implement SISs in light of the life saving impacts of such facilities. The argument suggests state inaction with respect to the implementation of SISs is immoral given the high rates of preventable disease and overdose deaths in the absence of a SIS. For example, in an online commentary, *The Lancet* states: "Misplaced moral judgments have underpinned the neglect of people who inject drugs. Yet, it is wholly immoral to let people become infected with HIV or die when evidence based interventions exist to prevent these outcomes. A bold and human response is needed from governments. Lives are at stake" (VS485). Similarly, Dr. Thomas Kerr claims: "Logic, compassion and basic decency require us to act. We cannot continue to close our eyes to the staggering amount of disease and death in British Columbia, resulting not just from injection drug use, but also from government failure to put a comprehensive prevention and treatment strategy in place" (VS10). Further, an anonymous individual states: "There is new, dramatic evidence that if Insite closes, people will die. No government can, in good conscience, ignore such evidence" (OC105).

4.2.4 SISs provide PWUD a health service

Additionally, proponents of SISs argue medically supervised drug injection falls within the continuum of health care—because it is a health service—and should therefore be permitted to operate. In *PHS Community Services Society v. Attorney General of Canada* (2008), Judge Ian Pitfield stated, the criminal law when applied to the users of *Insite* "…denies the addict access to a health-care facility where the risk of morbidity associated with infectious disease is diminished, if not eliminated" (OC75). The claim that SISs provide a health service is also employed by proponents of SISs, for example, Dean Wilson, president of VANDU suggests: "The whole site is a comprehensive medical facility that provides addiction medicine to the people of the Downtown Eastside" (VS480). In addition, proponents of SISs argue that as a health service, such facilities should be permitted to operate without a federal government exemption from *Criminal Code* provisions. For example, Dr. Joel Kettner, president of the Public Health Physicians of Canada (PHPC) states: "We do not need to have these sites enshrined in criminal legislation. Instead, local public health agencies should be able to integrate these services, when required, into the range of harm reduction interventions that are needed by their local communities, …" (OS125). Similarly, at the Dr. Peter Centre in Vancouver, clients are permitted to inject psychoactive substances under the supervision of nurses, akin to the service offered by SISs, however the centre does not operate as a government sanctioned SIS[130]. Bonnie Lantz, president of the Registered Nurses Association of B.C. argues the Dr. Peter Centre does not require an exemption to operate since "… the service falls within the scope of the things that registered nurses are allowed to do, because they can educate patients to prevent disease" (VS10). Moreover, in Ottawa, the director of the Oasis program at the Sandy Hill Community Health

[130] In other words, the centre does not possess a section 56 exemption from *Health Canada* in order to operate, unlike the requirement for the establishment of SISs in Canada.

Centre (SHCHC), Rob Boyd, suggests the possibility for a SIS to be integrated with other services offered at the SHCHC. For example, Boyd states: "…if one day a safe injection site is slated for Ottawa, the centre could look at hosting the service, as might other health centres" (OS60).

4.2.5 Benefits of SISs outweigh potential benefits of prohibition

In light of the alleged benefits described above, some proponents of SISs argue the merits associated with the establishment of such facilities supersede the possible harms that may transpire. For example, a Liberal MP, and vice-chairwoman of the House of Commons Special Committee on the Non-medical Use of Drugs, Carole-Marie Allard states: "the benefits of the proposed sites far outweigh any negatives" (OC1). The judicial decision rendered in *Canada v. PHS Community Services Society* (2011) reflects a similar standpoint. For example, *The Ottawa Citizen* writes:

> The ruling was clear: applying the Controlled Drugs and Substances Act (CDSA) to Insite was arbitrary, undermining the very purposes of the CDSA, which include public health and safety. It is also grossly disproportionate: the potential denial of health services and the correlative increase in the risk of death and disease to injection drug users outweigh any benefit that might be derived from maintaining an absolute prohibition on possession of illegal drugs on Insite's premises (OC150).

4.2.6 SISs do not contravene international drug control treaties

Supporters of SISs also refute the claim that such facilities contravene international drug conventions. For example, *The Vancouver Sun* writes: "Lawyers advising Health Canada came to a similar conclusion about the legal status of Insite before its opening, and lawyers in Germany, the Netherlands, Slovenia and Switzerland have all concluded that SIFs don't violate drug control

treaties" (VS350)[131]. In addition, lawyers with the UN International Drug Control Program suggest:

> It would be difficult to assert that, in establishing drug-injection rooms, it is the intent of parties to actually incite or induce the illicit use of drugs, or even more so, to associate with, aid, abet or facilitate the possession of drugs…It seems clear that in such cases the intention of governments is to provide healthier conditions for IV drug abusers, thereby reducing their risk of infection with grave transmittable diseases and, at least in some cases, reaching out to them with counselling and other therapeutic options (VS350).

4.2.7 Reconciling harm reduction and treatment

As previously discussed, the city of Vancouver utilizes a four pillars drug strategy, which incorporates harm reduction while the federal drug strategy is comprised of enforcement, treatment and prevention. Proponents of SISs however, argue a comprehensive drug strategy must include harm reduction and SISs. For example, Mark Townsend of the Portland Hotel Society (PHS) criticizes the federal government's approach: "Simple Jenny Craig diet-type programs don't work. We need to have a comprehensive plan. Stephen Harper thinks there's a simple way out of addiction, …" (OC85). Similarly, Liz Evans, Executive Director of the PHS also claims:

> The public is aware that addiction is a complex issue that requires a comprehensive strategy –one that incorporates improved enforcement, comprehensive prevention programs, and flexible and accessible detox and treatment interventions. But it also needs to include harm reduction– so people don't die unnecessarily, and parents don't continue to lose their children (OC65).

In addition, Dr. Mark Tyndall argues:

> Statements from the Health Minister claiming that her government favours prevention and treatment over "so-called" harm reduction are offensive to those impacted by addiction and show a total disconnect from the plight of inner-city drug addicts. Of course it would have been better to prevent the addiction in the first place, but it didn't happen. Of course treatment would be great, but it isn't available. What we have are simple, common-sense ways to prevent disease and suffering with the opportunity to engage people in care and treatment when they are ready and able to do it. This is called harm reduction. A

[131] SIFs refer to safe injection facilities or supervised injection facilities.

> supervised injection site is a few chairs, a table, and some clean needles where people can use their drugs under the care and supervision of a trained health care worker. What could be simpler than that? (OC150).

Moreover, some individuals express cautious support for SISs, wherein their support is contingent upon the combined application of harm reduction with enforcement and treatment. For example, in Vancouver of 2002, mayoral candidate Jennifer Clarke stated:

> Like my colleagues on council, I continue to support the much talked about "four-pillar approach" which provides an integrated framework for dealing with the tragedy of drug addiction and its debilitating impact on people and neighbourhoods. I've had the chance to take a firsthand look at a similar approach in Frankfurt and Amsterdam which pioneered the notion that drug addiction is, first and foremost, a health issue. In both cities, their supervised injection sites are part of an integrated plan that combines law enforcement with treatment and harm reduction… (VS20).

Similarly, *The Vancouver Sun* also writes: "Safe injection sites are just a small part of that strategy. There is a great deal of other work that needs to be done, improving treatment, strengthening enforcement and teaching those at risk that addiction to hard drugs puts them on a slippery slope to a place none of us wants to visit" (VS135).

Proponents of SISs also argue the facilities fall within the spectrum of treatment for PWUD because it allows individuals to slowly transition from drug use to cessation. For example, Chris Buchner, manager of the Vancouver Coastal Health HIV/AIDS Harm Reduction Programs, suggests SISs are a first step to treatment: "People just don't jump from the gutter to abstinence. You need a ladder to get there and there are several intermediary steps and the first step is to bring people here" (VS340). Similarly, Dr. Philip Berger a professor of medicine at the University of Toronto argues:

> It is a treatment to try to reduce the injury and disarray...when everything else has failed, […] This will bring it under control. It will be on the side of more control, not less. There are some people who have failed every drug treatment plan, model, philosophy. It's better that their injection drug use take place in a supervised environment where at least they're still part of the treatment system, are welcomed into it rather than being tossed out of it and left on the streets (OC15).

In addition, an anonymous individual writes:

> Opponents of Insite say they want to focus on prevention and rehabilitation, and they worry that allowing addicts a safe place to shoot up sends a mixed message, enabling the very behaviour the government wants to discourage. That logic is flawed. The two approaches are not mutually exclusive. Insite actually increases the use of detox and addiction services, partly by establishing a link between addicts and the public-health system (OC105).

Proponents also argue that harm reduction strategies such as SISs help to address a service gap for PWUD. For example, the provincial health officer of B.C, Dr. Perry Kendall, states: "The supervised injection site and the prescription heroin trials fill gaps in our present system where we need to face the fact that not all illicit drugs can be kept off the street, not all drug use can be prevented, not all drug users are susceptible to our present treatment options and no amount of wishing it were otherwise will make it so" (VS235). Similarly, former Health Minister George Abbott states: "…he strongly agrees with harm reduction measures because they are part of a continuum of services to combat the challenges of addiction" (VS455).

4.2.8 There is public support for SISs

Those who favour SISs also suggest there is public support for the implementation of such facilities. For example, Liz Evans states with reference to *Insite*: "…the facility has virtually everyone on side and just needs the approval, not even funding, from the federal government (VS395). In Ottawa, The Campaign for Safer Consumption Sites (CSCS), a grassroots group in support of the implementation of SISs states: "…it will release full results Monday of a survey of nearly 200 Lowertown and Byward Market homes and businesses that found more than 70% support for a site" (OS135).

More specifically, proponents highlight support from health care providers and organizations as reason to establish SISs. For example, a spokesperson for Health Minister

George Smitherman, Laurel Ostfield, claims "We are concerned about keeping Ontarians healthy and we look to WHO and they support the use of safe injection and inhalation sites, …" (OS25)[132]. Dr. Thomas Kerr and Dr. Julio Montaner also claim: "The program now has the support of leading national health organizations such as the Canadian Medical Association, the Canadian Association of Nurses, and the Canadian Public Health Association. Health organizations in other parts of Canada are now advocating for similar programs in their jurisdictions" (VS515). *The Vancouver Sun* also writes: "Support for the site in downtown Vancouver appears solid, with everyone from Downtown Eastside groups to City Hall, the regional health authority and the provincial government saying it should stay open" (VS315). Furthermore, *The Vancouver Sun* notes "The Insite project was endorsed again Thursday by the Vancouver Coastal Health Authority and the B.C. Nurses' Union" (VS315).

Conclusion

By drawing on the debates from two Canadian cities where the implementation of SISs has emerged as a controversial issue, Vancouver, where a SIS has been in operation for over a decade, and Ottawa, where a community health centre is in the application process for a Health Canada exemption to implement a SIS, this chapter has attempted to situate the nature of the SIS debate in Canada. These findings will serve as a useful point of departure for the following discussion with respect to the construction of social problems.

[132] WHO refers to the World Health Organization.

CHAPTER 5: ANALYSIS AND DISCUSSION

It is first useful to recall the different approaches to drug control that have emerged in response to claims regarding drug abuse as a social problem[133]. The legal/moral approach relies on the criminal law, or prohibitionist drug policies to eradicate the use of illicit psychoactive substances. The medical approach also aims to eliminate illicit drug use in society; however, under this approach, treatment strategies are employed in an attempt to "cure" PWUD. In contrast, the public health approach aims to minimize the spread of infectious disease associated with injection drug use through the use of harm reduction interventions, which are non-abstinence based. Each of these approaches can be understood as a response to the construction of drug abuse as a particular kind of troubling condition. The legal/moral approach attempts to address the use of illicit psychoactive substances as a moral failure or a criminal act, while the medical approach confronts drug addiction as a disease. In contrast, the public health approach takes a neutral stance on the use of illicit psychoactive substances, but it is however, concerned with the consequences of drug use. This is of particular significance for the analysis of claims-making because the claims advanced by opponents of SISs reflect the conceptualization of addiction from a legal/moral or medical approach as opposed to the humanitarian perspective espoused by harm reduction strategies. Unsurprisingly, opponents of SISs demonstrate a preference for prohibitionist strategies and treatment strategies, while proponents favour the use of harm reduction strategies under the public health approach.

5.1 Rhetoric of Claims

[133] For details, refer to the theoretical framework.

Bearing in mind the presentation of data in the previous chapter, I will now present an analysis of the rhetoric of the claims utilized by opponents and proponents of SISs. This analysis also aims to address the secondary research objective by exploring the way in which claimsmakers portray the SIS. I will do so by way of three main concepts advanced by Best (2008): rhetorical grounds, warrants and conclusions[134]. Proponents of SISs construct the (public) health problems associated with the use of illicit psychoactive substances as the troubling condition, and suggest the SIS is an appropriate solution to address this aspect of the 'drug problem'. In contrast, opponents respond with counterclaims that portray the SIS as the troubling condition in its own right, suggesting that the implementation of SISs will exacerbate other aspects of the 'drug problem,' specifically drug abuse and crime.

The first section presents an analysis of the claims advanced to construct a 'drug problem' by proponents of SISs and their attempt to portray the intervention as a solution through various justifications. The second section will present an analysis of the counterclaims advanced by opponents of SISs in response to proponents' proposed solution to address the drug problem. I will also discuss the role of politicization in the social problems process.

5.2 Proponents' Rhetoric: Part I

5.2.1 Rhetorical Grounds

Claimsmakers must first persuade the audience that the alleged troubling condition is indeed troubling enough to justify a response to address the condition. They do so by constructing the grounds of a claim, which are "assertions of fact" and provide evidence in support of their assertion (Best, 2008, p.31). Best (2008) suggests claimsmakers follow a basic

[134] Although Best (2008) refers to this part of the claim as a conclusion, I will employ the term "solution" for the headings in this chapter to avoid confusion with the conclusion section.

rhetorical recipe in order to construct the grounds of a claim, which is comprised of a typifying example, a name and a number. In order to construct the public health problem as troubling, proponents of SISs use typifying examples, which are often atypical. Within the SIS debate, claimsmakers suggest there is a worrisome public health crisis amongst the injection drug using population, specifically that this group suffers from a disturbingly high rate of fatal overdose and high rates of infectious disease such as HIV/AIDS or HCV. The typifying example is often presented by proponents of SISs in the form of a story about a friend or a relative who has fallen victim to a fatal drug overdose in the absence of assistance from a health care professional. For example, a practicing lawyer in Vancouver writes about her client's experience with addiction: "Ultimately he died of a heroin overdose in the bathroom of a restaurant in the Downtown Eastside. He was in his 30s. Insite did not yet exist. I think we can and should provide better protection for people like him. Insite is a necessary part of that better protection" (VS305). Similarly, during the municipal election in Vancouver, the *From Grief to Action* association[135] organized a town-hall meeting where the mayoral candidates were invited to present their positions in regard to the implementation of SISs. Members of the association also recounted their stories, "…with several of the parents getting up and giving short descriptions of the tragedies they have had to endure –including one woman in pearls who stood up and said at the end of her question to the candidates, simply, "And oh yes, my daughter, Alexandra, died of an overdose." The words caught in her throat (VS80). These typifying examples help portray the troubling condition as a matter of life or death, which further invokes a sense of urgency to address the condition. The examples also challenge what Small et al. (2006) refer to as the

[135] Henceforth referred to as the association. As previously discussed in the review of literature, the association is comprised of upper class parents' of children who use drugs. The group advocates for the implementation of harm reduction interventions, including SISs.

"addiction habitus" by humanizing addiction through the reminder that PWUD and individuals with addictions do not exist in isolation, apart from "the rest of us".

Furthermore, proponents provide an estimate or a number to exemplify the extent of the rate of overdose death and the spread of infectious disease amongst PWUD. For example, *The Vancouver Sun,* citing a report[136], suggests: "In 1999, 34 per cent of the estimated 4,190 new HIV or human immunodeficiency virus infections in Canada were among injection drug users. More than 60 per cent of the approximately 4,000 new hepatitis C cases each year are related to injection drug use. In B.C. alone, more than 2,000 illicit drug overdose deaths have occurred since 1992" (VS10). This should not be understood as merely an attempt to draw attention to the troubling condition since the development of the report indicates the troubling condition has already garnered enough attention to warrant further study. Rather, the use of these statistics by proponents of SISs should be regarded as an attempt to, again, convey a sense of urgency about the need to address the troubling condition. Similarly, *The Ottawa Citizen* writes: "And the fact that Ottawa has one of the highest rates of new HIV infections in the country is one sign of the harm being done by unsafe injection drug use. New HIV cases were up by nearly 50 per cent in Ottawa during the first half of this year - something that is, understandably, raising alarm bells among the city's public health officials" (OC110). The estimate also employs an additional ground; the assertion that the number of HIV infections has increased substantially in Ottawa during 2011 reflects a worsening condition (Best, 2008), which expresses a need to respond before the problem becomes uncontrollable. Moreover, the claim that "unsafe injection" is the cause of the spread of HIV sets the groundwork for proponent's conclusion to address the troubling condition, which will be discussed in a subsequent section.

[136] See Elliott et al. (2002).

Another estimate is employed by Wendy Muckle, Executive Director of Ottawa Inner City Health, who suggests with respect to the injection drug using population in Ottawa: "They're tremendously likely to die…Every 10 days in this city, someone dies of an overdose and nobody seems to care. These are people's children" (OS135)[137]. Muckle uses a disturbing estimate to convey the magnitude of the problem, in an attempt to call attention to the condition. Proponents also employ an additional ground, the kind of people affected (Best, 2008), which suggests individuals who are affected by this troubling condition are first and foremost, human beings who are connected to "the rest of us" in some fashion. In this instance, Muckle is able to establish a connection between individuals who suffer fatal overdoses and other members of society, solidifying the relationship as one between a parent and child. In addition, this comment challenges an element of the traditional "addiction habitus," the notion that PWUD are not deserving of care (Small et al., 2006). Muckle suggests that this is problematic since individual's who are dying "…are people's children" and therefore deserving of care and compassion from the public (OS135). This comment not only helps to humanize PWUD, it also speaks to the maternal and paternal feeling to protect and care for children in light of the vulnerability that is often associated with this population. Similarly, a resident of Arnprior, Ontario, in letters to the editor of *The Ottawa Citizen* suggests: "I would ask everyone who is opposed to remember that every single one of those drug users is somebody's child, someone's son or daughter. Try to imagine that. It could be your child" (OC160). This strategy, attempts to elicit empathy by asking the audience to picture themselves as the parent of a child who uses drugs and can be understood as an attempt to garner more support for the implementation of SISs in particular, from parents. The suggestion that "it could be your child" also highlights the range of people affected (Best, 2008). This comment relegates the notion that the drug abuse problem is not limited to the most

[137] This typifying example also includes a statistic.

marginalized individuals in society, but affects individuals "from every level of society" (OC125), which helps to create an image of a collective rather than caste society.

It should also be noted that proponents do not appear to advance claims about addiction as a medical condition or moral failing. In contrast, the grounds regarding addiction and SISs are consistent with the public health approach to drug control where proponents espouse a humanitarian stance with respect to the use of illicit psychoactive substances. In other words, the grounds advanced by proponents suggest addiction is not the main target of the intervention, but rather the consequences related to addiction, such as the risk of overdose fatality, injuries and infectious diseases.

5.2.2 Warrants

The warrants of a claim are the implicit values claimsmakers allude to in their arguments. They are the reasons why we should be concerned with an alleged troubling condition or the justifications for the conclusions set out by a claim. Proponents of SISs suggest the public health problem is troubling for three main reasons: human lives are lost; infectious diseases spread beyond PWUD; and it is highly costly to the health system (taxpayers).

The incidents of fatal overdose are often employed by proponents to persuade the audience that the public health problem is troubling and therefore deserving of a response. Activists and academics in particular attempt to appeal to the audiences' values of humanitarianism and the right to life by suggesting that individuals who suffer a fatal overdose are not simply "junkies" or "addicts" but human beings, who have familial ties to the wider public, more specifically that these individuals are people's sons and daughters. For example, former mayor of Vancouver, Philip Owen states: "Those who are addicted are our children, siblings, fathers and mothers, they did not choose a life of addiction, illness, crime and eventual

early death. They are the victims and they require medical assistance" (VS375). When Owen refers to this population as "victims," he invokes a familiar type of problem, which provides the audience with a frame of reference from which to think of PWUD, not as criminals, but as victims. This role reversal may be an effective strategy to convince the audience to view PWUD as deserving of care, which further challenges elements of the traditional "addiction habitus" that suggest PWUD should be made to feel uncomfortable (Small et al., 2006).

In addition, proponents of SISs utilize the argument that infectious diseases such as HIV/AIDS and HCV are not exclusive to the injection drug using population. For example, *The Ottawa Citizen* writes: "Diseases spread beyond circles of addicts, too –to secret users' unknowing sex partners, to prostitutes' johns and their families, to police officers who get stuck during arrests" (OC10). This can be understood as an attempt to persuade the audience that the troubling condition is widespread in that it is not only problematic for PWUD but also for the public. Every individual who is exposed to the claim may be self-interested in addressing the problem "before it affects him or her" (Best, 2008, p.35). Therefore, in framing the troubling condition as widespread, proponents may elicit agreement for their proposed course of action from a wider support base. This warrant also helps to reinforce the claim that the troubling condition is related to public health.

Finally, proponents of SISs advance an economic argument in an attempt to convince the public that the condition is indeed troublesome. Proponents, such as academics, activists, officials and members of the public suggest the treatment of infectious disease, injuries or infections related to injection drug use is highly costly to the health system and therefore, taxpayers. By framing this troubling condition as an economic disadvantage for taxpayers, proponents are able to once again construct the issue into one that has a widespread impact. There is also a greater level of certainty that this condition will impact the public in comparison to the first two warrants

regarding the potential lives lost to overdose or the spread of disease. Thus, this warrant may be understood as a last resort when the appeals to humanitarianism are not enough to convince the audience that this issue is troublesome. These warrants are intended to help proponents establish the framework for their proposed solution, which is described below.

5.2.3 Solutions

Finally, claimsmakers propose conclusions, or solutions to address the alleged troubling condition. The above grounds and warrants portray the troubling condition as one that is related to individual and public health and therefore concerning for a widespread audience. They help to shape the SIS as an appropriate solution to address the 'drug problem' as proponents suggest the appropriate solution is in the form of the provision of health care services to PWUD in a closed environment to reduce the spread of disease and public injection drug use. Specifically, activists, academics, medical authorities, health care professionals and elected officials partake in claims-making to portray the implementation of a SIS as a solution to the 'drug problem'. For example, a researcher at the University of Ottawa, Dr. Lynne Leonard, who conducted a feasibility study in regard to the establishment of SISs, suggests: "It's very clear that for Ottawa (a safe injection site) would fit very well and definitely relieve the community's concern of public injections" (OS40). Similarly, Provincial health officer Dr. Perry Kendall states with respect to SISs: "I think it's the best chance that the city has to deal with the injection drug use and substance use problem that the city has…" (VS15). Proponents reinforce this solution by suggesting SISs provide PWUD a health service because the intervention facilitates contact between PWUD and health care professionals and helps to avert the spread of infectious disease (*Canada v. PHS Community Services Society*, 2011). The Supreme Court of Canada (SCC) in *Canada v. PHS Community Services Society* (2011) also affirms the argument that SISs provide a health service to PWUD,

which serves to legitimize the solution advanced by proponents. In framing SISs as a health care service, proponents are able to bolster the claim that the implementation of a SIS is a humane, and necessary response to the 'drug problem'.

5.3 Proponents Rhetoric: Part II

In keeping with the main research objective, this section proceeds with a slight digression from Best's (2008) framework, as I will present an analysis of the rhetoric of the justifications advanced to support the implementation of SISs. These justifications should not be understood as the grounds, warrants or solutions of proponents' claims, but as justifications for the conclusion advanced by proponents of SISs. Although these justifications[138] have been identified in the previous chapter, this section will offer further analysis of the rhetoric employed by proponents where it is possible.

5.3.1 SISs benefit the community and PWUD

Supporters of SISs, namely academics, suggest this intervention will reduce public nuisance and therefore benefit the community[139]. For example, Dr. Berger from the University of Toronto suggests SISs "will bring it [the drug problem] under control" … (OC15). Academics argue SISs can help bring the 'drug problem' under control in two ways: first, by removing PWUD from public view and second, through the requirement of mandatory registration and adherence to the policies and regulations of the facility (Kerr, Wood, Small, Palepu & Tyndall, 2003). As clients of SISs, PWUD are subject to extensive monitoring, what Hathaway and Tousaw (2008) refer to as "compassionate surveillance" (p.14). From this perspective, harm

[138] These justifications include: SISs benefit the community and PWUD, the benefits of SISs outweigh potential benefits of prohibition, SISs save lives, reconciling harm reduction and treatment, there is public support for SISs and SISs do not contravene international drug control treaties.
[139] The terms public nuisance and the "honey pot hypothesis" are used interchangeably throughout this analysis.

reduction interventions may be employed so as to govern PWUD and drug use through public health and law enforcement (Fischer et al., 2004; Miller, 2001; O'Malley, 1999). Therefore, this justification can be understood as an attempt to appeal to societal values with respect to law and order by suggesting that this intervention allows for more "control" over both the 'drug problem' and PWUD.

Similarly, advocates argue SISs benefit the community in that it enhances the aesthetics of public space. This claim is structured akin to a conditional statement that suggests if the public presence of PWUD is diminished, it will lead to an enhancement in the aesthetics of the surrounding space. It is important to call attention to the manner proponents refer to the impact of a SIS on public space as "cleaning up" (VS185) an area or making streets "neater" (OS135). These terms reflect an initial assumption about the public presence of this population as a contributing factor to disorder. In addition, if we consider the fact that SISs are typically constructed in areas with an existing open drug market (Fischer et al., 2004), this justification may be regarded as an effort to persuade the public, in particular, communities where drug trafficking and drug use take place, that the implementation of a SIS will be of benefit to their neighbourhood through the "purification" of public space.

5.3.2 SISs save lives

In light of the scientific evidence proponents employ as previously discussed, activists and academics in particular attempt to appeal to the audiences' values with respect to the right to life. In reference to research findings that conclude SISs are effective in preventing the occurrence of fatal overdose, some proponents argue this evidence is compelling enough to warrant the implementation of SISs, and that the failure to act is immoral because it would constitute "letting" people die. By framing this harm reduction intervention as a humane response

to address the 'drug problem,' proponents are able to paint those who oppose SISs as uncaring and perhaps cruel.

5.3.3 Reconciling harm reduction and treatment

This argument is employed by proponents to portray the SIS as compatible with treatment strategies advocated by opponents of SISs. Proponents argue that harm reduction measures such as a SIS allow individuals to transition from drug use to cessation as they provide PWUD a point of contact to addiction counselors and health care professionals. Thus, proponents assert the SIS falls within the treatment continuum as it fills a service gap unaddressed by treatment strategies and other harm reduction measures. Because opponents of SISs argue the objectives of harm reduction are inconsistent with treatment goals, this justification can be understood as an attempt by proponents to invalidate opponent's assertions. Additionally, the use of this justification demonstrates the way in which proponents of SISs attempt to appease individuals who favour abstinence-based measures to address addiction.

5.3.4 There is public support for SISs

Proponents also argue that there is public support for SISs from credible and esteemed public health organizations such as the WHO and the Canadian Public Health Association, the Canadian Association of Nurses, the Canadian Medical Association (VS515), academics, and most importantly, the community where SISs have been proposed. The suggestion that the public supports SISs should be interpreted as a strategic move to elicit a response from policymakers, that is to prompt action with respect to the proposed solution.

5.4 Opponent's Rhetoric

This section will present an analysis of the opponent's rhetoric in the SIS debate. In sum, opponents suggest the implementation of SISs is problematic such that it would have a disadvantageous impact on communities, which would outweigh the potential benefits derived from its implementation. It is useful here to recall the traditional "addiction habitus" (Small, Palepu & Tyndall, 2006) as discussed in the review of literature. The authors utilize the term "addiction habitus" to describe the dominant narratives in relation to drug addiction. A necessary cultural shift in conceptions of addiction was paramount to the acceptance of *Insite* in Vancouver (Small et al., 2006). Various elements of the traditional "addiction habitus" can be identified within the claims advanced by opponents of SISs, including the notion that services for PWUD will attract more "addicts," harm reduction interventions "keep people on drugs," and PWUD "should be made more uncomfortable to prevent and not enable addiction" (Small et al., 2006, p.74). The prevalence of the traditional "addiction habitus" may pose a significant challenge to the acceptance of SISs as an appropriate solution to the 'drug problem'.

5.4.1 Rhetorical Grounds

While proponents of SISs suggest the intervention will alleviate the public health problem associated with the use of injection drugs, opponents disagree and advance counterclaims suggesting SISs are ineffective and even harmful, in particular for communities. Best (2008) suggests many claimsmakers concentrate on typifying examples and refrain from constructing a definition of the problem (p.32). In a similar fashion, opponents of SISs do not name the troubling condition but instead employ a number of typifying examples. For example, opponents suggest the neighbourhood will become a dangerous place if a SIS is established and public safety will be placed at risk. This is exemplified in the following quote from an *Ottawa Sun* editorialist: "By enabling drug users we are harming our community. We are putting pedestrians

at risk of robbery. We are putting family homes at risk of being broken into. We are also doing more to further drug use than we are to reduce it." (OS80). This example reflects the assumption that SISs enable or facilitate drug use and that the SIS attracts a dangerous population to the neighbourhood—portrayed not only as PWUD, but criminals. Furthermore, the assertion that PWUD will commit crimes helps to reinforce the notion that this population will be a detriment to the community. Similarly, comments that suggest the implementation of a SIS will create a "No-Go Zone" within the immediate surrounding in which the facility is established reflects a misconception. A "No-Go Zone" refers to an area where law enforcement agents are not permitted, the establishment of a SIS does not result in the creation of a "No-Go-Zone," rather it is individuals who possess and or consume illicit psychoactive substances and the SIS staff who are exempt from the possession and trafficking provisions of the *Controlled Drugs and Substances Act* (CDSA). Thus, the use of this typifying example can be understood as an attempt by opponents of SISs to portray the implementation of the intervention as detrimental to the community by creating a state of lawlessness in the surrounding area.

5.4.2 Warrants

In regard to the warrants of opponent's claim, critics argue that something must be done to address the implementation of SISs because they are harmful; unethical and unlawful; and send "the wrong message".

5.4.2 (a) SISs are harmful

Opponents argue SISs are harmful because they will exacerbate other aspects of the 'drug problem,' in particular, drug abuse and crime. Specifically, opponents claim SISs are harmful for the community because they encourage drug use**,** create public nuisance**,** enable illegal conduct, threaten public safety, and lead to social deterioration of the neighbourhood. In other words,

opponents portray the implementation of SISs as part of the drug problem rather than a solution to it.

The assertion that SISs encourage drug use reflects an attempt by opponents to portray the intervention as exacerbating the problem of drug abuse. Because the intervention does not require abstinence from individuals—a key characteristic of harm reduction interventions—opponents capitalize on this aspect of the SIS in order to construct the strategy as an inappropriate or illogical response to addiction. In so doing, opponents ignore the harm reduction philosophy guiding such an intervention but instead, employ measures of effectiveness in terms of its capacity to "cure" individuals with addictions to psychoactive substances—which is the goal of treatment and prohibitionist strategies. It is important to note that the intended objective of SISs, and all harm reduction measures, is not to target addiction but to minimize the harms associated with drug use without requiring abstinence. However, opponents often misrepresent the goal of SISs through the assertion that SISs simply enable PWUD to continue to use psychoactive substances and by labeling the intervention as ineffective. This warrant can be understood as an appeal to morality and as a strategy to garner support from individuals who view abstinence as the only acceptable state with respect to illicit psychoactive substances.

Moreover, opponents present the SIS as a facilitator of illegal conduct, which reflects an attempt to portray the intervention as exacerbating the drugs-crime connection. Critics argue that SISs facilitate illegal conduct by providing a space where PWUD may consume illicit psychoactive substances consequence free (also referred to as a technical offence). The proposal to implement a SIS crosses moral boundaries for those who are of the opinion that drug use is immoral and or illegal (e.g. the conceptualization of addiction as criminal). For example, a resident of Ottawa suggests: "This goes against the very fabric and ideals of a law-abiding society. Put more effort into stopping the criminals, either prosecuting or rehabilitating them.

Creating a specific area where the law will not be enforced is definitely not the answer" (OS65). This claim can be understood as an attempt to appeal to the societal value of law and order as opponents allude to an inherent contradiction in the idea of implementing a SIS, in that it allows for an otherwise illegal act to occur. However, it is important to note that the implementation of SISs aims to address a public health issue, not the 'drug problem' in its traditional sense (e.g. addiction). The assertion that SISs encourage drug use, allows opponents to present the SIS as ineffective in addressing the 'drug problem' and therefore, as an inappropriate response to the troubling condition. Thus, another point of contention between opponents and proponents appears to revolve around the nature of the troubling condition.

The facilitation of illegal conduct is deemed harmful for the community when PWUD commit crimes of acquisition in order to support their use of psychoactive substances. Opponents suggest the condition should be considered troublesome because the implementation of SISs will pose a threat to public safety. This is a two-part claim built on the assumption that the establishment of a SIS will create public nuisance, that is, attract an influx of PWUD and PWSD to the area. It reflects the broken windows theory, where a high level of social disorder within a community acts as a gateway to crime[140] (Kelling, Coles & Wilson, 1996). This warrant further reflects the assumption that individuals who utilize the facility may be dangerous or pose a danger to members of the community. For example, the suggestion that establishing a SIS within a community is analogous to "…holding surrounding communities hostage" (OC135) reinforces the view of PWUD as criminals and suggests the community will fall victim to this population if a SIS is implemented. This warrant also reflects an element of the traditional "addiction habitus," that "drugs promote violence" and ultimately serves to bolster the drugs-crime connection, which

[140] However, this hypothesis has been disproved by scholars such as Taylor (2001), who found no distinct link between disorder and rates of crime in a neighbourhood.

opponents attempt to associate with the establishment of SISs in order to frame the intervention as harmful to communities. Opponents further suggest the implementation of SISs will lead to the social deterioration of a neighbourhood. The social decay of the neighbourhood is attributed to the implementation of a SIS, which is thought to produce an increased presence of PWUD and PWSD, and an increase in crime. From this perspective, the deterioration of the neighbourhood is more related to the presence of PWUD in certain public spaces rather than the SIS per se. This warrant should be understood as an attempt to elicit concern from a larger audience (e.g. communities) about the profitability of businesses and the livability of communities.

5.4.2 (b) Ethical and legal objections

Opponents also raise ethical and legal objections to the provision of medically supervised injection to PWUD. The former federal health minister, Tony Clement argues, "…allowing heroin addicts to shoot up is against a health professional's code of ethics" (OC85). Clement further argues supervised injection "undercuts the ethic of medical practice and sets a debilitating example for all physicians and nurses, both present and future in Canada, who might begin to question whether it's all right to allow someone to overdose under their care" (OS45). These comments can be understood as an attempt to discredit health care professionals who support SISs by questioning their professional judgment with respect to the provision of supervised injection services. The portrayal of supervised injection as an unethical practice for health care professionals could be understood as an attempt to garner opposition from this segment of the population, whom are fundamental to the operation of a SIS.

Furthermore, the International Narcotics Control Board argues that the implementation of SISs violates international drug control treaties. According to news reports, the United Nations (UN) advised the former federal Health Minister to shut down *Insite* on account of this assertion.

Opponents also suggest that the implementation of SISs violates the law because technical offenses are permitted in the facility (e.g. possession of illicit psychoactive substances). These arguments reflect the conceptualization of drug use from a moral/legal perspective and should be understood as an attempt to present the implementation of SISs as deviant or immoral. This assertion is also misleading given that the implementation of a SIS in Canada requires an exemption from *Criminal Code* provisions, which suggests the operation falls within legal bounds.

5.4.2 (c) SISs send "the wrong message"

Moreover, opponents advance warrants that reflect hostility to the harm reduction philosophy, or opposition to the acceptance of some level of drug use. Opponents suggest the implementation of SISs would risk sending "the wrong message" with respect to drug use, that such conduct is acceptable, or worse sanctioned by the state. For example, in letters to the editor of *The Ottawa Citizen,* an anonymous individual writes: "…allowing addicts a safe place to shoot up sends a mixed message, enabling the very behaviour the government wants to discourage" (OC105). In light of this warrant, opposition may be understood as an attempt to maintain a societal commitment to abstinence with respect to drug use. Opponents further suggest the implementation of SISs should be considered problematic because they are ineffective in eliminating drug use. This argument is voiced by RCMP Staff Sergeant, Chuck Doucette, who at the end of *Insite*'s three-year scientific trial period suggested: "…there's "no evidence" to show that Insite users are going to drug treatment and…there has been no decrease in public drug use in the area around the facility" (OC35). Similarly, opponents suggest harm reduction measures accept defeat in the war on drugs because the intervention aims to minimize the harms related to drug use rather than eradicate all drug use as treatment and prohibitionist strategies. Thus critics

describe harm reduction measures as "giving-up" (VS505) or "a big shrug of the shoulders" (VS505). In addition, opponents suggest by allowing the operation of SISs, the objective and importance of the criminal law would be undermined (VS405) because the facility allows a criminal act to take place. The elimination of drugs and drug use is highly valued within a "war on drugs" societal context and for opponents abstinence is the single tolerable state with regard to illicit drugs (Riley, 1999, C9).

Politicization of Science

Evidence plays a significant role within the SIS debate as both proponents and opponents rely on evidence to substantiate their claims. The portrayal of the goal of harm reduction as incompatible with treatment strategies has allowed opponents to shift the debate into a matter of whether SISs are effective. Hathaway and Tousaw (2008) note the SIS debate has been "(re)constructed into a disagreement about *whose* science ultimately counts" (p.14). Media reports suggest opponents such as Tony Clement, the former federal Health Minister, the federal Conservative government under the leadership of Prime Minister Stephen Harper, the Canadian Police Association, the RCMP and Dr. David Berner from the Drug Prevention Network of Canada (DPNC) have demonstrated skepticism towards the scientific research conducted by the B.C. Centre for Excellence in HIV/AIDS[141], calling into question the validity of the SIS research (VS320, VS400, OC60, OS120, OC35, OS135). For example, Clement's claim that "…the only thing research to date has proven conclusively is drug addicts need more help to get off drugs" (VS320) points to the way in which opponents evaluate the effectiveness of SISs using the same standard of measurement for treatment programs. In contrast, proponents emphasize that the studies of *Insite* conducted by the Centre are peer-reviewed and have been published in "the

[141] Henceforth referred to as the Centre.

world's most renowned medical journals including The Lancet, the New England Journal of Medicine, the British Medical Journal, and the Canadian Medical Association Journal" (OC65). They also call attention to the fact that the reports opponents rely on, specifically, the piece written by Dr. Colin Mangham (2007), "…weren't peer-reviewed, empirical studies. Rather, they were essays published on a web-site owned by the Drug Free America Foundation rather than in a scientific journal" (VS470). Proponents, in particular academics, including the evaluators of *Insite*, claim the science that opponents rely on is "ideologically biased" or "political" (VS360). This accusation serves to undermine the validity of the evidence cited by opponents of SISs, and weakens the credibility of opponents who utilize Mangham's report as "science". In turn, opponents do not address the factuality of proponents' accusations regarding the federal government's ideological opposition; rather opponents call the objectivity of scientists into question, arguing that the evaluators of *Insite* are biased and the research is "desperately flawed" (OS135). This comment can be understood as an attempt to undermine the validity of the evaluator's findings with respect to the merits of SISs.

This portion of the debate reflects the process of politicization as described by Radimecký (2007), whereby officials disregard evidence-based recommendations from addictions experts. The politicization of science can also be understood as an attempt by the federal government to obtain ownership of the claim regarding an alleged troubling condition (Best, 2008) in order to dictate the appropriate solution to address the condition. Through the application of Best's (2008) concept of claims-making and Radimecky's (2007) assertions regarding politicization, the counterclaims advanced by opponents can be understood as an attempt to displace drug abuse experts and academics in order to re-construct the 'drug problem' as being exacerbated by the implementation of SISs. From this perspective, the re-construction of the troubling condition is

necessary in order to reinforce the primary conclusion advanced by opponents, which will be described below.

5.4.3 Solutions

Opponents voice two types of conclusions; the primary conclusion suggests SISs should not be implemented and the secondary conclusion suggests the 'drug problem' should be addressed through abstinence-based measures in lieu of SISs. In regard to the primary conclusion, opponents assert SISs are ineffective and that its implementation would be harmful to communities, thus, such facilities should not be established. Some opponents demonstrate a concern for the potential consequences that may result in the event of the implementation of a SIS, characterized as "not-in-my-backyard" (NIMBY) attitudes. Opponents who espouse NIMBY attitudes assert the establishment of a SIS will result in economic, social, and physical harms, such as a decrease in property values, a reduction in commerce for business owners or a depreciation in the aesthetic value of certain public spaces. For example, an elected official explains his opposition to SISs as the absence of a suitable location for a facility without causing businesses to "evaporate quickly" (VS455). This example reflects a concern with the aesthetics of space, and the perception that PWUD will contribute to a decrease in the physical attraction of a community or the social deterioration of the neighbourhood. In addition, some opponents suggest SISs "should not be located near schools or on residential streets" (OC1). This sentiment is further reflected in a Conservative campaign flyer against SISs, which suggests: "junkies and drug pushers don't belong near our children…" (VS450). While these comments reflect concerns for public safety and the most vulnerable populations, they primarily espouse opposition to the presence of a specific population in residential neighbourhoods rather than the implementation of a SIS. Further to this point, this sentiment invokes the traditional "addiction habitus" in that it

speaks to the type of person a drug user is by homogenizing PWUD with the most extreme typifying example.

5.5 Discussion

Opposing conceptualizations of drug use appear to account for some of the discord within the SIS debate. While opponents of SISs espouse the view of addiction as a disease or a criminal act/moral failing, proponents tend to espouse a humanitarian approach towards drug use. From the medical and legal/moral approach, opponents are in agreement that abstinence should be the main objective of the intervention or drug strategy. This view is a key challenge to the acceptance of harm reduction interventions such as SISs, since abstinence is not required of PWUD[142]. For some, the view of addiction as criminal/immoral is also intertwined with the notion that addiction is a personal choice (see VS80). Interestingly, despite some opponent's conceptualization of addiction as criminal/immoral or a personal choice, these claimsmakers demonstrate support for treatment rather than criminalization, with the exception of a few claimsmakers who argue PWUD should be imprisoned if they are unwilling to enter treatment. For example, in letters to the editor of *The Vancouver Sun*, a resident of Vancouver writes: "The only solution is to give individuals a choice: treatment or jail" (VS75). Similarly, another resident of Vancouver states: "Addicts not committing to live-in treatment would be a policing problem, with junkies jailed for using illegal drugs on the street" (VS115). These comments also demonstrate the prevalence of the traditional "addiction habitus" in the claims advanced by opponents (Small et al., 2006, p.74-75).

Specifically, opponent's claims reflect the following elements of the traditional "addiction habitus": that services for PWUD will attract more "addicts," harm reduction interventions "keep

[142] This is not to suggest that harm reduction strategies preclude abstinence.

people on drugs," and PWUD "should be made more uncomfortable to prevent and not enable addiction" (Small et al., 2006, p.74). Most notably, opponents utilize the term "addict" or "junkie" when referring to PWUD[143]. According to Dean and Rud (1984) the term "drug addict" invokes the image of "disoriented, unhealthy, thin, low-class" individuals with "behavioural and skin problems who suffered from a disease" (p.859). In a similar way, Corrigan et al. (2009) note PWUD are predominantly described using the terms "dangerous" and "blameworthy". The failure to take issue with the term "addict" reflects societal acceptance of it (Cortina, 2013), which further reinforces the addiction stigma and perpetuates the dehumanization of PWUD. Furthermore, when these depictions of PWUD remain uncontested, they can be viewed as true portrayals of all individuals who use drugs and negatively impact the public's perception of this group's "deservingness of pragmatic services" (Cortina, 2013, p.102). Thus, the prevalence of the traditional "addiction habitus" in the claims of opponents can be understood as a cultural barrier to the acceptance of harm reduction interventions such as SISs.

In contrast, proponents attempt to humanize addiction through additional grounds such as the "kind of people affected" and "the range of people affected" (Best, 2008) by suggesting PWUD are above all, people, and from all levels of society, not only the most economically deprived. In contrast, opponents attempt to portray PWUD as dangerous or as posing a potential risk to others (e.g. the public) in order to bolster their claim that the implementation of SISs would be harmful for communities. In this instance, risk is often constructed as a risk of victimization (e.g. the risk of being robbed, or victim to a break and enter). This type of portrayal reinforces the traditional "addiction habitus" and allows opponents to present the implementation

[143] It should also be noted that some proponents also employ the term "addict," despite their preference for harm reduction measures such as SISs. Cortina (2013) suggests the use of the term "addict" by professionals who advocate for the humanization of PWUD is disconcerting given that the term perpetuates the addiction stigma (p.105).

of SISs as an unreasonable response to the 'drug problem,' facilitating the continued resistance to harm reduction interventions further.

What constitutes harm?

Moreover, while both sides of the debate claim there are harms associated with illicit drugs there is disagreement over what constitutes harm, which harms are to be reduced and how to reduce the harms. Through an analysis of the claims advanced, it becomes clear that opponents and proponents are implicitly referring to different aspects of the 'drug problem,' or what is allegedly harmful. According to proponents, the high rates of overdose death and infectious disease constitute harms for both PWUD and the public. Thus, proponents portray the SIS as a solution to this aspect of the 'drug problem'. In contrast, opponents view illicit psychoactive substance use as harmful, and as a catalyst for another troubling condition, crime. Because the SIS is specifically designed to allow PWUD to consume psychoactive substances—albeit in a less risky manner—opponents suggest this intervention constitutes harm. Opponents portray the SIS as a harm addition measure that exacerbates aspects of the 'drug problem' related to drug abuse and crime, asserting that the SIS itself is a harm to be reduced.

'No easy fix'

Claimsmakers within the SIS debate tend to portray the intervention as a solution that benefits the community or as problematic and harmful to the community. Interestingly, some proponents refrain from representing the SIS in terms of binary oppositions[144], but instead suggest SISs "are just a small part of that strategy"[145] (VS135) to addressing the 'drug problem'. They argue a comprehensive strategy is needed, one that includes social housing, more treatment

[144] Binary oppositions "take the form of A and not-A relations, in which one term is positively defined and the other is defined only as the negative of the first" (Grosz, 1989, p.xvi).
[145] In this sense, "that strategy" refers to the Canadian drug strategy.

facilities, prevention efforts, but also a SIS to keep people alive in the meantime. For example, Liz Evans, Executive Director of the PHS Community Services Society, a co-operator of *Insite* suggests: "InSite is neither the problem nor the solution. It is one measure designed to prevent drug overdose deaths, which it has done; reduce public disorder, which it has done; reduce the spread of HIV, which it has done; provide a doorway into the health system and into treatment, which it has also done" (OC65). While this portrayal of the SIS is uncommon throughout the debate, it is important to draw attention to this view to highlight the way in which the debate has become increasingly rhetorical to appeal to the audience's emotions (e.g. compassion or fear) and diverging from research and expert recommendations.

The focus of the debate revolves around whether the SIS will reduce or exacerbate harms, and the claims advanced by proponents and opponents represent the SIS as either a solution to the 'drug problem' or problematic in itself. Although proponents and opponents conceptualize harm differently, the capacity for the SIS to achieve the objectives voiced by both opponents and proponents, without exacerbating drug abuse and crime should be stressed in order to help reconcile this discord. In the heat of the debate, the value of scientific evidence is overlooked and emotional rhetoric takes centre stage. A serious implication of this is that public policy becomes shaped by populist beliefs regarding crime and addiction rather than the best available evidence (Garland, 2002).

CONCLUSION

This study has provided insight into the SIS debate in Canada and shed light on the way in which the 'drug problem' is constructed by proponents and opponents of this particular form of harm reduction strategy. In particular, proponents assert the high rates of HIV/AIDS, hepatitis C and overdose fatality associated with injection drug use constitutes a public health problem and attempt to call attention to the condition by constructing it as widespread, deadly and costly. The implementation of SISs is advanced as a solution to address this troubling condition as proponents assert it is a cost-effective harm reduction intervention that reduces the spread of infectious disease and averts fatal overdoses. In comparison, opponents attempt to call attention to the implementation of SISs as problematic through assertions that the intervention will maximize harms and be detrimental to communities rather than alleviate the harms associated with public injection drug use. Thus, opponents advance two conclusions; primarily they argue SISs should not be implemented and secondarily, opponents suggest PWUD require treatment rather than a place in which they are permitted to continue to use psychoactive substances.

This project may also strengthen our comprehension of the barriers to the acceptance and scale up of SISs, such as the pervasiveness of the traditional "addiction habitus" and views that suggest the SIS is harmful to communities. Erickson and Butters (1998) assert the 'drug problem' needs to be constructed differently in order for harm reduction to be accepted as an appropriate framework for the development of drug strategies and interventions (p.189). Since dominant constructions of the 'drug problem' frame the condition as homologous to crime and criminal behaviour, the criminal/legal approach and prohibitionist strategies are seemingly appropriate responses. In contrast, the public health approach and harm reduction strategies appear too "soft on crime" and are thus rejected as a reasonable policy response. The SIS serves as a prime

example as opponents attempt to construct the intervention as an ineffective or even harmful response to the 'drug problem'. Furthermore, the findings of this study offer an illustration of how the claims-making process may be employed to better understand the construction of public policy. Specifically, the results may be applied to the current policy proposal in regard to the implementation of SISs to better explicate the Canadian federal government's continued resistance to this intervention.

In Canada, recent policy proposals suggest the debate regarding the implementation of SISs in Canada is far from over. If we recall Best's (2008) natural history model of the social problems process, the fourth stage involves policymakers reacting to claims-making, the media and the public. Although the stated intention of *The Respect for Communities Act* is to respond to the Supreme Court ruling in *Canada v. PHS Community Services Society* (2011), the analysis of opponent's claims presented in this thesis offers an alternate explanation. According to Best (2008), claimsmakers inevitably attempt to persuade in order to draw attention to a condition and/ or elicit a policy response but only persuasive claims will have an impact on policy-making. From this perspective, the proposed policy can be understood as a response to claims alleging that SISs are ineffective and harmful for communities.

As previously discussed, on June 6, 2013, the former federal Health Minister, Leona Aglukkaq introduced *The Respect for Communities Act* as Bill C-65, which died on the order paper in September of 2013 when Prime Minister Stephen Harper prorogued Parliament (Webster, 2013). On October 17, 2013, the new federal Health Minister, Rona Ambrose, reintroduced Bill C-65 as Bill C-2[146]. The Bill proposes an amendment to section 56 of the *Controlled Drugs and Substances Act* (CDSA) to change the application process for an

[146] From thus forth, Bill C-2 shall be referred to as the Bill.

exemption to lawfully operate a SIS, by making it more difficult to obtain (Webster, 2013). According to Aglukkaq, the Bill is a response to the 2011 SCC decision regarding *Insite* (Health Canada, 2013). However, critics suggest the Bill places an onerous burden on applicants to meet an extensive criteria, including the provision of letters of support from local chiefs of police, letters of opinion from municipal leaders, the provincial medical health officer, and the provision of evidence regarding the impact on crime and public nuisance as well as scientific evidence indicating "a medical benefit to individual or public health" (Webster, 2013). Elements of the new criteria that applicants must satisfy in order to be considered for an exemption reflect some of the concerns advanced by opponents of SISs. For example, the need for extensive consultation and support from the community as well as the local police department can be understood as a response to the claim that alleges SISs create public nuisance or threaten public safety. In addition, the requirement for applicants to obtain evidence of medical benefit to individual and public health before an exemption will be considered reflects an acceptance of the claim that alleges SISs are ineffective. Similarly, in a press conference to announce the introduction of the Bill, the former federal Health Minister, Leona Aglukkaq stated:

> Our Government believes that creating a location for sanctioned use of drugs obtained from illicit sources has the potential for great harm in a community…Accordingly, we believe that the application process needs to be changed to create formal opportunities for local voices to be heard, and their views considered before an exemption would be considered (Health Canada, 2013).

The claim that the implementation of a SIS "has the potential for great harm in a community" demonstrates the way in which this proposed Bill embodies the claims advanced by opponents of the intervention. Furthermore, while the former Health Minister suggests the proposed Bill aims to "create formal opportunities for local voices to be heard," critics argue the Bill is constructed in a manner that prioritizes public opinion over scientific evidence demonstrating the life saving value of SISs (Zlotorzynska et al., 2013).

In response to the introduction of the Bill, there has been much criticism, most notably from medical professionals, public health researchers, lawyers, and officials (Zlotorzynska et al., 2013; Webster, 2013, p.1478). Various groups and individuals have vocalized their opposition to the Bill, including the Canadian Medical Association (CMA); the Canadian HIV/AIDS Legal Network; the Chief Medical Health Officer of Toronto, Maxine Davis; Executive Director of the Dr. Peter AIDS Foundation (Webster, 2013); Doctor Ahmed Bayoumi, researcher at the Centre for Research on Inner City Health at St. Michael's Hospital in Toronto; and Doctor Mark Tyndall (Eggertson, 2013). Doctor Mark Tyndall argues, "the new legislation goes further than the Supreme Court intended and is ideologically motivated" (Eggertson, 2013). This claim is in reference to the extensive criteria for future applicants to meet in order to renew or apply for legal exemptions to maintain or establish a SIS in Canada.

In light of this policy proposal, it is important to note the potential influence of insider claimsmakers in regard to the introduction of the Bill. Insider claimsmakers such as officials and elected officials have resources and pre-existing relationships with policymakers to influence the policymaking process (Best, 2008). The data employed in this study indicates there is SIS opposition from a number of insider claimsmakers, including Prime Minister Stephen Harper, the former federal health minister, Tony Clement, and Senator Vernon White. This is not to suggest the introduction of the Bill was the direct result of these claimsmakers' efforts, but rather to highlight the possible influence that insider claimsmakers may have on the policy-making process. As Hughes (2009) suggests, the politicization of a troubling condition may propel the social problems process forward, moving quickly towards the creation, implementation and evaluation of a particular policy to address the identified problem. Bill C-2 has passed through the second reading in the House of Commons, and it has been referred to the Standing Committee

on Public Safety and National Security, as the debate continues the fate of supervised injection in Canada remains uncertain.

Further exploration of the policy implications of Bill C-2 on the implementation of SISs may be warranted if the act passes through Parliament. In light of the time restraints for the completion of this research project, this feat was not possible. Additionally, it was not feasible for the author to examine all stages of the social problems process given that the future of the proposed bill has yet to be determined. However, a study of this magnitude, with a focus on the policy-making stage, may help to illuminate additional barriers to the implementation of SISs at the institutional level. A study of this nature would also be a valuable contribution to the harm reduction and social problems literature and serve to enhance our understanding of the SIS controversy. Finally, it is also worthwhile to explore public or community concerns with respect to the establishment of SISs to help move the debate forward. This study has pointed out some of the public concerns with respect to the safety and the livability of communities, however it would be beneficial to conduct a specific study in this respect to highlight community members' concerns and provide interested parties a channel through which to work collaboratively to develop a strategy to facilitate SIS implementation in locales that display a demonstrable need.

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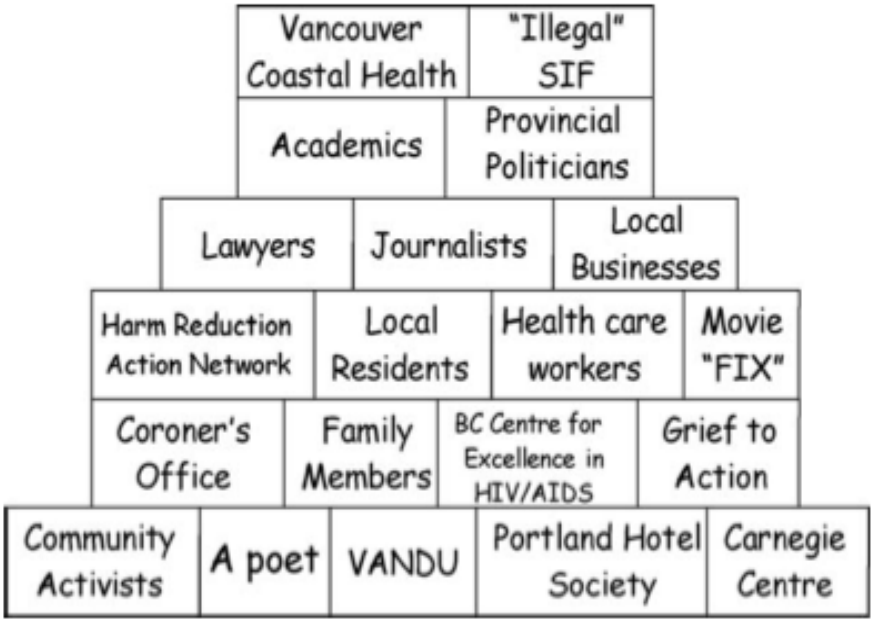
Appendix

Appendix A

Figure 1: The principal stakeholders involved in the establishment of *Insite* in Vancouver (Small et al., 2006, p. 74)



Appendix B

Table 1: Approaches to Drug Control [147]

Approach	**Legal/Moral**	**Medical**	**Public Health**
Objectives	To eliminate drug use (achieve a drug free society).	To rehabilitate people who use drugs (PWUD)[148]. To eliminate drug use (achieve individual abstinence from drug use).	To reduce the health, social, and economic harms related to drug use.
Targets	Specific acts relating to drugs (e.g. possession and trafficking of illegal drugs under the *Controlled Drugs and Substances Act*)	PWUD	Harms related to drug use for both PWUD and the broader community
Strategies	**Prohibitionist strategies**: Control drug use by placing criminal sanctions on drug related behaviours. Punitive methods that involve the use of law enforcement agents, criminal courts and prison systems.	**Treatment strategies**: Rehabilitation through treatment programs, and counselling.	**Harm reduction strategies**: Drug education and outreach services. Referral to health and social services. Implement low-threshold[149] programs to help PWUD do so more safely in order to reduce the harms related to drug use (e.g. needle exchange programs, methadone maintenance treatment, and supervised injection sites). **Legalization as a strategy** for the successful implementation of harm reduction programs where the possession and or sale of drugs may remain illegal.

[147] Adapted from Quirion (2003, figure 1).
[148] Since approaches to drug control are not exclusive to people who use injection drugs, the acronym "PWUD" should be understood in a broad sense as "people who use drugs" for the purpose of this table.
[149] Low threshold services refer to those that do not require user abstinence (British Columbia Ministry of Health, 2005).

Appendix C

Table 2: Sample Coding Sheet

	Category	Sub-Category	Codes (Indicators)
Opposition to SISs	Hostility to the harm reduction philosophy (acceptance of drug use)	SISs are ineffective	Claims were assigned this category if they suggested SISs were not effective in reducing overdose fatalities, or reducing the spread of infectious disease such as HIV/AIDS, and hepatitis C or "getting people off drugs" (to be abstinent).
		SISs encourage drug use	Claims were assigned to this category if they suggested the intervention facilitates or enables the use of psychoactive substances.
		SISs divert resources from treatment	The argument suggests that SISs divert resources from treatment. Claims that were assigned to this category suggest abstinence is the desired goal for any intervention that seeks to address drug use. Since SISs do not require cessation from use, this argument presents the intervention as incompatible with treatment strategies.
		SISs send "the wrong message"	Claims that suggest the SIS embodies the view that drug use is acceptable, or that the state sanctions such conduct are assigned this category.
		SISs undermine the national objective of prohibition	Claims that were assigned to this category suggest interventions that are sanctioned by the state, which accept drug use, undermine the symbolic function of the criminal law prohibiting the possession and trafficking of illicit drugs.
		SISs accept defeat (in the war on drugs)	Claims that suggest harm reduction interventions reflect "giving up" on the goal of abstinence were assigned to this category. Criticism of harm reduction interventions as a "soft on crime" approach that does not penalize PWUD and people who sell drugs (PWSD).
		There is no such thing as safe drug use	Despite the aim of harm reduction to minimize the risks associated with drug use, claims under this category suggest drug use, under any circumstance, is a risky behaviour.

		The hidden agenda argument	Claims under this category suggest SISs (and other harm reduction measures) are utilized as a tool to abate concern about the use of illicit psychoactive substances (allowance of interventions like SISs will erode morals and societal values) and act as a façade for the legalization of drugs. Criticism is at times, directed towards individuals who support SISs, suggesting that these proponents have ulterior motives for advancing this matter.
	SISs are harmful for communities	"Not-in-my-backyard" (NIMBY)	Claims were assigned to this category when objections were directed to the implementation of the intervention in certain neighbourhoods, rather than opposition to supervised injection per se.
		SISs create public nuisance	This category includes arguments that suggest the intervention will attract an influx of PWUD or PWSD to the area where a SIS is implemented. This is also referred to as the "honey pot hypothesis".
		SISs enable illegal conduct	Claims under this category suggest the intervention facilitates criminalized acts such as the possession and trafficking of illicit psychoactive substances.
		SISs threaten public safety	Claims were assigned to this category if objections reflect a concern with an increase in crime, in particular crimes of acquisition to obtain the means to finance an individual's drug use (e.g. theft, robbery, and break and enter). The safety of individuals is deemed to be at risk when there is a presence of PWUD, therefore this claim is dependent upon the "honey pot hypothesis".
		SISs lead to the social deterioration of neighbourhoods	Social deterioration is measured in terms of the rate of crime as well as public nuisance. This category includes claims that suggest the livability, property values, and commerce will decrease in the area where a SIS is implemented.
			Under this category, the claims

		Lack of clear scientific evidence demonstrating the effectiveness of SISs	advanced suggest SISs lack scientific evidence to support claims about its effectiveness, or that the available evidence on SISs is questionable. The effectiveness of SISs is measured in terms of its ability to achieve public health, public order, as well as treatment and prohibitionist (the ability to reduce drug use) objectives.
	Medically supervised drug injection is unethical		Claims fall under this category when objections to the medically supervised aspect of SISs are advanced. Criticism is directed specifically towards health care professionals, suggesting that the supervision of illicit drug use violates the professional code of ethics.
	SISs violate international drug control treaties		This category includes claims that suggest SISs contravene the principle United Nations drug control treaty which stipulates illicit drug use only be employed for scientific or medical purposes. Allowing drug use at the SIS is not considered a medical nor scientific purpose. Thus, the argument suggests the state is facilitating criminal acts such as possession and trafficking.
Support for SISs	SISs benefit the community and PWUD	SISs are an effective public health measure	Claims included under this category make reference to the ability of SISs to reduce overdose fatality, reduce the spread of infectious disease (e.g. HIV/AIDS, Hepatitis C), prevent drug related infections and injuries, connect PWUD to health and social services, and facilitate access to drug education and entry into detoxification.
		SISs reduce public nuisance	Claims are assigned this category if they suggest SISs reduce public injection drug use, and the presence of PWUD and PWSD.
		SISs improve public safety	Public safety is measured in terms of the presence of PWUD/PWSD and the rate of crime in the area. This category includes claims that suggest the SIS does not increase/have an impact on the rate of crime, particularly crimes of acquisition, in the area where the

			intervention is established.
		SISs enhance the aesthetics of public space	Claims that fall under this category refer to an improvement in the physical appearance of the area (e.g. as "cleaning up" the space, or making it "neater") in light of the implementation of a SIS in the area. Indicators include an increase in property values, a reduction in drug-related activities in the area (e.g. public injection drug use, litter from drug use, drug trafficking, etc.).
		SISs provide PWUD a "therapeutic space of acceptance"	This category includes claims that suggest the SIS offers more than just medical supervision of drug use but that the SIS acts as a humanizing space where PWUD may feel a sense of dignity, and care from the community which is tied to the notion that harm reduction interventions avoid making moral judgments of PWUD to reduce the stigma attached to drug users.
		SISs provide PWUD a safer environment	Claims are assigned to this category if they reflect the notion that the SIS is an effective micro-environmental intervention in that it provides a safer or rather cleaner, and more sanitary space to PWUD in comparison to alternative public injection drug use settings such as alleyways, public bathrooms, or shooting galleries. The following elements constitute a safer space: the provision of sterile injection equipment, clean water, lighting, a booth that offers more privacy, and most importantly, that the space is free from law enforcement agents where PWUD are exempt from the criminal law (*Controlled Drugs and Substances Act*).
		SISs are cost effective	Under this category, claims suggest emergency room expenditures for injection drug use related injuries and infections and the treatment for diseases such as HIV/AIDS and Hepatitis C is more costly than the cost to implement and operate a SIS in light of the facilities' capacity to avert or reduce

			such consequences.
	SISs provide PWUD a health service		This category includes claims made by the judiciary, which suggest the SIS constitutes a form of health care service for PWUD because medical professionals are staffed to respond to overdoses and provide sterile injection equipment in order to reduce the risk of disease.
	SISs do not contravene international drug control treaties		Claims under this category suggest SISs do not violate international drug control treaties because the intention of the government in establishing this intervention is not to facilitate drug use or drug trafficking, but to reduce the adverse consequences associated with injection drug use (e.g. address overdose fatalities and the spread of infectious disease).
	SISs save lives		This argument refers to the ability of the SIS to save lives in a metaphysical sense. That is, the SIS is presented as a form of life support, or an intervention that keeps PWUD alive until they are ready to make a change in their lives (e.g. to enter detoxification, or seek treatment to achieve abstinence). Further to this point, the claim asserts there is a moral imperative to establish or trial SISs in light of scientific evidence suggesting the intervention reduces overdose deaths.
	Reconciling harm reduction and treatment		Under this category, the SIS is presented as a small, but necessary part of the larger drug strategy to combat addiction. The intervention is described as a measure to address the service gap between certain harm reduction services (e.g. needle exchange programs) and

	Reconciling harm reduction and treatment		Under this category, the SIS is presented as a small, but necessary part of the larger drug strategy to combat addiction. The intervention is described as a measure to address the service gap between certain harm reduction services (e.g. needle exchange programs) and abstinence-based treatment. Because abstinence is not a feasible goal for all PWUD, the SIS is considered as a realistic and pragmatic strategy. In other words, the SIS is presented as an exceptional intervention for individuals who have been unsuccessful in abstinence-based treatment programs. Additionally, claims were assigned to this category if SISs are portrayed as an intervention that allows PWUD to gradually transition from drug use to recovery, or abstinence.
	SISs are an evidence-based harm reduction intervention		Claims are assigned this category if they refer to scientific evidence on the benefits of SISs as justification for the implementation of this intervention.
	Benefits of SISs outweigh potential benefits of prohibition		This category includes claims that suggest the benefits of SISs, namely that it saves lives, is greater than any potential benefit that may result from the adherence to strict prohibition.