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Insite or Outside the Law: Examining the place of safe injection sites within the Canadian legal system

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Abstract

In response to the mounting number of HIV/AIDS and overdose deaths directly attributable to intravenous drug use during the 1980 and 1990's, governments across the world began considering alternatives to traditional prohibitionist drug policies. These alternatives, generally described as harm reduction strategies involving needle exchange programs and safe injection sites, rapidly gained acceptance across Europe. By contrast, they encountered significant opposition in North America. This thesis summarily traces the history of Canadian drug law, describing the development and impact of the harm reduction movement in Canada and the establishment of the first and only safe injection site (SIS) in North America (Insite). Employing a repressive formalist analysis of the application of federal drug laws, I then examine the role of the current Conservative government in contesting harm reduction strategies and refusing full legalization of Insite. I illustrate that through the strategic manipulation and discriminatory enforcement of drug laws and political gamesmanship relating to the criteria grounding Insite's exemption from current drug laws, the government has failed to fulfill a set of fundamental social values with respect to Insite's users and members of the downtown eastside of Vancouver. Interviews with injection drug users, workers at Insite and residents of the local community provide empirical support for the beneficial effects of safe injection sites, and expose the politics of the struggle for Insite's continued existence. I also show how the Conservative anti-drug ideologues have led a resistance against classifying drug addiction as a health-related rather than criminal problem, despite significant scientific evidence to the contrary, and how this resistance has resulted in the further marginalization of injection drug users.

Key words

Insite; Harm Reduction; Safe Injection Sites; Repressive Formalism; Ideology; Criminal Law; Drug Policy; Canada; Social Values; Intravenous Drug Use (IDU); Policing; Downtown Eastside (DTES)

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Table of contents

Introduction

This thesis examines the social and political factors influencing Canada's transition towards a four pillars[1] approach to drug policy in response to a significant increase in drug related HIV/AIDS infections and deaths. I set out the reasons for the initial delay in incorporating harm reduction (HR) strategies for drug use, and review the motives for the current Canadian government's reinstitution of a zero tolerance national drug policy. I analyze the historical role ideology has played in shaping national drug policies, even in the face of significant scientific research suggesting the ineffectiveness of the traditional prohibitionist/criminal model to adequately repress drug use or to prevent the transmission of disease. I argue that the delayed institution of harm reduction programs in Canada can be directly attributed to an attitude towards law that may be considered as repressive formalism, acted out intentionally by public policy makers and law enforcement agents. In order to gain some insight into how and why this repressive formalist approach is being applied in Canada I visited North America's only safe injection site (SIS) (Insite, in Vancouver, B.C.), conducting interviews with the people directly involved in its operation and others indirectly affected by the ideological attack on its continued existence.

This topic represents an important area of socio-legal research as it seeks to identify the reasons behind, and factors connected with the way the law relating to drug use is inequitably being implemented. The topic is also relevant because it shows how ideology can trump science, especially where marginalized populations are affected. Moreover, the topic illustrates how applying law in a "formal manner" to addicted intravenous drug users not only contributes to their problem by denying them access to life-saving health services, but also by imposing standard regulatory procedures which, by design, inadequately take into account relevant socio-demographic factors and the nature of their illness.

To begin, I provide a brief description of my theoretical approach, highlighting key aspects of David Trubek`s *fulfillment of social values* conceptual model and his notion of *repressive formalism*. Following this theoretical discussion (s.1), I then review the history of Canadian drug law, reporting the central influences that shaped its evolution (s.2). Next, I move into an in-depth discussion of the development and push towards a harm reduction strategy as an alternative to the crime-control approach that has predominated to date (s.3). Section four further develops the discussion in section three by focusing on a specific harm reduction strategy (safe injection sites). I provide a detailed history and analysis of the operation of the Insite safe injection site in Vancouver, British Columbia, in section five. Section six reports on my field research beginning with a description of my visit to Insite, followed by a presentation of my research question and my methodological approach. I then set out the results of my field research. Finally, in section seven, I discuss how my theoretical approach applies to the harm reduction situation (particularly Insite) in Canada, using it as a framework to understand the current Government policy and its impact on the harm reduction movement. This approach also enables me to organize and evaluate the results of my interviews.

Section 1: Theoretical Approach

This section locates and explains the theoretical approach to law I adopt in this thesis. I begin with the traditional conceptual analysis used by lawyers (traditional formalism). I then examine a functionalist alternative: David Trubek's *Fulfillment of Social Values model* (1977, p.551). This enables me to identify repressive

[1] A four pillars approach adds harm reduction to the classic 3-pronged model (prevention, treatment and enforcement) traditionally used when dealing with drug addiction. This progressive neoteric model was first developed and implemented in Switzerland and Germany during the 1990s (Savary, Hallam and Bewley-Taylor 2009).

Oñati Socio-Legal Series, v. 1, n. 1 (2011)
ISSN: 2079-5971

formalism as the theoretical approach that best captures the actual situation reflected in Canadian drug law. In general, the value in using a theoretical approach stems from its presentation of a framed method of inquiry, a well defined structure to assess policy, and a matrix for assessing responses arising in my field research.

1.1. Conceptualizing Law

Law can and has been conceptualized in many ways, from Marxist class rule and a mechanism of social control, to a set of social norms, under which neglect or infraction is met in threat or fact of physical force (Milovanovic 2003). The key proposition here is the threat of application of force (physical, punitive, financial), from a *staff* of people possessing the socially recognized privilege of acting (Milovanovic 2003). Donald Black in *The Behavior of Law* defines law as "governmental social control" (Black 1976, Milovanovic 2003) and others have presented it as normative institutional order (J.R. Bengoetxea, personal communication, September 21 2009).

Despite their varying definitions, most theorists agree that law, when applied properly, serves a fundamental purpose in holding society together by maintaining social order. This order, Milovanovic (2003) argues, is achieved by law filling three distinct yet equally valuable functions: the repressive, facilitative, and ideological. Law's repressive function is concerned with coercion in law, the degree and mobilization of force in order to maintain social control (Milovanovic 2003). According to some, depending on the goals being sought, a certain level of repression is necessary for law to be effective. However, anything in excess of this optimal level is considered "surplus repression" (Milovanovic 2003). Further, this "surplus repression" is viewed as force generated by political elites whose interests lie in dominating non-elites and maintaining their ruling authority (Milovanovic 2003). It is manifested in a political exertion of force presented at various levels in society, from minor coercion up to instrumental Marxist "all out control" perspectives (Milovanovic 2003).

Further, it is suggested that "Law systematically embodies the values of some people, but disregards some values of others" (Milovanovic 2003, p.14). The differences in the equitable application of law to members of different social classes such as gender, race, class, and sexuality has occupied a prominent role in the study of sociology of law. Milovanovic (2003, p.14) claims that "ideological and repressive functions in law often appear together, with the former often disguising the later". Therefore, the overarching scope of ideology itself can be unpacked into several critical concepts central to examining its function in law: e.g. domination, legitimation, hegemony, and reification (Milovanovic 2003). They are all representative of common goals/outcomes of ideological law. In any given society each of these dimensions exerts its own level of influence over the application of law. That said, this inventory of critical concepts enables us to see that the legitimation principle is commonly used with regards to drug addicts, in an attempt to justify how they participate and contribute to their own oppression.

1.2. Traditional Formalism

The doctrine of legal formalism is commonly thought to have been first introduced around the end of the 18th and beginning of the 19th centuries (Kennedy 2001). Yet, despite its longstanding theoretical life and practice, no scholar has yet provided a single, generally accepted definition of the term (Milovanovic 2003). For this reason, I will adopt a more abstract, generic description of formalistic thought.

Kennedy (2001, p.8636) believes "the general theory represents law as having a gapless, meaning-based internal structure, responsive to outside imperatives of some kind". According to him, our modern understanding of formalism was borne out of two phenomena: primitive justice (the deciding of arguments through "irrational" methods such as oracles, or trial by battle); and formulary justice or

strict law (where a claimant would get redress by fitting their claim into a particular set of claims of "forms" required by the legal system) (Kennedy 2001). Kennedy (2001) claims that we can compare the intricacies (assess internal change, whether at the level of detail, of a large ensemble of rules, or of a system as a whole) of various types of legal regimes across some formalist dimension, assessing the degree to which they represent a "high" or "low" level of formalism (Kennedy 2001). For Kennedy (2001), two important dimensions of formality are the degree of insistence on compliance with formalities (what exceptions are permitted?), and the degree of absoluteness of the sanction of nullity for failure to comply (what remedies, if any, for a person who fails to comply?).

In one understanding of the term, Fred Schauer (1988) suggests that there are various levels on which systems can be formal, those being procedurally, transactionally, administratively, textually, and rule formalist (Schauer 1988, Kennedy 2001). Even further expounded, formalism is considered "a range of techniques of legal interpretation based on the meaning of norms (whether established privately, as in contracts, or publicly, as in statutes), and refusing reference to the norms' purposes, the general policies underlying the legal order, or the extrajuristic preferences of the interpreter" (Kennedy 2001).

Another descriptive use of the term formalism in legal discourse refers to theories that purport to derive particular rules of law, or prohibitions on adopting particular rules, from a small group of internally consistent abstract principles and concepts (e.g., corrective justice, fault) understood as morally binding on legal actors (Weinrib 1988). In addition, some formalists like Weinrib (1998) have argued that formalism is not just a way of defining a systemic collection of norms, but also a theory of justification, a form of social arrangement responsive to moral argument.

In like fashion, Lawrence Solum's (2005) definition of formalism entails a commitment to a set of ideas generally grounded in and reinforcing the following assumptions: Law consists of a set of rules, these rules can be meaningful, they can be applied to particular facts; some actions accord with meaningful legal rules, other actions do not, and the standard for what constitutes following a rule *vel non* can be publicly knowable and the focus of intersubjective agreement (Solum 2005).

1.3. David Trubek's Fulfillment of Social Values Conceptual Model

In 1977, David Trubek conceptualized a theoretical model to analyse the relationship between law and legal order and the fulfillment of social values (Trubek 1977, Milovanovic 2003). Trubek asserted the need for scholars to understand a society's ideals, in order to assess the relationship between legal institutions and these ideals (Trubek 1977, Milovanovic 2003). In his view, law and its contributions must be judged by some standard, and its ultimate legitimacy rests on the promise that it promotes certain values in a given social organization (Trubek 1977, Milovanovic 2003).

Trubek's (1977) model is elaborated in two dimensions: on one axis rests the degree of autonomy (the degree of independence of a legal order from any particular individual or interest group) and generality (the degree to which decisions and rules are made according to previous rules, and applied to all without favourable treatment to any). A system placing high on this scale would be seen as highly autonomous/general, whereas one placing on the low end represents a system controlled by a powerful group and discriminatorily applied (Milovanovic 2003). The second axis of his model represents the realization of a "social values" category, incorporating equality (equal treatment by the state), individuality (degree of self actualization that is realizable), and community (degree to which participating and sharing in a greater group is possible) (Trubek 1977, Milovanovic 2003).

Oñati Socio-Legal Series, v. 1, n. 1 (2011)
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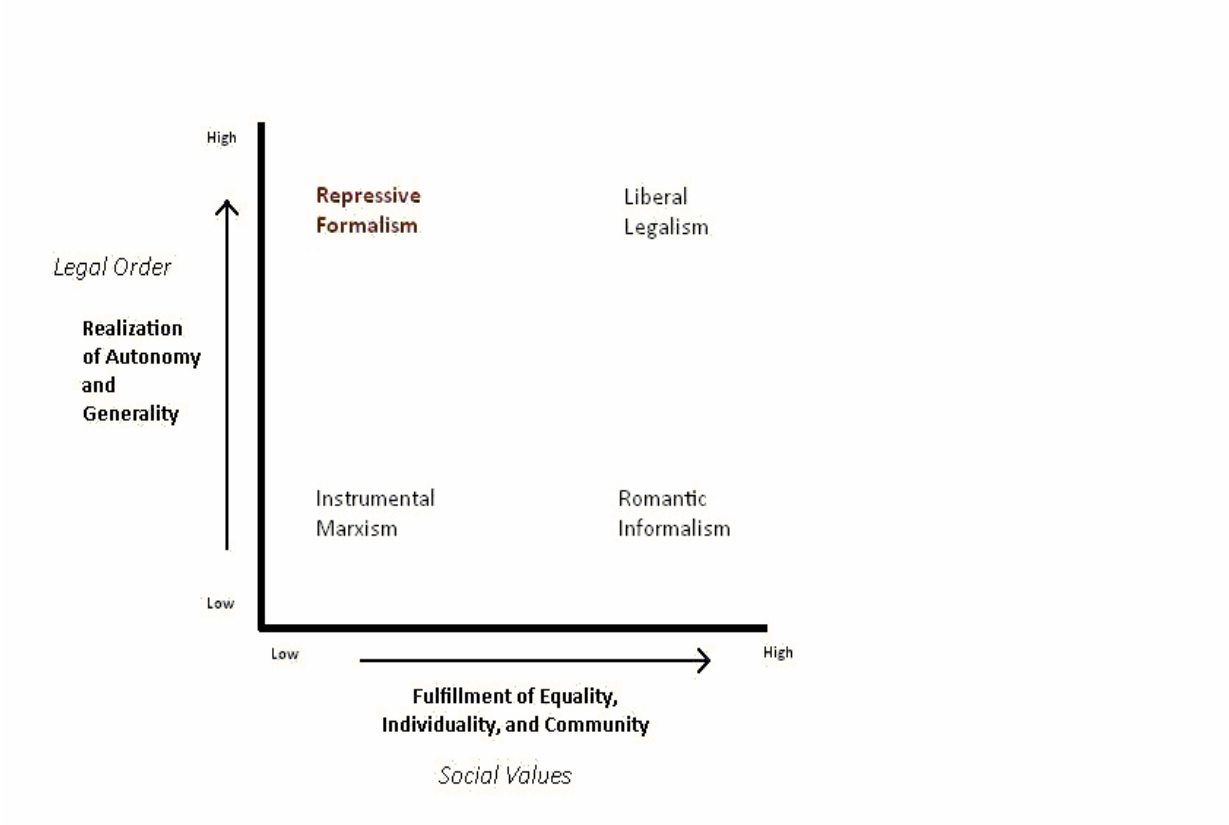

Figure 1. Conceptual Model, (Trubek 1977, p.551, Milovanovic 2003, p.19).

1.4. Trubek's Notion of Repressive Formalism

What Trubek (1977) identifies as repressive formalism, is a system that centers itself in the upper left quadrant of his conceptual model, where the legal order is highly autonomous and general, yet low on the fulfillment social values scale. In RF legal systems, he believes, law is highly structured, in that its premise is founded by an adherence to some form of legal order by using previous law, rules, and decisions in its application. This presents the illusion of law as being fully autonomous from the direct control of the ruling/capitalist class as a whole by seemingly rendering the principle of formal equality a central place in society (Milovanovic 2003). Unfortunately, Trubek (1977) posits, this only masks the reality of the situation, as genuine equality, individuality and community will be denied (Milovanovic 2003). In a RF legal order individual economic disparities are overlooked and transformed into privileges for the powerful (Milovanovic 2003). Further, Trubek suggests that formal equality may hide and perpetuate substantive inequality, oppression and legal discrimination (biases for class, race, gender, etc) (Milovanovic 2003). The problem pointed out by Milovanovic (2003, p.22) here is that "ironically, activists who advocate some commonly accepted ideals might at times be unintentionally reinforcing a more hidden form of oppression".

1.5 How and Why Trubek's Model is Used

In this thesis, I apply Trubek's (1977) theoretical notion of repressive formalism to the transformations of Canadian drug law post-1980, in order to illustrate how, while maintaining its regulatory autonomy and generality, it has actually failed to achieve the proper fulfillment of the key social values (freedom, effective enforcement of aim, prevention of conduct seen as morally wrong, protection of vulnerable people) that were intended by Parliament upon enactment of contemporary drug laws. What is more, I use RF to show how various aspects of drug law enforcement in Canada, despite being autonomously designed and

implemented following regulatory procedure and enforcement protocol, have in fact been manipulated by a variety of infant groups with largely overlapping membership (social conservatives, street level law enforcement bureaucracies, drug entrepreneurs who corrupt the system), intent on achieving a set of predetermined goals.

The reason I have chosen Trubek's (1977) conceptual model is because it lays the framework for my research question/analysis by presenting an important illustration of disjunctions between law in books and law in action. Laws can often be enacted to further a principle of equality, but sometimes, while remaining structurally and systematically non-discriminatory in its objectives, in its application law serves to advance the goals of a dominant class, while unintentionally ignoring those of inferior status. Further, within the specific context of my target population (intravenous drug users (IDU) and members of the downtown eastside (DTES) of Vancouver), Trubek's (1977) model provides an accurate conceptualization of how the law was written in an unbiased, non-discriminatory, fashion, but at the same time how it is not being delivered and applied according to the supposed principle of equality it articulates. Trubek's (1977) model highlights the importance of considering the socio-demographic and socio-geographic factors that ultimately affect law's success in meeting its fundamental goals. Finally, I feel that Trubek's (1977) model raises key questions about law, such as how it can be used to achieve an intended set of goals, the ways it can be used to perpetuate class differences, and the manner in which ideological motives can direct its force and application. By utilizing Trubek's (1977) fulfillment of social values model, I can independently examine the design and application of Canadian drug law and the effect it has on society (IDUs, DTES, etc., its intended population), and then comparatively assess the correlation between the two.

Section 2: A Brief History of the Evolution of Canadian Drug Law

This section provides a brief description of the evolution of Canadian drug law, discussing the major transitions and shifts in the objectives pursued by various statutes. The definition of "drugs" as used in this section consists of what would nowadays be considered "recreational" but "illicit" drugs, including and not limited to marijuana, opiates/heroin, cocaine, and designer drugs (LSD, Ecstasy). Despite their severe addictive properties, and the fact that some have at one time or another been prohibited or highly regulated in Canada, other recreational drugs like alcohol, nicotine and caffeine, and other medicinal drugs like barbiturates, and amphetamines will be excluded from consideration.

2.1. The Early Years, 1908 - 1920

Although the manufacture, sale and consumption of alcohol had been subject to prohibition and restrictive licensing since the mid 1800s, the first attempt to regulate, control, and prohibit "drugs" in Canada came in the form of the *Opium Act* (Statutes of Canada 1908), which was passed by the Canadian Parliament on July 20, 1908 (Dias 2003). However, the circumstances surrounding the enactment of this statute had more to do with class, and racial prejudice, particularly in relation to immigrant populations, than of preventing drug use. According to Stephen Brickley and Elizabeth Comack (1986) "the decision to criminalize opium use, one must consider a key variable: the change in form and intensity of the British Columbia trade union movement which had dramatically altered the nature of class relations in the province" (Brickley and Comack 1986, p.7). Moreover, despite the previous acceptance of opium use, there was a growing push from religious groups and moral reformers intent on curbing the spread of the Chinese-introduced opium dens in Vancouver and Victoria (Atidion 1999). The government suggested that "the unrest and discontent of the era were due to the 'moral laxity' of various groups, particularly foreigners or aliens—in the country. And, from this perspective, the solutions to the country's ills lay not in a fundamental realignment of the basis

of Canadian society, but in the manipulation of consciousness" (Brickley and Comack 1986, p.7). These immorality arguments were a guise for genuine anti-immigration sentiments, and did little to conceal the true intentions of Parliament. Since other anti-immigration measures such as a "head tax" on Chinese immigrants and major labour demonstrations directed at Asian immigrants were proving ineffective, the regulation of opium was seen to be a partial substitute (Dias 2003). To summarize, this legislation was uniformly percieved as a racist response, generated out of social stigma and anti-immigration sentiments, rather than of a viable moral or health concern.

In 1911, the 1908 *Opium Act* was repealed in order to implement the *Opium and Other Drugs Act* (Statutes of Canada 1911) which included morphine and cocaine among proscribed drugs (Atidion 1999, Dias 2003). According to Robert Solomon and Melvyn Green (1998) the 1908 *Opium Act* had created a black market for opium, which law enforcement interests believed could be curtailed by imposing harsher penalties (including imprisonment) and expanding enforcement powers (Solomon and Green 1988, Dias 2003). The 1911 statute represented an important shift in policy, since by responding to concerns of law enforcement officers Parliament was enacting a drug law that was actually designed to control substance use, rather than immigration.

The act was once again amended by the *Opium and Narcotic Drugs Act* in 1920 to include several policing provisions and further expand enforcement powers in order to reflect a new moralistic "hard stance" towards drug use (Atidion 1999, Dias 2003). Now included among enforcement powers was the ability to deport foreigners who broke the law, a provision which re-instituted control of immigration into legislative policy (Atidion 1999, Erickson 1980).

2.2. 1920 – 1960

From the 1920s *Opium and Narcotic Drugs Act* up until the 1960s, drug laws in Canada underwent a series of minor amendments. In the 1930s, these changes included an increase in penalties for drug use, and a new prohibition against marijuana and hashish. The targeting of marijuana followed a similar prohibition in the U.S., where the same moral crusade that produced a constitutional amendment prohibiting alcohol manufacturing, sale and consumption in 1917, was extended to marijuana and hashish (Riley 1998). As in the earlier case of opium regulation, the prohibition of marijuana was aimed especially at certain groups (in this instance the urban black population) rather than at consumption generally.

2.3. 1960 until the Present

In 1961, the Canadian *Narcotic Control Act* was enacted (Atidion 1999, Dias 2003). This was a highly punitive statute designed to implement the provisions outlined in the *Single Convention on Narcotic Drugs*[2] (International Narcotics Control Board 1961) which itself was designed to consolidate the existing international drug control treaties into one instrument (Special Committee on Illegal Drugs 2002).

Between 1969 and 1973, the Commission of Inquiry in the Non-Medical Use of Drugs (also known as the Le Dain Commission[3]) studied illicit drug issue in Canada (Bennet 1974). In 1973, the Le Dain Commission issued a report recommending the gradual withdrawal of criminalization of illegal drugs (Erickson and Smart 1998,

[2] Along with consolidating all existing treaties, the *Single Convention on Narcotic Drugs* extended the existing control systems to include the cultivation of plants that were grown as the raw material of narcotic drugs and aimed to limit the possession, use, trade in, distribution, import, export, manufacture and production of drugs exclusively to medical and scientific purposes (International Narcotics Control Board 1961).

[3] A commission of inquiry into the non-medical use of drugs that recommended the removal of cannabis from the *Narcotic Control Act,* along with a need to further study usage and the social and health effects of other drugs (Bennet 1974).

Dias 2003). "The Commission recommended greater leniency for the crime of possession including the abolishment of imprisonment. The Commission also recommended that the possession of cannabis should not be considered an offence. Despite these recommendations, Canada's drug policy remained unchanged."[4] (Erickson and Smart 1998 cited Dias 2003).

The last major amendment to Canadian drug policy came in 1997 in the form of *The Controlled Drug and Substances Act* (Controlled Drug and Substances Act 1996). This statute further expanded police powers of enforcement and once again brought the Canadian drug laws into accordance with international conventions (Atidion 1999). The manifest failures of prohibition strategies in the 1960s and 1990s led many to conclude that a new approach was needed. In 2002, the Senate of Canada struck a special committee under the chairmanship of Senator Nolin to examine whether consumption of certain soft drugs should be either legalized or simply decriminalized (Senate of Canada 2002). Once again, like the Le Dain Commission, the committee report recommended decriminalization of soft drugs, and again the Parliament of Canada did not act on this recommendation.

Section 3: Crime Control or Harm Reduction?

Policing approaches towards socially undesirable behaviours can be analyzed according to whether the legislative objective is to repress the behaviour (usually through criminal law sanctions) or whether the legislative objective is to reduce the collateral damage caused by the targeted behaviour. The regulation of “drugs” is a field where these two approaches have long been in tension. In Canada, the crime control approach has been predominant, although for the past 2-3 decades many have argued that regulatory policy should be re-oriented towards a harm reduction approach. This section provides an outline of the goals of harm reduction policies and methods by which they are being accomplished. After introducing the main components of harm reduction ideology, I briefly examine the history of the harm-reduction movement in Canada.

3.1. Defining Harm Reduction

Depending on the situation, the definition of harm reduction can vary. Generally speaking, however, the most basic principle encountered in all harm reduction strategies is an emphasis on minimizing preventable harms associated with various dangerous behaviours. As David Ostrow, the President and Chief Executive Officer of Vancouver Coastal Health (VCH)[5] explains, “Harm Reduction is anything that reduces the risk of injury whether or not the individual is able to abstain from the risky behaviour (Harm Reduction History and Definitions n.d). The focus here is to assist individuals in engaging in safer, less risky behaviours, rather than changing or preventing them altogether. At times, a slight form of modification may be required in terms of methods of behavioural engagement, but the fundamental goal remains health-related. Further, as Michael Scavuzzo, a U.S. harm reduction advocate states, “Harm Reduction differs from current models in that it does not require individuals to remove their primary coping mechanism until new coping mechanism (*sic*) are in place. Thus, creating a (*sic*) easier more obtainable avenue for desired behavioral change” (Harm Reduction History and Definitions n.d). While the harm reduction strategies can take many forms (from minor and less-controversial interventions such as condom distribution programs for prostitutes, all the way to major and extremely controversial ones such as the prescription of

[4] Despite the would-be uniformity of their application, the underlying motives behind the Le Dain commission’s recommendations have often been questioned, and directly attributed to a desire to protect specific groups. It has been posited that the recommendation to reduce marijuana penalties was done out of concern over the growing number of white youths being arrested and subsequently labelled as “criminals” for use and possession during the marijuana-abundant 70’s.

[5] The largest academic/tertiary health authority in British Columbia (Vancouver Coastal Health 2010).

Oñati Socio-Legal Series, v. 1, n. 1 (2011)
ISSN: 2079-5971

heroin by medical doctors), the focus of HR in the context of this paper will solely be on safe injection sites for recreational drug users.

Harm reduction strategies in the form of methadone maintenance and opioid substance programs have existed as early as the 1920s in Europe and the 1960s in North America (EMCDDA 2008). However, as an alternative to conventional prohibitionist war-on-drugs policies, HR has gradually been gaining popularity across the globe, with safe injection sites and needle exchanges now being offered in numerous countries. The rapid progression from theoretical HR propositions into real-life applications came during the height of the HIV/AIDS epidemic of the 1980s when a significant increase in the number of HIV/AIDS-related deaths were being attributed to intravenous drug use (IDU) and needle sharing. Governments throughout Europe and North America were suddenly faced with a sharp rise in preventable deaths, essentially leaving them little choice but to take drastic measures by employing a policy as unconventional as harm reduction.

3.2. Harm Reduction in Canada

In 1987, the Canadian government adopted a harm reduction policy as part of the framework for its National Drug Strategy (CDS)[6] (Zilkowsky 2001). Defining harm as "sickness, death, social misery, crime, violence and economic costs to all levels of government" (Harm Reduction History and Definitions n.d) became the initial step in its transition towards a “four pillars” approach to drugs.

Immediately following this shift in policy advocates began to plead for institutionalized responses. Needle exchange programs were opened unofficially in Toronto in 1987 and officially in Montreal and in Vancouver in 1989 (Cactus Montreal 2005). It is estimated that there are over 200 needle exchange sites operating across Canada (Cactus Montreal 2005). The most significant advancement in Canadian harm reduction policy came in 2003 when Insite, the country’s first safe injection site, was opened in the downtown eastside of Vancouver, British Columbia (British Columbia Center for Excellence in HIV/AIDS 2009). Seven years later Insite remains the only operating SIS in North America.

Section 4: The Origins of Injection Sites and Safe Injection Sites Across the World

This section develops the discussion of harm reduction in s.3 by focusing on a specific harm reduction strategy: the establishment and legalization of safe injection sites. In order to understand how and why safe injection sites were developed, it is necessary to examine how the idea of “injection sites” first came into existence. This section then takes a global look at SIS, beginning with an analysis of the first implementations in Europe leading to the more recent ones in Australia and Canada.

4.1. Injection Sites as Commercial Enterprises

Underground drug injection facilities have existed for several decades. These unofficial sites long predated and typically had no connection with legitimate harm reduction strategies. Indeed, the first attempts at creating injection site facilities came not from users, nor from social activists, but rather, from entrepreneurial drug dealers who realized the increased profit that could lie in implementing a *one stop shop* for addicts (Kimber *et al.* 2003).

Historically, there were basically two types of commercial drug-facilitating enterprises in Canada; those regulated and taxed by the government, and those

[6] The stated aim of the CDS is to reduce the harms of alcohol and other drugs on individuals, families and communities (Public Health Agency of Canada 2010). A noted dilemma is that the framework of the CDS, as either three or four pillared, continuously faces redefinition depending on the Government in power.

run by drug dealers and not subject to government control. In the years before the *Opium Act* of 1908, opium dens were run in the isolated immigrant ghettos of Vancouver and Victoria under government regulation (Dias 2003). They were not seen as a social problem, but rather as taxable enterprises for the government to profit from. In 1871, for example, the licensing fee of an opium factory was $500 (Dias 2003).

The more modern type of drug consumption facilities were designated “shooting galleries” for IDU and crack consumption. Similar to most legal SISs, these injection houses were operating in urban slums densely populated by a wide variety of drug users. They offered users a place to both purchase and then engage in drug using behaviour. Essentially these commercial sites were run as an “assembly line” type of operation to maintain addiction, with users buying, getting high, and then heading back to the streets to earn some money to repeat the cycle all over again. “Safe injection” was not a part of the economic calculus, as dealers would simply sell users supplies, indifferent as to how the drugs and associated paraphernalia were actually being used (Dolan *et al.* 2000).

These shooting galleries contributed to the removal of injection drug use from the public domain, hiding the actual act of using these sites and for the most part, hiding individual users while they were high. Consequently, in doing so these sites also contributed to the degradation of certain neighbourhoods by attracting large numbers of drug users and transients (MSIC Evaluation Committee 2003).

Moreover, despite the prevalence of shooting galleries in communities densely populated by drug users, they did little to contribute to the overall reduction of deaths. Instead they appeared to contribute to the rising death rate (Dolan et al. 2000). For example, individuals overdosing were either ignored or thrown out of the houses in order to protect its location from the police and rarely, if ever, did they receive proper medical assistance (Jay, personal communication, 14 July 2010).

4.2. Safe, but not yet Legalized

In response to the growing number of preventable deaths and the continued failure of prohibitionist policy in preventing drug use, social activists took it upon themselves to introduce their own set of harm reduction measures regardless of their illegality at the time.

The Netherlands was the birthplace of the modern drug injection facility when in the early 1970s, St. Paul’s church in Rotterdam offered a fully staffed place for users to inject their drugs as a part of an "alternative youth” service (Dolan *et al.* 2000). In addition to providing a safe place to use drugs, the church provided many of the same types of services replicated in SIS nowadays, such as a drop-in center which advised individuals on health care, an informal lounge room, and food and laundering services (Dolan *et al.* 2000). Furthermore, St. Paul’s also introduced the then novel idea of providing users with clean needles for free or in exchange for used ones (Dolan *et al.* 2000). In doing so they became pioneers in initiating the push towards improving the psychosocial situation of drug users as opposed to solely focusing on preventing use (Dolan *et al.* 2000). Although this center wasn’t officially sanctioned until 1996, it received a level of support, or more realistically a lack of opposition, from law enforcement and local government officials up until that point (Dolan *et al.* 2000).

4.3. Still a Legal Gray Area

Despite the Netherlands’ pioneering advances in safe injection practices, Berne, Switzerland became the site of the first fully-legalized injection facility (Haemmig and Van Beel 2005, Davies 2007). Initially run as a traditional café for intravenous drug users who had no other place to go, staff eventually turned a blind eye to

injection on the premises and the café gained a reputation amongst users as a place to shoot up free from police harassment (Haemmig and Van Beel 2005, Davies 2007).

At first, the site only offered health-related information, provided condoms, clean needles, and made referrals for counselling. As popularity grew, the usage of drugs was also permitted. After having discussions with the police and legislature, it was determined that the café would be legally sanctioned as a drug-consumption facility on the condition that no one under the age of 18 was admitted (Haemmig and Van Beel 2005, Safe Injection Site n.d).

Throughout the 1990s a number of European countries began embracing harm reduction ideology. Legal injection facilities emerged in cities across Germany, Switzerland, and the Netherlands. The 2000s saw a similar growth as countries such as Spain, Norway, Canada and Australia further entertained the idea of SIS's (EMCDDA 2008).

The two most researched SISs are located in Sydney, Australia, and in Vancouver, Canada (Russ Maynard, personal communication, 13 July 2010). The Medically Supervised Injecting Center (MSIC) in Sydney became the first supervised injection site in the English speaking world, opening in May, 2001 (Medically Supervised Injecting Center 2010). In addition to reducing drug-related deaths (in 1999 more than 3 deaths a day were attributed to opioid use), MSIC was instituted as a means to combat street crime and reduce police corruption, becoming the first SIS to attempt to alleviate alternative drug-related social ills as well (MSIC Evaluation Committee 2003). The MSIC was granted a medical exception to the existing drug statutes as a result of an amendment to the law allowing for the operation of illicit drug-related "research studies" (MSIC Evaluation Committee 2003, Sydney Medically Supervised Injection Center 2010).

Canada's SIS (Insite) was opened in 2003 under a similar "legislative medical exemption" as the MSIC in Sydney, and it too was run under a strict set of conditions as a "scientific inquiry into harm reduction measures" (British Columbia Center for Excellence in HIV/AIDS 2009). Examples of these conditions include the recording of drug user information for longitudinal studies on long term effects of drug use such as age, number of visits, and type of drug being used, and an examination of variables immediately impacted, such as reduction in crime, drug-related litter, and deaths from overdose.

4.4. Evaluations of the Effectiveness of Safe Injection Sites

As of 2009, there were approximately 92 SIS facilities operating in 61 cities across the world, 54 of which were in European cities: Netherlands (30), Germany (16), and Switzerland (8) (European Center for Monitoring Drugs and Drug Addiction 2010). In Europe, the majority of the facilities operate as a part of local social services, while in Norway, Canada, and Australia, they are currently labelled as pilot scientific studies operating under special law, or by virtue of an exempt status from general criminal prohibition (EMCDDA 2008).

Overall, the main scientific inquiries concerning SISs pertain to their effectiveness in the prevention and reduction of exposure to life-threatening diseases, death from overdose, and overall levels of drug use. Research has not been limited solely to these issues, as the contribution of SISs to attendance in detoxification programs, the reduction in drug-related crime and litter, and the reduction in other drug-related social ills (crime, violence, etc), to name a few, are also under measurement.

During the 1990s, the first set of SIS facilities that appeared in Europe were studied extensively, generating enough favourable results to justify their continuation. One of the notable conclusions of a major study was that the injection rooms "contributed to improved public and client health and reductions in public nuisance"

(European Monitoring Center for Drugs and Drug Addiction 2004). The overall results of these initial studies were positive. However, researchers stressed the limitations of the evidence and called for further and more comprehensive evaluation studies into the impact of such services.

Section 5: Insite in Context

Insite is the only supervised drug injection site in North America and, by virtue of a medical exemption to Canadian federal drug laws, the only place where illicit drugs can be legally injected. While other HR measures for IDUs have been implemented across the continent, unlike Insite the extent of their service is limited to needle exchange and detoxification. This section will begin with a description of the history of Insite and a contextual presentation of the human and physical geography of its location. Section 6 will report on an empirical investigation into the operations and practices of Insite in the summer of 2010.

5.1. The Forming of Insite, 1995-2006

The incidence of injection drug addiction and related unsafe practices became widely known in Canada during the two decades following the Le Dain Commission, and as noted, harm reduction was proposed as a policy approach. For 20 years, nothing happened. Then in January of 1995, Vince Cain, Chief Coroner for British Columbia, issued a major report on drug overdose deaths recommending that addiction be treated as a health issue instead of a criminal one (Weinstein 2009). His concern over what he found (331 deaths from overdoses in 1993 alone as compared to 39 less than 10 years earlier (Figure 2.) (Kent 1996) led him to propose a radical form of harm reduction: "the distribution of government-regulated heroin freely to users "(Weinstein 2009). Although rejected outright as a legitimate possibility, the nature of his proposal offered a rare glimpse into the desperation of the situation, and the lengths to which activists such as the Portland Hotel Society[7] (PHS), residents of the downtown eastside of Vancouver (DTES), and users themselves were willing to go in order to address the mounting number of deaths among members of Vancouver's IDU community (Weinstein 2009).

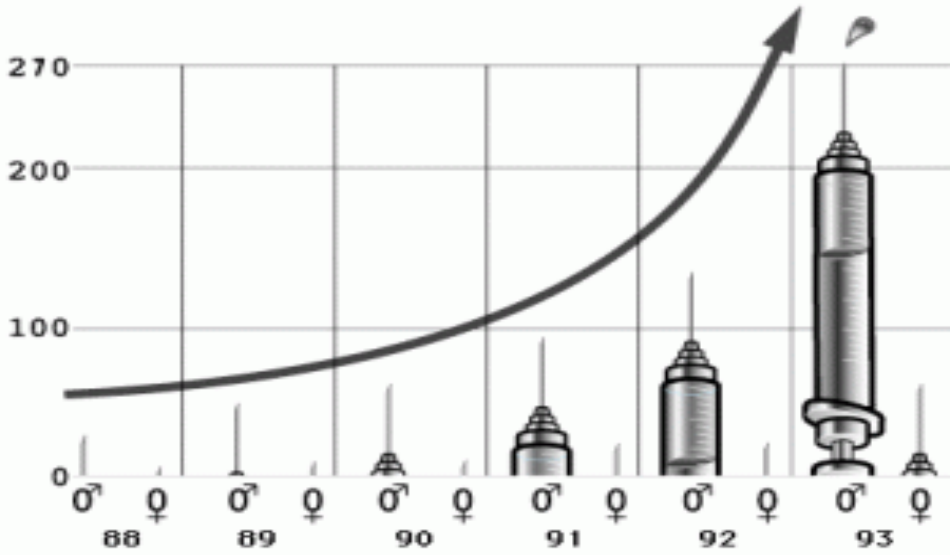

Figure 2. Chart of IDU overdose deaths in British Columbia from 1988-1993 (Kent 1996).

After several years of failed public activism and street level campaigns pushing for supervised injection sites, a second major health report was released in July of

[7] The Portland Hotel Society is a non-profit housing society that provides a supportive living space for the worst affected members of the DTES (DTES 2010).

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1998 (Weinstein 2009). This report by then British Columbia public health officer John Millar decried the situation in the province as an "epidemic" of death and disease caused by drugs. At the time of its release, overdose deaths had spiked, and HIV and hepatitis C infection rates had reached Third-World levels (Weinstein 2009).

In 2001, the city of Vancouver, mirroring its European counterparts, adopted a "four pillars" approach to drug policy (Weinstein 2009). Consistent with the national drug strategy at the time, this new approach identified substance abuse as primarily a public health concern, rather than an enforcement issue (Weinstein 2009).

In September of 2003, Health Canada granted Vancouver Coastal Health a three-year exemption under Section 56 of the *Controlled Drugs and Substances Act* (CDSA) to establish North America's first supervised injection site as a scientific research project (British Columbia Center for Excellence in HIV/AIDS 2009). This type of exemption is granted by the Chief Medical Examiner, and traditionally is only given to pharmaceutical companies using illicit substances in the production of other drugs (British Columbia Center for Excellence in HIV/AIDS 2009). The exemption called a "public health inquiry" became the vehicle for legalizing the SIS project at Insite (British Columbia Center for Excellence in HIV/AIDS 2009) which is located in the highest IDU populated area in Canada, the DTES of Vancouver. Researchers from the B.C. Centre for Excellence in HIV/AIDS act as evaluators of Insite under a 1.5 million dollar grant from Health Canada and the remainder of Insite's funding is provided by the government of B.C (Weinstein 2009).

In 2005, shortly after Insite became fully operational, the Drug Prevention Network of Canada (DPNC)[8] was formed in what would become one of many concerted attempts by opponents of harm reduction to close down Insite (The Drug Prevention Network of Canada 2008). However, the greatest threat to the harm reduction movement and Insite came not from civil society organizations, but from the parliament of Canada. January 24, 2006 saw the election of a Conservative government in Ottawa. Contrary to the policy of the Liberal government led by Prime Minister Jean Chretien that first granted Insite permission to operate, the new government under Prime Minister Steven Harper sought to implement a tougher stand on "law and order" issues. The Conservative policy platform opposed the legalization of marijuana and the government became closely allied with the U.S. Bush administration which at the time was involved in its own war on drugs (The Conservative Party of Canada 2009).

5.2. Evidence and Ideology, 2006-2008

On June 7th, 2006, the first study on Insite was published in *The New England Journal of Medicine*, reporting findings that the more often an IDU visits Insite the more likely he/she is to go into a detoxification program (Weinstein 2009). Detox programs involve the gradual administration of a heroin/opioid substitute (usually methadone) in lesser and lesser quantities, until a user is no longer dependent (Vancouver Coastal Health 2010). Nonetheless, in September of the same year, the B.C. division of the Royal Canadian Mounted Police (RCMP) and the Canadian Police Association issued statements against keeping Insite open. The former proclaimed: "The RCMP does not support legalization of any currently illicit substances, or any initiatives that encourage their use" through their media spokesperson (The Globe and Mail 2006). In addition, the RCMP commissioned a private researcher (Colin

[8] The Drug Prevention Network of Canada is a privately funded organization consisting of radical anti-drug activists, many of whom are former RCMP, police and lawyers. According to their mission statement, the goals of the DPNC include, advancing abstinence-based drug and alcohol treatment and recovery programs, promoting a healthy lifestyle free of drugs and opposing legalization of drugs in Canada (The Drug Prevention Network of Canada 2008).

Mangham) to write a critical review of the studies conducted on Insite (Weinstein 2009).

In September 2006, when its initial exemption was about to expire, Insite was granted a one year extension until December 2007**.** The Federal government claimed the current evidence was inconclusive, and wanted more research on how SISs affect levels of prevention, treatment and crime. Despite its demand for additional scientific inquiry, the government retracted all funding it had initially been providing for research concerning Insite. That same year, the Centre for Excellence in HIV/AIDS published a report in *The Canadian Medical Association Journal*, concluding that Insite does not encourage drug use, that the addicts who use the site are more likely to be referred to treatment, and that they are also less likely to share needles and overdose (British Columbia Center for Excellence in HIV/AIDS 2009, Weinstein 2009). The government of B.C issued a statement to the effect that Insite was doing a good job in improving services to people, and Premier Gordon Cambell declared, "We think it's a positive step, and we believe it should continue" (Priest 2006).

By 2007, and despite a growing body of scientific evidence in favour of Insite, the Federal government's support for Insite waned. This prompted Steven Hwang, a St. Micheal's Hospital researcher, to write a commentary accusing the Federal government of "allowing ideology to trump science" (Weinstein 2009). More than 130 scientists and physicians co-signed his commentary. Later that year, in the face of continued Federal government wavering over its plans for Insite, again, Premier Gordon Campbell publicly endorsed the facility (The Vancouver Sun 2007b). Notwithstanding these studies and testimonials, the Federal government declined to renew Insite's exemption.

5.3. Insite in Court

In response to news that Insite's exemption was not being renewed, two IDUs along with The Vancouver Area Network of Drug Users [9] (Vancouver Area Network of Drug Users 2010) and the PHS (DTES 2010) mounted a constitutional challenge to the Federal government's power to close the facility arguing that the site addresses a public health crisis (*PHS Community Services Society v. Attorney General of Canada* 2008, Weinstein 2009, Chu 2010). In these actions, the plaintiffs claimed that Insite was a health care undertaking, authority for the operation of which lay with the province (Chu 2010). As a consequence, federal constitutional power to legislate with respect to criminal law could not interfere with the provincial constitutional power with respect to health care because of the doctrine of inter-jurisdictional immunity (*PHS Community Services Society v. Attorney General of Canada* 2008, Chu 2010). This argument was rejected by the court. However, the plaintiffs' secondary claim "that Sections 4(1) and 5(1) of the *CDSA* were unconstitutional and should be struck down because they deprive persons addicted to one or more controlled substances of access to health care at Insite" was accepted (*PHS Community Services Society v. Attorney General of Canada* 2008, Chu 2010).

In the PHS decision, Justice Pitfield found that sections of the Federal *Controlled Drugs and Substances Act* are inconsistent with Section 7 of the Charter of Rights and Freedoms (*PHS Community Services Society v. Attorney General of Canada* 2008, The Canadian Press 2008, Chu 2010) and that denying access to Insite would be ignoring the illness of addiction. Further, he found that instead of being rationally connected to a reasonable apprehension of harm, the blanket prohibition contributed to the very harm it sought to prevent (Chu 2010). It was inconsistent with the state's interest in fostering individual and community health, and

[9] The Vancouver Area Network of Drug Users (VANDU) is a local support group consisting of users, former users, and volunteers who work to improve the lives of people who use illicit drugs (Vancouver Area Network of Drug Users 2010).

preventing death and disease (*PHS Community Services Society v. Attorney General of Canada* 2008, Chu 2010). Justice Pitfield then granted Insite a one year extension to their current exemption, and ordered Parliament to amend s. 4(1) and s. 5(1) by June 30, 2009 (*PHS Community Services Society v. Attorney General of Canada* 2008, The Canadian Press 2008, Chu 2010).

The Federal government immediately appealed the decision to the British Columbia Court of Appeal (B.C.C.A.) but on January 10, 2010 the appeal was dismissed on similar grounds to those given at trial and Insite was allowed to continue to operate (Chu 2010, *PHS Community Services Society v. Canada (Attorney General)* 2010). The Federal government again appealed the decision of the B.C.C.A. to the Supreme Court of Canada and the case is currently pending (Canadian Broadcasting Corporation 2010, Chu 2010).

5.4. Images of the Human and Physical Geography of Insite

Insite as a harm reduction institution offers a variety of health-related and counselling services to members of the DTES. Its services are not restricted to DTES residents, but its choice of location was no coincidence, and rarely do non-DTES residents venture to Insite to facilitate their habits. In the press, and to the common critic/observer, Insite is a black hole, a lawless zone where individuals are breaking the law and are legally permitted to use drugs. The Federal government has gone as far as labelling it as “drug enabling”. To these critics Insite represents a place where addicts, rather than being forcibly pressured to stop their addiction, are instead given a free pass to use drugs (at the expense of tax-payers), in a so-called sanctuary out of the grasp of the legal system.

By contrast, for Insite staff and IDUs, what began as an experiment in 2003 has grown into one of the most recognizable and indispensible landmarks in the DTES. This facility is seen as much more than the services it provides, and holds a powerful symbolic place in the world of IDUs. It instantiates human compassion and provides a degree of hope in an area where hope can be the difference between giving up and continuing to fight, and between living and dying.

The DTES of Vancouver is far and away Canada’s most disadvantaged neighbourhood in terms of its elevated levels of drug use, poverty, and homelessness. According to some estimates, living in the eight block radius surrounding Insite at the intersection of Main and East Hastings (Figure 3.), there are approximately 15,000 homeless, and between 5,000 to 7,500 intravenous drug users (R. Maynard, personal Communication, 12 July 2010). These alarming rates are a direct result of several socio-demographic, environmental and climate-related factors which have made it the hub for homelessness and drug use in Canada, attracting all sorts of transients from across the country. Among the denizens, there is a disproportionate number of minorities compared to national numbers, and conservative estimates indicate that around 70% of the drug users are male, and up to 30% are aboriginal (R. Maynard, personal communication, 13 July 2010). Given that only 4.4% of Canadians are Aboriginal (Statistics Canada 2010), it is apparent that the Aboriginal population is being affected quite severely by injection drug use.

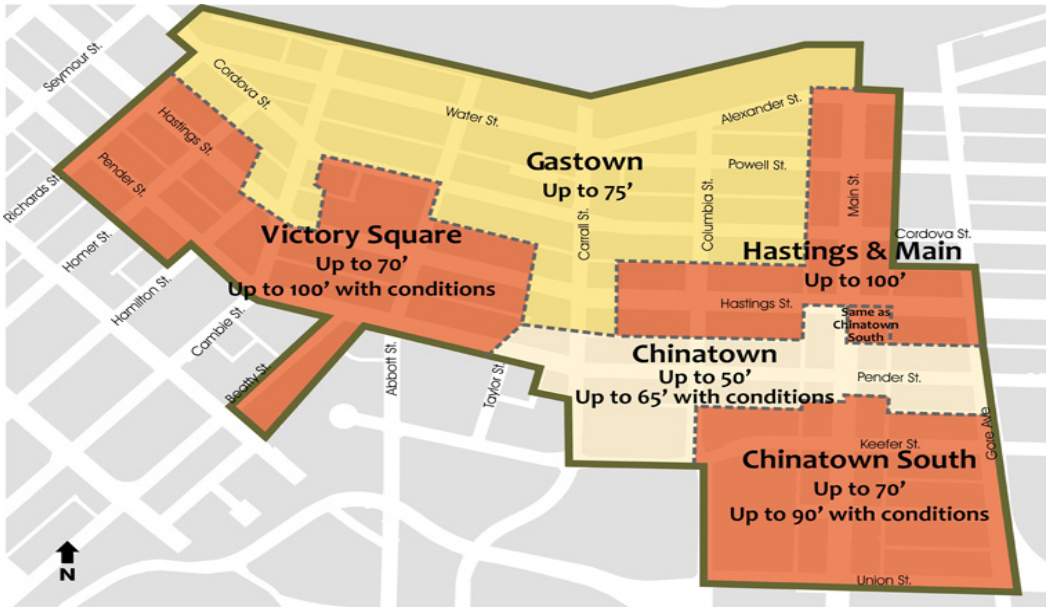

Figure 3. Map of DTES of Vancouver, with its heart & Insite located at the intersection of Hastings and Main (Historic Area 2009).

Insite has become the ideological battleground between those who see IDUs as the consequence of broader social pathologies, and those who see IDUs as criminals who need reforming. As Russ Maynard, Project Coordinator at Insite notes, despite several detoxification programs, social assistance, inpatient programs, Insite and the PHS all operating in the DTES, it is the unforgiving nature of the marginalized, socially stigmatized and underprivileged environment that is a main factor contributing to user recidivism and preventing recovery (R. Maynard, personal communication, 13 July 2010).

Section 6: An Empirical Overview of Insite

This section deals with the findings of a visit to Insite and interviews with users and service providers. It begins with a description of the facility, and a statistical profile of the clientele. Next, the methodology of the visit and interviews with subjects will be discussed.

6.1. A Visit to Insite

6.1.1. Intake

The success of Insite is due in part to the design and layout of its physical premises. From the outside the building looks normal, with a non-descript front door. Inside a totally different picture presents itself. Insite consists of three main rooms and a couple of offices for users to consult with supervisors about health-related behaviours and problems they are having in the community, or to obtain basic emotional support. The first room is a user registration/waiting room, where upon entry the user provides a name (generally a pseudonym to maintain anonymity) and indicates the type of drug he/she will be using. The reason for recording the type of drug being used is due to the fact that, despite being granted an exemption, the program is still in the midst of conducting and being subject of research for longitudinal scientific studies (Abbey, personal communication, 13 July 2010). After registration, the user waits for the next available injection stall to free up, and then is granted entry to the connecting "injection room". This injection room contains 12 booths, each equipped with several mirrors to help the users inject, and allow the nurses to see the users' facial expressions and body posture to minimize chance of overdose or injury from other drug-related complications. A safe needle disposal box is also found in each stall. Insite handles on average 600

injections daily (R. Maynard, personal communication, 13 July 2010). The injection room is monitored by two certified nurses who are trained to look for signs of overdose. They also clean and disinfect each booth after every usage. In other countries nurses aren't required to supervise actual usage, but a condition of Insite's operation is that registered nurses oversee the functioning of the injection room[10].

6.1.2 Routine

The typical routine for a user after registering would consist of walking up to the main counter, gathering his/her needed supplies (a wide assortment of paraphernalia is provided, such as rubber bands, cooking trays, matches, needles, swabs, band-aids, and even condoms) and then proceeding to an allocated booth to inject. Drug usage isn't limited to heroin. Morphine, codeine, cocaine and other prescription drugs are also used. In addition, considering the high volume of daily visits, individuals are typically advised to stay in the injection room for a maximum of 15 minutes at a time. This limits the waiting time for newcomers, ensuring that they don't become too restless and leave the facility to inject on the street. As I was observing the injection room, in came a user furious over the fact that he had previously been issued a 24 hour temporary moratorium for monopolizing one of the booths. There is no limit on how many times per day a user can visit Insite. The only requirement is that each time he/she must re-register at the front desk (again, a condition imposed as part of the exemption and intended to guarantee robust statistical data).

6.1.3 Post-Injection Services

The third and final room of the Insite facility is a lounge type of area where users are encouraged to hang out and "come down" from their highs, thereby limiting the time spent on the streets and in public view while under the influence of drugs. In this area users are given free coffee or juice upon request, and are monitored by two supervisors trained to look for signs of overdose. As one former addict, turned supervisor, Ron repeatedly emphasized the importance of his job, "Coffee is good and all but we are here to save lives, man" (Ron, personal communication, 13 July 2010).

6.2. Insite by the Numbers

Insite is by far the most researched SIS in the world, being subjected to a multitude of scientific, non-scientific, qualitative and quantitative inquiries covering a range of issues from its direct impact on the reduction of intravenous drug use to its impact on crime rates in the DTES community.

The most recent statistics found that in 2009 alone, 5,447 active drug users in the DTES made 276,178 recorded visits, an average 702 visits per day (Ministry of Healthy Living and Sport Government of British Columbia 2010). Of these visits, there were 484 overdose interventions and 2,492 other instances requiring first aid and medical care, and 6,242 referrals were made to other social and health services (Ministry of Healthy Living and Sport Government of British Columbia 2010). There were zero recorded deaths (Ministry of Healthy Living and Sport Government of British Columbia 2010). Comparatively speaking, in the 10 years before Insite was in operation there were approximately 147 overdose deaths annually (British Columbia Center for Excellence in HIV/AIDS 2009).

As noted, of the 484 overdoses that have been treated at Insite there have been zero fatalities. Based on a 5% mortality rate if they had occurred in the community,

[10] The requirement of nurse supervision remains one of Insite's greatest costs and biggest barriers towards remaining operational 24 hours a day. Were it to simply employ properly trained non-nurse supervisors like in other countries, their operating cost would be reduced drastically and overnight staffing of the injection room would be far easier (R. Maynard, personal communication, 13 July 2010).

24 of them would have resulted in death (Ministry of Healthy Living and Sport Government of British Columbia 2010). Furthermore, Insite's role in effectively managing overdoses and other health-related problems has saved British Columbia over eight million dollars in medical and hospital care. In addition, in the downtown eastside of Vancouver in 2006 there were just 30 new cases of HIV reported, compared to over 2,100 a decade earlier (British Columbia Center for Excellence in HIV/AIDS 2009).

Another significant finding was that the use of Insite was correlated to an increase in the use of detoxification programs for intravenous drug users wishing to quit (Ministry of Healthy Living and Sport Government of British Columbia 2010). It has also reduced the visibility of drug usage in downtown Vancouver, by reducing public injecting and drug related-garbage. Insite has been found to attract the highest risk users, individuals who are most likely to have or to contract HIV, who are most likely to overdose, and who were contributing to public drug use and unsafe syringe disposal (Ministry of Healthy Living and Sport Government of British Columbia 2010). It has reduced the amount of needle sharing, and most patrons report a significant decline in such behaviour. It also provides valuable intravenous drug use health and safety education as nearly one third of Insite's users and community members receive this information. Finally, Insite has not led to an increase in drug-related violent crime. Rates of arrest for drug trafficking, theft, armed robbery, and vehicle break-ins have declined significantly (British Columbia Center for Excellence in HIV/AIDS 2009).

6.3. Interviewing Those Involved with Insite: Methodology

In accordance with the ethical guidelines for research involving human subjects in Canada, I have conducted interviews solely for the purposes of including a "voice" of personal experiences and opinions (Canadian Institutes of Health Research 1998). As a whole, the findings from these interviews are not intended to reflect the views of an entire population, nor do they make claims of statistical accuracy, reliability or even truth of the factual statements of persons interviewed. The responses given are reported unedited, in order to give a narrative voice to a selection of people whose lives have been affected by Insite. This being said, the interviewing process went relatively smoothly, with most participants willingly and openly agreeing to speak about their circumstances. The conduct of the interviews varied, depending on the interviewee. However, a general set of questions was followed as often as it could be. The list of questions can be found in the appendices.

The interview style also varied with each individual, as temperament, attitude, mental status, and behaviour played a role in responding in certain cases. The form of each interview was semi-structured, free speak, with no interruptions by the interviewer. Each interview was recorded, and later transcribed. Some participants had initially refused to be recorded out of fears of incriminating themselves by discussing the usage, purchase, or distribution of drugs. Nonetheless, they consented after being assured anonymity and the ability to use pseudonyms if they desired.

The types of questions asked were intended to gather different perspectives on how people involved with Insite (employees, users, volunteers) understand and are affected by the legal circumstances surrounding the site. An example of a question asked users is, "Do you have any concerns about, or have you faced any repercussions such as arrest, threats, or confiscation of drugs as a result of your usage of Insite?" Moreover, the questionnaire instrument was designed in order to gain an understanding of the interviewee's own experiences in the DTES, and personal opinions on why Insite has been so controversial. The questions were framed to elicit respondents' perceptions of the role of state law that, on its face

and in its administration, met the criteria of repressive formalism. In the next Section I track relevant responses in my discussion of repressive formalism.

6.4. Subjects

In total, the number of participants interviewed who had a direct connection to Insite through drug using or employment was 9. Six of these participants were IDUs who had previously used or still used Insite, two were former users currently working at the facility, and one was the project coordinator for the program. Several other interviews were conducted with members of the DTES and adjacent Gastown community. These however were short, unstructured and conducted as casual conversations, rather than through a series of pre-defined questions.

6.5. Results and Observations from the Interviews

6.5.1. The Perspectives of Users and Members of the DTES

The majority of the IDU's interviewed were quite open to speaking with me, gladly agreeing to be interviewed and comfortably addressing the main issues. Personal opinions, of course, do not necessarily reflect those of the majority, nor do they reflect any actual knowledge of the impending legal situation and current legal status of Insite; however, they do offer valuable insight into the mind frame of a user who has been granted a venue to legally inject drugs.

From the interviews I gathered with denizens of the DTES, I could sense an overwhelming sense of entitlement, in a perverse sense of the word. Not exactly entitlement as in "I deserve such and such because I am special" but rather an expectation that since Insite operates under an alternative set of legal guidelines, they too have inherited a similar exemption from the guidelines as well. This point is emphatically illustrated by a comment from Todd, "If I get caught with drugs, I just tell them I'm going to Insite, and that way they can't do nothing" (Todd, personal communication, 15 July 2010). Whether or not the police actually exert their proper authority under such circumstances is another story altogether, but that misguided notion of being untouchable/free from prosecution was certainly present among several of the individuals I interviewed. This misconception was coupled with a belief that ever since the institution of Insite, it was semi-legal, or less illegal to possess and buy drugs, and/or drug paraphernalia in the surrounding areas. There was supposedly an implicit understanding that the police would be more lenient towards addicts, and that actual rates for arrest would decrease. This was an interesting conclusion, as one of the initial fears among users was that police would be monitoring the injection facility in order to profile, and occasionally to unethically/unfairly target them knowing that they were in possession of controlled substances.

Comments such as the previous one by Todd, display what I would consider a negative effect of the site, whereby drug usage in general is no longer seen as an *illegal* behaviour, but instead an acceptable unavoidable one. The harm reduction movement does in fact push for addiction to be seen as a health problem. However, for non-radical harm reductionists this is the extent of their claim. They do not advocate all out decriminalization or legalization of illegal substances as some believe. In addition, the overall police presence was noted to be higher the during the pre-Insite days. Despite the appearance of more police since the opening of Insite, they are generally not nearly as intrusive and interfere far less in the daily lives of users. As Sheila explained, gradually as the police became more familiar with the site and its users, minor possession and loitering near Insite became less scrutinized (Shelia, personal communication, 15 July 2010). The consequence seems to be that once users gain a reputation as a patron of Insite, they gain a level of immunity from minor drug infractions. Further, Sheila revealed that she wasn't an initial supporter of the site and that it took her over a year to overcome her concerns about police profiling, "spying", and targeting of Insite users before

she began making use of its services (Shelia, personal communication,15 July 2010).

From my observations and interviews, I concluded that the general consensus in regards to Insite's value to the IDU and DTES community was that it was a necessity in order to "save lives", and that it represented a type of "achievement milestone". That is, Insite appears to be a means by which the outside world (non-IDU/DTES community members) are able to express an understanding of the difficulties associated with drug use, and overcoming addiction.

A major dilemma with this belief is that some of the users misconstrue what exactly Insite provides. As a result of their limited access to information and in many cases difficulties in learning (such as reading and writing disabilities), for the majority the "knowledge" they have of Insite is hearsay from other users and Insite advocates. This is not to say that Insite is feeding IDUs inaccurate information. Rather, the information they are exposed to over-represents the positive findings so as to make the achievements of Insite appear more favourable than they actually are.

6.5.2. Insite Employees

Similar to the denizens of the DTES, workers at Insite (some of whom are ex-users) offer extremely positive outlooks about the success and value of the Insite facility. At Insite I spoke with the registered nurses, the director, and two ex-users who were hired to work in the "come down" lounge serving coffee and water while monitoring post-use IDUs for signs of life. According to Ron "coffee is good and all" but, their main job is to "Save lives, man".

The nurses provided valuable insight into how exactly the injection room works, the way studies were run, what data they needed to collect, and how they react during instances of overdose (there are pure oxygen canisters on hand to be administered to individuals showing signs of lifelessness and having difficulty breathing). While interviewing the nurses "on their job" I collected much eye-opening observational data about the actual process of using injection drugs, and getting high.

The project coordinator/supervisor of Insite, Russ Maynard gave the most extensive interview touching on all aspects of Insite's operation, success, importance, and legality. Often it was difficult to keep him on track. First, he tended to follow a prepared "script", fitting his preconceived responses to almost any type of question I asked, and second, he was so passionate about discussing Insite that he barely gave me an opportunity to interject. One of his key points was a well-detailed illustration of how Insite's success is ultimately reliant on changing the way society views addiction along with its inherent biases towards members of different social classes (R. Maynard, personal communication, 13 July 2010). Further, he emphasized that even despite Insite's success so far, it still cannot meet the demand of the drug using population (it is only open 10am-until 3am, and is limited to 12 injection booths), and in order to truly make an impact in the DTES and IDU community many supplemental support structures and counselling services are needed.

6.5.3. Members of Gastown

The most revealing perspectives I gained were from the members of the adjacent, extremely affluent Gastown community. The heart of Gastown is located just a couple of blocks from Insite, adjacent to a Salvation Army and public park where a large number of DTES residents spend their days and nights. In a distance of two blocks, you exit an area where a hamburger can cost as much as 12$ and enter one where a leisurely stroll down the street presents you with ample opportunities of purchasing spare bike tires, used vacuum cleaners, assortments of shoes, knick-knacks, and various other electronic devices. High rise condos suddenly transform into low rise abandoned apartment buildings and well-dressed white professionals turn into shirtless minorities and aboriginals. The DTES is intimidating for outsiders,

and understandably so, as the residents of Gastown I interviewed claimed to avoid the area as much as possible. In general, the majority of individuals I interviewed expressed initial concern over the opening of a safe injection site, noting that they believed it would lead to an increase in drug-related social problems such as visibility of usage (public injecting, drug selling, and drug related garbage), and draw more transients and users to the area, resulting in an increase in crime and eventually an overall decline in the quality and value of their neighbourhood.

6.6. Methodological Limitations

In designing my instrument and my protocols for its administration I sought to gather data that would enable me to test whether Trubek's model provided explanatory insight into the recent evolution of Canadian drug law. While conducting interviews I discovered a number of limitations to my survey methodology. Some related to the way I framed my questions; others to the way I administered them; still others to the difficulties of eliciting coherent answers from my respondents.

6.6.1 Limitations Related to a Quantitative Study

The most significant limitation with the empirical survey was that it was not structured as a quantitative study meant to test a null hypothesis. Instead of gathering measurable data, I focused on collecting qualitative data about how respondents perceived their experiences with Insite. Although this approach enabled me to report specific responses that confirmed the Trubek (1977) hypothesis, it lacked the requisite statistical validity, and generalizability of a well-executed quantitative study. What my surveys and the unstructured observational data I noted during the four days I spent in the DTES reveal is the importance of following up with a randomized quantitative survey with specific codable questions that generate answers that can be tested for statistical significance.

6.6.2 Limitations Related to Respondent Characteristics

A second limitation is related to the difficulties of obtaining uniformly reliable data from different sets of participants, as each group of research participants presented a unique set of characteristics when it came to honest, accurate, and knowledgeable responding.

In as far as IDUs were concerned there were two aspects to this. First, when interviewing drug users and members of the DTES, it was difficult to discern whether or not the individuals were under the influence of drugs, and if so, whether it influenced their patterns of responding. Upon reflection, had I considered their "state of mind" I could have either created a section for opinions of individuals under the influence or excluded them from participating altogether. Another more developed study could be designed to measure how the degree of "fiending"[11] influences an individual's choice to utilize a SIS. Second, another cause for scepticism about IDU responding stemmed from a form of "interviewer responding bias" whereby I had a feeling participants were tailoring their responses to say what they think I wanted to hear, or making up facts they didn't know because they expected to be rewarded for providing the most "best" answers. These interview and mood biases surely played a role in responding trends when IDUs were interviewed, but were much less observable among members of the Gastown and high rise community.

The IDUs were not the only population to present a challenge interviewing. Gathering participants from Gastown and the high rise area proved far more difficult than initially expected. Perhaps, this was a reflection of the general

[11] An extreme form of craving often described as a feeling of bugs crawling under the skin. Such an affliction can lead an individual into doing almost anything in order to get drugs that alleviate the symptoms (Jay, personal communication, 15 July 2010).

"s*nobbish"* attitude of wealthy communities or maybe the unfriendly, self-centered nature of certain long-time Vancouver residents. Either way, the only individuals from these areas willing to discuss the topic were in their mid 20s to mid 30s and had a casual/laid back appearance. Although I was successful in gathering participants, this still presented a substantial problem in attempting to understand community perception, as the younger individuals are less likely to express the same type of resolute anti-drug ideologies as the older members of these communities.

Interviews with the staff at Insite were also problematic at times. For example, it was difficult to keep the focus on my instrument with one of the respondents, an ex-IDU who preferred to talk about his "castle in Hungary". Another seemed more interested in convincing me how important he was in harm reduction circles. By contrast, the project coordinator of Insite provided the most knowledgeable and in-depth interview. Of course, this was expected since his job regularly involves providing tours to governmental officials and giving them his well-prepared harm reduction/Insite spiel. Although I met him informally for dinner prior to my visit, it would have been interesting to have had an informal de-brief with him after my visit and interviews, when I would have had a better understanding of the challenges facing Insite.

Section 7: Discussion of History & Politics of Insite

This discussion will center on a repressive formalist analysis of the topics covered throughout this thesis, initially examining the RF constructs noted in section 1.3 independently then measuring their correlation to one another. To begin, with respect to Insite and the treatment of IDUs in the DTES, I look at the autonomy and generality of Canadian drug law and the ways in which it promotes or impedes the fulfillment of social values. I then combine these analyses into a discussion of how a repressive formalist approach to drug law by the current Canadian government is being used to delay and even prevent the development of harm reduction measures in Canada. In doing so, I show how the law is being used by members of dominant groups (Government, police, economically privileged classes) as a means to advance and enforce a set of ideological goals un-conducive to the protection and promotion of the requisite social values of the subordinated group it targets.

In concluding this discussion I use the framework of my theoretical approach to categorize the results of my empirical research into actions and practices of IDUs, Insite, and members of the DTES. In classifying the results of my research I highlight notable findings, patterns, or reported instances of disaccord between how the law is being implemented (on the street, to the people, and in regards to Insite) and the fundamental principles it is supposed to achieve (prevention of trafficking of drugs, equal treatment of all, regulation, and order).

7.1. Theory of Repressive Formalism Applied to Insite

Socio-legal analyses undertaken from a formalist perspective have generally been tailored towards understanding the role of legal actors, such as judges and lawyers, in interpreting and applying law. The discussion in this section however, focuses not on the actions of judges and lawyers, but instead on those of the federal government and law enforcement officials in manipulating the law to produce negative impacts on Insite and the harm reduction movement in Canada. The fundamental proposition of my theoretical approach suggests that a highly autonomous and general application of law fails to meet and fulfill an important set of social values. By breaking down this general proposition into its separate key concepts, I reveal its applicability to the HR approach in Canada and the legal situation of Insite.

Viewed in terms of its autonomy from serving the interests of a particular group or groups, Canadian drug law has historically performed fairly poorly. The *Opium Act of 1908* is a paragon of non-autonomous legislation, having been implemented to fulfill a specific ideologized goal (curbing immigration and controlling immigrant populations), and designed to serve the interests of particular groups (notably moral reformers, anti-immigration nativists, labour activists). As Canadian society evolved so did its drug legislation, shifting from "interest-oriented" regulation such as immigration prevention, to "policy-oriented", such as the regulation of substances due to their harmful effects. While the basis for many of the provisions of Canadian drug law is a "policy orientation", certain ideological influences remain. Recently these influences have been less scrutinized as they promote the institution of a "zero tolerance" policy on drugs, in accordance with that outlined in national and international conventions. Viewed in terms of its autonomy from the interests of a dominant group, the formal proscriptions of Canadian drug law, by design, are relatively high. However, despite this formal textual neutrality, the law in action since the 1960s has in fact demonstrated a system that can be considered anything but neutral. With the recent advent of a harm reduction movement, the longstanding ideological influences on the enforcement of drug law are being exposed.

As for generality, Canadian drug law fares much better. Decisions and rules are made according to accepted legislative and judicial practices, and coherently with previous rules and conventions. Moreover, they are seemingly applied equally to all without favourable treatment to any. The design and intended application of drug laws in this sense, conforms to a predetermined, ostensibly equitable structure, following a set of guidelines to achieve a regulatory (in best interest for all) type of goal. For example, in the case of the DTES there may be higher representations of minority groups convicted for drug crimes, but this is not as strongly related to the generality of the law itself as it is with the actions of individuals entrusted with its enforcement. Apart from these particular derogatory actions the law is being applied as it was intended (to prevent drug use), and being exercised within the limits of its proper authority (to arrest individuals in possession of or using illegal substances). The logical consistency in statutory creation along with the motives for narcotic regulation have long been established; however, in situations as precarious as the DTES, often the best results are achieved by interpreting a statute in every way possible other than the most logical.

The "social values" construct requires us to examine equality (equal treatment by the state), individuality (the degree of self-actualization that is realizable), and community (the degree to which participating and sharing in a greater group is possible) (Milovanovic, 2003). Here is where it becomes apparent that the effects of a uniform application of a "same law for everyone", is ineffectively addressing the problems associated with drug addiction by contributing more to the worsening the overall crisis than to remedying it. For example, inequality is represented by the discriminatory policing of IDUs, the refusal to acknowledge addiction as a legitimate health problem, and obstructing access to vital services while only tolerating or forcibly imposing "state approved" treatments. Further, the fulfillment of the individuality aspect of social value is jeopardized by state denial of addiction as an illness, and drug use as a health problem. IDUs are consequently stigmatized as "criminals", perpetuating beliefs that addiction is a personal lifestyle choice instead of a serious life threatening illness. A failure to attend to the community aspect of social values can be seen in the fact that labelling of IDUs as criminals inhibits their timely access to proper treatment and social services, as well as to other important social belongingness functions like acquiring gainful employment and becoming members of non-using social groups.

Using these three constructs of repressive formalism permit me to identify a number of recurring themes from my analysis of Canada's transition to a four pillars

drug policy, the legal battle over Insite, and interviews with the residents and IDU's of the DTES. Four merit notice.

1. Ideology has and continues to play a dominant role in the development and enforcement of law with respect to drugs, and drug usage.
2. The stigmatization of drug use and a failure to appropriately re-define the classification of addiction, negatively impacts IDU's by limiting the provision of and their access to "health" related treatments, along with severely jeopardizing their ability and motivation to gain membership in a greater social community.
3. There are inherent difficulties in policing the DTES and Insite, such as consistency of application, the high risk of corruption, and the temptation to engage in discriminatory profiling.
4. Social class and race influence the application of law and the levels of support for movements aimed at rectifying inequality of treatment.

7.2. The Conservative Government Backlash (2006-2010) as a Reflection of Repressive Formalism in Action at the Policy Level

As just noted, ideology has played a dominant role in the historical development of Canadian drug policy. However, this sub-section will only look at the most recent (2006-onwards) developments relating to the introduction and operation of Insite.

7.2.1. The role of Ideology in Recent Drug-related Politics

Over the past four years, the Conservative government has surreptitiously attempted to reverse the advancements of harm reduction policy in Canada, while at the same time promoting a "law and order" anti-drug agenda. The government determined that before it could fully endorse Insite as a viable HR strategy, more research needed to be conducted. This decision came despite the existence of an already large body of scientific evidence indicating its effectiveness in everything from reducing drug-related litter, lowering the number of new HIV/AIDS infections, increasing IDU attendance numbers in detoxification programs, and preventing avoidable deaths from overdose. After misleading members of the DTES into believing that Insite would remain a fixture in their community, the federal government acted on its predetermined plan to shut it down, refusing to extend its medical exemption and engaging in an increasingly virulent campaign against Insite and the inclusion of harm reduction policies into the National Drug Strategy. For example, after disregarding the results of independent nationally and internationally funded studies on Insite, Tony Clement as the Minister of Health, called Insite "an Abomination" and suggested that the safe injection facility was exacerbating the harms of injection drug use (Weinstein 2009). Additionally, Prime Minister Steven Harper, obviously targeting Insite, stated "We as a government will not use taxpayers' money to fund drug use" (CanWest News Service 2005), wrongly implying that the services offered by Insite constitute "drug use", and that they come at the expense of "taxpayers' money". Furthermore, the government has consistently sought to downplay positive findings of peer-reviewed scientific studies by pointing out, and greatly exaggerating obvious methodological limitations, instead choosing to note the "significant" findings of pseudo-"scientific" (non peer-reviewed) studies by anti-harm reduction cohorts.

Most recently, the federal government has removed the fourth "harm reduction" pillar from the Canadian national drug strategy, in an attempt to re-establish a "zero tolerance" drug policy (Department of Justice 2010). This shift followed a public campaign against Insite and is seen by many as retaliation for the constitutional challenge mounted by users. Also, to re-ignite public dispute over the scientific evidence advocating harm reduction practices and in an effort to generate support for its preferred policy, the government has initiated its own research projects aimed at proving the efficacy of the obsolete three pillared approach

(Department of Justice 2010). Such initiatives have led researchers to accuse the government of allowing "ideology to trump science" (Weinstein 2009).

It is difficult to locate the source of these anti-harm reduction beliefs, but a couple of "educated" guesses may be advanced. Firstly, the influence of organized religion (notably Pentecostals and the Roman Catholic Church) on Canada's Conservative movement cannot be downplayed. The issue of morality is consistently being raised and used at the political and legal levels as a legitimate argument against the acceptance of any non-traditional practices such as abortion, gay marriage, assisted suicide, and harm reduction approaches to drugs. Secondly, Canada's close political alliance with the United States has led the Conservative government to attempt to emulate or adopt a similar political stance on major and controversial issues. The war in Afghanistan is one example, and the zero-tolerance anti-drug ideology fuelled by the United States-led war on drugs with South-America is another. Furthermore, Canada's economic reliance on the United States as its largest trading partner has also entrenched a role for American ideology in Canadian politics. What is more, this trade dependence has essentially confined Canada to a subordinate position, as previous attempts at re-configuring the national drug policies have been met with hostility and threats of trade restrictions (Global National 2002).

7.2.2. Pragmatic Reasons (Excuses?) Offered for Contesting Insite

By comparing Canada to other countries that have adopted a harm reduction framework, it is easy to identify a sharp contrast in levels of restrictive policy and governmental control**.** Why must Canadian SISs continue to be obliged to operate under the protocol constraints of a rigorous scientific study? The initial reason for this requirement came from of a combination of the novelty of the strategy to Canada, and the nature of existing federal drug laws. However, its retention as a mandatory condition of compliance ignores the reality of the situation in areas like the DTES, and shows a refusal to adjust policy to accommodate the vicissitudes of a society in transition. This is not to say that further research is unnecessary. But hinging the operation of Insite to the requirement of routinely finding "positive scientific evidence" contributes nothing to the further development of harm reduction initiatives. The government has placed an onus on Insite not only to come up with supporting evidence, but also to come up with enough supporting evidence to convince *moral crusaders* of the benefits it provides. Unfortunately for advocates of harm reduction, it has been difficult to discern how much evidence is needed and what this evidence must show. A couple of examples of areas that have needed *moral* justification include the following questions which themselves represent ideological "excuses" used against Insite.

The following are examples of questions where the evidentiary burden is used as an "excuse" to attack Insite.

1. The operation of Insite has been argued to be too costly. Does this mean the government's interest lies in getting a return on its "dollar", by comparing money spent against drug use prevented? If this quantification of the cost of addiction is its true purpose, then it has already been presented with sufficient evidence indicating that the cost of treatment of HIV/AIDS per person (approximately 30 000$ annually) on the British Columbian health care system would be significantly reduced.
2. A second argument has centered on the fact that there has been no significant reduction in drug user rates in the DTES, and that Insite is only used by approximately 5% of the IDU community. How can the government rationally expect to achieve a higher percentage when it is constantly placing the status of the site in jeopardy. Many users are unwilling to commit to the substantial lifestyle change of the program unsure of whether

it will remain open. Regardless, those who have committed alone have justified its continued existence.

3. Thirdly, it is argued that Insite hasn't contributed any other positive impacts to the community. Studies have indeed measured Insite's positive impacts on the surrounding neighbourhood, such as reduction in drug-related litter, petty crime, loitering, public drug use, etc. While the prevalence of these behaviours has been found to have decreased since Insite's opening, the fact is that they still remain, and are often unrelated to the site.
4. Finally, Insite is a drug enabling program when the goal should be to get users off of drugs. One of the biggest barriers to granting full legality to Insite has been a refusal by the federal government to classify "drug addiction" as a health problem rather than a criminal one. It appears that nomenclature is one of the most significant threats to the continued existence of Insite.

What is most troubling is that even with positive scientific results in hand the Canadian government refused and still refuses to acknowledge the value of Insite. By requiring all matters of Insite's operation to be in accordance to "the letter of the law" the government is ignoring the social values of users of the site and members of the DTES community, and has contributed to the continued marginalization of these groups. Consistently with the RF construct, by re-instituting a formal approach to drug law (treating all types of drug use and every type of user the same), and specifically applying these formalities to the operation of Insite, the federal government is perpetuating the suffering of the users, essentially binding them to their disadvantaged position in law by denying them a means of overcoming this inequality.

7.3. The Police and Law Enforcement Response as a Reflection of Repressive Formalism in Action at the Operational Level

Examining the way drug use in the DTES vicinal to Insite is policed reveals that it too represents a manifestation of repressive formalism in action. The theory posits that formally equal treatment for substantially unequally situated legal actors is not a proper solution, and itself facilitates oppression and legal discrimination on the basis of class, race, gender, etc (Milovanovic 2003). In general, with regards to drug use, this discrimination can be viewed in terms of biases in policing evidenced through the unethical targeting of drug users (class bias) as well as with the racial disparities in incarceration rates for drug offences, both of which then "reinforces the political popularity of criminalising drug users and undermines HIV prevention and other health promotion efforts" (Ahem *et al.* 2007).

Moreover, despite the illegal nature of the behaviours that go on at an injection site, there is supposedly an implicit notion that a certain degree of leniency will be exercised when dealing with possession of minor quantities of drugs and paraphernalia in the proximity of the site. Unfortunately, evidence illustrates the opposite as the Human Rights Watch found, "In many places, police target harm reduction services, seeing easy opportunities to harass, entrap, and extort clients" (Human Rights Watch 2009). As with crackdowns on traffic violations, a requirement of fulfilling specific "arrest quotas" seems to be one of the explanations for this phenomenon (Human Rights Watch 2009). Furthermore, having such requirements as a means for promotion or funding exacerbates police abuse by encouraging them to seek out easy targets, like drug users, to meet their work goals (Human Rights Watch 2009). By exercising their authority in a rigid, inflexible manner and in acting out their duties expressly and overzealously on an already vulnerable population, the police are consciously preventing access to the site and contributing to marginalization of users.

Technically, the police are acting within their jurisdiction, enforcing the law, and performing their job as it was intended. This uncompromising formality, however,

disproportionately affects users based on levels of addiction and economic status and is directly manipulating the successes of harm reduction programs by negatively influencing the results of scientific studies. For example, a middle or upper class user arrested for possession is likely, depending on quantity, to have their drugs confiscated, spend a night in jail, and pay a fine. Other than experiencing a marginal level of embarrassment, this enforcement of law has little or no lasting consequences. A lower class user or addict on the other hand, endures this application of law far more severely. Although, the force and nature of the law mobilized remains identical (same loss of drugs, night in jail, and fine) it ultimately affects lower class users entirely differently. For them, the fine is basically un-payable (which might eventually lead to more jail time) and having their drugs confiscated directly and indirectly impacts their lives across several different axes. For example, if the drugs weren't fully paid for the user would become enslaved to the dealer, further a temporary lack of drugs may severely affect user temperament significantly increasing their level of distress and multiplying the extent of fiending experienced. In addition, jail time means loss of even casual employment, a factor that might compel addicts to temporarily or permanently engage in criminal behaviour in order to generate the substantial financial means necessary to support their habit. There are too many intangibles associated with drug use to expect that a punishment strategy designed for middle and upper class users can be imposed on lower class users with equal effect.

What is more, the negative impact of the increased police presence in proximity to Insite is exponentially multiplied by having mandatory registries or sign-in policies which record personal and drug-related information. Although, necessary in terms of gathering scientific data, registries and sign-in policies do little to alleviate fears of users who already feel as if they are unreasonably being targeted.

RF is also exhibited through the way the federal government has attempted to forcefully impose a "one size fits all" type of detoxification program onto individuals attempting to quit using. In doing so, it is failing to take into account the important socio-demographic and socio-geographic factors that contribute to addiction and relapse. According to Russ Maynard, detoxification programs are designed for middle and upper class drug users who have access to extensive social and financial support networks which contribute as equally to rehabilitation as the detoxification procedure itself (R. Maynard, personal communication, 13 July 2010). Addicts, who have no alternative but to return to a drug saturated environment filled with drug-using peers, face the very likely reality of re-using. A notable factor that further contributes to this detoxification dilemma is that its success rates are generally favourable for middle and upper class users, which places unrealistic expectations on lower class IDUs. When similar results aren't achieved, the IDUs bear the brunt of the blame, rather than the ill-fitting system they are being forced to conform to.

7.4. Interview Results, as a Reflection of Repressive Formalism in Action

From the interviews I conducted, it was not hard to see the extent to which IDUs continue to be marginalized by the surrounding Gastown community, law enforcement officers, and policy makers. This section will discuss several examples which illustrate such an effect, drawing conclusions and patterns from the data I collected. These conclusions do not imply that Canadian drug law nor the specificities of the Insite case are perfect illustrations of RF in action, but simply that they illustrate the extent to which certain manipulations of law can be seen as a reflection of the RF construct.

7.4.1. General Attitudes Reflected by Different Populations

For residents of Gastown group and the high rise condos surrounding the DTES there was a mistaken belief that Insite was actually providing users with drugs, instead of just supplies. Also, among this group other common issues of ignorance concerned the expenditure of hard earned tax dollars, the negative impact Insite

would have on property value, and even fears that it would attract an influx of users from across the province and country. Occasionally, from comments like, "Isn't that where people are allowed to do drugs?" it seemed as if anti-harm reduction propaganda was in fact making an impact (this appeared to be the case for those least educated about Insite, but for others who had at least some knowledge of the site, this wasn't observable). It is however, partially understandable how such unfavourable opinions are generated, as commonly with areas as depraved as the DTES, negative opinions are evoked solely from TV/Newspaper reporting and word of mouth, not through first hand experience.

This public opinion of course is a stark contrast from how users understood its function as a vital health service and essentially a constitutional right. While several DTES respondents expressed a poor understanding of Insite's actual function, its legality, and the overall drug laws in Canada, this did nothing to deter them from using its services. Rather, this confusion speaks volumes of the way Insite is being forced to dedicate considerable amounts of time and resources towards convincing the wrong people of its value to the community. The majority of DTES residents are left in the dark in regards to policy-making, and it is quite evident that the technical issues and intricacies of Insite's functioning have been left for the forums of debate of members of the drug-free bourgeoisie class.

It was alarming to discover that many of the people intended as the target population for the program were unaware of its true function and underlying goals. Some users and members of the DTES felt they were being unfairly targeted by police, in a "profiling" sort of way. This seemed to occur in two general ways. First, both expressed concern that they were being unfairly targeted when they would leave the vicinity of the DTES, such as when entering the neighbouring Gastown area. There was a general sentiment that police would seek them out and question what they were doing in the area (Ron, personal communication, 13 July 2010). Secondly, some of the IDUs complained that police knew who they were, and seemed to be monitoring them (Ron, personal communication, 13 July 2010). Whether this type of harassing profiling is actually the case is unknown, but my impression was that there was a strong sense of paranoia with regards to all instances of police intervention.

Both of these examples illustrate how selective, or even threats of selective law enforcement are being applied to IDUs and in the DTES. The intentional targeting of individuals leaving the DTES forcefully circumscribes them to a marginalized geographic location and the intentional targeting/profiling of IDUS within these confines acts as a nearly insurmountable obstacle for IDUs. Furthermore, it illustrates the intense stigmatization IDUs and DTES members must face, and how this relegates them to a position of unequal legal status as a result of their inferior social positioning.

These interviews reveal that uncertainty about the legal status of Insite and permissible conduct in and around the premises enables law enforcement officials to maintain selective and discriminatory control of the IDUs in the DTES. Users believe that full legalization would resolve this conflict and result in a defined set of rules, which would improve their understanding of the laws, and result in less discrimination. As it stands, the current situation reflects the practices predicted by the RF construct.

7.4.2. Maynard's Metaphor

Russ Maynard provided enlightening insights into some of the ways RF is experienced throughout the DTES, and one of his more interesting observations came when he metaphorically compared drug addiction to type-two diabetes (also referred to as late on-set diabetes) (R. Maynard, personal communication, 13 July 2010). He posited that drug addiction is an illness not too far removed from type-two diabetes in that both are consequences of individual choices, which as a result

now require a lifelong dependency on some sort of treatment/medicine for survival (R. Maynard, personal communication, 13 July 2010). Moreover, he argues that although both outcomes (diabetes and drug addiction) are dependent on the health care system for treatment (with the treatment of diabetes placing a far greater financial strain), the way the respective diseases are classified has resulted in only one of them being properly treated (R. Maynard, personal communication, 13 July 2010). This comparison, and more specifically the failure to classify addiction as an illness, displays a form of RF in action as it represents unwillingness by the government to initiate alternative strategies to the formal legal requirements concerning drug use in order to protect a group of vulnerable individuals from having their rights impinged upon by the law.

Conclusion: Along with Suggestions for Future Studies

Through the years the philosophy of harm reduction has encountered considerable opposition from religious moralists, legal purists, and social conservatives among others. While the science justifying the harm reduction approach has generated a large body of supportive evidence, to date this evidence has failed to convince the anti-harm reduction ideologues who have played a central role in creating and enforcing drug laws. Even though the shortcomings of the prohibitionist model have become increasingly apparent, there has been significant federal opposition to adopting harm reduction strategies in Canada.

While Canada had the benefit of briefly transitioning to a four pillars approach to drug policy, it has still wavered on taking the necessary steps within that forth pillar to sufficiently address the individual and social problems associated with drug use. In fact, over the past four years, Canada has actually regressed with respect to harm reduction acceptance by removing the fourth pillar altogether (Department of Justice of Canada 2010). Currently the federal government is resorting to utilizing a repressive formalist application of law to severely inhibit all levels of the operation of Canada's only SIS, with the ultimate goal of shutting it down. In doing so, the government has manipulated the meaning and intention of the medical exemption, so as to disproportionately target Insite and members of the DTES and to burden the program with unrealistic expectations. What is more, in attempting to close Insite and cut back on harm-reduction strategies, the federal government has foregone any effort to fulfill the social value principles already enshrined in law.

In this thesis, I have provided a brief history of the harm reduction movement in Canada, using the specific case of Insite to illustrate how a repressive formalist approach to law is being used to prevent its further development. I found, that similar to other "morally" sensitive issues, the future success of HR strategies' success lies in overcoming ideological barriers. Re-categorizing drug addiction as a health problem is a first step in this process. Although this thesis addresses only some of the repressive formalist social legal factors associated with Insite and harm reduction strategies, it does, however, point to several critical areas in need of more research. Further studies should examine issues such as: the impact that "repressive" ideology has on individual users, and their own "legal consciousness". A look at the overrepresentation of minorities (especially aboriginals) in the DTES, and a careful analysis into whether anti-HR ideologies are a reflection of negative sentiments held towards minorities would prove to be valuable compliments to this thesis. Research into the connection between Canadian drug policies and those in the United States, and how Canadian harm reduction decisions are influenced by the United States policies is another important topic for future study. Again, a closer look at theological factors, such as the Vatican's attempt to influence the results of a European convention on UN drug policy by claiming that "so called harm reduction leads to liberalisation of the use of drugs", could provide crucial insight into the underpinnings of ideological resistance to adopting HR strategies.

Although the government's appeal of the *PHS Community Services Society v. Canada* case to the Supreme Court of Canada is pending, and Insite's legal situation remains uncertain, there have been some positive signs for the future of harm reduction in Canada. The RCMP has recently decided to engage in a "bridge-building" process with B.C. Center for Excellence in HIV/AIDS with regards to Insite, and they have hinted at formally acknowledging the positive results reported in scientific studies (Geddes 2010). Moreover, Toronto has just become the first city in the world to officially endorse the Vienna Declaration[12] on the criminalization of drugs (Paperny 2010). Finally, if the appeal relating to Insite is ultimately denied by the Supreme Court of Canada, the door will be open for Parliament to amend Canada's drug laws to reflect modern approaches to the regulation of drug use. Entrenching harm reduction within the statute is the only way to guarantee its protection, and prevent it from being the subject of ad hoc implementation on the basis of ministerial permits. Until then, the only certainty is that crime-control ideology will continue to undermine efforts in Canada to re-adopt a four pillars approach to drug policy.

References

Bibliography

AHERN, J., STUBER, J., GALEA, S., 2007. Stigma, discrimination and the health of illicit drug users. *Drug and Alcohol Dependence*, 88 (2-3), 188-196.

ATIDION, G., 1999. *The Structure of Drug Prohibition in International Law and in Canadian Law* [online]. Thesis (PhD). University of Montreal. Available from: http://www.parl.gc.ca/37/1/parlbus/commbus/senate/com-e/ille-e/presentation-e/dion-e.htm#APPENDIX%202 [Accessed 12 August 2010].

BAILEY, S. L., *et al.*, 2003. The Use of Needle Exchange by Young Injection Drug Users. *Journal of Acquired Immune Deficiency Syndrome*, 34 (1), 67-70.

BEISER, V., 2008. First Reduce Harm. *Miller-McCune* [online], 27 october. Available from: http://www.miller-mccune.com/health/first-reduce-harm-4151/ [Accessed 16 August 2010].

BELETSKY, L., *et al.*, 2008. The Law (and Politics) of Safe Injection Facilities in the United States. *American Journal of Public Health* [online], 98 (2), 231-237. Available from: http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2376869/ [Accessed 23 July 2010].

BENNET, J. S., 1974. Le Dain Commission of Inquiry into the Non-Medical Use of Drugs tables fourth and final report. *Canadian Medical Association* [online], 110 (1), 105-108. Available from: http://www.ncbi.nlm.nih.gov/pmc/articles/PMC1947221/pdf/canmedaj01573-0103.pdf [Accessed 12 August 2010].

BLACK, D., 1976. *The Behavior of Law*. New York: Academic Press.

BRICKLEY, S. L., COMACK, E., 1986. *The Social Basis of Law; critical readings in the sociology of law*. Toronto, Canada: Garamond Press.

BRITISH COLUMBIA CENTER FOR EXCELLENCE IN HIV/AIDS, 2009. *Findings from the Evaluation of Vancouver's Pilot Medically Supervised Safer Injection Facility – Insite* [online]. Available from: http://uhri.cfenet.ubc.ca/images/Documents/insite_report-eng.pdf [Accessed 12 August 2010].

[12]A declaration that argues for a full drug policy reorientation because: *The criminalisation of illicit drug users is fuelling the HIV epidemic and has resulted in overwhelmingly negative health and social consequences* (The Vienna Declaration 2010).

CACTUS MONTREAL, 2005. *About Cactus: Historical Background de Cactus* [online]. Available from: http://cactusmontreal.org/en/historique.html [Accessed 25 July 2010].

CANADIAN BROADCASTING CORPORATION, 2010. Ottawa to appeal injection site ruling [online]. *In: CBC News*, Feb 9. Available from: http://www.cbc.ca/canada/british-columbia/story/2010/02/09/bc-supreme-court-appeal-supervised-injection-site.html [Accessed 16 June 2010].

CANADIAN CENTER ON SUBSTANCE ABUSE, 2009. *Discussion Forum: Supervised Injection Site Evaluation Research* [online]. Available from: http://www.ccsa.ca/2009%20CCSA%20Documents/ccsa0117852009_e.pdf [Accessed 5 August 2010].

CANADIAN INSTITUTES OF HEALTH RESEARCH, NATURAL SCIENCES AND ENGINEERING RESEARCH COUNCIL OF CANADA, SOCIAL SCIENCES AND HUMANITIES RESEARCH COUNCIL OF CANADA, 1998 with 2000, 2002 and 2005 amendments. *Tri-Council Policy Statement: Ethical Conduct for Research Involving Humans* [online]. Available from: http://pre.ethics.gc.ca/eng/policy-politique/tcps-eptc/ [Accessed 5 August 2010].

CANWEST NEWS SERVICE, 2005. Drug Crackdown may cut safe-injection site funds. *The Vancouver Sun* [online]. 5 December. Available from: http://www2.canada.com/national/features/decisioncanada/story_05.html?id=135e9983-3c42-42e6-83dc-e71c05150925 [Accessed 25 July 2010].

CHRISTIE, T., GROARKE, L., & SWEET, W., 2008. Virtue ethics as an alternative to deontological and consequential reasoning in the harm reduction debate. *International Journal of Drug Policy*, 19 (1), 52-58.

CHU, S. K. H., 2010. Canada Court of Appeal Upholds Supervised Injection Site's Right to Operate. *International Yearbook on Human Rights and Drug Policy*, 1.

COTTERAL, R., 1992. *The Sociology of Law, An Introduction*. 2nd ed. New York: Oxford University Press Inc.

CSETE, J., 2007. Do Not Cross: Policing and HIV Risk Faced by People Who Use Drugs. *Canadian HIV/AIDS Legal Network* [online]. Available from: http://www.aidslaw.ca/publications/interfaces/downloadFile.php?ref=1080 [Accessed 12 August 2010].

CSETE J., ELLIOTT R. and FISCHER B., 2008. *"Viral time bomb": Health and human rights challenges in addressing hepatitis C in Canada*. Victoria: Centre for Addictions Research of BC.

DAGMAR, H., *et al.*, 2010. Chapter 11: Drug consumption facilities in Europe and beyond. *Harm reduction: evidence, impacts and challenges* [online]. Lisbon: EMCDDA, Available from: http://www.emcdda.europa.eu/publications/monographs/harm-reduction [Accessed 27 July 2010].

DAVIES, G., 2007. A Critical Evaluation of the Effects of Safe Injection Facilities. *The Journal of Global Drug Policy and Practice* [online], 1 (3). Available from: http://www.globaldrugpolicy.org/1/3/2.php [Accessed 13 August 2010].

DEPARTMENT OF JUSTICE OF CANADA, 2010. *National Drug Strategy Implementation Evaluation, Final Report* [online]. Available from: http://www.justice.gc.ca/eng/pi/eval/rep-rap/10/nasie-snaef/p1.html [Accessed 26 August 2010].

DIAS, G., 2003. Canada's Drug Laws: Prohibition is not the Answer. *Perspectives on Canadian Drug Policy. The John Howard Society*, 1, 9-24.

DOLAN, K., *et al.*, 2000. Drug consumption facilities in Europe and the establishment of supervised injection centres in Australia. *Drug and Alcohol Review* [online], 19, 337–346. Available from: http://www.drugpolicy.org/docUploads/harm_reduction_digest_injecting_centres.pdf [Accessed 24 July 2010].

DRUG FREE AUSTRALIA, 2007. The Case for Closure - Detailed Evidence. *Drug Free Australia* [online], 12. Available from: http://www.drugfree.org.au/fileadmin/Media/Reference/DFA_Injecting_Room_Detailed_Research.pdf [Accessed 9 July 2010].

DTES.CA, 2010. *Portland Hotel Society* [online]. Available from: http://www.dtes.ca/cms/index.cfm?group_id=2952 [Accessed 26 August 2010].

ELLIOTT, R., 2002. *Establishing Safe Injection Facilities in Canada: Legal and Ethical Issues*.

ERICKSON, P. G., 1980. *Cannabis Criminals: The Social Effects of Punishment on Drug Users*. Toronto: Addiction Research Foundation Publishers.

ERICKSON, P. and SMART., R., 1988. The Le Dain Commission Recommendations. *In:* J. Blackwell and P. Erickson eds. *Illicit Drugs in Canada: A Risky Business*. Scarbourough: Nelson Canada, 336-343.

EUROPEAN MONITORING CENTER FOR DRUGS AND DRUG ADDICTION (EMCDDA), 2004. *European Report on Drug Consumption Rooms* [online]. Luxembourg: EMCDDA. Available from: http://www.emcdda.europa.eu/attachements.cfm/att_2944_EN_consumption_rooms_report.pdf [Accessed 27 July 2010].

– 2008. *A cannabis reader: global issues and local experiences. Volume 1, European Monitoring Centre for Drugs and Drug Addiction* [online], Monograph series 8, , Lisbon: EMCDDA. Available from: http://www.emcdda.europa.eu/publications/monographs/cannabis [Accessed 27 July 2010].

– 2010. *Harm reduction: evidence, impacts, and challenges* [online]. Luxembourg: EMCDDA. Available from: http://www.emcdda.europa.eu/publications/monographs/harm-reduction [Accessed 27 July 2010]

FULLER, C. M., *et al.*, 2003. Social Circumstances of Initiation of Injection Drug Use and Early Shooting Gallery Attendance: Implications for HIV Intervention Among Adolescent and Young Adult Injection Drug Users. *Journal of Acquired Immune Deficiency Syndromes*, 32 (1).

GEDDES, J., 2010. RCMP and the truth about safe injection sites. *Macleans* [online], 20 August. Available from: http://www2.macleans.ca/2010/08/20/injecting-truth/ [Accessed 29 August 2010].

GLOBAL NATIONAL, 2002. Canadian Marijuana Reform Concerns U.S. *In: Global National Television news* [online], 13 May. Available from: http://www.cfdp.ca/general4.htm#global [Accessed 23 August 2010].

HAEMMIG, R., VAN BEEL, I., 2005. Supervised Injecting Rooms. *In:* R. Pates, A. McBride, & K. Arnold. *Injecting Illicit Drugs*. United Kingdom: Blackwell Publishing, 160-169.

Harm Reduction History and Definition [online] (n.d). Available from: http://www.addictioninfo.org/articles/256/1/Harm-Reduction-History-and-Definitions/Page1.html [Accessed 10 July 2010].

HEALTH CANADA, 2008. Final Report of the Vancouver Insite Expert Advisory Committee. *Health Canada* [online]. Available from: http://www.hc-sc.gc.ca/ahc-asc/pubs/_sites-lieux/insite/index-eng.php#insite [Accessed 19 April 2010].

Historic Area Height Review [online], 2009. Available from: http://forum.skyscraperpage.com/showthread.php?t=168126 [Accessed 8 October 2010].

HUMAN RIGHTS WATCH, 2009. *Drugs, punitive laws, policies, and policing practices, and HIV/AIDS* [online]. Available from: http://www.hrw.org/en/news/2009/11/30/drugs-punitive-laws-policies-and-policing-practices-and-hivaids [Accessed 20 August 2010].

INTERNATIONAL NARCOTICS CONTROL BOARD, 1961. *Single Convention on Narcotic Drugs* [online]. Available from: http://www.incb.org/pdf/e/conv/convention_1961_en.pdf [Accessed 15 August 2010].

KANE, S., MASON, T., 2001. AIDS and Criminal Justice. *Annual Review of Anthropology*, 30, 457-479.

KENNEDY, D., 2001. Legal Formalism. *In: The Encyclopedia of the Social and Behavioral Sciences*. Place of publication: Pergamon, 8634-8638.

KENT, H., 1996. Harm-Reduction Strategies Weapon of Choice in BC's Battle with Drug Addiction. *Canadian Medical Association Journal* [online], 155 (5), 571-573. Available from: http://www.ncbi.nlm.nih.gov/pmc/articles/PMC1335040/pdf/cmaj00101-0077.pdf [Accessed 15 August 2010].

KIMBER, J., *et al.*, 2003. Drug Consumption Facilities: an update since 2000. *Drug and Alcohol Review/Harm Reduction Digest*, 21 (22), 227-233.

KLEIN, A., 2007. *Sticking Points: Barriers to Access to Needle and Syringe Programs in Canada*. Toronto: Canadian HIV/AIDS Legal Network.

MANGHAM, C., 2007. A Critique of Canada's INSITE Injection Site and its Parent Philosophy: Implications and Recommendations for Policy. *The Journal of Global Drug Policy and Practice* [online], 1 (2). Available from: http://www.globaldrugpolicy.org/1/2/2.php [Accessed 17 August 2010].

MILOVANOVIC, D., 2003. *An Introduction to the Sociology of Law*. 3rd ed. New York: Criminal Justice Press.

MINISTRY OF HEALTHY LIVING AND SPORT GOVERNMENT OF BRITISH COLUMBIA, 2010. *North America's First Supervised Injection Site* [Fact sheet] [online]. Available from: http://www.housingmattersbc.ca/docs/dtes_insite.pdf [Accessed 28 August 2010].

MSIC EVALUATION COMMITTEE, 2003. *Final Report on the evaluation of the Sydney Medically Supervised Injecting Center* [online]. Sydney: Kaldor, J., et al. Available from: http://www.druginfo.nsw.gov.au/__data/page/1229/NDARC_final_evaluation_report4.pdf#Final%20Report%20of%20the%20MSIC%20Evaluation [Accessed 28 June 2010].

PAPERNY, A. M., 2010. Toronto formally endorses harm reduction on drug use. *The Globe and Mail* [online], 26 August. Available from: http://www.theglobeandmail.com/news/national/toronto/toronto-formally-endorses-harm-reduction-on-drug-use/article1686999/ [Accessed 26 August 2010].

PRIEST, L., 2006. Pressure Mounts to Keep Injection Site. *The Globe and Mail* [online]. Available from: http://www.theglobeandmail.com/archives/article839395.ece [Accessed 19 August 2010].

PUBLIC HEALTH AGENCY OF CANADA, 2010. *Harm Reduction and Injection Drug Use: an international comparative study of contextual factors influencing the development and implementation of relevant policies and programs* [online]. Available from: http://www.phac-aspc.gc.ca/hepc/pubs/hridu-rmudi/canada-eng.php [Accessed 25 August 2010].

RILEY, D., 1998. *Drugs and Drug Policy in Canada: A Brief Review & Commentary* [online]. Available from: http://www.cfdp.ca/sen1841.htm [Accessed 18 July 2010].

Safe Injection Site [online] (n.d). Available from: http://medlibrary.org/medwiki/Safe_injection_site [Accessed 18 July 2010].

SAVARY, J.F., HALLAM, C., BEWLEY-TAYLOR, D., 2009. The Swiss Four Pillars Policy: An Evolution From Local Experimentation to Federal Law. *The Beckley Foundation Drug Policy Programme*. Place of publication: Publisher.

SCHAUER, F., 1998. Formalism, *Yale Law Journal*, 97, 509-548.

SENATE OF CANADA, 2002. *Special Committee on Illegal Drug* [online]. Available from: http://www.parl.gc.ca/common/Committee_SenHome.asp?Language=E&Parl=37&Ses=1&comm_id=85 [Accessed 21 August 2010].

SOLOMON, R., GREEN, M., 1988. The First Century: The History of Non-Medical Opiate Use and Control Policies in Canada, 1870-1970. *In:* J. Blackwell and P. Erickson. *Illicit Drugs in Canada: A Risky Business*. Scarbourough: Nelson Canada, 88-104.

SOLUM, L., 2005. *Legal Theory Lexicon 043: Formalism and Instrumentalism Introduction* [online]. Available from: http://legaltheorylexicon.blogspot.com/ [Accessed 16 July 2010].

SPECIAL COMMITTEE ON ILLEGAL DRUGS, 2002. *Cannabis: Our Position for a Canadian Public Policy. Volume 3: Part 4 and Conclusions* [online]. Available from: http://www.parl.gc.ca/37/1/parlbus/commbus/senate/com-e/ille-e/rep-e/repfinalvol3-e.htm [Accessed 24 July 2010].

STATISTICS CANADA, 2010. *Aboriginal Peoples Highlight Tables, 2006 Census* [online]. Available from: http://www12.statcan.ca/census-recensement/2006/dp-pd/hlt/97-558/index.cfm?Lang=E [Accessed 4 August 2010].

SYDNEY MEDICALLY SUPERVISED INJECTION CENTER (MSIC), 2010. *Sydney Medically Supervised Injection Center* [Fact Sheet] [online]. Available from: http://www.sydneymsic.com/__data/assets/file/0010/53965/MSIC_FACTSHEET_Updated_6_August_2010.pdf [Accessed 24 August 2010].

THE CANADIAN PRESS, 2008. Drug Laws Unconstitutional: B.C. Supreme Court. *CBC News* [online], 27 May. Available from: http://www.cbc.ca/canada/british-columbia/story/2008/05/27/bc-supreme-court-insite.html [Accessed 28 July 2010].

THE CONSERVATIVE PARTY OF CANADA, 2010. *Founding Principles* [online]. Available from: http://www.conservative.ca/party/founding_principles/ [Accessed 26 August 2010].

THE DRUG PREVENTION NETWORK OF CANADA, 2008. *DPNC* [online]. Available from: http://www.dpnoc.ca/default.html [Accessed 18 July 2010].

THE GLOBE AND MAIL, 2006. RCMP Oppose Expanded Injection Sites. *The Globe and Mail Company* [online]. Available from:

http://www.treatingyourself.com/vbulletin/showthread.php?t=15420 [Accessed 21 August 2010].

THE VANCOUVER SUN, 2007a. Safe Injection Site Breaks Treaties, UN agency says. *The Vancouver Sun* [online]. Available from: http://www.canada.com/vancouversun/news/story.html?id=f9922177-8a0b-4f2f-8323-8bec41ef2819 [Accessed 28 August 2010].

– 2007b. Keep Insite Open, Premier Says. *CanWest MediaWorks Publications Inc* [online]. Available from: http://www.canada.com/vancouversun/news/westcoastnews/story.html?id=237a918c-f92b-42bc-9e4d-307bc6b9d5f3 [Accessed 27 July 2010].

THE VIENNA DECLARATION, 2010. *The Vienna Declaration* [online]. Available from: http://www.viennadeclaration.com/the-declaration.html [Accessed 28 August 2010].

TRUBEK, D., 1977. Complexity and Contradiction in the Legal Order: Balbus and the Challenge of Critical Social Thought About Law. *Law and Society Review*, 11, 529-569.

VANCOUVER COASTAL HEALTH, 2010. *About us* [online]. Available from: http://www.vch.ca/home/ [Accessed 18 August 2010].

VANCOUVER AREA NETWORK OF DRUG USERS (VANDU), 2010. *About Vandu* [online]. Available from: http://www.vandu.org/ [Accessed 18 August 2010].

WEINRIB, E. J., 1998. Legal Formalism: On the immanent rationality of law. *Yale Law Journal*, 97, 949-1016.

WEINSTEIN, T. (Producer), 2009. Staying Alive: Timeline Insite. *In: The Fifth Estate* [online]. Vancouver: CBC-TV. Available from: http://www.cbc.ca/fifth/2008-2009/staying_alive/timeline.html [Accessed 17 June 2010].

WOOD, E., *et al.*, 2003. The Potential Public Health and Community Impacts of Safer Injecting Facilities: Evidence From a Cohort of Injection Drug Users. *Journal of Acquired Immune Deficiency Syndromes*, 32, 2–8.

ZILKOWSKY, D., 2001. Canada's National Drug Strategy. *Forum on Corrections Research Focusing on Alcohol and Drugs* [online], 13 (3). Available from: http://www.csc-scc.gc.ca/text/pblct/forum/e133/133a_e.pdf [Accessed 21 August 2010].

Statutes

Statutes of Canada [1908, c. 50].

Statutes of Canada [1911, c. 17].

Controlled Drugs and Substances Act [1996, c. 19].

Cases

PHS Community Services Society v. Attorney General of Canada, 2008 BCSC 661 (B.C. Supreme Court).

PHS Community Services Society v. Canada (Attorney General),2010 BCCA 15 (B.C. Court of Appeal).

Abbreviations

B.C.: British Columbia

CDS: Canadian National Drug Strategy

DPNC: Drug Prevention Network of Canada

DTES: Downtown Eastside

GVA: Greater Vancouver Area

HIV/AIDS: Human Immunodeficiency Virus/Acquired Immune Deficiency Syndrome

HR: Harm Reduction

IDU: Intravenous Drug User (s)

MSIC: Medically Supervised Injection Center

PHS: Portland Hotel Society

RCMP: Royal Canadian Mounted Police

RF: Repressive Formalism

S.C.: Statutes of Canada

SIS: Safe Injection Site

VANDU: Vancouver Area Network for Drug Users

VCH: Vancouver Coastal Health

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Appendix A

Interview Questions

Section 1: For Russ Maynard and Insite Employees

Issues surrounding the current situation:

1. What were the main reasons behind the opening of Insite, what were the barriers, and what challenges does Insite currently face?
2. What is the pending situation regarding Insite's legal status? What is the expected outcome of the current trial and what are the main arguments being put forth, and on what basis is its operation being challenged?

The program's success:

3. As of yet, what do you feel has been the program's biggest success and how do you measure this success? Is it in terms of stopping drug use altogether, promoting healthy behaviour, and/or preventing deaths from overdose?
4. What are the difficulties in accurately measuring these rates? How can Insite ensure that users don't engage in risky behaviour during its closing hours?
5. Is there a specific way, or method by which users are measured for research purposes?
6. What has been the main barrier in gaining federal approval/full legality? Do you feel it has to do with the type of behaviour (drug use) or the population of users (poor, minorities, mentally challenged)?
7. How has the public reacted so far to the program? Has there been an increase or decrease in public support? During this past year a lot was made of cleaning up Vancouver for the winter Olympics. Was there an attempt to hide, or remove Insite from the public sphere and public discussion during the games?
8. How does Onsite operate, how do users generally feel about that program, and do you encourage them to make use of its services?

Legal Issues:

9. What is the main argument for Insite's operation?
10. What measures will you take if the Supreme Court overturns the decision to allow Insite to operate?
11. Who is arguing the case, and on what basis?

Human Rights issues:

12. Do you feel that the users' rights (such as right to health care) are being denied or infringed upon by our current drug laws? Is it unfair to have a set of laws simply penalizing behaviour without taking into account context? To what extent do you feel that the response is inequitably being applied to this group?
13. Can a rights claim be raised when the individual is knowingly engaging in a harmful behaviour? Is it improper to blame a system that was designed to prevent this problem in the first place?

Goals/Plans for the Future:

14. If granted legality what changes would you wish to make, or add to the current program?
15. Do you feel that more of an attempt should be made to encourage users to make use of Onsite, or to get off drugs entirely?

16. Is there a chance of remaining open for 24 hours a day?
17. In Germany they have needle vending machines in similar types of neighbourhoods, do you think that is a possibility in Canada as well? If Insite loses its status, could these alternative measures be undertaken to help achieve similar results as when it was operational. Are there alternative strategies in place in case of a loss.

Section 2: For Insite users and members of the DTES

Personal Views:

1. What do you think of the Insite facility? Have you ever used it's services or do you know people who have?
2. Do you have any suggestion on how its services can be improved?

Knowledge of the site:

3. Are you aware of the current legal situation surrounding Insite?
4. Do you feel it has had a positive impact on the community?
5. Are you worried about policing of the site?
6. What challenges do you experience living in the DTES and dealing with police hostility?
7. Do you experience any problems with Gastown residents?