TOWARDS A SOCIOLOGY OF HARM REDUCTION:
A COMPARATIVE STUDY OF DRUG POLICY CHANGE IN CANADA AND
THE UNITED KINGDOM BETWEEN THE YEARS 1985 AND 2017

by

Steven Hayle

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Graduate Department of Sociology
University of Toronto

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ABSTRACT

The primary goal of this dissertation is to advance a sociological understanding of harm reduction policy development and change. Drawing on social constructionism, as well as comparative and historical methodologies, this dissertation accomplishes the abovementioned goal by comparing and contrasting the development of harm reduction policies for intravenous drug use (IDU) in Canada and the United Kingdom (UK). This dissertation addresses a gap in the drug policy scholarship: namely a lack of sociological research using comparative methods to explain similarities and differences in the development of harm reduction policy across geographical locations and over time. While there exists a large, multi-disciplinary literature that explores the development of specific harm reduction programs such as needle exchanges and drug consumption rooms, to my understanding this is the first large-scale study to approach the topic from a sociological perspective. To accomplish the goals set out in this paper, I analyse content drawn from federal and provincial Hansard documents, municipal council documents, committee reports and newspaper and online news articles from Canada and England and Wales that were published between 1985 and 2017.
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CHAPTER ONE- INTRODUCTION

The primary goal of this dissertation is to advance a sociological understanding of harm reduction policy development and change. I accomplish this task by critically analysing the development of harm reduction policies for intravenous drug use (IDU) in Canada and the United Kingdom (UK) from a social constructionist perspective. Drug harm reduction encompasses policies, programs and practices that aim to reduce the harms associated with the use of psychoactive drugs in people unable or unwilling to stop” (Harm Reduction International, 2015). I am particularly interested in how harm reduction policy developments in Canada and the UK are linked to ways in which injection drug use and people who use drugs are socially constructed. This dissertation addresses a gap in drug policy scholarship: namely a lack of sociological research using comparative methods to explain similarities and differences in the development of harm reduction policy across geographical locations and over time. While there exists a large, multi-disciplinary literature that explores the development of specific harm reduction programs such as needle exchanges and drug consumption rooms (see for example Berridge, 1999; Tempalski et al., 2007; Small et al., 2006; Zampini, 2014) to my understanding this is the first large-scale study to approach the topic from a sociological perspective. Furthermore, there are only a very small number of studies that compare harm reduction policy development across geographical locations (whether they are nations, states, provinces, regions, or municipalities), none of which are explicitly sociological in orientation (see Tempalski et al., 2008; Zampini, 2014).

Historian Virginia Berridge (1996) proposes that more research on drug policy be carried out in order to better understand the “levers” of harm reduction.. Furthermore, Fischer (1999) acknowledges that there is a lack of research examining the social and political “determinants” of drug policy reform, and he proposes that this gap can be addressed with more cross-national comparative research. Hyshka (2009) argues that
findings from drug policy reform research in single countries are necessarily “tenuous” because they are not contextualized with data and evidence from other similar countries. She similarly proposes cross-national comparative analysis to help address this research problem. Analytically then, comparative research serves an important function by allowing scholars to situate drug policy change occurring in one location within a larger, international context.

In order to develop a stronger understanding of harm reduction policy change within Canada, this dissertation applies a social constructionist framework in order to compare the development of harm reduction policy across Canada to what has taken place across the UK. Social constructionism proposes that individuals attempt to comprehend their experiences by creating models of the social world and then “reifying” and “sharing” these models using language (Berger and Luckmann, 1966). This dissertation can also be considered a structural analysis of harm reduction policy change as structural sociology is interested in how social activity is influenced by the configuration of macro-level social institutions such as the family, religion, and the nation state (Dennis and Martin, 2005). This study explores how the structural distribution of power across political institutions within the two countries helps to explain divergences in harm reduction policy change (a point that will be elaborated upon below in the section about analytical framework). Various different theories and conceptual frameworks are drawn upon throughout the three papers that make up this dissertation (for example Multiple Streams Theory and Simon Lenton’s drug policy change model). Having said that, an underlying theme that connects these theoretical and conceptual approaches is the question of how the social construction of injection drug use helps to explain harm reduction policy change.

This dissertation draws on data about harm reduction policy change that covers a relatively long period of time (between the years 1985 and 2017 to be specific) and that traverses cities, provinces, nations (England and Wales, Scotland, and Northern Ireland)
and countries (Canada and the UK) in order to be able to generate conclusions that can be
generalizable beyond just one place and one particular time. These conclusions will be
helpful for developing a sociological framework for comprehending harm reduction policy
change that is international in scope.

THE CENTRAL ARGUMENT

Collectively, the three papers in this dissertation will introduce empirical evidence which
suggests that harm reduction policy development has varied in Canada and the United
Kingdom because power over the administration of healthcare is structured differently in
both countries. Firstly, this is because Canada is a federation, where governance over
healthcare is shared between national and local political entities, whereas the United
Kingdom is not a federation, and thus governance over healthcare there is centralized within
its national political entities. Consequently, whereas in Canada, the “levers” of power over
harm reduction policy development lie within local political entities such as provincial,
regional and municipal governments, in the UK the “levers” of power over harm reduction
policy development lie within the national governments including the British government
(herein referred to as the “central government”), and the devolved parliaments of Scotland
and Northern Ireland. In both Canada and the UK, harm reduction policy development is
most significant when intravenous drug use is socially constructed as a health problem by
those with power over healthcare law and policy. And as noted above, the distribution of
power over health care law and policy differs significantly in both countries.

The findings and arguments laid out in this dissertation help illuminate an
important insight regarding the politics of harm reduction: that the development of
harm reduction drug policy within a nation can be influenced by the way in which power
over healthcare is distributed in that country. This is demonstrated multiple times in
different time periods and in more than one country, as will be presented in the evidence
introduced below. The remainder of this chapter will accomplish the following tasks. First, it will outline the analytical framework of the dissertation. Next, it will define harm reduction and then review the international scholarship on harm reduction policy development. After this, it will overview the data collected for this dissertation and the research methods used for its analysis. Finally, it will introduce each of the three substantive chapters, and outline how each chapter helps to advance the central arguments set out above— that structural differences in the distribution of power over healthcare in Canada and the UK help to explain variations in harm reduction drug policy developments in both nations. 

FOCUS AND SCOPE OF ANALYSIS

This dissertation is a study of policy change surrounding primarily two specific harm reduction programs: needle exchange and drug consumption rooms. Needle exchange programs (NEPs) are places where individuals who inject illicit drugs such as heroin and/or cocaine can exchange used needles for clean ones (Parsons et al., 1999; Parsons et al., 2002). Drug consumption rooms (DCRs) are facilities where individuals lawfully inject illegally purchased illicit substances under medical supervision with clean syringes in order to prevent overdose death and the transmission of HIV and HCV (Hepatitis-C) (Hunt, 2006).

In focusing specifically on needle exchange and drug consumption room policies, this dissertation is not suggesting that these are the only two harm reduction strategies operating in either Canada or the United Kingdom. Having said that, to be clear, the purpose of this dissertation is not to document all changes in all harm reduction policies in both countries. Rather, the goal of this dissertation is to provide a better understanding of how and why harm reduction changes through a careful analysis of select policies and programs. Furthermore, there is a consensus among Harm Reduction organisations and drug policy research groups that both needle exchange and drug consumption rooms
constitute key examples of harm reduction policy (European Monitoring Centre for Drugs and Drug Addiction, 2010; Harm Reduction International, 2015; Canadian Harm Reduction Network, 2017).

While this dissertation is a comparative analysis of harm reduction policymaking in Canada and the UK, when comparisons are made regarding policymaking at the national level, the focus is squarely on developments within the British central government, and not the devolved parliaments of Scotland and Northern Ireland. British central government, as noted above, currently has control over healthcare and drug policy in England and Wales. The decision to focus on the British central government reflects the scope of data analysis for each of the three papers within this dissertation, and not a lack of developments in harm reduction in either Scotland or Northern Ireland.

Nevertheless, it might seem that this dissertation should be more appropriately called a comparative analysis of harm reduction policy in just Canada and England and Wales since it is the British government being studied and not those of either Scotland or Northern Ireland. However, this would not reflect the full scope of analysis, since drug policy developments in Scotland which took place in the 1980s are explored in this dissertation. In the first substantive chapter of this work, as will be discussed in more detail below, the development of needle exchange policy during the late 1980s and early 1990s is examined, and much attention is devoted to events which have taken place in Scotland. During this time, however, Scotland did not have its own parliament, and thus drug policy and health care ultimately fell under the jurisdiction of the British government. It is for this reason that this dissertation should be understood as a comparative analysis of harm reduction drug policy in Canada and the UK, as opposed to just Canada and England and Wales.

In the second substantive chapter in which drug consumption room policy
developments within the British government during the 21st century are being studied, the focus of the analysis is specifically Canada and England and Wales, and in the third substantive chapter, the focus is squarely on Canada. It is for this reason then, that even though this dissertation compares harm reduction policy developments between Canada and the UK, the focus of national government policy making is on the Canadian and British governments.

ANALYTICAL FRAMEWORK

Social Constructionism

Social problems are defined differently by those who approach their examination from either an objectivist or a subjectivist perspective. Objectivist sociologists understand social problems to be conditions that in some way harm society. For example, Leon-Guerro (2014) defines a social problem as a “…social condition or pattern of behavior that has negative consequences for individuals, our social world, or our physical world” (p.8). Subjectivists counter this conceptualisation of social problems by arguing that individuals within society often disagree over what conditions are harmful and why they are harmful. In response, they have come to understand social problems as efforts to raise concern about conditions within society (Best, 2013). An example of a definition of social problems that fits this perspective is that of Spector and Kitsuse (1977) who define social problems as the “…activities of individuals or groups making assertions of grievance and claims with respect to some putative conditions” (p.75). Social constructionists examine social problems from a subjectivist perspective. They propose that individuals (and groups) interpret objective conditions subjectively, and through communication and interaction they socially construct these objective conditions as being problematic or un-problematic (Goode, 1989). They can also socially construct the degree to which a condition is problematic, or how severe the problem is.
Although objectivists and subjectivists both agree that social policies are developed in reaction to social problems, they have different understandings about how this process unfolds which are shaped by the different ways in which they define social problems. Whereas objectivists believe social policies are direct responses to human suffering and social need, subjectivists think of social policies as being official public reactions to the activities of claims makers, or those who try to convince others that there is a troubling condition about which something ought to be done (see for example Blumer, 1971; Spector and Kitsuse, 1977). Joel Best (2013), for example, advances a ‘natural history of social problems’ model, in which he suggests that policy development occurs directly in response to the activities of ‘moral entrepreneurs’, or individuals who make ‘claims’ that certain conditions are social problems that require certain solutions. Becker (1963) suggests that moral entrepreneurs, or ‘rule creators’, have the ability to ‘create deviance’ by making rules whose infractions constitute ‘deviance’.

The natural history of social problems model can be understood as a social constructionist theory of policymaking because it suggests that the ways in which claims makers define ‘social problems’ can influence policymakers and the decisions that they make surrounding these ‘problems’. Best suggests that claims makers’ construction of issues as problems can be reported on news media, ensuring that their claims reach a ‘broader audience’ (Best, 2013). Large members of the public who consume the media will then focus on the social problem initially typified by claims makers, and consequently, lawmakers will create or amend social policies in order to address the concerns raised by their constituents who have become aware of the claims advanced by claims makers via the mass media (Best, 2013).

Best concludes by noting that cross-national policy variation with respect to similar conditions can be partially explained by cross-national differences in the way these
conditions are socially constructed by claims makers including scientists, doctors, activists, and the mass media. Theoretically, my research addresses Best’s claim by examining how differences in the way injection drug use is socially constructed helps to explain cross-national variation in harm reduction policy between Canada and the United Kingdom.

Best (2013) acknowledges that social conditions and circumstances can either enable or constrain claims making within the social problems process. For example, he notes that while claims makers are theoretically capable of constructing claims in whatever way that they choose, that in fact such claims have to make sense by aligning to the larger ‘culture’ within which they are constructed (p.54). Similarly, he notes that ‘opportunity structures’ (cultural and political conditions) can either enable or constrain the claims making activities of activists (Best, 2013:80). Sociologists investigate social problems and the policies designed to address them because they are interested how policy change is influenced by the way in which conditions are socially constructed by claims makers including activists, scientists, and the media. They see policies as responses to societal reactions to conditions rather than rational solutions to objective problems.

This dissertation seeks to extend Best’s line of thinking further by examining how opportunity structures can also either enable or constrain the impact that claims making has on the development of social policy. Put differently, it explores how opportunity structures not only mediate the construction of social problems, but also the connection between the construction of social problems and the development of social policy within Best’s historical model. The opportunity structure that this dissertation is chiefly interested in is the distribution of political power across branches of government. More specifically, this dissertation explores how the decentralisation of political power has mediated the influence that the social construction of injection drug use as a public health problem has on the
development of harm reduction policy in Canada, and conversely, how the centralisation of political power has mediated the influence that the social construction of injection drug use as a public health problem has on the development of harm reduction policy in the UK. Let us now turn to a more detailed discussion of the distribution of political power in Canada and the UK.

Alexis de Tocqueville’s *Theory of Good Government*

Since the founding of the discipline, the work of Alexis de Tocqueville has been enormously influential in the development of American sociological theory and research (Zeitlin, 2001). Tocqueville’s writing is instructive in the study of harm reduction drug policy development because it provides useful insight into how the distribution of political power can influence social life. In comparing social conditions in the United States and France, Tocqueville argues that the absence of a centralised state helps explains the unobtrusive and unoppressive character of the American state. He believed that when political power was concentrated in a centralised state (such as was the case in France), then this centralised bureaucracy ultimately becomes “the absolute master of liberty and life”. Conversely, when political power was de-centralised, such as in the United States, de Tocqueville claimed that “people accomplish their tasks by and for themselves”.

Tocqueville notes that in the United States “…the majority, which so frequently displays the propensities of a despot, is still destitute of the most perfect instruments of tyranny” (Tocqueville, 1945:271). He goes on to claim that when political power is decentralised the will of the majority, as represented by a central national government, must be delegated to subnational authorities such as state governments or township councils.
The central government frequently has no control over these bodies, and consequently, within such an arrangement the power that central government has over society is limited (Tocqueville, 1945:271). He proposes that political checks and balances, such as constitutionalism, are also effective in preventing political domination from a central national government. Again, he cites the United States, where he claims that the Constitution governs the legislator as much as private citizens, since it is perceived to be the “first of laws” and thus cannot be modified by any laws (Tocqueville, 1945:101). American law dictates that judges, including those on the US Supreme Court (the highest court in the land) have the right to base their decisions within the Constitution (the first of laws) rather than the current laws. What this means is that the US Supreme Court has the ability to strike down laws passed by the federal government, which serves as balance and check to the domination of American society by the centre. Tocqueville unites both principles together into a theory of good government in which he suggests that both decentralisation of power as well as the existence of political checks and balances are necessary in order to ensure that society is not dominated by a central government (Zeitlin, 2001:90).

Tocqueville’s theory of good government is helpful for interpreting some of the central findings in this dissertation. This dissertation will advance evidence which suggests that the ability of the central government to shape harm reduction policy and practice in a society is relatively more limited when power over the administration of health care is decentralised and subject to political checks and balances. Below, I provide a brief sketch of the ways in which power is distributed in Canada and the UK, focussing in particular on the distribution of power over health care and its administration in both countries.
Distribution of Power over Healthcare in Canada and the UK

Canada is a federation composed of ten provinces which are governed by both their own autonomous legislative assemblies, as well as a national parliament. The British North America Act (1867), Canada’s first constitution established in the year the country was founded, dictates that political authority over healthcare be shared between the federal and provincial governments, meaning that despite the fact that governance over healthcare is centralised in Canada, the administration of healthcare is decentralised. In Canada, health care is publicly funded by the federal government through the Canada Health Act (1984). While on the face of it, this seems to suggest that healthcare falls under federal jurisdiction, what it in fact means is that the federal government provides health care funding to the provinces, whereas the provincial governments have the political authority to use the federal funding to administer healthcare in the ways that they believe are appropriate. This is due in particular to Section 92(7) of the British North America Act, which grants provinces with exclusive jurisdiction over the establishment, maintenance, and management of, among other things, hospitals and asylums.

The Canada Health Act stipulates a number of criteria upon which provincial governments must follow in order receive federal health care funding, known as federal “transfer payments”. These include the following: 1) Public Administration- which demands that provincial health insurance plans must be "administered and operated on a non-profit basis by a public authority, responsible to the provincial/territorial governments and subject to audits of their accounts and financial transactions." (Section 8); 2) Comprehensiveness-which stipulates that health insurance plans must cover "all insured health services provided by hospitals, medical practitioners or dentists" (Section 9); 3) Universality- meaning that all insured persons must be covered for insured health services "provided for by the plan on uniform terms and conditions" (Section 10); 4) Portability- which suggests that individuals
must be covered by their plans regardless of whether or not they are located within their province; and lastly 5) Accessibility- that insurance plan must provide for "reasonable access" to insured services by insured persons, "on uniform terms and conditions, unrepled, unimpeded, either directly or indirectly, by charges (user charges or extra-billing) or other means (age, health status or financial circumstances);" (Section 12.a). Provided that the provinces meet these criteria, they are allowed considerable latitude in deciding how they wish to spend their transfer payments and administer their healthcare systems, and this is largely due to Section 92:7 of the British North America Act.

In contrast, in the United Kingdom each of the four countries (England, Northern Ireland, Scotland, and Wales) delivers their own public health care systems known as the National Health Services (National Health Service UK, 2017). Together, the four services are referred to as the National Health Service, but in reality each of the four systems are independent from each other (the UK government administers England’s National Health Service). A crucial difference with Britain’s health care is that within each country the National Health Service program falls under the constitutional jurisdiction of the national governments. Although health authorities (health boards in the case of Scotland; health trusts in the case of Northern Ireland) are established and operate in regions and municipalities across England and Wales, Scotland, and Northern Ireland, they derive their authority and are ultimately answerable to their respective national governments, and not any local (provincial and regional) governments (for example city or town councils) such as occurs here in Canada (National Health Service UK, 2017).

The importance of these structural differences in the political institutions will prove important in the three papers presented in this dissertation. For now, it is key to note that the UK political structure has changed over the years. Whereas today Scotland and Northern Ireland are governed by devolved parliaments, during the 1980s, they were each controlled
by the British government (Cairney, 2011; Jackson, 2003). Scotland and Northern Ireland
were under the control of a Scottish Ministry and Northern Ireland Ministry, both of whom
were headed by ministers who sat as members of the British government’s cabinet and
thus were answerable to the Prime Minister and the British House of Commons (Cairney,
2011; Jackson, 2003).

INTRODUCTION TO HARM REDUCTION

What is harm reduction? Harm Reduction International, a leading non-governmental
organisation that promotes the advancement of evidenced-based drug policies which are
respectful of human rights, defines harm reduction as a range of “…policies, programmes
and practices that aim to reduce the harms associated with the use of psychoactive drugs in
people unable or unwilling to stop” (Harm Reduction International, 2015). The organization
stresses that the “defining features” of harm reduction are: a) a “focus” on the people who
continue to use drugs; and b) the “prevention of harm” to continuing drug users rather than
the “prevention of drug use itself”. Similarly, the Canadian Harm Reduction Network
defines harm reduction as “policies, programs and practices that aim to reduce the negative
health, social and economic consequences that may ensue from the use of legal and illegal
psychoactive drugs, without necessarily reducing drug use” (Canadian Harm Reduction
Network, 2017). Both definitions identify the reduction of negative health consequences
without necessarily reducing drug use as a defining feature of harm reduction.

In May 2002, a special ad-hoc committee on harm reduction was formed by the Centre for
Addiction and Mental Health. While they conceded that a “one-size-fits-all definition” of harm
reduction does not exist that would satisfy all addiction practitioners, they nevertheless indicate
that harm reduction can be best defined as “…any policy or program designed to reduce drug-
related harm without requiring the cessation of drug use” (Erickson, 2002). The
committee points out that “interventions” may be targeted at the individual, family, community, or society; however, they emphasize that the “primary focus” of harm reduction should be on drug users potentially experiencing “harm” due to their current substance use.

Organisations such as Harm Reduction International and the Canadian Harm Reduction Network have also clearly outlined the main goals and objectives of harm reduction programming. Harm Reduction International stresses that the harm reduction approach is premised on a strong commitment to public health and human rights. They posit that harm reduction initiatives are intended to be evidenced based, cost-effective, and geared towards the needs of individual drug users (Canadian Harm Reduction Network, 2017; Harm Reduction International, 2017). They also claim that harm reduction programs oppose policies and practices that deliberately hurt and inflict harm on people, and that deliberately stigmatize drug users.

The Harm Reduction Coalition, which aims to advance harm reduction policies and programs, claim the following principles as being “central” to harm reduction policy: a) that licit and illicit substance use is a social fact and that members of society should strive to reduce harmful effects of substance use instead of “ignoring” or “condemning” them; b) that substance use is a “complex, multi-faceted phenomenon” comprising a “continuum of behaviors” ranging from chronic use to complete abstinence; c) that some forms of drug use are safer than others; d) that members of society should prioritise “quality” of individual and community life and not the abstinence of drug use; e) that services should be non-judgmental, non-coercive and designed to reduce harm; f) that substance users should have a “real voice” in the establishment of harm reduction policies; g) that substance users are the “primary agents” in reducing their own drug-related harms, and that users should be
“empowered” to share information and support each other in the establishment of harm reduction; h) that poverty, class, racism, social isolation, past trauma, sex-based discrimination and other social inequalities impact user’s “vulnerability” and ability to address their drug-related harm; and lastly, i) that members of society should not downplay or neglect the harms associated with licit and illicit substance use (Harm Reduction Coalition, 2017).

HARM REDUCTION POLICY DEVELOPMENT SCHOLARSHIP

Scholars have charted the developments of harm reduction drug policy in various countries. This is an area that has garnered quite a bit of scholarly attention due to interest in the role of harm reduction policy in the reduction of the spread of the Human Immunodeficiency Virus (HIV) and Hepatitis C, as well as the prevention of accidental overdose deaths. Program reviews of drug consumption rooms (DCRs) in Europe and North America provide detailed descriptions of different facilities, noting in particular, similarities and differences between various program delivery models (Anoro et al., 2003; Broadhead et al., 2002; European Monitoring Centre for Drugs and Drug Addiction, 2010a; Hunt, 2006). Anoro and colleagues (2003) discuss Espacio de Venopuncion higienica Asistida (EVA), the first drug consumption room established in Barcelona, Spain in September 2001. They authors review the program, noting that although it has an excellent track record for ensuring the safety of its clients, it is significantly underfunded (Anoro et al., 2003). Reports by Broadhead and his colleagues (2002), Hedrich et al. (2004), and the European Monitoring Centre for Drugs and Drug Addiction (2010) provide descriptive overviews of programs in Europe, Australia, and North America, noting details about where the programs are located, how they are staffed, and what specific services they provide within their facilities.
Hunt describes three drug consumption room service delivery models that are widely used around the world. The first model, the *integrated facility*, represents drug consumption rooms that are part of a wider group of services (2006:2). He explains that integrated facilities are typically connected to (with) existing services for homeless people or “drug addicts” (Hunt, 2006:2). Drug consumption room users are one group of clients who make use of the services provided in this facility (Hunt, 2006). *Specialized facilities* are drug consumption rooms that are solely used by injection drug users. These facilities are typically located near “illicit drug markets” and “open drug scenes” (Hunt, 2006:2). Lastly, *informal* facilities are drug consumption rooms that are often managed by current and/or former drug users, and that cater to drug smoking and inhalation as opposed to injection drug use (Hunt, 2006:2).

Researchers have reported on the opinions and attitudes of both community stakeholders and members of the general public toward various harm reduction drug policies. (Kimber and Cusick, 2006; Sterling, 2005; Wenger et al., 2011). Reid (2009) reports widespread misunderstanding and hostility among members of society in sub Saharan Africa toward harm reduction programs such as needle exchange programs, which are places where individuals can exchange dirty and used needles for clean ones. Needle exchange programs predate drug consumption rooms as they were first established in Europe in the middle of the 1980s. They are similar to drug consumption rooms in that they serve to prevent the spread of diseases like the Human Immunodeficiency Virus (HIV) and Hepatitis C through needle sharing; however, they differ in that they do not include any form of direct medical supervision like drug consumption rooms do. In a study published in 2000, Lewis and colleagues administered an anonymous survey to 1, 250 medical students and observed that, whereas students who identified as “liberal” were more likely to support harm reduction
strategies like needle exchange programs, those students who identified as “conservative” were more likely to oppose such programs.

Strike and colleagues (2004) conducted semi-structured interviews with needle exchange program staff, in Ontario, Canada, and found that community members in neighbourhoods where needle exchange programs were being proposed were concerned about the dangers that they posed to residents, as well as the potential for communities and workplaces to be stigmatized by the presence of needle exchange programs in their neighbourhoods. Vernick and colleagues (2003) carried out a systematic review of US national surveys that asked questions about approval of needle exchange programs and found that support for such facilities ranged from 29 to 66 percent. The authors note that the wording of the question was strongly correlated with levels of support for needle exchange programs (i.e. articles using terms like “drug addicts” led to higher levels of opposition to needle exchange programs), suggesting that there is no general consensus surrounding such facilities (Vernick et al., 2003). Treloar and Fraser (2007) analyse a small number of national representative samples and surveys collected from local communities where needle exchange programs are being proposed. The authors find that community perceptions toward needle exchange programs are primarily positive (Treloar and Fraser, 2007).

Cusick and Kimber (2007), for instance, interviewed 100 residents working in high drug use neighbourhoods in the United Kingdom, and found that they believed drug consumption rooms were ineffective because they addressed the “symptoms” but not the overall problematic social conditions that gave rise to drug use in their communities. Wenger and colleagues (2011) report from interviews with 20 San Franciscan stakeholders that some San Franciscans are opposed to the implementation of a drug consumption room in their city because they are concerned that it would hinder the community’s ability to control safety and
cleanliness, and that they are skeptical about whether harm reduction strategies are truly effective in addressing drug use. Although program reviews and studies of public attitudes toward harm reduction strategies are instructive, I submit that we must move beyond descriptive accounts of historical changes in harm reduction drug policy, and reports of public opinion polls/interviews, and endeavour to carefully explain how and why social conditions contribute to changes and developments in harm reduction drug policy.

Scholars world-wide have examined how the specific actions of individuals and groups, as well as broader social structural factors and processes, shape the development of harm reduction policies (Small et al., 2006; Treloar and Fraser, 2007; Reid, 2009; Strike et al., 2004; and Shaw et al., 2002). Uchtenhagen (2010), for example, finds that policy changes to heroin assisted therapy programs in Switzerland were influenced by the large size and visibility of the heroin problem in Switzerland, and the rise of rates of Acquired Immune Deficiency Syndrome (AIDS). The author also believes that progressive changes were facilitated by Swiss society’s programmatic attitude toward allowing private health institutions to take the lead in official drug policy changes (Uchtenhagen, 2010).

Certain demographic and socio-political conditions have been found to be highly correlated with whether or not a needle exchange program exists in a community (Zibbell, 2009). For instance, Gent (2000) finds that municipal level social conditions such as levels of religious conservativism within the population, and the percentage of the population who are college students, gay persons, and/or intravenous drug users, are strongly related to the existence of a needle exchange program in a city. Tempalski and colleagues (2007) find that the presence/absence of needle exchange program(s) in a community can be predicted based on social conditions such as the percentage of the community population with a college
Analysts have also investigated the historical development of drug consumption room policies, focusing on how broad social structural conditions such as national legal environment, religion, and cultural tradition can either facilitate (or pose barriers) to the implementation of facilities. Beletsky and colleagues (2008) find that the political and legal environment both play an important role in explaining why drug consumption rooms are not implemented in the United States. They explain that, although state laws permit the establishment of drug consumption rooms, federal authorities and politicians can still interfere and prevent such programs from becoming established (Beletsky et al., 2008). They conclude that the only way for a drug consumption room to be opened in the States is if there is support from the federal authorities (Beletsky et al., 2008).

Historical events that have also been examined include: social movements; the election of certain leaders and parties into political power, the formation of global agencies advocating for or/against drug consumption rooms; and the globalization of national social policies (Beletsky et al., 2008; Mendes, 2002; Small et al., 2006; Small, 2007; Wenger et al., 2011). Lloyd and Hunt (2007) examine the drug policy context in the UK as they chronicle the International Working Group’s research and advocacy for the establishment of DCRs in the country. They note the national government’s rejection of the IWG report, citing the government’s arguments that drug consumption rooms condone drug use (Lloyd and Hunt, 2007).
Mendes (2002) notes that experiences with harm reduction abroad played a significant role in the establishment of a drug consumption room in Sydney, Australia. He explains that debates surrounding the establishment of a West Australian drug consumption room took into serious account the success and failure of drug consumption rooms already created in Europe (Mendes, 2002). Furthermore, Small and colleagues (2006) cite the election of former coroner Larry Campbell as mayor of Vancouver during the 2002 municipal elections as instrumental in the development and eventual creation of InSite. Campbell was “well connected” to community activists and health care providers before the election, had been a volunteer director for a downtown Eastside community agency, and worked with members of the Portland Hotel Society who would go onto become key players in the creation of InSite (Small et al., 2006:7). Philbin et al. (2008) argues that religious and cultural factors affect the acceptance of drug consumption rooms (as well as needle exchange programs and syringe vending machines). They find, for example, that statements made by religious leaders can play an important role in determining how a society will respond to drug consumption room policy (Philbin et al., 2008).

Analysts have also investigated what types of historical, socio-cultural, and political factors can determine whether or not harm reduction strategies, including drug consumption rooms and needle exchange programs, are implemented (Gent, 2000; Tempalski et al., 2007; Beletsky et al., 2008; Tempalski, 2005). Although research spans the globe, particularly, North America (Canada, the U.S., Mexico), Europe (Spain), Asia (China), and Oceania (Australia), very little attention has been paid to how the development of harm reduction policy has unfolded similarly or differently around the world.
Despite a healthy literature investigating a wide variety of factors and conditions that explain the development of harm reduction policies, federalism and/or federal political institutions and structures are not factors that have been sufficiently explored. McCoun and Reuter (2001) note in a background to their discussion of drug consumption rooms in Switzerland, that the country is a federal state par excellence, and that drug policy there can be established at the level of the ‘canton’ (sub-national political unit). However, they stop short of outright attributing the successful and early development of drug consumption rooms in Switzerland to the country’s federal political structure. Lastly, despite the robustness of the literature above, it is composed entirely of case studies that focus on harm reduction policy development in one particular location. There currently exists only a very small literature that examines harm reduction policy making internationally and comparatively (see Hayle, 2015 and Zampini, 2014), and these studies have not invoked the lens of social constructionism as this dissertation does.

RESEARCH DESIGN, DATA AND METHODS

Research Design- Comparative Historical Sociology

In order to carry out my research, I have adopted a comparative and historical research design. According to the American Sociological Association, comparative historical research is a ‘method’ of social scientific research that can be used to investigate historical events in order to generate explanations that are valid beyond a particular time and place, by direct comparison to other historical events (American Sociological Association, 2017). Drawing on this definition, it becomes clear that the comparative historical method is ideally suited to the task of investigating harm reduction policy developments over multiple periods of time.
and in more than one country. The comparative historical approach is indispensable for achieving one of the primary goals of this dissertation, which is to move toward generating a general theory of harm reduction drug policy change that transcends spatial and temporal boundaries.

Using the comparative historical approach, I will be studying numerous harm reduction policymaking events from numerous different time periods and numerous different jurisdictions within both Canada and the UK. Furthermore, I will be comparing and contrasting all of these events with one another which will allow me to observe and identify similar processes and factors that influence harm reduction policymaking throughout time and across jurisdictions.

Data

To accomplish the goals set out in this paper, I analyse content drawn from federal and provincial Hansard documents, municipal council documents, committee reports and newspaper and online news articles from Canada and England and Wales that were published between 1997 and 2014. More information on the specific number of documents selected for analysis will be provided in each of the substantive chapters. The year 1997 was chosen as the start date for this particular study’s analysis as it is as far back as “official” discussion surrounding SCSs can be traced in either city’s documents. I also draw on secondary data from published literature (including scientific and statistical reports).

Content analysis of government documents and newspaper articles is suitable for analysing harm reduction drug policy change since it provides useful data pertaining to who is problematizing injection drug use, and how they are doing so. Committee documents and
newspaper articles provide quotations illustrating how injection drug use has been framed during harm reduction policy discussions. Hansard debates and council minutes include decision makers’ quotations that provide insight into what factors influenced their policy choices. Recognising the potential for editorial bias in newspaper articles, I only turn to press coverage for historical data on events and activities and quotations from public statements when I was unable to find this in government records and/or secondary reports.

The government documents chosen for analysis include the following: 1) federal/national and provincial legislative debates (sixteen from the Canadian House of Commons and seven from the Canadian Senate; seven from the UK House of Commons); 2) federal/national and provincial committee proceedings and reports (in Canada twelve reports are from the Special Committee for the Non-Medical Use of Drugs; one is from the Standing Sub Committee on Social Affairs, Science and Technology; one is from the Sub Committee on Population Health; one is from the Standing Committee of Health; and in the UK one is from the final report of the Home Affairs Select Committee); 3) one Canadian Supreme Court ruling; and 4) municipal council documents. Municipal council documents included: city council agendas and minutes from both localities, city council committee reports (including evidence, minutes, and sometimes recommendations), press statements, municipal drug strategies, minutes and summaries from town hall meetings, and public health board meeting minutes and recommendations.

Data were drawn from the following news sources: The Globe and Mail; The National Post; The Toronto Star; The Toronto Sun; The Vancouver Sun; The Vancouver Province; The Ottawa Citizen; The Times (London) (including the Sunday Times); The Independent (London); The Observer (London); The Guardian (UK); The Brighton Argus; Global News (Online); CBC News (Online) and the online website for Canadian Television News (CTV).
More information on the specific number of articles selected for analysis will be provided in each of the substantive chapters. Since my focus is on national-level policymaking, I chose national newspapers that covered injection drug use across the country, and paid attention to the activities of national politicians and national government committees. I also included the local newspapers for cities featured in drug policy debates as potential locations for DCRs (i.e. Brighton). Search terms included heroin”, “HIV/AIDS”, “hepatitis C”, “overdose death”, “harm/risk reduction/minimisation”, “drug consumption/rooms”, “safe/clean injection/injecting sites/rooms/houses/facilities”, “supervised consumption sites/facilities/rooms/houses”, “shooting gallery(ies)”, “needle exchange”; “syringe exchange”, “syringe distribution”; “heroin prescription”; “heroin clinics”; and “heroin assisted therapy”. From each newspaper, I collected and analysed all pertinent articles retrieved using these search terms. These articles included news stories, analysis pieces, editorials, and letters to the editors.

Research Design and Rationale

Earlier I discussed the theoretical and analytical reasons for carrying out cross-national comparative analysis of harm reduction drug policy reform. Here I wish to briefly discuss the methodological reasons for choosing Canada and the UK as my points for comparison. I chose to compare these two countries for three reasons. First, Canada and the U.K. share similar social configurations. As I will discuss in more detail below, comparative analysis of different policy outcomes in two states that are similar to one another is preferable as it allows for the researcher to control for a variety of social conditions so that it is easier to identify processes and conditions that differ across both states that help explain cross-national variations in policy outcomes. For example, English is an official language in both countries; both countries are capitalist democracies that share similar common law system;
and both countries have similar drug laws (i.e. the same substances are outlawed in both countries) and roughly similar criminal penalties for breaking said laws.

When I began collecting data for this dissertation, rates of problem drug use in Canada and the U.K. were also similar (2.5-4.3/100 000 in Canada vs. 2.3-8.9/100 000 in the U.K.) (Health Canada, 2011). Rates of illicit drug use in 2011 among those 15 and older (15-59 in the U.K.), across various substances, were similar in both Canada and the U.K.: for cannabis use, 10.7 in Canada and 6.6 in the U.K.; for cocaine, 0.7 in Canada and 2.5 in the U.K.; for ecstasy, 0.7 in Canada and 1.6 in the U.K., for heroin, lifetime drug use prevalence is 0.7 in Canada and 0.9 in the U.K. (past year prevalence statistics available for Canada but not the U.K. so not comparable). (European Monitoring Centre for Drugs and Drug Addiction, 2010b, Health Canada, 2011).

Despite similarities in rates of drug use, as well as similarities in language (English), legal systems, including criminal law and criminal justice (common law), criminal laws, economic systems (capitalism), political systems (democratic) culture (many elements of culture shared due to the fact that Canada is a former colony of the UK), and the nature of illicit drug use and drug law enforcement, Canadian and British literature on drug policies suggest that the trajectories of harm reduction development in each country have been very different.

The United Kingdom has been described in the literature as a “pioneer” in the “medicalization” approach to drug abuse as it was the first country in the world to allow its physicians to prescribe drugs like heroin and cocaine to substance users on a “maintenance” basis. This decision to allow general practitioner physicians to prescribe heroin for
maintenance purposes arose out of the 1925 Rolleston Committee report in which a group of prominent British physicians advised that, under certain circumstances, “addicts” should be prescribed drugs to “reduce” the “harms” of drugs and to be able to live and lead productive lives (Cook, 1970; 49; Marlatt, 1996:784). Heroin maintenance has fallen into disfavour in recent years (Marlatt, 1996).

Since 1968, only doctors with special license have been legally permitted to prescribe heroin to addicts, however, McKeganey (2006) suggests that in 2002 nearly 87% of all drug users had access to some form of “drug prescription service” (p.558). This contrasts sharply with Canada where heroin prescription has been illegal since the 1920s (Giffen et al., 1991). The first trial of a heroin assisted treatment program, known as the North American Opiate Medication Initiative (NAOMI) began only in 2005, which is 85 years after British doctors began legally prescribing heroin to their patients) (North American Opiate Maintenance Initiative, 2006). Thus, the heroin assisted therapy has followed definitively different legal trajectories in Canada and the U.K. Needle exchange programming has also developed differently in both countries. Research indicates that needle exchange programs were piloted in Canada and the U.K. around roughly the same time. The first needle exchange opened in the U.K. in Liverpool in 1986 at the Mersey Region Drug Treatment and Information Centre, whereas the first needle exchanges opened in Canada in Vancouver and Toronto in 1989.

The uniquely early acceptance of heroin prescription appears to suggest that harm reduction has been a much more successful drug policy in the UK compared to Canada. However, this seems at odds with the fact that, whereas Canada is currently home to two legally sanctioned drug consumption rooms (with more on the way), the UK is not. In contrast, drug consumption rooms were operating in the UK over thirty years earlier during
the time of the “60s drug scene” (Hunt, 2011). Hunt refers to these facilities as “vestigial drug consumption rooms” and suggests that they were largely discredited due to their “increasingly chaotic environment” (Hunt, 2011). He notes that all the U.K. consumption rooms were shut down during the 1970s, and there has been no type of consumption room established in the country since (Hunt, 2011). Thus, regardless of similar linguistic, cultural, political, economic, social and legal backgrounds, historical evidence shows that harm reduction has unfolded differently in both Canada and the U.K. Hence, these two countries are suitable for a case-oriented cross-national comparison because it will be possible to isolate those unique historical events and social structural factors that can explain differences in harm reduction policies between the two countries.

METHODS

*Comparative Methods*

I use a cross-national comparative and historical methodology to contrast the socio-political, historical, and economic contexts of each country. Legal scholars of drug policy have looked to the social structure of different country’s (or states) societies in order to explain similar or unique developments in drug law (Cook, 1970; Scheerer, 1978; Hyshka, 2009; Reichel, 2005; DiChiara and Galliher, 1994). Specifically, I have collected and analysed data using a *case-oriented comparative sociological approach*, which involves studying nation-states as unique socio-historical configurations, as well as using empirical sources like archival documents to investigate how social “entities” are influenced by distinct historical contexts (Goldthorpe, 1997; Rueschemeyer and Stephens, 1997).
I compare harm reduction drug policy in Canada and the UK using a *most similar* system design approach. According to political scientists such as Landman (2008) and Lim (2006), the most similar system design strategy involves “…matching up and then comparing two or more systems that share a whole range of similarities (political, social, demographic, economic, cultural, and so on) but also differ in at least a couple of important respects” (Lim, 2006:34). Employing the most similar design system allows comparative scholars to control for social conditions that are the same across both countries, and subsequently to identify factors that are dissimilar across countries that may be causally related to the social phenomenon at interests them.

*Grounded Theory*

I use *grounded theory methods* (herein referred to simply as grounded theory) to analyse this collected data. Grounded theory refers to a group of data analytic strategies that are *inductive* in design, meaning that they require the researcher to begin with individual “cases, incidents, or experiences” (or empirical data), and from this data identify “patterned relationships” and develop more “abstract conceptual categories” (Charmaz, 2000:497; Glaser and Strauss, 1967). These procedures are suitable for handling “rich qualitative materials” (Charmaz, 2000:497).

Grounded theory is appropriate for my research because the data that I have collected from government documents and newspapers is dense and contains a significant amount of information, requiring efficient and careful analysis. Since my aim has been to locate socio-historical factors that explain successful or unsuccessful establishment of harm reduction policies *across* countries, then identifying patterned relationships that emerge *across* all the data (a key component of grounded theory), will be crucial to carrying out my objectives.
Furthermore, grounded theory is appropriate for studying the “reciprocal effects between individuals and larger social processes”, which is consistent with my aim to understand how the connection between the actions of individuals and large scale historical processes interact to explain drug consumption room policy (Charmaz, 2000:494).

The specific grounded theory procedures I employed include line-by-line coding, focused coding, memo writing, and theoretical sampling. *Line-by-line coding* involves reading *every* single line of newspaper articles and government documents and “naming” each line with a “code” word (Charmaz, 2000:506). Line-by-line coding forces researchers to ground their broader conceptual analysis in the data (Charmaz, 2000). *Focused coding* entails using the codes created from line-by-line procedures to organize the large amounts of data collected (Charmaz, 2000). Whereas line-by-line coding and focused coding has been most helpful for organizing what will be a very large dataset, *memo writing* has facilitated the analysis of our now categorized data. Memo writing involves taking conceptual categories apart and carefully and comprehensively identifying each category’s properties and characteristics. Memo writing has been particularly helpful for engaging in comparative analysis; grounded theorists encourage memo writing to be used for making detailed comparisons between categories (Charmaz, 2000). Written memos were then used to direct me to where I needed to collect more data in order to further develop my concepts and emerging theories (referred to as *theoretical sampling*).

**Data Analysis**

The documents were analysed in Microsoft word format without the use of any additional electronic software programs. The first stage of my analysis involved a superficial examination (or “skimming”) of the documents in order to familiarise myself with the data
The second stage involved a more thorough analysis of the ‘content’ found in each document drawing on “thematic analytic methods” (Freday and Muir-Cochrane, 2006). Thematic analysis is a process in which “coding” and “category construction” are performed in order to uncover thematic patterns pertinent to the topic under study (Freday and Muir-Cochrane, 2006).

Consistent with Bowen’s (2009) recommendation to anchor one’s thematic analysis in grounded theory, I invoked open coding techniques, in which each line of content from documents was broken down into “discrete units” in order to facilitate interpretation (Strauss and Corbin, 1990). Discrete units were distinct thoughts, ideas, and/or statements that could be compared and contrasted with one another and then grouped together into larger categories to facilitate analysis (Rohleder and Lyons, 2014). This process was carried out without any predefined codes or categories in order to ensure that the central themes emerged directly from the data (Altheide, 1996).

Initially, over 100 codes were generated through line-by-line coding, however, this list was gradually reduced to thirty codes through more focussed coding techniques which involved the thematic categorisation of paragraphs or even entire documents. These codes were then used to generate thematic categories pertinent to the analysis of harm reduction policymaking in Canada and the UK. Both latent (specific words and phrases composing content) and manifest content (meaning of content) was coded (Strauss and Corbin, 1990).

Verifying Authenticity and Truthfulness

In order to ensure that the documents collected and analysed are authentic and accurate, I have employed historiographical methods that involve carefully scrutinizing: the qualifications and motivations of the document authors; the methods used by document authors to collect information; and the extent to which other secondary sources corroborate
or challenge information contained in the document (Dibble, 1963; Platt, 1981).

OUTLINE OF CHAPTERS

Chapter Two: The Power and Politics of Needle Exchange Programming

The first paper examines the development of harm reduction policy in Canada and the UK, focusing specifically on the advent of needle exchange programs in the 1980s. It questions how differences in the trajectory of harm reduction policy in Canada and the UK can be partially explained by differences in the distribution of political power. The article explores how the social construction of injection drug use as a public health problem in both countries has helped encourage policy development with regards to allowing for government funded programs to provide clean needles to people who inject drugs. However, the paper investigates how the social construction of injection drug use and its impact on harm reduction policy development has been moderated by political structure. It examines how the decentralization (or separation) of power(s) over the administration of healthcare helps to explain why needle exchange policy has unfolded slowly and unevenly across the country, and similarly how the UK’s centralization of power (or the doctrine of parliamentary sovereignty) over healthcare administration facilitated the dissemination of needle exchange programs across the country at a speed unprecedented anywhere else in the world. It then considers how the varying distributions of political power in Canada and the UK also explain varying policies with respect to drug consumption rooms in both countries.
Chapter Three: Comparing Drug Policy Windows Internationally

The second chapter, entitled “Comparing Drug Policy Windows Internationally”, questions why, in 2002, the Canadian federal government approved the establishment of North America’s first drug consumption room, InSite, whereas the British government has continually rejected calls to establish drug consumption rooms in England and Wales. The paper explores how political and historical circumstances have unfolded differently in both countries, and how these differences have led to the two countries following different trajectories with respect to harm reduction policy, and specifically, the development and establishment of drug consumption rooms. This article will demonstrate that an important factor which has helped explain why drug consumption room policy was established in Canada and not England and Wales is that because, whilst in Canada, injection drug use was socially constructed as a public health problem (i.e. it has been medicalized), in England and Wales injection drug use was primarily constructed as both crime and law and order problems.

This paper also presents evidence that speaks to the important role that decentralized administration has played in constraining the influence that social constructionist processes have on harm reduction policy development in Canada. In this dissertation I will consider how the separation of political powers in Canada helps to explain why a government supportive of drug consumption rooms and the notion that injection drug use was a nationwide public health problem only moved to support the establishment of one facility in Vancouver, British Columbia. I will also consider how the separation of power over healthcare helps explain how Vancouver’s injection site was able to remain open despite fierce opposition from a federal government which wanted to see it closed.
In contrast, this paper shows that in England and Wales, the social construction of injection drug use as a crime problem is one that occurred at the national government level. Although calls for drug consumption rooms have been made on multiple occasions by politicians and activist groups, the British government has repeatedly reaffirmed its opposition to establishing such facilities in England and Wales. Similar to Canada, calls have been made for the establishment of a drug consumption room in the City of Brighton, which has one of the highest rates of injection drug overdose death across the entire country. Similar to Vancouver, local members of parliament and public health officials have attempted to socially construct injection drug use as serious public health problem in Brighton. But in contrast, the British government did not support and approve the establishment of a drug consumption room in Brighton in the same way that the Canadian government did in Canada. In the conclusion of this dissertation I will explore how social constructionist processes in Brighton were constrained due to the centralization of power over the administration of healthcare in England and Wales.

Chapter Four: A Tale of Two Cities

The third chapter, “A Tale of Two Cities”, will provide an illustration of the consequences of the decentralization of power over the administration of health care on harm reduction policymaking in Canada. I turn my attention specifically to municipal drug consumption room policy making. Specifically, I question how and why the City of Vancouver was successful in establishing a drug consumption room (the first in North America), whereas, in contrast, proposals for drug consumption rooms have only recently (July 2016) been approved by Toronto’s city council. I explore how and why factors specific to the municipality can influence harm reduction policy making. Factors that I explore include local
public opinion and the opinions of local politicians and local law enforcement officers. I am particularly interested in how these factors and conditions influence local political support for drug consumption rooms. Consistent with the first chapter, I explore in this paper how, in both Vancouver and Toronto, the social construction of injection drug use as a public health problem plays a role in influencing drug consumption room policy making.

This chapter speaks to the decentralization of political power over healthcare in Canada by exploring the influence that the 2011 Supreme Court ruling and subsequent 2015 Respect for Communities Act passed has had on drug consumption room policymaking across the country. The act sets out the guidelines and criteria that must be met in order for the federal government to approve the establishment of a drug consumption room. The paper investigates how the new act has allowed provincial and municipal authorities the ability to express their opinions about drug consumption rooms in their jurisdictions, thus providing subnational political authorities including provincial governments, provincial health ministries, local city councils and local police forces with the ability to heavily influence drug consumption room policy development within their jurisdictions. In the conclusion, I question how the actions of subnational governments have influenced the federal government’s most recent positions on DCRs, including its repeal of many of the provisions found within the Respect for Communities Act.

In conclusion, this dissertation provides a comparative analysis of harm reduction drug policy development in Canada and the United Kingdom between the years 1985 and 2017. I explore the relationship between harm reduction drug policy change and the social construction of injection drug use in both countries during this time period, and in particular I question how the distribution of political power mediates this relationship. I argue in this
dissertation that whereas in Canada, the “levers” of power over harm reduction policy development lie within subnational political entities such as provincial, regional and municipal governments, in the UK the “levels” of power over harm reduction policy development lie within the national government. Harm reduction policy development has been most significant in both countries during this time period when IDU was framed as a health problem. But differences in the distribution of power over health care law and policy in both countries help to explain cross-national differences in harm reduction policy development. This comparative work is significant as it allows us to better comprehend the social processes underlying harm reduction policy development in both countries, which in turn allows us to further advance a distinctly sociological analysis of harm reduction drug policy change. Following the three dissertation chapters, I will discuss further implications of this work in the concluding chapter of this study.

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CHAPTER TWO: THE POLITICS OF NEEDLE EXCHANGE PROGRAMMING: A COMPARATIVE ANALYSIS OF NEEDLE EXCHANGE POLICY IN CANADA AND THE UNITED KINGDOM

ABSTRACT

Although there are over two thousand needle exchange facilities currently operating across the UK, Canada is home to less than two hundred needle exchange programs. Although the population of Canada is roughly one half of that of the UK, it is unlikely that this factor, alone, explains the enormous discrepancy in the number of needle exchange facilities found in each country. Drawing on government records, policy documents, newspaper articles, and secondary literature, this paper seeks to better understand how and why needle exchange policy has developed as differently as it has in both countries between the years 1985 and 2015. Utilising social constructionism and political sociology as analytical frameworks, this paper concludes that divergent political structures found in each country help to explain cross-national variations in drug policy development.

POLITICAL TIMELINE

The United Kingdom

1979-1990 Conservative Majority National Government; Prime Minister Margaret Thatcher
1990-1997 Conservative Majority National Government; Prime Minister John Major

Canada

1984-1993 Progressive Conservative Majority Federal Government; Prime Minister Brian Mulroney; Health Minister Perrin Beatty

British Columbia

1991- New Democratic Party Majority Provincial Government; Premier Mike Harcourt
INTRODUCTION

This paper explores how the distribution of political power helps to explain cross-national variations in harm reduction policy, through an investigation of the divergent historical trajectories of needle exchange program (NEP) policymaking in Canada and the UK between the years 1985 and 2015. Since 1997, the UK has been home to over 2000 NEPs, or places where individuals who inject illicit drugs such as heroin and/or cocaine can exchange used needles for clean ones (Parsons et al., 1999; Parsons et al., 2002). The programs are “well established” across the country, located in England and Wales, Scotland, and Northern Ireland. Of the 2000 programs that are currently operating, over 1, 500 of them operate within community pharmacies, while the remainder operate out of specialist services (Parsons et al., 1999; Parsons et al., 2002). The United Kingdom is a trailblazer in needle exchange policy, having established the first 15 needle exchanges (pilot programs) in 1987, ahead of most other countries around the world (Parsons et al., 1999; Parsons et al., 2002). Roughly 120 services were operating by 1989/1990 (Donoghoe et al., 1992) and by 1993, then Prime Minister John Major proudly announced in the House of Commons that roughly 300 programs were in operation (Major, 1993).

The situation in the UK can be sharply contrasted with circumstances in Canada where there are estimated to be just slightly over 100 needle exchange programs. Although Canada’s population is one half the size of the UK, its ratio of programs to population is still considerably lower with only a twentieth of the number of needle exchange programs that the UK has. Canada opened its first needle exchange in 1989, not long after the first programs opened in the UK; however, unlike the latter country, considerably fewer needle exchange programs opened, and at a much slower rate. Unlike in the UK, needle exchanges are less evenly distributed across Canada. Whereas 216 needle exchange programs are operating in the province Ontario (180 of which are satellites), only 14 needle exchange programs operate
in the province of British Columbia, 6 operate in the province of Alberta, 2 operate in the province of Prince Edward Island (PEI), and the provinces of Newfoundland, New Brunswick, Manitoba and Saskatchewan each only have one needle exchange. Only four needle exchange programs service the Atlantic region of Canada altogether.

Recent studies point to the effectiveness of needle exchanges in preventing the spread of HIV and HCV (hepatitis) by reducing the sharing of dirty needles contaminated with these blood borne viruses (Abdul-Quadar et al., 2013; Aspinall et al., 2014; Des Jarlais et al., 2013; Lemon and Shah, 2013). They have also been found to reduce improper syringe disposal (Franciscus, 2013), as well as facilitate connections between injection drug users (IDUs) and medical health facilities (Avert, 2013; Des Jarlais et al., 2009). Despite the promising research findings, there are many states around the world where needle exchange provisions do not exist, including Kenya, Zambia, Botswana, the Philippines, Sri Lanka, Thailand, Myanmar, Malaysia, PDR Laos, Japan, Hong Kong, Bhutan, Turkmenistan, Kosovo, Montenegro, Turkey, and Iceland. And the provision of needle exchange varies enormously across the Canada, as noted above. As a result, millions of drug users around the world lack access to the important services provided by needle exchange programs, including harm reduction and medical attention.

An important first step to improving needle exchange provision around the world and across Canada is developing a better understanding of how and why needle exchange programs and policies are initially developed and then expanded upon. Research on this question is limited and in need of further investigation in order to better understand the processes and mechanisms behind needle exchange policy development. There is a small literature that explores social and political conditions determining the success of needle
exchange programs (see Gent, 2000; Heimer et al., 1996; Tempalski, 2007), but this scholarship is limited by an absence of cross-national research comparing needle exchange policy development in multiple countries. Cross-national comparative analysis improves our understanding of policy development and change by situating them within their national historical and socio-political contexts (Hyshka, 2009). This paper addresses this task by comparing the history of needle exchange policy development and expansion in both Canada and the UK. Particular attention will be played to the role of power and politics in the development and expansion of these policies in both countries. It responds to a call made by drug historian Virginia Berridge (1999) to carry out cross-national comparative policy analysis in order to develop a better understanding of what the “levers” of harm reduction are, and how they work.

Drawing on documentary evidence from government records, newspaper articles, and secondary literature, this paper investigates how differences in the distribution of power over healthcare across political institutions in Canada and the UK helps to shape different NEP policies and programs in both countries between the years 1985 and 2015. There is a rich and growing literature in which power and politics are offered up as causal variables to explain the development criminal law and crime policy (Bayley, 1973; Friedman, 1975; Nelken, 2000). The role of politics in shaping drug policy has also received attention from a number of scholars (Gusfield, 1967; 1986; Cook, 1970; Hyshka, 2008; 2009; Scheerer, 1978; Zampini, 2015). However, despite an ever growing literature examining the politics of criminal law and drug policy, comparatively little attention has been paid to how power and politics help to explain cross-national differences in NEP policy. Cross-national comparative analysis is important in this field because it broadens our knowledge of drug policies
operating around the world, as well as enhances our understanding of drug policymaking processes. Additionally, it provides insight and analysis into drug policymaking that can be useful to other countries wishing to adopt similar policies or experiencing difficulties overcoming obstacles or barriers to implementing such policies.

I begin by overviewing literature on the politics of drug law and policy as well as ‘sociological institutionalism’, the theoretical framework being adopted for this paper. Next, I present findings from our study of needle exchange policy development over the past thirty years and consider how differences in policy between Canada and the UK can be explained by unique social structural factors found in each country.

LITERATURE REVIEW

There exists a large and growing literature that explores the relationship between power and politics and the development and change of criminal law, criminal justice practices, and crime policy. However, there is a dearth of scholarship examining the politics of harm reduction drug policy, and in particular, needle exchange programming and policy. Conflict criminologists, for example, are interested in how criminal law serves to protect the economic and political interests of the dominant classes from the masses who are powerless. Conflict over economic resources between dominant Caucasians and suppressed African Americans and/or Asian, Mexican, and European immigrants have been explored by various scholars (Reinarman and Levine, 1997; Cook, 1970; Giffen et al., 1991; Gusfield, 1986), and male control over female drug users has also been examined (Giffen et al., 1991). Bayley (1972) has studied the organisational structure of policing worldwide, and has developed a theoretical model that links the political structure of a nation to the policing practices adopted
in that country. He argues that there is a correlation between authoritarian systems of
government (i.e. the former Soviet Union) and single national police forces, as well
as democratic systems of government and multiple, de-centralised police forces.

Harm reduction policy change has been studied extensively by an inter-disciplinary
and international community of scholars. Topics that have been investigated have included
the development of heroin prescription policies (Berridge, 2005; Cook, 1970; Fischer, 2000);
heroin assisted therapy programs (Uchtenhagen, 2000), drug consumption rooms (Schutz,
1989; Wolf et al., 2003; Kimber et al., 2003; Skretting, 2006; and Hobourg and Frank,
2014), and needle exchange programs (Gent, 2000; Tempalski, 2007; Heimer et al., 1996).
Heimer and colleagues (1996) explore social structural factors that serve as barriers to the
successful development of NEPs, while Gent (2000) identified several demographic factors
(SES, concentration of same sex households) and macro level variables such as political
climate and religious traditionalism which he concluded were “significant determinants” for
the development of needle exchange programs in US cities. Tempalski and colleagues
(2007) argue that city-level factors including the percentage of a population with college
education and the percentage of a population who are men who have sex with men “predict”
whether or not a needle exchange program will be established in the city.

There is a small literature that explores drug policy comparatively across nations;
however, this area of research remains underdeveloped. This scholarship has focussed almost
totally on cross-national comparisons of cannabis policy (Scheerer, 1978 and Hyshka,
2009) and drug consumption rooms (Hayle, 2015; Zampini, 2014). However, cross-national
comparative scholarship can be enormously beneficial as it can help us better understand
how a country’s drug policy is shaped by the power of political institutions found within the
nation (Scheerer, 1978). To date, there are no cross-national comparative studies of needle exchange policy and programming in the academic literature. Much can be learned about how the distribution of power across political institutions can help explain the development of needle exchange policies if we subject them to cross-national comparative analysis. By comparing harm reduction policy development in two countries, we can better comprehend to what extent, and why, cross-national differences in harm reduction policy development can be explained by cross-national variations in the way power is distributed across political institutions. This paper attempts to achieve this goal by comparing the development of needle exchange policy and programming in Canada and the UK.

**ANALYTICAL FRAMEWORK: SOCIAL CONSTRUCTIONISM AND THE DISTRIBUTION OF POLITICAL POWER**

*Social Constructionism*

Social constructionism posits that the social world is not an “objective” reality external to individuals; rather the social world is composed of “ideas” and “meanings” that are adopted by members of society. These ideas and meanings can pertain to whether something is acceptable or unacceptable, normal or deviant, moral or immoral, or proper or improper (Berger and Luckmann, 1966). Social constructionists are interested in how members of society take part in constructing their perceived social realities. They believe that “social phenomena” are ultimately created, institutionalised through social interactions between members of society. Social constructionism is a useful analytical framework for this study because it helps us understand the important connection between harm reduction drug policy development and change and the ways in which IDU is defined and framed by members of society.

This study will look at how the framing of IDU as a public health problem and IDUs as individuals requiring health services helps explain the degree and extent to which needle
exchange programs are developed and expanded across a country. It also explores how the relationship between IDU social construction and needle exchange policy is influenced by the structural distribution of power across a country’s political institutions.

**Alexis de Tocqueville’s Theory of Good Government**

Alexis de Tocqueville’s theoretical writing on the structural distribution of power across political institutions in the US and France is instructive in the study of harm reduction drug policy development because it provides useful insight into how the distribution of political power can influence social life. In comparing social conditions in the US and France, Tocqueville argues that the absence of a centralised state helps explains the unobtrusive and unoppressive character of the American state. He believed that when political power was concentrated in a centralised state (such as was the case in France), then this centralised bureaucracy ultimately becomes “the absolute master of liberty and life”. Conversely, when political power was de-centralised, such as in the United States, Tocqueville claimed that “people accomplish their tasks by and for themselves”. He goes on to claim that when political power is decentralised the will of the majority, as represented by a central national government, must be delegated to subnational authorities such as state governments or township councils (Tocqueville, 1945:271). The central government frequently has no control over these bodies, and consequently, within such an arrangement the power that central government has over society is limited (Tocqueville, 1945:271).

Tocqueville’s writing provides a useful analytical framework for explaining differences in the way needle exchange policy has developed and expanded in Canada and the UK. It appears that the ability of the central government to shape harm reduction policy and practice in a society is relatively more limited when power over the administration of health care is decentralised and subject to political checks and balances.
DATA AND METHODS

This article is based on a content analysis (1985-2015) of 120 federal, provincial, and municipal government records and policy documents (Canada and the UK), 1,075 news reports retrieved through the Factiva search engine, and secondary published research. It is part of a larger project involving the analysis of Canadian and British archived documents published between 1985 and 2015 in order to compare and contrast harm reduction policy developments in both countries.

I compare harm reduction drug policy in Canada and the UK using a *most similar system design* approach. According to political scientists such as Landman (2008) and Lim (2006), the most similar system design strategy involves “…matching up and then comparing two or more systems that share a whole range of similarities (political, social, demographic, economic, cultural, and so on) but also differ in at least a couple of important respects” (Lim, 2006:34). Employing the most similar design system allows comparative scholars to control for social conditions that are the same across both countries, and subsequently to identify factors that are dissimilar across countries that may be causally related to the social phenomenon that interests them.

Canada and the U.K. share similar social configurations: for example, English is an official language in both countries; both countries are capitalist democracies that share similar common law system; and both countries have similar drug laws (i.e. the same substances are outlawed in both countries) and roughly similar penalties for breaking said laws. Rates of problem drug use in Canada and the U.K. are also similar (2.5-4.3/100,000 in Canada vs. 2.3-8.9/100,000 in the U.K.) (Health Canada, 2011). Rates of illicit drug use
among those 15 and older (15-59 in the U.K), across various substances, are similar in both Canada and the U.K: for cannabis use, 10.7 in Canada and 6.6 in the U.K.; for cocaine, 0.7 in Canada and 2.5 in the U.K.; for ecstasy, 0.7 in Canada and 1.6 in the U.K., for heroin, lifetime drug use prevalence is 0.7 in Canada and 0.9 in the U.K. (past year prevalence statistics available for Canada but not the U.K. so not comparable). (European Monitoring Centre for Drugs and Drug Addiction, 2010b, Health Canada, 2011).

Despite similarities in rates of drug use, as well as similarities in language (English), legal systems: including criminal law and criminal justice (common law), criminal laws, economic systems (capitalism), political systems (democratic) culture (many elements of culture shared due to the fact that Canada is a former colony of the UK), and the nature of illicit drug use and drug law enforcement, Canadian and British literature on drug policies suggest that the trajectories of harm reduction development in each country are very different. Content analysis of government documents and newspaper articles is suitable for analysing needle exchange policy and program development since it provides useful data pertaining to who is problematizing injection drug use, and how they are doing so (see also Hayle, 2015). Committee documents and newspaper articles provide quotations illustrating how injection drug use has been framed during DCR policy discussions. Hansard debates and council minutes include decision makers’ quotations that provide insight into what factors might have influenced their policy choices and how.

The year 1985 was chosen as the start date for this particular study’s analysis as it is as far back as discussion surrounding needle exchange programming can be traced in either country. Government documents were retrieved using government website search engines in order to capture the widest range of materials. They included national government debates,
national government policy papers, regional health board reports, and municipal
council meeting minutes. Newspapers were searched using Factiva. I collected and
analyzed all pertinent articles that were retrieved using these search terms, including
news stories, analysis pieces, editorials, and letters to the editors.

Recognising the potential for editorial bias in newspaper articles, I rely on press
coverage primarily for historical data on events and activities and quotations from public
statements if I was unable to find this data in government records and/or secondary
reports. Press coverage is not used for data on public opinion since the sample of articles
and newspapers/websites is non-representative. News data was drawn from national
sources: Globe and Mail (n=301); Toronto Star (n=160); London Times (n=334), UK
Guardian (n=147), UK Independent (n=133).

Although Franzosi (1987) argues that newspaper data about specific events is
reliable, it is generally acknowledged that newspaper evidence is a far less credible source
of qualitative empirical evidence compared to government documents or peer-reviewed
literature. However, much of the evidence presented in this paper is drawn from newspaper
articles because they deal with contemporary municipal events that have not yet been
analysed by scholars. Furthermore, city council minutes do not include verbatim transcripts
of meetings, and so we must turn to newspapers for public statements made by decision
makers. Wherever possible, however, claims are supported by multiple pieces of evidence,
which themselves are supported by multiple articles from multiple newspapers in order to
increase confidence in the validity and reliability of the data (Mariampolski and Hughes,
information corroborated in other articles from several different newspapers were weighted
heavier and given more serious consideration compared to articles with information that was not corroborated by other sources (Platt, 1981). Search terms included “heroin”, “AIDS”, “HIV”, and “needle exchange”. From each newspaper, I collected and analysed all pertinent articles that were retrieved using these search terms. These articles included news stories, analysis pieces, editorials, and letters to the editors.

The data was analysed in Microsoft word documents without the use of any electronic software. The first stage of my analysis involved a superficial examination (or “skimming”) of the documents in order to familiarise myself with the data as well as determine which articles were inappropriate or not pertinent to the research questions and thus worthy of being excluded from the analysis (Bowen, 2009:32). The second stage involved a more thorough analysis of the ‘content’ found in each document drawing on “thematic analytic methods” (Freday and Muir-Cochrane, 2006). Thematic analysis is a process in which “coding” and “category construction” are performed in order to uncover thematic patterns pertinent to the topic under study (Freday and Muir-Cochrane, 2006). Consistent with Bowen’s (2009) recommendation to anchor one’s thematic analysis in grounded theory, I invoked open coding techniques, in which each line of content from documents was broken down into “discrete units” in order to facilitate interpretation (Strauss and Corbin, 1990). Discrete units were distinct thoughts, ideas, and/or statements that could be compared and contrasted with one another and then grouped together into larger categories to facilitate analysis (Rohleder and Lyons, 2014). This process was carried out without any predefined codes or categories in order to ensure that the central themes emerged directly from the data (Altheide, 1996). Although I reached a stage of data saturation with regards to testing the validity of the
themes that emerged from my data, nevertheless, as noted above, all documents collected were ultimately coded and analysed (O’Reilly and Parker, 2013) ¹.

Initially, over 50 codes were generated through line-by-line coding; however, this list was gradually reduced to ten codes through more focussed coding techniques which involved the thematic categorisation of paragraphs or even entire documents. These codes were then used to generate thematic categories pertinent to the analysis of needle exchange policymaking in Canada and the UK. Both latent (specific words and phrases composing content) and manifest content (meaning of content) was coded (Strauss and Corbin, 1990). Thematic codes relevant to this particular study that will be referenced include the following: 1) injection drug use as a public health problem; 2) the injection drug user as a conduit for an AIDS epidemic; and 3) needle exchange policy resistance.

FINDINGS

The United Kingdom

The evidence presented below will show that variations in the development of needle exchange policy in Canada and the UK can be explained, in part, by differences in the way power is distributed across political institutions in both Canada and the United Kingdom. One of the key themes that emerged from my data was the defining and framing of injection drug use as a public health problem and people who use drugs as those in need of health services. In the United Kingdom during the middle and latter part of the 1980s, injection drug use became socially constructed as a healthcare problem requiring an immediate and effective public health solution. This is explained by the onset of HIV/AIDS as a

¹“Theoretical saturation” occurs when enough qualitative data has been collected and analysed that the sampling of further data does not reveal any more information useful for addressing one’s research questions (O’Reilly and Parker, 2013; Seale, 1999).
communicable disease spreadable through the sharing of blood tinged syringes. Scientist Roy Robertson and colleagues (1986) tested blood samples of injection drug users taken during a hepatitis B outbreak several years earlier and found that roughly 50% of the sample tested seropositive for HIV - a rate considerably higher than that in the rest of the UK, Europe, and much of North America. Robertson convened a news conference in 1986 where he claimed that the sharing of contaminated needles among IDUs was one of the primary reasons for the rapid and wide spread of the disease, and along with members of the Greater Lothian Health Board, he called for a “less punitive approach towards drug control and greater availability of injecting equipment” (Berridge, 1996:93).

In response to Robertson et al.’s (1985) findings, a report was released by a government led research task force named the “Scottish Committee on HIV Infection”, in which the members proposed that the reason why rates of HIV prevalence were so high among IDUs in Edinburgh but not other parts of Scotland (such as Glasgow) was because police officers were actively confiscating clean syringes when they were found as well as discouraging pharmacists from selling them (McClelland Report, 1986:7). Robertson and colleagues (1985) similarly noted that the pharmaceutical association in Edinburgh was discouraging or preventing pharmacists from selling clean syringes in the city. The committee similarly recommended a “wider availability of sterile injecting equipment” be made “readily available” to IDUs (McClelland Report, 1986). Furthermore, in 1988 the Advisory Council on Drugs Misuse produced a report in which they boldly asserted that:

The report’s first conclusion is that HIV is a greater threat to public and individual health than drug misuse. The first goal of work with drug misusers must therefore be to prevent them from acquiring or transmitting the virus. In some cases this will be achieved through abstinence. In others, abstinence will not be achieved for the time being and efforts will have to focus on risk reduction. Abstinence remains the ultimate goal but efforts to bring it about
in individuals cases must not jeopardise any reduction in HIV risk behavior which has already been achieved [ACMD, 1988:1-2].

The report went on to assert that “The report considered the issues in some depth and concludes that a combination of syringe exchange schemes and over-the-counter sales from community pharmacies offers the best solution” (ACMD, 1988:2).

A second theme to emerge from my data was the notion that IDU served as a direct conduit through which AIDS could be spread from a small, drug using population to the much larger, more general, non-drug using, and heterosexual population. But this theme was far more prominent amongst British government documents and newspaper article compared to Canadian ones. Central government moved surprisingly quickly to approve, fund and establish pilot needle exchange programs across the country. They were heavily influenced by the scientists’ recommendations noted above, in addition to tabloid media claims that socially constructed AIDS as a heterosexual disease at risk of becoming a nation-wide pandemic (Berridge, 1996). Tabloid headlines such as “Have you got AIDS? Ten ways to find out”, “Needles of Fear”, and “Playtime AIDS Scare as Kids Find Needles” stoked concerns about heterosexual drug users (including inmates) acquiring the disease through sharing dirty needles, and then spreading the disease to the general population (non-drug using women and their unborn babies) via unprotected heterosexual intercourse (Anonymous, 1987:4; Anonymous, 1987:2a; Berridge, 1996). One article articulated the ease of spread with the following excerpt:

A British family out for a walk: father (39), mother (35), two teenage children and a baby. They look happy and heathy. But from what we now know about the way the AIDS epidemic is developing, all are potential victims. The father could be infected by a prostitute or by a homosexual relationship his wife through an affair with a casual stranger- or from her husband. And the boy and girl, if they have a drugs problem, could pick it up from an infected hypodermic needle. Even the baby could be infected, if either parent was a carrier.
Many like these may soon be under threat” [Wilsher and Hodgkinson, 1986 quoted in Berridge, 1996].

News articles published by Liverpool’s local newspaper *The Echo* routinely reported on cases of young toddlers picking up dirty needles at parks and/or accidentally pricking themselves or others and having to go through the “traumatic” ordeal of awaiting the results of an HIV test (Anonymous, 1987:2b; Burns, 1987:5; Turnbull, 1987:3). Other stories reported on streets and “car parks” where scores of used and blood tainted syringes were found on the ground, once again highlighting the risk they posed to unsuspecting pedestrians and in particular children. In one article entitled “Danger Point: AIDS madman on loose in city”, journalist Peter Sherlock (1987) reports that:

A MADMAN infected with AIDS may have launched an evil campaign to take as many people as possible with him, it is feared. Used needles have been found in parks throughout Liverpool jutting out from grass like deadly spears. The razor sharp needles have been deliberately placed to injure a child or someone walking, according to an angry union leader [p.8].

These stories were part of a larger context of reportage representing a general media panic regarding the AIDS virus. Stories regarding sales of breastmilk being halted, hotlines being jammed with callers inquiring whether they have symptoms of AIDS, companies selling AIDS safety and protection kits, and the proliferation of AIDS free dating communities, help to illustrate both the collective anxiety surrounding AIDS in England at the time, but furthermore the role of the tabloid media in articulating and communicating these anxieties and fears to the general public in the country (Anonymous, 1987:4; Anonymous, 1987:7; Gough, 1987:2 Holland, 1987:2).

Prime Minister Margaret Thatcher’s central government was heavily influenced by both scientists’ and the media’s representations of the relationship between IDU and the spread of AIDS to the heterosexual population, and they responded by very quickly devising policy to help prevent the spread of the disease. This policy included endorsing harm
reduction drug policy and supporting and financing needle exchange programming (Berridge, 1996). Following a heated debate in the House of Commons in December of 1986, in April 1987 the government approved the establishment and funding of twelve pilot needle exchange “schemes” at a cost of £250, 000 coming “directly” from the Department of Health and Social Security (Hughes, 1987; Rifkind, 1987; Newton, 1987). They were to be located in cities including Liverpool, Glasgow, and Edinburgh. In the 1992-1993 fiscal year, after several evaluations of the needle exchange pilots showed them to have been successful in largely averting an AIDS epidemic, the health department committed a further £1.4 million toward the establishment of needle exchange schemes across the entire country, and in the 1994-1995 fiscal year, between £25-238 million was budgeted by the health department for the further expansion of needle exchanges. By this time, it was reported that over 300 government supported needle exchanges were operating across the country (Major, 1993).

Despite the overwhelming government commitment there was considerable opposition to needle exchange programming from various subnational governments and politicians. A key theme that emerged from my data pertained to “resistance” of power over needle exchange policy. In both Canada and the UK, we see evidence of subnational governments attempting to “resist” policy change and developments with respect to needle exchange coming from the national government. However, my data suggests that in the UK, attempts by subnational governments to “resist” needle exchange program development were largely unsuccessful.

When central government initially announced the establishment of needle exchange trials in Glasgow and Edinburgh (as per the request of the Lothian and Greater Glasgow Health Authorities), the Scottish Office, and in particular its health ministry, very quickly
opposed the decision. The Scottish Office Health Minister John MacKay stated in an interview with the national newspaper the *Scotsman* that:

I am personally and, on principle, against it. It goes against my own view of these matters. I think that heroin addiction is wrong, that we ought not as a Government, as a country, be encouraging it, by giving people the means. I think from the police side it is going to be a very real problem, because certain doctors will be aiding and abetting people in what is a criminal activity [Smith and Wishart, 1986:3].

He, furthermore, explained that the Scottish Office did not believe that there was a “public demand for extra resources to ‘deal with an AIDS epidemic’” (Smith and Wishart, 1986:3). He told the newspaper that the rise of AIDS cases “…will just have to be treated as one of the problems of the health service” (Smith and Wishart, 1986:3). Within days of making this announcement, Scottish Secretary Malcolm Rifkin announced a major cabinet shuffle in the Scottish Office in which MacKay was moved out of the health portfolio and transferred into the leadership of the education ministry. MacKay’s interview with the *Scotsman* caused significant embarrassment for Thatcher’s administration, and that the cabinet reshuffle represented central government’s attempt to suppress opposition to the “battle against AIDS” and re-affirm their nation-wide commitment to tackling the virus (Berridge, 1996:96). Within months of the cabinet reshuffle, Scottish Home Office approved requests by central government to establish needle exchange trials in both Edinburgh and Glasgow.

We see here an example of power centralisation influencing the development of needle exchange policy. Structurally, the UK is a ‘unitary State’ in which the central government is supreme, and subnational governments are simply administrative units tasked with carrying out duties delegated by the national authority (Spicker, 2015). During the 1980s, Scotland was not yet a devolved parliament. While a political office responsible for the country existed (known as Scottish Office), it was merely a department under the control of central government headed up by the Secretary of State for Scotland, who was a member of the cabinet appointed by the prime minister (Torrance, 2006). Hence, the administration of Scotland was simply delegated from central government to Scottish Office, and the central
government had the ability to make changes to the portfolio if they were dissatisfied with how the Scottish portfolio was being managed. What happened in this case was that central government exercised its authority in order to ensure that the policy changes they wished to see implemented in Scotland were not thwarted.

Second, local residents and political authorities in Glasgow, Scotland opposed the operation of a needle exchange pilot program in the Ruchill neighbourhood. On the first day of operation of Glasgow’s needle exchange pilot program, protesters gathered around the facility, two of whom were carrying a large banner stating, “Needle Exchange-No Thanks” (Steele, 1987:2). Members of the Ruchill local community council, among dozens of other protesters, gathered to state their opposition to a fixed needle exchange being placed in their neighbourhood. Mrs. Georgina Sorbie, the chairperson of the community council, told the Scotsman that, “We are not trying to do down the unfortunate people who are involved in drugs, but this area, which is improving all the time, does not need a fixed place for addicts…it would be better if a mobile needle exchange scheme was available to tour areas where the addicts need it” (Steele, 1987:2). Here an attempt was made to socially construct IDU as a law and order or public safety problem threatening the Ruchill community if a needle exchange program were to be established there.

According to the 1987-1988 Greater Glasgow Health Board report, the protests at the needle exchange were initially effective in deterring drug users from coming to the facility (p.16). In response to the concerns expressed by Ruchill council representatives, a spokesperson for the health board told the Scotsman that:

We had expected that with the protest being staged there would be no response on this first day. We have considerable sympathy with the local people over their feelings about the centre but there are some misunderstandings…One of the main objectives of the centre is to counsel addicts and not to help them in any way with their habit [Steele, 1987:2].

In response to the suggestion of a mobile unit, the spokesperson noted that, “A mobile unit would not be successful as it would be difficult to let addicts know where the unit is going to
be at any given time” (Steele, 1987:2). The protests continued for a second day in which the facility was opened, however after this, reportage of the protests ended and so it is unclear exactly how long these protests continued and what form they took (Crame, 1987:2). Glasgow Health Board’s 1987-1988 report indicates, however, that the “…main obstacle to establishing new needle exchanges is opposition from local residents”, thus suggesting that local opposition continued for some point (1988:16). Despite this, the report indicates that the Board continued funding and operating the Ruchill service, and that by 1988 an average of 13 people were attending the clinic weekly (many coming from the Easterhouse neighbourhood), prompting the board to expand the service to a facility operated by the Easterhouse Committee on Drug Abuse (Glasgow Health Board Report, 1988:139).

Thus, it appears that, despite opposition from local residents and local city council members, health authorities moved forward with establishing and operating needle exchange programs and did not give any sense that they would reconsider these moves because of local resident and political opposition. Once again, these decisions can be explained in part by the centralisation of power over healthcare in Britain. In this case, it is important to note that, at the time, health authorities comprising the National Health Service of Scotland, including the Greater Glasgow Health Board, were under the ministerial oversight of the Scottish Office, which as noted above, was a cabinet portfolio within the Thatcher government’s ministry. As was indicated to the Scotsman by a spokesperson for the Greater Glasgow Health Board, as well as noted in national Hansard debates, the facility’s opening was at the desire of the Scottish Home and Health Department (Crame, 1987:2; Forsyth, 1988). It would be inaccurate to suggest that Thatcher’s central government simply imposed needle exchange on Glasgow. However, it is also clear that local political claims makers who expressed strong
vocal opposition to needle exchanges were unable to prevent them from coming to their communities. Admittedly, community councils are not official political bodies in the same sense that local and regional councils are in Scotland. However, they are recognised by the Scottish government as the “most local tier of statutory representation in Scotland” with the responsibility to “ascertain and express the views of the community to the local authority and other public bodies” (Scotland, 2015). They are also responsible for “promoting the wellbeing of their communities”. As such, local authorities (the Glasgow and Strathclyde regional and local councils) were undoubtedly aware of the concerns of the Ruchill community council and could have acted upon them themselves. However, Glasgow’s regional and local council minutes reveal that there were no discussions at either table regarding the needle exchange program. I argue that this is because the Greater Glasgow Health Board was under the direction of a ministry that reported directly to central government in London. Health board officials proceeded with the operation of needle exchanges against the opposition of the local community council by exercising central government’s political authority over healthcare across the nation (including Scotland).

Third, opposition toward needle exchange programming at the Merseyside clinic was expressed by Liverpool City Council members in the early 1990s, at the very time when central government was expanding its funding for needle exchange programming across the country. Since 1985, Liverpool’s council had pursued a policy supporting drug education programming in elementary and secondary schools. At a March 22, 1990 meeting of the city council, the Drugs Sub-Committee made the following pronouncement regarding the Merseyside Health Department’s needle exchange program and other harm reduction policies:
That the Sub-Committee: a) views with great concern the activities of Mersey Regional Health Authority in relation to services for drug misusers and believes the policies being pursued by the Health Authority will only serve to increase the misuse of drugs and promote the message that drug addiction should be accepted by society; b) believes that in pursuance of their ‘Safer Drug Use’ policy the Mersey Regional Health Authority is guilty of promoting an acceptance of drug misuse and spreading the message of ‘it is safe to use drugs’ across the city and country; c) condemns the remarks made by a representative of the Department of Health which exposes the fact that drug users in Liverpool and Merseyside are being used as ‘guinea pigs’ in a mass experiment in pursuance of a theory to control the misuse of drugs, a theory which is flawed and therefore the experiment is doomed to failure and will further exacerbate an already difficult situation; d) calls upon the Government [central government] and the Regional Health Authority to consult with representatives of the City Council as a matter of urgency on future services for drug misusers in the city; and e) urges the Government and all those concerned in drug issues to provide the necessary finance to support the City Council’s policy of prevention through education and act in a positive way to achieve ‘demand’ reduction and therefore get closer to a drug free society” [Liverpool, 1990a].

Here an attempt was made to socially reconstruct harm reduction and needle exchange as “unsafe” and dangerous as opposed to a public health policy intended to promote health and safety. Liverpool’s city council pleaded with the Merseyside health authority (and its central government masters) to sit down with them in order for them to make their opposition to needle exchange known. However, council documents do not record a meeting ever taking place, and the needle exchange along with other harm reduction programs forged ahead despite the opposition from the city. The city council responded to the continuation of the abovementioned programming by introducing a resolution (moved by the council chair) that:

a) This Sub-Committee supports in principle the submission from Vision crest ltd. To hold dry and alcohol free parties and requests the city Building surveyor, the City Estates Surveyor, and the City Planning Officer to hold discussions with organisers and the Police and Fire Authority to find a suitable venue for the event and to ensure that all necessary safety precautions are taken…c) this Sub-Committee wishes to reiterate its commitment to providing alternate activities which will help dissuade young people from getting involved in the misuse of drugs (Liverpool, 1990b).

Liverpool’s city council lacked structural resources to exercise authority over regional drug policy since healthcare programming and policy was under the purview of the Mersey
regional health authority, which reported directly to central government in London. Under British law at the time, health care fell completely under the jurisdiction of the unelected health authorities which answered to central government and not local governments (Local Government Act, 1972; National Health Service Reorganisation Act, 1973). As we turn our attention to Canada, we will see that needle exchange policies and practices unfolded rather differently there due to differences in the way power is distributed over healthcare across political institutions.

**Canada**

Similar to the UK, criminal law is governed nationally in Canada. For this reason, the Canadian federal government was in a legal position to *fully* support and finance needle exchange programs across the country in the same way that central government did in Britain. However, this did not occur. Instead, needle exchange remained largely the financial responsibility of the provinces, and in some cases, municipalities. I argue that this happened, ironically, for the very same sociological reasons that central government fully supported and financed needle exchange in the UK.

Revisiting an earlier theme, we see that, similar to in the UK, injection drug use was linked with AIDS and therefore socially constructed as a public health problem. Consistent with Britain, needle exchange programming was framed as a healthcare solution. Prime Minister Brian Mulroney’s Progressive Conservative government reacted similarly to Thatcher’s government and initially supported needle exchange. In 1987, amidst growing concerns over the spread of AIDS through needle sharing, the federal Health Minister Perrin Beatty called on provincial governments to support and establish needle exchange programs in order to help prevent the spread of the disease. Minister Beattie was quoted by the
Vancouver Sun stating, “It’s a program that’s proven highly effective in some jurisdictions in other parts of the world” and “If we move quickly now we can help to head off that second round of AIDS coming through drug users” (Anonymous, 1989:A1). Minister Beattie announced that he was committed to providing $100,000 to each province that agreed to match equal funding for such program trials. Similar to the UK, Minister Beattie did not in any way direct provinces to establish needle exchange. However, policies diverged significantly in the early 1990s when the British government invested millions of pounds into needle exchange programming, whereas Mulroney’s federal government funding of needle exchange ceased after only two years. Furthermore, no successive federal governments moved to fund needle exchange across Canada in the same way that subsequent British governments did and continue to do today. Instead needle exchange programs have been funded almost entirely by provinces and municipalities.

I argue that the Canadian government’s unwillingness to provide further funding of needle exchange programming is related to the distribution of power over healthcare. Federal authorities were likely hesitant to fund needle exchanges across the country because of the federalist structure of healthcare governance in Canada. To begin, unlike in the UK where the national health services of England, Scotland, Wales and Ireland were all administered and governed by central government in the late 1980s, in Canada healthcare has and still is assumed to fall under the jurisdiction of subnational provincial governments. This is despite the fact that the country’s original Constitution Act of 1867 did not explicitly define which level of government should have control over healthcare (BNA Act, 1867). In the late 19th and early 20th century the federal government and provinces struggled for control over healthcare. The provinces argued that healthcare fell under their jurisdiction since Section 92
of the British North America Act granted them power over hospitals and asylums. The federal government perceived population health to be part of the “peace, order, and good government”, which according to Section 91 of the Act fell under their jurisdiction.

Being a British dominion at the time, politicians deferred the healthcare question to the Judicial Committee of the Privy Council (one of the highest courts in the UK) which ruled that the provinces had control over the “administration” and “delivery” of healthcare whereas the federal government had the responsibility of protecting the health and well-being of the Canadian population. Consequently, provincial governments assumed responsibility for funding and administering healthcare in their jurisdictions. This became problematic as fiscal resources and fiscal capacity varied widely from province to province. The federal government attempted to implement programs to equalise healthcare funding across the country, but then faced legal battles initiated by the provinces. To prevent subsequent legal action, the federal government adopted a healthcare policy of “fiscal federalism”. The federal government would assist the provinces in funding healthcare, but they would impose very few conditions to the funding in order to avoid antagonising the provinces. As a case in point, Medicare, which is Canada’s equivalent to the UK’s NHS, is governed under Canadian federal law (the 1984 Canada Health Act). However, the Act mandates that public health is administrated through independent provincial insurance programs that are funded through “transfer payments” from the federal government. While the Act establishes criteria that must be followed in order for provinces to receive funding, these provisions do not dictate what types of programs can and cannot be funded through the health transfer (Canada Health Act, 1984).
When we consider the actions of Brian Mulroney’s federal government in light of the history of healthcare governance in Canada, then we can understand Health Minister Perrin Beatty’s needle exchange policy as a reflection of the federal governments’ policy of fiscal federalism. While they offered incentives to encourage provinces to establish needle exchanges, they also respected provincial government’s jurisdiction over healthcare and did not attempt to force any of them to initiate programs.

Consequently, while some provinces embraced needle exchange and supported it, others succeeded in opposing needle exchange and preventing such facilities from being established within their jurisdictions, which relates back to the theme of policy “resistance”. The Ontario provincial government supported and financed needle exchange, leading to the first facility in Canada opening in Toronto in 1989. After months of calls for needle exchanges from opposition Members of Provincial Parliament (MPPs) including Progressive Conservative Perry Sound MPP (and former Premier), Ernie Eves, Liberal Health Minister Elenor Caplan pledged that, if Toronto’s city council and board of health approved the establishment of a needle exchange, that they would provide financial support (Anonymous, 1988:A14). With the Quebec provincial government pledging to provide $150,000 to support the initiatives, Montreal became the second city to open a municipal needle exchange program, which operated through CACTUS Montreal, an organisation dedicated to reducing the spread of blood borne diseases like HIV and Hepatitis C (Kumar, 1989:A7).

In contrast, the Manitoba government asserted its independence from Health Minister Perrin Beatty and did not support and/or finance a needle exchange program. This prompted a then city councillor Glenn Murray to warn publicly in the press that AIDS would spread rapidly if the province did not finance a program (Anonymous, 1990:A12 – Canadian Press).
But the Winnipeg City Council did not have the political power to resist the opposition of the Manitoba government, since public health fell under the jurisdiction of the provincial government and not the municipal government (Public Health Act, 1987).

Similarly, BC’s ultra conservative Social Credit government chose not to support or fund such facilities despite Health Minister Perrin Beatty cost sharing program. Health Minister Dueck publicly explained that both himself and BC Premier Bill Vander Zalm questioned the use of needle exchanges and thus refused to fund any programs. Dueck was quoted by the *Sun* stating; “What are we trying to achieve?...It's explained by some people as the number of needles you can get handed in, but that's not success to me…It's somewhat of a copout. Are we really addressing the root problem?” (Kavanagh, 1989:B1). He also told the paper in the same interview that, “Free heroin in England was treated as the panacea and it was a dismal failure. So let's not get on the bandwagon…The answer is not a supply of free needles, it's to turn these kids around”. When pressed on his government’s decision to not fund needle exchange programs in BC on a CBC nationally broadcasted radio Program entitled *As it Happens*, he stated, “There are many cases where perhaps it is a self-inflicted wound, if you want to call it that…Some people in fact by their lifestyle have invited that disease…because it is not a very easy disease to get - you practically have to go out and be very, very careless to contract that particular virus” (Hunter, 1989:A1). In a later interview with the *Sun*, Dueck once again defended his government’s stance, stating;

“I know there are people who have AIDS who are innocent, they did not go out and willfully or very carelessly through their lifestyle contract that disease…It goes on and on and governments cannot be in every place at all times protecting society. We must teach people they also have responsibility” [Hunter, 1989:A1].

When asked if his government’s position was based on a moral stance, he acknowledged that
they were treating AIDS as a medical issue, but also added; “We all have our biases, we all have our moralities and what's wrong with morality?” (Hunter, 1989:A1). Taking collectively, these statements were attempts to socially reconstruct IDU as not a public health problem but rather a moral problem, and needle exchange as an immoral and unethical policy solution.

Despite the fact that Health Minister Dueck was forced to resign less than a week later due to negative reactions to his comments, Vancouver’s needle exchange was unable to take advantage of federal government cost-sharing funding since the BC government refused to submit an application. However, as will be seen below, the provincial government’s attempts to keep needle exchange out of BC were ultimately unsuccessful because Vancouver had the political power to resist the dominance of provincial government action with respect to healthcare.

Section 92(8) of Canada’s Constitution Act declares that municipal institutions shall fall under the jurisdiction of the provinces, and therefore each province has its own municipal act (Canada Act, 1982). In contrast to the UK, in Canada, the responsibility over public health is “shared” between federal, provincial, and municipal governments, with “delivery” of health care being largely under the purview of both provincial and municipal governments (Canada Act, 1982; Health Canada, 2011). For example, the BC Government’s *Vancouver Charter* (1953) allows for Vancouver’s City Council to establish a “health department” and appoint a Medical Health Officer. The Charter further permits the city council to pass “health by-laws”:

for providing for the care, promotion, and protection of the health of the inhabitants of the city and for preventing the spread of contagious, infectious, or other disease, and, for that purpose, for regulating, controlling, and restricting persons and their activities [Section 330.a of the Vancouver Charter, 1953].
Therefore, under BC law, Vancouver’s council was structurally able to commit funding and resources to needle exchange programming without fear of opposition and intervention by the provincial health minister. Ultimately, Vancouver had to independently finance their needle exchange program until Mike Harcourt’s New Democratic Party (NDP) was elected provincially in BC and subsequently took over funding of needle exchanges across the province (Vancouver, 1998). Conversely, a similar bylaw did not exist under Manitoban legislation, which explains why Winnipeg city authorities lacked the power to attempt a similar policy move.

The enormous disparity in needle exchange policymaking across the country in more current times can also be explained by provincial drug policy and Canada’s federalist structure. In 2009, the province of Saskatchewan’s government revealed in their Speech to the Throne that they intended to cap the number of syringes being distributed by needle exchange programs, claiming that:

Ultimately, this program cannot be allowed to function as a source of unlimited free needles…We will cap the number of needles given out at any one time, thus creating more frequent contact with health professionals, which in turn means more frequent opportunity for intervention and treatment. Our goal should not simply be safer drug use. Our goals should be to reduce drug use, to break the deadly cycle of addiction and to better ensure the safety of all” (Saskatchewan, 2009).

In the province of Newfoundland and Labrador, the provincial government did not provide financial support for needle exchanges until 2005, when it provided the AIDS Committee of Newfoundland and Labrador with $50,000 to establish a needle exchange facility entitled the “Safe Works Access Program” (Ottenheimer, 2005). The province of Prince Edward Island’s Department of Health did not begin needle exchange programming until April of 2009 (Currie, 2009). Meanwhile, in contrast, hundreds of government funded needle exchanges have been operating in provinces like Ontario and Quebec (Canadian HIV/AIDS Legal
Network, 2007). While it might be argued that the disparity is a reflection of variation in the population sizes of various provinces, this answer does not account for why Alberta, the fourth largest province with a population of 4.146 million, only has four needle exchange programs (Statistics Canada, 2016).

The checkerboard pattern of needle provisioning described above stands in stark contrast to the UK where, in all parts of the country, hundreds of needle exchanges have been in operation since the late 1980s and early 1990s. In Canada, despite strong federal government support for needle exchange, provincial governments were able to draw on their power over how to administer healthcare to exercise autonomy over harm reduction policy within their boundaries. While Ontario and Quebec used this power to welcome needle exchange as early as the 1980s, Newfoundland and Labrador and Prince Edward Island drew on this power to delay the arrival of needle exchanges until the first decade of the twenty first century. BC drew on this power to prevent needle exchange from being established in BC. However, Vancouver in turn drew on their own political power over healthcare with respect to infectious diseases to establish a needle exchange despite provincial opposition.

DISCUSSION AND CONCLUSION

This analysis has shown that national variation in the distribution of political power plays an important role in helping explain the differences seen in needle exchange policy in Canada and the UK. In both countries, needle exchange facilities were established in response to high rates of AIDS spread and the social construction of IDU as a public health problem. However, whereas in Canada only roughly two hundred needle exchanges have been opened (with some areas of the country with significantly less coverage than others), in the UK, there are over one thousand facilities in operation.
I argue that the differences sketched above can be partly explained by unique social structural factors found in both countries. Canada’s federalist structure and the federal government’s policy of fiscal federalism helps explain why needle exchange programs only opened in certain provinces (such as Ontario and Quebec) but not others (like Manitoba). In order to avoid being seen as interfering with the province’s jurisdiction over healthcare, the federal government followed legal precedents set by previous court cases and allowed provincial governments to decide whether or not they wanted to approve and fund needle exchange programs. This is despite the fact that the federal government was strongly supportive of needle exchange and offered financial incentives for every province to participate in the establishment of such facilities.

Conversely, Britain’s unitary structure helps explain the relative rapidity in the growth and establishment of needle exchanges across the entire country. In Britain, municipal and regional health authorities took the lead in establishing trials for needle exchange programs. But because authorities were agencies working on behalf of the central governments’ health ministry, they were able to receive approval for these facilities from London relatively easily. Thus, variation in the distribution of power across political institutions appears to play an important role in explaining cross-national differences in the establishment and administration of drug policy.

To my knowledge, this analysis represents the first cross-national comparative study to explore the relationship between the distribution of power and needle exchange policy. It is also one of the first studies to comparatively explore differences in harm reduction policy, with a focus centred on power and political institutions. Furthermore, while there are a handful of studies which examine drug policy (and more rarely harm reduction policy)
comparatively, this paper makes a significant contribution by carrying out one of the first cross-national comparative analyses of needle exchange policy.

The findings from this study have important implications for our understanding of the “levers of harm reduction” and how such policies develop and change. Our findings suggest that future research might profit from a cross-national exploration of how cross-national differences in how power is distributed across political institutions relates to international variations in drug consumption room, heroin therapy clinic, pill testing, and naloxone policies. Future research such as this will allow us to move closer to deriving generalised theoretical explanations for harm reduction policy development. We can generate more concrete understandings for why harm reduction programs succeed and fail in becoming established. This research can be particularly useful to practitioners and policymakers wishing to establish needle exchange programs and other forms of harm reduction programming in countries where significant barriers to such drug policy exists.

One key limitation of this study is that it relies exclusively on documents such as newspaper articles and council minutes, as opposed to interviews with actual policymakers. As a result we cannot know with absolute certainty whether what is recorded in the official records actually represents actual opinions and beliefs. Furthermore, while we have attempted to canvass needle exchange policy in multiple cities and regions across each country, more can be learned from more in depth analyses in specific places such as Toronto, Quebec, and Glasgow. Lastly, the focus of this paper is primarily on political institutional structures. It is hoped that future research will explore the role of other non-political social structures including religion, cultural values, and geography.
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CHAPTER THREE- COMPARING DRUG POLICY WINDOWS INTERNATIONALLY: DRUG CONSUMPTION ROOM POLICY MAKING IN CANADA AND ENGLAND AND WALES

Drug consumption rooms; safe injection sites; harm reduction; heroin use, policy windows; comparative/historical analysis.

ABSTRACT

In this article, I compare and contrast policymaking processes in Canada and England and Wales between 1997 and the present day to provide insight into why the Canadian government approved the opening of a downtown Vancouver drug consumption room (InSite) in 2003, and why the British government has not yet done so. I also shed new light on why, since 2003, subsequent drug consumption rooms have not been opened in either Canada or England and Wales. I briefly consider future prospects for drug consumption rooms in both places. To accomplish this, I draw on Kingdon’s (1984) “Multiple Streams Theory”, which suggests that national government decision makers such as politicians are most likely to enact policy changes when there is an alignment of problems, policy options, and political circumstances. I argue that such conditions existed in Canada but not England and Wales, which helps explain why the Canadian government approved the opening of a drug consumption room but the British government did not. I draw on primary data from national, provincial, and municipal government documents and national and local newspaper articles in both jurisdictions to make my argument, along with secondary data from published literature. In the process I highlight the strengths and weaknesses of Kingdon’s work for understanding policy development in the highly controversial area of illicit drug use.

POLITICAL TIMELINE

The United Kingdom

1990-1997 Majority Conservative National Government; Prime Minister John Major

1997-2010 Majority New Labour National Government; Prime Minister Tony Blair; Prime Minister Gordon Brown (2007-2010)

2010-2015 Conservative-Liberal Coalition National Government; Prime Minister David Cameron

2015-2017 Majority Conservative National Government; Prime Minister David Cameron; Prime Minister Teresa May (2016-2017)
Canada


2004-2006 Minority Liberal National Government- Prime Minister Paul Martin

2006-2011 Minority Conservative National Government- Prime Minister Stephen Harper

2011-2015 Majority Conservative National Government- Prime Minister Stephen Harper

2015-2017 Majority Liberal National Government- Prime Minister Justin Trudeau

Vancouver

1993-2002 Mayor of Vancouver- Phillip Owen; Governing Party: Non-Partisan Association

2002-2006 Mayor of Vancouver- Larry Campbell; Governing Party: Committee of Progressive Electors (COPE)
INTRODUCTION

In 2003, the Canadian government granted Vancouver, British Columbia’s health authority an exemption from the Controlled Drugs and Substances Act (Canada’s drug legislation) to open a legal drug consumption room, (InSite), for a three year scientific trial (Small et al., 2006). Drug consumption rooms (DCRs) are facilities where individuals lawfully inject illegally purchased illicit substances under medical supervision with clean syringes in order to prevent overdose death and the transmission of HIV and HCV (Hepatitis-C) (Hunt, 2006). Globally, DCRs have either been: established as public health services (often beginning as scientific trials like those in Canada and Australia); incorporated into existing social services catering to clients like homeless people and those who use drugs; or opened as non-professional centres by current or former drug users (Hunt, 2006:2). In 2002, the British Parliament’s Home Affairs Committee recommended to British Home Secretary David Blunkett that DCRs be legally sanctioned in England and Wales, however he rejected the recommendation. As of November 2014, a DCR has not opened in England and Wales.

Scholars have explored socio-political factors that explain the establishment of lawful DCRs in countries such as Switzerland (Schultz, 1989), the Netherlands (Wolf et al., 2003), Australia (Kimber et al., 2003), Norway (Skretting, 2006), Canada (Small et al., 2006; Hathaway and Tousaw, 2008; Kerr et al., 2008; Watson et al., 2012; Hyshka et al., 2013), and Denmark (Hobourg and Frank, 2014). Factors identified include: concern for drug users’ dignity; social movement activity; the election of pro-harm reduction politicians; and the publicised attitudes of religious leaders (Beletsky et al., 2008; Philbin et al., 2008; Wenger et al., 2011).

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2 The Home Affairs Committee is responsible for examining the administration of Home Office. Home Office, which is led by the Home Secretary, is the government Ministry responsible for drug and crime policy (UK Parliament, 2013).
DCR policy scholarship in Canada has focused on socio-political factors leading to the establishment of InSite. Small and colleagues (2006) discuss several “forces” and events which contributed to attitudinal changes toward addiction in Vancouver that were necessary for the establishment of InSite. These included police support, international conferences, public demonstrations, and the 2002 civic election. The focus of this research, however, has been on the impact of local and provincial activists and politicians, and not the role of the national government. Research on barriers to the establishment of DCRs in England and Wales is limited to a brief discussion in the Joseph Rowntree Foundation’s 2006 DCR feasibility study. This report suggests that UN Drug Conventions and UK narcotics legislation pose potential, but not insurmountable hurdles to opening a DCR in Britain (Joseph Rowntree Foundation, 2006; Lloyd and Hunt, 2007).

Little attention has been paid to what policymaking processes explain why DCRs are legally sanctioned by some national governments but not others. This represents a gap in our understanding of the politics of harm reduction policymaking that must be addressed. In particular, there has been no analysis of the role national governments play in DCR policymaking in Canada. Consequently, we lack a complete understanding of why InSite opened, and why it is currently the only lawful DCR in Canada. Likewise, knowledge about the politics of DCRs in England and Wales is limited; however, Zampini’s (2014) recently published study suggests that electoral considerations influenced the British government’s decision to reject DCRs in England.

The primary goal of this article is to compare and contrast policymaking processes in Canada and England and Wales between 1997 and today to provide insights into why Canada approved the opening of a lawful DCR in 2003, and why Britain has not done so. I accomplish this using John Kingdon’s Multiple Streams Theory (MST) of policymaking, and
data from government documents, newspaper articles, and published literature. A secondary
goal of this study is to evaluate whether MST is a viable model for explaining cross-national
differences in DCR policy. The evidence in this paper will be used to illustrate the strengths
and shortcomings of MST in drug policy analysis. I chose 1997 for the start date of my
analysis because, although records of political and media discussions of DCRs did not
surface in England and Wales until 2001, they are traceable to 1997 in Canada. Although
this study focuses on the period between 1997 and 2003, it also sheds light on why
subsequent legal DCRs have not been opened in Canada or England and Wales since 2003,
and it considers future prospects for legal DCRs in both places.

Canada and England and Wales are suitable for comparison because they share
similar social configurations (language, economic system, and political institutions), drug
laws, and drug use rates (EMCDDA, 2010a; 2010b, Health Canada, 2011). In both locations
drugs legislation falls under national government jurisdiction. In order to open a legal DCR,
national governments in both places must adopt a policy or alter existing policy so that it
allows for the legal sanctioning of drug taking at these specific facilities. In the first section
of this article, I will briefly overview MST and then discuss the data and methods I employ.

APPROACH: MULTIPLE STREAMS THEORY

In 1984 Kingdon published *Agendas, Alternatives, and Public Policies*. In this work he
proposed that national level policymaking involves the establishment of an agenda containing
problems needing to be addressed by the government (and policy options that could address
those problems), and the authoritative choice of one or more policy options from the
alternatives on the agenda (pp.2-3). He conceptualises problems, policies, and politics as
separate “streams” within the policymaking process that normally do not intersect
one another (Kingdon, 1984). On rare occasions, windows of opportunity open for policy change in one or more of the streams, typically the problem or politics streams. Decision makers are *most* likely to seize these opportunities when all three streams are aligned, and when policy windows are open in *both* the problem and politics streams. Policy entrepreneurs and decision makers must seize opportunities quickly before policy windows close since windows open infrequently and for short periods (Kingdon, 1984).

Kingdon (1984) suggests that, within the “problem stream”, a “systematic indicator” directs the attention of decision makers to an objective condition (p.90). Policy entrepreneurs and decision makers subjectively interpret these indicators in different ways, and it is through this constructionist process that statements and empirical data about “conditions” are made into “claims” about “problems” (Best, 2013:18; Kingdon, 1984). Policy entrepreneurs direct decision makers’ attention to problems by highlighting “focussing events”, which are unusually memorable or surprising incidents, crises, or disasters (Kingdon, 1984:94-100). When policy entrepreneurs alert decision makers’ attention to a “problem”, a policy window in the problem stream opens.

Within the policy stream, solutions are proposed, and those initiatives perceived to be most feasible become short listed on the national agenda. Certain proposals are taken more seriously than others because they are perceived to be more feasible, better aligned with policy makers’ values, and likely to overcome public and political opposition (Kingdon, 1984:138-145). A policy window for a proposal opens when it is short listed near the top of the agenda.
Within the political stream, circumstances and events set the stage for whether decision makers seize opportunities for policy change (Kingdon, 1984). These include electoral conditions such as who (or what administration) holds power, which party forms the government, and the ideological position of executives and parties. How the public feels about matters, which Kingdon calls “public mood”, affects how motivated decision makers are to implement a proposal. Decision makers consider how pleased their constituents might be if they made certain choices, and how such decisions would impact their future electoral success (Giffen et al., 1991; Kingdon, 1984; Lenton, 2004). If conditions are favourable to a policy change, then a policy window opens in the political stream.

Several drug policy scholars have adopted MST to explain why governments decriminalise cannabis possession (DiChiara and Galliher, 1994; Lenton, 2004; Hyshka, 2009). Hyshka (2009), for example, compares policy windows in Canada and West Australia to determine why, unlike in West Australia, the Canadian government did not decriminalise cannabis between the years 2001 and 2006. My project is the first to use MST to explore harm reduction initiatives, and in particular, DCR policymaking.

Before continuing, some initial comments must be made about the advantages and limitations of MST for explaining variation in DCR policy in Canada and England and Wales. Although MST is well-established and widely used in public policy research today, it is thirty years old, and more recent theories have been advanced since Kingdon’s (1984) work (Sabatier, 2007; Zahariadis, 2003). Several scholars criticise MST for inappropriately conceptualising problems and politics as being independent processes (Mucciaroni, 1992; Bendor et al., 2001; Sabatier, 2007). Sabatier (2007) argues that Kingdon’s (1984) conceptualisation of problems, policymaking, and politics as independent “streams” is
incorrect since research documents cases where policies are developed in the problems or politics streams instead of the policy stream (p5). Carol Bacchi (2009) proposes that problems are constructed in the politics stream through written policies that decision makers produce, instead of representing responses to problems. Policy statements and documents actually construct problems through the ways in which they represent the conditions they are designed to address. As I will show, evidence from this study supports these criticisms by illustrating how the three streams can at times be highly interrelated.

Despite the limitations noted above, MST stands out among more recent policy theories as a useful conceptual framework for understanding how and why decision makers’ choices are influenced by political conditions such as public mood and elections (Zahariadis, 2003). Bacchi’s (2009) model focusses primarily on how problems are constructed through discourse in policy documents. Although this framework opens doors for fruitful analyses, less attention is paid to the role of decision makers, and how their choices are influenced by political circumstances. Similarly, Complexity Theory argues that policy outcomes are influenced by a complex and ever-changing policymaking environment. Since this environment is constantly in flux, it is difficult to predict whether policies will be successful (Cairney, 2012). Teisman and Klijn (2008) suggest that, although policymakers can improve the effectiveness of their policies by better understanding the policymaking environments within which they operate, they generally do not do so. Again, however, Complexity Theory focusses more on the consequences of policy change and less on the political circumstances that influence policy choices that decision makers make.

Lastly, MST is suitable for this study because it accounts for policymaking by national-level decision makers, which is the focus of this paper. Zahariadis (2003) argues that this framework is ideal for cross-national comparisons of policymaking. MST can help
examine how policy actors, contextual factors, and political circumstances unique to each country help explain cross-national variation in policymaking. In the next section I review the data and methods used for this study.

METHODS

To accomplish the goals set out in this paper, I analyse content drawn from 30 federal Hansard documents, 2 municipal council documents (Vancouver City Council minutes), 16 committee reports and 1,009 newspaper and online news articles from Canada (N=866) and England and Wales (N=143) that were published between 1997 and 2014. I also draw on secondary data from published literature (including scientific and statistical reports).

Content analysis of government documents and newspaper articles is suitable for analysing drug policy change using MST since it provides useful data pertaining to who is problematizing injection drug use, and how they are doing so. Committee documents and newspaper articles provide quotations illustrating how injection drug use has been framed during DCR policy discussions. Hansard debates and council minutes include decision makers’ quotations that provide insight into what factors influenced their policy choices. Recognising the potential for editorial bias in newspaper articles, I only turn to press coverage for historical data on events and activities and quotations from public statements when I was unable to find this in government records and/or secondary reports.

The government documents chosen for analysis include the following: 1) federal/national and provincial legislative debates (sixteen from the Canadian House and seven from the Canadian Senate; seven from the UK House); 2) federal/national and provincial committee proceedings and reports (in Canada twelve reports are from the Special Committee for the Non-Medical Use of Drugs; one is from the Standing Sub Committee on Social Affairs, Science and Technology; one is from the Sub Committee on Population
Health; one is from the Standing Committee of Health; and in the UK one is from the final report of the Home Affairs Select Committee); 3) one Supreme Court ruling; and 4) municipal council meeting minutes.

Data were drawn from the following news sources: The Globe and Mail (n=178); The National Post (n=79); The Toronto Star (n=50); The Vancouver Sun (n=471); The Ottawa Citizen (n=86); The Times (London) (including the Sunday Times) (n=47); The Independent (London) (n=58); The Observer (London) (n=6); The Guardian (UK) (n=22); The Brighton Argus (n=10); CBC News (Online) (n=2) and CTV News (Online). Since my focus is on national-level policymaking, I chose national newspapers that covered injection drug use across the country, and paid attention to the activities of national politicians and national government committees. I also included the local newspapers for cities featured in drug policy debates as potential locations for DCRs (i.e. Brighton). Search terms comprised “heroin”, “HIV/AIDS”, “hepatitis C”, “overdose death”, “harm/risk reduction/minimisation”, “drug consumption/rooms”, “safe/clean injection/injecting sites/rooms/houses/facilities”, “supervised consumption sites/facilities/rooms/houses”, and “shooting gallery(ies)”. From each newspaper, I collected and analysed all pertinent articles retrieved using these search terms. These articles included news stories, analysis pieces, editorials, and letters to the editors. The following section is a presentation of the study’s main findings. DRUG CONSUMPTION ROOM POLICY MAKING

My data analysis indicated that within the policy stream, DCRs were proposed to address injection drug use problems in both Canada and England and Wales. As early as 2001 federal Health Minister Allan Rock gave serious consideration to DCRs (Canada. Parliament, 2001). In 2002, the British Home Affairs Committee recommended to the Home Office that “…an evaluated pilot programme of safe injecting houses for heroin users is established without
delay and that if...this is successful, the programme is extended across the country” (UK. Parliament, 2002). The Home Office provided a memorandum to the committee weighing arguments in favour of and against DCRs, illustrating that the government had given consideration to such facilities (UK. Parliament, 2002). The role of elected decision makers (who according to Kingdon operate in the politics stream) in crafting proposals in the policy stream illustrates the strong interrelatedness of streams which MST purports to be largely independent. This evidence suggests MST underemphasises the interrelatedness of the policy and politics streams under certain circumstances. We will encounter this issue again further into the analysis.

In both Canada and England and Wales the opening of Australia’s Medically Supervised Injection Clinic (MSIC) was used by decision makers to reinforce the importance of DCRs. When decision makers and policymakers in the UK recommended opening DCRs, they clarified that such facilities should be similar to Australia’s MSIC (Flynn, 2002; UK. Parliament, 2002). In Canada, decision makers such as Vancouver East Member of Parliament (MP) Libby Davies cited the opening of Australia’s MSIC as justification for why Canada should consider DCRs (Davies, 2001). However, differences in the way injection drug use was problematized in both places (problem stream), along with differences in political circumstances (political stream), help explain why the Canadian government approved the opening of a DCR whereas the British government did not.

Socially Constructing Injection Drug Use as a Problem

Injection drug use presented significant health risks to users in both Canada and England and Wales, and although in 2002 the prevalence of HIV and HCV among current IDUs was higher in Canada (HIV- 7.2%, HCV-55%) than in England and Wales (HIV- 1.5%; HCV-41%), the rate of HCV infection among IDUs in England and Wales was still high, and the difference in overdose death rates among IDUs in Canada (3.22/100,000) and England and
Wales (3.13/100,000) was small (Remis, 2002; Hope et al., 2005; Fischer et al., 2006; Sweeting et al., 2009; UK Statistics, 2013). These statistics suggest conditions were ripe in both places for injection drug use to be constructed as a healthcare emergency; however, this only happened in Canada. The Canadian government’s perception of injection drug use as an emergency was influenced by claims makers’ reporting on the rapidly deteriorating health conditions of those who injected drugs in the downtown eastside (DTES) neighbourhood of Vancouver, British Columbia.

During the 1990s, public health authorities in Vancouver were alerted to an epidemic of opiate overdose deaths, and sharp increases in HIV and HCV transmission from needle sharing (Small et al., 2006). Illicit drug deaths peaked at 201 in the year 1993 and ranged from between 116 to 160 per year between 1994 and 1998 (McClean, 2000). In 1997, 1/5 of IDUs in Vancouver reported a new HIV infection (VIDUS, 2000), and since 1994 roughly 70% of almost 2000 new cases of HCV infection have been attributed to injection drug use (McClean; 2000). In September 1997, the Vancouver Regional Health Board declared a healthcare “emergency” (Wood and Kerr, 2006). This served as a focussing event which attracted the attention of the Canadian government. The perceived severity of the problem was amplified in March 2000, when BC Centre for Excellence in HIV/AIDS director Dr. Michael O’Shaughnessy disclosed to the Globe and Mail that up to 90% of IDUs in Vancouver were infected with HCV, suggesting that it was the highest rate among IDUs in the “western world” (Mickleburgh, 2000:A9). In reporting this, the Globe helped construct injection drug use in the DTES as a “third world” type of problem, making a solution to the problem seem all the more urgent.
Between 1997 and 2003, Vancouver East Member of Parliament Libby Davies (NDP) repeatedly rose in the House to demand that the government address the healthcare crisis by approving the establishment of a DCR in the city. Statements made by cabinet ministers indicate not only that the government recognized that the conditions in the DTES were problematic, but also that the government was reconstructing the healthcare emergency of injection drug use from a unique Vancouver problem to a problem spanning the entire country. When Libby Davies rose in the House on May 3, 2002 to call on the government to establish a DCR in Vancouver, Human Resources Development Minister Jane Stewart (2002) replied; “Mr. Speaker, without question Health Canada recognizes that injection drug use is a serious health problem for Canadian cities (emphasis added)”. Furthermore, federal Health Minister Allan Rock promoted the notion that health problems associated with injection drug use were a Canada-wide problem by stating in public during a visit to Vancouver that; “We don't do enough as a country to deal with drug addiction as a harm-reduction issue…It was obvious to me [then] that this is not a law-enforcement issue. This is an issue of people who are ill” (Bula, 2001).

Statements such as these reconstructed the public health crisis in Vancouver into a pan-Canadian problem, and there is no evidence to suggest that any policy entrepreneurs or decision makers disputed this claim or believed that the problem was limited to the DTES. Rock’s statement also illustrates how the government constructed injection drug use as a health problem but not a crime problem. An exhaustive search of federal government documents with the search term “injection drug use” showed that injection drug use was always discussed in tandem with HIV/HCV transmission and accidental overdose death,
whereas I was unable to find any documents in which the law and order elements of injection drug use were stressed.

Injection drug use was problematized differently by the British government. Although national policymakers recognized the health risks facing IDUs in England and Wales, these concerns did not overshadow crime concerns like they did in Canada. Evidence shows the government was concerned about the health of drug users. In response to a report released by Home Office indicating that 99% of the country’s “drugs bill” was directed to “hardcore addicts”, Drugs Minister (responsible for drug policy) Bob Ainsworth informed the House that the government’s future drug policy would aim to reduce drug-related deaths by 20% and further support the universal provision of needle exchanges across the country to continue preventing the spread of HIV and HCV (UK. Parliament, 2002).

Compared to Canada, there is no documentary evidence to suggest the health conditions of IDUs were perceived as an emergency in England and Wales. Furthermore, crime issues related to injection drug use in England and Wales remained an overarching concern for the British government, receiving more attention than health concerns. Both the government’s 1998 and 2002 drug strategies gave roughly two to three times as much space and attention to crime issues compared to health concerns (HM Government, 1998 and 2002). In the 1998 strategy, two of the four aims (protecting communities and reducing the availability of drugs on the street) are related to crime whereas only one aim (treatment) is related to health. And the treatment aim is, in reality, a hybrid of treatment and crime, because the strategies it proposes focus on enabling current users to live both healthy and crime free lives (HM Government, 1998:4). In the 2002 strategy, two sections (24 pages) focus on crime issues (reducing supply and protecting communities) whereas only one
section (9 pages) focusses on health issues (treatment and harm minimisation) (HM Government, 2002:3). A review of drug policy debates shows that, in 2002, Home Secretary Blunkett took more time to discuss crime issues such as drug-related theft/violence and organized crime compared to health issues such as HIV/HCV transmission and overdose death (UK. Parliament, 2002). The Home Office was concerned that IDUs were engaging in high rates of theft and robbery in order to fund their addiction.

Why was the British government driven to frame injection drug use in England and Wales as a crime problem? I would argue it is due to widespread concern among politicians and senior police chiefs that British law enforcement did not have the resources to win the “War on Drugs” under its current drug strategy. Similarly high levels of concern surrounding the inability of Canada’s law enforcement to combat drugs could not be found in government documents or newspapers. Evidence of this concern in England and Wales can be traced back to as early as 1999 when Chief Constable Barry Shaw of the Cleveland Police Department (in Northeast England) published a report concluding that Britain was losing the “War on Drugs” (Dean, 2013). News articles claimed the report found that “serious” heroin users required £100 a day to support their habits and that as much as 70% of property crime in Cleveland was attributable to “drug addicts” stealing money to buy drugs (Akbar, 2001; Bright, 2001). Chief police officers interpreted the findings from the Cleveland report as indicative of law enforcement failure. In 2001 Sir David Phillips, President of the Association of Chief Police Officers (ACPO), told the Guardian that; “We are losing the war against organised crime. The courts are designed to deal with Miss Marple cases, not the kind of criminality we are currently facing” (Phillips quoted in Bright, 2001). Blunkett shared ACPO’s concern that Britain was losing the war on drugs, and in 2001 he requested
an “adult debate” on drugs and tasked the Home Affairs Committee with carrying out an investigation to determine whether Britain’s drug policy was working (UK. Parliament, 2002).

The analysis above highlights how policy choices are influenced by the way problems are constructed. This finding is consistent with MST, which connects the social construction of problems to policymaking. However, this analysis also points out limitations in MST as a model for explaining DCR policy change. It challenges an overly strict MST interpretation by highlighting the role that elected decision makers from the politics stream (Health Minister Rock, Home Secretary Blunkett), played in the problematization of injection drug use in the problem stream. Thus, it illustrates the strong interrelatedness of the problems and politics streams, whereas MST suggests that these streams are highly independent. The next section explores in depth the politics streams for DCR policymaking in Canada and England and Wales.

The Politics of Drug Consumption Rooms in Canada and England and Wales

This section focusses on the public mood surrounding DCRs in Canada and England and Wales, along with political/electoral circumstances in each jurisdiction.

Public Mood

The Canadian government had access to several sources of information which suggested that large numbers of Vancouverites favoured DCRs. In May 2001, Vancouver City Council voted unanimously to accept the Mayor’s Plan, which committed to the establishment of DCRs (MacPherson, 2001; Vancouver City Council, 2001b). Polls conducted in Vancouver in 2001 found that 71% of Vancouverites approved of DCRs (Kent, 2001). When town hall
meetings were held in Vancouver to solicit community feedback about the proposed Mayor’s Plan in 2000, the majority of attendees approved of DCRs (Vancouver. City Council, 2001a). This overwhelming support made it clear that if the government allowed a DCR to open in Vancouver, it would be well received by most citizens. Consequently, in November 2001, federal Health Minister Rock publicly announced in Vancouver that, “We will do everything we can to facilitate pilots in cities across the country if those cities decide this is part of the strategy that they want” (Bula, 2001).

One of the most important sources of information for the federal government was the results for the 2002 Vancouver election. After promising to open a DCR in Vancouver within thirty days of taking office (Small et al., 2006), Mayoral candidate Larry Campbell (former chief coroner) received twice as many votes as his opponent Jennifer Clarke, and his left-wing COPE (Coalition of Progressive Electors) party captured nine out of the eleven council seats (Vancouver. Data Catalogue, 2002). Unsurprisingly, in November of that year, federal Health Minister Anne McLellan announced that the government was finalising guidelines that would allow organisations to apply for approval to establish DCRs (McLellan, 2002). Hence, evidence suggests the government’s decision to approve a DCR in Vancouver was linked to indicators of public mood towards DCRs.

Conversely, there were no clear indications that public mood was favourable to DCRs in any part of England and Wales. Although the Home Affairs Committee received testimony from numerous people supporting DCRs (including Norfolk Chief Constable Andy Hayman, public health sociologist Gerry Stimson, and addiction professor John Strang), there were no data from polls, surveys, or town hall meetings indicating whether large numbers of people supported or opposed DCRs (UK. Parliament, 2002). Furthermore, unlike in Canada, no
mayors went on record supporting or opposing DCRs. The national government was limited to data from British Crime Surveys which indicated that, between 2000 and 2002, roughly 1/3 of citizens believed drug use and drug dealing were “major problems” (UK Statistics, 2011:95).

**Political and Electoral Circumstances**

Turning back to Canada, in the 2000 General Election, Prime Minister Jean Chretien and the federal Liberal Party were re-elected to a majority government, winning 57% of House seats (Dorman and Pammett, 2001). Another 17% of seats were secured by the left-wing Bloc Quebecois and New Democrat parties. The right-wing Progressive Conservative and Canadian Alliance parties occupied only 26% of the House seats after the election. Thus, the Liberals were in a position to implement more progressive drug policy without too much opposition in the House.

During the 1990s and early 2000s, Chretien’s Liberals dominated Canadian politics. The opposition Reform Party (renamed Canadian Alliance Party in 2000) was rarely able to win seats east of the western province of Manitoba (Dorman and Pammett, 2001). This was problematic for them considering the majority of seats were in Ontario and Quebec (central Canada). Since the Liberals were the only party with strong enough backing in both provinces at the turn of the millennium, they were the only party capable of forming Canada’s government (Dorman and Pammett, 2001). Under such circumstances, a policy change by the Liberals would have to be significantly upsetting to voters in order to bring the government down in an upcoming election.

During the 2000 election healthcare and social programming were the number one concerns of Canadian voters, whereas crime was not a significant issue (Dorman and
Pammett, 2001). It is no surprise then that at the turn of the millennium the Liberals were beginning to commit to more progressive drug policies. The government legalised medical access to cannabis on July 30, 2001, and on May 27, 2002 they introduced a bill to decriminalise possession for personal use of less than 15 grams of cannabis (Thaczuk, 2003; Health Canada, 2013). It is within this political context that a policy window opened for DCRs in the political stream. Critiques levelled in Commons debates or during campaigns were unlikely to upset significant numbers of Canadian voters (particularly those in Ontario and Quebec) who were concerned about healthcare and social programming, not crime.

The political climate was different in England and Wales in the early 2000s. Although New Labour commanded a majority in the House, the government believed that their success depended on their ability to be “tough on crime” (Downes and Morgan, 2006). Conservative governments dominated British politics throughout the 1980s and much of the 1990s, during which time they maintained strong “law and order” approaches to crime. The opposition Labour party remained critical of the Tory’s strict law and order stance, in particular opposing the increased police powers granted by the 1984 Police and Criminal Evidence Act (Downes and Morgan, 2006). However, the Conservatives remained popular by capitalising on public concern over rising crime rates and inner city riots.

After the 1992 election and the Conservative’s fourth electoral victory, Labour renamed itself the “New Labour Party” and rebranded itself as a tough law and order party (Downes and Morgan, 2006, p.205). During the 1997 election, New Labour leader Tony Blair criticised Prime Minister John Major’s Conservatives for providing insufficient resources to police at a time when crime was purportedly reaching “unprecedented” high rates (Downes and Morgan, 2006, p.205). Polls showed police effectiveness was a key issue
for voters during that election. New Labour promised to increase police numbers and convinced voters they could manage the law enforcement budget more effectively than the Tories (Downes and Morgan, 2006:291). New Labour was subsequently elected to a majority government with 63% of House of Commons seats (Morgan, 2001). In 1998, they enacted the Crime and Disorder Act and several other statutes which brought into force punitive measures against convicted offenders (Downes and Morgan, 2006). They were re-elected in 2001 with only two fewer House of Commons seats (Downes and Morgan, 2006). Police effectiveness was again a key issue for voters (Downes and Morgan, 2006).

Downes and Morgan (2006) suggest that all three political parties believed that New Labour’s victory could be partly attributed to its ability to convince voters it was tougher on crime and more fiscally responsible with the law enforcement budget than the Tories. This is evidenced by the fact that during the 2001 election, each party pledged to be the toughest on crime and the most committed to improving law enforcement. Each party attempted to outdo the other in the numbers of police officers they promised to hire (Downes and Morgan, 2006). Consequently, although New Labour had a majority government, they were limited in the types of proposals they could safely pursue. Zampini (2014) suggests that New Labour considered DCRs to be electorally “dangerous” and inconsistent with their “tough on crime” policy (p.982). Consistent with her observations, my findings indicate New Labour believed DCRs were dangerous to support because they could be construed by the media and others as being “drug dens” for selling heroin, which would go against the government’s commitment to being “tough on crime”. This is evidenced by a memorandum sent to the Home Affairs Committee by Drugs Minister Ainsworth which indicated the government’s concern that DCRs might be negatively construed by the media as crime facilitators (UK. Parliament, 2002). Such facilities might encourage theft and robbery since IDUs would still need a way
to fund their drug usage (UK. Parliament, 2002). As Home Secretary Blunkett explained in the House:

The Government are not convinced that shooting galleries, as they have been described, would be helpful at the moment. We want to build a consensus around the rapid development of heroin prescribing for the right patients. We want to do so in association with the country's medical services so that there is confidence in such prescribing. That confidence was undermined when the experiments that began in the early 1970s were misused, and drugs were sold on [Blunkett, 2002].

The “experiments” Blunkett referred to were several illegal, non-government sanctioned DCRs that operated in London during the late 1960s and early 1970s, but which were shut down, largely due to drugs being sold on site (Strang and Gossop, 2004).

In sum, the government believed their electoral victories hinged on a pledge to be “tough on crime”, and so approving the establishment of DCRs would be too politically risky. Consequently, a policy window did not open in the political stream for DCRs, and it remained shut throughout the rest of the government’s tenure. However, the same political conditions that kept a policy window shut for DCRs allowed a policy window to open for another harm reduction strategy, namely heroin prescription. The government was considering granting more heroin prescription licenses to physicians, as well as piloting heroin maintenance therapy programs (see Blunkett’s quotation above) (Blunkett, 2002). Expanding heroin prescription was politically advantageous because it provided the government with an opportunity to publicly commit to improving police efficiency while simultaneously appearing tough on crime and committed to the health of drug users. Existing literature shows governments of all political stripes often decriminalise minor cannabis possession out of a desire to free up police resources in order to better tackle drug traffickers (DiChiara and Galliher, 1994; Scheerer, 1978). These governments believed that under a decriminalisation regime, the time and resources spent policing minor cannabis possession
can instead be used to target higher level sellers and traffickers. Similarly, heroin prescription was seen as cost effective because it would free up police resources for officers to more effectively target higher level drug traffickers (UK. Parliament, 2002). According to ACPO, free heroin provision would enable officers to spend less time policing heroin possession since users would be receiving their drugs from doctors and, thus, have no reason to buy them illegally (UK. Parliament, 2002). By adopting this policy, the government would appear to be both tough on crime and fiscally responsible with scarce law enforcement resources. This was possible because the government could present itself as tough on property crime and organised crime, as well as economical in its decision to focus resources on serious drug crimes as opposed to more minor possession offenses.

The government (in particular Home Secretary Blunkett and Drugs Minister Ainsworth) also chose to frame heroin prescription as a crime fighting tool. It argued that such a policy would eliminate the need for users to commit theft in order to buy drugs because it would provide them with regular access to the drug (Blunkett, 2002. UK. Parliament, 2002). Similar to DCRs, heroin prescription clinics provide drug users with a safe place to inject heroin under medical supervision and with clean syringes. One crucial difference, however, is that they do not require users to bring their own illegally purchased heroin. Hence, within the political stream, a policy window opened for expanding heroin prescription, but not for piloting DCRs.

DISCUSSION AND CONCLUSION
My analysis suggests that in Canada, policy windows were open in all three streams. The Vancouver healthcare emergency (problem stream), DCR policy proposals (policy stream), public concern over the quality of Canadian healthcare (the political stream), and the
government’s stronghold on central Canadian voters (political stream) occurred simultaneously, meaning that the three streams aligned to make conditions favourable for the government to approve the establishment of InSite. In England and Wales, the three streams were not aligned, and although policy windows opened for DCRs in the problem and policy streams, a window was not open in the political stream. Political conditions were not ripe for DCRs since the government believed their future electoral success largely depended on appearing to voters as “tough on crime”. DCRs were perceived as inconsistent with the goal of being tough on crime since they condoned the use of illegally bought illicit drugs, and because they ran the risk of turning into havens for drug selling. The misalignment of the streams and the closed policy window in the political stream resulted in the government not seizing the opportunities to establish DCRs that were present.

Conversely, in England and Wales there was strong alignment among the streams for heroin prescription policy, as policy windows opened in both the problem and political streams. Expanding heroin prescription (policy stream) aligned with concerns over high rates of drug related theft, robbery, organised crime, and police inefficiency (problem stream) because people who use drugs would not have to commit theft, robbery, or buy heroin off the black market, thus freeing up police resources for targeting higher level traffickers. Lastly, heroin prescription aligned with the political stream because it could be framed as a “tough on crime” policy in order to satisfy the public and minimise criticism from opposition parties and even the media. As a result, the British government chose to say no to DCRs but yes to expanding heroin prescription. They approved a trial of three heroin prescription maintenance clinics (where free heroin is given to patients under close medical supervision) in London, Brighton, and Darlington between 2005 and 2007 (Groshkova et al., 2013).
Since the completion of the heroin prescription trials there has been little discussion or movement on the part of the British government toward establishing further maintenance facilities. The 2010 election of Prime Minister David Cameron’s Conservative-Liberal Democrat coalition closed the policy window for heroin prescription maintenance therapy in the political stream (Hough, 2013). Cameron currently leads a hung (or minority) Conservative government, and thus his party is on politically shaky ground and cannot risk progressing on previous New Labour policies (such as heroin prescription maintenance therapy) that might be unpopular with their more conservative supporters. Like heroin prescription, DCRs are also a risky political move for Cameron’s current hung government.

Turning to Canada, the election of current right-wing and anti-drugs Prime Minister Stephen Harper’s first minority Conservative government on January 23, 2006 effectively shut the policy window for DCRs in the political stream. The closing of the policy window can be explained by an ideological shift in the Canadian government’s position toward drug use. Harper has pledged to end Canada’s “drug habit” and “drug culture” which according to him have, since the 1960s, often “romanticized” drug use (National Anti-Drug Strategy, 2007). Harper publicly opposed harm reduction initiatives (including InSite), and after his election, he turned to the Royal Canadian Mounted Police for advice on whether the facility should remain open (Small, 2007). In 2006, federal Health Minister Tony Clement refused to consider further applications for DCRs until research on the effectiveness of such facilities was reviewed by the government (Hathaway and Tousaw, 2008).

On September 30, 2011, the Supreme Court of Canada ruled that closing InSite would be unconstitutional, hence preventing Harper from doing so legally (Canada vs. PHS Community Services Society, 2011). They also ruled that future proposed DCRs could not be
rejected if evidence shows that the proposed facilities will improve the health conditions of
its clients and not lead to rising crime rates. The ruling also strongly encouraged the
government to take into consideration the opinions of municipal governments, health
officials, police chiefs, and provincial health ministers when deciding whether or not to
approve DCRs. On October 16, 2013, federal Health Minister Rona Ambrose introduced Bill
C-2 which lays out requirements that must be met in order for an organisation to be granted
permission to establish a legal DCR (“Bill C-2”, 2013). Consistent with the supreme court
ruling guidelines, the bill requests organisations provide information about: the potential
impact DCRs will have on crime rates and public health in proposed locations; the feasibility
of DCRs; and whether or not and the local community, municipal government, provincial
health minister, and local police support the opening of DCRs. Although on October 26,
2013, MP Libby Davies introduced a motion that the House decline giving the bill second
reading, claiming that it goes against the Supreme Court’s ruling and sets up “unjustified”
hurdles for the creation of subsequent DCRs in Canada, the motion was defeated a month
later (Davies, 2013; Scheer, 2013). On May 27, 2014, the House voted to move Bill C-2
onto its second reading, and they referred the bill to the Standing Committee on Public
Safety and National Security (“Bill C-2”, 2014) for further review. There have been no new
developments since.

The requirements that have been set out in Bill C-2 share similarities with the
conditions necessary for a policy window to open. As with the problem stream, groups must
provide evidence that a health problem exists, and that a DCR could help alleviate the
problem (without raising crime). Akin to the policy stream, a group must show that a DCR
is a technically feasible option. Lastly, and perhaps most importantly, by requesting
information about the opinions of provincial health ministers, police chiefs, city councils and community groups, the government is asking applicants to provide information about the public mood and political conditions of the organisation’s city. If Bill C-2 passes into law, it has the potential to mitigate against the opening of DCRs in cities like Toronto and Ottawa where there is public opposition from police chiefs (Bill Blair in Toronto, and Charles Bordelau in Ottawa), and where the mayors (Jim Watson in Ottawa, Rob Ford in Toronto) have made their opposition known to the national press (Bayoumi and Strike, 2012; Watson, 2011).

In the unlikely event that Bill C-2 does not become law, DCRs are still unlikely to be established in Toronto or Montreal in the near future since a policy window is not open in the national politics stream. Kindgon’s (1984) model shows us that under current circumstances, and notwithstanding future turnover in key political personnel (such as Toronto and Ottawa’s mayors), the public mood and political conditions in these cities are preventing DCR policy windows from opening in the political stream, which partly explains why the government would likely reject any applications coming from such places. However, Toronto is seeing turnover in some key political posts, which may alter conditions in the national political stream. Rob Ford stepped down from the mayoral race on September 13, 2014, and on October 27, 2014, Ontario’s former Progressive Conservative Party leader John Tory was elected to the top civic post (Toronto City Clerk’s Office, 2014). Tory has not publicly commented on DCRs, and so it is unclear at this point how a change in mayoralty in the country’s largest city might impact the national politics stream. However, had circumstances been different and Ford had been re-elected, the scandal surrounding his own illicit drug use has likely damaged his credibility to the point that his opinions about DCRs
would not have carried the same weight they did before within the national politics stream (Canadian Press, 2013a). Lastly, the Toronto Police Services Board announced on July 30, 2014 that they will not be renewing Chief Bill Blair’s contract and that his term will end on July 25, 2015 (Toronto Police Services Board, 2014). If the Board chooses a successor who is more sympathetic to DCRs, this has the potential to alter the national politics stream making conditions more favourable to a DCR opening in Toronto.

On December 11, 2013, the Montreal Public Health Director Richard Masse announced to CBC News that the Health Department had plans to open three DCRs in existing city clinics, and one mobile DCR (Canadian Press, 2013b). According to CBC News, at present, the Montreal City Council supports the plan. If the health department is able to garner support from the provincial health ministry and the city’s police department, then they may meet the Supreme Court ruling’s requirements, along with the requirements set out in the “Respect for Communities Act” (assuming Bill C-2 is passed into law before Montreal’s application reaches Ottawa). Under such circumstances, it is possible that the government will choose to accept their application, making Montreal home to North America’s second legal DCR.

In the cases presented above, Kingdon’s (1984) model illustrates that the government’s decision would, again, be influenced by an alignment of open policy windows in the problems, policies, and political streams. In order to meet the requirements, the government would require evidence of a drug-related healthcare problem in Montreal (problem stream) and proof that one or more DCRs would be a feasible solution to the healthcare problem (policy stream). Although the governing federal Tories are ideologically opposed to DCRs, support from city council and the police chief would highlight to the government a public
mood and political climate favourable to DCRs in Montreal (political stream). The possible consequences of disregarding the Supreme Court ruling for ideological reasons (i.e. lawsuits) would quite likely outweigh the risk of upsetting anti-DCR conservative supporters and losing votes in the next election. The government could maintain their ideological opposition to DCRs but lament that they have no choice but to comply with the Supreme Court’s demands. Hence, alongside indicators showing that pro-DCR Liberal party leader Justin Trudeau is currently ahead in the polls leading up to the next federal election, the current events in Montreal suggest that an open policy window in the politics stream may be on the horizon.

Up until recently, British public health officials and Brighton’s MP Caroline Lucas had been discussing the possibility of opening a DCR. A policy window had opened within the problem stream, as drug use in Brighton had come to be perceived by locals as a serious, life threatening issue. This was largely because there had been 104 drug-related deaths in Brighton between 2009 and 2011, the highest rate in the UK for each of those years (James and Trace, 2013). Within the policy stream, DCRs were floated as a feasible solution because they would ensure someone would be supervising the user who could intervene in the event of an overdose. However, in May of 2014, the Independent Drugs Commission for Brighton and Hove released their final report recommending against the establishment of DCRs at the moment (James and Trace, 2014).

The findings from this study point to a number of weaknesses and strengths of MST. To begin, the specific mechanisms and processes described in Kingdon’s (1984) model often do not conform exactly to empirical reality. Although MST suggests that problems are constructed by policy entrepreneurs in the problem stream, in both Canada and England and
Wales we see evidence of injection drug use being socially constructed as a problem by
decision makers in the politics stream including MPs (Libby Davies, David Cameron), home
secretaries (David Blunkett) and health ministers (Allan Rock, Anne McClellan). Hence,
those responsible for deciding on whether or not DCRs should be approved or rejected also
had a hand in determining whether injection drug use should be framed as a healthcare or
criminal justice problem. Nevertheless, MST offers useful conceptual tools for
understanding how the combination of political circumstances and the way in which
problems are socially constructed can significantly influence decision makers’ policy
choices. It lends itself very nicely to cross-national comparative analysis because of its focus
on national policymaking. Problems, policy, and politics streams are understood to be unique
to each country, and therefore these streams are comparable. Hence, this paper demonstrates
that Kingdon’s (1984) model has much to offer policymaking research provided it is not
adhered to too rigidly. Analysts must be open to flexibility in the model, and understand that
it cannot serve as an exact blueprint of the policymaking process.

There are some limitations to the extent to which this paper has been able to explore DCR
policymaking processes in Canada and England and Wales. A complete and fully
comprehensive understanding of the three policy streams in Canada requires an in-depth,
intimate comprehension of political circumstances in Vancouver and other large cities such as
Toronto and Calgary, Alberta. However, this paper has limited its focus to national-level factors
in order to explore them in greater depth. Our understanding of the success of InSite in
Vancouver can be further enhanced by a better comprehension of why DCRs have failed to gain
popularity and support in other major Canadian cities, and future research will hopefully ponder
this question more deeply. However, this paper offers an important starting point in the cross-
national comparative analyses of DCR policymaking in Canada and
England and Wales, which will hopefully stimulate further comparative research into harm reduction policymaking.

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CHAPTER FOUR: A TALE OF TWO CITIES

ABSTRACT

The Canadian government recently sanctioned a supervised consumption site (SCS) that currently operates in Vancouver, British Columbia. The government is open to sanctioning more sites across the country; however, by law the federal health minister must consider whether such facilities are supported by local governments representing the cities where the sites are proposed to be located. Until 2016, the government of Canada’s largest city, Toronto, did not support SCSs. Drawing on Lenton’s (2004) cannabis policy research, this study analyses government documents, policy papers, scientific reports, and newspaper articles and secondary literature to identify some of the significant barriers that minimised the likelihood that Toronto’s council would support SCSs between 2003 and 2016. The report compares conditions in Toronto to those of Vancouver where SCSs have enjoyed council support since 2001. This study find that three conditions play an important role in explaining why SCSs were supported in Vancouver 14 years before they were endorsed in Toronto: 1. Strong public support; 2. Favourable electoral conditions; and 3. Law enforcement support. Changes in Toronto surrounding these conditions help explain why its council endorsed SCSs in 2016. This study concludes that Lenton’s research holds utility as a socio-legal theory of municipal drug policy change.

POLITICAL TIMELINE

Canada


2004-2006 Minority Liberal National Government- Prime Minister Paul Martin

2006-2011 Minority Conservative National Government- Prime Minister Stephen Harper

2011-2015 Majority Conservative National Government- Prime Minister Stephen Harper

2015-2017 Majority Liberal National Government- Prime Minister Justin Trudeau

Vancouver


2002-2005 Mayor of Vancouver: Larry Campbell ; Governing Party: Committee of Progressive Electors (COPE)

Toronto

2003-2010 Mayor of Toronto: Phillip Owen
2010-2014 Mayor of Toronto: Rob Ford
2014-2017 Mayor of Toronto: John Tory
CHAPTER FOUR- A TALE OF DRUG POLICY IN TWO CANADIAN CITIES: COMPARING AND CONTRASTING SUPERVISED CONSUMPTION SITE POLICYMAKING IN TORONTO AND VANCOUVER

INTRODUCTION

Vancouver is home to North America’s only two national government-sanctioned supervised consumption sites (SCS). The first one is InSite, which opened in 2003 as a scientific trial under the approval of the then Liberal party-led national government. It operates as a stand-alone facility in the Downtown Eastside neighbourhood of Vancouver (Small, 2006). The second facility is run through the Dr. Peter Centre, a renowned HIV/AIDS clinic. Although the site has operated for the past fourteen years, in January 2016 it received formal approval from the country’s current Liberal party-led national government (Woo, 2016).

Supervised consumption sites are places where individuals can legally consume illegally purchased illicit drugs under medical supervision to prevent overdose death and HIV and/or Hepatitis spread (Hunt, 2006). Other services offered by SCSs include needle exchange programming, counselling, and legal advice (Kimber et al., 2005, p.22). Since the first facilities opened in Switzerland during the 1980s, SCSs have expanded globally, opening in Germany, Luxembourg, Spain, Norway, Australia, and Canada (Hedrich et al., 2010). SCSs have been established as public health services, incorporated into existing services for homeless and drug using clients, or opened as non-professional centres by current/former users (Hunt, 2006, 2). Such facilities are examples of harm reduction, which seeks to reduce the harms associated with illicit drug use among people unable or unwilling to stop (Cheung, 2000).

Since 2002, the Canadian government has entertained applications from organisations to establish SCSs through an exemption under Section 56(2) of the Controlled Drugs and
Substances Act. The original guidelines and application procedures put forth by the Health Ministry in 2002 mandated that, in order for an SCS application to be approved, it must have community approval, which includes support from elected municipal and/or regional politicians (Health Canada, 2002). In 2008 the then Conservative party-led Canadian government (elected in 2006) refused to renew InSite’s Section 56(2) exemption (SCC, 2011). However, in 2011, the Supreme Court of Canada declared the future closure of the Vancouver facility to be unconstitutional and issued a mandamus ordering the government to grant the facility another exemption (SCC, 2011). Furthermore, the court ruled that, on future applications, the Minister of Health must consider whether refusing to grant an exemption to an SCS would result in, among other things, “deprivations of life and security of the person” (SCC, 2011). The court advised the Health Minister to grant exemptions: a) if a proposed SCS will reduce the risk of death and disease and; b) if there is little to no evidence that the facility would have a negative impact on public safety (SCC, 2011). It specified factors that must be taken into consideration including: a) evidence on the impact the facility would have on crime; b) local conditions demonstrating need for an SCS; c) the “regulatory structure” present to support a facility; and 4) “expressions of community support and/or opposition” (SCC, 2011, paragraph 153).

In 2015, the Conservative government enacted the “Respect for Communities Act” which specifies that the government must consider, among other things, the written opinions of local police chiefs and city councillors when deciding the fate of SCS applications (S.C.2015, c22). The recent decision to sanction the Dr. Peter Centre’s SCS indicates the

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3. The Controlled Drugs and Substances Act has, since 1996, been Canada’s national drug statute. It serves as the implementing legislation for the Single Convention on Narcotic Drugs, the Convention on Psychotropic Substances, and the United Nations Convention Against Illicit Traffic of Narcotic Drugs and Psychotropic Substances (Government of Canada, 1998). The Act prohibits the possession of substances including cannabis, opiates (heroin and morphine) and cocaine. For this reason, in order for a facility to allow users to safely and legally possess such substances on their property, they must by law seek an exemption from the Controlled Drugs and Substances Act (Criminal Code, 1985, S56(2)).
new government is open to approving further facilities. However, under the Respect for Communities Act, organisations will have more difficulty receiving approval if they are located in places where police chiefs and aldermen do not support SCSs. Until this year, Canada’s largest city, Toronto, was a prime example of one such place. Since InSite’s opening and right up until July of this year, Toronto’s city council would not officially (or unofficially) support SCSs. This is despite Toronto’s Board of Health adopting a 2013 recommendation from the public health department advising city council to support SCSs (Toronto Board of Health; 2013; Toronto Public Health, 2013). This paper questions why, between 2003 and 2015, Toronto’s city council would not officially endorse SCSs, particularly in light of the municipal health department’s recommendation to do so. It simultaneously considers what changes have occurred in the past two years that can help to explain why city council has now decided to endorse SCSs.

While there exists a large international literature on the politics of SCSs, this scholarship primarily consists of single jurisdiction case studies at the national, provincial/state, or municipal level. Cross-comparative analysis of SCS establishment in multiple locations is more limited, however, see Hayle (2015) and Zampini (2014) for notable exceptions. Furthermore, while there are a small number of studies that have looked at local SCS policymaking, this research has focussed primarily on conditions and circumstances facilitating successful SCS establishment rather than barriers and obstacles preventing successful SCS establishment (see Fitzgerald, 2013 for a notable exception). This is particularly the case in Canada where scholarship has focussed almost entirely on the establishment of InSite in Vancouver, whereas SCS politics and policymaking in other cities has been all but ignored. There are few, if any, studies that have systematically compared and contrasted the politics of SCS policymaking in multiple cities. No studies of this kind have been carried out in Canada.
To remedy this gap, this report analyses government documents, policy papers, scientific reports, newspaper articles, and secondary literature to identify and explain some of the significant barriers to city council support of SCSs between the years 2003 and 2016. I compare and contrast conditions and processes in Toronto to those of Vancouver, where SCSs have enjoyed city council support since 2001. This comparative-historical analysis of circumstances in both cities will allow us to tease out what unique local conditions found (or not found) in Toronto help explain the more than decade long time-lag between the two cities in question.

To carry out this analysis I draw on Simon Lenton’s research, (2004), in which he outlines several conditions that he believes are necessary in order for proposed drug policy schemes to be successfully translated into law. While Lenton’s (2004) observations have been applied to the study of cannabis policymaking in Canada (see Hyshka, 2009), they have not yet been extended beyond the topic of cannabis policy. While this paper draws on Lenton’s research to generate new insight into the politics of SCS policymaking, this paper seeks also to contribute to drug policy scholarship by demonstrating the applicability of Lenton’s (2004) findings beyond the realm of cannabis policymaking. It explores the prospects of generating a socio-legal theory of the politics of local drug policymaking from Lenton’s research.

LITERATURE REVIEW

Illicit drug policy reform has received considerable scholarly attention for over half a century (see Reinarman and Levine, 1997; Scheerer, 1978; DiChiara and Galliher, 1994; Pycroft and Bartollos, 2014). Within this literature, there is a body of scholarship that explores the socio-political conditions explaining harm reduction policy development. Scholars have explored a wide range of harm reduction measures including heroin prescription (Berridge, 1999; Cook,
Researchers have studied socio-political conditions explaining the creation of legal SCSs in countries including Switzerland (Schultz, 1989), the Netherlands (Wolf et al., 2003), Australia (Kimber et al., 2003; Fitzgerald, 2013), England (Hayle, 2015; Zampini, 2014); Norway (Skretting, 2006); Denmark (Hobourg and Frank, 2014), and Canada (Hayle, 2015; Watson et al., 2012; Hyshka et al., 2013). Conditions include: concern for drug users’ dignity; SCS activism; the election of politicians supporting harm reduction; and the opinions of spiritual leaders (Beletsky et al., 2008; Philbin et al., 2008; Wenger et al., 2011). Leaving aside Hayle’s (2015) comparative analysis of SCS policymaking in Canada and England, Zampini’s (2014) comparative analysis of SCS policymaking in England and Australia, and Fitzgerald’s (2013) comparative analysis of SCS policymaking in Melbourne and Sydney, Australia, the above research is restricted to single-jurisdiction case studies. But findings from cross-comparative jurisdictional studies are advantageous because they provide more nuanced analyses of policy change that are grounded in stronger evidence (Fischer 1999; Hyshka 2009b).

SCS policymaking in Canada has garnered scholarly interest, however the focus of the academic literature has been primarily on the conditions which facilitated the opening of InSite, rather than barriers to SCS establishment in other cities (Small et al., 2006; Hathaway and Tousaw, 2008; Kerr and Wood, 2008; for exceptions see Hyshka et al., 2013 and Watson et al. 2012). Small and colleagues (2006) discuss several ‘forces’ and events that shifted public opinion toward addiction in Vancouver, which ultimately paved the way for InSite’s opening. These included police support, international conferences, public demonstrations, and the 2002 municipal election. Focussed socio-political analyses explaining why SCSs
have not been implemented in other cities and provinces across Canada are lacking, although the topic of barriers to SCS implementation at the local level has received some limited attention in the US (Beletsky et al., 2008).

Local drug policymaking has been explored by a relatively small number of scholars. This research has included the study of drug policy activism and advocacy on the local scene (Blain, 2002); local politicians’ involvement in national or state drug policy making (Bullington, 2007); the local implementation of national or state drug policies (Terry-McElrath and McBride, 2004), and finally the creation and reform of municipal drug policy by municipal politicians (Blanken et al., 1999; Hobourg and Frank, 2014; Kubler and Walti, 2001). The vast majority of these reports are single case studies, however, and so there is a paucity of comparative research exploring variations in drug policy making between cities both within and across countries.

One important exception is Fitzgerald’s (2013) paper in which he explores policy narratives in Australian government documents in order to understand why, outside of Sydney, there has been a lack of movement toward establishing SCSs across the country. As a consequence of this dearth in research, the development of local drug policy remains a relatively unexplored area (European Monitoring Centre on Drugs and Drug Addiction, 2015). The European Monitoring Centre on Drugs and Drug Addiction’s 2015 report, Drugs Policy and the City in Europe makes important headway by providing a descriptive overview of written drug strategy documents from twenty-one European cities including Dublin, London, Oslo, Copenhagen and Amsterdam. While this research represents an important step forward, this research needs to be further complemented with rigorous analyses of policymaking processes in major cities such as these.
This paper seeks to contribute to drug policy scholarship in three ways. First, it aims to introduce more comparative data on SCS policymaking in order to further strengthen knowledge and understanding of the politics of harm reduction. Second, within the Canadian context, this paper will expand knowledge and understanding of the barriers to the implementation of harm reduction policy in Canada by looking at the circumstances that had, for years, discouraged Toronto’s city council from endorsing SCSs. Thirdly, this paper will contribute to local drug policy scholarship by providing further comparative analysis of the politics of local drug policymaking.

ANALYTICAL FRAMEWORK

Lenton (2004) proposes several conditions necessary for successful drug policy reform. They were derived from research investigating socio-political conditions surrounding the 2004 decriminalisation of possession of small amounts of cannabis in Western Australia. First, he suggests policy change must be in accordance with “generally accepted interpretations of the international drug treaties and conventions” (p.226). Second, he proposes policy change must be grounded in evidence supporting its’ effectiveness. Third, Lenton (2004) argues policy change must be supported by police, a clear majority of the public, and drug users (p. 224). Fourth, he argues policy reform must not be politically risky. Policymakers must be confident that if they change policy it will not jeopardise future electoral success. Lastly, he suggests policy reform must be subject to review and change.\footnote{Since the Respect for Communities Act stipulates that SCSs must be subject to review, the focus of this paper will be on the remaining criteria (S.C. 2015, c22-see Section 56:1[4]).}

Although Lenton’s (2004) observations pertained directly to cannabis change in Western Australia, his discussion of “necessary conditions” is also grounded in
criminological theory. He draws on material from criminologists, sociologists, and political scientists who have explored criminal law and policy change on a more general and theoretical level (Kingdon, 1984; Silberman 1976; Tyler 1990). He draws on insights from these studies to better understand the cannabis policymaking process in Western Australia. His use of the phrase “drug policy reform” as opposed to “cannabis policy reform” or “cannabis policy reform in Australia” implies he expects these “necessary” conditions to be applicable to other drug policy contexts as well (p. 224).

Lenton’s (2004) analysis has been used to study barriers to cannabis policy change in Canada (see Hyshka, 2009b). However, his analysis has not been extended outside of this context, meaning that its broader generalizability to other drug policy contexts requires further examination, which this paper sets out to accomplish. DATA AND METHODS

This article is based on a documentary analysis (1997-2015) of 47 municipal government documents (Toronto and Vancouver), 1,091 news reports retrieved through the Factiva search engine, and secondary published research. The year 1997 was chosen as the start date for this analysis as it is as far back as “official” discussion surrounding SCSs can be traced in either city’s documents. Government documents were retrieved using search engines accessible on the individual government’s websites.

Municipal government documents included city council agendas and minutes from both localities, city council committee reports (including evidence, minutes, and sometimes recommendations), press statements, municipal drug strategies, minutes from town hall meetings, and public health board meeting minutes. News data was drawn from national sources (The Globe and Mail [n=178], The National Post [n=220], CBC News Online [n=2], Global News Online [n=1], and CTV News Online [n=1]); and relevant local news sources
(The Star (Toronto) [n=50]; The Sun (Vancouver) [n=471], The Sun (Toronto) [n=45]; and The Province (Vancouver) [n=123]). Secondary published research included previous studies on drug policymaking as well as scientific reports and research studies addressing drug use and SCSs in both cities. Keyword search terms included “heroin”, “HIV/AIDS”, “hepatitis C”, “overdose death”, “harm/risk reduction/minimisation”, “drug consumption/rooms”, “safe/clean injection/injecting sites/rooms/houses/facilities”, “supervised consumption sites/facilities/rooms/houses”, and “shooting gallery(ies)”. All pertinent articles that were retrieved using these search terms, including news stories, analysis pieces, editorials, and letters to the editors, were collected analysed.

The documents were analysed in Microsoft word format without the use of any additional electronic software programs. The first stage of my analysis involved a superficial examination (or “skimming”) of the documents to familiarise myself with the data (Bowen, 2009, p.32). The second stage involved a more thorough analysis of the ‘content’ found in each document drawing on “thematic analytic methods” (Freday and Muir-Cochrane, 2006). Thematic analysis is a process in which “coding” and “category construction” are performed in order to uncover thematic patterns pertinent to the topic under study (Freday and Muir-Cochrane, 2006). Consistent with Bowen’s (2009) recommendation to anchor one’s thematic analysis in grounded theory, I invoked open coding techniques, in which each line of content from documents was broken into “discrete units” to facilitate interpretation (Strauss and Corbin, 1990). Discrete units were distinct thoughts, ideas, and/or statements that could be compared and contrasted with one another and then grouped into larger categories to facilitate analysis (Rohleder and Lyons, 2015). This process was carried out without any predefined codes or categories in order to ensure that the central themes emerged directly from the data (Altheide, 1996).
Initially, over 50 codes were generated through line-by-line coding; however, this list was reduced to ten codes through more focussed coding techniques which involved the thematic categorisation of paragraphs or even entire documents. These codes were then used to generate thematic categories pertinent to the analysis of SCS policymaking in Toronto and Vancouver. Both latent (specific words and phrases composing content) and manifest content (meaning of content) was coded (Strauss and Corbin, 1990).

FINDINGS

In this section, I introduce Lenton’s “necessary conditions” successively and explore their relationship to SCS policymaking in both Vancouver and Toronto. First, I overview conditions and factors which the evidence suggests was met in both Vancouver and Toronto. Second, I overview conditions and factors which the evidence suggests have existed in Vancouver for over a decade but have only emerged in Toronto within the past two years. I consider how this time gap helps explain why Toronto’s city council did not endorse SCSs until 2016. I explore how and why the appearance of these conditions within the past two years helps to explain the Toronto council’s sudden change in position. Finally, I comment on Lenton’s criteria of drug user support.

International Conventions

Evidence suggests Lenton’s (2004) criteria that policy change must comply with international conventions was met in both Vancouver and Toronto. A strict reading of the conventions suggests countries are obligated to prohibit possession of narcotics. Article 4 of the 1961 Single Convention states:

The parties shall take such legislative and administrative measures as may be necessary: (a) To give effect to and carry out the provisions of this Convention within their own territories; (b) To co-operate with other States in the execution of the provisions of this Convention; and (c) Subject to the provisions of this Convention, to limit exclusively to medical and scientific purposes the production, manufacture, export, import, distribution of, trade in, use and
possession of drugs. The UN’s International Narcotics Control Board (INCB) has been critical of Canada and other countries for implementing SCSs, citing such facilities as being “…contrary to the fundamental provisions of the international narcotics control treaties” (INCB, 2002). With that said, key provisions from the 1961 and 1971 conventions create an obligation to “treat” addicts. Article 38 from the 1961 convention, entitled “Measures Against the Abuse of Drugs” and Article 20 from the 1971 convention both stipulate:

The Parties shall give special attention to and take all practicable measures for the prevention of abuse of drugs and for the early identification, treatment, education, after-care, rehabilitation and social reintegration of the persons involved and shall co-ordinate their efforts to these ends” (pp.19 and 20 respectively).

In 2002 the Legal Affairs Section of the UN’s Office on Drugs and Crime (UNCDP) concluded that preventing exposure to pathogens qualifies as “treatment”:

If, for example, the purpose of treatment is not only to cure a pathology, but also to reduce the suffering associated with it (like in severe-pain management), then reducing IV drug abusers exposure to pathogen agents often associated with their abuse patterns (like those causing HIV-AIDS, or hepatitis B) should perhaps be considered as treatment. In this light, even supplying a drug addict with the drug he depends on could be seen as a sort of rehabilitation and social reintegration…[UNCDP, 2002].

Hence, international conventions and the UN Office of Drugs and Crime consider harm reduction programs such as SCSs to constitute treatment, rehabilitation, and social reintegration since they help reduce “drug abuser’s” exposure to HIV/AIDS and Hepatitis by providing clean needles to them (Schatz and Noguier, 2012). Therefore, it appears international law does not, in and of itself, pose a significant barrier to city councils supporting SCSs in either Vancouver or Toronto. INCB opposition may pose a more significant barrier to local support of SCSs than the international laws themselves. However,
in neither city’s documents did I find statements alluding to concern about the INCB, suggesting that this an area that requires further research.

Evidentiary Support

Lenton’s criterion that drug policy must be supported by evidence was met in both Vancouver and Toronto with respect to SCSs, however, the findings suggest this evidence was interpreted differently in each city. Local policymakers in Vancouver began to take notice of evidence supporting SCSs as an effective solution to HIV spread and overdose death during the 1998 “Out of Harm’s Way” conference and the March 2000 “Keeping the Doors Open” conference (Small et al., 2006). Academics, policymakers and drug practitioners from European countries with legally sanctioned SCSs spoke at both conferences about the effectiveness of such facilities in curbing HIV spread and overdose. Nearly 700 people (some of who were policy makers) attended the “Out of Harm’s Way” conference, which suggests that there was the potential for these European visitors to have a significant impact on policy making in Vancouver (Kerr et al., 2008).

Furthermore, public health staff from the City of Vancouver had the opportunity to travel to Europe and tour facilities in the Netherlands and Germany. In their 2000 report, they noted that rates of HIV spread among drug users in Germany had decreased from 25% to 14% after the introduction of SCSs (Clarke, 2000). The findings of this report were cited and referenced in the Vancouver’s 2001 official drug strategy, the *Four Pillars Framework of Action* (MacPherson, 2000). Additionally, Vancouver’s drug strategy referenced Frankfurt police statistics indicating the annual number of drug overdose deaths decreased from 61 to 47 after the implementation of an SCS (MacPherson, 2000, p.29). This evidence appears to
have significantly influenced Vancouver councillors. The *Four Pillars Framework* was presented to city council in May of 2001, and within one month the council voted unanimously to endorse the plan and all its recommendations (City of Vancouver, 2001).

Evidence about the effectiveness of SCSs did not appear to influence politicians in Toronto the same way that it did in Vancouver. In 2005, Toronto’s council opposed SCSs citing a *lack* of evidence as influencing their decision. City councillors questioned whether SCSs would be suitable for Toronto and lamented that information on the potential effectiveness of SCSs in the city was lacking. This was illustrated by the 65th recommendation of the city’s 2005 drug strategy (endorsed by the council in December 2005), which recommended that, “The City of Toronto conduct a needs assessment and feasibility study for supervised consumption sites taking into account the decentralized nature of drug use in Toronto” (p. 59). The strategy goes on to state:

> The reality is we don’t know if Toronto needs a supervised consumption site. But, we need to find out and that requires targeted research to see if people would use it, if there is sufficient community and political support for it, and also what type of service model would be most appropriate for Toronto...There is open drug use and unsafe drug use in Toronto as well as neighbourhoods that have become overwhelmed by street level drug dealing. A needs assessment and feasibility study will help us determine if supervised consumption sites are an appropriate response for the people of Toronto [2005, p.59].

Interestingly, this drug strategy referenced studies including the “Year One Summary evaluation of InSite” completed by the BC Centre for Excellence on HIV/AIDS (2004), an overview of harm reduction drug policies in Frankfurt (Frerichs, 2001), a review of impact studies of SCSs operating in Germany and the Netherlands (Kimber et al., 2000), and the final report of the evaluation of Sydney, Australia’s Medically Supervised Injection Facility (MSIC Evaluation Committee, 2003). Evidently, the authors of Toronto’s drug strategy were not operating within a research vacuum on the effectiveness of SCSs. Yet, whereas
Vancouver’s council drew on available evidence in order to fully endorse SCSs, Toronto’s council drew on the same evidence to support conducting further investigations into feasibility of SCSs operating in Toronto.

Several councillors, while acknowledging the benefits of SCSs, expressed doubt as to whether they were appropriate for Toronto. Toronto Centre-Rosedale alderman Kyle Rae, who in 2005 strongly advocated for an SCS feasibility study, conceded to the *Toronto Star* newspaper that he believed crack- cocaine was the drug of choice for Torontonian users, and *not* heroin (Porter, 2005, p.B01). He questioned whether SCSs would be appropriate in Toronto since the city had fewer heroin users than Vancouver did (Spears, 2006). He told the *Star*, “I'm really skeptical that a safe injection site would work in Toronto” and that “Alcohol is the major drug problem in this city” (Spears, 2006, p.FO2). Cabbagetown councillor Pam O’Connel expressed similar concerns to the *Star*, claiming, “I don't think a neighbourhood safe injection site is going to be the solution that comes forward, and it's not one that I would support” (Spears, 2006, p.F02). Then mayor David Miller echoed Councillor Rae’s skepticism, commenting to the *Star*; “We don’t know if its applicable here (SCSs) because the issues here are alcohol and crack…Safe use houses work best when the problem is mainly heroin, so there might not be one in Toronto” (Cowan, 2005:A18; Gray, 2005, p.A15). The excerpts highlight, not Toronto councillors’ skepticism over evidence regarding the effectiveness of SCSs, but rather skepticism over whether SCSs were necessary and suitable for their city.

The SCS feasibility study mandated under the 2005 drug strategy (TOSCA- or the Toronto and Ottawa Supervised Consumption Assessment Study), was completed and released to the public in 2012. It found that large numbers of IDUs engaged in unsafe
practices carrying high risk of HIV and HCV spread and overdose death such as needle sharing (18% use dirty needles and 20% give used needles to others), and injecting in public spaces like washrooms, stairwells (54%), and alleys or on the street (46%) (Bayoumi and Strike, 2012). Deputy Mayor Doug Holyday reacted to the findings by telling the Star, “I have some doubts as to whether or not there is real benefit and whether or not you don’t just attract more problems so I would like to really get the thorough results of other places that have done this [open an SCS] and I’d like to hear from other experts on the matter” (Ogilvie, 2012). His statements (along with others cited above) appear to suggest that the availability of international evidence on SCS effectiveness did not appear to influence Toronto’s council in the same way that it did Vancouver’s.

Public Support

Lenton (2004) suggests public opinion is ‘crucial’ in explaining successful drug policy reform. He argues successful reform is likely when a ‘clear majority of the general public’ are in favour of it. The findings suggest a strong majority of the public supported SCSs in Vancouver but not Toronto. Public opinion polls taken in 2001 reported 71% of Vancouverites favoured SCSs (Kent, 2001). Written summary reports from focus groups held by Vancouver Mayor Owen in 2000 indicated the ‘vast majority’ of attendees supported SCSs (Vancouver. City Council, 2001a). These reports were provided to councillors prior to their unanimous endorsement of SCSs in 2001 (City Council, 2001).

Until this year, circumstances have been considerably different in Toronto. In 2003 a Centre for Addiction and Mental Health (CAMH) monitor survey found 87% of Ontarians in Ottawa and Toronto had “mixed opinions” about SCSs (78%) or “strongly disagreed” with
them (9%), while only a small minority (11%) “strongly supported” them (Bayoumi and Strike, 2012, pp.78-80). A more recent 2009 Centre for Addiction and Mental Health (CAMH) Survey Monitor found the majority of Torontonian respondents had mixed opinions about (67%), or strongly disagreed with (11%), SCSs, while only a minority of Torontonian respondents strongly agreed with SCSs (22%) (Bayoumi and Strike, 2012, pp.78-80).

Lenton’s (2004) theory would suggest the lack of strong public support for SCSs has presented a significant barrier to SCS endorsement by Toronto’s city council. This is because it is unlikely councillors would support an SCS application if large number of their constituents (who voted them in) oppose such a measure.

It is unclear exactly why public opinion polls varied so strikingly between the two cities, and more research is required in this area. One clue, however, comes from stakeholder interviews reported in the TOSCA study. Stakeholders who expressed mixed feelings or opposition to SCSs believed that such facilities were more appropriate for cities like Vancouver where IDU was more ‘visible’ and ‘widespread’ (Bayoumi and Strike, 2012, p.97). They believed SCSs would only be appropriate for Toronto if conditions reached the same level of ‘crisis’ that they had reached in Vancouver. It is possible, then, that part of reason Torontonians were skeptical about SCSs is that they did not perceive them to be necessary in the same way that their Vancouverite counterparts did. While more research is needed to substantiate this hypothesis, it points to the potential importance of perceived need in explaining political support for SCSs.

Future Electability

Lenton (2004) suggests drug policy reform must not place politicians’ future election at risk. He further suggests public opinion polls of drug policy change can also serve as indicators of
how politically risky such change is. Findings indicate supporting SCSs carried relatively low political risk in Vancouver compared to Toronto.

In Vancouver, Larry Campbell was elected mayor in 2002 with an overwhelming majority of the popular vote (57.79%) after campaigning to open an SCS thirty days after taking office (Small, 2006; Vancouver Election, 2002). His left-wing COPE (Coalition of Progressive Electors) party (which supported Campbell’s commitment to SCSs) captured nine out of the eleven council seats (Vancouver. Data Catalogue, 2002). This overwhelming victory seemed to strongly indicate to the council that submitting an SCS application would not jeopardise their future electability.

Conversely, in Toronto, there is a lack of concrete evidence indicating to what extent submitting an SCS application would impact the future electability of the council and its mayor. In 2010, Etobicoke Councillor Rob Ford, a vocal opponent of SCSs, was elected mayor (Ogata et al., 2014). Mayor Ford repeatedly made his opposition clear to the media. On April 15, 2011, he told the Star, “I’ve always been opposed to those…I’ve never been in favour of safe injection sites” (Ogilvie, 2011a; Ogilvie, 2011b). On July 3, 2013, he told the Toronto Sun, “No way, no, I’m not supporting that whatsoever…Trust me, it’s the worst thing that could happen to this city right now” (Peat, 2013). On July 10, 2013, Global News (online) quoted Mayor Ford reiterating; “I’m not going to support it…The taxpayers obviously don’t want it, so they (councillors who support SCSs) are going to have to listen to the taxpayers” (Armstrong, 2013).

Mayor Ford stylised himself as a tough-on-crime politician in his early days as a councillor, opposing the 2005 Toronto Drug Strategy and leading anti-drug use campaigns in
the city (Wortley and Gartner, 2013). As councillor and mayor, he repeatedly championed lower taxes and public spending cuts, and he won the mayoralty in 2010 (48% of the vote) on a platform of fiscal austerity (Ogata et al., 2014). In 2013 Ford confirmed he would seek re-election as mayor, however, early election polls showed that his support levels were steadily decreasing (from 40% in January to 27% in April). Although we can never fully understand Rob Ford’s political strategy in the 2014 municipal election, nor how he subjectively perceived his own electoral chances in that race, what we can suggest is that supporting SCSs would have carried a much higher degree of electoral risk for Mayor Ford in Toronto than it would have for Mayor Campbell in Vancouver. The limited public opinion data available (reviewed above) from 2003 and 2009 suggested significantly large numbers of people in Toronto would not support such a policy move. Given Rob Ford’s tenuous position in the polls, such a political move would likely have carried considerable risk to his future electoral survivability.

**Law Enforcement Support**

Lenton (2004) argues support from police is important in increasing the likelihood of a successful drug policy change. Previous research demonstrates that in Vancouver, public support was vocalised by the police, including police chief constable Jamie Graham, and officers Gill Puder, Scott Thompson, Kash Heed, Ken Doern, Ken Frail, and Bob Rich (Small et al., 2006). In contrast, evidence suggests Toronto’s police chief in the early 2000s, Julian Fantino, opposed SCSs. In his 2007 autobiography, *Duty: The Life of a Cop*, he writes:

> …some city councillors think this would be a good idea and advocate safe-injection sites. *But there is no such thing as the safe injection of illicit drugs.* Those who advocate this are
sugar-coating things with a palatable, harm-reduction theme so the public will accept it. But the reality is, we are losing the battle and not doing what we should to get young people off these drugs. We do not need safe-injection sites and needle exchanges (Fantino, 2007).

While we should not draw definitive conclusions from autobiographical evidence (typically written to portray the author in a favourable light) (Platt, 1981), we can infer from this (and a lack of competing evidence) that Fantino did not publicly support SCSs during his tenure as chief. Fantino resigned as police chief in 2005 and was replaced by Bill Blair. Blair also publicly opposed SCSs during his time in office, telling the Star in April 2012:

My concern is there needs to be sufficient assurances within the community that the quality of life will not be put in jeopardy…They have been doing it in Vancouver for some years and there have been issues that have arisen there. I don’t know of any place in Toronto where that couldn’t have a significant negative impact on the communities (Ogilvie, 2012).

A qualitative study carried out by Watson and colleagues (2012) found Toronto police officers (not just the chiefs) opposed SCSs, believing they: 1) do not “solve” the problem of addiction; 2) send an ambiguous message about the “acceptability” of illicit drug use; and 3) undermine and interfere with law enforcement efforts (p.367). One officer was quoted in their study explaining Toronto police officer opposition as such:

The concern would be that we, as a police service, can deal with those people where they are. The difference is when you have the site that’s safe, we now can’t get in there to deal with that. And that’s the concern, is that they can go safely in there and do the drugs without the thought that the police service is going to do anything to them. These other places, we can see up on them, we have ways to deal with them. We have officers on foot. We have other things. And that’s clear, and that’s why we can maybe stop it (Watson et al., 2012, p.368).

Police officers are often viewed as ‘experts’ when it came to knowledge about crime (Best, 2013). Police chiefs, by virtue of their command of municipal police forces, hold key administrative posts within their local polities. As such, it is likely that the statements and opinions of local police chiefs on SCSs would have been taken into consideration by councillors in both cities. For this reason, police opposition in Toronto over the past two decades has presented a considerable barrier to city council support of SCSs.
Drug User Support

Lenton (2004) suggests cannabis policy change will not occur unless it is supported by cannabis users. Unfortunately, reliable and comparable data on IDU’s opinions about SCSs in Toronto and Vancouver does not exist. With that said, evidence suggests IDU support appeared to be much clearer and more pronounced in Vancouver compared to Toronto due to mainstream media coverage of large demonstrations.

When SCSs were debated in Vancouver in the early 2000s, a strong IDU activist movement developed, orchestrated largely but not exclusively by VANDU (the Vancouver Area Network of Drug Users) (Small et al., 2006, p.78). In 1997, activists struck 1,000 crosses in the ground of a downtown eastside park (Oppenheimer Park) to commemorate the lives of 1,222 people who died from overdosing since 1993 (Small et al., 2006). It was also the venue of the 1998 “Out of Harm’s Way” and 2000 “Keeping the Doors Open” drug policy conferences discussed in an earlier section. In 2000, 2000 crosses were struck in the ground of Oppenheimer Park to represent the lives lost to overdosing over the past decade (Small et al., 2006). At all of these events, activists called on local authorities to open SCSs. Consequently, there were numerous examples of staged events made known to the public, via the media. Through media coverage of the events, it is likely Vancouver’s council became aware of the fact that relatively large numbers of IDUs strongly supported the creation of SCSs.

In Toronto, there have been comparably fewer instances of demonstrations orchestrated by IDUs to draw attention to their support of SCSs. Both the Sun and the Globe reported on one staged event in Toronto in which activists attending the 2006 International
AIDS Conference halted traffic at some of the city’s busiest intersections. Banners were carried which read; “100s will die if safe injection site closes-Save Lives, Keep InSite” (Cobb, 2006, p.A4; Mick, 2006, p.A20). However, this event in Toronto involving SCS activists (which did attract significant media attention) was intended to draw media attention to activist support for SCSs in Vancouver (which the federal government was at the time considering closing) and not Toronto. Furthermore, it was unclear what proportion of these activists were drug users.

More recently, there have been a number of events organised by SCS supporters. This includes an incident on May 26, 2013 in which several members of the activist group “AIDS Action Now” dropped banners at a Toronto Blue Jays baseball game (professional league) at the Rogers Centre (baseball stadium) reading: “End Austerity NOW! People are dying of AIDS!”, and “We need a safe injection site NOW!” (AIDS Action Now, 2013). These demonstrations did not appear to attract anywhere near the numbers of protesters who attended the Toronto demonstrations in 2006 or the Vancouver demonstrations of 1998 and 2000. Moreover, I was unable to find any newspaper coverage of these events, suggesting that they did not attract mainstream media attention. Finally, it is unclear whether the demonstrators at these more recent events were drug users themselves.

The above findings do not suggest an actual absence or lack of drug user support for SCSs in Toronto. Although overall public opinion towards SCSs is far more mixed in Toronto than it was and is in Vancouver, this certainly does not preclude the possibility that support among IDUs in Toronto is comparable to support among IDUs in Vancouver. Nor do the findings suggest an absence or lack of activism and demonstrations by IDUs supporting SCSs in Toronto. The findings do, however, suggest that compared to in Vancouver,
demonstrations orchestrated by IDUs supporting SCSs in Toronto have gained very little, if any, traction in the mainstream media compared to in Vancouver. Consequently, important information and details about SCS support among drug users has been less likely to reach the attention Toronto’s city council. Compared to in Vancouver then, it is less clear to Toronto’s council how strong IDU support is. This may have presented a barrier to council support; however, more research is required to confirm this.

TORONTO COUNCIL’s SCS ENDORSEMENT

In March 2016, Toronto’s Health Board voted to begin community consultations regarding the establishment of three SCSs in Toronto (Bayoumi and Strike, 2016; Toronto Board of Health, 2016a). The results of the consultation were presented to the Board in June, and on July 14, Toronto’s Council endorsed SCSs in the city by a vote margin of 33-3 (Toronto Board of Health, 2016b; Toronto, 2016). This section considers whether Lenton’s model can improve understanding of the sudden change in council’s position. With regard to the criterion of public support, Toronto’s Medical Officer of Health presented to the Health Board findings from a community consultation process that took place between March and June of this year (Toronto Board of Health, 2016b). An online survey was administered and completed by 1,285 individuals. The results show that, whereas 96% of respondents believed that implementing SCSs would be ‘beneficial’, only 14% of respondents expressed concerns about it. In certain locations, support was lower and concerns expressed were higher (i.e. in the Queen West neighbourhood, 85% of respondents believe SCSs would be beneficial whereas 35% of respondents expressed concerns), but in all places the ‘vast majority’ of respondents believed implementing SCSs would be beneficial whereas only a minority of respondents expressed concerns (Toronto Board of Health, 2016b). These findings suggest
that, since 2009, public support in Toronto for SCSs has grown dramatically. With respect to the criterion of future electability, these findings likely indicated to councillors that supporting SCSs would not carry significant political risk in the upcoming municipal election, which is over two years away.

Furthermore, Toronto’s current police chief Mark Saunders has publicly supported SCSs, thereby satisfying another one of Lenton’s necessary criteria for policy change (Toronto Board of Health, 2016b). Although we do not know the extent to which attitudes have changed across the city’s police force, it is likely that endorsement from the department’s ‘commander in chief’ will indicate to officers that they are required to support the facilities if they receive government approval. In terms of drug user support, during the consultation process, a group of ten “Queen West Harm Reduction Clients” were invited to participate in a focus group. It was reported to the Health Board that the primary concern raised by these clients was that there would be ‘overcrowding’ and ‘lineups’ when attempting to access SCSs. This suggests support for the implementation of more or larger facilities (Toronto Board of Health, 2016b). With that said, this group represents an extremely small and unrepresentative sample of drug users, and so more rigorous research is required in this area.

In conclusion, the findings reveal two common conditions in Vancouver and Toronto. In both cities, SCS policy was consistent with international conventions. Furthermore, evidence about SCS effectiveness was available to politicians in both cities, although in Toronto the evidence was interpreted differently than it was in Vancouver. Due to a lack of reliable and comparable evidence, we were unable to compare rates of drug user support of SCSs in Toronto and Vancouver. What the findings suggest, however, is that drug user
activists fighting for SCSs in Toronto have been less successful garnering media attention to their cause than those in Vancouver. This suggests that, due to a lack of media attention, drug user support for SCSs has been less apparent and clear to politicians in Toronto than it has been to politicians in Vancouver.

The analysis reveals three key areas where, until recently, social conditions were different in Vancouver and Toronto. First, whereas the vast majority of citizens in Vancouver clearly support SCSs, until 2016, the opinions of Torontonians were more mixed. Second, evidence suggests the risk to electoral survivability for local politicians is relatively low in Vancouver compared to in Toronto. Thirdly, whereas in Vancouver both police officers and police chiefs support SCSs, in Toronto police chiefs and police officers continually opposed SCSs up until 2016. Recent events have led to an alignment of these three conditions. Online surveys administered this spring reveal that the vast majority of citizens now support SCSs, suggesting that the political risk of establishing such facilities is not as serious as it once was. Furthermore, the police chief has now endorsed SCSs. This paper suggests that the alignment of these conditions helps to explain why Toronto’s council has most recently endorsed SCS.

DISCUSSION

The findings of this study are significant for several reasons. First, for Canadian drug policy scholarship, this study extends our understanding of the politics of SCS policy making in Toronto. More broadly, this study moves forward literature on harm reduction policy development in Canada by generating further insight into barriers to the expansion of SCSs outside of Vancouver, BC. Second, this study lends tentative support to Lenton’s (2004) assertion that his “necessary conditions” of successful cannabis policy reform in Western Australia hold applicability for drug policy reform in other contexts. The findings from this study point to the utility of Lenton’s research in explaining harm reduction policy reform at
the level of the municipality. While more research is required, this paper concludes that it is appropriate, at present, to treat Lenton’s analysis as a socio-legal theory of drug policy, and that his theory ought be subjected to further testing and, if necessary, revising. This conclusion is based on a definition of sociological theories as being statements about how and why particular facts about the social world are related. Lenton’s analysis, indeed, provides observations about how and why social factors and conditions are related to drug policy reform.

Nevertheless, the findings illuminate some limitations in Lenton’s model when attempts are made to reconceptualise it as a socio-legal theory. While Lenton’s model focusses predominantly on micro-level phenomena such the actions of individual actors it focusses less on macro-level variables such as political structures. For example, the findings revealed a strong indicator of SCS public support in Vancouver was the election of a mayor and political party which ran on a campaign to establish an SCS (Small et al., 2006). However, that these election results could point so strongly to public support is partly explained by the fact that Vancouver has a municipal electoral system in which mayoral and councillor candidates run together as ‘parties’ under single platforms. Under such structural conditions, if a party wins an overwhelming majority of seats including the mayoralty, this can be construed as a ‘mandate’ to implement its platform. Conversely, in Toronto, mayoral and councillor candidates run independently. The election of a mayor or councillor does not constitute a mandate in the same way as if an entire party were elected in Vancouver. Consequently, political structure appears to be an important variable for consideration when explaining why drug policy change does or does not occur.
Another limitation concerns the application of Lenton’s theoretical model to public health facilities. While Lenton discusses the necessity of evidentiary support for the effectiveness of drug policy, he does not address the importance evidence about the need for a drug policy. It is possible that SCSs received support in Vancouver and not Toronto because health conditions were perceived to be serious and in need of urgent resolution in the former city but not the latter. Data from the period when SCSs were endorsed in Vancouver show that rates of HIV prevalence among IDUs was roughly 20% in Vancouver, but only 5% in Toronto (Health Canada, 2004; Strathdee et al., 1997; Tyndall et al., 2001). Furthermore, overdose deaths in Vancouver peaked at 201 in 1993 and then ranged between 116 and 160 per year between 1994 and 1998. In comparison, in 2001 there were only 44 reported overdose deaths reported in Toronto (Office of the Chief Coroner, 2001; McClean, 2001). It is interesting to note that Toronto council’s endorsement of SCSs this year came just four months after the city’s Health Officer reported in a press statement that there were 206 overdose deaths in the city in 2013, and that the number had risen by 41% over the past decade (Lunn and Zimonjic, 2016). It is possible that Council’s endorsement was heavily influenced by this evidence. In sum, the findings suggest that if Lenton’s model were to be developed into a socio-legal theory, his criteria of evidentiary support ought to be clarified so that it applies to both evidence of effectiveness as well as evidence of need.

These observations point to some conclusions regarding future applications of Lenton’s research to drug policy change analysis. While the findings do not suggest that the criteria put forth by Lenton are necessarily problematic (though future research in this area would be fruitful), they do suggest that his research might have some limitations when it is revised into a theoretical model for analysing drug policy change in other contexts, as this
article suggests. While the necessary criteria appear to help explain harm reduction drug policy change in Vancouver and Toronto, this analysis reveals that there potentially many other factors and conditions that are key in explaining DCR policy change in Canada that are not captured in Lenton’s research. As such, while it is encouraged that future scholars to draw on Lenton’s work as a theoretical model, this paper proposes that future research explore what other factors and conditions might usefully be added to Lenton’s model in order to further develop and round out the theory.

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CHAPTER FIVE: CONCLUSION

The three articles in this collection have explored harm reduction policy change and development in Canada and the United Kingdom. Each of the three papers in this dissertation speaks to the relationship between the social construction of injection drug use and harm reduction drug policy, and how this relationship is mediated by the distribution of power across political institutions.

As noted in the introductory chapter, although this dissertation is a comparative study of harm reduction drug policy development in Canada and the United Kingdom, the focus of attention is on the political activities of the British government, and neither the Scottish nor Northern Irish governments. This is largely because of the scope of analysis of each paper. The first paper examines policy developments in the United Kingdom in the 1980s when Scotland and Northern Ireland did not yet have their own independent parliaments, and thus healthcare policy in these two countries fell under the jurisdiction of the British government. The second paper examines policy developments in England and Wales in the early 21st century, at which time Scotland and Northern Ireland were fully devolved, and thus they were not a part of the analysis. The third paper focusses on developments in Canada alone. For these reasons, although the Scottish and Northern Ireland governments do not feature in this analysis, the dissertation as a whole can still be understood as a comparative analysis of drug policy change in Canada and the United Kingdom.

In the first dissertation chapter, I discuss the politics of needle exchange policy in Canada and the United Kingdom. Recall that needle exchange is one of the earlier developments in the history of harm reduction policy expansion in both Canada and the United Kingdom. While needle exchange exists in both countries, the policy regimes are
markedly different. In the United Kingdom, there exists over a thousand needle exchange programs that can be found evenly distributed across the country. A large number of these programs are found integrated within pharmacies. In contrast, in Canada while the exact number of needle exchanges is unknown as the federal government does not keep an actual record, it is estimated that the number is closer to three hundred. This is a significantly smaller proportion compared to that of the UK where the country’s population double that of Canada. Furthermore, needle exchanges are very unevenly distributed across the country. While there exist over one hundred needle exchanges in Ontario, only one facility exists in certain Atlantic provinces such as Newfoundland and Prince Edward Island. More striking is the fact that until the late 2000s, provinces including Newfoundland and Prince Edward Island did not have any needle exchanges. Alberta, which is the fourth most populated province in Canada, has only six needle exchange programs.

This paper explores the reasons behind the variation between the two countries and concludes that once again much can be explained by the decentralisation of power over healthcare in Canada and the centralisation of political power over healthcare in the UK.

In the UK, in response to concern that Acquired Immune Deficiency Syndrome (AIDS) could be spread to the heterosexual population by heterosexual people who use drugs who have contracted the virus via needle sharing, the British government, and in particular the Ministry of Health, moved quickly to approve and fund needle exchange pilots across the country. They came to understand injection drug use has a medical emergency due to its role in the potential spread of an epidemic of Acquired Immune Deficiency Syndrome (AIDS), and in turn needle exchanges became constructed as a medical tool to prevent the disease spread. Upon recognising their success in preventing the Human Immunodeficiency Virus (HIV) from reaching rates as high as these in North America, the government proceeded to
establish and fund hundreds of facilities across the country, and to encourage their integration within pharmacies. My findings reveal, however, that in the UK there was considerable opposition to the establishment of needle exchanges by Scotland’s health minister, the Liverpool city council, and the residents’ council of Glasgow. However, given the urgency reportedly felt by the British government, and the fact that the administration of healthcare falls under central government’s jurisdiction, the government moved forward despite significant opposition.

In Canada, the government came to construct injection drug use as a healthcare problem in the same way as they occurred in the UK. And similar to the UK, the federal government supported and advocated for needle exchange. With that said, there did not seem to be the same level of urgency since the potential for Acquired Immune Deficiency Syndrome (AIDS) to become an epidemic afflicting large numbers of heterosexuals was not perceived in the same way. Furthermore, while the federal government funded needle exchanges, this was done as part of a cost sharing program with the provinces. The decision to take advantage of the funding, then, was ultimately left in the hands of the provinces. While some provinces like Ontario and Quebec took advantage of the federal government’s funding offer and established needle exchanges, other provinces such as British Columbia and Manitoba did not. Furthermore, the federal government ceased funding facilities after 1990. This I suggest can be explained by a key difference in Canada: the fact that the administration of healthcare falls under the purview of the provincial governments. This allowed for some anti-harm reduction provincial governments to assert their independent political authority and prevent needle exchanges from being funded and administered within their provinces. It helps explain the significant variation in the number of facilities found in
each province, and why some provinces have only begun to fund and administer needle exchange facilities within the past ten years.

The third chapter presents evidence which suggests that one of the reasons why drug consumption rooms have enjoyed support and have been established in Canada but not England and Wales is that in Canada injection drug use has been constructed as a public health problem in a manner and degree not seen in England and Wales. In Canada, in the late 1990s and early 2000s, injection drug use became socially constructed as a public health problem by claims makers including doctors, public health officials, people who use drugs, the mass media and politicians at all levels of government.

Medical health experts published peer reviewed articles noting the high rates of the transmission of the Human Immunodeficiency Virus (HIV) and Hepatitis C between people who use drugs as well as the high rates of accidental overdose death seen across the country. When rates of the spread of the Human Immunodeficiency Virus (HIV) and accidental overdose death reached alarmingly high levels in Vancouver, rivalling levels seen in African developing countries, the Vancouver Coastal Health Authority declared a medical emergency, further problematizing injection drug use in the city as a healthcare emergency. The constructionist process was further reinforced by activists, in particular people who use drugs, who raised awareness of the health conditions of users in Vancouver, as well as news media outlets that paid disproportionately more attention to the health problems facing people who use drugs compared to matters such as drug related crime. Taken together, these claims makers were successful in capturing the attention of politicians, and we see evidence of injection drug use being reconceptualised as a health problem by federal officials and policymakers. As a result of this social reconstruction of drug use at the federal level, the Canadian government in power at the time (the Liberals) ultimately approved the
establishment of a drug consumption room in Vancouver’s Downtown Eastside Neighbourhood.

In contrast, in England and Wales, at least since the late 1990s, injection drug use has and continues to have been framed as primarily a law and order problem by the central government. Although some claims makers, including politicians and police, have stressed the important public health role drug consumption rooms can play in reducing drug litter in public places, the central government continues to oppose drug consumption rooms out of concern that they would be in violation of international treaties by permitting the use of illicit substances at a government sanctioned facility. Furthermore, the central government supported the expansion of heroin prescription and heroin assisted therapy clinics, not necessarily because of their health benefits for users, but rather their potential to prevent people who use drugs from engaging in drug-related crime such as theft and violence in order to acquire money to purchase drugs.

The distribution of political power is important to this paper primarily because it helps to explain why drug consumption room policy development initially only occurred in British Columbia, primarily in Vancouver. While Canada enacted landmark policy by being the first country in North America to approve the establishment of a drug consumption room, it is only since January of 2016 that the federal government has approved the opening of more facilities (seven to date- three in Montreal, Quebec; three in Toronto, Ontario; and one in Vancouver, British Columbia) (Zimonjic, 2017; Woo, 2016). The federal government approved the establishment of InSite after it heard a strong level of support expressed from the mayor and city council of Vancouver, Vancouver’s public health department, as well as the British Columbia government and its health minister. The procedure set up by the federal health ministry in 2002 mandated that the government must only approve drug consumption
rooms if they have the support of the local community within which they would be located. This in part explains the lack of movement by the federal government in approving the establishment of drug consumption rooms in the City of Toronto, where evidence suggests there was a notable lack of political support until as late as 2015. This policy was consistent with the federal government’s harm reduction policy in the late 1980s, when the then Health Minister, Perrin Beatty, offered to support and partially fund needle exchange programs only in provinces where there was support from the provincial governments.

In contrast, when the British Home Office decided to oppose drug consumption room establishment in England and Wales, there did not appear to be any consultation or acknowledgement of any municipal leaders in the country, which my evidence indicates can be explained in part by the country’s unitary political structure. In fact, the Home Office and the Home Secretary appeared to be influenced more by international political actors and agencies such as the United Nations and the international drug conventions than they were of municipal or subnational leaders and/or governments, which is in stark contrast to the situation in Canada. This can be seen most clearly in the case of investigations into the feasibility of opening drug consumption rooms in Brighton, England, which took place between 2013 and 2014. Recall that in Canada, municipal policy makers have generally announced their desire to open drug consumption rooms and have requested approval from the federal government to do so, while in contrast, in England, local policy makers in Brighton, including municipal public health officials, set up a commission to investigate the feasibility of drug consumption rooms. As opposed to requesting approval from the national government, such as was done in Canada, instead they sought opinions from Home Office regarding the feasibility of opening a drug consumption room in Brighton. Home Office responded by expressing concern that if Brighton opened a drug consumption room that it
would be contravention of British and international law, and in turn the commission responded by recommending against pursuing the proposed project further. Furthermore, an executive director of a top drug law consulting agency in the United Kingdom informed me that Home Office’s advice came more in the form of a directive instructing the commission not to pursue the matter any further (Personal Communication, May 22, 2014). Similarly, in 2001, when the then Home Secretary, David Blunkett, supported the expansion of heroin prescription across the country, it does not appear as though local approval or local public opinion were crucial factors influencing their decision. An exhaustive review of government documents failed to reveal any evidence from official meetings that the Home Office had to seek approval from any municipal authorities before committing to expand heroin prescription. Furthermore, when the Home Office established trials of heroin assisted therapy clinics in London, Brighton, and Darlington, once again, there is no evidence to suggest that they received (or had to receive) official support or approval from local official leaders in any of these cities before piloting their projects.

It appears, then, that unlike in Canada, in the United Kingdom, harm reduction policy developments in the early twenty first century were largely driven by central government rather than local or subnational governments. This is consistent with advancements and development in harm reduction policy in the late 1980s and early 1990s when needle exchange services and programs were initially established, funded, and ultimately expanded under the authority of central government and its health ministry, even when opposition existed from local and subnational governments such as Scottish Health Minister, the Glasgow Residents Council, and the Liverpool City Council. Social constructionist processes play a key role in the development of drug consumption rooms in Canada because the initial facilities were established and approved to government officials in response to high rates of
drug related spread of the Human Immunodeficiency Virus (HIV) and accidental drug overdose
death. In these cases, the criminal act of drug use was reconstructed as a public health problem
demanding a public health response, which helped set the stage for debates surrounding harm
reduction and drug consumption rooms. Furthermore, debates surrounding drug use morphed
into discussion about harm reduction and drug consumption rooms primarily in cities and parts
of Canada where the spread of the Human Immunodeficiency Virus (HIV) and accidental
overdose deaths were highest such as Vancouver, British Columbia, and Montreal, Quebec. In
turn, as is illustrated more fully in the second paper, outside of Vancouver and Montreal, the
rapid proliferation of discussion and debate surrounding drug consumption rooms has only
occurred within the last two years. And where discourse has emerged surrounding drug
consumption rooms (for example Toronto and Hamilton), once again, the evidence suggests that
in these cities injection drug use has been framed as a health problem and drug consumption
rooms have been socially constructed as public health facilities. This suggests that the impact
that the social construction of drug use has on federal drug policy is partially mediated by the
decentralisation of political power.

The federal government could have responded to the public health construction of drug
use in Vancouver by committing to establish drug consumption rooms across the country. While
in the United Kingdom, injection drug use has been framed as a public health problem by some
claims makers (particularly those from the city of Brighton), it has occurred on a significantly
smaller scale compared to what has taken place in Canada. Furthermore, the central government
has not responded to injection drug use as a public health problem in the same way that the
federal government has done so in Canada. The rate of accidental drug overdose death was
particularly high here, and this resulted in the emergence of discourse about drug consumption
rooms. However, the link between the public health construction of
and drug consumption room policy development was limited in the United Kingdom due to the non-federal, centralist structure of the British government. If the governance of England and Wales was structured federally, it is possible that a subnational government representing Brighton might have approved and funded the establishment of a drug consumption room. This might have been particularly the case if healthcare was mandated to subnational governments in England and Wales. However, as healthcare, law, and the administration of justice all fall under the authority of the central government, and as the central government has up until now opposed drug consumption rooms, then the local discourse framing injection drug use as a health problem could not be translated into political action supporting the establishment of drug consumption rooms.

Turning to the fourth dissertation chapter, here a similar question is posed but at a different level: what socio-political factors help to explain why cities’ authorities decide to either support or oppose the establishment of drug consumption rooms. My analysis focussed specifically on Vancouver, where the first drug consumption room was established in 2002, and a second was more recently established in January 2016; and Toronto, where city officials began to express support for drug consumption rooms in 2016. Utilising Simon Lenton’s theory of drug policy change, I conclude that several conditions existed in Vancouver but not Toronto which help explain why drug consumption rooms gained local support in the former city much sooner than in the latter. These included public support, law enforcement support, and favourable political circumstances. While in Vancouver, public opinion polls in 2001 indicated strong public support, in Toronto, polling in 2003 and 2009 indicated that the vast majority of residents were either opposed or expressed “mixed feelings” about drug consumption rooms. Second, Larry Campbell’s landslide 2002 mayoral victory along with the overwhelming success of his municipal council party, the Committee
of Progressive Electors (COPE), indicated that drug consumption rooms would be a politically viable move since Larry Campbell and his party collectively campaigned together on a commitment to open drug consumption rooms within thirty days of taking office. In contrast, in Toronto, due to mixed public opinion surrounding drug consumption rooms, mayors and city politicians were reluctant to support drug consumption rooms as they did not see their establishment as a policy position that could necessarily survive the scrutiny of a civic election. Furthermore, between 2010 and 2014, Toronto was led by an ultra-conservative mayor who styled himself as a tough on crime politician and relied on a conservative support base that likely was opposed to illicit drug use. Thirdly, whereas in Vancouver police chiefs and police officers have supported the establishment of drug consumption rooms since the early 2000 when harm reduction proposals were being discussed and debated, in Toronto police chiefs and police officers have been strongly opposed to drug consumption room establishment. In July of 2016 City Council reversed its decade long opposition and supported drug consumption rooms, which can be largely explained by changes in the socio-political factors.

Online surveys carried out by the Toronto Board of Health in the spring of 2016 found that, across the city, the vast majority of residents (between 85-96%) believed that drug consumption rooms were beneficial whereas only a small minority expressed concerns. The evidence from these online surveys suggested that a political climate existed in Toronto in which city council and mayoral support for drug consumption rooms would likely not have been perceived to be politically risky. For this reason, we should not be surprised that, in July of 2016, there was overwhelming support for drug consumption rooms around the council table as well as an endorsement from current Toronto Mayor John Tory. Lastly, the change in council position can be explained to an extent by the change in position of the current
police chief, Mark Saunders, who is the first senior police officer in Toronto history to come out in support of drug consumption rooms. Taken together, the change in these three factors helps to explain why, although city council has opposed drug consumption rooms repeatedly and continuously over the past decade, this suddenly shifted in the summer of 2016.

This fourth chapter serves to illuminate the discussion of the relationship between the distribution of power over healthcare and drug consumption room policy development in Canada. Whereas, in England and Wales, discussion and debate surrounding drug consumption room development has occurred almost exclusively by the country’s national government, in Canada we see here the active role that subnational governments play in the policy process. This is, in part, the result of the recent 2015 Respect for Communities Act which makes it an obligation of the federal Health Minister to take into serious consideration the attitudes of local political officials including mayors and police chiefs when deciding whether or not to approve the establishment of a drug consumption room in a certain community. Such legislation does not exist in the United Kingdom, and furthermore, while the British government has solicited opinions from the Association of Police Chiefs on drug consumption rooms (composed of local police chiefs), these discussions pertained to drug consumption rooms more generally, and not the establishment of drug consumption rooms in any particular localities. Further, in discussions and debate surrounding drug consumption rooms, local politicians including mayors have not been consulted. Certainly, there is no evidence of any occasions where the national government has discussed the possible establishment of a drug consumption room in a particular location, and where they have consulted local officials in that city in order to make their decision. Instead, as noted in the first chapter, the central government was consulted by Brighton officials about their possibly
opening a drug consumption room in the city, and the government responded by recommending strongly against it.

IMPLICATIONS FOR THE FUTURE OF DRUG POLICY IN CANADA

There appears to be a potential movement towards drug consumption rooms occurring in Ontario at the moment (Duffy, 2017). The City of Ottawa has joined Toronto in formally submitting an application to receive an exemption to the drug law in order to operate a drug consumption room. While Ottawa Mayor Jim Watson has, for years, been expressing firm public opposition to drug consumption rooms, there are signs that he may be softening his approach. Mayor Watson has long supported the need for more funding to funnel into drug treatment programs, and in the spring of 2016 he told the press that, although he personally continues to oppose such drug consumption rooms, he will accept the decision and judgments of Ottawa’s health board, if they feel that such facilities are a necessary part of treatment (Reevely, 2016). Furthermore, in January 2017, Mayor Watson wrote a letter to be included in an application package being put forth by the Sandy Hill Community Health Centre, a public health organisation in Ottawa that is interested in establishing the city’s first drug consumption room. Mayor Watson indicates in the letter that the decision on whether or not to support a drug consumption room ultimately lies with Ottawa’s public health department (Willing, 2017).

In fact, according to the Respect for Communities Act, the federal government requires information on levels of support from both the health board and city council. Mayor Watson’s attempt to defer judgment to the health board may be an attempt to indirectly support drug consumption rooms even though he has opposed them in the past and continues to personally oppose them to date (Willing, 2017). However, the political benefit behind maintaining opposition to drug consumption rooms may be questionable, given that recent
public opinion polls conducted online suggest that the majority of Ottawa residents now support these facilities (Duffy, 2017). Mayor Watson’s decision to discontinue expressing vocal opposition to drug consumption rooms may indicate that he no longer perceives the opening of such a facility as being an electorally unsurvivable move with regards to the October 2018 municipal election. However, his decision to defer responsibility to the health board may suggest he still has political or personal reservations about drug consumption rooms (such as concerns over how supporting drug consumption rooms might impact his success in the next municipal election). More research needs to be carried out in this area.

Across Ontario, both in London Thunder Bay are in the midst of carrying out feasibility studies of drug consumption rooms (Richmond, 2017). In Hamilton, the Board of Health voted almost unanimously (Councillor Lloyd Ferguson was the only member to vote against the motion) to begin surveying the public about attitudes toward drug consumption rooms. The Health Board is now moving quickly to complete a feasibility study given the now less stringent requirements being proposed by the current federal liberal government (Van Dongen, 2017). While the Hamilton Health Board’s vote is undoubtedly an important drug consumption room policy development for the city, it is important to situate it within a wider context. Toronto’s City Council similarly endorsed (almost unanimously) a feasibility study of drug consumption rooms in 2005. The study was not complete until seven years later (2012), and while the study strongly recommended the establishment of drug consumption rooms across the city, politicians including then Mayor Ford, then Deputy Mayor Holyday, then police chief Bill Blair and then Health Minister Deb Matthews rejected the study’s findings and opposed drug consumption rooms. Furthermore, the same feasibility study endorsed the establishment of drug consumption rooms in Ottawa, where it was similarly rejected by then (and current) Mayor Jim Watson and then (and current) police
chief Charles Bordeleau. History shows that positive findings and recommendations from feasibility studies do not automatically predict local political or public support for drug consumption rooms.

Across the country, the provincial government in Alberta has now publicly announced that it is planning to support applications for the establishment of drug consumption rooms in both Calgary and Edmonton (Kornik, 2017). Alberta may be a surprising location to see harm reduction policy development, given that it has been governed by right-of-centre provincial parties over almost a century (Canadian Broadcasting Corporation News, 2015). Furthermore, the vast majority of Alberta’s federal parliamentarians represent the Conservative party, which for years opposed drug consumption rooms (Elections Canada, 2017). Nevertheless, it is important to remember that, as anomalous as it is, Alberta is governed by the left-of-centre New Democratic Party (Canadian Broadcasting Corporation News, 2015). But as this dissertation has shown, the partisanship of political parties plays only a small role in explanations of drug consumption room policy development, and in this case it appears that a significant factor influencing the health ministry in Alberta is the recent fentanyl overdose death crisis. The government reports that up to September 2016, 338 people died of apparent opioid overdose death, and of them, 193 were attributable to the more potent drug fentanyl (Logan, 2017). Revisiting the second chapter of this dissertation, we can recall that John Kingdon’s multiple streams theory suggests that the alignment of political conditions and social problem can increase the likelihood that policy change will occur. Politically, a more liberal and progressive government has been elected to power. But more importantly, in terms of the problem stream, an extremely serious opioid overdose death emergency has been recognised, and this seems to have galvanised the government to take action and make preparations to support the opening of facilities in the province’s two largest cities.
At the federal level, there appears to have been significant change in both the problems and politics streams. First, within the problems stream, medical expert claims makers along with politicians including New Democratic Party Member of Parliament Don Davies have defined the current high rates of opioid overdose death as a “national health crisis” and have called on the government to move quickly to address it (Zimonjic, 2016). Medical health experts, including Dr. David Juurlink, the head of pharmacology and toxicology at Toronto’s Sunnybrook Health Sciences Centre, are pressing the federal government to declare the problem a “public health emergency” (Ireland, 2016). The recognition of a healthcare emergency has allowed for a large policy window to open in the problems stream, which in part explains the government’s shift in position on drug consumption rooms. While Jane Philpott has supported drug consumption room establishment since her appointment to the cabinet post of Minister of Health, as of August 2016, the health ministry had no intentions of repealing or making any changes to the current drug consumption legislation under the Respect for Communities Act. However, in September, less than a month later, in response to Member of Parliament Don Davies’ calls for the government to quickly address the “opioid health crisis”, the health minister altered her position, calling upon her staff to take into consideration the emergency and in turn review the Respect for Communities Act and remove or amend any sections that present unnecessary barriers to cities establishing drug consumption rooms quickly for the purposes of reducing opioid deaths (Zimonjic, 2016).

Secondly, within the politics stream, in 2015 we saw a significant change in power when the right-of-centre majority Conservative government was defeated and replaced by a majority left-of-centre Liberal government (Elections Canada, 2015). Among other things, Prime Minister Justin Trudeau’s Liberal government promised to fully legalize and regulate cannabis use and sale (Liberal, 2017). However, the third chapter provides an important
lesson that can be applied here: namely that despite an alignment of policy streams at the federal level, this does not mean that we should automatically expect to see immediate policy changes across the entire country. Because drug consumption rooms have been framed within the Canadian context as medical solutions to a national healthcare crisis, this results in drug consumption room policy falling largely under the jurisdiction of the provinces, who have constitutional authority over the administration of health care. Since the government traditionally avoids infringing on the province’s jurisdiction over the administration of healthcare, they are unlikely to approve the establishment of drug consumption rooms in provinces where the provincial premier and healthcare officials oppose drug consumption rooms. This is exactly what we saw during the 1980s when the federal government encouraged provinces to establish needle exchanges, but did not force such programming on the policies, as this would have in effect been an infringement on the provinces’ authority over the administration of healthcare in a manner they see fit. One option that is available to the federal government is that they could amend the law in order to remove barriers such as the requirement of support from the mayor and/or the provincial health ministry. But again, it is unlikely that the federal government will do this, in light of the history of federal provincial relations regarding healthcare that is outlined above and discussed in more detail in the third dissertation chapter. Presently, the Saskatchewan Minister of Health has indicated that his government is not looking into drug consumption rooms at the moment (MacPherson, 2017). They made the announcement in response to calls made from the Saskatoon Tribal Council to see drug consumption rooms established (Bridges, 2016). As of September 14th, 2017, there have also been no comments made by any officials from Manitoba, New Brunswick, Nova Scotia, or Newfoundland and Labrador. To what extent this matters is Questionable; however, it is noteworthy to bear in mind that Prime Minister Justin Trudeau and his Liberal government campaigned on a platform that involved working
more closely with the provinces and provincial leaders (Liberal, 2017).

Despite the fact that the Saskatchewan health minister has opposed drug consumption rooms, and there has been no word from provincial authorities in the provinces noted above, it is also unclear whether or not there have been any discussions about these facilities among local politicians or health boards. It might be interesting to consider whether these provincial governments would oppose drug consumption room establishment if there are municipal health department, health boards and/or city councillors advocating for them. I anticipate that there will continue to be considerable opposition from Saskatchewan’s Health Minister. The health minister has said that the government is not looking into the establishment of drug consumption rooms at the moment; however, Alberta’s health minister made a very similar claim this past spring, and yet they have since then altered their position. But in contrast to Alberta’s current New Democratic Party government, Saskatchewan is governed by the right-of-centre Saskatchewan Party, and similar to Alberta, the vast majority of Members of Parliament represent the Conservative Party at the federal level (Elections Canada, 2015; Elections Saskatchewan, 2016). Again, however, political leaning is only part of the story and a more compelling answer comes from the past behaviour of the government. Recall from the second chapter of this dissertation that, in 2009, it was the same Saskatchewan Party who, under the same Premier Brad Wall, decided to place a cap on the number of needles that could be handed out by needle exchange facilities, citing the fact that more money and resources should be funnelled into drug treatment and drug prevention that aim to end drug use as opposed to harm reduction programs that tolerate drug use.

Are there any lessons on offer in this dissertation that can be used to better understand the current policy transition taking place with respect to recreational cannabis use? The
federal liberal government tabled legislation in the House of Commons on April 13th of 2017 (the “Cannabis Act” which proposes to legalize and regulate the possession and sale of small amounts of cannabis for recreational purposes (Government of Canada, 2017). The experience with harm reduction suggests that the proposed Cannabis Act may not be met with a considerable amount of opposition. After all, the Liberals have a majority government and so assuming that all members of the Liberal caucus support the legislation, then the new legislation is likely to pass relatively easily (Elections Canada, 2015). There may be attempts made by opposition parliamentarians to slow the debate down, and the senate may request revisions when they read the bill, but nevertheless, its passage to into law is quite assured. This is furthermore supported by the fact that most recent public opinion polls indicate that a majority of Canadians support legalisation across all regions of the country, thus demonstrating that a policy window is open wide in the politics stream (Leblanc, 2016). Similarly, the Respect for Communities Act was passed in 2015 with relative ease. Despite significant opposition, the Conservatives had a majority and were thus able to pass the bill into law with little difficulty.

With that said, this dissertation has shown that things become far more challenging at the level of administration when it comes to harm reduction as provincial and municipal governments and political leaders play an important role in determining not only whether or not harm reduction strategies should exist, but how they should operate as well. Ontario Premier Kathleen Wynne was the first provincial premier to come out and publicly support legalising recreational cannabis use, and she has indicated that she would like to see cannabis sold within stores operated by the government controlled Liquor Control Board of Ontario (Benzie, 2016). However, this poses interesting questions for the rest of the country, where
similar stores do not exist. Whereas Ontario this year began allowing for liquor to be sold in a select number of grocery stores, all forms of alcohol have been available for sale in grocery stores as well as variety and corner stores in Quebec for decades (Canadian Press, 2015; Government of Ontario, 2017).

Furthermore, while liquor sales are restricted to those over 19 years of age in Ontario, they are available to those 18 and older in certain provinces including Quebec and Alberta. In Alberta, liquor is exclusively through private retailers, and so the sale of recreational cannabis, in following the alcohol model, would have to operate much differently there than in Ontario (Canadian Press, 2015). Indeed, the proposed Cannabis Act indicates that provinces will have the authority to determine how cannabis will be sold in retail outlets, whether or not it should be sold in liquor stores or separate storefronts, whether and where it consumed within public spaces, and how cannabis production, sale, and possession will be monitored and inspected (Maccharles, 2017). It appears that, consistent with needle exchange and drug consumption room policy in Canada, there will be considerable cross-provincial variation in cannabis policy despite a new federal cannabis law that will apply to the entire country. Indeed, this is preliminary evidence that the federalist structure of Canada will quite possibly influence the subsequent development of cannabis policy across the country. More research needs to be carried out in this area, but this preliminary conclusion points to the possibility that the political structural argument made in this paper can be extended beyond harm reduction and be used to explain other forms of drug policy change in Canada and around the world.

In conclusion, Virginia Berridge (1999) has called for research to examine comparatively, and cross-nationally, the historical trajectory of harm reduction policy
developments in multiple countries in order to develop a better understand of the “levers” of harm reduction. This dissertation has attempted to respond to Berridge’s call using sociological theory and methods. Collectively, the three papers in this dissertation have demonstrated that harm reduction policies, including needle exchange and drug consumption rooms, are more likely to be supported and established by governments during times when injection drug use is predominantly framed as a public health problem. But it appears as though this relationship is influenced by power structures.

The three papers of this dissertation have demonstrated that the impact that public health frameworks of injection drug use have on the development of harm reduction policy development is mediated by the unique ways in which power over the administration of healthcare is distributed across political institutions. In a country like the United Kingdom where power over healthcare is centralised within a national government, we see historically instances of both rapid and expansive harm reduction development (such as occurred with heroin prescription in the 1920s and needle exchange in the 1980s and early 1990s) or next to complete stagnation in harm reduction development (as is currently the case with drug consumption rooms). In contrast, in Canada, a country where power over healthcare is decentralised and distributed across provincial governments, and checked by judicial bodies with the power to enforce healthcare rights, we see a more uneven development of harm reduction policy. The approval and establishment of needle exchange programs in provinces like Prince Edward Island and Newfoundland dates as recently as 2009, even though the first needle exchanges were established and opened in Ontario, Quebec, and British Columbia in the late 1980s.

This dissertation has attempted to advance a sociological understanding of harm
reduction policy development. It proposes that the development and trajectory of harm reduction policy is related to both the way in which injection drug use is socially constructed by influential members of society and the structural distribution of power over political institutions. The strength of these preliminary findings lies in the fact that they were not derived from just one place at one period of time. These conclusions have been derived from a study of harm reduction policy development between the years 1985 and 2017. They draw on findings pertaining to the development of multiple different harm reduction strategies including heroin prescription, heroin assisted therapy clinics, needle exchange programs, and drug consumption rooms. And they draw on insight from harm reduction policy developments in both Canada and the United Kingdom.

At present, the findings and conclusion derived from this dissertation regrettably remain tentative and tenuous. Despite the large data set retrieved and utilised in this project, the conclusions are based on policy making in only two locations. In order to strengthen these conclusions and increase confidence in the potential applicability of these findings beyond injection drug use as well as beyond Canada and the United Kingdom, more research needs to be carried out across more research sites and in places where socio-political and cultural circumstances vary more widely. Only then will be able to truly be able to develop an understanding of the “levers of harm reduction” (Berridge, 1999). A first logical step would involve research in similar Western nations with centralised and decentralised political systems. Potential countries of interest that have relatively centralised political structures include Western European countries such as France and Italy, and the Oceanic country New Zealand. In contrast, countries such as the United States, Australia, and the Federal Republic of Germany may be potentially interesting comparators due to their more decentralized political structures.

A second important step would be to move beyond the West and to consider the
extent to which the findings from this dissertation hold applicability for countries that reside in non-Western regions of the world such as Asia. There is a growing literature that is documenting and analysing harm reduction developments in Asian countries, such as the practice of methadone maintenance therapy in the People’s Republic Of China and Taiwan, and the introduction of needle exchange programming in Macau (see Cheung and Ch’ien, 1999; Stone, 2015). It would be beneficial to learn more about the political structures of these countries, in order to better understand the extent to which centralisation and/or decentralisation of power help to explain similarities and differences in the development of harm reduction policy across the Asian continent. It would also be useful to investigate the degree to which authoritarian (such as the People’s Republic Of China) and democratic structures (Japan) of government also play an important role in explaining similarities and differences in the development of harm reduction policies across the countries.

References


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