HOW THE FRAMING OF SUPERVISED INJECTION SITES CAN HINDER IMPLEMENTATION

by

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Abstract

This thesis looks at the contradictory discourse surrounding supervised injection sites (SISs) in Canada. I define two major political camps with differing perspectives regarding the efficacy and safety of SISs and a third minor coalition that provides a unique perspective on the matter. These camps are the *public order camp*, the *public health camp*, and the *governmentality camp*. The positions of the three camps are profoundly political and substantiated on distinct moral and evidence-based claims with little discourse between them. I will rely on framing theory to demonstrate my hypothesis that there is little room for discourse between groups because each group depends on different forms of evidence to support its claims. Although this will help highlight the specific barriers limiting the efficacy of SISs, it will also demonstrate some of the limitations of evidence-based medicine in the face of highly polarizing political issues.

Statement

This thesis aims to present the debate on SISs as value-neutral as possible. As such, the various camps are all presented in a way that gives them equal standing. Although I have personal convictions regarding which camp frames SISs most accurately, the goal of this thesis is not to persuade the reader toward my view but rather to demonstrate how the different interest groups frame SISs to garner support for their positions. I have opted to write my thesis in a way that does not place my personal beliefs on the matter at the forefront of the conversation. I have chosen this approach to reflect that although I believe the public health camp may have higher standards for evidence, this does not make the public order camp any less influential. The goal of my thesis is not to convince the reader about the benefits of SISs but rather to demonstrate the political terrain as it appears, rather than as I believe it should be. The public order, public health, and governmentality camps rely on distinct evidence to support their claims. Although the standards are different, the reality is that the claims they make are convincing for many people, regardless of the quality of evidence relied upon to support them. Rather than critiquing the camps based on my personal beliefs, this thesis aims to show the lay of the land and highlight a significant barrier that SISs face in policy design and implementation.

Chapter One: Introduction

This thesis examines the politics of supervised injection sites (SISs) in Canada. Supervised injection sites are a component of a harm reduction approach to substance misuse, focusing on decreasing the harms associated with drug use instead of targeting drug use itself. Although a harm reduction model can be applied to any substance use, SISs focus on decreasing the risks of injection drug use. SISs and harm reduction are especially contested public health interventions as they invoke strong responses from various interest groups. Although the design of SISs is informed by evidence, the evidence used to support them is often not sufficient to alter the positions of their critics. It is helpful to think of harm reduction as a policy arena mired in a moral and political debate where there is little room for compromise (Hyshka et al., 2017; Hyshka et al., 2019). It is also beneficial to keep evidence-based policy-making (EBPM) in mind throughout the discussion of SISs as they firmly demonstrate some of the limitations of the assumption that having a strong evidence base will directly facilitate policy implementation.

EBPM follows the “rational expectation that improved policy analysis will flow from a better evidence base” (Head 2010, 77). In other words, the assumption is that a greater evidence base will lead to better analysis of existing policies and thus greater support for the development of future policies. EBPM emerges from the field of evidence-based medicine and, though they are distinguishable, the similarities are manifest. EBPM responds to a gap between evidence and policy (Cairney & Oliver, 2017), whereas evidence-based medicine

responds to a lack of rigour in clinical medicine due to a focus on clinical authority rather than scientific criteria (Sur & Dahm, 2011). The goals of evidence-based medicine are twofold: firstly, to gather evidence on health interventions, and secondly, to ensure that evidence directly impacts practice by influencing practitioners to replace inadequate interventions (Cairney & Oliver, 2017). This can be restated in terms of policy-making as a twofold process: firstly, there is a process of evidence-gathering on competing policies and policy recommendations. Secondly, the competing evidence is weighed, and the evidence deemed superior directly impacts policy implementation by replacing the lesser effective policies with more effective ones. However, the premises of EBPM are overstated: in practice, EBPM faces the significant hurdle that different interest groups will use a variety of manipulative and persuasive strategies to frame policy problems in ways that render evidence ineffective (ibid.).

This thesis uses an analysis of SIS policy in Canada to substantiate this critique of EBPM. Two powerful groups, each comprising an informal alliance of interested stakeholders, dominate the debate surrounding SISs, and they both raise distinct concerns about the ethics and efficacy of SISs which they use to frame the debate. I will call these the *public order camp* and the *public health camp*. I will also look to a third, the *governmentality camp,* to highlight some pertinent observations about SISs that are generally not acknowledged by the dominant ones. The tensions between these positions are deeply problematic as they have led to the inconsistent use of policy surrounding SISs across Canada. To better understand this problem, I ask why policy surrounding SISs is so

inconsistently implemented in Canada. I hypothesize that due to the polarizing nature of SISs there is little room for cross-coalition cooperation as each coalition frames SISs differently through distinct arguments based on discrete forms of evidence. This leaves little room for dialogue between the groups, which translates to inconsistent implementation of SISs nationwide as a strategy to address increasingly high rates of fatal overdoses (Belzak & Halverson, 2018).

The different perspectives surrounding SISs are rooted in distinct and disconnected beliefs that constrain the possibility of addressing increasingly high rates of fatal drug overdoses across the country. Although my research focuses primarily on the theoretical debate underpinning SISs and their impact on society, it is important not to stray too far away from the concrete reality of SISs and the historical context that frames them. To best evaluate the current barriers to cooperation in this policy arena, it is crucial to clearly outline the context within which they occur. With this consideration in mind, the chapters in this thesis are organized to reflect my approach of beginning with a largely descriptive section which moves onto the theoretical evaluation and discussion. This chapter will examine the unique political and legal struggles that SISs have faced and how attempts to overcome these struggles has led to the inconsistent implementation of SISs across the country. Chapter Two acts as a background chapter that will outline the history of SISs and demonstrate how this history has furthered the incoherent and disjointed state of policy on SISs in Canada. It will comprise an explanation of how harm reduction came to be in Canada and a description of the current distribution of SISs. Chapters Three to Five will set out the various

claims and positions of each group. These chapters will include a description of the actors and dynamics in each camp and an evaluation of their positions. Chapter Three focuses on the public order camp, Chapter Four examines the public health camp, and Chapter Five discusses the governmentality camp. Chapter Six will then round out the analysis and evaluation provided in the previous three chapters with a discussion of how the three coalitions' have each framed the subject so uniquely. This will be done with the intent of highlighting the obstacles to cross-coalition cooperation on policies surrounding SISs.

Although I will go into further detail about the topic in the next chapter, a few key points need to be made. SISs are just one aspect of a broader harm reduction framework that aims to reduce the negative impacts of drug use. Harm reduction is based on an ethos that advocates for improving drug-using practices instead of advocating for reduction or abstinence from drug use (Riley & O'Hare, 2000). There are many different aspects and strategies that make up a harm reduction approach, and some would argue that Canada has had them implemented since the 1960s in the form of methadone programs (Riley & O'Hare, 2000). However, methadone is more often framed as a transitional drug used to try to reduce the use of (or quit) other opioids. A more apt harm reduction intervention that makes central the value-neutral position is a needle exchange program. Canada has had needle exchange programs since the late 1980s, and they were primarily embraced as a response to rising HIV rates at the time (CCSA, 2006). In contrast, more contemporary harm reduction approaches such as SISs have a more targeted focus on reducing the increasingly high rates of

fatal overdoses (Hyshka, 2019). Harm reduction in its most familiar form, with the advent of needle exchanges, began in Canada in the 1980s, and this will mark the beginning of the time period that this thesis will examine. Beyond the background chapter, however, I will primarily focus on documents from the early 2000s to the current date as these are more specifically about SISs.

Table 1: SISs in Canada by Province and City

Province	City	Number of SISs in City
Alberta	Calgary	1
	Edmonton	3
	Grande Prairie	1
British Columbia	Kamloops	1
	Kelowna	1
	Surrey	1
	Vancouver	4
	Victoria	1
Ontario	Guelph	1
	Hamilton	1
	Kitchener	1
	London	1
	Ottawa	4
	St Catherines	1
	Thunder Bay	1
	Toronto	9
Quebec	Montreal	4
Saskatchewan	Saskatoon	1

Table 1: (Health Canada, 2021)

Although the discussion of SISs will be expanded in subsequent chapters, it is worth noting some specifics about them. Firstly, there are similar forms of intervention that are often confused with SISs. Two prominent examples are supervised consumption sites and overdose prevention sites. Supervised consumption sites generally have a broader mandate and may allow other consumption methods beyond injection drug use (TOSCA, 2012), but are quite similar in mandate and regulations. These are not the focus of my research, as I am looking specifically at *harm reduction related to injection drug use in the form of supervised injection sites*. Overdose prevention sites are similar to SISs but are distinct in that they do not have the same legal exemption from s56 of the criminal code, which allows for the use of illicit substances within the facility (Davidson, 2020). Often, local community members or advocacy groups set up overdose prevention sites and

they do not undergo the same application and sanctioning process as SISs. As of 2021, there are 37 formally sanctioned SISs in the country. These are spread amongst only five of the thirteen provinces and territories in Canada (Health Canada, 2021).

Although the primary service provided by SISs is the supervision of people as they self-inject, this is not the extent of the services offered. The primary goal of SISs is to decrease fatal overdoses through supervised injection. However, they also act as a clean needle distribution area, providing people who inject drugs (PWIDs) with clean gear to reduce the risk of transferring blood-borne viruses (Kennedy et al., 2020). Additionally, SISs serve an educational role where the trained staff show PWIDs how to safely and sterilely do so. This encourages users to continue to practice safer injection even when they are outside of the SIS. SISs also serve as a point of contact for public health and social workers to reach their clients and for the clients to access a variety of medical and social services should they need (ACCH, 2019). SISs also provide referrals to patients who desire treatment and detox options. However, it is not a mandatory precondition of accessing the services, as this would be contradictory to the harm reduction ethos (Rapid Response Services, 2014). Not requiring referrals for treatment and detox is one of many contentious components of SISs and different interest groups maintain different positions about whether the mandate of SISs should require referrals to these services.

My thesis will describe the differing claims made by the various camps to highlight the troubling disconnect between them. It will become evident that the

distinct frames of SISs put forth by these camps strongly limits the ability for cross-coalition cooperation. It is beneficial to think of the claims of each coalition as frames which govern their thoughts and actions regarding SISs. The frames all rely on privileging different forms of evidence and normative principles within each of the groups. Each coalition justifies their claims in ways that are ignored or devalued by the others. Although I will give equal attention to the public health, public order, and governmentality coalitions through the thesis, it is important to be mindful that in terms of political influence, the public order and public health coalitions hold the most clout. The governmentality coalition is primarily an academic perspective and has less direct influence over the policies on SISs. Having said this, the governmentality coalition is still worthy of consideration as it introduces a valuable perspective with unique implications to the highly contested policy arena.

Beyond the evidence used to justify the highly polarizing positions of these different coalitions, the policy debates surrounding SISs have some inherently complex practical considerations. SISs involve many distinct components that occur at varying levels of government. This lack of centralized decision making hinders standardized implementation. Federal, provincial, and municipal governments are involved in these decisions; and multiple government departments may be involved at each level. Policy planning involves several complex topics such as the sanctioning of illicit drug use, a public health component, government spending, and a significant shift to Canada’s dominant approach to the use of illicit substances. These factors make SISs unpalatable

for many who believe that drug use is inherently problematic and should be prohibited by the government. Members of this group argue for the continuation of prohibitive efforts to minimize and prevent drug use. Any of these components are enough to cause political tension; and the way that they intertwine in this case makes it exceptionally difficult to negotiate resolutions that satisfy the various political and social concerns.

Policy surrounding SISs require a large amount of political cooperation as they require approval from different departments across several levels of government. This cooperation is difficult to achieve because of political differences and priorities at the level of the local, provincial, and federal government. The legal exemption required to operate SISs is provided at the federal level, but even if the federal government supports the opening of more SISs, this does not necessarily translate to their use being expanded on a larger scale. Harm reduction and SISs also fall under the umbrella of health policy, a provincial responsibility, which allows for the different political and social priorities of the provinces and territories to shape policies about SISs as they see fit. To add yet another layer of complexity to the operational barriers limiting SISs, local municipal governments must also have the political will to formally apply for SISs, all while considering their local constituencies and other concerns such as zoning. Local governments are also under the jurisdiction of the larger provincial mandates, and this can be problematic because even if a local government would like to embrace harm reduction and SISs, there is no guarantee that they will be able to do so if their province does not endorse them.

I will use framing theory as the methodological framework to demonstrate that the major barrier to the further implementation of SISs is not the lack of evidence but rather how that evidence is mobilized through distinct frames being put forward by competing interests. Framing has multiple definitions, and I will rely on a fairly broad one that aptly captures the major problem surrounding SISs. Nierderdeppe et al. (2015) define framing as ”words, images, phrases, and presentation styles that a speaker uses when relaying information about an issue or an event to an audience” (839). In the context of SISs, the camps I will define and the messages that they all put forth are the unique ways they frame SISs. It is also worth considering that this thesis focuses on how SISs are framed, more generally, in a top-down manner. In the context of the dominant camps, my thesis focuses on those who hold political influence and can effectively mobilize their frames to garner support for their positions. A notable consequence of this is that I do not focus on the intervention’s recipients but rather on how SISs are framed on a broader scale. While there is still room for further research on the perceived benefits and value of SISs from the perspective of the people the intervention aims to attract and assist, that is beyond the focus of this thesis.

Framing theory lends itself well to my work because it helps to understand how the perception of the same subject can vary so widely and how these different understandings can be mobilized to either garner support or opposition (Nierderdeppe et al., 2015). Framing is a tool that aims to create stability in public opinions within specific cohorts or camps, and the way it is mobilized can lead to significant changes in public perspective on a given issue (Chong & Druckman,

2007). To help demonstrate how framing can cause shifts in opinion, Chong and Druckman use the example of free speech. When framing free speech, how it is discussed is influential in shaping the likely reaction of the targets of discourse. For example, when free speech is framed as an inalienable right, it is likely to evoke a response that would resist allowing any form of censorship, regardless of the content of speech. Alternatively, when unmitigated free speech is framed as a potential vehicle for hate speech or the promotion of violence, it becomes much more likely to evoke a reaction where the subject would accept some limitations on free speech. This example parallels the issue of SISs, as the various coalitions have unique ways of framing their evidence to evoke distinct emotional and practical responses from their target audiences. This will be explained in more detail in later chapters.

Framing is exceptionally influential on people with limited or no direct experience on a topic. The use of framing in this context can create links where there were none before (Becktel et al., 2021), and when these links connect with our pre-existing biases and opinions, frames serve to give order to our perceived reality (Carter, 2013). When various actors frame a topic, they select some parts of reality and privilege them in communication. Framing serves to not only give order to reality, but can also alter existing frames (Carter, 2013). It is important to recognize that although framing may appear as a top-down exercise where frames are provided by those in positions of power and influence, the truth is more nuanced. It is a multifaceted process where influence travels in all directions (Borah, 2011). This means that although frames are often initially

provided in a top-down manner through politicians, media, and other actors with influence, they are constantly adapting and changing over time. As frames are interpreted through the lens of individuals' distinct biases and opinions, the meaning that they impart changes. Over time, the frames can either intentionally or unintentionally be altered.

Frames are also unique because they are not directly commensurate with persuasive tactics. Even though they can be very persuasive and influence peoples' thoughts heavily, framing is a more subtle process (Carter, 2013). Rather than direct persuasion, framing serves as a mechanism to shape the social construction of reality (Carter, 2013) by limiting the salient information on a given topic in such a way as to lead people to a given conclusion. This need not necessarily be done in an obvious way, and sometimes small changes in the presentation of a topic can lead to significant changes in opinion (Chong & Druckman, 2007). I would also like to draw attention to the fact that framing is neither an inherently positive nor negative process. It can be seen in both lights (Chong & Druckman, 2007). A positive conception of framing sees it as a process by which people gain shared beliefs and coordinate over a social norm. On the other hand, it can also be described as a manipulative and deceitful process by which peoples' opinions are shaped in subtle ways that help powerful interest groups maintain or forge their interests. I will not offer an opinion on the nature of framing in this text, but it is worth noting that there are differing opinions on whether framing is positive or negative.

Throughout this thesis I aim to show that how SISs are framed and discussed between different coalitions at different levels of government largely dictates whether they will be embraced as a public health intervention (Fitzgerald, 2013). Additionally, this discourse, or lack thereof, between groups shapes how SISs will be designed, should they be permitted to operate. There is a serious inconsistency in the programs from province to province, due primarily to the inability to create a dialogue between the various interest groups. This limits the development of any standardized implementation protocol. The inconsistent program design and the failure to foster productive dialogue between the multiple coalitions result in the continued use of SISs more as a political tool rather than a health intervention. SISs acting as a political flashpoint adds more stress to their already tenuous position as they are susceptible to shifts and alterations with the political climate. The use of SISs as a political tool to push through the different agendas is exemplified by the 2015 election of the federal Liberal government, which led to the more widespread endorsement of SISs by Ottawa (Hyshka, 2017). An opposite effect occurred in the 2018 provincial election of a Conservative government in Ontario which led to a widespread shift to SIS policy within the province. The changes to SISs in Ontario have been criticized as shifting the services away from their roots as a harm reduction intervention towards a more traditional drug use reduction approach (Russel et al., 2020). The lack of a consistent position between key established interests has been profoundly problematic and requires further research as it continues to politicize a policy that offers a practical health intervention.

Chapter Two: The History Of Harm Reduction In Canada

SISs are a relatively new health intervention in Canada (first implemented in 2003) but they are rooted in an older debate. Underlying this debate is a discussion about the ethics and morality of harm reduction. The broader discussion about harm reduction has been ongoing since at least the 1960s in Canada. This chapter will describe the tumultuous history of harm reduction in Canada using the example of methadone programs beginning in the 1960s, the needle exchange programs (NEPs) of the late 1980s, and will culminate with a description of the development of SISs. Although there are many parallels with the past, SISs also face hurdles that are uniquely their own. By describing the historical, current, legal, and political barriers to the implementation of SISs, I will provide a robust background to the subject that elucidates the roots of this policy debate.

Domestically, harm reduction has existed to varying degrees for over half a century. Constant throughout this period is that, regardless of the intervention, it is marked by disagreement and a slow path to nationwide implementation. In part, this is due to the inherent contradiction between harm reduction's ideals of pragmatism, humanistic values, focus on harms, and the prioritization of immediate goals versus a common perspective of drug use as intrinsically problematic and requiring a law enforcement approach to address it (Riley et al., 1999). This is true now, and was true with the advent of methadone clinics in the 1960s. Methadone was first implemented with the logic that providing illicit drug users with a regulated opioid supply would help reduce the harms and criminality

of illicit drug use. Although the idea gained popularity in the 1950s, it was not until 1964 that Canada's first clinic opened in Ontario (Fischer, 2000). The use of methadone marked a significant shift from viewing drug addiction as a criminal and moral issue, but it quickly became apparent this shift in perspective would not be easily adopted on a wide scale.

Beyond the similarities between SISs and methadone clinics as forms of harm reduction, they have also faced similar practical barriers. Methadone programs initially saw a fair bit of support, and by 1972 there were 23 clinics in Canada (Fischer, 2000). However, significant resistance against the programs led to a host of restrictive policies being put in place throughout the 1970s. These restrictive policies essentially paralyzed the implementation of other methadone clinics across the country and little changed throughout the decade. It was not until the 1990s that methadone programs saw a revitalization and became much more widespread (Fischer, 2000). Furthermore, in 1995 the federal government relinquished all control over methadone programs and placed them squarely under the provincial health mandate (ibid.). This signaled the federal government's wish to distance itself from the controversial policy.

The development of methadone clinics highlights that the implementation of harm reduction is not linear but rather is marked by a push and pull between the proponents and critics of the intervention. It is useful to consider methadone programs when researching harm reduction in Canada as they serve to demonstrate a long-standing conflict between priorities of public health and public order. One must also keep in mind that methadone programs are a distinct

form of harm reduction that is not entirely comparable with SISs. NEPs are more similar to SISs and they too follow a similar struggle to implementation. A significant distinction between NEPs and methadone programs is that methadone is typically prescribed with the goal of promoting abstinence. Although this is still a form of harm reduction, it garners support by promoting an avenue with which people who use drugs may quit. On the other hand, NEPs are a low threshold intervention that provides PWIDs with clean syringes so that the subject may inject in as hygienic a manner as possible (CCSA, NEP, 2004). This is distinct from methadone programs and more similar to SISs, as NEPs focus most of their effort on reducing the immediate harms associated with injection drug use rather than the reduction of drug use itself. SISs also act as NEPs as they provide clean gear for injection drug users.

Although NEPs spread across Canada much more rapidly than methadone programs, they still faced significant opposition. The first NEP opened unofficially in Toronto in 1987 and was quickly followed by government-sanctioned ones, in Toronto and Vancouver, in 1989 (CCSA, NEP, 2004). Yet, it was not until 2005 that they became available in every province (CCSA, NEP, 2004). Regardless of the bounty of health evidence highlighting the positive effects of NEPs, they still took over 15 years to implement nationwide. The lethargy with which this intervention spread is a bi-product of the political backlash against the transition away from a law enforcement-based approach to illicit drug use and the Canadian system of governance and distribution of power.

The second point is made evident in a study comparing the expansion of NEPs in the UK and Canada.

A comparative study of the pace at which NEPs developed in the UK and Canada highlights that the Canadian system of federalism has been a significant barrier in creating widespread harm reduction policy and holds direct parallels with the current state of SISs. Not to be taken as a judgment on the merits of federalism, this study merely describes how the lack of centralized health authority in Canada resulted in a unique set of barriers for implementing NEPs that were not faced in the UK. In the UK, the first NEP opened in 1987, and by 1993 there were 300 of them nationwide. Canada, in contrast, opened its first NEP in 1989, and by 1994 there were only 30 (Hayle, 2018). At this time, there were several other similarities in the political landscape of both countries that are worth noting. For example, both the UK and Canada had conservative prime ministers (Thatcher in the UK and Mulroney in Canada). Both were responding to a common problem of the rapid spread of HIV linked with injection drug use. Both leaders desired to implement NEPs in their respective countries, but due to the centralized nature of political power in the UK it was much more successful than in Canada.

The study describes how resistance at the subnational level of government was the major impediment to implementing a broader scale NEP strategy in Canada. In the UK, when subnational governments resisted NEPs, the national government could coerce them into implementing the intervention. In contrast, Canada's distribution of political power resulted in the federal

government's inability to force the provinces to implement NEPs (Hayle, 2018). This severely limited the spread of NEPs across the nation. Furthermore, the distribution of political power in Canada severely limits the consistency of harm reduction policies, and this trend is notable in the more contemporary harm reduction debate on SISs.

SISs have existed internationally since the 1970s in the Netherlands, the 1980s in Switzerland, and the 1990s in Germany. And although their existence certainly influenced the policy in Canada, a large flashpoint for the development of Canadian SISs was in 1994 when then chief coroner of BC, Vince Cain, released a report highlighting the need for a shift in policies surrounding illicit drug use (Canadian Drug Policy Coalition, 2020). The report, commonly referred to as the Cain report, described the potential benefits of decriminalizing heroin and enacting harm reduction interventions, sparked interest in the viability of SISs in Canada (Kerr et al., 2017). Initially, government action was minimal, leading to user-led initiatives such as the group IV Feed opening an unsanctioned, user-led SIS commonly referred to as "Back Alley" in 1996 in Vancouver (Kerr et al., 2003). The government closed this, and other, unsanctioned SISs down within a year, but a spark had been lit, and a push for an expansion of harm reduction strategies began. By 2000, a coalition of users, activists, health professionals, and researchers formed the Harm Reduction Action Society to advocate for SISs. Through their advocacy and the advocacy of others, the government began to reconsider its strategy. Late in 2000, the federal government embraced a four-pillar drug strategy that expanded to include harm

reduction. The persistent advocacy proved effective, and in December of 2002, Health Canada released guidelines to apply for a pilot research program, and the first SIS was set to open in 2003 (Kerr et al., 2003).

As part of the pilot program Insite, Canada's first SIS, opened in Vancouver in 2003 with a three-year exemption to s56 of the Controlled Drugs and Substance Act (CDSA). This exemption allowed for the consumption of illicit substances within the facility. By 2006, when a renewal of this exemption was required, 22 peer-reviewed papers had been published on Insite, and none of them found negative impacts that could be associated with the site (Wood et al., 2008). However, this body of evidence did not translate to a renewal of the s56 exemption as the newly elected conservative federal government refused it (Kerr et al., 2017). Tony Clement, then federal health minister, justified the refusal to renew their exemption primarily based in support of the public statements made against SISs by the Canadian Police Association (CPA) and the RCMP. In addition to endorsing the claims made by the CPA and RCMP, Clement also cited two studies that found SISs had negative impacts (Dooling & Rachlis, 2010). Interestingly, neither of the two studies referenced were peer-reviewed, and the Point Legal Society uncovered that the RCMP funded these studies through the freedom of information act years later (ibid.). Before funding these two studies, the RCMP initially financed one that aimed to be peer-reviewed, but when this study concluded there were benefits to SISs, the RCMP quickly distanced themselves from it and proceeded to fund the two that Clement would often cite (Dooling & Rachlis, 2010).

The 2006 refusal to renew the s56 exemption was met with significant resistance, and in 2008 the PHS Community Services Society took the matter to court on behalf of Insite. The legal battle, including appeals, lasted until 2011 when the Supreme Court of Canada sided with both the Superior Court of BC and the BC Court of Appeals in a 9 to 0 ruling enshrining Insite's right to operate based on s7 of the Charter of Rights and Freedoms, the right to life liberty and security of the person (Manson-Singer & Allin, 2020). Although this ruling protected the right of SISs to operate at Canada's highest level of court, the decision also maintained the federal government's role in approving SISs and did not place SISs firmly under the provincial jurisdiction (ibid.). This decision underscored the need for continued cooperation between federal and provincial governments due to shared jurisdiction. The continued involvement of the federal government in the design and approval of SISs led to further barriers being put in place, serving to limit the spread of SISs across Canada.

Likely in response to the Supreme Court ruling, the federal government, which still vehemently opposed SISs and harm reduction, began to draft a bill that would create rigorous new conditions within which SISs were required to operate. This became Bill C-2 and was implemented in 2014 as the Respect for Communities Act (CBA, 2014). Although it could not legally prohibit SISs, it was able to, and did, create an arduous application process. Included in this process were 26 requirements that needed to be met before an application would be reviewed. The entire application also needed to be completed in full before a review could begin (ibid.). Due to Insite's legal battle, the resistance of the federal

government, and the implementation of Bill C-2, there were no new SISs approved to open in Canada until 2017. Similar to methadone programs in the 1970s, excessive regulation effectively hindered the intervention to the point of near extinction (Fischer, 2000).

Bill C-2 was short-lived, and in 2015, a new liberal federal government was elected, marking a widespread shift in policies surrounding SISs. Although the new government voiced support for harm reduction, it was not until 2017 that their rhetoric turned to action with the implementation of Bill C-37, an Act to amend the Controlled Drugs and Substances Act and to make related amendments to other Acts. This served to amend the CDSA and superseded Bill C-2's onerous restrictions (Health Canada, 2017). Bill C-37 contained some amendments to help law enforcement tackle the illicit drug trade more effectively but primarily marked a colossal shift in the requirements for opening SISs. The number of requirements was reduced from 26 to 8, the application process for SISs was to be made more transparent and could begin as long as the applicant had the key considerations completed (ibid.). Though this marked a commitment to promises made by the new Liberal federal government during the election, it did not translate to a national spread of SISs as the ultimate impetus for SISs is in the hands of the provinces.

Similar to NEPs, the division of political power in Canada has played a significant role in the status quo of SISs, wherein different provinces have significantly different policies, if they even have them. As noted in the introductory chapter, of the 13 provinces and territories in Canada, only 5 have SISs: Alberta,

British Columbia, Ontario, Quebec, and Saskatchewan (Health Canada, 2021). Similar in effect to the NEPs, which took nearly 20 years to become available in all provinces, the distribution of political power in Canada allows each province discretion over health-related policy and has hindered the spread of SISs. Although the Supreme Court ruling defends SISs right to remain open under s7 of the Charter, the federal government does not have the power to force provinces to open SISs. Currently, the federal government endorses SISs, but faces resistance from numerous provinces. However, this division of power also means that should future federal governments resist the spread of SISs, provinces will be able to chose for themselves whether they would like to use SISs as a part of a harm reduction strategy. The division of political power has led to distinct policies forming from province to province, which is reminiscent of the difficulties NEPs faced in their propagation. Beyond the interprovincial differences, there are also ongoing political debates within the borders of any given province.

The instability of SIS policy within the provinces is evident when we consider a few examples. Firstly, in 2018 the Ontario government overhauled their entire SIS program and relabeled them as Consumption Treatment Services (CTS) (Russel et al., 2020). This overhaul created more onerous barriers to opening a site. For example, it made the service conditional on seeking treatment, and limited the number of sites provincewide to 21 (Russel et al., 2020). This has been criticized as a political play with potentially dangerous implications for Ontario's injection drug-using population. Saskatchewan is a

unique example as the provincial government technically endorse SISs, but provides inadequate funding. The inadequate funding sends a mixed message and, as a result, Saskatchewan's first SCS (it allows for smoking) became a crowdfunded endeavor where the public had to fund a full-time paramedic's salary (McMillan, 2020). The shifting policies and priorities within the provinces are also highlighted in Alberta, where Calgary has recently announced the closing of Safeworks, the most heavily used SIS in the province (Smith, 2021). Although this announcement was made with a statement that two other locations would open and replace it, the details are limited.

These examples demonstrate the potential pitfalls of provincial power over SISs, but the division of power between Ottawa and the provinces can also be conceived of as potentially beneficial for SIS policy. If future federal governments are anti-SIS the provincial governments will have the ability to pursue harm reduction policies that Ottawa does not endorse. This scenario has already been exemplified in the early history of SISs where British Columbia endorsed them, opposing the federal government. Federalism is not an inherent barrier to the opening of SISs, but it allows for more diversity in health policy nationwide, limiting its consistent implementation. The ability of each province to champion its health policy means that regardless of the federal government's position, they hold the power to either advance or obstruct policies as they wish.

The debate on SISs in Canada is a relatively new one, as the intervention has only been implemented within the last 20 years. However, the debate about harm reduction underlying SISs has been ongoing for over half a century. A

pattern becomes clear when one looks at methadone programs, NEPs, and SISs as different pieces of the same harm reduction puzzle. Due to a blend of different political and public interests and the distribution of political power in Canada, harm reduction has remained an ever-contentious policy arena. It is critical to understand the historical context which has shaped the current debate if one is to understand the tenuous position of SISs. This chapter has outlined the similarities that SISs have with previous harm reduction interventions and provides the necessary historical context to the ongoing policy debate.

By highlighting numerous similarities that SISs share with past harm reduction interventions and how Canadian governance systems have been a barrier in the spread of SISs, this chapter has addressed the question of how some barriers limit the implementation of SISs. However, merely addressing the question of how barriers make implementation more difficult does not completely explain why such resistance continues. Though federalism may allow for distinct policies between the provinces, it does not eliminate the potential for consistent policymaking across Canada *per se*. Although it is evident that Canada's system of federalism has limited the policy-making process of SISs, there are still other variables constituting barriers that are worthy of study. By considering what arguments are used to support the claims made by the various camps outlined in Chapter One, I will further evaluate the difficulties in developing consistent, nationwide policy on SISs.

Chapter Three: The "Public Order" Camp

3.1 Description

In the previous chapter, I outlined the difficult path to implementing various harm reduction strategies in Canada. The debate between the proponents and critics of harm reduction interventions has been ongoing since the 1960s. Though earlier forms of harm reduction have become significantly more widespread, the current vanguard of harm reduction, SISs, continue to face significant public and political opposition. The focus of this chapter is to detail a major source of resistance against SISs. Although the *public order camp* it is not a deliberately constituted coalition, it is comprised of several groups with similar positions that can be loosely grouped together. They are characterized by a skepticism that SISs are a beneficial public health strategy, and they believe that the intervention fails to address the negative outcomes and impacts of illicit drug use. Additionally, these beliefs are centered around more normative claims about the nature of drug use and potentially negative societal impacts of SISs. As I have stated, this group has not come together deliberately, but the constituents are still worth considering as a single stakeholder group. This is because the group shares similar interests and approaches to addressing problems associated with illicit drug use that are rooted in shared ideological and practical concerns that are reflected in their framing of SISs.

3.2 Subgroups of the "Public Order" Camp

Though there is discernable variation amongst the subgroups that make up the public order camp, for analytical purposes, it can broadly be divided into

four subgroups. A key subgroup in the public order camp is Canada's Conservative leadership. The second subgroup, which also maintain significant influence is law enforcement. The third subgroup worth considering consists of members of the general public who may not have particularly strong convictions about harm reduction on principle but are motivated by the not in my backyard (NIMBY) phenomena. This subgroup consists of a diverse group of people including parents who are concerned about their children being in close proximity to a space where illicit drug use is sanctioned. The final subgroup is characterized by a negative view of harm reduction based on a critique of the medicalization and professionalization of drug treatment strategies. In this chapter, I will describe how these subgroups come together to frame SISs in light of public order concerns, as well as the justifications used to support their framing. This group is distinct from the public health camp in that it is much more loosely organized and, rather than overt cooperation, is based on shared ideas about the nature of drug use and the potential negative implications that sanctioning illicit drug use, even in a supervised setting, may have on society.

3.3 Political Subgroup

The previous chapter demonstrated that, at a federal level, there is a clear division between the current Liberal government, which supports SISs, and the Conservative party, which strongly opposes SISs wherever possible. The Conservative resistance to SISs is of course not limited to the federal level, and can be seen in numerous provinces. This is exemplified by looking at some statements from conservative provincial leaders. Alberta's Premier Jason Kenny,

for example, has said that, “helping addicts inject poison into their bodies is not a solution to the problem of addiction” (Karim, 2018). Kenny’s quote demonstrates his view that SISs are ineffective, counterproductive, and serve to aggravate problems associated with drug use. Similarly, Manitoba’s Premier Brian Pallister has cautioned about the “unintended consequences” of SISs in his rejection of the research touting their benefits (Froese, 2019). These statements demonstrate a skepticism of SISs and highlight a predominately conservative perspective that frames SISs and harm reduction as deeply problematic. The framing of SISs as problematic has also been emphasized by Ontario’s Premier, Doug Ford, who has said, “I don’t believe in safe-injection areas, as I call them. I believe in supporting people, getting them help” (CBC, 2018). These statements serve to frame SISs as a poor policy alternative that actively perpetuates addictions instead of providing effective treatment. Furthermore, some stakeholders believe that SISs send the wrong message about drug use to society and act as a form of implicit government support for the illicit drug trade (Tzemis et al., 2013).

3.4 Law Enforcement Subgroup

The notion that harm reduction sends the wrong message about drug use to society is echoed by law enforcement agencies in Canada. Unfortunately, due to significant barriers in navigating law enforcement bureaucracies and hierarchies, it can be difficult to find data about police perspectives on the topic. However, one qualitative study from 2012 does clearly set out the perspectives of law enforcement agents. This study is based on the interview data of numerous police officers from various jurisdictions in Ottawa and Toronto, which concluded

that “participants generally do not consider harm reduction to be a viable or effective response to illicit drug use. […] [the] dominant view among the police in our study positioned harm reduction as simply enabling illicit drug use” (Watson et al., 2012, 367). It also notes that the police involved are largely concerned with the risk of normalizing drug use. They display concern that the ambiguous message of SISs may create an impression that using illicit drugs is normal behavior (Watson et al., 2012).

Something given limited attention, but worth noting, is that police often refer to their experience with the crimes associated with illicit drug use, such as theft and solicitation of prostitution, to demonstrate their expertise on drug-related issues (Watson et al., 2012). One officer in this study said, “we go out there. What we are looking for, we’re looking for crack users and people committing crime. So when I go out on patrol, that’s what I’m looking for” (Watson et al., 2012, 367). This alludes to a correlation between one's interactions with people who use drugs (PWUDs) as shaping the priorities and perspectives associated with the drug-related interventions and policies they advocate for. For many in law enforcement, their perspective is shaped by their interactions with PWUDs in their professional capacity, shaping their perspectives. Police largely interact with PWUDs when they are called to do so or intervene in criminal activities connected with drug use. As such, their perspective is shaped by these generally more negative experiences. It is also worth noting that not all police are vehemently against SISs, but even in their support, they are mainly concerned with public order. A clear example of this comes in the form of recent public

statements made by Robert Walsh, the chief of police in Cape Breton, Nova Scotia, who not only advocates for SISs but also for the safe supply of illicit drugs as a necessary prerequisite to them (DATAC, 2021). This position is radical, especially coming from a member of law enforcement. Unsurprisingly, his justification for this position demonstrates that even in supporting SISs, Walsh's primary concern is linked to public order. This is evident when he discusses the paradoxical nature of PWUDs needing to acquire them illicitly to then use them in a legal setting. He is concerned with how this impacts law enforcement's capacity to enforce the law. He is quoted saying, "asking police to turn a blind eye to drug dealing is something that's not appropriate" (DATAC 2021, 2). This comment connects his support for a safe drug supply with a reduction to drug dealing and demonstrates a link between SISs and the implicit way that they support the illicit drug trade.

In conjuncture with framing SISs as sending wrong message about drug use, is the idea that SISs undermine efforts to reduce drug use (Hyshka et al., 2017; Kolla et al., 2017; Fischer et al, 2004) and, by extension, support for SISs is tantamount to the government implicitly supporting the drug trade at large (King, 2020). This argument is robust and effective. It is also echoed in a 2020 report from Alberta, which aimed to look at the efficacy of SISs and states that, "Canada's Drug Strategy is based on four pillars: prevention, enforcement, treatment and harm reduction. Supervised consumption sites speak to the issue of harm reduction. However, the way this multipronged approach is currently implemented in Alberta, harm reduction has taken precedence over the other

three pillars" (Alberta Health, 2020, 34). In short, the report claims that too much focus on harm reduction has led to the other pillars falling to the wayside. The perceived shift away from the pillars of prevention, enforcement, and treatment are deemed problematic by the public order camp because their primary concern is to reduce drug use in and of itself, as opposed to reducing the harms associated with drug use.

There is an irresistible logical clarity to the argument that SISs support the illicit drug trade, and this argument also hints to some potentially dire consequences for society. In a position paper on SISs, the Ontario Association of Chiefs of Police (OACP) put forward a profoundly convincing argument. As a starting point, the OACP quotes a United Nations Office on Drugs and Crime report from 2007, which states that drug trafficking must be addressed at, "its source – the drug users" (OACP n.d., 16). The logic to this is that PWUDs must get drugs from somewhere, and while the local level drug retailers are normally smaller street gangs, these gangs are procuring their goods from larger scale organized criminal groups (OACP, n.d.). The best way to disrupt this supply chain is to decrease the demand from the consumer. At the same time, there is an implication that policies that do not decrease drug use serve to support the drug trade up to the highest levels of international crime. It is problematic to support the international drug trade as it is largely controlled by extremely violent organized criminal groups, including terrorist organizations (UNODC, 2020). This train of thought is rooted in a large-scale consideration of the implications of government policies that do not explicitly prohibit illicit drug use. Beyond these

implications for the drug trade at large, there are also more immediate local concerns cited by law enforcement and many who fall under the NIMBY subgroup.

Another concern commonly raised by the public order camp is that SISs will lead to a “honey pot effect”. The honey pot effect assumes that should a SIS open, there will be an increase in drug-related crimes like assault, theft, and drug trafficking due to an increase in the drug-using population in the vicinity of the site (Burnet Institute, 2017). The honey pot effect is an enticing idea with strong commonsense appeal that significantly informs the negative framing of SISs. Other than anecdotal claims about the honey pot effect, there is no evidence to support the claim. However, it is almost irrelevant whether the honey-pot effect occurs or not; what is relevant is whether people believe that it occurs. The negative implications of a honey pot effect on local communities has such a strong appeal that in 2013 Jenni Byrne, the PC party’s National Campaign Manager, opened an email to conservative constituents by appealing to this concern. In her email, she says, “do you want a supervised drug consumption site in your community? […] I don’t want one anywhere near my home” (Byrne 2013, para. 1). In this email, Byrne is clearly demonstrating a belief that SISs are undesirable and detrimental to local communities.

3.5 Public/NIMBY Subgroup

Another significant source of resistance to SISs comes from people with little personal opinion regarding harm reduction and SISs specifically, but have concerns about the effect of SISs on their communities and I will call them the

NIMBY faction. This faction is not fundamentality against harm reduction *per se*, but rather is motivated by the NIMBY sensibility which is closely linked with a belief in the honey pot effect. NIMBYism, in this context, is based on the rejection of SISs in one's own community rather than an outright ideological rejection of the intervention (Ziegler et al., 2019). This is made clear in a statement by a member of a local neighborhood group in Ontario who says (about SISs), "it's a good idea if it's not in my neighborhood" (Ziegler et al., 2019, 107). The NIMBY faction is distinct from the more outspoken portion of the public order camp for the primary reason that they may or may not adhere to the central normative position of the public order camp that drug use is intrinsically bad. Nonetheless, they are influenced by this position, and Canada's history of approaching drug use as a criminal issue and moral failing makes NIMBYism a sort of default position for those with little interest or understanding of the public health or public order positions. There is a significant contradiction to the NIMBYism position, as it posits that SISs are neither good nor bad; simply that they need to be contained elsewhere (Kolla et al., 2017). Regardless of the lack of strong normative convictions invoked to support this position, the NIMBY faction aligns with the public order coalition due to its resistance to SISs.

3.6 Medicalization of Harm Reduction Subgroup

The fourth subgroup maintain a unique position with limited overlap to the ones described thus far above. The subgroup is characterized by a scathing critique of harm reduction and the medicalization of drug addiction on principle. The point is quite clearly stated by a Canadian organization, Real Women of

Canada, when they state that, “the drug disaster has spawned a drug bureaucracy of social workers, nurses, and harm-reduction outreach workers who operate these sites. This bureaucracy needs the addicts for their continued employment - the more addicts, the more business – and justification for their presence at the sites” (Real Women of Canada 2018, 3). They are not alone in upholding this view, and Dalrymple’s *Romancing Opiates: Pharmacological Lies and the Addiction Bureaucracy* goes into much depth on the topic. Dalrymple, a psychiatrist with a bounty of professional experience working with people who experience drug addiction through his work in the prison system, outlines a vested interest in framing addiction as a medical issue due to the careers built around treating addiction as such. Although there are several examples in his book which demonstrate the perverse incentives to the medicalization of addiction, one that stands out is his assertion that, “nothing frightens such a [healthcare] worker more than an addict who thinks on his own initiatives and decides to give up drugs and drug workers alike” (Dalrymple, 2006, loc.1245). He follows this up with the example of a woman who, after using drugs for twenty years, developing Hepatitis B and C, and having several children removed from her at birth by social workers, professed a desire to reduce her dose of methadone to work towards eventual abstinence. In response, her doctor warned her that there could be dire consequences. Dalrymple continues to ask and answer a question: “dire consequences for whom? Worse than having her children taken away from her? Worse than contracting Hepatitis B and C? No: the danger was the bad example she would set if she did as she threatened. If

other addicts followed suit, what future would there be for drug clinics?" (Dalrymple, 2006, loc.1255). Though this criticism is quite unique when compared with the other subgroups, the end result is a rejection of the purported benefits of harm reduction that ensures the faction fits squarely in the public order camp. It is an effective criticism and a thought-provoking idea that undermines the notion of harm reduction as a health intervention.

3.7 The "Public Order" Position

The public order camp believes that SISs are harmful not only to PWUDs but also to society. The impact on PWUDs is succinctly captured in this quote from the Real Women of Canada: "[SISs] enable [PWUDs] to inject their poisons by the presence of drug injection sites. No one is really helping the addicts" (Real Women of Canada 2018, 3). The normative claims about the negative implications of SISs on society are abundantly clear when we consider the justifications for this resistance outlined throughout this chapter. Whether it be concern for local communities or the risk of implicitly supporting the international drug trade, these claims are value-driven and also deeply practical. The public order and public health camps are in agreement that Canada has problems associated with addiction and drug use, but they differ strongly on how to best address these problems.

Rather than focusing on the immediate harms associated with drug use, the public order group instead argue that sanctioning drug use for potential short-term benefits comes at the expense of broad, negative societal impacts. For the public order camp, merely reducing the harms associated with illicit drug use is

not enough. The focus needs to be on reducing drug use, as this is the only way to adequately address the problems associated with it. It is impossible to effectively do so if harm reduction strategies are prioritized because they undermine effective enforcement, prevention, and treatment interventions. The concessions made by the public health camp are deemed unacceptable in working towards a future unencumbered by the worst effects of drug addiction. Even if the public order camp was to recognize some of the immediate benefits of SISs, they would not be willing to accept these immediate gains at the expense of the future. The claims made by the public order camp are provoking and have an undeniable attractiveness to them, both in their logical clarity and the goal they pursue.

This chapter has demonstrated that the public order camp's framing of SISs is rooted in concerns about how SISs have negative societal impacts, are ineffective as a health intervention, and are normatively suspect. The following chapter will highlight how the public health camp has attempted to counter the criticisms levied against SISs. Whereas the public order camp relies on a strong moral position that brings to light the potential risks that SISs have for society, the public health perspective aims to distance itself from the ethical debate by presenting their argument as a scientifically supported position, although it is inherently grounded in a concern for the respect and well-being of marginalized and vulnerable groups. Instead of responding to normative claims with oppositional ones, the public health camp has attempted to frame their stance in as value-neutral a way as possible. This strategy was in some ways born of

necessity and a (mis)calculation that evidence would be the most effective tool in proving that SISs are a valuable health resource. Though the public health camp frames their position as value neutral, there are some normative claims that underlie it, and I will uncover some of these as I evaluate the position.

Chapter Four: The "Public Health" Camp

4.1 Description

In the previous chapter, I began to describe and evaluate the various interest groups starting with the public order camp. In doing so, I note that these coalitions are not deliberately formed, but rather are grouped together based on shared moral and practical concerns and convictions regarding SISs. This chapter evaluate the makeup, various claims, and evidence made by the second dominant coalition, the *public health camp*. Although I will describe and assess the evidence and arguments advanced by the proponents of SISs, I will also uncover some of the normative claims that dictate the position. The public health coalition state that their position is based on empirical evidence, and although this is true, it is only one element of their position. The makeup of the coalition, the evidence they rely upon, and how this evidence is used to frame SISs as a worthy health intervention is all crucial to help further our understanding of how the lack of communication between camps is limiting further policy on the matter.

4.2 Makeup of the "Public Health" Camp

Before evaluating the public health position, it is important to understand who is in this group. Just as the public order camp comprises several subgroups, the public health camp does as well. There is a fairly consistent trend at both the federal and provincial levels that the Liberal party is supportive of harm reduction strategies. Naturally, there are differences between the provinces and specific politicians, but we need only look to the federal Liberal leader, Justin Trudeau, to see that there is clear Liberal support for SISs. There is also clearly an aspect of

politicization of the topic coming from Liberal sources. This was made evident when Trudeau publicly questioned Ontario's shift from a SIS framework to a Consumption and Treatment Service framework when he said, "we know that the evidence is very clear: safe injection sites save lives. And the fact that the conservative government in Ontario and indeed conservative politicians across the country are putting vulnerable people at risk by shutting down consumption sites, really makes you wonder where their priorities are" (Stone 2019, para. 4). This passage demonstrates that SISs, and other harm reduction strategies are being used as a political tool to aid in criticizing the opposing party rather than fostering further discourse between the groups.

There is an inherent attraction for more liberal parties to support SISs and harm reduction as they generally favor a more active role for the state. Likewise, there may be a hesitancy towards harm reduction from more conservative parties as they endorse policies that focus more on individual responsibility and smaller government. Having said this, the public health camp is not only made up of politicians, but also includes various other stakeholders. By large, health professionals and academics seem to be in consensus that SISs work. This is not to say that they all have strong convictions regarding SISs on a personal level. But, in terms of peer-reviewed literature, both clinical and academic, the results are resoundingly in favor of SISs as a successful health intervention. There is significant research lending itself to the conclusion that SISs are effective.

This research and subsequent framing of SISs as beneficial has led to considerable support for SISs amongst health professionals. In 2018, a group of over 120 different health organizations and practitioners called on the Ontario government to reconsider the restructuring of SISs. This group included people such as Gigi Osler, the president of the Canadian Medical Association, who says, “there is a long-standing evidence, evidence in academic, scientific, peer-reviewed journals that already conclusively demonstrates that supervised consumption sites are effective and save lives” (Giovantetti & Woo 2018, para. 10). Compounding with the voices of medical professionals and academics who have routinely found evidence in favor of SISs, there is plenty of advocacy from community groups like the Vancouver Area Network of Drug Users (VANDU) (Tyndall et al., 2006). Often, the support for SISs is framed as an adoption of a public health and human rights approach (Alliance for Healthier Communities, 2021), but this framing of the intervention is sometimes at odds with commonly cited justifications and evidence used to support SISs.

Osler’s comment about the long-standing, robust evidence regarding SISs is an often-echoed sentiment by the proponents of SISs. Trudeau touched on this evidence when he criticized Ontario’s restructuring of SISs, but an important question remains: what exactly is this evidence? Furthermore, beyond understanding what evidence is used by the supporters of SISs, it is also important to understand how this evidence is leveraged to frame SISs in a way that fosters support for the intervention. It is helpful to divide the evidence into three broad categories: absolute reduction in lives lost due to reversals of

potentially fatal overdoses, improvements to people who use drugs overall health and quality of life, and general benefits for society. As I describe these three categories in more detail, it will become evident that although the public health coalition aims to uphold SISs primarily for the public health benefits, the reality is that much of the evidence relied upon has more to do with broader societal benefits. This is in contrast to the framing of SISs as worthy of pursuing solely for health purposes.

4.3 Applying the "Public Health" Evidence

Of the three categories of evidence that I have demarcated, the first is the most clear and simple argument relied on by the public health camp. It directly links SISs to their use as a health intervention that saves lives. By highlighting the ability of SISs to reduce fatalities through prevention and reversal of potentially fatal overdoses, the public health coalition demonstrates that by their metric, SISs work. As was noted earlier in the thesis, the history of SISs can be traced back to grassroots, user-led initiatives that aimed to reduce overdoses. This paved the way for SISs to become a component of a public health strategy to decrease harms associated with illicit drug use (Tyndall et al., 2006). As such, the primary marker of success has continued to be whether SISs can reduce the incidence and severity of overdoses (Kerr et al., 2006). This marker has been an absolute and resounding success across the country. It is made evident when considering that there has yet to be a single fatal overdose within a SISs, nationwide (Rapid Response Services, 2014; ACCH, 2019; Davidson, 2020; Young & Fairbairn, 2018). A focus on safe injection and staff training to reverse

overdoses at SISs has effectively created a space where fatal overdoses amongst injection drug users are non-existent. Thus, demonstrating that SISs are achieving their primary goal and alluding to the fact that harm reduction is an effective strategy that can shift the view of fatal overdoses as an unavoidable reality associated with illicit drug use to one where they are a preventable outcome.

The second category of evidence is based on some of the secondary goals of SISs as public health hubs that provide educational tools, social supports, and medical referrals to the traditionally marginalized community. A plethora of evidence demonstrates that SISs act as sites for referrals, often unrelated to drug use. In a community-based report on the efficacy of Alberta's SISs it was found that they have provided over 35,000 health service referrals over only a couple of years. Less than 30% of them were for treatment and addiction services (ACCH, 2019). Highlighting that SISs are not only a place to practice safe injection but also a place that provides people who use drugs access to other health services. This trend has been noted before in a study published in 2006, which found that SISs act as a referral site for health care services and that, at that time, 40% of the referrals were for addiction treatment services of various forms, with the rest being referrals unrelated to substance use (Wood et al., 2006). This demonstrates the secondary benefits of SISs and points to the beginning of a shift from the role of SISs as a triage type of health intervention towards an intervention with broader societal benefits. The quantity of referrals to drug-related treatment services also highlights avenues towards

abstinence that are available through SISs. This goal is in line with the public order coalition's interests, yet little emphasis has been placed on it to help create cooperation between the dominant camps.

This leads to the third type of evidence, proof of general societal benefits. The first two types of evidence focus on the target population of SISs, but this third category focuses on those who do not use the services. This category of evidence is important because it aims to demonstrate the concrete benefits of SISs, in direct response to the concerns of the public order camp. Evidence that focuses solely on public health markers carries little persuasive power in the debate about SISs and points to the issue that evidence is ineffective due to the distinct framing of SISs by each group. Whether it is an intentional strategy that aims to bridge the divide between the camps, much of the evidence in support of SISs has to do with the financial benefits that SISs can provide.

As a forward to the research about financial benefits, it is noteworthy to consider that much of the cost savings attributed to SISs come from modeled and actual reduced rates of HIV and other blood-borne illnesses (Bayoumi & Zaric, 2008). As such, the cost savings associated are also intrinsically linked with a tangible health benefit for drug-using populations accessing SISs. However, the way in which this evidence has been leveraged has served to remove it from this context. Instead of focusing on the quality of life and life-saving benefits of reducing HIV rates, this argument focuses on cutting costs for the state and taxpayer. A study about SISs in Alberta heavily stressed that SISs would save, on average, $5 for every $1 spent (ACCH, 2019). Research on Insite in

Vancouver found that it saved between $2.85M-$8.55M annually, once again highlighting the cost savings associated with SISs (Rapid Response Services, 2014; Drucker, 2006). One study also noted that each prevented fatal overdose saves an estimated $660,000 (Davidson, 2020). It is likely that the emphasis placed on saved costs is not only due to a concern for government spending but is also strategically emphasised in an attempt to create a dialogue between the public order and public health camps. In practice, however, the societal benefits of SISs are not often cited in framing SISs and have been ineffective in establishing common ground with the public order camp.

It is also worth noting that although SISs are framed as a public health intervention, the burden for costs that they must live up to is very high. Although naturally concerned with costs, many health interventions need not necessarily create a net negative in spending but rather need to prove that the spending is effective in achieving its goals. The public health research on SISs has demonstrated definitively that SISs achieve all of their health goals. However, there is still a need to prove that they will also save the state money. In principle, health care services come at a cost to the state, and although, naturally, they will try to reduce the costs associated with health interventions, health care carries a cost. SISs are unique in that they need to both prove their health benefits and also create a financial benefit to validate their existence. The burden of evidence necessary to support SISs is very high, and the variety of evidence needed beyond the efficacy of SISs has led to advocacy groups toeing a line that is simultaneously concerned with the health of PWUDs but also requires a

disproportionate amount of consideration for the broader societal benefits outside of the target population.

This leads to a curiosity that I have noted throughout my research of the public health perspective. There is a dichotomy between the ethos underlying harm reduction as a humanistic approach focused on saving lives and the often times, seemingly, cold and calculating evidence leveraged to support the position. In attempting to frame SISs as purely practical for the sake of political palatability, those who support SISs have stepped away from the moral underpinnings of their argument. Helen Keane, a sociology professor at the Australian National University, echoes this sentiment when she describes that harm reduction, more broadly, is limited by practical and ideological problems because of an attempt at neutrality through a deeply empirical approach which leads it to have to sacrifice its inherent commitment to human rights and liberty-based values (Keane, 2003). Where the public order camp use strong moral underpinnings and convictions to frame SISs in a negative light, the public health camp has limited their framing as one without any moral underpinnings, severely decreasing its appeal in a policy arena mired in so many emotionally charged normative claims about the nature of drug use.

It is not inherently problematic that a large part of the public health coalition's evidence is rooted outside of immediate health concerns. Health policy considerations do not occur outside of their context and, as such, health policy is influenced by numerous factors such as attitudes, values, and sociopolitical dynamics in conjuncture with scientific evidence (Wild, 2017). The problem is that

when SISs are publicly framed the evidence is only being alluded to in vague comments that decrease it to a single talking point. Those in positions of political influence cite the evidence, but do not critically engage with it in a way that frames SISs beyond its primary goal as a life saving intervention. This also may not be a good strategy, because by focusing too much on the external benefits of harm reduction, the goals and strategies used to achieve it may shift away from helping what is an already at-risk community towards using them to further political objectives such as the gentrification of neighborhoods. This can, in turn, lead to the further ostracization of PWIDs from the nondrug using population. This critique is at the heart of the governmentality camp's position which is concerned that the design of SISs may lead to the further ostracization and exclusion of people who use drugs from society (see Chapter Five).

The public health camp supports further implementation of SISs under the premise that it is a health intervention with a wide set of benefits, but the way in which it frames SISs inadequately addresses the resistance against SISs and the power dynamics underlying the intervention itself. The governmentality coalition, which I will evaluate in the next chapter, is concerned with how the structure and justifications used to advocate for SISs and harm reduction can potentially negatively affect personal freedom and governmental power. This is a crucial component of the debate surrounding SISs that the dominant public order and public health groups often ignore. The governmentality coalition is worthy of consideration on this topic because the drug using population directly targeted by

the policies and practical design of SISs is already an underrepresented and often socially excluded group.

Chapter Five: The "Governmentality" Camp

5.1 Description

The final group that I am evaluating is the *governmentality camp*. This group is based predominantly in an academic perspective. Just like the public order and public health camps, it is not an explicit coalition but rather is constituted by people with shared views on the connection between neoliberal governmentality and SISs. It is worth noting that although this coalition is critical of SISs, this is not to say that they are against the intervention in and of itself. Rather, they critique the design of SISs as a form of intrusive, neoliberal governmentality that undermines the goals of harm reduction and reinforces problematics apparent throughout the neoliberal model of governance. Throughout this chapter, I will further clarify the position of the governmentality camp. Firstly, a brief outline of how this approach understands neoliberal governmentality in principle is necessary to help contextualize the argument. Secondly, I will demonstrate why the coalition believes SISs are an instance of intrusive neoliberal governmentality. The position of the governmentality coalition will be elucidated by highlighting the various abstract and tangible connections between SISs and neoliberal governmentality. Before delving too deeply into the coalition's position, it is crucial to understand what neoliberal governmentality is.

5.2 Defining Governmentality

At its broadest level, governmentality is a political rationale that shapes the conditions of possibility of thought and action (Collier, 2009). The conditions of possibility of thought and action are shaped by modifying behavior to normalize

certain behaviors that are deemed acceptable. Normalization occurs through a combination of regulatory power and discipline (Collier, 2009). Neoliberal governmentality is a specific form of this behavior modification that elevates market-based principles to the state-sponsored norm (Fraser, 2018), intending to create the social conditions to produce good participants in the global economy or "*homoeconomicus"* (Hamann, 2009). The ultimate regulatory power within a country is the state, and different forms of governmentality will use various forms of discipline to create sets of normalized behavior. In neoliberal governmentality, discipline is not directly flowing from a central point, but rather it produces the conditions for discipline to be self-producing and intensifying (Collier, 2009). Rather than being passed from the top down, it is the product of collective life.

The processes of neoliberal governance are less concerned with directly controlling subjects' actions than regulating the conduct of their behaviour (Lemke, 2002). Neoliberal governmentality expresses its power by governing the possible actions of the subject and creating conditions where the possible actions are complementary to the neoliberal goal of creating the *homoeconomicus.* The manufacturing of subjects' possible actions is an active process of institutionalized subjectification that consists of using several social mechanisms to uphold the values and principles that it preaches (Hamann, 2009). By fostering the habits and expectations of the good citizen, the neoliberal government can subtly shape its subjects' behavior and ways of life (Lorenzini, 2018). Fundamental to this process is the creation of subjects who aim to maximize their capital by competing in the global market. Such economically driven subjects are

easily governable within an economically focused neoliberal system (Lorenzini, 2018). This stream of thought provides a unique connection between the goals of neoliberal governmentality and SISs, as most of the site's clients exist outside of the traditional economic incentives that most of the state's subjects have internalized.

The good neoliberal subject is eminently governable due to their self-governance (Lorenzini, 2018). Though the subject may see themselves as authors of their own fate, they are also all fundamentally good subjects who follow the codes of conduct outlined by the neoliberal government as they actively participate in the global economy. Neoliberal governmentality essentially produces the blueprint for its subjects to follow while simultaneously maintaining limited responsibility by fostering the values and principles of self-reliance and individual responsibility. By promoting individual responsibility, neoliberal governmentality implicitly creates a morality that needs not aim to fix social ills, such as addiction and homelessness, as these are viewed as personal failings rather than public ones (Hamann, 2009). Fundamentally, neoliberal governmentality is concerned with economic prosperity and participation. In the context of SISs, this focus can be problematic as the people who access the supposed health intervention are often at the margins of society and, by extension, the economy. With this understanding of neoliberal governmentality, I will describe how the governmentality coalition views the link between SISs and neoliberal governmentality as problematic.

5.3 Applying Neoliberal Governmentality to SISs

The governmentality camp's position on SISs as a form of intrusive neoliberal governmentality can be divided into two major streams of thought. First, their argument highlights more abstract and philosophical connections between SISs and neoliberal governmentality. Secondly, they emphasize how the physical realities of the design of SISs provide a further connection between SISs and neoliberal governmentality. Rather than viewing SISs as a place where its clients will overnight become *homoeconomicus*, the governmentality coalition sees SISs as a stepping stone towards this goal. By emphasizing such ideals as empowerment and responsible drug use, harm reduction technologies create a responsible drug-using subject in contrast to the merely deviant one (Fischer et al., 2004). It is not benevolence that inspires this. Rather, it is an attempt to govern people and "take back public spaces (streets, plazas, parks), which had apparently been 'stolen' by the disorderly, deviants, and criminals" (Fischer et al., 2004, 359). In other words, under the guise of fostering better health and creating safe spaces for people to use drugs, SISs actually remove those who are not deemed desirable away from the public sphere.

As noted earlier in this chapter, SISs take people who are and have been outside of the fold of neoliberal control and attempt to mold them into a more easily controlled subject. Harm reduction itself is based on neoliberal ideals of rationality, autonomy, and prudence (Duncan et al., 2017), and as such, it promotes behavior that is in line with these ideals. By designing harm reduction in line neoliberal ideals, it implicitly views the subject as a "health-conscious citizen capable of rational decision making, self-determination, and risk

management” (Duncan et al., 2017, 93). However, this assumption about the people accessing the services is not necessarily correct. Whether it be due to personal or structural barriers, many people who access the SISs demonstrate limited health-conscious behavior. As such, the founding assumption that SIS design is based on is problematic. The governmentality coalition continues their critique by noting that the goals of SISs to create a governable subject are entirely in line with the design of SISs. Through a process of external surveillance and modifying the conduct permitted within the space, those who access the SISs must self-regulate and modify their behavior for continued access to the services. All of this is to say that the practical and physical design of SISs support the claim that SISs are a form of intrusive neoliberal governmentality.

The physical design of SISs as an extension of neoliberal governmentality is due primarily to the systems set in place to monitor and modify the behavior of the people accessing the services. The governmentality coalition’s position is that this is an extension of control over the subjects' conduct. Using Insite as an example, we see some stringent policies in place to access its services, and these restrictions are echoed in other SISs across the country. When one first accesses Insite’s services, they are registered and given a unique identifier that records their subsequent visits, health referrals, nursing treatments, and ODs, amongst other things (Small et al., 2011). Additionally, rules are set in place that must be followed to continue to access the SIS. This is a widespread practice amongst SISs, and many of the regulations in place alter the typical behavior of injection drug users. For example, some of the rules include no drug sharing,

which prevents the widespread practice of pooling funds to purchase illicit substances. PWIDs do this to help decrease the financial burden of their drug use. Additionally, assisted injection is prohibited within the confines of SISs, which is a restriction that disproportionately affects female drug users who are more often the recipients of assisted drug injection and those with mobility issues who are incapable of injecting themselves (Small et al., 2011). It is not only the rules within SISs that are reflective of the attempt to modify the subject's behavior by governing what they can do but also the physical design of injection rooms is a direct reflection of the panopticon, a prison design developed by Jeremey Bentham and later used as a metaphor to describe the internalization of power and surveillance by Michel Foucault.

Benjamin Scher writes about how the design of Insite and other SISs have direct parallels with the panopticon prison design (see Image 1). The panopticon was first developed by Jeremy Bentham in 1791 and was later picked up by Michel Foucault (Scher, 2020). Bentham describes the panopticon as a prison designed in a circular fashion where at its center is a guard tower that provides a single guard the ability to see every cell, all the while none of the imprisoned can see the guard. The logic behind this design is that due to an inability to track the guard, the prisoner constantly assumes that they are being watched. The sensation of being continually observed leads to an internalization of surveillance which causes the

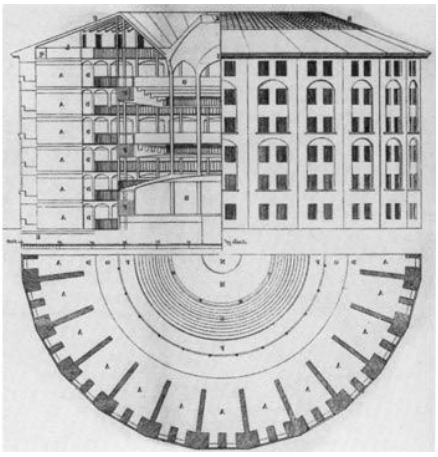

Image 1: Bentham's Panopticon (Watkins, 2007)

imprisoned to self-modify their behavior as if they are being observed even when they are not. The internalization of surveillance leads the imprisoned to behave themselves even if they could have viably committed some acts against the rules without repercussion. In Foucault's analysis of the panopticon, he removes the physical prison. Instead, he argues that the subject of neoliberal governmentality internalizes state surveillance and is constantly self-modifying their behavior to act as a good subject (Scher, 2020). Scher expands on this by describing how the injection rooms in SISs are designed similarly to the panopticon. There is a supervisor stationed in the center of the room surrounded by injection booths that have mirrors allowing the supervisor to see what each person is doing within them (See Image 2) (Scher, 2019). Though the images of Bentham's panopticon and Insite's injection room are of different composition, the similar nature of a centralized authority observing all is evident. Although it is impossible for the supervisor to watch all the drug users simultaneously, the ability of the supervisor to potentially watch any of them at any all times creates an internalized sense of surveillance which leads the user to act in accordance with the rules set out by the SIS. The end goal is to create an internalization of harm reduction norms which will then be enacted outside of the injection room. This goal and how it is pursued is viewed as problematic by the governmentality coalition for many reasons.

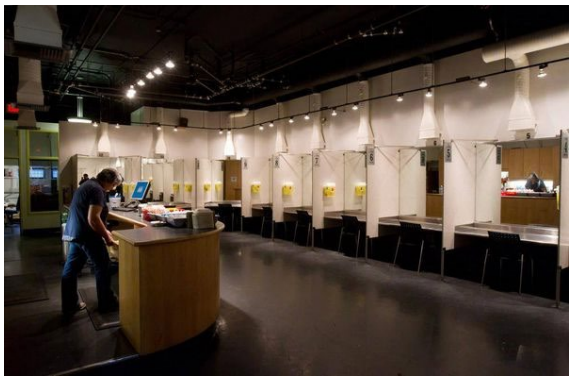

Image 2: Insite Injection Room (Bailey, 2013)

The governmentality coalition views neoliberal governmentality in the context of SISs as problematic because it limits the goals and efforts of harm reduction strategies as a whole. Instead of acting as a novel method of addressing problems associated with injection drug use, the SIS instead becomes another place of government control, allowing the state to ignore the structural and systematic barriers that enable the status quo to continue. This sentiment is echoed in the following passage, “a relentless emphasis on personal responsibility can do little to overcome the structural patterns and cultural geographies in which drug markets flourish” (Campbell & Shaw 2008, 709). Another way to describe this is that rather than solving the problems that SISs set out to solve, they are merely serving to hide them (Fischer et al., 2004). Not only are SISs a space where neoliberal governmentality is practiced, but the continued emphasis on personal responsibility has also been one of the most significant barriers against the effective uptake of SISs. Due to the nature of the neoliberal subject as responsible for their own fortune or misfortune, there is substantial resistance to SISs along this line of thought. The people who can most benefit from harm reduction interventions are, under a neoliberal framework of self-responsibility, accountable for their position and, as such, interventions that allow them to continue their behavior, although modified, are difficult to support for many, as is made evident when we consider the public order position (Pauly, 2008).

There are also concerns that SISs and other harm reduction policies are not built with adequate consideration for those accessing the services but rather

those implementing them (Fischer et al., 2004). The framing of SISs by the public health coalition as a strictly public health intervention with economic and social benefits limits the potential viability and usage rates of SISs. The incentives that drive drug users towards drug use are inadequately considered by looking at drug use only in the negative light of its health impacts. Should the design of SISs be more effective, it would require looking further than the negative health impacts and relying instead on some of the more subjective truths of drug use. For example, there is an oversight in designing SISs on the pleasure aspect of drug use (Duncan et al., 2017). The clinical and surveillance-driven design of SISs can make them unappealing to the people the intervention aims to attract. Although, for many PWUDs, addiction is the driving force behind their continued drug use, there are also many pleasures associated with drug use that maintain people's addictions. The governmentality coalition views the neoliberal design considerations of SISs as an intrusive form of governmentality that serves to act as a form of social control that acts to hide the problems associated with injection drug use rather than fixing them (Fischer et al., 2004).

The governmentality coalition offers an interesting contrast to both the public order and public health perspectives as it highlights flaws in both their claims. The public order coalition paints SISs as catering to drug users and creating an unsustainable and likely dangerous approach to curbing the worst outcomes of drug use. The governmentality coalition demonstrates that the main priorities of SISs are to control and modify the behavior of drug-using populations. So while the public order coalition frames SISs as allowing drug use

to continue unabated, the governmentality coalition demonstrates that the main priorities of SISs are to modify injection drug users behavior heavily. In the same vein, the governmentality coalition highlights that the logic and ethos that the public health coalition put forth in their support and advocacy of SISs are overstated. SISs fail to live up to the very ideals that they espouse. The reality of SISs as they currently stand, and as the governmentality coalition describes them, is one in between the alleged goals of the public order and public health coalitions. The governmentality coalition does not argue against the health benefits of SISs but lays out the path to these goals as one that directly increases public order.

Chapter Six: Discussion

6.1 Review

My thesis aims to explain why it is that, despite the overwhelming evidence of their effectiveness, there has been relatively modest implementation of SIS facilities. In Chapters Three, Four, and Five, I have shown that views on SISs tend to coalesce around three distinct positions. This chapter will apply the framing theory described in Chapter One to these three positions. In doing so, I will challenge the common perception held by advocates of "evidence-based policy-making" that policies are likely to be adopted if enough sound evidence is presented to support them. There is copious evidence that SISs effectively achieve their primary objective, harm reduction. However, this evidence is only part of one framing of SISs and has proven ineffective in facilitating broad implementation. The problem is that other interests are able to describe SISs in a way that neutralizes the clear evidence that speaks to their effectiveness. This has been largely outlined in the description of the dominant coalitions in Chapters Three and Four, but there is also a third "framing" of SISs that, politically, plays a negligible role in the policy arena. Intellectually, however, this third perspective suggests, in its own way, that the two dominant framings of SIS policy are not as polarized as adherents of these camps might believe.

In this chapter, I argue that the frames put forth by each respective group act as barriers for the progress of a consistently implemented, nationwide SIS program because each side frames the subject in such a way that limits opportunities for dialogue between the groups. A lack of flexibility from their

ideological base in presenting the issue to their constituents has served as an effective barrier to developing further policy on the matter. The lessons learned from applying framing theory to SISs help demonstrate the limitations of evidence-based policy-making in other contentious policy arenas. It shows that the quantity and quality of empirical evidence does not always lead to more straightforward policy-making. This chapter focuses on how the different frames of SISs put forth by the three camps have limited SISs from being implemented on a broader scale.

6.2 Evidence-Based Policy-Making

Deconstructing the debate over SIS implementation in Canada shows how the framing of information can create barriers and divisions that limit the cooperation necessary for widescale policy-making decisions. The focus on SISs makes for an interesting case study that underscores this point and acts as a lesson about other difficult to implement policies. Simply put, the application of framing theory underscores how even policies with a consistent empirical evidence base to support them must navigate a complex landscape where ideas, perceptions, and beliefs can undermine well thought-through and highly defensible policy options.

Evidence-based policy-making is an intuitively attractive method that aims to privilege impartial evidence over more subjective attitudes of a given policy recommendation. The goal of evidence-based policy-making is to “spend money on programs that have been shown by rigorous research to reduce the problems they were designed to combat” (Haskins 2018, 10). Thus, evidence-based policy-

making is the design and implementation of policy based on rigorous testing and empirical research to foster the highest chance of success. In many calls for evidence-based policy-making, the goal is to collect considerable data during the formulation of new policy and use this data to guide policy implementation on a wider scale (Banks, 2009; Haskins, 2018). In the case of SISs, the assumption behind evidence-based policy-making is turned on its head. Rather than requiring further research, there is already a large body of domestic, peer-reviewed literature demonstrating the successes of SISs. Yet it has not led to the development of a broad, coherent national policy. It is as if the evidence seems to disappear in the policy-making process (Haskins, 2018). I will show that this occurs because the unique frames applied to SISs by the dominant interest groups limit the ability for evidence to dictate policy effectively.

6.3 Framing Theory

There are numerous formations of framing theory, but at its heart is the idea that framing is a set of, “words, images, phrases, and presentation styles that a speaker uses when relaying information about an issue or an event to an audience” (Nierderdeppe et al., 2015, 839). Frames create a shared understanding of a given topic within specific groups. Although the rhetoric used may not always be subtle, framing itself is a relatively subtle process that fosters links between people’s pre-existing beliefs and new sets of information. The links between pre-existing beliefs and new information alter public perception of a given issue (Chong & Druckman, 2007). Therefore, it is beneficial to use framing theory to analyze barriers towards implementing SISs as each of the groups I am

studying put forth unique SIS frames that effectively garner support for their position.

As described in previous chapters, the three groups I have defined provide competing frames and rely on different strategies to uphold their positions. Competing frames come to exist when “multiple interest groups compete to define a problem, specify its causes, assign moral judgements, and propose (or oppose) solutions to address it” (Nierderdeppe et al., 2015, 838). The public order position relies on seemingly logical arguments to frame SISs as a failed health intervention that is too focused on the short-term goals of reducing immediate drug use fatalities without adequate consideration of the unintended consequences that arise from the state sanctioning illicit drug use. In contrast, the public health position frames SISs as a largely successful health intervention that can demonstrate short- and long-term health and economic benefits by focusing on the empirical evidence. In contrast to the two dominant groups, the governmentality position looks beyond the health frame. Instead, it is critical of SISs as a space where government overreach occurs through instances of discipline and surveillance in line with modalities of neoliberal governance.

Looking at the frames put forth by the three groups, there is some similarity between the public order and public health perspective distinct from the frame put forth by the governmentality camp. The dominant views largely diverge from the governmentality position in their framing of SISs primarily based on the outcomes of the intervention. This is to say that the public order group opposes SISs on the premise that they fail as a health intervention, and even if this

concern was mitigated, other problems such as the implications of governmental support for illicit drug use and the drug trade still need to be addressed. On the other hand, the public health group frames SISs as achieving their health goals and providing other secondary benefits for society. The dominant groups put forth frames that largely diverge on evaluating the effectiveness of SISs as public policy. The governmentality's framing of SISs is entirely different by design. Rather than focusing on how effective SISs are at achieving their goals, this camp questions the morality of the intervention due to the nature of SISs as a space where excessive governmental control is exercised over its subjects. This is framed as especially concerning because the target population of SISs is already a marginalized one that is the target of punitive government policies. The public order and public health camps largely frame SISs in the context of the societal and health benefits of SISs, whereas the governmentality camp diverges by almost entirely focusing on the potentially harmful implications of SISs for the freedoms of the target population of the intervention.

6.4 Framing the Public Order Camp

The framing of SISs by the public order camp as a failed health intervention was manifest in the Premier of Ontario's comment that "I believe in supporting people, getting them help" (CBC 2018, 2). This brief passage demonstrates how framing can subtly work to create support for one's position both by what is being said and who the person saying it is. By stating that he believes in "getting people help" in a statement publicly rejecting SISs, Ford effectively calls into question the efficacy of the intervention in achieving its

health goals and suggests that the normative assumptions held by the public health advocates are inappropriate. This also demonstrates a distinction between direct persuasion and the more subtle process of framing (Carter, 2013). Ford was not directly calling for the public to reject SISs, but instead was subtly suggesting that SISs do not provide the appropriate kind of support and help for people experiencing addiction. Advocates for the public order position uphold ideals of personal responsibility and question whether the state should be financially supporting the choice of drug users to continue their practices. Although this passage highlights the more subtle nature of framing, it is not to say framing cannot work parallel with more emphatic persuasive tactics as exemplified by the advocacy group Real Women of Canada. This group actively pits the non-drug using population against those who use drugs in disparaging comments such as, “those brave individuals [non-drug using] who do walk near the sites are accosted by beggars, prostitutes and drug traffickers” (Real Women of Canada 2018, para. 1), to demonstrate the problematic nature of the sites.

Real Women of Canada frames SISs in a way that directly links the intervention with criminal activity and the harassment of those who, in their view, are productive community members. This framing of SISs calls into question the effectiveness of the intervention and the worthiness of those being targeted by it. It can be said that “to frame is to select some aspects of perceived reality and make more salient in a communicating text” (Borah 2011, 248). In this context, Real Women of Canada are highlighting a problem that SISs have for general public by highlighting the perception of them as a public nuisance. When this

rhetoric connects with a pre-existing perspective of drug use and drug users as immoral, it effectively builds further resistance against SISs. Although it is possible to dismiss the comments of more marginal groups such as Real Women of Canada, when people in positions of power and influence such as Ontario's Premier frame SISs in this light, it is very influential.

6.5 Framing the Public Health Camp

Much like the public order camp, there are people of influence amongst the public health camp that help advance their frame of SISs. A commonly cited reference amongst this position is "the evidence" existing about SISs to support the position that they are a deeply practical intervention with proven benefits. Regardless of the specifics of the large body of peer-reviewed literature corroborating the successes of SISs, the references to evidence are intentionally vague in popular media. Rather than providing clear examples of this evidence, people in positions of power and influence echo one another on the simple point that SISs are informed by evidence and, on this basis, are a policy worth pursuing. By not engaging publicly with the evidence's specifics, the information is filtered to the wider public through expert opinions. This is evident when we look to Justin Trudeau's framing of SISs as achieving their health goals when he says, "we know that the evidence is very clear: Safe-injection sites save lives" (Stone 2019, para. 4). Although not a doctor himself, it is not a radical assumption to assume that his position is informed by the advisement of medical professionals. When disseminated by such influential people as the prime minister, such messages effectively frame SISs in a positive light.

The public health position also benefits directly from those within the health care system advocating for SISs. This is exemplified by Gigi Osler, the former president of the Canadian Medical Association, who says that “there is a long-standing evidence […] that already conclusively demonstrates that supervised consumption sites are effective and safe lives” (Giovantetti & Woo 2018, para. 10). Having legitimate health credentials, Osler speaks from a position of knowledge and is influential in framing SISs as effectively achieving their goals. As discussed in Chapter One, SISs are not the first harm reduction strategy in Canada’s toolkit, and the framing of SISs as a successful health intervention resonates with those who were likely already sympathetic to using harm reduction strategies to address health problems associated with illicit drug use.

Lacking from much of the public health discourse is an overt recognition of their normative position that the target populations of SISs require further state support because they are already marginalized people in need of help. Frames provide reference to the public about what is important (Carter, 2013), but by focusing solely on the health benefits and not the motivations behind its beliefs, the public health camp lack much of the persuasiveness that makes the public order camp so appealing. The framing of SISs solely in the context of a health intervention without adequate consideration of the structural barriers to health care for those accessing the services is inadequate in fostering further support for the intervention. Not all people that use drugs are the focus of SISs: rather, they target people who lack the resources to acquire clean gear and a safe

space to practice safer injection. Although open to all, SISs target the most vulnerable drug-using populations of people who experience homelessness or fluctuating and unstable living conditions. Regardless of the framing of SISs as an evidence-based health intervention, there is also an implicit normative position that all of society are worthy of support, care and the freedom to make their own choices, even if these choices are not the healthiest.

6.6 Discussion of Public Order and Public Health Positions

Although frames can shift perspectives on a given topic, they are more effective at mobilizing biases to garner support amongst those with similar views. SISs, because they involve the sanctioning of illicit drug use, connect with many core beliefs and prejudices that are difficult to alter. As such, framing serves more effectively to mobilize these beliefs rather than alter them. For example, those who already view drug use mainly as a health issue connected to structural problems in society, such as poor socioeconomic conditions, are more likely to be influenced by the framing of SISs as a health intervention that can reduce some of the adverse effects of drug use. Thus, the public health camp can effectively mobilize support amongst those with existing sympathies for PWUDs by framing SISs as effective in saving lives and improving the quality of life of their patients. In the same vein, the public order coalition frames SISs as implicitly supporting the illicit drug trade and as a health intervention not worthy of pursuing due to its permitting drug users to continue their harmful behavior. This frame lends itself to garnering support from those who believe in the amorality of drug use for the public order camp.

The distinct framing of SISs put both by the dominant coalitions is problematic because they are ineffective in creating dialogue or altering the beliefs of those in the other group. Framing can create links and is effective in garnering support when somebody has limited direct experience on a topic (Becktel et al., 2021), but where there are existing personal biases framing acts upon these and has limited ability to radically change them. As Chong and Druckman, state, “people draw their opinions from the set of available beliefs stored in memory” (2007, 111). This highlights that using distinct frames of SISs is ineffective when it does not connect with people's existing biases (described above as a set of beliefs stored in memory). The framing of SISs as an evidence-based health intervention will not sway those who believe that drug use is an immoral activity that should be addressed through enforcement strategies. Strong core convictions and beliefs about drug use and how to best address its problems are unlikely to be altered by the relatively subtle process of framing. The dominant coalitions are not talking with one another, nor are they directly addressing the points that resonate most fulsomely with supporters, so no constructive dialogue is possible.

6.7 Framing Applied to the Governmentality Camp

Distinct from the public order and public health framings of SISs in terms of policy implementation, the governmentality camp’s framing of SISs is a more intellectual exercise with limited direct applicability to policy-making. Rather than looking at SISs through the lens of health, the governmentality camp frames SISs as a space primarily concerned with exercising control over marginalized

subjects to turn them into active economic agents for the state. The governmentality coalition's framing of SISs has little to do with the success or failure of SISs. Instead, it draws attention to the potentially negative repercussions for personal freedom built into the very design of SISs. By highlighting the need for clients to alter their behavior to access services at SISs (Small et al., 2011), and how these alterations to behavior become reinforced as an internalized form of social control (Fischer, 2004) with the explicit intent of creating good participants in the global economy (Hamann, 2009), the governmentality group frame SISs as an intrusive form of neoliberal governmentality. This unique frame of SISs as an exercise in governmental power over a marginalized community render, in their view, the success or failure of the intervention moot.

6.8 Discussion

SISs provide a valuable subject of study to demonstrate that framing is an effective tool for fostering support for a policy initiative where there are already strong convictions related to the matter. The public order and public health camps can effectively mobilize people's views on drug use to gain support for their positions on the benefits of SISs as a health intervention. The governmentality coalition mobilizes concerns about the government shaping the conduct of its subjects by calling to attention the conditional access to SISs based on the forced alteration of the target population's behavior. While the public order and public health frames compete to highlight the benefits or failings of SISs, the governmentality frame looks at the ethics of conditionally offering

health care to people based on their observance of regulations that aim to create amenably governable citizens.

At first glance, the governmentality coalition's framing of SISs seems inapplicable to the debate between the dominant groups, but it offers valuable insight when considering the implications of practicing neoliberal governmentality to ensure compliance when accessing a health service. The public health camp frames SISs as a health intervention informed by evidence, while the public order camp attempts to discredit this by highlighting a lack of broader social concerns due to the implicit support for illicit drug use. The governmentality camp shows that to access the services of a SIS, a person's behavior requires significant modification that, in effect, are facilitating key goals of the public order group such as the control and modification of "antisocial" behavior. Rather than solely being a space where drug use is permitted to continue unabated, the governmentality frame demonstrates that the service requires significant behavioral changes and also removes drug users from public spaces, a concern that is clearly articulated by the public order camp. The governmentality frame also highlights that a major success of the SISs for achieving its public health goals is the continued alteration of PWIDs behavior outside of the confines of the sites.

Framing is an effective way to bolster support for any intervention but can also act as a barrier in the uptake of evidence-based policy-making because, rather than foster productive discussion between those who hold diverging views, it relies on mobilizing deeply entrenched biases. The nature of the public order

frame relies on normative claims about the morality of drug use. The public health camp attempts to frame its position as having little concern about the normative issues by focusing on evidence. These distinct focuses make the dominant groups largely incompatible. They are so concerned with advancing their agendas by promoting their unique frames that the space for dialogue between the groups is minimal. Although lacking in political salience, the governmentality coalition provides a novel consideration of SISs as an intervention concerned with issues raised by both the dominant groups. It highlights how SISs aim to offer health benefits and create what can be described as “socially acceptable” members of society. The two dominant groups share a stated desire to address problems associated with injection drug use, but both put forth frames of SISs that are incompatible and create feedback loops within each group, rather than attempting to reach across them. The quantity and quality of evidence, in this way, are simply not as relevant as the way that any existing information can be mobilized and communicated.

Chapter Seven: Conclusion

Throughout this thesis, I have noted three distinct arguments that, in opposition to each other, constrain the further implementation of SISs to address some of the adverse effects of injection drug use. The primary goal of SISs is to decrease rates of fatal drug overdoses. The problematic this thesis has looked at is how the tension between the various interest groups framing of SISs has led to the limited and inconsistent use of a life-saving policy across Canada. Throughout the thesis, I have demonstrated that one key barrier to developing consistent SIS policy nationwide is the product of the distinct framing of SISs by the dominant camps. These frames are deeply incompatible and limit opportunities for cross-coalition cooperation. The different frames also demonstrate severe limitations to evidence-based policy-making as they demonstrate that the framing of a subject is effective at undermining the role of empirical evidence in guiding policy.

The public order camp frames SISs as failing to act as an effective health policy and an intervention akin to the government implicitly supporting illicit drug use. This position is in stark contrast to the public health camp that frames SISs as a life-saving intervention supported by peer-reviewed research. Moreover, the public health camp implicitly demonstrates a belief that policy will follow robust evidence by opting to not engage in the normative debate about the morality of SISs. Finally, the governmentality camp frames SISs as a form of intrusive neoliberal governmentality that is predominantly concerned with altering the behavior of people who use drugs. By its measure, this is done through

processes of subjectification and discipline marked by the internalization of surveillance. Under the governmentality frame, this is deeply problematic because PWIDs are already a marginalized group and SISs serve as another form of marginalization that hides the problems associated with drug use rather than actively addressing them.

The competing frames are incompatible for several reasons. Most obviously, the positions emerge from distinct bases. The public order camp predominantly relies on normative claims about the immoral nature of drug use in contrast to the public health camp, which depends mainly on a scientific method to demonstrate that SISs achieve their health goals while distancing themselves from normative claims to support their position. Like the public order camp, the governmentality camp relies on normative claims to support its position about the negative effects of SISs. However, the governmentality camp is not overly concerned with the nature of drug use or the effectiveness of SISs as a health intervention. Rather, the governmentality frame is informed by a skepticism of the nature of neoliberal governance and the morality of forcing people who access SISs to alter their behavior in significant ways.

Although the three groups discuss the same intervention, they are effectively having different conversations within their groups rather than conversing with one another. The public order camp's framing of SISs focuses on the morality of drug use rather than the effectiveness of SISs. It garners support amongst those who already have a negative view of the role of illicit drug use in society. This is in stark contrast to the public health camp whose framing of SISs

focuses on the public health benefits while ignoring the broader question of whether any policy that supports drug use is worthy of being pursued. The public health camp also ignores the potential ramifications of implicitly supporting illicit drug use. These competing frames are ineffective in fostering productive dialogue between the dominant camps as they inadequately address the concerns raised by the other camp. The governmentality camp is unique to the dominant coalitions as it is largely an intellectual viewpoint and holds negligible political influence. However, it is beneficial to consider because its framing of SISs shows the intervention to be deeply concerned with fostering order and highlights that many concerns raised by the public order camp are addressed by the design of SISs.

The effect of the competing frames of SISs is that there is little room for cooperation amongst the camps. Each group frames SISs in a way that speaks to their constituents but does not register amongst the other groups. This also demonstrates some inherent limitations to EBPM, as evidence has little ability to dictate policy on this matter due to an inability of each group to alter the underlying moral positions of their opponents. As such, SISs provide a valuable case study to show that even when there is a plethora of evidence in support of a policy, it is often ineffective in shaping the policy. A paper on EBPM notes that "political leaders […] are unlikely to fund, or even notice, research projects whose findings encourage policy-makers to jettison dearly held but failing policies" (Head 2010, 87). This passage aptly speaks to the problems SISs face. Although the peer-reviewed evidence demonstrates their benefits, evidence alone is

ineffective in fostering wide-scale alteration to the dominant policies of enforcement, prevention, and treatment.

Studying the competing frames of supervised injection sites highlights that in complex and contentious policy arenas mired in deeply held political and moral sentiments, framing actively limits the potential for dialogue and cooperation between distinct interest groups. The limited dialogue decreases the likelihood of an effective uptake in evidence-based policy-making. The debate about SISs is split between the public order camp, which effectively frames the issue with normative claims to garner support for their position, and the public health camp, which is ineffective in translating its strong evidence into a convincing argument that can reach beyond its constituents. The governmentality camp inadvertently demonstrates that the public health camp could likely foster further support for SISs by highlighting their role in controlling drug-using populations. However, this would be against the goals of the governmentality camp, which is critical of the controlling nature of neoliberal governmentality. The distinct framing of SISs by the various camps outlined throughout the thesis limits productive dialogue between them and demonstrates the limits of EBPM by highlighting that evidence does not necessarily dictate policy.

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