



A Critique of Canada's INSITE Injection Site and its Parent Philosophy: Implications and Recommendations for Policy Planning

Colin Mangham, PhD

Director of Research
Drug Prevention Network of Canada

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Abstract

This report provides a critical analysis of the evaluations done on INSITE, the drug injection site in operation in Vancouver, British Columbia, and billed as North America's first medically supervised injection facility. In doing so, it provides a documented historical discussion laying out INSITE's context within a national drug strategy that has been driven increasingly toward an ideology of harm reduction, as distinct from specific adjunct harm reduction strategies in support of a broader policy.

An informed critique is made of the specific published INSITE evaluations. Serious problems are noted in the evaluations' reporting and interpretation of findings. Specifically, the published evaluations and especially reports in the popular media overstate findings, downplay or ignore negative findings, report meaningless findings and overall, give an impression the facility is successful, when in fact the research clearly shows a lack of program impact and success. The published findings actually reveal little or no reductions in transmission of blood-borne diseases or public disorder, no impact on overdose deaths in Vancouver, very sporadic individual use of the facility by individual clients, a failure to reach persons earlier in their injecting careers and very little or no movement of drug users into long-term treatment and recovery. The fact that the evaluators and the funders of INSITE nonetheless have hailed the program as successful reveals a serious problem in drug policy today. It is argued that harm reduction has so permeated governments and the civil service and so politicized drug policy that evidence against the philosophy and its practice are being ignored, information is being managed in support of it, voices in opposition are decreasingly being included in drug policy dialogue and a culture of defensiveness has taken hold. This can only harm efforts to reduce drug problems and produce negative impacts on prevention and treatment, which are discussed along with other implications and recommendations for future policy directions.

This paper offers an independent critique of the evaluations of the INSITE supervised injection site in Vancouver, British Columbia and of the broader ideology of harm reduction that has given rise to such programs. To do so effectively, it provides first a historical context with an informed critique of harm reduction ideology as it has emerged in Canadian drug policy over the past decade. It then examines the published evaluations of INSITE, pointing out clear problems in how the findings have been reported and interpreted. Finally, it provides a discussion of the effects harm reduction ideology has dealt on treatment and prevention in British Columbia and in Canada and offers suggestions for reforms and rebalancing of drug policies to refocus on prevention and treatment.

INSITE refers to the supervised injection facility opened in Vancouver's Downtown Eastside, an area defined by high drug use, crime, public disorder and homelessness.

Background and Context: Harm Reduction Ideology

Certainly until the early 1990s and to a degree until five or so years ago, Canadian drug policy rested on an implicit understanding that drugs hurt individuals, families and communities. The primary policy focus at least on paper was reducing the number of new drug users through **prevention** and helping people hung up with drugs to get off of those drugs and to recover their lives through **treatment**. These two pillars together constitute what we have called **demand reduction**. A third policy pillar, **enforcement** or **supply reduction**, was intended to support the demand reduction pillar by reducing the physical, economic and social availability of drugs in society.

These pillars have varied in degree of emphasis. Prevention for example is always given lip service, but its story unfortunately remains one characterized by failure to implement on a substantial scale other than in the cases of tobacco and drinking driving. In both of these cases we have evidence of substantial impact.

Treatment has taken up much of public addictions budgets and has ranged in success. Larger scale studies suggest that, overall, 50 to 75% of illegal drug users entering substantive treatment (longer term - inpatient treatment and recovery) attain fairly stable abstinence.

As for supply reduction, contrary to popular criticism, evidence does suggest it has maintained a positive impact on drug use patterns. Current prevalence data in Canada shows current use of cannabis by the Canadian public over age 15 at 14%. For all other illegal drugs prevalence remains from 0.5 to 3%. These prevalence rates are very low compared to the 30% range of prevalence for tobacco use and about 80% prevalence rate for alcohol. (1,2) Clearly, our drug laws hold overall rates of illegal drug use at substantially lower levels than their legal counterparts. It stands to reason we benefit from these lower prevalence rates through lower public health and social costs. While we trade some of these savings for costs required to fight drug trafficking and other related crime, illegal drugs still produce substantially less costs than do tobacco and alcohol. The costs of tobacco and alcohol far outstrip the income they bring to governments.

Today, drug policy in Canada has taken a complete about face. Today, harm reduction has become the foundation of drug policy. How has harm reduction – the parent philosophy of INSITE and other initiatives to facilitate “safer” drug use – managed to overtake Canadian Drug Policy so substantially? Why do we now hear literally nothing about prevention or treatment and everything about the vital importance of such programs as INSITE? Is this an evolution, a progression or is it devolution, a regressing? What are the implications? This is a topic where complete objectivity is impossible for the very reason it involves values, worldviews and ideologies. It is the central topic of this section and constitutes a key theme of the whole report.

Harm Reduction: The Parent of INSITE

Harm reduction has no single, official definition. For purposes of this report harm reduction is defined as it manifests itself in Canadian drug policies today, as an ideology viewing drug use as **not only as inevitable, but as simply a lifestyle option, a pleasure to be pursued, even a human right**. In taking this view it purports to be “values-neutral.” However, harm reduction is not values-neutral. The phrase “values-neutral” is in fact an oxymoron. The drugs issue is replete with values and the need to find and express values. Harm reduction simply represents a set of values summed up as, “There is no right or wrong choice, and your choice is your business. No one should tell you how to choose, and once you have chosen others should only be there to help reduce the consequences of your choice until if or when you choose to choose differently.” This set of values is interwoven with libertarian ideology. It contrasts significantly with the values implicit in demand and supply reduction, which might be stated as, “Certain choices are better than others. The choice to get involved with drugs too often leads to trouble. Such choices affect not only the person but also his or her family, community and all of society. If people get into a trap with drugs, we will help them out of that trap and try to keep them alive while doing it. We as a society affirm this through our actions. And having a few drugs legal by tradition does not justify legalizing all drugs.”

Harm reduction has moved from idea to ideology in a relatively short time. This transition has **not** come about through public demand or grass roots community involvement. On the contrary, it has followed a course of gradual infiltration – a fairly deliberate process laid out in the following excerpt from a text written by some of Canada’s leading harm reduction ideologists:

Although harm reduction is at odds with the dominant legal-sanction-based policy, the middle range and pragmatic nature of harm reduction measures makes it possible for certain harm reduction strategies to be tolerated, accepted, or even incorporated by legal authorities, without completely dismantling the counter-productive punitive policy. The support and cooperation of the police in needle-exchange programs for injection drug users is one of several examples of the diffusion of genuine harm reduction elements into the existing drug policy, enabling change to occur, and thereby bringing about gradual policy reforms. (3)

In Canada, we are past the first steps of needle exchanges and methadone maintenance, but not so far as Europe. INSITE represents a middle stage harm reduction initiative, requiring exceptions to drug laws but not outright changes to drug laws. But in order to expand and replicate themselves, such measures as INSITE ultimately require forms of drug legalization. Legalization and regulation of drugs are central in harm reduction ideology. The two things are interwoven, and Canadian drug policy has become vulnerable to the drug legalization movement.

As recently as 1996 in Canada, harm reduction was discussed publicly mainly as a “stopgap measure” to help keep people alive until they could get treatment. (4) Since that time it has increasingly been called a drug policy pillar, such as in the Vancouver Four Pillars Drug Strategy (www.vancouver.bc.ca/fourpillars).

However, by 2004, the Canadian Centre for Substance Abuse formally declared harm reduction as the first guiding principle of drug policy:

One goal of substance abuse policy is to reduce the use of alcohol and drugs, but the first priority should be to decrease the negative consequences of substance misuse. The primary goal of harm reduction is to reduce the health and social problems associated with the use and control of alcohol and other drugs among individuals, families and communities. Abstinence from alcohol and other drug use is an important goal for some, but it is not necessarily the only acceptable or even the primary goal for all substance abusers.(5)

The Canadian Centre on Substance Abuse (CCSA) has had (and still has as acting associates) founding members of the Canadian Foundation For Drug Policy, an organization that presses for liberalizing drug laws and decriminalization of cannabis. CCSA has criticized international treaties and has blamed drug laws for much of the drug problem. CCSA today advocates a strong bias toward harm reduction ideology. Because CCSA presents itself as Canada's key agency in the area of substance abuse, was created by an Act of Parliament and receives substantial public funding, the overtaking of CCSA by harm reduction ideology carries serious implications.

The CCSA is not the only source of pressure for Canada to adopt harm reduction as the guiding ideology of drug policy. Both the Senate and the House Committees on Illegal Drugs sought and heard a preponderance of testimony from persons and organizations in favour of harm reduction ideology/drug legalization. In the case of the Senate Committee, the bias was evident from the beginning.

In the instance of the House Committee, witnesses were chosen by Committee vote, and the committee contained a majority of harm reduction ideologists. So, most witnesses chosen to appear were predisposed toward harm reduction. The result was a second, biased federal report calling for significant liberalization of drug policy.

The situation is not significantly different as we move to Vancouver, the location of INSITE. The sitting and previous two mayors of Vancouver are outspoken advocates of drug legalization. This document does not address the ethics of public officials making unsubstantiated statements that can have a profound impact on public perceptions of drugs that in turn can lead to increased use and subsequent problems. However, the Mayors' open advocacy for harm reduction, including INSITE, add to the overall pressure and expectation to implement those approaches.

It is within the context of harm reduction as guiding ideology that INSITE has come about. In fact, INSITE holds a showcase position in harm reduction ideology that inevitably places huge pressure on it to continue. Vancouver forms a testing ground. Quoting from the agenda of a 2000 Vancouver symposium on harm reduction: "Vancouver, in particular represents an important test case and centre for the implementation and evaluation of drug programmes and policies."(6)

This enormous pressure to push forward with harm reduction measures alone makes any evaluation of such measures the necessary target of the closest scrutiny. So many public figures have spoken out in favour of INSITE, before and without having evidence of its clear benefit, that any evaluation would be under huge pressure to affirm those statements. It is for this reason that I have provided such background before getting into the INSITE evaluations.

A Critique of INSITE Evaluations

The INSITE evaluations as reported in various research journals include considerable overstating of findings as well as underreporting or omission of negative findings, and in some cases the discussion can mislead readers. The reports show no impact on the key issues that would most warrant its existence: spread of HIV or other blood borne disease, getting clients into treatment and off of drugs, reducing overdose deaths. The reported impact on public disorder that is discussed is questionable and so limited in scope as to be misleading. "Straw horse" findings are reported that also can be misleading. These are findings that one would naturally expect but that lack any real meaning.

The most conclusive finding is not discussed to any extent in the reports. Data in all of the reports suggest that only a small percentage of IV drug users use INSITE for even a majority of their injections. Most drug users use it only some of the time or not at all. This finding illustrates a shortcoming of harm reduction measures that has recently been highlighted by Neil McKeganey in the UK: an inability to control a free moving population of IV drug users sufficiently to control disease in **the face of continued use of drugs.** (7)

The potential bias is so substantial in the evaluations and the findings so weak that any deep analysis of the research is risky, because such inadvertently might lend validation to reports that demonstrate little or no impact of INSITE on key behaviours. The overall impression one gets from reviewing the research is that much more is made of the data than is warranted. The research by no means supports expansion of INSITE. Rather, it suggests alternative treatments need to be tried that may hold much more promise for not only reducing disease but also getting people away from and off of drugs.

Review of Individual Evaluation Reports

Wood E, Kerr T, Montaner JS, Strathdee SA, Wodak A, Hankins CA, et al. Rationale for evaluating North America's first medically supervised safer injecting facility. *Lancet*. 2004;4:301-6.

This editorial commentary by the lead INSITE researcher and others criticizes United States drug policy in response to a visit to Vancouver by the head of the Office of National Drug Policy. The article fails to acknowledge important distinctions between Canadian and US policy in the use of enforcement and incarceration. It displays a general disdain for supply reduction but does not recognize the role of laws in reducing the physical, economic and social availability of illegal substances. These effects in turn have contributed to the very low overall incidence and prevalence of illegal drug use in Canada – less than 2% of the population aged 15 and over compared to 79% for alcohol and 32% for tobacco. (8,9)

Most of the evaluation articles show indications of bias. The greatest indicator of this bias is that none show strong results or impacts on important outcomes, but all use terms such as “optimistic,” “promising,” etc. The potential for bias is so great that when it shows itself, as it does in the evaluations, it is even more difficult to trust anything coming forth from INSITE.

The article also makes a rather fatalistic assertion that people will “inevitably use drugs.” This statement is an opinion and contradicts the potential of prevention.

Wood E, Kerr T, Lloyd-Smith E, Buchner C, Marsh D, Montaner J, Tyndall M. Methodology for evaluating Insite: Canada's first medically supervised safer injection facility for injection drug users. *Harm Reduction J*. 2004; 1-5.

This and the other published articles do not adequately acknowledge the potential for bias in the samples used. The progressive cohort design does not account for nor control for the fundamental potential of differences in control and treatment groups. The most significant difference is **motivation**. Attendees at the site demonstrate a level of motivation that those not attending INSITE do not. This can explain differences found, if any, and renders findings that make comparisons both weak and invalid.

Additionally, self-report is used at times in the study. The extreme pressure for INSITE to be seen to succeed brings self-report by clients and staff into question. In particular, INSITE staff members are heavily prone to the Hawthorne Effect, which refers to the tendency for groups who know they are being evaluated to act differently as a result. Even drug users have some potential for bias. The Vancouver Area Network of Drug Users (VANDU) displayed active bias in the media in the weeks leading up to the federal decision to extend INSITE on September 8, 2006.

The samples may be biased further by the presence of compensation for participation (\$20 per follow-up visit). Together with the fact that the evaluations rely completely on correlational data, this risk of sampling area considerably weakens the evaluations.

A crucial omission in the INSITE evaluation is the lack of any comparison treatment. INSITE can only be compared to the status quo, which one can argue has been brought largely about through inaction in prevention and treatment. This is an important limitation given the cost of INSITE and the implications for future use of resources. In order to fairly assess the worth of INSITE, it has to be compared to alternatives. One sample alternative would be the substantial and effective implementation of drug courts, accompanied by changes to make entry into long-term treatment easy and immediate. Without a comparison treatment, we have no way of knowing if any impact of INSITE, were it to occur, is more efficient and effective than that we could obtain in another way.

Wood E, Tyndall M, Li K, Lloyd-Smith E, Small W, Montaner J, Kerr T. Do supervised injecting facilities attract higher-risk injection drug users? *Am J of Preventative Medicine*. 2005; 29: 126-130.

The finding of this article illustrates the first of a number of “straw horse” findings that tend to inflate the overall significance of INSITE. A straw horse finding is one that is completely to be expected but that does not mean anything in and of itself. In this case the researchers fail to acknowledge, in saying INSITE reaches high risk drug users, that the population served is all high risk, particularly those using drugs regularly. Thus it is not a useful finding nor does it suggest success other than output (the number of people coming in). Output evaluations in treatment and prevention have been routinely criticized.

This article reveals that the facility fails to attract younger users where interventions would come earlier in their drug use career. It can be argued that the most potential for change exists among young users. It underscores the “after the fact” nature of harm reduction strategies in general.

The article includes data that show the relative infrequent use of INSITE by individual IV drug users. In this evaluation, 178 of 400 participating drug users utilized INSITE during the study period, leaving over 50% who did not use INSITE at all. Of the 178 who did use INSITE, over half used it for less than a quarter of their injections. These findings illustrate a trend that precludes INSITE effectively controlling injection drug behaviours.

Wood, E., Tyndall, M., Qui Z., Zhang, R., Montaner J., & Kerr T. Service Uptake and Characteristics of Injection Drug Users Utilizing North America's First Medically Supervised Safer Injecting Facility. Am J of Public Health. 2005; 5:770-73.

This article constitutes another version of the previous article. It largely describes demographics. The article makes the statement that "no adverse affects or harms were reported by INSITE staff." Given the powerful pressure for INSITE to be seen to succeed, staff self-report is not a valid method of data collection.

This article acknowledges that most clients live within a few blocks of INSITE. Neither this nor other articles offer an estimate of the number, size and cost of injection sites that would be needed to make it physically possible to accommodate even a significant portion of total drug injecting in the DTES, even if drug users utilized safe injection sites consistently, which the evaluations show clearly they do not.

Kerr T, Stoltz J, Tyndall M, Li K, Zhang R, Montaner J, Wood E. Impact of a medically supervised safer injection facility on community drug use patterns: a before and after study. BMJ. 2006; 332:220-222.

None of the published reports discusses the implications of the fact that 37% of DTES drug users inject cocaine. Cocaine injection is frequent – 10 or more times a day. They do not acknowledge the impracticality of attempting to capture a significant percentage of these injections at the site.

This article does acknowledge the possibility that INSITE may create some "risk compensation" based on the finding that there was an increase in incidence of cocaine use after INSITE started up. The possibility of such compensation (feeling safer because one uses INSITE, then engaging in other high risk behaviour) is overshadowed by the fact that a facility such as INSITE cannot, to a significant extent, accommodate cocaine injectors.

_This article mentions that no overdose deaths occurred at the site. We do not know if any of the overdoses would have resulted in death outside the site. The number of overdose deaths in Vancouver and the DTES has increased since INSITE started up. This fact at least suggests that in its 3 years of operation, INSITE has produced no impact on overdose deaths.

_This article reports that the facility does not keep people from quitting drug use or stop people from seeking treatment. While it is important to "first do no harm," this is not an adequate finding to use to continue a program of this scope. Moreover, the data collected are not adequate in scope to warrant these claims. We do not know what negative effects the facility may have had on the availability of treatment, given the preoccupation with INSITE. Neil McKeganey's research in the UK suggests such programs may actually have an adverse effect by drawing focus and efforts away from incidence reduction (prevention) and prevalence reduction (treatment).

Wood E, Kerr T, Stoltz J, Quia Z, Zhanga R, Montanera SG, & Tyndall MW. Prevalence and correlates of hepatitis C infection among users of North America's first medically supervised safer injection facility. Public Health. 2005; 119: 1111–1115.

This study only discusses correlates of having hepatitis C. Two of the factors - involvement in the sex trade and having been incarcerated – actually suggest that variables are at work over which INSITE has no control at all. A third factor, sharing needles, is one on which the evaluations suggest INSITE is having very little impact.

Wood E, Tyndall M, Stoltz J, Small W, Lloyd-Smith E, Zhang R, Montaner J, Kerr T. Factors associated with syringe sharing among users of a medically supervised safer injecting facility. Am J of Infectious Diseases. 2005: 50-54.

This report, if not read carefully, is misleading. It implies that use of INSITE is associated with reduced needle sharing. Actually, only **exclusive use** of INSITE correlates with reduced sharing - an example of a "straw horse" finding. If someone uses INSITE for all their injections, it goes without saying they would not share needles. Only about one in ten HIV negative participants reported using INSITE for all of their injections. Only four HIV positive participants reported using INSITE all the time. These are the most important findings in the study but are not reported.

Wood E, Tyndall MW, Lai C, Montaner JG, & Kerr T. Impact of a medically supervised safer injecting facility on drug dealing and other drug-related crime. Substance Abuse Treatment, Prevention, and Policy. 2006; 1:13.

As with the previous report, this article makes only a "no harm" claim. It fails to acknowledge or discuss the impact of police activity. In fact, there was a substantial police presence during the period of the study. The following is a quote from the Vancouver Police when asked about police presence at and around INSITE:

Yes, four officers per day, 22 hours per day, 7 days per week, for one year from Sept 03-Sep 04 in the block at all times with cell phone access directly to them by SIS staff. These officers were paid on overtime callout at double time for that whole year. The Vancouver

agreement paid for that. At the same time 60 other officers were deployed in a 5-block area and still are to this day. The police took care of public disorder. The SIS enhanced public disorder.

It is misleading for any inference to be made that INSITE had any impact on crime or on public disorder. Police presence more than accounts for any changes in either.

Wood E, Tyndall M, Stoltz J, Small W, Zhang R, O'Connell J, Montaner J, Kerr T. Safer injecting education for HIV prevention within a medically supervised safer injecting facility. Int J of Drug Policy. 2005; 281-284.

This article reports very little – that being involved in the sex trade or requiring help injecting correlates with receiving safe-injecting education at INSITE. The finding that a minority of clients studied receive any such education is itself a finding but is not mentioned. One would look for some evidence that INSITE was providing actual education regarding drug use and options available to clients. None of this type of education is described in any of the studies.

Kerr T, Tyndall M, Li K, Montaner J, Wood E. Safer injection facility use and syringe sharing in injection drug users. Lancet. 2005; 366:316-8.

This report ignores the significant negative implications of the fact that, of 431 drug users studied, only 90 used INSITE some, most or all the time. It does not recognize adequately that half of these persons still shared needles. Research showing modest changes in the amount of needle sharing among a small portion of users is not a positive finding.

Wood E, Kerr T, Small W, Li K, Marsh D, Montaner J, et al. Changes in public order after the opening of a medically supervised safer injecting facility for illicit injection drug users. Canadian Med Assoc J. 2004; 171:731-4.

This study is misleading in asserting changes in public order. First, the methodology is flawed. The risk of bias is far too great to use observation and counting by a single individual. This is especially true given the overwhelming threat of bias due to the expectations of success among all levels of government.

The number of discarded needles and wrapping really says nothing about public disorder; at best it is a crude index of injecting outside of the confines of INSITE. No assumptions can be made from the data described. When asked for indicators of public disorder, the Vancouver Police Department provided the following:

- 1) People (usually crack addicts/IV users) setting up flea market set-ups on sidewalks all over the DTES
- 2) People congregating in the lanes/on the sidewalks and fighting with each other over drug-related matters
- 3) Drug trafficking on the street by addicted/non-addicted individuals - creating public disorder problems with their activities
- 4) Violence and assaults related to the drug trade in the DTES
- 5) People urinating and defecating all over the place
- 6) Open drug use - both injecting and smoking of drugs
- 7) Psychoses after drug use
- 8) Mental Health issues
- 9) Movement of stolen property
- 10) Intoxicated individuals in the DTES - from both bars (although not many are open any more in the DTES) and consumption of intoxicants like rubbing alcohol and mouthwash
- 11) Garbage scattered from one end of the DTES to the other – generated by the addicted individuals in the DTES

The evaluations address none of these indicators of public disorder. Indeed, an injection site could do little about any of these problems unless it engaged actively in getting people into long-term treatment. These problems with public disorder can only be addressed by dealing with addiction itself.

Tyndall MW, Kerr T, Zhang R, King E, Montaner JG, Wood E. Attendance, drug use patterns, and referrals made from North America's first supervised injection facility. Drug and Alcohol Dependence. 2006; 83:193-198.

This report describes the demographic profile of INSITE clients. It is largely an assessment of output – the number of people served, etc. It also mentions that there were no overdose deaths in INSITE. Mentioning that there have been no overdose deaths in INSITE without qualifying it (acknowledging that overdose deaths in Vancouver actually have increased) is misleading.

Wood E et al. Attendance at Supervised Injecting Facilities and Use of Detoxification Services. N Engl J Med. 2006 June 8.

Of all the reports, this one best exemplifies the transformation of limited findings into something entirely different in the media. This report's only finding is that some INSITE users go to **detoxification** upon referral. It does not show that INSITE increases use of detoxification, nor, more importantly, does it show that INSITE produces any increase or effect on people proceeding to actual **treatment**. Detoxification is often called a "revolving door." Going to detoxification is by no means the same as going for treatment, and this is a well-understood fact. In the media, this finding was somehow transformed into statements that INSITE was getting people into treatment and off of drugs.

Impacts of INSITE on Other Aspects of Drug Policy

None of the evaluations of INSITE consider the effects it may have on other drug policy pillars, whether directly or indirectly. INSITE and any other harm reduction initiatives have to be considered in unison with treatment, prevention and enforcement. In this section the potential impacts of INSITE on these pillars is discussed.

Impacts on Prevention

The principal impact on prevention of harm reduction as a major focus of drug policy has been to produce a relative void in prevention development and activity. No incidence reducing (primary) prevention programs appears to have been named or supported by the Health Authority, provincial government, federal government (outside RCMP Drug and Organized Crime Awareness) or City of Vancouver for the duration of INSITE's operation. Federally, no Social Sciences and Humanities Research Council (SSHRC) funding was found to be going to prevention-related research.

One formal prevention activity found to occur in B.C. for the term of INSITE was *A Dialogue on the Prevention of Problematic Drug Use*, a federally and provincially funded symposium in Vancouver in 2004. As the name suggests, the focus was on what was termed problematic drug use. The proceedings show clearly that little or no interest was paid to reducing the incidence of drug use. This carries serious implications because the key means to prevent incidence of addiction is to prevent drug use onset, and early illegal drug use onset (i.e., cannabis) is linked to significant increase of risk for later addiction and other drug problems. (10,11)

We cannot explicitly blame INSITE for this void. The parent philosophy itself is at fault. However, it is alarming to know that many supporters of INSITE want to see even more money put to such programs. This too would be money not available for other drug pillars. Given the ineffectiveness and inefficiency INSITE has shown, such spending would be considered unwise.

Impacts on Treatment

Similar to prevention, no expansion or innovation has been evident in treatment in Vancouver or in B.C. for years. A portion of blame for this inactivity must be placed on the Vancouver Coastal Health Authority and on provincial and federal governments for focusing almost entirely on INSITE. In interviews with directors of five area treatment facilities in association with completing this report, all reported having neither any connection to INSITE nor any clients coming to them because of INSITE. All supported some form of compulsory treatment, and all indicated that treatment, not INSITE, was the key to reducing drug problems including addiction, crime, disease, mental health issues and public disorder. None were consulted by INSITE or its proponents, nor did they know of colleagues who were. All reported their facilities as being badly short of funding. Each receives only \$40 per day for each client in residential care, and no change or increase in funding has been received from Vancouver Coastal Health Authority in the past 12 years. All reported waiting lists, from weeks to months. All but one reported going to a fee for service system, further placing treatment out of reach. All persons interviewed indicated that this creates a serious problem for addicted persons who may only briefly reach a point where, on their own, they will seek treatment.

Clearly, INSITE has not considered links to treatment in its planning. Even if INSITE staff actively worked with clients to get them into treatment, it appears such is not at all adequately available. Treatment as a policy pillar, like prevention, has been largely neglected in pursuit of harm reduction strategies.

Impacts on Enforcement

Little comment can be made here regarding the effect of INSITE and/or its underlying ideology on the

enforcement pillar. It is particularly difficult to obtain a full picture of because the Vancouver Police Department officially is on side with the project. Impacts INSITE and its parent philosophy may have on the enforcement drug strategy pillar likely will come through impediment of enforcement. In order for INSITE to operate, enforcement exemptions have already been necessary. More would be necessary in order to expand the project in scope. Over the longer term, if the project continues, it is entirely likely that some form of drug distribution will be requested.

The ideology underlying harm reduction as promoted today is on a collision course with enforcement. Proponents of drug policy reform in the form of legalization and regulation, which include many policy makers and advisors at the provincial and federal levels, leave little doubt they want to change Canada's drug laws. In some cases the lines are quite blurred between policy makers and law reform activists.

Recommendations for Future Action

The failure of INSITE to show, in three years of operation, impact on disease or on users achieving abstinence and recovery are not surprising. Two current examples are found in other countries: The UK and Australia.

In the UK very recently, the entire focus and preoccupation with harm reduction strategies has been called into question. Notwithstanding a strong harm reduction focus, HIV and hepatitis C levels remain high. And at least one researcher is questioning whether rises in drug use incidence may outmatch the system's ability to cope, expressing concern that prevention may have been overlooked with very negative consequences. (12) Raising such concerns is courageous in the current environment in which harm reduction seems sacrosanct.

In Australia, the King's Cross Injecting Room was also the subject of an extensive evaluation sponsored by the New South Wales government. However, a team of independent researchers and practitioners critiqued the evaluations (13) and found much the same pattern as this critique has of INSITE. They noted large differences between what was in the report and what was published in the media where the injection room was declared a success.

From this report, it appears at least that similar dynamics may be at play in Australia as in Canada. This process might be described as follows. A new ideology (harm reduction) takes over policymaking and develops a momentum all its own through self-selection (hiring, funding practices), management of information and progressively cutting off other options as it seeks justification to continue. More dangerously, it selectively seeks evidence supporting itself and runs the risk of ignoring anything and anyone that disputes it.

This and the UK case provide but two examples of "red flags" that, at the least, should warrant a careful stepping back and examination of drug policy, how it has evolved and what forces are driving it.

Harm reduction ideology is alive and well in Canada, and before any honest and open dialogue can be held about drug policy, some form of action to stop its momentum will be required. And unfortunately, harm reduction ideology has politicized drug issues, as evidenced by the sharp criticisms and even political threats directed at the federal government as it considered whether or not to continue funding INSITE. This politicization makes it even more difficult to step back and have an even-handed discussion of drug policy.

The infiltration of drug policy with harm reduction has involved co-opting organizations, selecting staff and funding practices that effectively cut off dissent. Today, having a room full of policy makers say they are all on board is not particularly meaningful. Any disagreement was taken care of long ago at all levels of government.

All of this has significant implications. How can INSITE, the further facilities it could lead to and other ideologically harm reductionist programs be stopped or slowed until we can back up and look openly and objectively at drug policies? How can we embark in a consultative process that is not selective and biased, as were the Senate and House Committees on Illegal Drugs?

Here are some recommendations for consideration as we move forward.

- 1. Depoliticize drug policy** by making clear that harm reduction is not about compassion and caring for the marginalized and poor. A great deal of marginalization comes not before but after addiction has taken hold and begins to consume financial and personal resources. Some poverty and marginalization comes about through preexisting mental illness. There is no reason that, in a modern and advanced society, mentally ill people should be left to fend for themselves. The entire system of identifying mental illness and protocols for taking care of them needs to be strengthened. Otherwise, more and more mentally ill persons will drift into the hellhole that is life on the street in the DTES. Addiction needs to be recognized as a major cause and contributor to all other medical and social problems a person experiences. Policy must make clear that dealing with the addiction comes first.

2. Strengthen treatment and create mechanisms to get people into treatment. The road from street to treatment needs to be opened up widely. Presently, some policymakers place little priority on abstinence. These people need to be made to understand that getting off of drugs is the first, not last, step to recovery into a stable existence. If policymakers sit down with the people running long term care treatment facilities, certainly ways can be identified to get people off the street into treatment forthwith. We already know that treatment need not be voluntary to be effective. It is time to put into place mechanisms that direct people into treatment who, because of their addiction, either break the law or are putting themselves and others at significant risk. Sweden has accomplished significant success with compulsory treatment and has among Europe's lowest crime, disease, medical and social problems stemming from addiction. Recently, a UN report described Sweden's success with their restrictive drug policy supported by all national political parties:

A compulsory care order in Sweden can only be issued if certain legal conditions are met. The two conditions are: (a) that the person is in need of care/treatment as a result of ongoing abuse of alcohol, narcotics and volatile solvents and that (b) the necessary care cannot be provided under the Social Services Act. The first option for the substance abuser is always voluntary treatment under the Social Services Act. The social welfare committee, which works on the prevention and countermeasures of abuse of alcohol and other addictive substances, acts in consensus with the individual. (14)

As a matter of fact, Canada would be well advised to examine Swedish drug policy carefully, so distinct are its relative successes compared to similar European countries pursuing harm reduction-focussed strategies. The research described in the report is most encouraging. Given that Sweden is not a conservative country, it may show a way to depoliticize drug policy in Canada. The only beneficiaries of politicized drug policy are the members of the drug legalization movement.

3. Examine national drug policy, how it has gotten where it is and take action to refocus it. Present drug policy is largely a "hijacked" policy that has become influenced by and susceptible to the movement to legalize and regulate drugs. Federal government support exists for creating a new drug strategy affirming demand and supply reduction as key pillars. This includes initiating and carrying out an open consultative process that includes many groups that have gone unheard for a long time such as recovering drug users, treatment and recovery workers, incidence-reducing prevention professionals, businesses, addiction medicine specialists who have not agreed with harm reduction but have not been heard, youth who do not use drugs and, very importantly, parents, youth organizations, and other institutions and organizations with a stake in Canada's youth and their future.

4. Rein in the civil service and other government created and funded bodies. This paper has pointed out examples of a civil service operating independently of elected governments in setting drug policy directions and has cited specific examples of conflict of interest arising from a mixing of drug reform activists in with and as policy makers. There is currently no check on civil servants and others. In a democracy, such things as drug policies must be transparent to and involve the voice of the people. Without significant checks and a balancing in the civil service, harm reduction ideology will continue to propagate and sink roots in policy and programs so as to become very difficult to reverse. The federal government got a taste of this recently as they considered the extension of INSITE.

5. Make drug policy permanently transparent and with balances. Drug policies and strategies must not be able to be constructed in back room committees, through self-selected coalitions and through information management. To the greatest extent possible within a general framework, local communities should be able to generate their own drug policies. If national policy is clear and built on sound principles, then communities can build on these sound principles.

6. Affirm a national commitment to reducing drug use and to getting people off of drugs. These principles have become lost in recent years, and we have paid a price in reduced public awareness and attention to drug issues and the risks attendant with drug use. If the government makes it clear that it wants to help families help their children and youth grow strong and free of the snare of drugs and that it cares for its citizens who are caught up in addiction and all the constellation of problems that go with it and will do all possible to help them off of drugs, then the families and communities of Canada become involved and have a rallying point. For some time now, drug policies have formed a rallying point mainly for drug legalization activists in and out of government.

7. Support and take action now in primary prevention. As we speak, a new cohort of Canadian children are growing up in an atmosphere void of positive prevention messages

except for what they might get at home or in a school program such as DARE. We know that when people start using cannabis in their teens, they are then more likely to go on to other drugs. It is some of these people who will, in a number of years, be in places like the Downtown Eastside. It makes sense then to work to address the factors that are causing young people to start using.

8. Support community partnering. Finally, communities are at the very root of action to address drug problems. Communities are where people live, raise children, work and play. Yet communities often are pulled apart, isolated and do not use nearly their potential in strengthening the ties that hold society together to buffer against crime, antisocial and self-serving behaviour. Drug use can often be merely a symptom. Anything we can do to increase cohesion, order, altruism, neighborliness, compassion and caring in communities as well as integrity and responsibility in youth will pay great dividends. Today, law enforcement plays an important role as one of the few institutions people can look to for leadership and a sign that things aren't yet "gone to hell in a handcart." Police can play a significant role today in helping pull a community together by providing a stable partner, offering leadership in prevention, lending authority and credibility to actions, and informally acting as an example and mentor in building up the community and its members, especially its young members.

Acting on recommendations such as these, governments and citizens can rebalance Canadian drug policy and ensure that we do not become locked in by ideology to strategies that miss the point in addressing drug problems but become unassailable because of political correctness.

Dr. Colin Mangham is recognized as one of Canada's foremost leaders in the theory and practice of prevention. He has taught, conducted research, trained, worked with the field, and developed, evaluated and implemented programs for governments and provincial and local community and school organizations in Canada since 1979. He is also the author of numerous prevention programs for youth and parents that are in use across the country today and that reflect evidence-based best practice in the field. Some of these include *Your Life Your Choice*, *Making Decisions I and II*, *Making Decisions: Classroom resources for Grades 8 and 9* and *By Parents for Parents*. A fervent advocate for primary prevention and healthy youth development, Dr. Mangham is Principal of Population Health Promotion Associates and serves on a volunteer basis as Director of Research for the Drug Prevention Network of Canada. He holds a PhD in School and Community Health from the University of Oregon.

I declare that I have no proprietary, financial, professional or other personal interest of any nature or kind in any product, service and/or company that could be construed as influencing the position presented in, or the review of, the manuscript entitled
except for the following:

I am affiliated in an unpaid capacity with the Drug Prevention Network of Canada. This information is based on a report produced for the Royal Canadian Mounted Police, a national partner with Insite.

Where views are expressed they are my own. The findings are based strictly on research conventions.

Colin Mangham

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