MPC MAJOR RESEARCH PAPER

THE CASE FOR SAFE INJECTION SITES: EXAMINING 'HARM REDUCTION' IN INSITE'S COMMUNICATION STRATEGIES

DEBBIE KWAN

Dr. Susan Cody

The Major Research Paper is submitted
in partial fulfillment of the requirements for the degree of
Master of Professional Communication

Ryerson University
Toronto, Ontario, Canada

August 31, 2012

AUTHOR'S DECLARATION

I hereby declare that I am the sole author of this Major Research Paper and the accompanying Research Poster. This is a true copy of the MRP and the research poster, including any required final revisions, as accepted by my examiners.

I authorize Ryerson University to lend this major research paper and/or poster to other institutions or individuals for the purpose of scholarly research.

I further authorize Ryerson University to reproduce this MRP and/or poster by photocopying or by other means, in total or in part, at the request of other institutions or individuals for the purpose of scholarly research.

I understand that my MRP and/or my MRP research poster may be made electronically available to the public.

ABSTRACT

The term "harm reduction" has been used as a label for certain policies and programs in the field of illicit drugs for many years, but there has never been a universal definition for the term or unanimous consensus on how the term should be used. Some proponents argue that harm reduction must be a movement that challenges traditional drug laws, while others believe that harm reduction should chiefly be a public health approach that aims to improve the overall health of drug users. Some scholars hail harm reduction for taking an amoral and value-neutral position towards drug use, while others criticize it for devaluing human rights and perpetuating the marginalization of drug users. Drawing on Foucault's framework of governmentality, Petersen and Lupton's (1996) concept of the "new public health," and Goffman's (1963) theories on stigma, this research investigates the types of claims and arguments that InSite—Canada's only supervised injection site and perhaps its most recognized harm reduction program—uses in its website and press releases to characterize and justify its services. Three news articles from *The Vancouver Sun* are also examined for a comparison of the complexities and diverse viewpoints that often arise in descriptions and defenses of harm reduction, supervised injection service, and illicit drug use.

ACKNOWLEDGEMENTS

I wish to thank my supervisor Dr. Susan Cody for her commitment, encouragement, and support. Dr. Cody's insight helped me navigate through the critical issues of this project with greater confidence. I also thank my second reader Dr. Jean Mason for her thoughtful advice and Dr. Catherine Schryer for her guidance in the early stages of research.

TABLE OF CONTENTS

Introduction

> The advantage of using 'harm reduction' or 'harm minimization' as a slogan or policy label is obvious. Who, in their right mind, could oppose the notion of reducing harm? (Nadelmann, 1993, p. 37).

It appears that "harm reduction," despite its positive connotation, has become a term that is used with caution in the arena of public health in Canada. In the aptly titled article, "The Redlining of Harm Reduction Programs," published in the *Canadian Medical Association Journal*, Webster (2012) states, "harm reduction programs are anathema to Prime Minister Stephen Harper's governing Conservative party" (p. E21). In December 2006, for example, federal funding was withdrawn from the safe tattooing programs in prisons (Webster, 2012). In October 2007, harm reduction approaches were purposely excluded from the National Anti-Drug Strategy (Webster, 2012). In May 2008, the only fixed-site needle exchange program in Victoria was forced to discontinue due to pressures from the community (Webster, 2012). Cathy McIsaac, executive director of Direction 180—a methadone clinic in Halifax—affirms, "You can't even use the term harm reduction anymore when applying for federal funding. The taps have been turned off" (as cited in Webster, 2012, p. E21).

Harm Reduction International (n.d.) defines harm reduction as "policies, programmes and practices that aim primarily to reduce the adverse health, social and economic consequences of the use of legal and illegal psychoactive drugs without necessarily reducing drug consumption." Although harm reduction can be applied to various substances, such as alcohol and tobacco, and has been applied to other areas of public health, such as prostitution and safe sex education, this paper focuses specifically on harm reduction as it relates to the use of illicit drugs, such as heroin and cocaine.

One of the most discussed harm reduction programs in Canada is perhaps InSite, a supervised injection site—commonly referred to as a "safe injection site"—located in Vancouver's Downtown Eastside. As a facility that provides unconditional health services to drug users, InSite is a harm reduction program because it employs nurses to supervise injections of illicit drugs with the primary aim of reducing risks and harms associated with drug use—such as the transmission of HIV through contaminated needles—rather than of ending drug use itself. Opened in 2003 under Liberal rule, InSite is the only supervised injection site in Canada as well as North America. When Stephen Harper's conservative party came into power in 2006, the government tried to deny InSite an exemption to federal drug laws required by InSite to operate. The case was eventually brought to the Supreme Court of Canada in 2011, which ruled in InSite's favour and granted the facility an indefinite exemption to the Controlled Drugs and Substances Act so that it could remain open. However, despite InSite's success, other cities in Canada have been struggling to launch sites of their own. In Toronto, for example, Health Minister Deb Matthews, Mayor Rob Ford, and Police Chief Bill Blair have all expressed resistance to the idea of opening a supervised injection site in the city despite the recently released Toronto and Ottawa Supervised Consumption Assessment Study, which recommends that Toronto would benefit from having three such facilities (Paperny, 2012).

There are several reasons why supervised injection sites and the harm reduction approach in general face much opposition, not least from federal, provincial and municipal governments. First, a central tenet of harm reduction is that it accepts the inevitability of people engaging in risky and criminal behaviour. Since society generally views drug use and addiction as undesirable, some people don't understand why drug users should be assisted to use drugs. They regard programs like needle exchanges, methadone treatments, and safe injection sites as

facilitators of criminal activity. In fact, as stated previously, InSite needs a constitutional exception to the Controlled Drugs and Substances Act to operate. Second, since harm reduction aims to *minimize the harmful effects* of drug use rather than *end* drug use itself, critics of the approach do not see it as a viable option for drug treatment or policy. They tend to favour the conventional "war on drugs" approach, which espouses a drug-free society and believes that those who use and distribute drugs should be incarcerated (Marlatt, 1996).

To complicate matters further, there are tensions within the circle of harm reduction workers and proponents. One source of disagreement concerns the ambiguity of the definition and its inability to state clearly what exactly harm reduction entails. According to Ball (2007), "The term 'harm reduction' has been used variously to describe a principle, concept, ideology, policy, strategy, set of interventions, target and movement" (p. 684). It has also been used interchangeably with "harm minimization," "risk reduction," and "risk minimization" (Riley et al., 1999). No universal agreement on a definition or use of the term exists (Ball 2007); thus it can be, and has been, applied to all manner of measures and policies. According to Riley et al. (1999):

> Some harm-reduction advocates consider the reform of laws prohibiting drug possession to [be] an integral part of harm reduction, while others do not. Some persons consider the imprisonment of drug users for simple possession to be a form of harm reduction. Practitioners dedicated to abstinence may also think of themselves as reducing the harms of substance use. (p. 10).

Another source of disagreement concerns the changes harm reduction has experienced since its inception. Rather than maintaining the initial "bottom-up" approach in which drug users advocate for equal rights and a legal system that doesn't oppress drug users, harm reduction has in many ways adopted a "top-down" approach in which drug users are expected to accept the authority of health professionals and be regulated for their own wellbeing (Roe, 2005). More

than twenty years have passed since the inauguration of harm reduction at the first International Conference on the Reduction of Drug Related Harm in Liverpool, but there continue to be debates about the rhetoric driving the movement and whether it is heading in the right direction.

In light of these complex issues, advocates of harm reduction face many challenges in communicating its benefits and value to policy makers and the public. Not only do they need to consider what types of arguments and claims they should make, but they also need to consider what type of harm reduction they are advocating. This paper investigates how one harm reduction program in particular—InSite—contends with these issues in its communication strategies in order to defend its policies. Questions guiding the research and analysis include: How does InSite define and characterize harm reduction? What strategies does InSite use to defend its harm reduction model? What type(s) of claims, evidence, or arguments does InSite use to justify its programs and policies? First, a review of literature offers some additional insight into the challenges of conceptualizing and thus communicating harm reduction.

Literature Review

The Roots of Harm Reduction

According to Riley (as cited in Riley and O'Hare, 2000), the origins of harm reduction can be traced back to North America, the Netherlands, and the United Kingdom. In Canada beginning in the late 1950s and the United States in the early 1960s, methadone maintenance programs became increasingly recognized as a strategy to reduce the harmful effects opioid drug use had on society (Riley & O'Hare, 2000). For example, crime rates decreased, and because doses of methadone were shown to relieve individuals of the cravings and serious effects of heroin addiction, drug users were able to stabilize their habits and reintegrate into the workforce (Rosenbaum, 1997). According to Newman (as cited in Rosenbaum, 1997), methadone was extoled as a "medical breakthrough…a Cinderella drug, which could be economically applied to hundreds of thousands of addicts, and, in short order, solve the narcotics problem" (p. 69). Thus, a significant feature in the emergence of harm reduction was the reconceptualization of substance use and abuse as a public health concern rather than a problem that only affected individuals (Erickson, 1999).

In the Netherlands, a number of important changes to national drug policies led many to regard the Dutch as the true pioneers of harm reduction (e.g. Roe, 2005; Marlatt, 1996; MacCoun, 1998; Inciardi & Harrison, 2000). In the 1960s, the growing prevalence of marijuana use and the difficulties of enforcing laws against it prompted the government to set up several commissions to search for more pragmatic solutions (Cohen, 1997; Roe, 2005). The resulting reports published in the late 1960s and early 1970s warned of the "counter-productive potential" of criminalizing drug use and of stigmatizing drug-using subcultures, especially with respect to soft drugs such as marijuana, which were often instances of youth experimentation and not

necessarily harmful (Cohen, 1997, p. 27). In 1972, The Narcotics Working Party in the Netherlands published a report advocating changes to traditional drug policies to better reflect the amount of risk involved in the consumption of different drugs and to ensure that consumers of marijuana were not suffering more harm from criminalization than from use of the drug itself (Engelsman, 1989; Marlatt, 1996). These recommendations were highly influential and policies thereafter recognized that if legal sanctions and criminal proceedings worsened the drug problem, they should logically be left aside (Engelsman, 1989).

According to Engelsman (1989), the Dutch opted for a "normalized" treatment policy in which "drug takers or even addicts [were neither] seen as criminals, nor as dependent patients, but as 'normal' citizens of whom [were made] 'normal' demands and to whom [were offered] 'normal' opportunities" (p. 215). In other words, the "drug user" was not to be seen as a special category of persons; the act of using drugs was not to be sensationalized or mythologized but instead discussed more openly (Engelsman, 1989). In addition, the government increasingly questioned abstinence based approaches; they began to favour programs aiming primarily to enhance drug users' physical health and social wellbeing (Engelsman, 1989). The government also recognized that in order to help drug users remain functional members of society, health and support services needed to be accessible to everyone. In other words, services needed to take a "low-threshold" approach and diminish barriers that could prevent drug users from seeking help (Marlatt, 1996). Open-door policies and fieldwork in jails, hospitals, and on the street, for example, would enable more people to receive assistance and get involved in treatment (Engelsman, 1989). The "Junkiebonden" (Junkie League), a type of trade union for drug addicts that formed in Rotterdam in 1980, was instrumental in providing these low-threshold services (Engelsman, 1989; Marlatt, 1996). One of their fundamental philosophies was that drug users

themselves knew best what impacted their wellbeing; thus they became advocates for their own needs and played a significant role in effecting the changes that improved their own livelihoods (Marlatt, 1996).

In 1984, the Junkiebonden helped establish the first needle exchange program in Amsterdam in an attempt to curb the spread of hepatitis B among injection drug users (Riley & O'Hare, 2000). The Junkiebonden received sterile needles and syringes from the Municipal Health Service for distribution and collected used equipment from drug users (Marlatt, 1996). Collaboration between drug users and public health officials was therefore also important in the early development of harm reduction programs (Roe, 2005). Later, in the mid-1980s during the HIV/AIDS crisis, needle exchange programs grew in popularity: van Brussel and Buning (1988) note that the quantity of exchanged needles and syringes increased from 100,000 in 1985 to 700,000 in 1987.

In the United Kingdom, the "harm reduction approach" was formally recognized in 1990 at the first International Conference on the Reduction of Drug Related Harm in Liverpool (Erickson, Riley, Cheung, & O'Hare, 1997). The conference, sponsored by the Merseyside Health Authority (Marlatt, 1996), was prompted in part by the success of the Mersey model of harm reduction as well as several other risk reduction programs implemented in countries such as the Netherlands and Australia (Erickson et al., 1997; Riley & O'Hare, 2000). Merseyside had become a model for harm reduction policy due to three key factors (Riley & O'Hare, 2000). First, the local drug dependence clinic prescribed opioids to patients so that they could avoid the most severe effects of addiction and continue to lead productive lives (Riley & O'Hare, 2000). Second, in 1986 the Mersey Regional Drug Training and Information Centre established the first syringe exchange program in the United Kingdom to provide sterile equipment to drug users in

the area, and third, the local police were cooperative with the policies and began to refer drug users to support services rather than arrest them (Riley & O'Hare, 2000). The HIV/AIDS crisis added to the import of the conference since the search for more pragmatic measures to prevent transmission among injection drug users became especially crucial (Erickson et al., 1997). Although harm reduction strategies previously showed promise as an alternative approach to drug treatment, it was the immediate threat of HIV being spread to the larger population that enabled the entry of harm reduction strategies into official drug policies and gave public health measures primacy over the traditional incarceration and punishment of drug users (Berridge, 1999; Erickson, 1999).

Problems of Definition

According to Jourdan (2009), the pursuit of a "workable consensus definition" (p. 516) for harm reduction continues despite numerous international conferences and articles that have attempted to provide some clarity. Jourdan (2009), for example, devised an inventory that assesses twenty-five different assumptions in the areas of drug control, treatment, and prevention to show the contrast between what is harm reduction and what is *not* harm reduction ("non-harm reduction"). Lenton and Single (1998) attempt to settle differences by classifying existing definitions of harm reduction in *narrow* or *broad* terms. According to Lenton and Single (1998), narrow definitions exclude policies and programs that have an abstinence-based component while broad definitions comprise any program or policy designed to reduce drug-related harm, including those with abstinence-based components (Lenton & Single, 1998).

Other scholars have attempted to define harm reduction by outlining its core principles. For instance, Riley et al. (1999) present the following features as integral to harm reduction: pragmatism (reducing drug-related harms is more feasible for the benefit of the community than

eliminating drug use altogether), humanistic values (an amoral, non-judgmental stance is taken towards any level or amount of drug use), a focus on harms (reducing risks and harmful consequences of drug use should take precedence over the fact or extent of drug use itself), balance of costs and benefits (the inclusion of measures to evaluate interventions is needed so that resources can be focused on priority issues), and priority of immediate goals (the most pressing needs should be considered first).

Marlatt (1996), on the other hand, distinguishes harm reduction as an *alternative* to traditional approaches in the addictions field. First, harm reduction takes a public health approach, which contrasts with the conventional moral/criminal and disease/medical models of drug use and treatment (Marlatt, 1996; Erickson et al., 1997). The moral/criminal approach—also known as the prohibitionist or "war on drugs" approach (Erickson et al., 1997)—frames heroin addiction as "morally wrong" and heroin addicts, as well as drug dealers, as criminals deserving of punishment (Marlatt, 1996, p. 785). Legal sanctions and law enforcement are thus put in place to reduce the supply of drugs and to work towards a drug-free society (Marlatt, 1996; Erickson et al., 1997). The disease/medical model frames heroin addiction as a biological illness that needs rehabilitation and drug users as ailing patients who need to be cured of their destructive behaviours (Marlatt, 1996; Erickson et al., 1997). Thus, prevention and treatment efforts focus on reducing the individual's demand for drugs (Marlatt, 1996). Unlike the moral/criminal and disease/medical approaches that aim for the reduction, or elimination, of drug use, harm reduction focuses only on the consequences of drug use (Marlatt, 1996). According to Marlatt (1996), harm reduction programs and policies do not consider whether drug use is right or wrong, nor do they require individuals who use drugs to remedy their desire for drug use.

The harm reduction approach, then, also presents itself as an alternative to programs that view abstinence as the only acceptable goal for drug treatment (Marlatt, 1996). Marlatt (1996) suggests that the harmful effects of drug use can be placed along a continuum with abstinence at one end and harmful consequences at the other. Thus, harm reduction promotes a "step-down" approach, which encourages drug users to move towards abstinence—an ideal outcome—but accepts as a viable goal any step to reduce the harmful effects of drug use (Marlatt, 1996). Third, harm reduction is a "low-threshold" alternative to traditional high-threshold approaches to drug treatment (Marlatt, 1996). By providing easier access to drug services, by reducing the stigma associated with drug use, and by recognizing that drug use often coincides with other high-risk behaviours and therefore should be viewed as "maladaptive coping responses rather than as indicators of either physical illness or personal immorality" (Marlatt, 1996, p. 788), harm reduction promotes a low-threshold approach, which breaks down the barriers drug users often face when seeking help (Marlatt, 1996).

Nevertheless, a constant obstacle to gaining a universal definition for harm reduction is the difficulty in characterizing harm itself (Lenton & Single, 1998; Ball, 2007; MacCoun, 1998; Riley et al., 1999). According to Ball (2007), "Harm occurs at different levels (individual, family, community, society) and in different forms (health, economic, social) and its measurement is often value-laden and determined by cultural norms and beliefs" (p. 686). Thus, calculating a program or policy's net gain or loss of harm may not be possible (Lenton & Single, 1998), and what exactly is entailed in reducing the most substantial harms becomes another source of contention.

Disagreements in Ideology and Rhetoric

The lack of a clear definition for harm reduction is also caused largely by disagreements among proponents about the key motivations that should underlie the movement and the core ideals that should be promoted in its name. Firstly, there are disputes about the extent harm reduction should get involved in drug law reform. Although many assert that harm reduction is absolutely distinct from drug legalization (e.g. Riley et al., 1999; Lenton & Single, 1998), others argue that if drug prohibition is the cause of significant harms, changes should logically be made (Nadelmann, 1993). Roe (2005) recalls the history of the harm reduction movement and notes how it began with drug user activists working with public health authorities to challenge the enforcement of futile drug laws. He argues that the current movement risks being a "brand" and a self-contained "paradigm" that has lost sight of its original intention to effect social change (Roe, 2005). According to Roe (2005), harm reduction has become a medical service that promotes health to "unreachable" communities, and by default has become a form of top-down control to elicit compliance from the very drug users who initiated the movement in the first place. He questions this new stance the movement has taken because although it doesn't criticize drug users and drug addiction, it doesn't criticize the legal, economic, and social systems that produce them either (Roe, 2005). Roe (2005) asserts that this path may be dangerous because while harm reduction minimizes harm in the short term, it may continue to sustain harmful systems in the long term.

After examining key accounts of harm reduction in the literature of previous international conferences, Hathaway (2001) criticizes the movement's weakening rhetorical strategy in its increasing emphasis on pragmatism over the concern for morals and human rights. He asserts that in order for harm reduction to progress it must prove its underlying morality (Hathaway,

2001). According to Hathaway (2001), the right to autonomy could be an effective argument, especially in view of evidence that some drug use is not necessarily harmful. For example, studies of adolescent drug experimentation have shown that those who experiment with drugs tend to be psychologically healthier than those who abstain or use them frequently (Hathaway, 2001). However, in harm reduction's reluctance to challenge prevalent notions of drug use in drug policy discourse, free will and autonomy are deemed to have no value (Hathaway, 2001).

In response to Hathaway's (2001) argument regarding the need for morality and human rights to be considered in the role of public health, Keane (2003) argues that an amoral and value-neutral perspective is in fact a powerful rhetorical strategy in the highly politicized climate of drug policy. According to Keane (2003), there are too many variables and questions in the realm of morals and human rights that would prevent harm reduction from making such claims. For instance, there are arguments that it is society's duty to protect vulnerable people from risk and harm but, as Hathaway (2001) asserts, society has the moral obligation to grant people freedom and autonomy (Keane, 2003). These contradictions are unavoidable during debates about human rights; there will always be competing interest groups to consider (Keane, 2003). For example, in regards to harm reduction, Keane (2003) asks: Is it the rights of drug users' free will that need to be protected or the rights of taxpayers (to not have to pay for drug users' habits) that need to be protected? Further, Mugford (1993a) indicates that a measure of "monetary values" may provide the only "universal" and "trans-contextual" (p. 23) assessment of harms. According to Mugford (1993a), "Harm reduction, then, must offer cost-benefit analyses of drug policies, otherwise harm is left unmeasured and one cannot make harm-*reduction* choices" (p. 23).

Reinarman (2004) questions the notion that the harm reduction movement must make a choice between giving primacy to public health or to human rights. Reinarman asserts that neither perspective described by Hunt (2004)—a public health perspective prioritizes the optimization of the entire population's health while a human rights perspective prioritizes the individual's right to sovereignty over his or her body—would be sufficient in all situations. According to Reinarman, the movement's "blending" (p. 240) of human rights and public health is precisely what has given the movement so much strength.

Recognizing the competing goals and priorities endorsed by different proponents of harm reduction, Tammi (2004) theorizes harm reduction as a school of thought consisting of three segments[1]. According to Tammi (2004), the most dominant has been the professional segment which is motivated by public health professionals, focuses on medically oriented care, and relies on evidence-based knowledge to justify their movement. In contrast, the mutual-help segment is motivated by drug users, focuses on rights to equal citizenship, and relies on tacit knowledge to defend their movement; thirdly, the global justice segment is motivated by global activists, focuses on ending the U.S. war on drugs, and relies on ethics and human rights as validations for their movement (Tammi, 2004). Rather than attempt to forge one common understanding for harm reduction, Tammi (2004) proposes that it "should be seen as a policy community consisting of [segments] that are in dialogue with each other and thus constantly redefining the meaning of harm reduction" (p. 395).

Governmentality and the "New Public Health"

Foucault's framework of governmentality has been used to critique the way drug users are governed in modern public health contexts (e.g. Miller, 2001; Roe, 2005; Mugford, 1993b;

[1] Tammi (2004) actually uses the term "fractions" throughout the paper to describe the three sub-groups in the harm reduction school of thought. Although it appears that "factions" is the appropriate term, I will use the term "segments" in this paper.

Fischer, Turnbull, Poland, & Haydon, 2004; Petersen & Lupton, 1996). According to Gordon (1991), Foucault defines "government" as "the conduct of conduct…a form of activity aiming to shape, guide or affect the conduct of some person or persons" (p. 2). "Governmentality," then, refers to:

> [A] way or system of thinking about the nature of the practice of government (who can govern; what governing is; what or who is governed), capable of making some form of that activity thinkable and practicable both to its practitioners and to those upon whom it was practised. (Gordon, 1991, p. 3).

With respect to public health, the government of individuals has increasingly taken the form of strategies designed to elicit self-discipline and regulation (Roe, 2005; Fischer et al., 2004; Petersen & Lupton, 1996). The identification and calculation of risks, for example, have enabled health promoters and agencies to endorse and validate certain interventions devised to prevent dangers from occurring (Petersen & Lupton, 1996). Cautionary messages such as the negative effects of smoking or the diseases caused by high sugar diets are disseminated widely throughout the public domain; individuals are thus called upon to monitor and control the behaviours (e.g. quit smoking, consume less sugar) that may put them at risk (Petersen & Lupton, 1996). Although the government regulates certain "risky" activities, such as smoking and alcohol consumption (e.g. they are restricted to certain ages and locations), the view that they are in fact "risky" pervades through the social body; thus when individuals engage in risky behaviours—whether legally or illegally—they are aware that they are putting themselves in the path of danger and that perhaps they should cease such activities. Regarding harm reduction programs, Miller (2001) asserts that while they seemingly allow drug users to consume drugs more freely, they are at the same time putting drug users under greater control by employing medical professionals to watch over and counsel them on proper—or safer—consumption techniques. Petersen and Lupton (1996) posit that this "government at a distance" (p. 19) is central to the

"new public health,"[2] which is "about the exercise of a particular form of power: one that presupposes and employs the regulated freedom of individuals to act in one way or another" (p. 26).

In addition, work on "the body" has become a central project in the new strategies of risk management (Petersen and Lupton, 1996). According to Petersen and Lupton (1996), it is through the body that "the individual can express publicly such virtues as self-control, self-discipline, self-denial and will power—in short, those qualifications considered important to being a 'normal', 'healthy' human being" (p. 25). Thus, according to Crawford (1994), the "healthy" body has become an indicator of merit and moral worth in contemporary Western society. Further, Petersen and Lupton (1996) propose that the new public health produces a new code of morality because attaining good health is no longer only considered a right of citizens, but also an *obligation*. Since good health is required for people to fulfil certain duties of citizenship such as staying active in the workforce, good health is also required for one to be deemed a "good citizen" (Petersen & Lupton, 1996). Consequently, the drug user is positioned as a "responsibilised agent whose prime responsibility—and 'right'—it is to manage the risks to self and others associated with his/her drug use" (Fischer et al., 2004, p. 358).

Moreover, in their critique of supervised injection sites, Fischer et al. (2004) assert that a key argument for such facilities is their potential to remove "disorderly" and "deviant" populations from urban centres and thus allow for the gentrification and re-claiming of city spaces for business and wealthy consumers. The displacement of drug users to hidden and peripheral spaces further marginalizes them (Fischer et al., 2004) and is in fact contradictory to

[2] According to Petersen and Lupton (1996), the "old" public health movement was predominantly concerned with sanitary reform and the control of infectious diseases that resulted in high mortality rates. At the end of the twentieth century, non-infectious conditions such as cancer and cardiovascular disease, as well as "lifestyle" issues such as diet and exercise, became the focus of "new" public health activities.

the core principles of harm reduction. In addition, those who are unable or unwilling to take the opportunity to transform themselves into "healthy" citizens are consequently differentiated and labelled as "high-risk," "beyond help," and "dangerous" (Fischer et al., 2004, p. 363). As a result, under the guise of public safety, disciplinary measures enforced on these drug users will appear warranted, and supervised injection sites, rather than replacing a penal approach to illicit drug use, may actually "enable and legitimise the maintenance or even amplification" of traditional methods of repression (Fischer et al., 2004, p. 363).

Stigma

According to Petersen and Lupton (1996), the prominence of epidemiology is also a principal strategy employed in the new public health. Since epidemiology relies on "rational," "scientific" methods to study disease and identify risk factors, the resulting measurements and standardizations tend to establish notions of what is considered "healthy" or "unhealthy" and to provoke moral judgements about social groups who are deemed at risk (Petersen & Lupton, 1996). Rumbold and Hamilton (as cited in Miller, 2001) find the dependence public health has on epidemiology problematic because "the discursive effect of epidemiological knowledge is in the allocation of the labels, such as 'normal' and 'abnormal' or 'pathological'" (p. 174). Through the examination of entire populations rather than individual cases, individuals are categorized by group characteristics; thus, the "epidemiological perspective may de-personalize and further marginalize the drug user" (p. 174). Petersen and Lupton (1996) also indicate that the "war on drugs" discourse places "otherness" upon drug users and consequently renders them as sites of "badness" (p. 55) and "contamination" from which majority groups need protection.

In his work on stigma, Goffman (1963) classifies people into three groups according to their "social identity" or, in other words, the way people are perceived and expected to act in

social situations. Goffman (1963) refers to the individuals who have a discreditable attribute—for example a "failing," "shortcoming," or "handicap" (p. 3)—as having a stigma and belonging to an "out" group comprised of members who share the same stigma. Members of this "out" group experience a similar plight as they all possess a quality that could interfere in daily interactions and might prevent them from being accepted by the "normals" of society (Goffman, 1963). Goffman (1963) refers to "normal" individuals who do not possess the "undesired differentness" (p. 5), and thus do not have to contend with issues of acceptance, as members of the "in" group. Third, the "wise" are those who are normal and from the "in" group, but have gained some sort of acceptance with the "out" group (Goffman, 1963). The "wise," for example, may be related to a stigmatized individual or may come to know individuals with a particular stigma through their employment (Goffman, 1963). Essentially, wise persons are sympathetic to the situation of the stigmatized, and "are the marginal [people] before whom the individual with a fault need feel no shame nor exert self-control, knowing that in spite of his failing he will be seen as an ordinary other" (Goffman, 1963, p. 28).

This paper investigates whether current harm reduction programs and policies can be considered "wise." In theory, the harm reduction approach is "wise" because it aims to view drug users as normal people and not in terms of their stigma (their drug use or addiction). However, given the aforementioned critiques of public health and Roe's (2005) assertion that current harm reduction discourse is sacrificing the normalization of drug users in favour of extoling medical and economic benefits to society, harm reduction's position as the "wise" may be difficult to uphold in practice. Mugford (1993a) warned long ago that the conception of harm reduction is problematic because harm reduction cannot reasonably claim all that it claims—for example, to

question traditional drug laws, to make policies more humane, to empower drug users—under the same label.

In the following sections, InSite's communications are examined for the ways they conceptualize harm reduction and the ways they characterize the drug users they aim to help. In studying the types of justifications and strategies InSite uses to defend its policies, this paper asks: What trajectory of harm reduction does InSite seem to follow? What harm reduction principles are most strongly reinforced and communicated by North America's only supervised injection site?

Methodology

Communications related to InSite present an important case study because as North America's only supervised injection site, InSite is often hailed as a prototype. In addition, because supervised injection service does not yet receive widespread acceptance, InSite continually needs to defend its practices and policies to various stakeholders. This was especially the case between the years 2006 and 2011 when the conservative federal government tried to deny the facility a constitutional exception to the Controlled Drugs and Substances Act—an exception that was needed by the facility to remain in operation. During this period, InSite received extensive media coverage, particularly in 2011 when the case was taken to the Supreme Court of Canada, which finally ruled on September 30, 2011 that InSite would be granted an indefinite exemption.

Data collection for this study consists of three parts. First, the InSite website and how the facility is presented to the public in general is examined. Vancouver Coastal Health, the health authority which is funded by the government of British Columbia and operates InSite in conjunction with Portland Hotel Society (PHS) Community Services, hosts the website. The website is divided into different webpages containing information about InSite's services, location, clients, research, legal status, media centre, and contacts. An eight-minute promotional video is also posted on InSite's homepage.

Second, the press releases issued by InSite during the Supreme Court of Canada trial in 2011 and the ways in which the facility was presented to the public during a period of increased media attention are examined. These two press releases (see appendices) are linked to the media centre page on InSite's website. The first (Appendix A) was issued on May 11, 2011, the day before the trial began, and the second (Appendix B) was issued on September 30, 2011, the day

of the ruling. To situate these press releases in a larger context and against possible differing viewpoints available to the public during the Supreme Court of Canada trial, a sample of news articles that were published at the beginning and end of the trial (the same period the press releases were issued) is also examined.

For this purpose, three articles from *The Vancouver Sun*, the largest regional newspaper in the city where InSite is located and where the ruling would certainly have an impact, were selected. The first two articles were published on May 12, 2011 (the first day of the trial) and report the news of the trial from the perspective of two external InSite supporters. The first narrates the story of Dean Wilson, a former drug user and plaintiff in the case. The second, written by Maxine Davis, the Executive Director of The Dr. Peter AIDS Foundation, affirms the "increasingly mainstream" nature of supervised injection service as demonstrated by The Dr. Peter Centre's own successful inclusion of supervised injection service in its programs which serve people living with HIV/AIDS. The third article was published on October 1, 2011 (the day following the court's decision) and reports on the ruling that InSite had won the legal battle against the conservative government and could remain open.

For the analysis, a modified grounded theory approach is used. Themes emerging from any claims, arguments, and evidence used to justify, characterize, or describe InSite's programs and services are identified. At the same time, however, concepts are influenced by themes and theories previously acknowledged in the literature review. For the news articles, any claims, arguments, and evidence used to question or oppose InSite's programs, services, and policies are also considered.

Due to the modest scope of this study—i.e., all the data are public documents and no representatives or employees of InSite, Vancouver Coastal Health, or PHS Community Services

are contacted—the results of the analysis cannot be contextualized by the intentions and motivations guiding InSite's rhetorical strategy. Thus the results are limited to an analysis of InSite's communications as they are ultimately presented. Similarly, given that the news writers are not contacted and their background, expertise, and objectives are not substantially investigated, the examination of the news articles is limited to a study of statements pertaining to InSite, supervised injection service, and harm reduction which are available to the public on the dates that InSite's press releases were published.

Results and Discussion

InSite: Website and Press Releases

The following table summarizes concepts that were identified in the examination of InSite's website (http://supervisedinjection.vch.ca/) and two press releases (see appendices).

Concept	Definition	Example
Medicalization	A reference to the facility as a provider of medical treatment and/or a description of its services as clinical in nature.	Since opening its doors in 2003, InSite has been a safe, health-focused place where people inject drugs and connect to health care services – from primary care to treat disease and infection, to addiction counselling and treatment, to housing and community supports. [Website, Homepage] In addition to supervised injection services, InSite offers a variety of other clinical services to its clients on Vancouver's Downtown Eastside such as wound care, counselling, abscess/vein care, foot care and referral to other health and addiction services. [Press Release: Appendix B]
Benefits to Health	A claim about the positive effect(s) the facility and its programs have on the health and wellbeing of clients/drug users, including the number of lives being saved.	Dr. John Blatherwick of Vancouver Coastal Health reports: "The number of overdose deaths clearly go down. The number of HIV infections clearly goes down in the group that use these sites." [Website, Video] Chief Medical Health Officer of Vancouver Coastal Health Dr. Patricia Daly: "The health benefits of InSite are many. In addition to reducing the risk of overdose deaths, there is a reduction in high risk injection behaviour associated with HIV and Hep C transmission among users. There is a reduction in behaviour that increases risk of other serious infections including sepsis and endocarditis. InSite nurses also treat skin and soft tissue infections and provide

		immunizations." [Press release: Appendix A]
Scientific/Statistical evidence	Objective claims, facts or statistics, which support the facility, its operations, or outcomes.	This study [Reduction in overdose mortality after the opening of North America's first medically supervised safer injecting facility: a retrospective population based study. Published in *The Lancet*, April 2011] found that fatal overdoses within 500 metres of InSite decreased by 35% after the facility opened compared to a decrease of 9% in the rest of Vancouver. [Website, Research section] There have been no overdose deaths in the site despite more than 1,500 overdose interventions, some of which have included full respiratory arrest. [Press releases: Appendix A, Appendix B]
Benefits to Society	A claim about the positive effect(s) the facility and its programs have on other people and the community.	Narrator: "In an effort to reduce the health risks and ease the pressure on hospital emergency rooms, Vancouver Coastal Health has built a supervised injection site at 139 East Hastings, a first for North America." [Website, Video] President and CEO of Vancouver Coastal Health Dr. David Ostrow: "…Earlier intervention on the part of InSite staff has not only saved lives but also alleviated the pressure on paramedic and hospital services which benefits everyone." [Press release: Appendix A]
Characterization of Clients as Not Normal	A description, depiction, portrayal of, or attribute assigned to the clients served by the facility and its programs as outside the norm, needing help, or disadvantaged.	About half of the people who use InSite are marginalized, which means they are homeless or living in shelters or have significant mental health issues. [Website: Our Clients section] It [Vancouver Coastal Health] also provides other services through OnSite, a no-appointment detox facility in the same building as InSite that has successfully served a significant number of this difficult-

		to-treat client group. [Press releases: Appendix A, Appendix B]
Endorsement	A quote or a mention of support from a significant body, organization, government, or person that approves the facility and its programs.	Heather Hay, Vancouver Coastal Health: "Everyone's involved in this. Our partners include the city, the police, health partners, the IV drug using community, the community at large, not-for-profit organizations like the Portland Hotel Society." [Website, Video] Last week, the BC Coroner's Service recommended IV drug users attend InSite for safety reasons due to tainted heroin circulating and causing overdoses in the province. [Press release: Appendix A]

Given that InSite is a public health facility funded by Vancouver Coastal Health, it is not surprising that the facility, both on its website and press releases, is portrayed in accordance with what Tammi (2004) labels as the "professional segment" of harm reduction. InSite refers predominantly to its facility as medical in nature, presents benefits to health as a major rationale for the necessity of its programs, and provides statistics and other objective measures as evidence to support its functions and achievements.

Conrad and Schneider (as cited in Erickson et al., 1997) use the term "medicalization of deviance" to explain the medical profession's widening reach in the management of "deviant behaviours" (p. 5), such as drug addiction, which were not always considered to be matters of medicine. This medicalization process redefines drug addiction as an illness and corresponds with the disease/medical model of drug use and treatment, which Erickson et al. (1997) and Marlatt (1996) explain should be distinct from the harm reduction model. Although InSite generally does not characterize drug use as a disease requiring medical attention, it does

demonstrate an inclination to do so, whether it is a result of InSite actually viewing drug addiction as a medical problem or of a rhetorical strategy attempting to make supervised injection service more saleable. This medicalization of deviance is especially evident in one statement contained in the September 30, 2011 press release. Dr. Julio Montaner, Director of the BC Centre for Excellence for HIV/AIDS, states, "We are thankful for the continued and unwavering support from the provincial government that has allowed us to set an example in Canada and the world for how to deal with addiction which is, indeed, *a medical condition* [emphasis added]" (Appendix B).

In most other instances, InSite's communications demonstrate a different sort of medicalization—one that echoes Tammi's (2004) "professional segment" of harm reduction in its emphasis on providing medically oriented care to improve the overall health of individuals. For example, the description of InSite as a medical establishment where clients receive health care services is particularly evident in the "Services" section of the website:

> InSite was not designed to be a stand-alone facility. It's part of a continuum of care for people with addiction, mental illness and HIV/AIDS. It was designed to be accessible to injection drug users who are not well connected to health care services. Partnering with PHS Community Services Society enabled Vancouver Coastal Health to bring health services to the Downtown East Side community in a way that was more accessible and pertinent.
>
> For people with chronic drug addiction, InSite is the first rung on the ladder from chronic drug addiction to possible recovery; from being ill to becoming well. (InSite, n.d., Services).

The consistent accounts of InSite being a facility where people get health treatment are epitomized in the subtitle on the homepage of InSite's website: "A health-focused place for people to connect with health care services" (InSite, n.d., Home). Further, the recurrent references to the presence and participation of nurses—not least in their role of supervising drug use at InSite—reinforces the clinical atmosphere of the facility.

Correspondingly, as the assumed outcome of seeking medical attention, benefits to health are presented as major justifications for InSite's services. According to Petersen and Lupton (1996), the attainment of good health has long been understood by Western society to be a citizen's right. In the new public health, Milio (as cited in Petersen & Lupton, 1996) posits that public policy is expected to "create environments" that enable individuals to "develop and pursue their personal views of 'health'" (p. 17). Thus, citing examples of medical conditions that cause poor health—such as the contraction of HIV and Hepatitis C from sharing needles or the forming of ulcers from untreated abscesses—to demonstrate why InSite's services are necessary coincides with, and appeals to, prevalent values that health and wellbeing should be achievable for all people. Moreover, highlighting conditions that could be treated by InSite emphasizes the harmful consequences of drug use—which many would likely agree should be prevented—rather than the fact of drug use itself. In the video posted on InSite's website, Dr. John Blatherwick from Vancouver Coastal Health states candidly, "The reason people should care is people are dying." By presenting a dire and widely recognizable harm, Dr. Blatherwick may be showing that the supervised injection site is not about facilitating drug use, but rather it is about saving people's lives.

The third feature that demonstrates InSite's parallel conceptualization to the professional segment of harm reduction outlined by Tammi (2004) is InSite's use of statistics and other objective measures to validate its clinical functions and benefits. For example, both press releases cite the following: "Since [2003], more than 1.8 million injections have been done at the facility under the supervision of nurses" (Appendix A; Appendix B). Research studies by third parties are also frequently mentioned to reinforce the value-neutral, scientific legitimacy of the facility and to affirm the health benefits that InSite is purported to yield. Detailed, quantitative

records of InSite's activities are displayed as well, further demonstrating their commitment to evidence-based medicine. A sample of statistics contained in InSite's May 11, 2011 press release is shown below:

- Total overdose interventions = 221
- Fatalities to date = nil
- Principle substances reported were heroin (36% of instances), cocaine (32%) and morphine (12%)
- Total referrals to health and addiction services = 5,268, mostly to detox and addiction treatment
- Total nurse treatment interventions, including wound care, abscess/vein care, foot care and other skin care = 3,383
- Total admissions to OnSite[3] detox = 458.

(Appendix A)

According to Tammi (2004), evidence-based knowledge has been vital to the professional movement of harm reduction; the conduction of numerous studies has equipped many proponents with proof of its effectiveness. Petersen and Lupton (1996) assert that there is an emphasis on evaluation in the new public health, with rational, scientific, and epidemiological devices being used not only to assess the success of public health programs, but also to construct "truths" about public health problems. Potter, Wetherell, and Chitty (1991) explain that statistics bring into effect the discursive strategy of "quantification rhetoric," or "the manner in which numerical and non-numerical quantity formulations are deployed when proposing and undermining argumentative cases" (p. 333). Often employed in depictions of epidemiological data, quantification rhetoric tends to imply that the precise measurements and numbers presented are unquestionable facts, especially when reinforced by visual graphs and charts (Petersen & Lupton, 1996). Accordingly, InSite's rigorous presentation of research and statistics may

[3] OnSite is the detoxification facility located above InSite in the same building. Also operated by Vancouver Coastal Health and PHS Community Services, OnSite admits clients who are prepared to access withdrawal services. It is presented as "part of a continuum of care for people with addiction, mental illness and HIV/AIDS" (InSite, n.d., Services). Displaying the number of OnSite admissions in InSite's communications could thus reinforce—whether intentionally or unintentionally—the traditional notion that quitting drugs is a valued outcome and appease those who believe InSite is a deterrent to abstinence-based programs.

strengthen its persuasive power by suggesting that there is no uncertainty about the quoted successes achieved by the facility, such as the number of admissions to detox or the number of overdose interventions.

In addition, Mugford (1993b) indicates that harm reduction strategies, as well as its rhetoric, have been influenced by the growth of rationalism and the "logic of utilitarian cost-benefit analysis" (p. 373). According to Lenton and Single (1998), basing policy decisions on hard empirical evidence has been standard practice since the beginnings of harm reduction. Although they recognize that it is impossible to quantify aggregate harm, Lenton and Single (1998) assert that at the very least, some attempt should be made to provide evidence that the intervention or policy decision will likely reduce the net amount of drug-related harm. Thus, an appeal to "economic rationalism" (Miller, 2001) has always motivated the harm reduction movement**,** and value-neutral economic benefits to society have often been used as validation for harm reduction programs (Roe, 2005; Hathaway, 2001).

It is somewhat surprising, then, that the benefits of InSite to the larger community are not as prevalently cited as justifications for InSite's policies. Although identifying the primary users and target audience of the website and press releases is outside the scope of this paper, and thus it is not known whether InSite has chosen to tailor its claims to pacify specific audience groups, it appears that InSite gives more primacy to the improved health of individuals than to the financial savings for the community. In addition, the few instances in which benefits to society are employed to defend InSite's services are primarily contained in the video displayed on the website's homepage. For example, Dr. John Blatherwick of Vancouver Coastal Health and Sheree Hudson of Pender Community Health Centre discuss in the video the huge burdens caused by intravenous drug use on the healthcare system which InSite helps to alleviate (InSite,

n.d., Home). Thus, presenting claims about InSite's benefits to society primarily in the format of a video, which is more difficult to access than a medium designed for reading—for example, a quieter or more private location is needed to listen to the video, special software might be needed to open the video file—further pushes claims of InSite's benefits to society to the background. This might suggest that InSite is attempting to demonstrate a focus on drug users and a priority on minimizing the harms posed to their health and wellbeing. It is also possible that InSite expects more non-drug users to view the video than drug users and thus the messages in the video are more attentive to the resistances and objections that might be raised by "normals" in the community.

However, even if InSite exhibits concern for the welfare of drug users by giving greater emphasis to the benefits its services have on their overall health, InSite does not exactly reflect in its communications the notion that drug users should be empowered or that there should be no stigma associated with drug use. The other benefits to society presented on InSite's website are not typified as economic and actually demonstrate InSite's tendency to suggest that drug users can be a public nuisance. For example, a section of the video poses the question, "How will it benefit the community at large?" (InSite, n.d., Home, timestamp 06:58). In response, Dr. John Blatherwick of Vancouver Coastal Health states, "The benefit for the community is they don't have these people in the alleyways, in the crawl spaces, all over the place, shooting up drugs. They're in a safe, warm place, they're off the street. The community benefits both ways" (timestamp 07:01). Although this statement reflects compassion for drug users and presents the value of providing them with a "safe, warm place," it also depersonalizes drug users and perhaps even associates them with the vermin that is usually imagined to occupy places like "alleyways" and "crawl spaces." Moreover, InSite asserts that a key reason for the importance of its services

is that "it brings stability to the community by improving public order and reducing the number of injections taking place on the street" (InSite, n.d., Location). Thus, the suggestion that the relocation of drug use from the street (where it can be seen by the public) to inside the facility (where it is concealed from the public) would bring stability and improve public order functions as an appeal to the community, but at the same time it reinforces the labels of "deviant" and "disorderly" on drug users, which further marginalizes them (Fischer et al., 2004). The benefit of InSite to society, then, is presented as having a community more free from the "deviance" of drug use, and the notion that drug users are a group of people who need or warrant regulation resonates in InSite's statements.

These examples also demonstrate that the clients served by InSite are characterized throughout InSite's communications as not normal. Rather than portraying drug users as individuals who have made the free choice to use drugs, drug users are framed throughout InSite's communications as "marginalized," "vulnerable," and a "difficult-to-treat" client group. Moreover, claims about free will, autonomy, or even drug users as normal people with rights, are absent in the website and press releases. Thus, rather than using language that works to "normalize" drug users and far from reflecting the priorities of the "mutual-help segment" described by Tammi (2004), which rely on the tacit knowledge of drug users to promote equal citizenship, drug users are characterized by InSite as a disadvantaged group that needs, and perhaps deserves, help and support from the larger community. This is further shown on the Clients page of the InSite website:

> About half of the people who use InSite are marginalized, which means they are homeless or living in shelters or have significant mental health issues.
>
> Many of our clients are older and have been using drugs for a long time. Their long-term drug use and chaotic lives have seriously compromised their overall health. (InSite, n.d., Our Clients).

Highlighting the poor health and living conditions of InSite's clients also portrays the clients as being "at risk." Petersen and Lupton (1996) explain, "To be labeled as being 'at risk' means entering a state in which an apparently healthy body moves into a sphere of danger" (p. 48). In new public health discourses, a sense of moral obligation and personal responsibility is placed upon those deemed "at risk" to act upon those risks and prevent the associated illnesses and dangers from occurring (Petersen & Lupton, 1996). Thus, by underlining the vulnerability of drug users served by the facility, InSite is in effect depicting itself as the "dutiful" body who has taken on the responsibility of transforming hard-to-reach populations into "healthy citizens."

Further, InSite exhibits the view that drug users need to be reached and provided guidance. In the video (InSite, n.d., Home) displayed on the website, Sheree Hudson of Pender Community Health Centre states:

> Hopefully we'll reach a population that we don't normally reach. That don't come to the clinics for help unless they're in dire straits. Or don't go to the emergency department. And once they come in to the supervised injection site, and they see that it's okay, they can come in, they can use safely, people are there to help them, support them, and we can go about *educating them* [emphasis added]. (timestamp 03:25).

This characterization of InSite's clients highlights that there is something "wrong" (with drug users) requiring that they be remediated. Thus, rather than taking a non-judgmental and amoral stance towards drug use, InSite's language choices reflect a judgmental and moral stance on *safer drug use*. Those who refuse to be "reached" or come to the facility, then, risk being depicted as especially difficult and maybe even "immoral."

These connotations of drug users needing help and education also exemplify Roe's (2005) assertion that the harm reduction movement has moved away from being a drug user centered approach to being a model that places drug users under the surveillance of medical professionals. Also, rather than situating itself as Goffman's (1963) "wise" and representing drug

users as "ordinary others" (p. 28) in its language choices, InSite tends to imply that drug users may in fact have a discreditable quality. Thus, it appears that InSite might be surrendering the normalization of drug users and the value of human rights in its rhetoric in order to endorse the public health benefits of its facility and services. InSite may believe that ensuring the health of the entire population is most important and that tolerating the portrayal of drug users as a stigmatized group is acceptable.

However, even though InSite's communications do not generally characterize drug users as "normal," they do attempt to position the facility in the domain of what is considered "normal"—that is, in the sense that members of the majority accept its policies and practices—in part by its wide use of endorsements. InSite's two press releases, for example, include several statements by executives of Vancouver Coastal Health commending the health care services offered by the facility and its saving of many lives. According to Petersen and Lupton (1996), endorsements invoke the influential device of expertise, which is also central to the governing powers of the new public health. Petersen and Lupton (1996) explain:

> Public health expertise can be seen, then, as a particular example of a more general deployment of expert knowledge for shaping the thoughts and actions of subjects in order to make them more useful and 'governable'. In order that subjects be governable, however, social life needs to be rendered into a calculable form; for example, in the form of reports, pictures, numbers, charts, graphs and statistics…Public health has developed many techniques for defining and circumscribing a governable terrain, and in this respect expert 'theories' play a decisive role (p. 15).

Thus the medical establishment, with its foundation in "objective" scientific data, has particularly been able to articulate, justify, and deploy programs of government (Rose and Miller, 1992). Accordingly, InSite's use of endorsements by medical experts may strengthen its claims of having a positive impact on the community.

News Articles

In McKnight's (2011) article published on May 12, 2011—the first day of the Supreme Court of Canada trial—McKnight tells the story of Dean Wilson, the very first user of InSite's services in 2003. McKnight reveals that Dean Wilson had struggled with drugs since the age of twelve and after many attempts to quit, had finally managed to end his 40-year drug habit at OnSite, the detoxification facility housed above InSite. Health benefits, including psychological, physical, and spiritual wellbeing, are cited most often in this article to support InSite's services. For example, Wilson speaks about InSite's "offer of hope," "InSite [giving drug users] a sense of self worth," and "InSite [saving] lives" (McKnight, 2011).

However, the first justification of the importance of InSite, which opens the article, differs significantly from those observed in InSite's communications. McKnight (2011) states, "Dean Wilson does not shoot drugs at InSite. In fact, he doesn't shoot drugs at all. And this is precisely why the supervised injection site must remain open." Although it is possible that McKnight is confusing InSite with OnSite, this statement endorses InSite's significance as being a facility that helps drug addicts *end* drug use, which is at odds with a central assumption of harm reduction: abstinence is not a goal for drug treatment. Further, the use of metaphors such as "mistress" is used to characterize drugs throughout the article, thus indirectly underpinning the moral stance on drug use generally taken by society and reinforcing the notion that drug use is morally corrupt, not conventionally acceptable, and, like a mistress, should be hidden from public view. As a result, the drug user is situated outside the norm and InSite is portrayed in parallel with approaches that value "use reduction" (Marlatt, 1996, p. 785). Moreover, a spiritual theme permeates the article, which sensationalizes drug use and drug addiction further. McKnight (2011) writes:

> In keeping with the spiritual motif, we can also say that Wilson has been no angel in his life, since he confesses to, among other things, having sold a lot of drugs back in the day. But freed as he is now from the physical and psychological bonds of drug addiction, he can finally dream of a future for himself, and it is a future that promises spiritual redemption as well.

Although the elimination of, or freedom from, drug use in theory is not a priority for supervised injection sites or most other harm reduction programs, McKnight (2011) uses it liberally as a defence for InSite, which perhaps demonstrates the ease with which the principles of harm reduction get misinterpreted and or misrepresented. McKnight (2011) again reaffirms the destructive nature of—and hence the need for release from—drug addiction at the conclusion of the article:

> While proudly declaring "I am not a drug addict," Wilson promises that he will spend the rest of his life helping others to become free as well, that he will address the damage done by drugs and the politics of drugs, that ultimately, he will "stand with the users and fight this until the day I die." (McKnight, 2011).

Petersen and Lupton (1996) note that members of stigmatized groups themselves often adhere to the attributions of what is "decent" and "indecent" and make moral judgements about others regarding risk status. Notions about the corruptness of drug use and the discreditable quality of drug addiction thus remain unquestioned and unchallenged.

In the second news article written by Davis (2011) aptly titled "InSite is increasingly mainstream," Davis emphasizes the normality and "increasingly mainstream thinking" of supervised injection service by claiming that supervised injection service has been successfully incorporated into the range of health care services that The Dr. Peter AIDS Foundation, the centre she represents, offers. Similar to InSite's communications, Davis' (2011) commentary employs the concepts of medicalization, benefits to health, and scientific/statistical evidence to defend the practice of supervised injection service. For example:

> A March 2011 report from the B.C. Office of the Provincial Health Officer, Decreasing HIV Infections Among People Who Use Drugs by Injection in British Columbia:

> Potential Explanations and Recommendations for Further Action, recommends that access to supervised injection services should be incorporated into routine public health clinics through B.C., using the Dr. Peter Centre model. (Davis, 2011).

Thus, Davis (2011) also emphasizes a public health rationale in accordance with Tammi's (2004) "professional segment" of harm reduction. However, the device Davis (2011) uses most prominently in her arguments is endorsements. For example, Davis (2011) highlights the support supervised injection service receives from the regulatory body for nursing in British Columbia: "The College [of Registered Nurses of British Columbia] confirmed that it was within the scope of registered nursing practice to provide individuals with evidence-based information so they can give themselves injections more safely, and that teaching and promoting such self care prevents illness and promotes health." Further, Davis (2011) portrays The Dr. Peter Centre's supervised injection service as an ordinary part of the neighbourhood and asserts that its presence should present no reason for any sort of controversy:

> The Centre, a part of Vancouver's downtown West End neighbourhood alongside heritage houses, daycares, and elementary school and, in the midst of a bustling urban life, continues to provide the service in its day health program and 24-hour skilled nursing care residence. (Davis, 2011).

However, even though Davis (2011) affirms that services provided to aid drug use are widely acceptable and should be considered "normal," she also implies that drug use is not. After explaining that teaching safer injection techniques promotes health and is within the standards of registered nursing practice, Davis (2011) adds, "Nurses do not touch, inject, or provide the drugs." Thus, Davis (2011) suggests that although supervising injections is expected to be part of a nurse's routine, any sort of role in administering the drugs is not. Distance is therefore created between nurses and drugs and the notion that drug use is not necessarily acceptable and is the domain of those outside the mainstream is once again implied.

The third article published on October 1, 2011 reports on InSite's success in the Supreme Court of Canada trial and offers the most diverse claims and arguments for analysis. Firstly, similar to InSite's communications and Davis' (2011) article, Mulgrew and O'Neil (2011) include benefits to health and scientific/statistical evidence as justifications for InSite's services. For example, Mulgrew and O'Neil (2011) explain that InSite was "launched as an experiment," which has "proven successful" and "has saved lives and improved health…without increasing the incidence of drug use and crime in the surrounding area" (Mulgrew & O'Neil, 2011, Harper Disappointed section, para. 7). Instances of medicalization are also included, but similar to InSite's communications, they tend to reflect the disease/medical model of drug use from which harm reduction models are theoretically distinct. Following are two examples:

> The judges said the ability to make choices must be weighed against the 2008 B.C. Supreme Court finding that addiction is a "disease in which the central feature is impaired control over the use of the addictive substance." (Mulgrew & O'Neil, 2011, Disease Impairs Control section, para. 3).

> "Their 'war on drugs' has not worked in Canada and has proven to be an abject failure everywhere else in the world. Addiction is a medical problem and requires medical and public health solutions," [B.C. Liberal MP Hedy Fry] said. (Mulgrew & O'Neil, 2011, Disease Impairs Control section, para. 15).

Although the second example distinguishes the "war on drugs" as a different approach, it aligns InSite's policies with the disease/medical approach and demonstrates again the confusion that often occurs in regards to what is harm reduction and what is not harm reduction.

Several themes were found to occur more prominently in the news articles—especially in Mulgrew and O'Neil's (2011) report—than in InSite's communications. They are outlined in the following table.

Concept	**Definition**	**Example**
Rights	A reference to a person's rights, including those in	Delivered by Chief Justice Beverley McLachlin, the high court's decision said

	the Charter of Rights and Freedoms, which is used to justify the facility's programs and policies.	Ottawa's attempt to close InSite was "arbitrary" and undermined the protection of health and public safety, a violation of the Charter of Rights. [Mulgrew & O'Neil, 2011]
Morality	An explicit characterization or indication of drug use, treatment, or policy as either moral or immoral.	Misplaced moral judgments have underpinned the neglect of people who inject drugs. Yet, it is wholly immoral to let people become infected with HIV or die when evidence based interventions exist to prevent these outcomes. A bold and human response is needed from governments. Lives are at stake. [Davis, 2011]
Opposing Argument	Any critical statement or rival point of view presented or made against the value of the facility and its programs.	Of course, detractors claim that InSite does validate drug use, that it merely enables and escalates users' self-destruction. [McKnight, 2011]

First, given that the news articles report on the Supreme Court of Canada trial, it is not surprising that the concept of rights emerged. However, the rights mentioned are not the rights to autonomy that Hathaway (2001) suggests should underlie the rhetoric of harm reduction. On the contrary, the rights mentioned pertain to a person's right to health and safety, as declared by the Charter of Rights and Freedoms. In Mulgrew and O'Neil's (2011) news article, a person's right to be free from disease is deemed more important than criminal laws prohibiting the use of drugs:

> The nine justices ruled unanimously Friday that citizens' health matters more than criminal anti-drug laws…Their decision said that the federal drug law is valid, constitutional and applies to InSite, but the effect of denying addicts the services of InSite increased their risk of death and disease and that outweighed "any benefit of the criminal drug prohibition." (para. 2).

Second, although the concept of morality makes a rare appearance in the data and is inconsistent in the way it is used to address drug issues, it is a noteworthy theme to examine

because it is usually a key subject of contention in harm reduction debates. For example, Mulgrew and O'Neil (2011) report:

> The ruling addressed the argument of some small-c conservatives that drug addicts have made a personal moral choice, and therefore shouldn't be assisted by the state in breaking the law… The ruling also said "morality" is irrelevant when it comes to determining Charter rights. (Disease Impairs Control section, para. 2).

This instance leaves intact traditional beliefs about the immoral nature of drug use by implying that drug use is wrong. However, in her editorial, Davis (2011) quotes an online commentary by *The Lancet*, a prominent medical journal, and presents another form of morality judgement: the immorality of denying injection drug users access to adequate healthcare, to proven interventions that prevent HIV infection, and to services that can save their lives. Keane (2003) indicates that the high manipulability of what is considered moral or immoral makes it difficult for morality claims to be made. Thus, by excluding such claims in its communications, InSite may be avoiding the challenges of having to defend them.

Given the contentious nature of InSite's policies, it is also worthwhile to examine the opposing statements made against the supervised injection site contained in the news articles. First, McKnight's (2011) article about Dean Wilson includes one opposing point of view. McKnight (2011) raises the question of whether InSite may in fact be validating the harmful and destructive activity of drug use. All other instances exhibiting opposing arguments are observed in Mulgrew and O'Neil's (2011) article on the Supreme Court of Canada ruling. Mulgrew and O'Neil (2011) report that Prime Minister Stephen Harper's government was disappointed with the ruling, "which has thrown open the door across the country to new supervised injection sites, dubbed 'shooting galleries' by conservative critics" (para. 6). Moreover, Mulgrew and O'Neil (2011) explain that Former Tory Health Minister Tony Clement is largely opposed to the ruling because he believes "the facility and similar 'harm reduction' programs diverted money from

proper addiction-treatment programs" (Disease Impairs Control section, para. 10). According to Harper (as cited in Mulgrew & O'Neil, 2011), "The preference of this government in dealing with drug crime is obviously to prosecute those who sell drugs and create drug addiction in our population and in our youth" (Harper Disappointed section, para. 4).

Thus, the news articles demonstrate that conventional sentiments regarding the moral corruptness of drug use, InSite's exacerbation of these "corrupt" activities, and the ideal of a prohibition/criminal model in dealing with drug use and treatment are employed to contest the practices of InSite. In fact, the Conservative government is shown to view the prohibition/criminal model as the only acceptable approach to drug policy: "The clinic was approved under the former Liberal government of Prime Minister Jean Chretien and the Conservatives always opposed it, balking at the idea addiction is an illness best treated by doctors instead of jailers" (Mulgrew & O'Neil, 2011, Disease Impairs Control section, para. 6).

Further, Harper not only criticizes InSite's supervised injection program but also misappropriates the term "harm reduction." For example, Harper (as cited in Mulgrew & O'Neil, 2011) states, "And when it comes to treating drug addiction, [the preference of the government is] to try and do so through programs of prevention and treatment, rather than through the issues that were in front of this court in terms of *so-called harm reduction* [emphasis added]" (Harper Disappointed section, para. 5). In this example, Harper is explicitly sceptical and dubious about InSite's capability to reduce harm.

The most unanticipated finding in this study, however, is that "harm reduction" is barely discussed in InSite's communications. In fact, there is absolutely no mention of "harm reduction" in InSite's press releases and only one mention of the term on InSite's website: "InSite operates on a harm-reduction model, which means it strives to decrease the adverse

health, social and economic consequences of drug use without requiring abstinence from drug use" (InSite, n.d., Home). This paper has already shown that various scholars have noted problems with the term and have questioned its functionality. Leshner (2008) goes further and suggests that the term "harm reduction" should be eliminated altogether because it has become to many a "euphemism" (p. 513) for drug legalization and policies too lenient toward drug use. As demonstrated in the sample of data examined in this paper, the most frequent mentions of "harm reduction" are contained in Mulgrew and O'Neil's (2011) news article and occur in statements exposing the opposition between Stephen Harper's conservative government and "harm reduction" approaches. In view of the minimal references to harm reduction in InSite's communications, it is possible that InSite does not wish to be associated with all the politics, misconceptions, and ambiguities associated with the term.

Since issues of legalization remain contested—for example, many people seem to be ready to accept the public health principles that underlie harm reduction, but not legalization or the granting of freedom for people to use whatever drugs they desire (Reinarman, 2004)—Leshner (2008) believes that the ideology behind the term has become a barrier to science and therefore should be "expunged" (p. 513) from the field. Hall (2007) also wonders whether it is sensible to hold on to a term that evokes so many different interpretations and attracts so much antagonism. Hall (2007) proposes:

> [W]e simply describe the strategies collected currently under the 'harm reduction' banner (and any new measures that prove to be similarly efficacious) as 'public health' measures for injecting drug use and HIV/AIDS. After all, that is what they are and that is how they can best be justified. (p. 692).

It is possible that rather than facing the potential—and onerous—task of defending harm reduction in its entirety, InSite has chosen to represent itself simply as a public health program with its own set of policies, goals and practices designed to service and improve the health of

injection drug users. It is also possible that the lack of references to harm reduction has been a result of convenience since it might be easier for InSite to describe its programs and policies in terms of specific public health measures than in terms of the harm reduction principles that support them. These speculations cannot be confirmed due to the scope and limitations of this study (only public documents are examined and no representatives at InSite are contacted), but additional research on InSite in the future could clarify whether InSite is in fact phasing out the use of "harm reduction" or if other reasons account for the term's absence in InSite's communications.

Conclusion

The examination of themes contained in InSite's communications has shown that InSite identifies with Tammi's (2004) "professional segment" of harm reduction and takes a public health approach to drug treatment and policy. In other words, by emphasizing the medically oriented character of the facility, by presenting benefits to health as a primary goal for its services, and by using objective, scientific measures as evidence of its achievements, InSite portrays itself as a public health program that addresses and alleviates issues of drug addiction in Vancouver's Downtown Eastside. In addition, InSite cites the wide support it receives from medical and public health experts as well as its benefits to society (although to a lesser extent) to affirm the importance of its programs.

These types of characterizations and justifications for InSite, however, seem to come with the cost of leaving the stigma associated with drug use intact. InSite characterizes its clients—injection drug users—as disadvantaged, needing help, and not normal, and subscribes to the ideas and expectations of "the new public health" posited by Petersen and Lupton (1996). By presenting its programs as capable of reaching "difficult-to-treat" populations who are "at risk" of events such as drug overdoses or diseases such as HIV, and capable of instructing them on how to practice the "risky" activity of injecting drugs in a safer, healthier, and "less risky" way, InSite appeals to the notion that helping people become responsible citizens who minimize the risks posed to themselves and others is a worthy cause.

Therefore, although InSite in essence takes a non-judgmental stance toward drug use by the very fact that it accepts the occurrence of drug use in the facility, it cannot truly claim to exhibit the value-neutral and amoral stance that is hailed by several proponents of harm reduction (e.g. Keane, 2003; Riley et al., 1999; Strang, 1993). Rather than implying judgment on

drug users for engaging in risky activities, InSite's communications imply judgment on drug users for engaging in *riskier drug use.* Petersen and Lupton (1996) assert that "the new public health is at its core a moral enterprise" (p. xii), and implications that citizens have the duty to avoid risk and lead the healthiest lifestyles possible—as well as help others avoid risk and lead the healthiest lifestyles possible—resonate in InSite's justifications of its policies. By reinforcing the notion that "healthy" is proper, and thus "unhealthy" is improper, InSite redefines moralist views toward drug use by suggesting that using drugs more safely under the supervision of nurses is "right" while using drugs outside the facility where there exist more risks is "wrong."

The inferences contained in InSite's justifications also exemplify Roe's (2005) assertion that harm reduction policies are increasingly requiring drug user groups "to accept the authority of medical and social service professionals in order to be deemed 'functional' and healthy organizations"; those who show resistance risk being "categorized as 'hard to reach' and 'service resistant' individuals who still need to be 'brought into service'" (p. 247). In addition, both InSite's communications and the news articles examined in this paper demonstrate an orientation to the disease/medical model of drug policy, which depicts drug users as being disabled by drug addiction. According to Roe (2005), this enables "newly mainstreamed harm reduction" to voice concern for the marginalization of drug users "in terms of medical outcomes" (p. 243) while remaining acquiescent to the existing social and legal systems that cause the marginalization. Further, InSite's communications provide evidence for Hathaway's (2001) allegation that harm reduction rhetorical strategies are moving away from the promotion of human rights, particularly the individual's right to autonomy, as a key argument and driving force for the movement. It appears, then, that promoting a public health rationale that values the welfare of citizens and relies on the expertise of medical science for the management of "health problems" may indeed

present the most palatable and effective argument for a harm reduction program such as a supervised injection site, which tends to garner much controversy. According to Reinarman (2004):

> The public health principles that [undergird] harm reduction practices have afforded much needed political legitimacy to controversial policies. This legitimacy is a precious resource, some of which might be jeopardized if the movement were to give loud primacy to the right to use whatever drugs one desires and to make legalization its principal policy objective. (p. 240).

The communications of other supervised injection sites, such as those in Europe or Australia, or the justifications of other harm reduction programs, such as needle and syringe exchanges, would present interesting case studies for future research. The manner in which these organizations choose to characterize harm reduction, the rationales they employ to defend their policies, and even their inclusion or omission of references to "harm reduction," would provide an illuminating comparison to the findings in the present study. In addition, the portrayal of drug users in other communications—such as those by the Junkiebonden in the Netherlands where the "normalization" of drug users is supposedly valued—would be worthwhile to examine, especially in exploring harm reduction's potential to be "wise" (Goffman, 1963) in the management of stigma in drug policy. Reinarman (2004) questions why the harm reduction movement must make a choice between public health and human rights. The question should perhaps be rephrased as: Can harm reduction judiciously defend both public health and human rights? Since this paper demonstrates that InSite accepts the characterization of drug users as not normal in order to endorse its public health rationale, a question for further research could be: Is it possible for InSite to promote public health values while also reducing the stigma associated with drug use?

Other challenges remain in the defense of InSite's policies. An inspection of the opposing

arguments made against InSite has shown that fear of the facility's programs increasing the rate of drug addiction among the population is still an obstacle to acquiring more enduring support for InSite. Thus, it may be effective for InSite's strategies in the future to exhibit more prominently the research demonstrating that InSite's programs do not in fact increase or promote the use of injection drugs. Currently, the only instances of such evidence are contained in the report, "Findings from the Evaluation of Vancouver's Pilot Medically Supervised Safer Injecting Facility – Insite," linked to the research page of InSite's website. For example:

> The study ["Circumstances of first injection among illicit drug users accessing a medically supervised safer injection facility"] found that the average InSite user had been injecting for 16 years. Only one person out of 1,065 reported performing their first injection at InSite. This strongly suggests that InSite has not promoted illicit drug injecting, but rather that it has attracted individuals with long histories of injection drug use. (Urban Health Research Initiative, 2009, p. 25).

In addition, even though promoting OnSite's detoxification services and highlighting the number of drug users who quit their drug habits through OnSite may give undue privilege to the value of abstinence and reinforce traditional notions of drug use, InSite may be able to assuage fears of unhampered drug use by emphasizing more of OnSite's functions.

Rival arguments also advocate the superiority of the prohibition/criminal approach to drug use and treatment. Thus, it may be constructive for InSite to demonstrate that the public health/harm reduction approach (whether or not it names it explicitly as such) is a viable, perhaps even more advantageous, alternative to drug treatment and policy. This is especially crucial in light of the March 12, 2012 passing of the conservative government's omnibus crime legislation (Bill C-10), which includes in its plans tougher sentences for drug offences. According to Rob Boyd, director of the Oasis Program at the Sandy Hill Community Health Centre in Ottawa, "The new drug legislation will further stigmatize an already stigmatized group…It will severely impede their ability to recover from their substance use disorder and it will put people in the

highest risk environment of all, prisons" (as cited in Webster, 2012, p. E21). With Stephen Harper's government currently in power with a majority, the situation for harm reduction programs will most likely get worse (Webster, 2012). Some organizations have already decided to replace "harm reduction" labels in policy descriptions with terms such as "secondary risk reduction" to circumvent the federal government's aversion to anything designated as harm reduction (Webster, 2012). The scarcity of references to "harm reduction" in InSite's communications may suggest that InSite has chosen to employ this strategy as well.

Hall (2007) makes an important point when he states, "'harm reduction' has probably reached its 'use-by date'" (p. 692). Perhaps using the term "harm reduction," which continues to cause much confusion and according to Mugford (1993a) is a great "sound bite" but may be a sound bite that will come to haunt us (p. 32), has to be forfeited—at least temporarily in Canada—in order for its underlying principles, goals, and policies to progress.

References

Ball, A. L. (2007). HIV, injecting drug use and harm reduction: a public health response. *Addiction, 102*(5), 684-690. doi:10.1111/j.1360-0443.2007.01761.x

Berridge, V. (1999). Histories of harm reduction: Illicit drugs, tobacco, and nicotine. *Substance Use and Misuse, 34*(1), 35-47. doi:10.3109/10826089909035634

Cohen, P. D. A. (1997). The case of the two Dutch drug-policy commissions: An exercise in harm reduction, 1968-1976. In P. G. Erickson, D. M. Riley, Y. W. Cheung, & P. A. O'Hare (Eds.), *Harm reduction: A new direction for drug policies and programs.* Toronto, ON: University of Toronto Press.

Crawford, R. (1994). The boundaries of the self and the unhealthy other: Reflections on health, culture and AIDS. *Social Science & Medicine, 38*(10), 1347-1365. doi:10.1016/0277-9536(94)90273-9

Davis, M. (2011, May 12). InSite is increasingly mainstream. *The Vancouver Sun.* Retrieved from http://ezproxy.lib.ryerson.ca/login?url=http://search.proquest.com/docview/866461661?accountid=13631

Engelsman, E. L. (1989). Dutch policy on the management of drug-related problems. *British Journal of Addiction, 84*(2), 211-218. doi:10.1111/j.1360-0443.1989.tb00571.x

Erickson, P. G., Riley, D. M., Cheung, Y. W., & O'Hare, P. A. (Eds.). (1997). *Harm reduction: A new direction for drug policies and programs.* Toronto, ON: University of Toronto Press.

Erickson, P. G. (1999). Introduction: The three phases of harm reduction. An examination of emerging concepts, methodologies, and critiques. *Substance Use and Misuse, 34*(1), 1-7. doi:10.3109/10826089909035631

Fischer, B., Turnbull, S., Poland, B., & Haydon, E. (2004). Drug use, risk and urban order: Examining supervised injection sites (SISs) as 'governmentality'. *International Journal of Drug Policy, 15*(5), 357-365. doi:10.1016/j.drugpo.2004.04.002

Goffman, E. (1963). *Stigma: Notes on the management of spoiled identity.* New York, NY: Simon & Schuster, Inc.

Gordon, C. (1991). Governmental rationality: An introduction. In G. Burchell, C. Gordon, & P. Miller (Eds.), *The Foucault effect: Studies in governmentality with two lectures by and an interview with Michel Foucault* (pp. 1-51). Chicago, IL: The University of Chicago Press.

Hall, W. (2007). What's in a name? *Addiction, 102*(5), 692. doi:10.1111/j.1360-0443.2007.01812.x

Harm Reduction International. (n.d.). Harm Reduction International statement on what is harm reduction. Retrieved from http://www.ihra.net/what-is-harm-reduction

Hathaway, A. D. (2001). Shortcomings of harm reduction: toward a morally invested drug reform strategy. *International Journal of Drug Policy, 12*(2), 125-137. doi:10.1016/S0955-3959(01)00085-8

Hunt, N. (2004). Public health or human rights: what comes first? *International Journal of Drug Policy, 15*(4), 231-237. doi:10.1016/j.drugpo.2004.02.001

Inciardi, J. A., & Harrison, L. D. (Eds.). (2000). *Harm reduction: National and international perspectives.* Thousand Oaks, CA: Sage publications, Inc.

InSite. (n.d.) Our Clients. Retrieved from http://supervisedinjection.vch.ca/our_clients/

InSite. (n.d.). Home. Retrieved from http://supervisedinjection.vch.ca/home/

InSite. (n.d.). Our Location. Retrieved from http://supervisedinjection.vch.ca/our_location/

InSite. (n.d.). Services. Retrieved from http://supervisedinjection.vch.ca/services/

Jourdan, M. (2009). Casting light on harm reduction: Introducing two instruments for analysing contradictions between harm reduction and 'non-harm reduction'. *International Journal of Drug Policy, 20*(6), 514-520. doi:10.1016/j.drugpo.2009.02.011

Keane, H. (2003). Critiques of harm reduction, morality and the promise of human rights. *International Journal of Drug Policy, 14*(3). 27-32. doi:10.1016/S0955-3959(02)00151-2

Lenton, S., & Single, R. (1998). The definition of harm reduction. *Drug and Alcohol Review, 17*(2), 213-220. doi:10.1080/09595239800187011

Leshner, A. (2008). By now, "harm reduction" harms both science and the public health. *Clinical Pharmacology & Therapeutics, 83*(4), 513-514. doi:10.1038/sj.clpt.6100478

MacCoun, R. J. (1998). Toward a psychology of harm reduction. *The American Psychologist, 53*(11), 1199-1208. doi:10.1037/0003-066X.53.11.1199

Marlatt, G. A. (1996). Harm reduction: Come as you are. *Addictive Behaviors, 21*(6), 779-788. doi:10.1016/0306-4603(96)00042-1

McKnight, P. (2011, May 12). Plaintiff is living proof of InSite's value to community; Supervised injection site returns feeling of self-worth to addicts, says Dean Wilson, who has been clean for 15 months and counting. *The Vancouver Sun.* Retrieved from http://ezproxy.lib.ryerson.ca/login?url=http://search.proquest.com/docview/866461665?accountid=13631

Miller, P. G. (2001). A critical review of the harm minimization ideology in Australia. *Critical Public Health, 11*(2), 167-178. doi:10.1080/09581590110039865

Mugford, S. (1993a). Harm reduction: Does it lead where its proponents imagine? In N. Heather, A. Wodak, E. A. Nadelmann, & P. O'Hare (Eds.), *Psychoactive drugs and harm reduction: From faith to science* (pp. 21-33). London, UK: Whurr Publishers Ltd.

Mugford, S. (1993b). Social change and the control of psychotropic drugs risk management, harm reduction and 'postmodernity'. *Drug and Alcohol Review, 12*(4), 369-375. doi:10.1080/09595239300185461

Mulgrew, I., & O'Neil, P. (2011, October 1). InSite wins fight to stay open; Ruling on controversial injection site a defeat in Harper government's war on drugs. *The Vancouver Sun.* Retrieved from http://ezproxy.lib.ryerson.ca/login?url=http://search.proquest.com/docview/895996470?accountid=13631

Nadelmann, E. A. (1993). Progressive legalizers, progressive prohibitionists and the reduction of drug-related harm. In N. Heather, A. Wodak, E. A. Nadelmann, & P. O'Hare (Eds.), *Psychoactive drugs and harm reduction: From faith to science* (pp. 34-45). London, UK: Whurr Publishers Ltd.

Paperny, A. M. (2012, April 11). Ottawa, Toronto resist call for supervised injection sites. *The Globe and Mail.* Retrieved from http://www.theglobeandmail.com/news/national/ottawa-toronto-resist-call-for-supervised-injection-sites/article2398395/

Petersen, A., & Lupton, D. (1996). *The new public health: Health and self in the age of risk.* London, UK: Sage Publications Ltd.

Potter, J., Wetherell, M., & Chitty, A. (1991). Quantification rhetoric—Cancer on television. *Discourse & Society, 2*(3), 333-365. doi:10.1177/0957926591002003005

Reinarman, C. (2004). Public health *and* human rights: The virtues of ambiguity. *International Journal of Drug Policy, 15*(4), 239-241. doi:10.1016/j.drugpo.2004.06.004

Riley, D., Sawka, E., Conley, P., Hewitt, D., Mitic, W., Poulin, C., . . . Topp, J. (1999). Harm reduction: Concepts and practice. A policy discussion paper. *Substance Use and Misuse, 34*(1), 9-24. doi:10.3109/10826089909035632

Riley, D., & O'Hare, P. (2000). Harm reduction: History, definition, and practice. In J. A. Inciardi, & L. D. Harrison (Eds.), *Harm reduction: National and international perspectives* (pp. 1-26). Thousand Oaks, CA: Sage publications, Inc.

Roe, G. (2005). Harm reduction as paradigm: Is better than bad good enough? The origins of harm reduction. *Critical Public Health, 15*(3), 243-250. doi:10.1080/09581590500372188

Rose, N., & Miller, P. (1992). Political power beyond the state: Problematics of government. *The British Journal of Sociology, 43*(2), 173-205. Retrieved from http://www.jstor.org/stable/591464

Rosenbaum, M. (1997). The de-medicalization of methadone maintenance. In P. G. Erickson, D. M. Riley, Y. W. Cheung, & P. A. O'Hare (Eds.), *Harm reduction: A new direction for drug policies and programs.* Toronto, ON: University of Toronto Press.

Strang, J. (1993). Drug use and harm reduction: Responding to the challenge. In N. Heather, A. Wodak, E. A. Nadelmann, & P. O'Hare (Eds.), *Psychoactive drugs and harm reduction: From faith to science* (pp. 3-20). London, UK: Whurr Publishers Ltd.

Tammi, T. (2004). The harm reduction school of thought: Three fractions. *Contemporary Drug Problems, 31*(3), 381-399.

Urban Health Research Initiative of the British Columbia Centre for Excellence in HIV/AIDS. (2009, June). Findings from the evaluation of Vancouver's Pilot Medically Supervised Safer Injecting Facility – Insite. Retrieved from http://supervisedinjection.vch.ca/research/

Van Brussel, G., & Buning, E. (1988). Public health management of AIDS and drugs in Amsterdam. *NIDA Research Monograph, 90,* 295-301.

Webster, P. C. (2012). The redlining of harm reduction programs. *CMAJ: Canadian Medical Association Journal, 184*(1), E21-E22. doi:10.1503/cmaj.109-4054

Appendix A
Press Release: May 11, 2011

Vancouver CoastalHealth
Promoting wellness. Ensuring care.

Supervised Injection Site focus of case before the Supreme Court of Canada

May 11, 2011

VANCOUVER, BC – Vancouver Coastal Health (VCH) will reinforce the importance of Insite, Canada's first supervised injection site, to the Supreme Court of Canada tomorrow in an attempt to keep the Downtown Eastside facility open.

VCH is the operator of Insite which opened its doors in 2003. Since then, more than 1.8 million injections have been done at the facility under the supervision of nurses. There have been no overdose deaths in the site despite more than 1,500 overdose interventions, some of which have included full respiratory arrest.

VCH provides all the funding for the facility and employs the medical staff (nurses and doctors). It also funds, under contract, counselling and peer support services provided by the Portland Hotel Community Services Society.

The court parties are appellants Attorney General of Canada and Minister of Health for Canada. The respondents are Portland Hotel Community Services Society; Dean Edward Wilson and Shelly Tomic; the Vancouver Area Network of Drug Users (VANDU); and Attorney General of BC.

VCH is an intervener in the Supreme Court of Canada Appeal that will be heard in Ottawa tomorrow (Thursday, May 12). An intervener is a party that may have its rights affected by a court outcome.

Other interveners include the Canadian and BC Civil Liberties associations; the BC Nurses Union; Canadian Public Health Association; and Canadian Medical Association.

The lawsuit was launched after the Federal government indicated it would not renew the drug law exemption that allows Insite to operate. The respondents won in BC Supreme Court, and the BC Court of Appeal in a split decision. The Federal government then appealed the case to the Supreme Court of Canada.

One of the key court arguments is jurisdiction under the Canadian Constitution where health care falls under provincial control, and is not a federal responsibility.

VCH supports Insite which, as evidence shows, has saved lives and provided other health benefits to a marginalized population. Notably, Onsite, a no-appointment detox facility in the same building as Insite has successfully served a significant number of this difficult-to-treat client group.

More than 30 research studies, many of them from the BC Centre of Excellence for HIV/AIDS, have been published in medical journals around the world and concluded that Insite saves lives and is a health benefit. The latest article was published in the Lancet in April 2011 and showed that drug overdoses decreased by 35% within 500 metres of Insite over several years of operation compared to only nine percent in the rest of Vancouver.

Last week, the BC Coroner's Service recommended IV drug users attend Insite for safety reasons due to tainted heroin circulating and causing overdoses in the province.

Insite stats for 2010 include:

- Average visits per day = 855
- Most visits in one day = 1,110
- Total visits in 2010 = 312,214
- Total individuals who visited in 2010 = 12,236
- 26% of participants were women
- 17% of participants identified as Aboriginal
- Average number of injections per day = 587
- Total overdose interventions = 221
- Fatalities to date = nil
- Principle substances reported were heroin (36% of instances), cocaine (32%) and morphine (12%)
- Total referrals to health and addiction services = 5,268, mostly to detox and addiction treatment
- Total nurse treatment interventions, including wound care, abscess/vein care, foot care and other skin care = 3,383
- Total admissions to Onsite detox = 458
- Completion rate at Onsite detox = 43% with the most challenging clientele in the country

- Insite's operational budget was $3.0 million last fiscal year out of a total addiction services budget in Vancouver of $44 million.

VCH is responsible for the delivery of $2.9 billion in community, hospital and residential care to more than one million people in communities, including Richmond, Vancouver, the North Shore, Sunshine Coast, Sea to Sky corridor, Powell River, Bella Bella and Bella Coola.

For more information about Insite: http://supervisedinjection.vch.ca/
For B-roll and photos: http://supervisedinjection.vch.ca/media_centre/b-roll/

Quotes:

President and CEO of Vancouver Coastal Health Dr. David Ostrow:
“Insite is one component in a range of services offered by Vancouver Coastal Health, all of which are intended to reduce the harm as a result of drug use. Insite also supports drug users in recovery measures. Earlier intervention on the part of Insite staff has not only saved lives but also alleviated the pressure on paramedic and hospital services which benefits everyone.”

Chief Medical Health Officer of Vancouver Coastal Health Dr. Patricia Daly:
“The health benefits of Insite are many. In addition to reducing the risk of overdose deaths, there is a reduction in high risk injection behaviour associated with HIV and Hep C transmission among users. There is a reduction in behaviour that increases risk of other serious infections including sepsis and endocarditis. Insite nurses also treat skin and soft tissue infections and provide immunizations.”

Medical Director of Insite, Dr. Ronald Joe:
“To be clear, it is never safe to inject heroin or any street drug. Insite is a clean place where people can go to inject their own drugs and connect to health care services. Clients of Insite are taking a step, albeit a small step, towards improving their health. In doing so we can provide them with other health care services including detox.”

CONTACT

Anna Marie D’Angelo
Vancouver Coastal Health
Tel: 604.790.4763
Email: Annamarie.dangelo@vch.ca

Appendix B
Press Release: September 30, 2011

Vancouver CoastalHealth
Promoting wellness. Ensuring care.

Supreme Court of Canada rules on Insite

September 30, 2011

VANCOUVER, BC – Vancouver Coastal Health today confirmed it will continue to operate Insite, North America's only supervised injection site, following a unanimous Supreme Court of Canada ruling today that supported its ongoing operation.

The ruling, handed down at 6:45am Pacific Time, follows a lengthy legal process that commenced in 2006 when a statement of claim was filed in BC Supreme Court seeking a declaration that the Federal Government could not constitutionally prevent Insite from operating.

The Supreme Court of Canada denied an appeal to previous rulings that supported that approach, ordering the Federal Minister of Health to grant an immediate exemption from the Controlled Drug and Substances Act in order to allow Insite to continue to operate.

"We are absolutely delighted that we finally have a clear decision on the legal framework for Insite," Dr. Patricia Daly, VCH Chief Medical Health Officer, said. "Since 2003, Insite has made a positive impact on thousands of clients, saved lives by preventing overdoses, and provided vital health services to a vulnerable population. Today's ruling allows us to continue the outstanding work Insite, its doctors, nurses, staff and partners provide."

Dr. Daly said that VCH will continue to study today's ruling to determine the full impact of the decision on the operation of Insite and other services.

The Supreme Court decision reflects the impact Insite has had on the community. More than 30 research studies, many of them from the BC Centre of Excellence for HIV/AIDS, have been published in medical journals around the world and concluded that Insite saves lives and is a health benefit. The latest article, published in the Lancet in April 2011, showed that drug overdoses decreased by 35% within 500 metres of Insite over several years of operation compared to only nine percent in the rest of Vancouver.

"This represents a victory for science," said Dr. Julio Montaner, Director of the BC Centre for Excellence for HIV/AIDS. "Prior attempts from the federal government to stop the activities of Insite have been ruled unconstitutional. We are thankful for the continued and unwavering support from the provincial government that has allowed us to set an example in Canada and the world for how to deal with addiction which is, indeed, a medical condition."

VCH is the operator of Insite which opened its doors in 2003. Since then, more than 1.8 million injections have been done at the facility under the supervision of nurses. There have been no overdose deaths in the site despite more than 1,500 overdose interventions, some of which have included full respiratory arrest.

It also provides other services through Onsite, a no-appointment detox facility in the same building that has successfully served a significant number of this difficult-to-treat client group.

In addition to supervised injection services, Insite offers a variety of other clinical services to its clients on Vancouver's Downtown Eastside such as wound care, counselling, abscess/vein care, foot care and referral to other health and addiction services.

VCH is responsible for the delivery of $2.9 billion in community, hospital and residential care to more than one million people in communities, including Richmond, Vancouver, the North Shore, Sunshine Coast, Sea to Sky corridor, Powell River, Bella Bella and Bella Coola.