HARM REDUCTION AND SUPERVISED SAFE CONSUMPTION SITES:
IDEAS AND POLICY IN TORONTO AND VANCOUVER

by

Emily-Anne Paul
B.A., University of Victoria, 2007

THESIS SUBMITTED IN PARTIAL FULFILLMENT OF
THE REQUIREMENTS FOR THE DEGREE OF

MASTER OF ARTS

In the
Department
of
Political Science

© Emily-Anne Paul 2010
SIMON FRASER UNIVERSITY
Spring 2010

All rights reserved. However, in accordance with the Copyright Act of Canada, this work may be reproduced, without authorization, under the conditions for Fair Dealing. Therefore, limited reproduction of this work for the purposes of private study, research, criticism, review and news reporting is likely to be in accordance with the law, particularly if cited appropriately.
APPREVAL

Name: Emily-Anne Paul
Degree: Master of Arts
Title of Thesis: Harm Reduction and Supervised Safe Consumption Sites: Ideas and policy in Toronto and Vancouver.

Examining Committee:
Chair: Andy Hira
Associate Professor, Department of Political Science

________________________________ ______
Lynda Erickson
Senior Supervisor
Professor Emerita, Department of Political Science

________________________________ ______
Laurent Dobuzinskis
Supervisor
Associate Professor, Department of Political Science

________________________________ ______
Douglas McArthur
Associate Professor, Public Policy Program

Date Defended/Approved: April 22, 2010
Declaration of Partial Copyright Licence

The author, whose copyright is declared on the title page of this work, has granted to Simon Fraser University the right to lend this thesis, project or extended essay to users of the Simon Fraser University Library, and to make partial or single copies only for such users or in response to a request from the library of any other university, or other educational institution, on its own behalf or for one of its users.

The author has further granted permission to Simon Fraser University to keep or make a digital copy for use in its circulating collection (currently available to the public at the “Institutional Repository” link of the SFU Library website <www.lib.sfu.ca> at: <http://ir.lib.sfu.ca/handle/1892/112>) and, without changing the content, to translate the thesis/project or extended essays, if technically possible, to any medium or format for the purpose of preservation of the digital work.

The author has further agreed that permission for multiple copying of this work for scholarly purposes may be granted by either the author or the Dean of Graduate Studies.

It is understood that copying or publication of this work for financial gain shall not be allowed without the author’s written permission.

Permission for public performance, or limited permission for private scholarly use, of any multimedia materials forming part of this work, may have been granted by the author. This information may be found on the separately catalogued multimedia material and in the signed Partial Copyright Licence.

While licensing SFU to permit the above uses, the author retains copyright in the thesis, project or extended essays, including the right to change the work for subsequent purposes, including editing and publishing the work in whole or in part, and licensing other parties, as the author may desire.

The original Partial Copyright Licence attesting to these terms, and signed by this author, may be found in the original bound copy of this work, retained in the Simon Fraser University Archive.

Simon Fraser University Library
Burnaby, BC, Canada
STATEMENT OF ETHICS APPROVAL

The author, whose name appears on the title page of this work, has obtained, for the research described in this work, either:

(a) Human research ethics approval from the Simon Fraser University Office of Research Ethics,

or

(b) Advance approval of the animal care protocol from the University Animal Care Committee of Simon Fraser University;

or has conducted the research

(c) as a co-investigator, collaborator or research assistant in a research project approved in advance,

or

(d) as a member of a course approved in advance for minimal risk human research, by the Office of Research Ethics.

A copy of the approval letter has been filed at the Theses Office of the University Library at the time of submission of this thesis or project.

The original application for approval and letter of approval are filed with the relevant offices. Inquiries may be directed to those authorities.

Simon Fraser University Library
Simon Fraser University
Burnaby, BC, Canada

Last update: Spring 2010
ABSTRACT

In 2003, the city of Vancouver opened North America’s first supervised injection site, Insite. Insite presents a case where the municipal government initiated change in drug policy and responded to a health crisis. It provides a case for understanding change in the ideas that guide policy making. In Vancouver, policy-maker’s decisions were informed by the idea of harm reduction. The extent to which this occurred is unique to Vancouver, and such developments have not taken place elsewhere in North America. In order to understand how this happened, Vancouver has been compared with Toronto. Through elite interviews and analysis of primary documents, the process of policy change in Vancouver and policy stability in Toronto are traced. Ultimately, in Vancouver an alignment of the public, media, politicians and police occurred, and all actors recognized the need for an alternative to the existing enforcement approach and Insite was part of that alternative.
DEDICATION

To my Mum and her unfailing perseverance and to my Step-Dad and his undying patience.
ACKNOWLEDGEMENTS

There are many people who have helped and supported me in the writing of this thesis. First, I want to thank my supervisors, Dr. Lynda Erickson and Dr. Laurent Dobuzinskis, for all their help, guidance, edits and feedback, and to Dr. Douglas McArthur for acting as my external supervisor.

I also want to give a special thanks to Donald MacPherson and Susan Shepard for connecting me to the communities in Vancouver and Toronto and for their support.

Finally, I want to thank Clinton Zirk for all the time he spent editing my drafts and for being the best friend anyone could ask for; the Next Up crew for the lessons I’ve learned and for being my surrogate family; my real family, my Step-Dad for cooking great food, telling me that anything was possible and for always being ready to have a good debate and my Mum for reading my drafts, her almost daily skyping, her endless support and being for my inspiration.
# TABLE OF CONTENTS

Approval .................................................................................................................. ii
Abstract .................................................................................................................. iii
Dedication ............................................................................................................... iv
Acknowledgements ............................................................................................... v
Table of Contents .................................................................................................. vi
List of Tables .......................................................................................................... viii
Glossary .................................................................................................................. ix

1: Introduction ........................................................................................................ 1

2: Methodology ...................................................................................................... 6
  2.1 Research Objectives ....................................................................................... 6
  2.2 Data Collection .............................................................................................. 6
  2.3 Elite Interviews .............................................................................................. 7
    Selection of Participants .................................................................................... 7
    Politicians ......................................................................................................... 9
    Staff ................................................................................................................. 10
    Interviews ....................................................................................................... 10
    Confidentiality and Ethics ............................................................................... 11

3: Ideas and Policy .................................................................................................. 12

4: Background ....................................................................................................... 20
  4.1 Epidemiology of Drug Use in Canada, Toronto and Vancouver .................... 21
  4.2 Harm Reduction ........................................................................................... 26
  4.3 Federal Drug Policy ...................................................................................... 29

5: Policy and Programs in Toronto and Vancouver .............................................. 34
  5.1 Toronto ......................................................................................................... 35
    Community ....................................................................................................... 36
    Government ..................................................................................................... 38
    Options ........................................................................................................... 45
    Decision .......................................................................................................... 46
  5.2 Vancouver ..................................................................................................... 50
    Community ....................................................................................................... 53
    Government ..................................................................................................... 60
    Options ........................................................................................................... 65
    Decision .......................................................................................................... 73
    Why Insite ..................................................................................................... 75
LIST OF TABLES

Table 1 Prevalence of HIV infection among injection drug users in Canada .................. 23
Table 2 Drug Overdose Deaths in Vancouver and Drug Related Deaths in Toronto ................................ ................................ ................................ ........... 24
GLOSSARY

CAMH   Centre for Addictions and Mental Health
CCENDU Canadian Community Epidemiology Network of Drug Users
CCPDT Coalition for Crime Prevention and Drug Treatment
COPE   Coalition of Progressive Electors
DERA   Downtown Eastside Residents Association
DEYAS  Downtown Eastside Youth Activities Society
DTES   Downtown Eastside
HCV    Hepatitis C Virus
HIV    Human Immunodeficiency Virus
IDU    Injection Drug Use
IV     Intravenous
NPA    Non-Partisan Association
PHS    Portland Hotel Society
SRO    Single Resident Occupancy
TPH    Toronto Public Health
TDS    Toronto Drug Strategy
VANDU  Vancouver Area Network Drug Users
1: INTRODUCTION

As Vancouver presented itself to the world with the 2010 Winter Olympic and Paralympic Games there was one neighbourhood that continued to make the pages of the local and national papers, the Downtown Eastside. Known as Canada’s poorest neighbourhood, the area is an epicentre for crime, homelessness and addiction. Yet within it there is an interesting case of policy change. In 2003, the City of Vancouver, with Vancouver Coastal Health Authority, Portland Hotel Society, the Province of British Columba and the Government of Canada, opened North America’s first supervised site for the injection of illicit drugs, called Insite. The supervised injection site not only illustrates a different direction for addressing addiction in Canada, but also provides an example of policy development, which differed from previous policy paths and decisions within Vancouver and throughout Canada.

In 2000 it was estimated that there were between 75,000 and 125,000 injection drug users (IDU) in Canada. They tend to be concentrated in major urban centres, with Toronto, Vancouver, and Montreal’s IDU populations comprising over one third of all users in Canada. Injection drug use poses a problem to the individual, as addiction and other health issues can arise, but it also poses a problem for the community. Costs to many service providers grow

---

in situations where there is a concentration of users: these include costs to the health care system, the police force and the city operations. Addressing the challenges of drug use, injection and other, can be a struggle for municipalities as they may lack resources, funding or political leadership to initiate change. A starting point for change is to engage the using population, and explore with them and the community alternatives to the dominant practice of enforcement. This is what the city of Vancouver did when it developed Insite.

The doors to Insite opened after years of preparation by the community and all three levels of government. Insite was a recommendation included in the City of Vancouver’s drug strategy. The strategy, called the *Framework for Action*, incorporated a number of critical components, including prevention, treatment, harm reduction and enforcement. This produced an approach to addressing drug misuse that accepted the nature of addiction, focused on education, provided treatment and upheld public order. Understanding the role and development of the *Framework for Action* is critical for understanding the process that led to Insite, a recommendation of the *Framework*.

As Vancouver was undergoing the policy exploration that led to Insite’s development, many turned to see what Canada’s largest city, Toronto, was doing to address its own growing drug problem. However, at the time of Vancouver’s drug strategy development, Toronto lacked a comprehensive approach to address the needs of its diverse drug using population.

---

In this thesis, the question of what factors led to the development of a supervised injection site in Vancouver before any other city in Canada will be explored. To answer this question, Vancouver will be compared to Toronto in terms of the development of drug policy, between 1994 and 2006. By evaluating city documents, public records and other primary sources, a framework for understanding the conversations at the municipal level will be established. These assessments will then expanded with data from elite interviews.

Through discussions with senior bureaucrats and politicians it was possible to trace the development of drug policy in both cities. The focus of the interviews was on the development of harm reduction practices, a concept which will be defined in greater detail in Chapter Four, but was critical to the development of supervised safe injection or consumption facilities.

Central to understanding why Vancouver adopted Insite is the way in which the idea of harm reduction was received by both local politicians and the community. The reception by the community, police and council to the idea of harm reduction was different in Toronto than it was in Vancouver. This difference can be understood by determining what factors facilitated the reception of the idea of harm reduction in Vancouver and what factors were absent in Toronto.

In this thesis, in order to understand what took place in these two cities, I will demonstrate that ideas changed in Vancouver and but did not, at least to the same extent, in Toronto. The underlying ideas of a given policy community
reinforce and legitimize existing policies.\textsuperscript{3} When these underpinning ideas change, there is room for the policy itself to change. Since ideas are part of the context of policy making, understanding what role they may have played may help us to understand what led to Insite, and contribute to a more general understanding of policy-making in this area. This thesis proposes an examination of the decisions made at city councils in Vancouver and Toronto, the factors that affected them and the outcomes that were chosen. It will not only provide an opportunity to assess the utility of ideational theory in understanding policy change, but it will also provide an opportunity to understand municipal level decision making in most similar systems.

\textbf{Chapter Outline}

The next chapter of this thesis outlines the methodology used within this study including the analysis of secondary materials and elite interviews with Toronto and Vancouver city councillors, staff and health staff.\textsuperscript{4} Chapter Three contains an explanation of ideational theory used in this thesis. Chapter Four contains an assessment of the epidemiology of drug use in Canada, Toronto and Vancouver and an introduction to harm reduction. Chapter Five contains an assessment of the policy paths taken in Toronto and Vancouver. This includes a demonstration of how policy remained stable in Toronto and was destabilized in Vancouver. Chapter Six contains an examination of the role of ideas in Toronto

\textsuperscript{3} Dietmar Braun and Andreas Busch, \textit{Public Policy and Political Ideas} (Edward Elgar: Cheltenham UK, 1999).
\textsuperscript{4} See Appendix I
and Vancouver and a demonstration of the role that the idea of harm reduction played in both cities.
2: METHODOLOGY

2.1 Research Objectives

The focus of my research was the development of drug policy in Vancouver and Toronto between 1994 and 2006 in order to understand what factors led to the development of Insite.

2.2 Data Collection

Data for this thesis were collected in two ways. The first was through process tracing, which included an examination of city documents, reports and media coverage. This data collection was undertaken in both Vancouver and Toronto. In each city, council meeting minutes were examined. They were searched initially by discussion topic. In both cities, minutes from meetings that discussed issues of drug addiction were examined. In Toronto, this search was expanded to include discussions of alcoholism and homelessness. Searches for keywords such as “drug addiction” did not yield sufficient results as they had not been discussed as frequently in city council. In Vancouver it was not necessary to expand the search because there were sufficient results and discussions around drug addiction. The council minutes provided the framework for the interview questions in each city and helped to establish a picture of the conversation occurring in both cities.
In addition to council meeting minutes, drug policy reports from both cities, provinces and the federal government were examined. These were used to understand trends in the epidemiology of drug use as well as details pertaining to the different drug using populations. The reports examined in both cities related to housing and homelessness, youth homelessness, addiction, mental health and HIV/AIDS and Hepatitis C. I also examined media coverage in both cities. To do this I searched the local papers for discussion around illicit drug use and service provision for users.

The second method used to collect data was elite interviews. In Toronto I conducted nine interviews and in Vancouver, seven. These interviews were conducted with city employees and city councillors who were working for the cities within the twelve-year scope of the thesis. This was partially because of the impact that the 1998 amalgamation of Metropolitan Toronto (described in Chapter Five) had on city policies, and partially because it was not until after Vancouver had developed their drug strategy and Insite that discussions around harm reduction and drug policy took place in Toronto.

2.3 Elite Interviews

Selection of Participants

I restricted my interview participants to city politicians, city staff and staff employed by health boards and programs. I started by interviewing city councillors and staff who had direct involvement with the drug strategies in both cities. Using a snowball method I extended my interviews to councillors who
were recommended by other councillors and Mayors. In using the snowball method I asked each interviewee for their recommendations for whom to interview. I then developed a list of individuals and contacted and or interviewed as many as were available. Unfortunately, due to the participation of many former city councillors in activities during the Olympics and the preparation for the upcoming Toronto municipal election, as well as the prorogation of the House of Commons, fewer interviewees were available than I initially contacted.5

I chose to use open-ended interview style similar to that defined by Schroenberger, in order to understand the “interplay among, strategy, history and circumstance”.6 As Cochrane notes, “all interview-based research will be influenced by the ways in which those being interviewed respond to the questions and to the interviewer.”7 Thus as Richards suggests, “it is important to create the right impression.”8 For each of the interviews I conducted I began by outlining my research objectives, the confidentiality of the interview and the role that they, the interviewees, would play in this academic project. Although the potential exists that elites may be defensive and unwilling to be frank or candid with the interviewer,9 I did not experience this. Of the individuals I interviewed all were willing to share their experiences.

---

5 Initially I sent out thirty requests for interviews, and was able to interview sixteen individuals.
8 Ibid.
Politicians

In determining which city councillors to interview in Vancouver, I started with those who had been mentioned most in the media coverage I examined and those who had been chairs of drug policy related committees. From there I received suggestions for further councillors with whom to discuss the development of Insite. For the most part, councillors were willing to discuss this issue frankly. This is most likely because of the media attention that has been given to Insite over the years as well as the ongoing discussion of the project.

In Toronto, it was more challenging to discuss with councillors trends in drug policy. Prior to amalgamation, the old city of Toronto had 16 councillors and a mayor, and in the metro area, including all original municipalities, there was a total of 106 elected officials. In 1998, the cities in the metro Toronto areas were amalgamated and total number of councillors was reduced to 57 councillors plus the mayor. This number was reduced again in 2004 to 44 councillors and the mayor. For many of the councillors who came from the original municipalities, drug abuse issues had not been as prominent. Furthermore, much of the drug-related policy was undertaken by agencies that either fell under the jurisdiction of, and reported to the Toronto Board of Health or were part of provincial programming. Thus many councillors on the post-amalgamation council did not have experience discussing drug policy. However, the development of the 2004 Toronto Drug Strategy and the councillors who were behind it gave me an idea of where to start. From there I was able to contact other councillors using the snowball method.
Staff

In Vancouver it was critical to discuss the development of the policy with Donald MacPherson, the city’s drug policy coordinator. MacPherson was the author of the *Framework for Action*, Vancouver’s drug strategy that will be discussed further in Chapter Five. As well he participated in the initial researching stages for the four pillars approach, was active in the community having been involved programs in the Downtown Eastside for many years, and served as the city’s drug policy coordinator from 1998 until 2009, through four different mayors. As with the politician interviews, I used a snowball method, beginning with MacPherson, to determine if there were any other staff recommendations.

It was more challenging to determine which staff in Toronto were most relevant to the development of drug policies because the discussions about drug policy were less public than they were in Vancouver. However, once I made contact with Susan Shepard, the current Manager of the Toronto Drug Strategy Secretariat, I was able to make contact with several other staff within the city and in arms-length organizations.

Interviews

I constructed two sets of questions for each city, those for staff and those for politicians. As noted, I used an open-ended style of interview and would return to the questions throughout the interview. The question sets for the two different groups of interviewees were the same in each city but differed between

---

10 See Appendix II.
cities; I had four sets of questions all together. The questions differed in Vancouver and Toronto to the extent that there were specific questions relating to the *Framework for Action*, Vancouver Agreement, a funding agreement between the Vancouver, BC and Canadian governments, and Insite in Vancouver that were not present in Toronto. These additional questions focused on the discussions that took place around their development and the relationship between the levels of governments and the different documents.

**Confidentiality and Ethics**

I worked with a consent form that allowed the interviewees to accept or deny being recorded, as well as giving them the option for the extent of confidentiality. Interviewees had the choice to remain completely anonymous, be referenced only by the position they held, or by name and position. Each interview began with a description of my research goal, an explanation of the consent and confidentially as required by the Ethics Review Board of Simon Fraser University. For individuals in Vancouver, having their identity remain confidential was not as important to them as it was in Toronto. Although the interviews were recorded, transcripts were not produced. I informed the participants that the purpose of the recording was to ensure accuracy in my notes. I recorded all interviews with city councillors, four in Toronto and five in Vancouver, but did not record interviews with city staff or health board staff with the exception of one in Vancouver.
3: IDEAS AND POLICY

The factors that led to the development of Insite are both political and social. However, through my research and the interview process it became clear that the important difference between Vancouver and Toronto was, and continues to be, the acceptance of the idea of harm reduction. The development of Insite did not occur in isolation. It took a change in ideas that inform the policy around it. Assessing the role that ideas plays requires an understanding of how policy changes. Judith Goldstein, in her examination of American trade policy, highlights four stages in the development of public policy: delegitimation and creation of a policy window, search for new ideas, policy experimentation, and policy institutionalization. It is the second and third stages that are of particular interest in this thesis. For policy to change, new ideas must present themselves, and these ideas must be “politically salient and carried by well-placed elites”\(^\text{11}\) in order to be accepted.

Once new ideas have been accepted, the policy development process moves to the experimentation stage. Although there are often many ideas present, it is at this stage that those with explanatory power may succeed while those without fail. Some ideas may have more longevity and are better able to address the policy problem; those ideas are then considered options for change.

attach themselves to particular views of the world so that change is difficult" if the proposed alternatives to the existing policy agree with those ideas then policy change may be possible. When the ideas presented are salient enough and the actors in decision-making roles are receptive to new ideas, policy change can incorporate those new ideas. It appears that in Vancouver this was the case and it lead to development of new policy but in Toronto there has not been individuals attached to new ideas or new options for change.

Policy change, of any sort, takes place within an institutional framework, and although it is important to understand how institutions structure relationships, understanding them on their own is not sufficient for understanding how they change. In order for policy to change, new ideas have to be accepted. As Vivian Schmidt explains in her work on discursive institutionalism, ideas exist at three levels: policy, program and philosophical. Through a comparison between Toronto and Vancouver the fifth and sixth chapters of this thesis will demonstrate ideational change at the policy, program and philosophical levels.

Understanding the role of ideas in the policy process through the use of ideational theory requires acknowledging the existence and complexity of policy ideas. Ideas are seen as roadmaps, strategic constructions, frames of reference and national traditions, and they differ in terms of their generality and their type.

---

12 Ibid. 16.
In order to examine and understand drug policy change or stability at the municipal level, the levels at which ideas exist should be considered.

Within the three levels in which ideas and change are discussed, there are two types of ideas, cognitive and normative. Cognitive ideas suggest to political actors how problems are defined, offer insight into how policy offers solutions, and suggest how to solve the problem.\textsuperscript{15} In addition, cognitive ideas also identify how policies and programs relate to deeper principles and disciplines.

Normative ideas attach values to political action and both legitimize and reinforce policies and programs.\textsuperscript{16} They serve to legitimize policies within a program by referencing their appropriateness, and they speak to how policies meet the aspirations and ideals of the general public and how programs as well as policies resonate with a deeper core of principles and norms of public life, whether newly emerging values of a society or the long-standing ones in the social repertoire.\textsuperscript{17}

In the assessment of a topic, such as drug policy, normative ideas are especially relevant. The nature of normative ideas is “what is good or bad about what is” in light of “what one ought to do”.\textsuperscript{18} The debate around whether or not illicit drugs and addiction should be addressed as a health issue or a law enforcement issue is very contentious. Ultimately, understanding how the normative ideas change is important for understanding how receptive people are to policy change, and without a change in normative ideas it is unlikely that actors would be receptive to a change in policy.

\textsuperscript{15} Schmidt, \textit{Discursive Institutionalism}.
\textsuperscript{16} Ibid.
\textsuperscript{17} Ibid., 307
\textsuperscript{18} Ibid, 306.
Cognitive and normative ideas occur at all three levels where policy change can take place. At the first level, the policy level, ideas are present in the solutions that policy makers are suggesting. These ideas need to both address the issue and be politically viable, containing both cognitive and normative elements. Cognitive ideas speak to how policies offer solutions, and normative ideas place the solutions within the greater context of public values and ideals.\(^{19}\)

Policy change may be the result of the merging of policy, political and program streams as Kingdon highlights and as will be explored later, or they may be influenced by greater cultural norms. Policy level analysis alone however, does not illustrate what does and does not make it into the agenda. Policy level ideas help to identify factors for change but to understand why some ideas succeed and some fail the program and philosophy levels must be considered.

The second level where ideas are present are in the programs that underpin the policy decisions. These ideas may be the underlying assumptions, the frames or référentiels, programmatic beliefs, or policy cores.\(^{20}\) Unlike the policy level, the program level defines the problems, the issues to be constructed and the goals to be achieved. At this level cognitive ideas define the problems to be solved, whereas the normative ideas, much like in the first level, speak to how these programs resonate with public ideals. Program level ideas must satisfy decision makers and the public. Change at the program level is likely not a result of internal factors as much as it is influenced by external processes and events.


\(^{20}\) Ibid., 306
that make a receptive environment for change. \textsuperscript{21} When examining the second level of ideas, scholars often look to the long-term problem solving potential of the ideas as an indication of their potential effectiveness.

At the philosophical level, the third level, ideas sit in the background as assumptions that underpin the policy and programs with the organizing ideas, values and principles of knowledge and society.

The success of a program does not just depend on the presence of cognitive ideas capable of satisfying policy makers that a given program will provide robust solutions. It also depends on the presence of complementary normative ideas capable of satisfying policy makers and citizens alike that those solutions also serve the underlying values of the polity. \textsuperscript{22}

The cognitive ideas serve to explain how policy meshes with deeper core principles and reflects greater norms and the normative ideas speak to how policies resonate with core public values. Although both the policy and program ideas can be seen and are frequently discussed, the philosophical ideas lie deeper as underlying assumptions and unless there is crisis, they are rarely discussed or contested. \textsuperscript{23}

Exploring these different levels can help us to understand why some ideas become policies, programs and philosophies and why some do not. At the policy level, ideas need to have administrative and political viability, and they must come together with the political and problem stream before they are adopted. As John Kingdon explains, it is when the political, problem and policy streams come

\textsuperscript{21} Ibid.
\textsuperscript{22} Ibid., 308
\textsuperscript{23} Ibid., 306
together that there is a window of opportunity for policy change. These windows are opened “either by the appearance of a compelling problem or by happenings in the political stream.” Once opened the three streams interact and policy may or may not be formed.

At the program level, ideas must satisfy the viability of the program and long-term problem solving potential. The cognitive ideas at this stage must be able to satisfy decision makers, while the normative ideas must be capable of satisfying citizens and policy makers. If both policy makers and citizens are satisfied then the likelihood of the policy being accepted is higher.

Ideas are critical in determining what options are available for creating new policy and institutionalizing it. As will be discussed later in this thesis, deviation from the emphasis on enforcement in drug policy in Toronto has not occurred because the core approach when addressing drug problems is both cognitively and normatively rooted in enforcement. This assessment was supported by interviewees who highlighted the police opposition to any harm reduction practices, the lack of discussion of alternatives to enforcement in city hall, and the struggles that health officials had to open the few harm reduction programs that do exist. In Vancouver, policy has expanded beyond enforcement to embrace harm reduction. Even though policy makers in Vancouver by and large adopted the idea of harm reduction, there was still a contestation of ideas. However, harm reduction seemed to be the approach that

25 Ibid., 204.
26 Schmidt, “Discursive Institutionalism”, 308.
27 Anonymous 1, interviewed by author, January 6, 2010; Anonymous 2, interviewed by author, January 21, 2010; Anonymous 3, interviewed by author, February 18, 2010;
best answered the questions policy makers were asking. The city has witnessed a discussion about embedded beliefs about drug addiction and drug policy, something which Braun highlights is a key piece of accepting ideas as greater philosophies.  

Ideas are not inherently forces for change. However change is informed by ideas, and can be understood through assessing ideas in the political and public realms. In addition, ideas are embedded in more general cultural belief systems shared by the political and public communities. As Schmidt highlights, even if policy makers and the public are not aware of the ideas that inform policy, at the philosophical level the ideas exist and guide decision makers. “Often the general principles and values which back ideas in negotiations are subject to a long-standing discussion within public forums outside the negotiation process in the political arena.”

The struggle of ideas in the political negotiation systems may be entirely different than those in the public forums. In the public forum, as Braun and Busch discuss, material interests are pushed to the back and the greater world views are discussed, where as in the negotiation systems material interests are relevant. In the case of harm reduction and the development of Insite, the discussions were taking place both among the public and at the policy negotiation level. This affected the discussion and is something which many

---

28 Dietmar Braun and Andreas Busch, Public Policy and Political Ideas. (Cheltenham: Edward Elgar, 1999).
29 Ibid.
30 Ibid., 28.
31 Schmidt, “Discursive Institutionalism”, 308.
32 Braun and Busch, Public Policy and Political Ideas, 28.
33 Ibid.
actors involved in Vancouver’s policy creation argue influenced success of the

*Framework for Action.*

“Ideational change in social science and society results also from external
processes and events that create a receptive environment for new ideas.”34

When an idea no longer has explanatory potential, new ideas are entertained. In
Vancouver the crisis situation in the Downtown Eastside created a window for
new ideas. This has not, apparently, been the case in Toronto. While it is
challenging to establish when change has taken place at the philosophical level,
it appears that in Vancouver change did occur.

34 Ibid.
4: BACKGROUND

In order to assess the developments in Toronto and Vancouver, an understanding of the epidemiology of drug use, the nature of harm reduction approaches to drug use and the policy situation in both cities must be established. In this chapter, I will first outline the epidemiology of drug use in Toronto and Vancouver, with particular attention to number of injection users, and the prevalence of HIV/AIDS and the Hepatitis C Virus (HCV). As harm reduction is a central idea in the development of the drug strategies in Canada, Toronto and Vancouver, I will provide a brief definition of this approach to drug use policies. Following the definition of harm reduction, I will provide a brief overview of the history of drug policy and programs in Canada.

In Chapter Five I will provide a history of policy in Toronto and Vancouver as well as well as how change occurred. Understanding the programming that exists and has been developed is important for understanding change. The main difference between the policy in Toronto and Vancouver is the extent to which the idea of harm reduction has been incorporated and accepted, politically and within the community.
4.1 Epidemiology of Drug Use in Canada, Toronto and Vancouver

Since the discovery of the Hepatitis C Virus (HCV) and the spread of both HCV and HIV there has been a growing focus on drug use in Canada. As a result, each year many annual reports on drug use in Canada, the provinces, and municipalities are produced and can be referenced in understanding drug user epidemiology. The Canadian Community Epidemiology Network on Drug Use (CCENDU) produces detailed reports, which illustrate the nature of drug use and its health effects in Canada. In this thesis, CCENDU reports will be used along with a variety of additional reports focusing on HIV and HCV. There are, however, many challenges to reporting on drug use and users. As Health Canada notes “[d]ue to the illegal nature of injection drug use as well as the negative society view, it is difficult to obtain reliable information on the extent of injection drug use in Canada, and the characteristics of people who inject drugs”.

Most of the information available on drug use and users comes from needle exchanges, treatment facilities and surveys. Although the data may not represent the entire illicit drug using community, it does provide an illustration of trends within the drug using community.

As mentioned previously, there were an estimated 75,000-125,000 users in Canada in 2000. In that same year in Ontario the number of users was

---

36 Health Canada, *Profile of Hepatitis C and Injection Drug Use in Canada*.
37 Ibid.
38 Ibid.
estimated to be 41,000, 15,000 of which were in Toronto.\textsuperscript{39} In addition, at the time of the injection drug report, users in Ontario comprised over 35\% of the national average and 4.7 \% of the national HIV population.\textsuperscript{40} In the same year in B.C., there were an estimated 15,000 drug users, with 12,000 located in Vancouver and 9,000 of whom accessed services in the Downtown Eastside.\textsuperscript{41}

In Toronto, drug use had remained relatively stable, although high, since the 1980s. Use of some illicit drugs such as heroin, hallucinogens, solvents, stimulants and sedatives were relatively low,\textsuperscript{42} but the use of crack and Oxycotton, and other injection opiates were on the rise.\textsuperscript{43} Indeed, crack cocaine is the most common drug amongst injection users and the street population in Toronto. Overall, however, as noted in the introduction, statistics on the number of injection drug users, in the Greater Toronto Area remain similar to those in Vancouver.

The severity of the issue is not simply the number of users, but also, the spread of disease associated with injection drug use. In Vancouver it is believed that 88\% of active drug users have HCV, and 23-30\% have HIV.\textsuperscript{44} In Toronto, the HIV rate was estimated to be lower, at 10\% in 1999, and no comparable

\textsuperscript{39} Ibid.
\textsuperscript{40} Robert S. Remis, Margaret Millson and Carol Major, \textit{The HIV Epidemic Among Injection Drug Users in Ontario: The Situation in 1997} (Toronto: Department of Health Sciences, July 1997).
\textsuperscript{41} Reka Gustavson, \textit{Supervised Safe Injection Site} (Vancouver: Vancouver Costal Health Authority, 2007).
\textsuperscript{42} City of Toronto, \textit{Report on Harm Reduction Programs Targeting Drug Users in the City of Toronto} report prepared by Sheila V. Basrur (April 28, 2003).
\textsuperscript{44} Gustavson, \textit{Supervised Safe Injection Site}
statistics on HCV are available.\textsuperscript{45} Table 1 provides a comparison of infection rate for HIV in Toronto and Vancouver from 1988-1999.

<table>
<thead>
<tr>
<th>Year; percent of HIV infection</th>
<th>Location</th>
<th>1988/89</th>
<th>1994/95</th>
<th>1998/99</th>
</tr>
</thead>
<tbody>
<tr>
<td>Toronto</td>
<td>4-5</td>
<td>8</td>
<td>10</td>
<td></td>
</tr>
<tr>
<td>Vancouver</td>
<td>1-3</td>
<td>6</td>
<td>23-30</td>
<td></td>
</tr>
</tbody>
</table>

Source: \textit{Injection Drug use and preventive measures}.\textsuperscript{46}

In addition to HIV infection, another indicator of the severity of drug addiction is deaths from injection drug use. Table 2 includes information on drug overdose deaths and drug related deaths in Vancouver and Toronto respectively. Although Table 2 presents overdose deaths in Vancouver and deaths related to drug use in Toronto, statistics that cannot be directly compared, they do provide evidence of the severity of drug use in Vancouver, particularly in 1993. Although the data was not available for drug related deaths in Vancouver, it is important to note that drug related deaths includes overdose deaths. In Vancouver, overdose deaths alone were higher than all drug related deaths in Toronto; if drug related deaths were included the death rate in Vancouver would be even higher.

\textsuperscript{45} Mancinelli, Smith, Loudfoot and Windsor, \textit{The HIV Epidemic Among Injection Drug Users in Ontario}.

\textsuperscript{46} Gustavson, \textit{Supervised Safe Injection Site}. 

23
Table 2 Drug Overdose Deaths in Vancouver and Drug Related Deaths in Toronto

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Vancouver</td>
<td>25</td>
<td>47</td>
<td>59</td>
<td>78</td>
<td>109</td>
<td>216</td>
</tr>
<tr>
<td>Toronto</td>
<td>137</td>
<td>157</td>
<td>159</td>
<td>158</td>
<td>143</td>
<td>155</td>
</tr>
</tbody>
</table>

**Source:** BC Coroner’s Report; Ontario Coroner’s Report

The *Framework for Action*, Vancouver’s Drug Strategy, was released following the 1997 Vancouver/ Richmond Health Board declaration of medical emergency in the Downtown Eastside. Drug related deaths were the number one killer for those between 30-49, and in the first months of 2000, Vancouver had 87 overdose deaths, more than twice the total number of deaths in 1988. In addition to a growing number of overdose deaths, 80% of new HCV and 50% of HIV cases were related directly to injection drug use. The rate of increase was a health concern which contributed to the push in Vancouver to address the issues in the Downtown Eastside.

Another indicator of the severity of the issue in Vancouver compared to Toronto is coverage by the media. In Toronto, a brief search of the major paper, the *Toronto Star* revealed twenty-two articles relating to the search term

---


50 Ibid.

51 Campbell, Boyd and Culbert, *A Thousand Dreams*. 
“injection drug use” in Toronto. In Vancouver, however, in the *Vancouver Sun* sixty-seven articles referenced injection drug use and in the *Province* twenty-two referenced it. With further reading, coverage in Toronto tended to be on HIV/AIDS and not on addiction. In Vancouver, however, coverage was predominantly on the severity of disease and addiction in the Downtown Eastside.

As well as having higher rates of infection and death in Vancouver compared to Toronto, the drug-using populations differ. In Vancouver, the population is mobilized and a very visible community. In Toronto the drug using population lacks a coherent voice (there is no main organization that represents users) and they are hidden. The visibility of drug use, the nature of the health problems and crime associated with it are somewhat greater in Vancouver.

As will be discussed in subsequent sections, much of the impetus for harm reduction programming since the 1980s has come from the spread of HIV/AIDS. The number of those with HIV/AIDS and HCV and the number of overdose deaths in Vancouver and Toronto is of great concern. In Chapter 5 a further explanation of existing services will be conducted. However, before the development of various programs can be explored, it is important to have an understanding of the idea of harm reduction, how it developed and the definition used most commonly in Canadian drug strategies.

---

52 Berridge “Histories of Harm Reduction”.
4.2 Harm Reduction

Harm reduction is currently a central element in drug strategies across Canada, however it was not until the late 1980s and through the 1990s that the idea was accepted as a method for addressing addictions. In many policies and strategies harm reduction has been defined as

a public-health approach to dealing with drug related issues that places first priority on reducing the negative consequences of drug use rather than on eliminating drug use or ensuring abstinence.\(^{53}\)

Any program that aims to decrease the harm associated with drug use is, then, by broad definition, harm reduction.

As Erick Single notes, “the essence of the concept of harm reduction is to ameliorate adverse consequences of drug use while, at least in the short term, drug use continues.”\(^{54}\) In recent years, and when discussing issues such as needle exchanges and supervised consumption facilities, definitions similar to the one Single provides have been adopted. One of the key features of this definition is that recognizing drug use in the short term does not rule out abstinence in the long term.\(^{55}\) Thus programs that advocate harm reduction approaches to addictions, be they illicit drugs, alcohol, or tobacco, are not looking to support indefinite use of substances, but to work towards long term abstinence.


\(^{54}\) Ibid.

\(^{55}\) Ibid.
Riley et. al suggest that harm reduction is based on the idea that “if a person is not willing to give up his or her drug use, we should assist them in reducing harm to himself or herself and others.” They outline five main components of harm reduction strategies: pragmatism, humanistic values, focus on harms, balancing costs and benefits, and priority of immediate goals. Together these elements combine to form strategies that shape long term programming designed to help addicts into treatment, prevent use, educate at risk populations and work to reduce the stigma associated with drug use.

Virginia Berridge notes that the situation in the developed world surrounding AIDS brought a ‘temporary’ alliance between the different policy communities and shifted the focus of HIV/AIDS policy towards harm reduction. Prior to the AIDS crisis, harm reduction was understood to be a much broader concept. However, with the severity of the crisis, programming became much more focused on specific harm reduction responses such as needle exchange programs. Berridge further notes that

the prevention of harm, the hierarchy of objectives, needle exchange schemes, harm reduction approaches in drug education – suddenly the flood gates seemed to be open to all types of previously publically and politically unthinkable approaches.

Injection drug use and sharing of equipment is recognized as one of the primary ways that HIV is spread, and harm reduction emerged as an alternative to

---

56 Ibid, 11.
57 Ibid.
58 Ibid.
59 Ibid.
abstinence oriented policy. This is important when evaluating the differences in policy between Vancouver and Toronto. In Vancouver, the alignment between policy communities occurred and opened the door for change, similar to that described by Berridge. In Toronto, this did not take place.

In her evaluation of harm reduction, Berridge argues that when policy is developed, policy makers are aware of the risks inherent in change or remaining with the existing policy. When assessing the degree of risk, “policies are put in place as a rational response to specific defined degrees of danger from particular substances.” However, danger must be understood in the time and place in which a substance is declared dangerous.

The AIDS epidemic highlighted the risk of intravenous drug use, which was perceived to be more dangerous than other methods of drug use at the time. Thus the response by policy makers included tactics not previously used, such as harm reduction. The danger and risk represent components of a greater social, moral, political and economic discussion around substance use, and as discussions take place around addressing HIV/AIDS, harm reduction grows as a tool for policy development. Understanding harm reduction practices is also important for understanding the connection between drug use and health care, a distinction which is important for advancing alternatives to enforcement.

In the next section, federal drug policy, which sets the legal framework for municipal policies, will be outlined briefly. Then, the development of policy in

---

60 Ibid; Riley et al. “Harm Reduction Concepts and Practice"
Toronto and Vancouver will be explored. This will be followed by an examination of idea theory.

4.3 Federal Drug Policy

Prior to 1996 and the development of the *Controlled Drugs and Substances Act*, drug policy in Canada had been predominantly the result of a government response to public disputes over who was engaged in drug trades. The first piece of legislation, the 1908 *Opium Act*, set the tone for subsequent legislation and was largely rooted in anti-Asiatic sentiments.\(^{61}\) It was not until the 1950s that the federal government began exploring the nature of drug use in Canada and the role for government intervention. The 1955 Senate Special Committee on the Traffic of Narcotic Drugs in Canada examined the nature of enforcement and the role of a health approach to addiction and ultimately advocated for a highly punitive approach which was subsequently enacted in the *Narcotics Control Act* in 1961.\(^{62}\)

In 1969 the federal government commissioned the Inquiry into the Non-Medical Use of Drugs (known as the Le Dain Commission). Between 1969 and 1973 the commission produced four reports whose recommendations included the gradual withdrawal of criminalization of illegal drugs.

The Commission recommended greater leniency for the crime of possession including the abolishment of imprisonment. The commission also recommended that the possession of cannabis


should not be considered an offence. Despite the Le Dain Commission's recommendations Canada's drug policy remained unchanged.\textsuperscript{63}

Despite movements within the medical community to promote addiction as a health issue, the enforcement-based approach continued to dominate. This was especially true after the 1986 US declaration of the war on drugs.\textsuperscript{64} Subsequent federal policies focused more on the enforcement of laws and prohibition of substances than the recognition of the health impact of drug use.

In 1996, however, policy approaches to drug laws started to shift. The \textit{Controlled Drugs and Substances Act} focused more on the health of drug users than did previous acts. In addition, it provided room for elements of harm reduction, recognizing the importance of preventing the spread of disease. However, the Act still contains strong elements of criminalization of drugs and prohibition and an overall focus on enforcement. Subsequent federal policies focused more on the enforcement of laws and prohibition of substances than the recognition of the health impact of drug use.

\textbf{Jurisdictional Issues}

The responsibility to address drug use in Canada is shared between jurisdictions. The federal government sets out the framework for the control of drugs in Canada through the \textit{Controlled Drugs and Substances Act} (CDSA). The CDSA provides legal definition of which drugs and drug-using equipment are

\begin{footnotesize}
\begin{footnotes}
\footnote{John Howard Society \textit{Perspectives on Canadian Drug Policy}.}
\end{footnotes}
\end{footnotesize}
illegal and the charges associated with them.\textsuperscript{65} Enforcement of the CDSA is the responsibility of the RCMP and local police forces. The provinces have constitutional responsibility to provide health-care services to their citizens, which includes treatment, such as detox and other associated methods of treating drug users. However, the delivery of services in provinces varies greatly from province to province.\textsuperscript{66}

In British Columbia, the Ministry of Health Services is responsible for “policy development, implementation, funding, service planning, monitoring and evaluation in the fields of mental illness and addiction”.\textsuperscript{67} In addition, the regional health authority (in the case of Insite, Vancouver Coastal Health) is responsible for governance, management and delivery of addiction treatment and mental health services. The core services provided include, emergency response and short term intervention, clinical services, addiction treatment, preventative measures, psychological rehabilitation, social support and, when required, assistance in accessing housing, income assistance and rehabilitation services and benefits.

In Ontario the provincial Ministry of Health and Long-Term Care provides funding for mental health and addiction programs across the province. These programs include services such as case management, treatment, crisis service,
court service, short term residential support and family supports. The *Health Promotion and Protection Act* requires that boards of health provide and ensure a minimum level of public health programming in specific areas across Ontario. In Toronto, the Board of Health ensures that Toronto Public Health delivers programs and services as well as advises city council on a range of health issues. Toronto Public Health is funded by Toronto city council as well as the Ministry of Health and Long-Term Care and is responsible for services and information relating to methadone clinics, needle exchanges, HIV/AIDS hotline, alcohol and drug use prevention, and mental health services.

Even though both Toronto and Vancouver had similar experiences with respect to drug policy until the 1990s, by the end of the decade they were addressing drug addiction in very different ways. Vancouver’s community and the city council were exploring alternatives to enforcement, while Toronto, was having limited engagement with drug policy at the political level. Although the Toronto Drug Strategy was developed and passed by the board of health, the conversations which led to its development took place outside of city council and the political realm. Understanding how these paths diverged resulting in the supervised injection site requires an understanding of what factors were at play throughout the decision making process, how issues were placed on the table, what options emerged and why some were chosen over others. Part of this assessment comes from understanding what ideas were involved in the discussions surrounding harm reduction and drug use.

---

In the next chapter the development of policy in Toronto and Vancouver will be traced, highlighting the diversity in programming between the two cities and demonstrating where policy in Vancouver was destabilised and areas where change did not take place in Toronto. In Chapter Six the role of ideas in relation to policy change will be explored.
5: POLICY AND PROGRAMS IN TORONTO AND VANCOUVER

Drug policy in North America is not traditionally a field where municipal governments lead policy development, yet in Vancouver, the city had laid the groundwork for provincial and federal discussions and initiated the first steps for policy change. In Canada, as previously described, the provinces have responsibility over components of drug policy relating to health care, education and housing. The federal government, on the other hand, has responsibility to enforce laws and protect the safety of citizens. However, the events that led to the development of Insite were addressed by neither the provincial nor the federal government. Instead the municipal government initiated discussions about harm reduction, health care and drug laws. Moreover, the outcome of policy discussions in the Vancouver municipal government influenced drug strategies at the federal level and throughout other jurisdictions in Canada.69 The resulting policy change was both politically risky and complicated, however, it was, at the time, supported by the governments at all levels.

As has been previously noted, policy change and ideas can be understood through examining four main stages. First, policy is delegitimized: the “status quo no longer meets the needs of political entrepreneurs, either because of

---

69 Donald MacPherson, interviewed by author January 6, 2010.
exogenous economic change or because of endogenous political change.”

Second, once the window opens, and a discussion about change begins, there is a period of searching for new policy. Third, there is a “period of experimentation, resulting either in a return to the status quo ante or in an agreement about the virtue of new policy”. Finally, there is a period of institutionalization, where the policy is given the chance to deliver on the promised effects and subsequent rules and norms that legitimate the policy develop.

In the following sections, the policy discussions in Vancouver and Toronto will be assessed using the interview data and focusing on steps two and three of Goldstein's theory of policy change: recognition of a problem and exploration of options. The data are broken down into four categories: the identification of the problem by the community, identification of the problem by the government, proposed solutions and the decision made. Once these data have been assessed the role of ideas in these processes will be explored.

### 5.1 Toronto

The nature of the drug using community in Toronto has been shaped by several factors, and assessing those factors will help to understand the programming and responses outlines below. First, the type of drug used in Toronto has impacted how the community developed. Despite the fact that they have comparable injection drug use numbers to Vancouver, the drugs that are the most challenging to address in Toronto are the illegal substance crack

---

70 Goldstein, Ideas, Interests, and American Trade Policy, 12.
71 Ibid.
72 Health Canada, Profile of Hepatitis C and Injection Drug Use in Canada.
cocaine and the prescription drug, Oxycotton. In Vancouver, however, heroin and cocaine are predominantly used. The second factor, which is related to the first, is the visibility of drug use. In some cities, injection drug use is very visible, and as a result there tends to be a greater community dissatisfaction with government policy. In Toronto, however that has not been the case.

The response to the drug using community in Toronto was early and decentralised. Unlike some cities, which operated needle exchanges out of fixed locations with set one-to-one exchange, from the beginning Toronto had many mobile sites both for the distribution of needles but also for the distribution of crack kits. One health official stated that this may have contributed to lower HIV/AIDS and Hep C rates in Toronto than other cities.

Community

Community mobilization can be used as an indicator to understand the extent to which problems of substance abuse are recognized by the public. Unlike Vancouver, community mobilization, both of groups supporting user services and groups from within the users have been limited in Toronto. That is not, however, to say that such do not exist or the ones that have existed have been completely ineffective. But, they have not been mobilized enough to

---

73 Mancinelli et al., Promoting Safer Use of Crack Cocaine.
74 Anonymous 1, interviewed by author, January 6, 2010.
76 When needle exchanges were first developed in Vancouver they operated under a one-to-one exchange, requiring a needle returned for a needle given. This was not the case in Toronto, where injection drug users could obtain as many needles as they needed.
77 Anonymous 1, interviewed January 6, 2010.
78 Anonymous 1, interviewed by author, January 6, 2010; Anonymous 3, interviewed by author, February 12, 2010.
destabilize existing policy. One example of programs engaging users is The Toronto Drug User Union that operates out of the South Riverdale Community Health Centre and CounterFit user support services. The Union facilitates the sharing of resources, education and tools between users, which helps not only to build awareness about drug use and harm reduction, but also to strengthen the community support and give the individual user a sense of belonging.\(^7^9\) Although this is not a Toronto-wide response, it is a model for engaging users and the using community in meaningful dialogue about safe practise and harm reduction, as well as health and wellness. It also demonstrates that while some part of the community recognizes a problem, it has not been sufficiently mobilized to destabilize existing policy.

Other programs engaging the community include the Safer Crack Kit Coalition and the Toronto Harm Reduction Task Force. The Safer Crack Kit Coalition provides important support within the community.\(^8^0\) In addition to responding through the distribution of crack kits to address the direct using need, it acts as a critical point of access for the user to the health system. Through the kits, which are distributed based on need, the Coalition teaches users about harm reduction, gives them access to treatment and helps develop important community bonds which assist users access other resources and learn from each other.

\(^7^9\) Anonymous 3, interviewed by author February 12, 2010.
\(^8^0\) City of Vancouver, *Harm Reduction in Toronto: Three Stories*, (Vancouver: Vancouver Costal Health) http://vancouver.ca/fourpillars/newsletter/Feb09/Torontostories.htm
The Harm Reduction Task Force, which operates through St. Michael’s Hospital, provides important education, training and awareness about harm reduction practices.\(^{81}\) The Task Force also acts as a conduit through which different agencies can access other resources and share their experiences, programs, and struggles. The Task Force has existed in Toronto since 1996 and is a fundamental part of developing awareness about harm reduction within Toronto.

Although programming exists within Toronto, and progress has been made in advancing service delivery within the community, such community activities which might highlight the problem of drug abuse have not gained the momentum needed to destabilize existing policy. Unlike Vancouver, the users in Toronto are not as mobilized or coherently represented. Where the Vancouver Area Network of Drug Users has been able to advocate clearly on behalf of the using community in Vancouver, Toronto users lack that movement. As such, even though there is recognition by the community that existing services are insufficient, there is not a large enough force of dissatisfaction to alter the existing policy.

**Government**

Government response to drug addiction in Toronto has not deviated from the norm of enforcement. Although support programs exist, they are services that exist across Canada and have not deviated from the status quo. Prior to 1998, the Greater Toronto Area was divided into the City of Toronto, East York, East York, 

---

\(^{81}\) Toronto Harm Reduction Task Force, www.torontoharmreduction.org
Etobicoke, North York, Scarborough and York. However, in 1998 the metropolitan government, which oversaw the affairs of the municipalities in the Greater Toronto Area and respective councils were dissolved and the City of Toronto was created. The impact on each former municipality was great. As former Councillor Michael Prue noted, municipalities were impacted because amalgamation affected citizens’ direct access to government, but also altered the way that programs, such as those pertaining to mental health, addictions and homelessness were addressed.\textsuperscript{82}

Prior to amalgamation, the city of Toronto was the home to the central downtown of the metropolitan region. With that came many of the challenges that exist in downtowns and inner cities, such as concentration of poverty, drug use and crime. Seeing the issues different neighbourhoods faced, the old city of Toronto could respond accordingly, as council was both physically smaller but also responsible for a geographically smaller area.\textsuperscript{83} Post-amalgamation, the power to address more contentious issues, like addiction, decreased and in some cases was diluted. This, as the councillors interviewed agreed, was because of the change in power dynamic and the growth of the affluent suburban vote within council.\textsuperscript{84} Prior to amalgamation, the old city of Toronto was able to respond to the needs of citizens with drug addiction issues. However post-

\textsuperscript{82} Michael Prue, interviewed by author, February 16, 2010.
\textsuperscript{83} Ibid; Gordon Perks, interviewed by author, February 18, 2010.
\textsuperscript{84} Gordon Perks, interviewed by author, February 18, 2010.
amalgamation the power of the councillors whose wards had a higher concentration of users was diluted by the suburban interests.\textsuperscript{85}

In many cases, within the outer suburban municipalities, which became part of Toronto in 1998, “the governments there weren’t investing in community infrastructure. You won’t find libraries, you won’t find community centres”.\textsuperscript{86} As a result there were areas of concentrated poverty in the municipalities around the old city of Toronto, as well as a cohort of youth who lacked the community options for engagement which would typically prevent them from engaging in crime, gang activity and drug use.\textsuperscript{87} Thus, in some parts of the city where there are no user supports and no coherent strategy to coordinate services the issues associated with drug use only grew.

In developing programs, Toronto Public Health (TPH) is responsible for a variety of different services, including mental health, alcohol, drug use, and the associated disease and health treatment within the city.\textsuperscript{88} TPH is governed by the Board of Health comprised of councillors and citizen representatives and is funded by the City Council and the Ontario Ministry of Health. In addition, with the support of TPH, the provincial government provides crack kits. The province of Ontario has mandated the delivery of needle exchanges in communities with drug-using populations which Toronto Public Health manages for the Toronto region. The Mandatory Health Programs and Services Guideline states that

\textsuperscript{85} Ibid.
\textsuperscript{86} Ibid.
\textsuperscript{87} Ibid.
\textsuperscript{88} Toronto Public Health, www.toronto.ca/health/aboutus.htm
the board of health shall ensure that injection drug users can have access to sterile injection equipment by the provision of needle and syringe exchange programs as a harm reduction strategy to prevent transmission of HIV, Hepatitis B, Hepatitis C and other blood-borne infections and associated diseases in areas where drug use is recognized as a problem in the community. The strategy shall also include counselling and education and referral to primary health services and addiction/treatment services.89

In addition to TPH, there is the Toronto Drug Strategy (TDS). The TDS was developed by the city of Toronto in 2004, and tasked with reviewing the programming and developing a comprehensive approach to drug use in Toronto. The strategy defines harm reduction as programs reducing health, social and economic costs associated with drug use, reducing harm to the community, offering practical cost-effective approaches to reducing crime and emphasizes key ethical, philosophical and practical values and principles required to address substance misuse.90 Within the city there are a number of different programs aimed at reducing harm. Community and Neighbourhood Services Department is responsible for the drug prevention activities, while Shelter, Housing and Support is involved with drug prevention/harm reduction work. These programs include:

- The Works a mobile and stationary needle exchange which provides “direct individual client support and services to drug uses and sex trade workers,“91 as well as safer crack kits,
- AIDS prevention grants provided to different community health centres to promote AIDS prevention and treatment,

---

90 Ibid.
91 Toronto Board of Health, *Harm Reduction Programs*, 5.
Drug Prevention Grants which aim to build capacity for local prevention initiatives,
Health Programs, Injury Prevention, Supportive Housing, policing, and
The Toronto Drug Treatment Court.

Although many drug use and addiction programs have existed for many years, until 2004 Toronto lacked a comprehensive drug strategy. It was reported to the Board of Health, by the Health Officer, following a harm reduction program review, that there was “no unifying framework to guide and/or co-ordinate all efforts” and that a strategy was needed to “articulate and establish a common vision and goals for the entire city to ensure strategic alignment of efforts.”

One example of a program that has been developed is the Annex at Seaton House, which operates a managed alcohol program. The Annex provides an example of a response by Public Health to need in the community. The Annex is home to 140 homeless men who have lived on the street for a very long time and need a lot of help because of alcohol addiction and other serious illnesses. The Annex helps homeless men get better through a harm reduction approach (reducing the harm they could do to themselves) that helps them with alcohol addictions and health problems. In some cases, their alcohol addictions are so severe they will drink mouthwash and rubbing alcohol. Therefore, at The Annex, the men and their alcohol intake are closely supervised to make sure they don't further harm themselves.

As former Councillor Prue and current Councillor Mihevc noted, the Annex provides a necessary alternative to using substances, such as shoe polish or mouthwash, which would have a greater impact on the user and the health care

---

92 Ibid.
93 Ibid.
system in the long run. Although neither councillor could comment on why the
decision was made initially to develop the facility, both noted that it was a
necessary component in providing care.

In addition, although the Annex has and continues to face criticism from
some among the public, advocates for its existence have been able to
communicate to the public the need for such a facility by placing the treatment
process in an economic frame. As councillors and public health officials noted,
the cost of serving alcoholics is far greater when a facility like this does not exist
than providing this kind of treatment and shelter. The individuals who are using
the facility are primarily older men who have been struggling with addiction
throughout their lives and without services like this are unable to break the cycle
of addiction. Although this has not stopped all public complaint, it has
alleviated some concern through developing an understanding of the need and
efficiency of such a program. Understanding the Annex is important because it
demonstrates an understanding of some elements of harm reduction but not to
the extent that council will extend its mandate to illegal substances, which a
supervised consumption site would require.

Assessing these programs is important because it demonstrates that there
are the resources to develop innovative programs, yet there is neither the
political will nor public pressure to do so for drug abuse. As noted, part of

94 Michael Prue, interviewed by author, February 16, 2010; Joe Mihevc, interviewed by author
February 16, 2010.
95 Anonymous 4, interviewed by author February 18, 2010.
96 Michael Prue, interviewed by author, February 16, 2010: Gordon Perks, interviewed by author,
February 18, 2010.
developing a framework for addressing drug abuse in Toronto included a review of harm reduction programming and a dialogue about alternatives to enforcement-based measures. The initial discussions around a drug strategy led to a series of working groups that aimed to discuss harm reduction and how substance misuse could be addressed in Toronto. They found that

Improving access to services for people who are homeless and use substances requires multiple strategies including:

a) expanding the number of services which operate from a harm reduction approach;

b) implementing a sector-wide education and training program for service providers; and

c) ensuring adequate funding, staffing and other supports are available to agencies so they can sustain harm reduction as an approach to service.98

The report cited above was presented to Toronto city council in April of 2003.

The Toronto Drug Strategy acknowledges the principles of harm reduction. It states, “we are a drug using society”, and acknowledges that people have used drugs to alter their perspective of reality for generations and regardless of what approaches are taken, this is not likely to change.99

Furthermore, the definitions of harm reduction provided highlight that not all drug use causes harm, but that which does needs to be addressed.

The development of the Toronto Drug Strategy and the example of The Annex indicates the recognition of a problem by health service providers in

98 City of Toronto, Toronto Drug Strategy: A comprehensive approach to alcohol and other drugs, (Toronto: City of Toronto, 2005).
99 Ibid., 2.
Toronto. However, it is important to note that the initiation of these projects has taken place outside of the city council, and have been developed by Toronto Public Health, or the Board of Health. In an examination of city council minutes little was found that illustrated conversations about any form of harm reduction programming had taken place. As Member of Provincial Parliament Prue noted, no politician would initiate these conversations, as doing so would be detrimental to their political career.\textsuperscript{100} Ultimately, it is not until the discussions surrounding these services and the additional required services take place at the political level that existing methods of enforcement will be replaced or supplemented with harm reduction methods and conversations about supervised consumption sites can take place.

**Options**

At this stage in the evolution of drug strategies developed by Toronto, multiple partners have been engaged in the Toronto and Ottawa Supervised Consumption Site Feasibility Study in assessing whether or not it is feasible for Toronto to have a supervised consumption site. As part of the 2004 Toronto Drug Strategy, Recommendation 65 recommends that “the City of Toronto conduct a needs assessment and feasibility study for supervised consumption sites taking into account the decentralized nature of drug use in Toronto.”\textsuperscript{101} The Toronto Drug Strategy Report highlights areas of need, as well as makes recommendations to both the Ontario and Canadian governments to develop

\textsuperscript{100} Michael Prue, interviewed by author February 16, 2010.
\textsuperscript{101} City of Toronto, *Toronto Drug Strategy*, 59.
comprehensive frameworks and strategies to maximise the resource use and minimize the harm of drug abuse. Yet, subsequent to recommendations, there has been little movement to establish frameworks or address existing challenges.

The interviewees noted that there needed to be a coordinated response in order to address the drug challenges faced by the Greater Toronto Area. In one example of uncoordinated services, public health officials would be distributing crack kits, and police would be confiscating them shortly after.\textsuperscript{102} In order to provide effective service to the using communities there needs to be a response from both the public health side, and from the political and policing side. To some councillors, this meant that the provincial and federal governments needed to work to establish formal policies regarding the different components of addressing addictions.\textsuperscript{103} Although the Toronto Drug Strategy provided recognition of drug abuse as an issue, the city has not specifically identified this as a core problem, nor has it identified options for change.

**Decision**

At this time the City of Toronto has chosen not to develop a supervised consumption site. However, the Toronto – Ottawa Supervised Consumption Site study, exploring the feasibility of consumption sites in Ontario, is set to be released in May 2010, and in November 2010 there will be a municipal election. This may or may not result in a supervised consumption site and the strategy may or may not become an election issue. In either situation the Strategy

\textsuperscript{102} Gordon Perks, interviewed by author February 18, 2010.
\textsuperscript{103} Ibid.; Joe Mihevc, interviewed by author February 16, 2010.
provides political decision makers an understanding of where the using community currently is and what gaps need to be filled in order to address those needs.

The problems faced by the City of Toronto with regard to addressing drug policy as identified by the interviewees for this study are four fold. The first is the lack of a national housing strategy. Without a national policy that directs and contributes to the development of housing, municipalities are greatly limited in what they can do. Without adequate housing, moving people who are addicted and homeless into shelters is challenging. The second factor is the lack of a provincial drug strategy. Without a provincial strategy, which dictates what the boards of health across Ontario are responsible for and what other services need to be provided, the City of Toronto is limited in what it can achieve. Third is capacity of governments to act. The municipal government does not have the funding, tools or capacity to develop drug policy for the community, thus it turns to the provincial government that also lacks the capacity to coordinate services and deliver a drug strategy. Finally, a change in attitude is needed between media, police and all partners involved in providing services to addicts.

As four councillors noted, the response from all levels of government also needs to be one that recognizes the different components of substance abuse.\(^{104}\) On one level there is the illegal drug aspect, on the other level there is an issue with the health of the users. The response, from all levels of government, needs

to include both pieces and get people engaged in the discussion the health impact of drug use. As Councillor Mihevc noted, this comes when people have direct experience with addictions and mental health, and when people realise the impact on the individual each of these problems they move away from the moral and absolute perspectives and begin to understand the role of alternatives to enforcement.105

During the 2000 Toronto municipal election, incumbent mayoral candidate Mel Lastman stated that there were no homeless people in North York.106 That statement being untrue, opened up a greater discussion about homelessness in suburban communities and a greater debate about the government’s responsibility to provide housing. Even though the comment did not prevent Lastman from being re-elected Mayor, the conversation around homelessness had forever changed. As Councillor Perks noted, people started to be aware of homelessness in their communities, and the mayor was proven wrong.107 As a result of his statement the mayor felt that he would lose too much support if he sided against new shelter developments and had to be careful of where he placed his support in future discussions around homelessness. The former mayor’s statements represent a resistance to recognizing problems and without that recognition and the subsequent discussions that recognition provokes, policy change cannot take place.

106 “Mel Lastman, Selling himself to a city,” CBC http://www.cbc.ca/toronto/features/mel/north_york.html
Another component, which may shape the policy choices that governments make, is the nature of the ward system in Toronto. Interviewees had two perspectives on the ward system. On one hand, it inhibits creation of new policy. The councillors are each directly elected within their wards and lines of local accountability are clear. While there may be a need within the city for a particular policy there is the potential that individual councillors will reject the policy because it is unpopular in their local ward and they may lose their position on council if they support it. On the other hand, as Councillor Perks noted, the direct accountability of the councillors to their wards means that they have to advocate on behalf of their wards, which in the long run will strengthen the programs that are developed because they will have worked to build support within the community and educate people. Even though the nature of the institution of the ward system may affect decision-making, Councillor Perks noted that he did not believe the ward system affected the decisions to pursue alternative drug policies.

Those engaged in service delivery, and the development of a feasibility study for supervised consumption sites imply that existing practices are not sufficient to address the need of addicts in Toronto. Interviewees noted that in order to move forward there needed to be coordination between provincial and federal governments with their own drug strategies but also between the municipal, provincial and federal governments. In addition there needs to be an expansion of programming from that which relates to legal substances to that

---

which embraces low barrier programs. Part of this comes from re-evaluating how
the debate is framed, as former mayor of Vancouver Philip Owen identified.\footnote{Philip Owen, interviewed by author, January 27, 2010.} As will be demonstrated below, in Vancouver the conversation focused on
addressing the health issue, not focusing on criminalizing the user. That move
has not been made in Toronto.

Whichever path Toronto subsequently takes it is likely to be an evolution
of policy not a revolution as Vancouver had.\footnote{Joe Mihevc, interviewed by author, February 16, 2010.} The political landscape, the
motivation of elected officials to make change, and the community response
have not, up to this point, been such that the existing policy has been
destabilized. By further developing their relationships with police, politicians and
the community, advocates of harm reduction may be able to slowly shift the
debate and to increase the amount of programming available. Even though the
Toronto Drug Strategy is studying the need for consumption sites and different
programming destabilization, the initial circumstances that Judith Goldstein notes
is necessary for major policy change, has not started. Whether Toronto’s
feasibility report will initiate discussions about a supervised injection site that may
lead to destabilization of policy and the move towards a new approach will be
seen only after the release of the study results.

5.2 Vancouver

In Vancouver, discussions about the shift away from the enforcement-
based approach to illicit drugs on the Downtown Eastside had started almost a
decade before the federal government began to examine the punitive *Narcotics Control Act* and replaced it with the *Controlled Drugs and Substances Act*. To many, the problem of drug use grew after 1986 and the Expo Worlds Fair.\(^{112}\) In addition to opening the city to people from around the world, Vancouver opened itself to new, stronger drugs, and the impact was visible.\(^{113}\) Late in July of 1986 notice went out warning users of a killer coke that was on the street. As the drug took its toll on residents of Vancouver, community advocates began searching for a solution to the growing drug problem.\(^{114}\) By 1988 advocates, such as John Turvey founder of Downtown Eastside Youth Activities Society (DEYAS), were handing out over three thousand clean syringes a month. Turvey and the DEYAS were able to secure funding for a needle exchange and in 1988 Vancouver became Canada’s first city to open an official needle exchange.\(^{115}\)

As the drug use continued to grow, it continued to receive public attention. In 1994, a group of community workers opened a site called the Back Alley Site.\(^{116}\) This was a place for addicts to inject, and it was occasionally visited by nurses who would bring clean materials and provide support. However, the Vancouver Police shut the site down a year later.

In the same year, B.C.’s Chief Coroner Vince Cain issued a major report on overdose deaths. He recommended that addiction be treated not as a criminal problem but as a health issue, and by 1997 the community in the

---

\(^{112}\) Campbell, Boyd and Culbert, *A Thousand Dreams*.

\(^{113}\) Ibid.


\(^{115}\) Campbell, Boyd and Culbert, *A Thousand Dreams*.

\(^{116}\) Ibid.
Downtown Eastside had begun to mobilize a street level campaign for safe injection facilities.\textsuperscript{117} This included dramatic protests by local groups and the development of Vancouver Area Network Drug Users (VANDU), a group who later proved pivotal to the creating policy change in the Downtown Eastside.

By 1998, a report by a senior B.C. public health officer had stated that the province was facing an “epidemic” of death and disease and that the overdose death spike and HIV/Hepatitis C infection rate had reached third world levels.\textsuperscript{118} After the release of this report, the issue of drug misuse and overdose deaths continued to grow in the Downtown Eastside, until it reached the point that the then Vancouver/ Richmond Health Board declared a medical emergency.

Despite the medical emergency in the Downtown Eastside, the Coroner’s Report and movement by the community to address the problem themselves through Back Alley, little was initially done by the municipal, provincial or federal governments to change the situation. However, by 2001 there was movement. The federal and provincial governments began discussing the Vancouver Agreement, an agreement between the federal, provincial, and municipal governments designed to address the impact of crime on the local cities. As the federal government was working with provinces and municipalities such as Winnipeg and Vancouver to address crime, upon closer analysis it became apparent that the greater issue in Vancouver, and the one causing much crime, was drug use. The focus of the Vancouver Agreement shifted to address

\textsuperscript{117} Ibid.
addiction as part of addressing the greater issue of crime in Vancouver, a process that will be explored further in chapter four.

In September 2003, Vancouver Coastal Health Authority was granted an exemption from the Controlled Drugs and Substances Act to pilot the supervised injection site called Insite.\textsuperscript{119} The federal government committed approximately 1.5 million dollars to fund the evaluation of the project, while the Government of BC was responsible for the funding and administration of all other aspects of the site. In addition, the site is co-managed by the Portland Hotel Society, a non-profit organization providing assistance for the homeless, hard to house and other at risk groups.\textsuperscript{120}

The recommendation for Insite emerged from the Framework for Action as a policy change, but the idea of a supervised injection site had existed in the community for almost a decade already. As the Framework for Action gained public support, pressure grew to develop a supervised injection site. The 2002 civic election in Vancouver was a turning point, as will be discussed in chapter six, but the ultimate decision to develop Insite was one which emerged politically from the four pillar approach and from the community because people were advocating for a safe space.

\textbf{Community}

As discussed in the harm reduction section the debate around danger and risk leads to a greater conversation about the culture of drugs. As Vancouver

\begin{flushleft}
\textsuperscript{119} Vancouver Coastal Health Authority, Supervised Injection Site, http://supervisedinjection.vch.ca
\textsuperscript{120} Ibid.
\end{flushleft}
experienced many levels of danger and perceived risk, the relationship with drugs and their impact on society began to change. This led to discussions about legalization of drugs, how to address a growing drug culture, and how to provide health care through programs such as needle exchanges and supervised injection sites.

These discussions took place within different policy communities and amongst different advocacy groups. As drug policy communities in Vancouver began to view addiction through a harm-reduction lens the dialogue began to shift from enforcement to harm reduction. But it was not just within the policy-makers’ community, but also among the general public that the conceptualization of addiction and illicit drug use began to change. Berridge notes that as such shifts take place, the broader cultural positioning of drugs within society changes. These changes in cultural positioning were seen in Vancouver, but not in Toronto, with regard to acceptance of harm reduction.

Community level mobilization in Vancouver was fundamental to the change in policy that ultimately took place. Efforts within the community to change how addiction was treated led to discussions that initiated some of the first harm reduction programming in Canada. The needle exchanges are arguably one example of the community reaction to the problem of addiction as those providing services took steps to minimise the associated harm. It was not, however, until the organization of the Vancouver Network of Drug Users

---

121 Berridge, “Histories of Harm Reduction”.
122 Ibid.
(VANDU) was formed that the interests of drug users were represented by a unified group who advocated on the behalf of the Downtown Eastside Community. VANDU emerged in 1997 as a support for drug users to discuss the issues they faced on the streets and the action they wanted to see taken. Facilitated by founders Bud Osborn and Anne Livingston, VANDU represented a group of individuals who wanted a space to receive treatment, counselling, or even a coffee without being restricted or judged. At the time of VANDU’s first meeting, it was hard for many facing addiction issues to find a place to socialize. Most facilities required users to be clean and sober before they could receive treatment which for addicts was not always possible.

In addition to giving users support, VANDU was mobilized and presented a coherent voice that could clearly identify the problems in the DTES and could advocate for change. From the beginning, they were engaged in educating people in the community about drug use and addiction through public meetings, gatherings and demonstrations. As the different levels of government were working towards Vancouver Agreement and the Framework for Action VANDU participated in any way they could. Even though they were engaging the using population, the work they did was instrumental in ensuring that conversations took place amongst the drug users, which would both educate users and build support and trust among them for government intervention and assistance. The existence of VANDU represents community identification of a problem. As MP Libby Davies highlighted, it was not just about enforcing the law it was about

---

123 Boyd, MacPherson and Osborn, Raise Shit.
recognizing a health problem, former mayor Larry Campbell echoed her comments and added that VANDU kept the pressure on to ensure that change did take place.\textsuperscript{125} If the issue had been effectively addressed on the Downtown Eastside there would have been no need for a user network or for the advocacy work that VANDU began doing.

In addition to VANDU, community mobilization in Vancouver was evident in the form of the Portland Hotel Society (PHS). The Portland Hotel was the first single resident occupancy (SRO) building in Vancouver operated by a non-profit organization.\textsuperscript{126} Jim Green, Downtown Eastside Residence Association President, hired Liz Evans, a former nurse working out of Vancouver General Hospital to provide care at one of his shelters. Evans became very active in the Downtown Eastside community, providing support and assistance to the mentally ill and addicted who were using the housing services the Portland Hotel provided.\textsuperscript{127} Evans and her partner Mark Townsend continue to operate the PHS which oversees many SROs around Vancouver as well as Insite and OnSite, the treatment facility associated with the supervised injection site.\textsuperscript{128}

The Portland Hotel Society was not only important because it operated a non-profit SRO, it represented a shift in how addicts and the homeless were assisted in the city.\textsuperscript{129} The Portland Hotel was one of the first SROs to allow tenants to use drugs in their room and would not evict residents if there were

\textsuperscript{125} Libby Davies, interviewed by author, February 23, 2010; Larry Campbell, interviewed by author, March 9, 2010.
\textsuperscript{126} Campbell, Boyd and Culbert, \textit{A Thousand Dreams}.
\textsuperscript{127} Ibid.
\textsuperscript{128} Ibid.
\textsuperscript{129} Ibid.
fights or disagreements.\textsuperscript{130} As Evans has said, “we believed everyone deserves housing. The very act of housing this population and not evicting them was shocking at that time.”\textsuperscript{131} The PHS represents a community recognition of the problems associated with drug abuse because of its very existence. As with VANDU, had the appropriate supports been in place the situation in the DTES, the PHS would not have developed the way it did and the services the two organizations provide would not have emerged from the bottom up.

In addition to VANDU and the PHS, other DTES organizations such as the Downtown Eastside Residents Association continued to advocate for change and policy solutions to the challenges in the DTES. Libby Davies, who has been involved in advocating for and working in the Downtown Eastside for many years, describes the movement as trying to bring about change in public and political attitude. Before the discussion had moved to the political level, there were many groups pushing to educate the public and politicians about the situation in Vancouver and the need for a solution.

As the situation in the Downtown Eastside worsened, specifically the alarming growth in overdose deaths, community activists responded with protest. One event, which many interviewees credited as a critical moment for bringing to the front of debate the crisis in the Downtown Eastside was crosses planted in Oppenheimer Park. In 1997, people from the Portland Hotel Society, VANDU and other organizations met and marched from the Carnegie Centre at Main and Hastings to Oppenheimer Park carrying a banner that read “The Killing Fields.”

\textsuperscript{130} Ibid.
\textsuperscript{131} Ibid., 90.
They planted a thousand crosses in memory of those who had died from overdose. As Donald MacPherson recalled, it was “the moment when things changed, it changed the discourse, it put names to crosses and they accused these people in power of creating the killing fields, which were harsh, harsh words.”

The success of the Framework For Action can partially be attributed to the work of the Portland Hotel Society’s education and outreach. In 1998, early in the discussion process about addressing issues in the Downtown Eastside, which led to the Framework, the Portland Hotel Society hosted a one-day, free to the public, event. Called Out of Harms Way, this event brought together people from the community as well as experts from European countries facing similar challenges. They discussed strategies like injection rooms, harm reduction and heroin prescription.

Out of Harms Way was an important move to educate the community, and took place around the same time as the event convened by the city’s Coalition for Crime Prevention and Drug Treatment. It was a particularly important community event because of the impact on people’s thinking about the issues. As Jenny Kwan remembers,

The speakers were so striking that they made people stop and think. They told stories of not just from scientific point of view, from a medical point of view, from a law enforcement point of view, and from a parent point of view.

---

133 Jenny Kwan, interviewed by author, January 8, 2010.
Addiction and the impact of drug use on individuals and communities, although heavily concentrated in the Downtown Eastside, was an issue that affected families throughout the Lower Mainland. Some affected were more affluent and mobilised their own network of support, a group called From Grief to Action. From Grief to Action was fundamental in the way it opened up and shifted the debate. The group was formed out of parents from an affluent area of Vancouver whose children had battled with drug addiction and together they began advocating for increased support systems. The recognition of the problem from communities outside of the Downtown Eastside was critical point in changing the debate and opening the door for policy change.

As Kwan notes, it highlighted that this “wasn't just a downtown eastside issue.”\(^{134}\) Not only did it highlight the spread of addictions in Vancouver, it impressed the then Mayor, Philip Owen, because it demonstrated drug use was affecting people within his own community. Addiction was not discriminating but was affecting every community in Vancouver. As Larry Campbell noted, these discussions highlighted the fact that addiction is an illness, it is not a character flaw. Having everyday, educated, citizens advocating for change demonstrated that the issues in the Downtown Eastside were not isolated in that neighbourhood.\(^ {135}\)

During the conversations around the *Framework For Action*, MacPherson recalled that “the whole Vancouver community had been engaged in some way,

---

\(^{134}\)Ibid.

\(^{135}\) Larry Campbell, interviewed by author, March 9, 2010.
you could not really have not heard about it.”136 Through activism on the ground in the Downtown Eastside to the middle class parents finding support in From Grief to Action, Vancouverites had heard and seen what the issues were with the drug scene Vancouver.

Other activities directed to the drug problem were also undertaken. In 1995, Anne Livingston started a group called IV Feed. With funding from the Downtown Eastside Residents Association she also created a site known as Back Alley.137 The Back Alley was an unsanctioned injection site that the police and city knew about, and initially did not react to. At the time, BC Coroner Larry Campbell (who would go on to become Mayor of Vancouver) spoke at the site. Initially, he had not supported it, but he was amazed by what had been accomplished. He observed, “I just looked at this humanity and I said, ‘You know, people, you’ve got to raise some hell about this. That’s about the only way the government is going to hear you.”138 The development of these programs and the statements by actors like Larry Campbell demonstrate community recognition of a problem and action that contributes to destabilization.

Government

The challenges facing the Downtown Eastside and the impact of substance misuse had been brought to the attention of the government as a pressing issue. In addition to the 1994 Coroner’s inquest into the rise in overdose deaths, numerous reports had been produced by the BC Government

137 Campbell, Boyd, Culbert A Thousand Dreams.
138 Ibid., 64.
highlighting the costs and challenges of drug abuse, specifically in the Downtown Eastside. As Libby Davies noted, the Coroner’s report emphasized the fact that addiction in the Downtown Eastside was a health issue. This view was eventually reflected in how Vancouver addressed addictions as part of the move away from an enforcement-based drug policy.

In 1997 the then Mayor Philip Owen and the city’s Urban Safety Commission established the Coalition for Crime Prevention and Drug Treatment. With over 60 partners, the Coalition initiated projects and conversations about drug addiction around the city. As Owen subsequently noted, they had watched other cities deal with crack cocaine and the impacts that it had, and anticipated that it would worsen the drug scene that existed. The city was warned that crack cocaine would really change the situation, and it did. The Coalition emerged following the declaration of medical emergency by the Vancouver/Richmond Health Board and is evidence that the government recognized a problem and was taking steps to address it.

At the same time as the Vancouver Agreement was being formed, the *Framework for Action: A Four-Pillar Approach to Drug Problems in Vancouver* was being negotiated at the municipal level. In developing the *Framework for Action*, the city entered into a consultation process that included six public forums and over thirty meetings with community groups and residents groups, community policing centres and community service organizations. The key

---

139 Libby Davies, interviewed by author, February 23, 2010; Cain, *Report on the Taskforce on Illicit Drugs*.
140 Libby Davies, interviewed by author, February 23, 2010.
141 Philip Owen, interviewed by author, January 27, 2010
themes resulting from these meetings included the lack of treatment resources, need for a diverse set of services, need for agency coordination, community involvement, action, enforcement, and the need to provide services across the city and to a diverse population. In addition to focusing on the consultation process, Vancouver also commissioned a survey to determine what the city knew about the issues in the Downtown Eastside, whether or not people supported the major action goals of the Framework For Action and whether or not they supported the Downtown Eastside Health and Safety Initiative.

Of those surveyed, 76% were aware of the Mayor’s Coalition for Crime Prevention and Drug Treatment, over 40% were aware of the Framework for Action. 90% supported the goal to create a strategy with provincial and federal support, 85% supported restoration of public order, and over 90% supported addressing the public health drug crisis in Vancouver. From the Framework for Action goals, people favoured public education and creating a Healthy City office, ensuring long term support for those who misuse drugs, and increasing policing and piloting a drug treatment court. Finally, almost 90% of those surveyed favoured going ahead with the Downtown Eastside Health and Safety Initiative, which “underscores both the importance of the issue and the public’s evident desire to tackle the problems sooner rather than later.”

The survey results are important in many ways. They show that the public was aware of the issue facing the Downtown Eastside, but also that the community was willing to support the city in its efforts to address the issue,

---

including the recommendations for the supervised injection site. The public support the *Framework* received made it safe for council to pursue the development of Insite.

The war on drugs, to this point had “only succeeded in increasing drug production, trafficking, corruption and fatalities”\(^{143}\) and the city of Vancouver was willing to take the risk and address addiction through a different mechanism. As drugs had become more available, more potent and more deadly, the issues associated with drug use impacted larger populations. Not only was there an increase in the potency of the drugs themselves there was a dramatic increase in the outbreaks of HIV and HCV, with alarming mortality rates all over the West Coast, from California to Vancouver.\(^{144}\) Furthermore it was clear that Vancouverites were willing to support the government in making changes to existing policies in order to address the public health problems of the Downtown Eastside.

As Councillor Raymond Louie highlighted in his interview, the past practices had failed and it was increasingly recognized that the conversation addressing addiction needed to be about redefining the challenges the city faced.\(^{145}\) In the past, the argument had been that addiction was a criminal problem but the dialogue was shifting from looking at addicts as criminals, to looking at how they were treated and recognizing that addiction needed to be redefined as a health problem. The discussion, as Louie stated, had to be

---

\(^{143}\) Dan Gardner, “How America Dictates the Global War on Drugs,” *Vancouver Sun* (September 5-18, 2000).

\(^{144}\) Ibid.

\(^{145}\) Raymond Louie, interviewed by author, January 28, 2010.
changed, to focus on the options and opportunities that the city and the community had to create a better society.\textsuperscript{146}

The options the city had were greatly informed by the experiences of other cities, and the successes other cities had in addressing similar problems. City staff and councillors had travelled to other jurisdictions that were taking alternative approaches to enforcement with regard to drug policy and the choices and recommendations the staff and councillors proposed were informed by these experiences.\textsuperscript{147} The decision to develop the \textit{Framework for Action} and Insite was about Vancouver focusing on addressing the challenges in the DTES “one block at a time”.\textsuperscript{148} This meant ensuring that the community in the DTES was protected and received the assistance needed to address substance misuse. It also meant working to develop a societal understanding of what caused the issues in order to determine how to address them within the community.

The emergence of community groups and government action plans signifies recognition of a problem, and the initiation by the city of conversations about alternative forms of addressing substance misuse highlight the destabilization of existing policy. In her analysis of American trade policy, Goldstein argues that there are three factors which are critical in the delegitimization process, “exogenous shocks… demographic changes… and

\begin{itemize}
\item \textsuperscript{146} Ibid.
\item \textsuperscript{147} Anonymous 5, interviewed by author March 10, 2010.
\item \textsuperscript{148} Raymond Louie, interviewed by author, January 28, 2010.
\end{itemize}
failure of current economic policies to generate desirable economic outcomes.”

Although she is referring to trade policy, exogenous shocks, demographic changes and failures of existing policy are relevant in the case of Vancouver drug policy as well, specifically the failure of existing policy to generate desirable outcomes. As Goldstein notes “the perception of a failed policy is necessary, thought not a sufficient, condition for fundamental change in economic policy”

In the case of Vancouver the perception of policy failure was enough to open the door for the evaluation of other policy options.

**Options**

At the same time that Portland Hotel Society was working to develop low-barrier housing and additional services, the City was working with people from around the world to learn about practices for addressing substance misuse, and the mayor was enlisting the support of his peers - mayors across Canada. These discussions were important discussions about options for changing the Downtown Eastside. As Owen said, the city had two options “do something or do nothing.” Doing nothing was not working so the conversation changed to focus on getting council and other levels of government together to respond and exploring what options were available to do something.

In 1997, the Philip Owen brought the idea about addressing drug policy reform to the Federation of Municipalities, specifically the 20 largest cities at a

---


150 Ibid., 14.
At this meeting, Owen began by highlighting the challenges in Vancouver and the choices they had to make. With provincial health officer Dr. Perry Kendall, Owen spoke to the mayors about how prohibition did not work, and that reform was the path they would have to take. Together Dr. Kendall and Owen pitched from their respective positions, as a provincial health officer seeing the health implications and as a mayor seeing the governmental implications. They argued that Vancouver had to do something and that the drug situation was a public health problem. Throughout the process of developing the groundwork for the Framework for Action and Insite, Owen noted that one of the challenges people faced was getting their minds around the user being ill and needing treatment, and the dealer being a criminal and needing to be arrested. By the end of the meeting a motion was passed that addiction was a health issue and that cities should engage harm reduction programs. All twenty mayors voted in support of it. This decision was fundamental in providing Owen the support he needed to return to the city and to start the process of addressing drug addiction in Vancouver.

In 1998, the Coalition for Crime Prevention and Drug Treatment, whose goal was to improve crime prevention and drug treatment in Vancouver, held a one day symposium on crime prevention and drug treatment. This was part of the CCPDT’s goal to facilitate discussions amongst community members in order to bring them together and look at solutions to substance misuse in the community. As MacPherson explained, the CCPDT invited experts from Europe.

---

151 Philip Owen, interviewed by author, January 27, 2010.
as well as people from around North America to discuss in the options that existed for addressing crime prevention and drug treatment. As the discussion developed they focused on practices like heroin prescription, new ways of policing and the failure of the war on drugs.

The Mayor and the CCPDT knew that addressing substance abuse would be a long-term process and the symposium was important for determining what Vancouver could do. As MacPherson pointed out, it introduced people to the experiences around the world and it provided different options for directions the discussions around policy could take. It was also very important because this was when the drug users joined the process. Owen started this conference with the Attorney General and the Chief of Police, whose commitment to the discussion about the Downtown Eastside he had already ensured. As Owen said “we had the chief of police, the attorney general, the health officer, the big city mayors conference was onside, now we had to work on the staff, council and the media.” But they also had the users involved, getting their perspectives and experiences and having them being part of the greater solution.

From the conference came it became apparent that the various players should coordinate and come up with a solid document outlining the process the city would take and the options they had. One of the recommendations from the discussions taking place would be a supervised injection site, a program that had been established in many of the European cases city council and staff had

---

152 Donald MacPherson, interviewed by author, January 6, 2010.
154 Ibid.
assessed. Although the supervised injection site was only one piece of a continuum of care it was one that was favoured by the community, and focused on heavily by the media. Once the draft *Framework for Action* had been developed, the mayor, health care professionals, police and the users themselves toured the city holding open discussions about what people thought about. “It was a real thorough process, and it’s hard to turn it off.”

At the same time as the draft was circulating, Owen was in touch with the media, working to ensure that they were at the discussion table and would support the process on which Vancouver was embarking. Newspapers from across the city participated in the process. Specifically, the *Vancouver Sun* ran a series highlighting the problems in the Downtown Eastside and supported the creation of a supervised injection site. Interviewees agreed this series contributed to the success of the program.

While the Mayor and others were presenting the draft *Framework for Action*, the provincial and federal governments were discussing the Vancouver Agreement. Jenny Kwan, who was part of that process at the provincial level, explained that the federal government was trying to address crime in cities across Canada and there was some money to put towards fighting crime. Through the discussions on the Vancouver Agreement, Vancouver was provided funds to increase enforcement of drug laws. However, as the situation was examined more closely in Vancouver, it became apparent that concerns in the DTES, including mental health and addiction, were the biggest barriers to

---

155 Ibid.
156 Jenny Kwan, interviewed by author, January 8, 2010.
overcome in order to address crime.\textsuperscript{157} The discussions surrounding the Vancouver Agreement were to go to the source of the problem and treat drug abuse as a mental health issue. As Owen explained, the Vancouver Agreement was very important because it ensured that all levels of government would know what their role was and that there would be continuity of policy delivery regardless of whether or not governments changed. He noted that there was often a great deal of staff turnover between different bureaucrats and politicians, but by signing this agreement, which included a clear plan for policy development, there could be consistency in the programming and the Agreement would ensure it worked. At the same time, at the federal level, discussions were starting to take place with the federal health minister about the situation in the Downtown Eastside and what needed to be done.\textsuperscript{158}

MacPherson and Owen both believed that the \textit{Framework for Action} would launch the discussion, from which the process for developing the supervised injection site and addressing the issues in the Downtown Eastside would emerge. As Owen noted, politicians often enter into a process to develop an idea that they have without doing the groundwork and without taking the time to make the process work. The ground-work, including the conversations which were part of the Vancouver Agreement and the consultation around the \textit{Framework For Action}, were all part of ensuring the process of addressing issues in the Downtown Eastside worked. From that process emerged options the city

\textsuperscript{157} Ibid.
\textsuperscript{158} Libby Davies, interviewed by author, February 23, 2010.
had for implementing the new practices and the further policy choices they could make.

The process surrounding the *Framework for Action* and the recommendation of Insite, however would not have worked without support from the community. Actors at the both the municipal level and the provincial level emphasised the importance of the public education campaigns which were directly and indirectly taking place in Vancouver. From public protests, through to the international symposiums put on by the PHS and the city of Vancouver discussions that took place across the city provided an opportunity to educate the public. These venues were important not only to put a face on the issues facing the Downtown Eastside but also emphasized the importance of the scientific and medical research and the need to shift the discussion of substance misuse from a conversation on enforcement to one about health embedded in a framework of treatment, prevention, harm reduction and enforcement.\(^{159}\)

As Owen explained, even though the momentum towards favouring a harm reduction approach was hard to stop once support was established, that is not to say there was not a great deal of opposition. Within Council, although many supported the *Framework for Action* there was a fear of political retaliation. The process for developing the *Framework*, as MacPherson said, was concentrated in the Mayor’s office. Prior to making the *Framework* public, MacPherson and other staff were working on a paper, people knew they were working on it, but no one really knew what the content was. Members of council

\(^{159}\) Jenny Kwan, interviewed January 8, 2010.
were concerned both because they were not as involved in its initial development and because they were worried that they were going to take the political heat. The concerns were there that drug abuse was seen as a criminal justice problem, a problem on which city should not initiate change and that the city did not have the capacity to change.

Once city council had the chance to view the draft proposal, they began the process of evaluating it and changing components. But as Macpherson said, they did not take out any of the core elements. The paper that emerged was a more collaborative version than what council had initially been given. This further contributed to a greater process for change in the DTES. As one former councillor noted, the discussions in Council were all in support of the Framework for Action, and the supervised injection site. Where resistance emerged was surrounding the extent to which additional supportive programming should be included. Council still supported the development of the Framework for Action, but was concerned about only opening a supervised injection site.

Many members of city council were concerned about how action on drug issues was being perceived by the public. Owen raised expectations that Council could solve the drug problems, but council wanted there to be more support from different levels. As the debate continued about the direction of the policy, media coverage of Council, public interpretation of the discussions at Council and discussions in Council themselves became very polarized. Council

---

160 Donald MacPherson, interviewed by author, January 6, 2010
162 Ibid.
felt constrained by what they could do given the media’s coverage of them and the fact that there was an election in the middle of the initial implementation stages of the *Framework for Action.*

Opposition to the proposed solutions to drug abuse in the DTES also existed in the community. Jenny Kwan recalled the attacks that she received from the Chinese community. When the Vancouver Agreement was launched, people were initially sceptical that anything would happen to address issues in the DTES. However once Insite was established people were angry at the focus of program delivery in the Downtown Eastside as opposed to moving the health and community services elsewhere. As is highlighted in the documentary *The Fix,* the Chinese community in the Downtown Eastside and the business community there as well as in neighbouring Gastown were very mobilized against moves to support user services in the neighbourhood. Although they were able to mobilize a resistance, they were not able to prevent services from being provided.

City Hall also received many complaints from people in the business, Chinese and resident community actively mobilizing against any options which resulted in service development for addicts in the Downtown Eastside. Many wanted the problem moved out of the area. But, as MacPherson said, that was not the purpose of the initiative. Services were going to be developed where they were needed most, so, responding to and addressing the community

---

163 Ibid.
concern was challenging. The opposition to the new direction included petitions and active demonstrations against the government plans. As Councillor Raymond Louie noted, there was a great deal of fear of the unknown in the community and a fear of what harm reduction meant, and of what treating people in the area where they live meant to the non-addicted populations and the business communities.\footnote{Raymond Louie, interviewed by author, January 15, 2010.}

In the third stage of Goldstein’s theory of policy change, policy makers seek out options. In this case, the development of the Framework for Action, and the Vancouver Agreement were both part of a process of exploring different ways to address addiction. At the time that both documents had been approved by their respective governments there had been no commitment to one specific strategy, just an evaluation of options. These came in the form of recommendations within the Framework for Action. Policy makers recognized that the city had to do something. This meant exploring the alternatives to the failing system of enforcement. City Councillors also recognized that the alternative to the existing practice of enforcement would include harm reduction.

**Decision**

The fourth stage of Goldstein’s process of policy change is the stage of delegitimization. Although that includes a process of institutionalization and socialization it starts with the selection of a policy path. In the case of Vancouver that was the decision to pursue the harm reduction pillar of the four pillar approach.
The choice to pursue Insite was not an overnight decision. The culmination of processes and pressures at the community and government levels was the result of almost ten years of conversations about how to address the problem of drug use and its effects in the Downtown Eastside. It was also, as Kwan, Davies and both emphasized, about improving the quality of life for the user and the community.\footnote{166 Jenny Kwan, Interviewed by author January 8, 2010; Philip Owen, interviewed by author, January 27, 2010; Libby Davies, interviewed by author, February 23, 2010.} As many interviewees noted, the discussion around Insite as an option to address issues in the Downtown Eastside was not about partisan politics but rather good public policy and changing a bad situation.

For Insite to be developed, many elements had to change. As Owen emphasized, the enforcement-only process was not working. There had to be a shift, separating the user from the dealer in order to address the health concerns of addiction and the criminal elements of dealing. This change in understanding opened the door for a shift in the conversation and gave a political piece to each group in the health versus enforcement divide. Those who believe in heavy enforcement could address the dealer, and those focusing on the user could look to health impacts. This was critical to ensure those who advocated for enforcement could still do so, but it characterized the user as sick and the dealer as the criminal, allowing room for health care options such as Insite.

Owen describes the process for developing the Framework for Action that led to the supervised injection site, as one of the choices. He emphasized the fact that enforcement was not working, and the city had to do something. They started small, had dialogues with community members and users, and worked
towards a larger goal. This meant not only having a document outlining the four pillar approach but actually selecting components of the approach and enacting them and advocating for Insite. The decision to act on the situation, as Owen noted, was part of realizing that the addicts in the Downtown Eastside were sick, and that sick people needed medical treatment.

The options city council explored initially included a supervised injection site as well as the remaining components of a four pillar approach. However, as one interviewee noted the supervised injection site was a solution that came about externally from others engaged in the community and advocating for the change that they wanted to see.\(^{167}\) Although many on council felt that it would be an important part of a continuum of care it was not the only piece they wanted to see implemented.

**Why Insite**

In 2002, after the process of implementing the *Framework for Action* had been initiated, Vancouver had a civic election. Leading up to the election, Mayor Philip Owen had announced he was not going to run again and stepped down from his party, the Non-Partisan Association (NPA). After his announcement, the Vancouver Sun ran a story that framed his resignation as him being removed from the party. The coverage alluded to his departure as influenced by his advocacy for the *Framework for Action* and the disagreement within council over how to implement and develop the *Framework* and subsequent supervised injection sites. Although one interviewee stated that Owen had resigned and

\(^{167}\) Anonymous 5, interviewed by author, March 9, 2010.
another individual had been encouraged to put forth their bid for mayor, the coverage was already public, and heavily criticized the NPA. The interviewee argued that Vancouverites did not have the opportunity to understand all of the events.\textsuperscript{168} In that election, former Coroner Larry Campbell ran for the Coalition of Progressive Electors (COPE) and won. Not only was Campbell elected mayor, COPE secured a majority of seats on council. There was also the second highest voter turn out in the city of Vancouver since records on turn out were collected, in the 1930s.\textsuperscript{169} The development of a supervised injection site was one of the main issues in the election, and Campbell advocated for it and the remaining three pillars.\textsuperscript{170} Campbell had long served as Coroner, a position that gave him first hand experience with the drug problem in the DTES and his opinions on changing the DTES were publically known.

In the interviews I undertook for this thesis, a number of factors emerged as explanations for the development of Insite. These factors included alignment of actors and values, media support, the economics of harm reduction over enforcement, and public education. The interviewees, in each individual interview emphasized different aspects of these components when describing what they believed to be at play.

Donald MacPherson, former City of Vancouver drug policy coordinator describes the decision to adopt the four pillar approach and pursue Insite as an

\begin{flushright}
\end{flushright}

\begin{flushright}
City of Vancouver, Voter Turn Out 1930-2005 
http://vancouver.ca/cyclerk/elections/voter_turnout.htm
\end{flushright}

\begin{flushright}
\end{flushright}
There was an alignment between politicians but also between public, police and political actors where each group saw a problem and found part of a solution in the four pillar approach. There was an alignment between political actors across levels. The groundwork had been done by the city and Philip Owen had demonstrated throughout his political career that he was a successful and supported politician and the establishment of Insite would be successful. As MacPherson says, politicians supported him because they believed in him and his ability as a politician.

After the election of Larry Campbell, the political support for the Framework for Action that Owen had established remained. As Owen recalled, Campbell received direct support from then Prime Minister Paul Martin who explicitly supported the initiatives in drug policy and the supervised injection site. This relationship was critical for maintaining an alignment of values and for the advancement of harm reduction policy.

In addition to political figures, the police supported the initiatives to address the issues in the Downtown Eastside. As Owen explained, he was the chair of the police board and was in a position to demonstrate to the chief of police how the Framework for Action would be more of a solution than a problem in the Downtown Eastside and was in turn able to ensure police force support throughout the process. In addition, as Jenny Kwan and Libby Davies noted, there were individual officers on the street who worked hard to advocate on

---

behalf of people on the Downtown Eastside, but also to ensure that other officers understood the issues.\textsuperscript{173}

Another segment of the community whose support was part of the alignment were the churches such as First United Church. These organizations had been providing food and shelter services for many years in the neighbourhood and were willing to assist in educating people and supporting the developments that were needed.\textsuperscript{174}

From the beginning, the city worked closely to keep the media informed and to ensure that they participated in the process. As MacPherson and Owen said, early on they spoke with reporters from the \textit{Vancouver Sun} and gave them embargoed access to the \textit{Framework for Action} so that they could then go and learn more themselves about supervised injection sites and four pillar approaches.\textsuperscript{175} Part of the results from this was a 12 part series by the \textit{Vancouver Sun} on the Downtown Eastside and the challenges it was facing.\textsuperscript{176} As Jenny Kwan noted, the media took a humanist approach that appealed to the individual Vancouverites and helped shift the focus from the overdose deaths towards appealing to people to help those suffering from addictions and to shift the emphasis from the crime and failures in the Downtown Eastside to focusing on what could be done. As Libby Davies noted, there as a change in perspective

\textsuperscript{173} Jenny Kwan, interviewed by author, January 8, 2010; Libby Davies, interviewed by author, February 23, 2010.
\textsuperscript{174} Jenny Kwan, interviewed by author, January 8, 2010.
\textsuperscript{175} Donald MacPherson, interviewed by author, January 6, 2010; Philip Owen, interviewed by author, January 27, 2010.
and as the media continued to support and to cover positively the development of Insite it became okay for the politicians to support it\textsuperscript{177}.

In addition to providing on-the-ground activism and representation, groups like the Portland Hotel Society and VANDU provided education to the public that was fundamental to advancing new drug policies. They worked to ensure that the community in the Downtown Eastside and around Vancouver knew what harm reduction was and what the changes would be to existing practices. Each of the interviewees stressed the importance of the Portland Hotel Society in laying the foundations for understanding the process and the actual form that policy would take once implemented.

One of the critical components of education was the \textit{Framework For Action} which gave the actors involved language for addressing the issue that they had never had before. When the drug use was only understood in terms of enforcement, there was no simple way to discuss alternative options. With the introduction of European models and the language of harm reduction understanding spread concerning ways to address addiction through a four pillar approach. In addition, they gave politicians a framework for debating how to move forward with drug policy. Owen noted one of the important pieces that occurred when Paul Martin was elected was that he had the language required to continue the conversation and support the respective policy makers as it made decisions and worked to gain an exemption from the \textit{Controlled Drugs and Substances Act}. Furthermore, as Insite was developed he understood and could

\textsuperscript{177} Libby Davies, interviewed by author, February 23, 2010.
advocate on behalf of the developments Vancouver was making in the rest of the federal government.

Another element which was a critical factor was the branding of the situation. MacPherson noted that as people were more educated, as they gained the language required, they understood what the Framework for Action stood for and what it would be doing in the community. As the four pillar approach was better understood people knew what a supervised injection site would be and how it would address the problems in the Downtown Eastside.

The focus on the four pillar approach resulted in increased awareness of what harm reduction is. However harm reduction is not the only component of this approach. In addition, the framing of policy change through the four pillar approach made harm reduction more politically acceptable as it was part of a greater change in how drug abuse was addressed. As Libby Davies noted, the Framework for Action made what council was trying to do safe.178 As many involved at the city level have noted, there is a hope that once the issue of the legality of Insite is addressed, the remaining pillars can be properly implemented. By framing the debate through the four pillar approach many interests could be represented and even when the supervised injection site was established the goal of changing the situation in the Downtown Eastside transcended political lines. Libby Davies described it as looking at the rights of the user and the pragmatic issues around life and death.179 These sentiments were supported by Kwan who further noted, the community was united for the change and

179 Ibid.
advocated to save lives because it was necessary.\textsuperscript{180} Both Kwan and Owen argued, it was good public policy, it made sense and it was putting aside partisan politics for a public policy that would have a positive impact on the community.\textsuperscript{181}

\textsuperscript{180} Jenny Kwan, interviewed by author, January 8, 2010.
\textsuperscript{181} Ibid.; Philip Owen, interviewed by author January 27, 2010.
6: IDEAS AND CHANGE IN VANCOUVER AND TORONTO

In Chapter Three, the role of ideas in policy change was introduced. Using Vivien Schmidt's theory of ideas, in this chapter I will demonstrate that Vancouver experienced change in ideas at the policy, program and philosophical levels and that Toronto has not. There has been policy development in Toronto aimed at programs, which support harm reduction practices, but the ideas that inform policy remain enforcement based.

Toronto

As was explained in the fifth chapter, there were four main factors that help to explain why Toronto has not developed a supervised consumption site. These factors also serve as an explanation for why the idea of harm reduction has not become the dominant philosophy on drug policy. Councillors interviewed stated that the lack of a national housing strategy and the lack of provincial drug strategy greatly constrained council's choices in addressing the drug using populations needs. Additionally, without the help of the provincial or federal government the city lacked the resources and political will to initiate the type of changes Vancouver made. Furthermore, Toronto lacks the support of the media and police for harm reduction programming. When combined these factors help to explain why the existing enforcement based policy paradigm has not shifted in Toronto and they have not yet developed a supervised injection site. Although these factors are, to some extent, present across Canada, they are particularly
constraining in Toronto because the city lacks a political advocate in the harm reduction field and there is no clear community pressure for more change.

In Toronto, interviewees primarily phrased the discussion of drug policy as something over which the municipality has little control. At a policy solution level, policies which did not radically alter the status quo tended to be the ones that were proposed. Although aimed at reducing harm, these programs did not change the existing frameworks with regard to innovative service delivery and appear to be ultimately driven by an enforcement perspective. In addition, the focus of harm reduction programs in Toronto was limited to abuse of legal substances, such as managed alcohol, and other programming such as needle distribution that already exist across Canada. Thus even though they were willing to adopt programs to reduce harm, they have not been as innovative as in Vancouver and harm reduction as a philosophy has not been established.

Although a four pillar approach is advocated for in the drug strategy, little has been developed by council to support prevention, treatment and harm reduction, especially with regards to illegal and injection drugs. Conversations are not occurring at the political level about what programs are needed to both reduce harm and further a harm reduction approach to addictions. As Councillor Perks noted, the committee responsible for the drug strategy had to work very hard to build relationships with the police and stakeholders in order to demonstrate that the strategy is not threatening to the enforcement based approach. Furthermore, as one member of the drug policy community noted,

---

there has not been the movement on the ground to galvanize harm reduction as a strategy.\textsuperscript{184}

In order for policy to change, the ideas that inform policy need to change. One indication that change in ideas has not taken place is that there have not been conversations about harm reduction and safe consumption facilities at the political level. The conversations that are taking place in Toronto to introduce new programs come from outside the political arena. When discussing harm reduction and drug policy with the former mayor of East York and former Toronto city councillor Michael Prue, he focused on how the discussion at City Hall, as well as in the provincial parliament, came from reports by the health officer not politicians. Having the health officer present proposals made the discussion safe and moved the debate from the political realm to the health realm. This change in reference meant that when the city of Toronto issued its drug strategy which made mention of the importance of harm reduction it did not reflect a philosophical shift at the political level.

Part of the constraints seen by city councillors is that they are only capable of doing so much.\textsuperscript{185} Although, the ward system, may encourage councillors to work hard to change the views of their constituents, it may also punish them when constituents object to new programming. As Councillor Mihevic noted, even though there are some who believe that the issue of drug use should be taken out of the criminal justice system and put into the health system, it was clear from discussing with other councillors that enforcement is

\textsuperscript{184} Anonymous 3, interviewed by author, February 12, 2010.
\textsuperscript{185} Anonymous 1, interviewed by author, January 6, 2010.
still the priority.\textsuperscript{186} There has not been change in ideas about harm reduction and many councillors fear losing re-election if they are to champion change.

Additional evidence that there has not been a change in ideas at the political level was suggested by those working in health care. There is a very diverse understanding of what harm reduction means, and when people work within a framework that focuses on harm reduction they understand that it is not about a cost benefit analysis but rather a pragmatic approach to a health issue.\textsuperscript{187} One interviewee noted that focusing on methods of reducing harm was not the discussion taking place in Toronto at any level yet. For the most part the debate pits abstinence only against public health approaches.\textsuperscript{188} Programs of harm reduction appear to have been developed not because of compassion but because of economics. For example, the Annex at Seaton house was a more affordable approach to chronic alcoholics than relying on ambulances and medical services as had happened before the Annex was established. In addition, providing harm reduction within a managed alcohol setting is not as complicated as providing a space for illegal drug use. An approach demonstrating a shift in ideas to harm reduction would include all addiction programming relating to substances.

The discussion in Toronto remains focused on enforcement. Although there has been some community recognition of a problem there has not been a unified voice advocating for change or developing programming from the ground up as there was in Vancouver. The media has not covered the issue in a

\textsuperscript{186} Joe Mihevc, interviewed by author, February 16, 2010.
\textsuperscript{187} Anonymous 4, interviewed by author, February 18, 2010.
\textsuperscript{188} Anonymous 5, interviewed by author, February 12, 2010.
supportive way that would influence public opinion, the police refuse to accept harm reduction and politicians are not engaging in a debate about harm reduction or a safe consumption site. The lack of public and political dialogue about a safe consumption site and harm reduction indicates that a change in ideas has not taken place.

**Vancouver**

The development of a supervised injection site in Vancouver has not been constrained by enforcement. The acceptance of harm reduction at the municipal level represents a shift in the core philosophy that informs addiction policy in Vancouver. As former drug policy coordinator Donald MacPherson and former mayor Philip Owen stated, after the discussion of the *Framework For Action* had taken place and Insite had opened, the conversation around how to address substance misuse in Vancouver had forever changed. Both Owen and MacPherson noted that no person could run for Mayor or leadership in Vancouver, regardless of political party, and not support the supervised injection site and expect to be elected. Insite represents a change in philosophy about how to address additions in Vancouver.

As previously argued, there are some central factors that led to the development of Insite: alignment of actors and values where both the community and political levels were focused on attaining the same goal using the same

---

190 Donald MacPherson, interviewed by author, January 6, 2010; Philip Owen, interviewed by author, January 27, 2010.
methods, media support, the economics of harm reduction over enforcement and public education. These factors both facilitated the change in ideas, and served to reinforce the idea of harm reduction which underpins Insite. As Donald MacPherson noted, the actors involved had roughly the same set of values relating to addressing the challenges in the Downtown Eastside before harm reduction became the focus. With research and experience, the dialogue began to change around how enforcement was not working and how harm reduction could offer potential solutions. The language of harm reduction and the four pillar approach gave actors shared tools for understanding and advocating for change. The relationship between politicians and the policy they supported was changed so that in order to be elected city councillors and the mayor had to support Insite. This indicates that a change in core philosophies was ultimately inverted so that you had to accept harm reduction in order to succeed politically in Vancouver.

As Schmidt notes, one of the important components of ideas being included in public values is that they are reflected through public processes such as elections. In Vancouver there was demonstrated support for those who fought for Insite. Jenny Kwan and Libby Davies were both re-elected and Larry Campbell who campaigned on the issue of supporting Insite, won the mayoral election. In addition to the previously sited poll reports on the Framework For Action, electoral success further demonstrates support for the idea of harm reduction.

---

192 Donald MacPherson, interviewed by author, January 6, 2010.
In my discussions with former mayor Philip Owen and MLA Jenny Kwan, it was clear that in Vancouver the motive for adopting the four pillars approach, although perhaps informed by economics, was one about good public policy that involved issues beyond economic considerations. As they both said, addressing the issues in the Downtown Eastside was not about partisan politics or making cost-benefit analysis it was about helping those who needed medical assistance.193 As Jenny Kwan noted it was about improving quality of life for the user, and ensuring there was support from all levels, not only about ensuring political success. Furthermore, as Libby Davies noted, change in the Downtowns Eastside was about trying to bring around a shift in public and political attitude, and framing the debate as a human issue. Although economics and the visibility of drug use played a role, people ultimately needed to see that it was a human issue. As Owen noted “you realize they are all sick, seeing what is not working makes you search for a new option.” That new option was harm reduction and ultimately Insite. The shift to advocating for Insite as a human and health issue represents a change from the focus on criminalizing the user and arresting all involved in injection drug use. This represents a change in ideas in Vancouver which did not exist in Toronto. Although there was a change in ideas from enforcement to harm reduction, that is not to say no other ideas existed. Harm reduction ultimately prevailed on the agenda over other options as the best answer to the policy problem.

---

Throughout this thesis reference has been made to Judith Goldstein’s theory of policy change. It was demonstrated in the fourth section that destabilisation, search for a new policy, and experimentation did not take place in Toronto but that they did in Vancouver. The role of ideas is important in the move from the search for a new policy to experimentation and the final step of institutionalization. Ideas must be present, specifically in this case harm reduction, needed to be widely accepted in order for Vancouver to move from the search for a new policy to the subsequent steps for creating the supervised injection site. In my interviews and media and documentary research it was clear that part of destabilization in Vancouver was the failure of the previous paradigm, enforcement. This was something that did not happen in Toronto.
7: CONCLUSION

The development of Insite in Vancouver, prior to any other city in Canada, was the result of many factors. These included an alignment of actors values at the public and political levels, a medical emergency on the Downtown Eastside and the support of the community, police and media. Each of these factors contributed to, and was influenced by, the role of the idea of harm reduction. In this thesis, I demonstrated that there was a change in ideas from focusing on enforcement to harm reduction based practices.

In Toronto, however, this was not the case. Although there is the recognition of a problem in the community, as demonstrated by the development of programming aimed at reducing harm to users and the commission of a supervised consumption site feasibility study, there has not been a shift values at the policy, program or political levels. There is an important distinction between Toronto and Vancouver, which is the extent to which programming to reduce harm is aimed at illegal versus legal drugs. As stated, the Annex at Seaton House is aimed at alcohol maintenance, a substance which is not illegal. The move has not been made to accept harm reduction programming as a method for addressing the challenges of illegal drug use.

In order to conduct this research I traced the policy process in Vancouver and Toronto using city council minutes, government reports and conducted 16 elite interviews with city councillors, staff and health board staff. With these data
I was able to demonstrate where policy was destabilized in Vancouver and how policy in Toronto comparatively was stable. This comparison was made in order to identify the community recognition of a policy problem, government recognition of a policy problem, options the cities faced and the decision that was made. This examination was used to determine where policy was destabilised in Vancouver and what prevented it from being destabilised in Toronto.

In Chapter Six, the policy in both cities was examined using Vivien A Schmidt’s ideas theory. In Toronto, it was clear in the evaluation of city council meeting minutes, and interviews with councillors and officials that the discussion was focused on enforcement. In addition, the statements that harm reduction was not and would not be discussed at the political level indicate that ideas in Toronto have not changed. This was not the case in Vancouver.

Both Donald MacPherson and Philip Owen emphasised that there had been a shift in understanding the problem in the Downtown Eastside, and an individual who was running for mayor would not be elected if they did not support Insite. This has been seen in subsequent elections, in both the 2005 and the 2008 elections, the Mayoral candidates came out and stated they supported Insite and a four pillar approach. As Insite represents harm reduction programming, it appears that the idea of harm reduction was supported in Vancouver from many levels. Furthermore, as it would be required of a candidate to support Insite, it is clear that the underlying ideas that inform policy in Vancouver have changed in a way that they have not in Toronto.
In both cities there were many factors that affected how policy developed, and understanding the roles of ideas has to include recognition that there may be many ideas present in the policy environment. As noted earlier, there was a contestation of ideas in Vancouver, but harm reduction prevailed as the idea that informed policy change. As well, institutions, such as the ward system mentioned in Chapter Five, may influence actors. Still the relationship between ideas in each city was such that in Vancouver, when the policy was destabilised harm reduction was the dominant idea, and enforcement remained the dominant idea in Toronto.

Understanding the role of ideas in policy appears to be important for understanding how dramatic changes in policy occur. The development of North America’s first supervised injection site took a change in the philosophical ideas that inform policy in Vancouver. In order to understand how this took place, Vancouver was compared to Toronto. In 1990, the two cities had relatively similar drug using populations and issues, however by 2004 the two had diverged greatly. This thesis demonstrated how ideas differed in the two cities and the factors that led to stability in Toronto and change in Vancouver.
APPENDIX I

List of Interviewees by date

John Fillion, interviewed by author, December 21, 2009.
Anonymous 1, interviewed by author, January 6, 2010.
Donald MacPherson, interviewed by author, January 6, 2010.
Jenny Kwan, interviewed by author, January 8, 2010.
Joe Mihevc, interviewed by author, February 16, 2010.
Carolyn Bennett, interviewed by author, February 19, 2010.
Libby Davies, interviewed by author, February 23, 2010.
Larry Campbell, interviewed by author, March 8, 2010.
APPENDIX II

Questions: Vancouver City Council
What roles did you serve in city council/provincial parliament?
Can you describe the issues surrounding substance misuse in Vancouver between 1990 and present day?
What options did city council have to address them?
What did they chose?
Can you describe that programming?
Can you describe the development of the Framework For Action?
What role did the Vancouver Agreement play?
When did the discussion shift to the supervised injection site?
Can you explain why that path was chosen over other paths?
Can you describe the role of harm reduction in drug policy?
What factors shaped the political debate?
What was the public response?
What was the role of the media?

Questions: Vancouver City Staff
What is your position? How does it relate to the city of Vancouver?
Can you describe the issues surrounding substance misuse in Vancouver since 1990?
What options did the city have for addressing those challenges?
What relationship did city staff have with council?
What role did staff play in developing those options?
Can you explain why the policy direction the city of Vancouver chose was taken over other directions?
Can you describe for me the development of the Framework For Action?
When did the discussion shift to the supervised injection site?
What role did the Vancouver Agreement play?
Can you describe the public response to substance abuse in Vancouver?
Questions for Toronto City Councillors
What roles did you serve in city council/provincial parliament?
Can you describe the issues surrounding substance misuse in Toronto between 1990 and present day?
What options did city council have to address them?
What did they chose?
Can you describe for me that programming?
Can you explain why that path was chosen over other paths?
Can you describe the role of harm reduction in drug policy?
What factors shaped the political debate?
Can you describe the public response to substance abuse in Toronto?
What was the role of the media?

Questions for Toronto Staff
What is your position? How does it relate to the city of Toronto?
Can you describe the issues surrounding substance misuse in Toronto since 1990?
What options did the city have for addressing those challenges?
What relationship did city staff have with council?
What role did staff play in developing those options?
Can you explain why the policy direction the city of Toronto chose was taken over other directions?
Can you describe the public response to substance abuse in Toronto?
REFERENCE LIST


--------- City of Toronto, Taskforce on Community Safety Key Activities and Accomplishments. (September 2003).


--------- Department of Justice. Controlled Drugs and Substances Act 1996 c.19.


--------- Health Officers Council of BC. A Public Health Approach to Drug Control in Canada. Canada, (October, 2005).


--- “How some homeless alcoholics are drinking their way to good health” Ottawa Citizens, January 2006.


--- Toronto Harm Reduction Task Force http://www.torontoharmredutction.org


O'Neil, Peter. “Tough on Drugs plans don’t work but get funds: study.” Vancouver Sun, (January 15, 2007).


Patrick, “The Drinks are on us at the homeless shelter” National Post January 7, 2006.


Sabot, Emmanuel “Dr Jekyll, Mr H(i)de: the contrasting face of elites at interview” *Geoforum* 30(4) 329-335 1999.


