Conditions of Possibility:
Bio-power and governance in the quest for a supervised injection site in Toronto

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Foreword

My plan of study draws upon a governmentality framework to investigate new modes of social service planning in the City of Toronto, with a particular focus on policy debates concerning supervised injection sites. My first learning goals are: to explore and expand my knowledge of governmentality studies; and to successfully create a governmentality analytical framework for debates relating to the study of social service provisions. My analysis of the Toronto Drug Strategy and media reports about supervised injection sites achieves this. My second learning goal pertains to the study of urban planning in Toronto. This learning goal has been achieved by investigating City of Toronto planning reports, as well as official plans and bylaws relevant to the provision of social services, in order to develop an analysis City of Toronto planning for social services. Lastly, my research topic also allows me to work towards my third learning objective to further research on social policy. I have attained this by developing an analysis of the institutional response and approach to “social” problems in Toronto.

Abstract

Drawing on Michel Foucault's bio-power lens, this paper argues that supervised injection sites are political and governmental spaces that have emerged from the harm reduction movement as an alternative to prohibitionist approaches to drug use. Within this movement, harm reduction as a "health" policy has emerged as the new truth discourse in which to justify supervised injection sites as the most appropriate technique to address urban drug problems. However, supervised injection sites do not actually function as a form of health care in the traditional sense of optimizing life and wellbeing. Drawing upon secondary and primary textual sources and using the creation of *The Toronto Drug Strategy* (2005) as my analytical focus I show how supervised injection sites operate new governmental and political spaces that naturalize drug use and the various modes of disadvantage that often go hand-in-hand with it. Rather than promoting health, such undertakings normalize the dying body outside the health promotion frame.

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Introduction

Using Toronto as my primary research site, this paper investigates supervised injection sites (SIS) as political and governmental spaces. Briefly, SIS's are legal facilities in which pre-obtained drugs can be consumed with access to clean equipment in a hygienic and medically supervised milieu. The expressly stated purpose of these facilities is to prevent overdoses and the spread of blood borne viruses. In recent years, the suitability of SIS's for Toronto has been a matter of intense discussion. These debates are set against the backdrop of a broader SIS movement, particularly in relation to the political struggles over the existence of Insite, North America's first SIS located in Vancouver's East End. The Toronto Drug Strategy, written by the Toronto Drug Strategy Advisory Committee, chaired by former Councilor Kyle Rae and released in October 2005, has been a focal point for policy development assessments of the potential benefits to be gained from launching one or more SIS's in Toronto. The local media has kept these issues in the public eye and a recent Supreme Court of Canada decision has opened the possibility for the creation of SIS's in Toronto. As yet, the political will for such an initiative is not forthcoming but the discussions surrounding the possibility offer a rare opportunity to examine the governmental and political implications of supervised injection sites.

My contribution to these discussions is to draw upon the lens of biopower introduced by Michel Foucault. Paul Rabinow and Nikolas Rose (2006, 197-198) have "extended and clarified Foucault's notion of biopower by delineating its three main elements." It "includes a 'truth discourse' pertaining to the vital attributes of human life that are espoused by experts and 'authorities considered competent to speak that truth.' This truth discourse is linked to strategies aimed at acting upon human life 'in the name of life and health.' Finally, these discourses and strategies are tied to 'modes of subjectification, through which individuals are brought to work

on themselves, under certain forms of authority, in relation to truth discourses, by means of practices of the self, in the name of their own life or health, that of their family or some other collectivity, or indeed in the name of the life or health of the population as a whole'" (Murray, Draft Paper). As I shall demonstrate, the debates concerning the possibility of creating a SIS in Toronto constitute a biopolitical struggle. It is a set of contestations over life, how life should be promoted (or not), by whom and to what ends.

With these themes in mind, the analysis is divided into five sections. Section 1 assesses how supervised injection sites work and how these facilities function as a form of governance. Section 2 two provides a broad overview of the harm reduction movement from which supervised injection sites have emerged from. Section 3 discusses Insite, North America's only supervised injection site, located in Vancouver, which has become a site of knowledge transmission for the Toronto context. Section 4 provides a critical analysis of the Toronto Drug Strategy, which both enables the possibility of a supervised injection site in Toronto and defines the "problem" of drug use in the City and the appropriate solutions. Lastly, Section 5 is a discourse analysis of Toronto print media, which explores three emerging editorial themes – risk, loss of the productive body, and the spatial and criminal implications of the addicted body. Through my analysis, I will indicate how various issues concerning the creation of an SIS in Toronto are fundamentally biopolitical struggles over what life is, whose life is valued, and how such value ought to best to be protected or managed.

1. Supervised Injection Sites as Governance

This section provides a broad overview of the discursive shift in debates about supervised injection sites, sometimes also referred to as safe or safer injection sites (SIS), which have emerged as a new technique to address urban intravenous drug use[1]. They are increasingly being deployed in urban centres internationally and offer a clean and supervised space for injecting illicit drugs. Supervised injection sites are located within the larger harm reduction movement, which seeks to mitigate the risks associated with drug use, rather than stop drug use in and of itself. These facilities are increasingly being articulated through a discourse of health and advocated for on the basis of access to health care. More implicit is their role in urban spatial politics, and most importantly, in creating the "good drug user" who conducts his or her drug use only within supervised injection sites. The "good drug user" conducts their drug use in a palatable, non-visible manner that reduces risk both to themselves and others. In this way, we see how at least one narrative about supervised injection sites is directly tied to efforts to produce subjects both willing and able to conduct their lives in accordance with norms that align with health, order, and stability, all of which support the overarching governmental aim of creating contexts for the production of wealth and capital.

Supervised injection sites are often understood as a "health" service and several countries have started to include these services as part of the provision of public health resources. Canada, Germany, the Netherlands, Switzerland, Spain and Australia have supervised injection facilities

[1] It should be noted that there is disagreement regarding the appropriateness of using "safe" or "safer" to describe injection facilities.

(Broadhead et al., 2002, 331). Supervised injection sites are often described as "legal facilities that enable the consumption of pre-obtained drugs in an anxiety and stress free atmosphere, under hygienic and low risk conditions" (Broadhead et al., 2002, 333). Users must register, sign in on all subsequent visits, and also might have to sign a liability release form (Broadhead et al., 2002, 336). The "clients" are typically given some or all of the following equipment: syringes, water, a dissolving agent, a cooker, cotton filters, a tourniquet, alcohol wipes, bandages, and paper towels to clean up after themselves (ibid). Injection rooms typically have seven to twelve injection spaces and users are allowed 30-45 minutes to inject, always with at least one staff member present (Broadhead et al., 2002, 336-337). The explicitly stated main function of supervised injection sites is to prevent the spread of blood borne viruses (HIV/AIDS, Hep C) and to stop overdoses. In this way, SIS's are not meant to treat addictions. Rather, they take addictions as a personal choice, but one that can be potentially disruptive. SIS's are therefore, in part, techniques for regulating choices that might otherwise interfere with the freedom of others (e.g., spread of disease, crime, open drug scene, etc.).

Supporters of supervised injection sites see them as representing a shift from punitive and repressive measures to the better management of drug use, defined by the need for regulating risks and stabilizing the socio-spatial order in the name of "public health" (Fischer et al., 2004, 357). Until the late 1990's, resources dedicated to combating illicit injection drug use in Canada had been predominately directed towards criminal justice interventions. As Table 1 shows, data taken from the Canadian Centre of Substance Abuse, which was used to justify the Vancouver Four Pillars Approach, estimated that the total cost in 1998 of health care and law enforcement in British Columbia was $96 million (Millar, 1998, 18-19). The cost of police enforcement alone was more than the entire medical costs for British Columbia in 1998. These

statistics are now outdated by more than ten years, yet policing continues to receive considerable allocation in budgets and policy documents.

Table 1: Comparison of Health and Policing Costs Relating to Drugs in Vancouver

Direct Health Care Costs	$
Hospitalization	$5,172,000
Co-Morbidity	$2,400,000
Residential Care	$4,854,000
Non-residential Treatment	$1,316,000
Ambulatory Care	$1,458,00
Prescription Drugs	$1,500,000
Other Health Care Costs	$321,000
Total	**$17,021,000**
Law Enforcement	
Police	$37,161,000
Courts	$20,020,000
Corrections	$20,020,000
Customs and Excise	$1,508,000
Total	**$78,710,000**
Total Direct Costs	***$95,731,000***

Source: Millar, 1998, 18-19.

One of the critical turns in public thinking about drug policy was the appearance of HIV in urban drug scenes. In part, this has re-defined the “drug problem” as a health issue for intravenous drug users and the population at large. The most prominently articulated public health concerns became intravenous drug users who share and re-use needles, leave their discarded equipment in public places, and engage in sex work (Fischer, 1995, 400). The implications of HIV infection and the threat to health not only in the drug using community, but to the "innocent public" made policy and decision-makers conclude that pragmatic health-oriented measures had to be taken. What helped to further crystallize the health-drug “risk”

discourse were studies that confirmed that the threat of AIDS generally did not stop users from injecting opiates. Research also showed an association between drug use and sex work. For example, in Frankfurt it was estimated that 8o percent of female heroin users were engaging in "prostitution activities" in order to pay for drugs (Fischer, 1995, 400). Inferred from this research was the possibility that these female injection drug users could have engaged in unsafe sex practices with a large number of clients (ibid). With this came the realization that current modalities of "treatment," namely prohibitionist and criminogenic techniques, were inadequate to address the problem of "drugs" and "drug users." These issues were now seen to be more threatening, moving beyond the intravenous drug using population to the population at large. It was here, where the mainstream population was seen to be at risk that we see the rise of a new discourse of "health" interventions.

With the rise of public health discourses on drugs, "treatment" was now not simply or even necessarily aimed at stopping an individual from using drugs. Rather, the goal was to address the larger project of teaching good citizenship as a means to reduce the harms of drug use (Moore, 2007, 33). Put differently, with SISs we see the general governance of drug users transforming from punishment to discipline and normalization (Bergschmidt, 2004, 63). As a matter of practice, this redefinition of treatment has been linked to the creation of various "harm reduction" approaches, as discussed in the next section, such as supervised injection sites. With the emergence of drug use being mainly articulated through discourses of health risks, intravenous drug users are now officially regarded as a primarily ill and diseased (e.g., addicted) rather than a primarily criminal population that must be stabilized through law and order approaches (McCann, 2008, 8). Nevertheless, while new techniques have purported to move beyond the criminal addict identity, a deeply embedded organizational and professional

mentality remains that seeks to change these former "lawbreakers" to improve their chances of becoming law-abiding citizens (Moore, 2007, 27). The governance of drug users is a consistent feature of contemporary governmental responses to drug use. What has changed, are the modalities to this end.

2. Harm Reduction

The rise of what might be called a "supervised injection site movement" is closely linked to the emergence of "harm reduction" as a new policy idea. The Canadian Centre on Substance Abuse defines harm reduction as a policy or program aimed at decreasing the adverse health, social, and economic consequences of drug use without requiring abstinence from drug use (Millar, 1998, 24). Harm reduction implies a concern with reducing the negative outcomes of drug use for the society, which includes those members of society who happen to use drugs (Lenton and Single, 1998, 218). One of the most common criticisms of harm reduction programs is that they are the first step towards the legalization of currently illegal drugs (Jaralis, 1995, 11). Other critiques argue that harm reduction enables society to continue causing harm to individuals without acknowledging the social, legal and economic source of the harms (Roe, 2005, 246).

The earliest harm reduction strategies included needle exchange programs, methadone maintenance programs, outreach programs for high-risk populations, law enforcement cooperation, and prescription of heroin and other drugs (Roe, 2005, 246). The notion of reducing harms posed by drug use arose in The Netherlands in the 1960's with the 'balance of harms approach.' This challenged to the idea that strict enforcement was the best approach to drug use (Roe, 2005, 244). Harm reduction as a policy movement can be grouped into three, loosely

defined, phases. The first phase stemmed from concern in the 1960's about the health risks associated with tobacco and alcohol use in the population. The second phase began in the 1980's with a sharp focus on AIDS prevention among injection drug users. We are now currently in the third phase, where an integrative public health perspective is being developed for all licit and illicit drugs (Cheung, 2000, 1699).

From the perspective of bio-power, in harm reduction discourses the drug addict and addiction are not natural truths. They are modern discoveries and identities that were exposed in order to facilitate a practice of governing (Moore, 2007, 125). Harm reduction accepts the occurrence of drug use and tries to mitigate the harms associated with it, as opposed to pushing an abstinence agenda. Substance abuse is a "problem" that is very scientifically accessible and can be read as an exclusively individual behaviour that enables the facilitation of assigning responsibility to the individual for how they conduct their drug use (Moore, 2007, 50). Drug users, once identified, can be subjected to interventions, often times in ways that overlap with socio-economic status, race, gender, etc. (Moore, 2007, 126). Interventions for upper class people have traditionally meant rehabilitation clinics (ibid). For "others," disadvantaged and often racialized and gendered populations, it has meant criminalization, forcible confinement, incarceration and disenfranchisement (ibid). Harm reduction has emerged as a new technique that most often is used to address "poor" drug use and is an attempt to not only prevent further harm to drug users, but also prevent harm from drug users to the general population. In this sense, the drug user is constructed as more than simply an undesirable body, but as an active health and economic threat to the productive and consuming population at large, as well as a threat to the wellbeing of the city. Within the harm reduction movement, supervised injection sites have surfaced as a new intervention to reorder urban spaces to facilitate processes of

governance. Thus, rather than being outside of government, the drug user, "bad" and "good," is integral to governmental objectives, the former being the problem and the latter the solution.

During the 1990's in North America, police and law enforcement departments routinely alerted the public to the possible presence of a serious drug problem in a local area by publicizing drug-related arrests, drug seizures and incarceration records (Cheung, 2000, 1698). Media reports tended to copy such behaviour by supplying anecdotal stories about victims who had "fallen prey" to drug abuse (ibid). The result in some cases was the manufacturing of a "moral panic" among the public. Public belief in an ever-growing drug problem fuelled the prohibitionist reaction to drug use and the user, which assumed illicit drug to be a morally corrupt behaviour violating mainstream norms (ibid). From this perspective, the control of such behaviour required strong law-enforcement and a drug policy that declared a "war" on drugs and heavily punished drug users (ibid). Canada followed this general trend. Resources were dedicated to combating illicit injection through criminal justice interventions – 94 percent of the 454 million dollars dedicated to addressing illicit drug use in 2001 was spent on enforcement and justice initiatives (W. Small et al., 2006, 85).

In the early 1990's, Vancouver was in the midst of an HIV epidemic in the eastern part of the city. In 1991 the Downtown Eastside saw a sudden increase in injection cocaine use and a general shift from heroin to cocaine as the drug of choice. This change increased the opportunity for sharing syringes, as cocaine users inject much more frequently than users of other drugs (Millar, 1998, 17). Injection drug users were infected with HIV at a rate three to four times higher than seen before (Smith, 2003, 500). By 1998 it was estimated that there were roughly 15,000 regular, frequent injection drug users in British Columbia (and likely many more occasional users). Most of these people were concentrated in the Downtown Eastside of

Vancouver. Of the 15,000, approximately 25 percent were HIV positive and about 88 percent had Hepatitis C (Millar, 1998, 17). Within this, it was estimated that close to half of the injection drug users either residing or frequenting the Downtown Eastside were infected with HIV (Smith, 2003, 500).

Between 1993 and 1997 over half of British Columbia's total 1,200 drug overdose deaths occurred in the Downtown Eastside, which led the Richmond and Vancouver Health Board to declare a state of health emergency (Millar, 1998, 17). These issues were also frequently framed as economic burdens. Data from the Canadian Centre of Substance Abuse estimated that in 1998 illicit drug use cost the British Columbia economy $209 million annually and estimated that direct costs arising from health care and law enforcement cost about $96 million annually (Millar, 1998, 18-19). During the health emergency, the B.C. Centre for Excellence in HIV/AIDS identified four factors in particular that were associated with injection drug users becoming HIV infected: borrowing syringes, unstable/poor quality housing, frequent injection (more than four injections a day) and cocaine use (ibid).

It was in this context that a harm reduction movement emerged in Vancouver as an alternative to enforcement and as an attempt to prevent HIV and AIDS moving from intravenous drug users and sex workers to the general population (Roe, 2005, 244). It became apparent that existing approaches were ineffectual in ceasing drug use and exacerbating the escalating health crisis. Nowhere was this ineffectiveness more obvious than with the 2003 large-scale police crackdown, referred to as the Citywide Enforcement Team (CET), which began in the Downtown Eastside, and was the largest visible enforcement operation ever undertaken in the neighbourhood (W. Small, et al., 2006, 86). Human Rights Watch conducted an investigation and reported observations of police misconduct, including instances of excessive force,

harassment and illegal searches. The report suggested that the CET compromised public health by discouraging drug users from accessing health services by driving them underground, and so increased risks associated with unsafe injection and overdose (ibid). The most immediate consequence of the increased police presence was the shift in injecting locales to less visible outdoor locations (W. Small et al., 2006, 88). The increases in street level enforcement also encouraged movement into less desirable and more dangerous injecting venues – those who continued to use in public venues sought secluded and private niches where they could escape the scrutiny of police officers (W. Small et al., 2006, 8). Drug users were at a higher risk because they were being forced into areas that they did not know and where there were no services that provided clean works or help. Users who injected in public settings in the Downtown Eastside were increasingly likely to be interrupted by the police while injecting, creating a climate that was not conducive to safer injecting practices as had been the case prior to the escalation in police activity (ibid). The resulting effect was hasty injections, shared syringes, and 'missed' injections – accidental subcutaneous injections instead of intended intravenous injections (ibid). Police also on occasion confiscated or destroyed syringes during encounters with drug users, including new sterile syringes (W. Small et al., 2006, 90). While it is legal to carry syringes, being found carrying new or used syringes often lead to more problems when drug users encountered police officers, and encouraged unsafe disposal as well as sharing syringes (ibid). What these examples highlight is that laws and policies pertaining to illicit drugs, as well as the enforcement practices used on the street, are important contextual factors that can partially determine a drug user's access to harm reduction programs (W. Small et al., 2006, 91).

After Human Right Watch findings were released, Vancouver police officers began to practice alternatives to arrest and confiscation of equipment, and increasingly began to rely on

warnings to drug users and referrals to addiction treatment. Police also started to avoid interacting with drug users at the point of injecting, as this practice often resulted in 'preventable harms' such as syringe sharing (W. Small et al., 2006, 92-93) As this example demonstrates, what can result from increased police presence and lack of police training are practices that run counter to harm reduction initiatives.

Even before the 2003 police crackdown in Vancouver's east end, a coalition of public health authorities and activists began to challenge the traditional model of enforcement of drug laws and advocated for adjustments to and reform of social and legal policies that had grown unpopular and in many cases expensive or difficult (W. Small et al., 2006, 92-93). The goal was not to legalize drugs or promote abstinence. At the practical level, the aim of harm reduction was to reduce the more immediate harmful consequences of drug use through pragmatic, realistic and low-threshold programs (Cheung, 2000, 1699). For these harm reduction proponents, police crackdowns might succeed in reducing the visible aspects of street drug markets, but also can be associated with negative public health consequences, including reductions in needle exchange utilization, increases in syringe sharing, unsafe injecting and improper syringe disposal. This health crisis was an important part of the genesis of Insite and the adoption of other harm reduction techniques in Vancouver.

3. Insite

The Vancouver Agreement set the framework for Insite's operations. Created in 2000 and expired in 2010, the agreement was a tri-level government agreement (federal, provincial and municipal) aimed at addressing social, health, economic and safety issues in Vancouver's inner

city, with a particular focus on the downtown eastside (Vancouver Agreement, 2012). The Agreement laid out funding and policy responsibilities for each government level. As part of this agreement, the City of Vancouver released *the Framework for Action: A Four Pillar Approach to Vancouver`s Drug Problems* (2000). The *Framework for Action* laid out four broad goals: public and federal responsibility; public order; public health; and coordinate, monitor and evaluate. In addition, the document set out 36 actions to achieve the goals (City of Vancouver, 2000, 2-3). The *Framework* also introduced the fourth pillar of harm reduction to be used in conjunction with the traditional approaches to drug use of prevention, treatment and enforcement (City of Vancouver, 2000, 3-4). With the introduction of a harm reduction approach, discussions around a supervised injection site became possible. The emergence of harm reduction as an official policy marked a shift away from prohibitionist approaches. This transformation was shaped by the context of increased overdose deaths and HIV infections and their effects on urban economies. Statistics such as the $500,000 lifetime cost per each new HIV infection (Insite Numbers, 2009) served to identify drug use as both a health and economic risk to cities.

Insite was officially opened in June 2003 under the auspices of Vancouver Costal Health and in partnership with the Portland Hotel Society Community Services (a non-profit organization created in 1993 that provides services for persons with concurrent disorders) as a research facility (Legal Status, 2009). Health Canada initially granted Insite a three-year exemption under Section 56 of the Controlled Drugs and Substances Act, which allowed drug users to poses narcotics on site, for the purposes of consumption only, an otherwise illegal action. In 2002 The Portland Hotel Society began operating what would later become Insite. While waiting for government approval of the legal exemption, a small storefront unofficially opened that offered a limited number of spaces for injection, supervised by a volunteer

community nurse (Small et al., 2006, 78). Although the application to Health Canada was well underway, the establishment of the unsanctioned facility was done to put pressure on policy makers to move quickly on a sanctioned site. Insite became an officially sanctioned facility in 2003, as previously mentioned.

Located at 139 Hastings Street in Vancouver's Downtown Eastside, Insite is not only North America's first and currently only legal supervised injection site but also a uniquely situated socio-economic-political space. The Downtown Eastside has a large concentration of low-income single room occupancy hotels, a high prevalence of mental illness among the population, and is generally seen as the "epicenter" of Vancouver's illicit drug and sex-trade economies (Wood and Kerr, 2006, 55-56). The Downtown Eastside is also the most central low-income neighbourhood in Vancouver. By 1998, overdose from injection drug use had become the leading cause of death for adults aged 30-49 in British Columbia, with more than 300 deaths annually (Millar, 1998, 5). The leading cause of HIV infection had become injection drug use and there were epidemics of hepatitis B and C related to injection drug use as well (ibid). These deaths were disproportionately concentrated in the Downtown Eastside, as previously discussed.

It is in this setting of extreme disadvantage that Insite seeks to fulfill its mandate, which is to be accessible to injection drug users who are not well connected to "health care." Insite defines clients who are not well connected to health care as people who use more than one drug; people who suffer from both addiction and mental illness; people who are homeless, live in shelters or have substandard housing and people who have tried unsuccessfully before to quit their addiction (Overview, 2009). Insite participants have access to a 12-seat injection room where they can inject their own drugs under the supervision of nurses and trained staff. Insite provides clean injection equipment, including syringes, sterile cookers, filters, water and

tourniquets (ibid). After injecting, participants move to a post-injection room where they stabilize before leaving the facility. Insite staff are also on-hand to connect participants with other services, including primary care for the treatment of wounds, abscesses and other infections, addiction counselling and peer support and referral to treatment services such as withdrawal management and opiate replacement therapy. Staff can also refer participants directly to Onsite, a 30-bed detox and treatment program that is co-managed by Vancouver Coastal Health and PHS Community Services Society, located directly above Insite (ibid).

Insite serves a diverse population of drug users, many with serious concurrent health issues. Statistical profiles of Insite clients and DTES drug users present similar patterns. Of active drug users in Vancouver, three out of ten in the Downtown Eastside are HIV positive, while 18 percent of Insite clients are HIV positive. There is also a very high prevalence of Hepatitis C among Vancouver drug users. Nine out of ten injection users in the DTES are infected and 87 percent of Insite clients have Hepatitis C (Insite Numbers, 2009). These similarities are due in part to the geographic clustering of drug users in the Downtown Eastside and the resulting strategic placement of Insite in the DTES; 68 percent of Insite clients live in the Downtown Eastside. Additionally, 80 percent have a history of incarceration, and 73 percent of users have injected in public before (ibid). Over 1.8 million people have used Insite, and there are currently approximately 12,236 registered users (User Statistics, 2011). In the 2010 operating year there were 312, 214 visits to the site, with an average of 855 visits a day and 587 injections each day (ibid). There were 221 overdose interventions, with no fatalities, 3383 clinical treatment interventions, 5268 referrals to other social and health services (majority to detox and addiction treatment) and 458 admissions to Onsite (ibid). In terms of a drug profile, heroin comprised 36 percent of injections in 2010, cocaine 32 percent and morphine 12 percent (ibid).

In 2009, 42 percent of injections were heroin, 26 percent were cocaine and 11 percent were morphine (Insite Numbers, 2009).

The criminal law exemption allowing Insite's clientele to posses and use illicit drugs on the premises, passed by a Liberal federal government in 2003, was extended several times by the Liberal and succeeding Conservative federal governments to allow for additional research. However, in 2007 the Conservative federal government took the position that the most recent extension, set to end on June 30, 2008, would be the last one, effectively leading to the closure of Insite (Legal Status, 2009). The federal government did so based on the premise that Insite violated federal drug laws. In August 2007, Vancouver Area Network of Drug Users (VANDU) and the Portland Hotel Society mounted a constitutional challenge to the federal government's ability to close Insite, arguing the facility addressed a public health crisis and should be under the sole jurisdiction of the Province (ibid). The B.C. Supreme Court ruled in 2008 that the federal government did not have the authority to close Insite and struck down sections of Canada's drug laws as unconstitutional, on the grounds that they prevented Insite from operating. The Court also granted Insite an immediate exemption and gave the federal government until June 30, 2009 to amend the country's drug laws to allow for the medical use of drugs if tied to a health care initiative (ibid). The Attorney General appealed this decision to the BC Court of Appeal, but the appeal was unsuccessful. This decision allowed Insite to continue operating (Legal Status, 2011). The Attorney General filed a further appeal with the Supreme Court of Canada. The case began on May 12, 2011 (ibid). On September 30, 2011 the Supreme Court ruled that the Health Minister could not deny legal protection to addicts and health care workers who would otherwise be penalized by federal drug laws. Thus Insite's continuance was constitutionally secured and the door opened for the possible establishment of SIS facilities in other parts of Canada (Toronto

Star, October 1, 2011). Nowhere was this decision more pertinent, perhaps, than in Toronto, as the next chapter discusses.

4. The Toronto Drug Strategy

In this chapter, I situate the emergence of supervised injection sites and the City of Toronto's interest in them in relation to a much wider historical context that has centred urban space as a key governmental milieu. The genesis of cities is inextricably bound to the quest for order in the city. Urban planning emerged in nineteenth century as part of the social reform movement in response to the need to exert social control over the emerging "ills" of expanding urban centres. Large cities were believed to produce the conditions of social unrest. Social problems (social, physical and spiritual) were seen as embodied in the very fabric of the city (Boyer, 1983, 16). In the early twentieth century a connection was made between the environmental chaos of the "American" city and the social pathologies of urban life. It was believed that with the proper environmental conditions, a sanitary, well-ordered environment could confine undesirable traits in the population (Boyer, 1983, 18). The physical environment itself could discipline humans to "achieve harmonious order with the urban world", and if a "conducive" social environment was provided, it would ensure the stability of the urban social order (Boyer, 1983, 14). Planning offered the state the opportunity to intervene into the social and physical city with disciplinary intentions, backed by the belief that environmental reform was the most important disciplinary order upon which cities would rise (Boyer, 1983, 6). In the large cities of the early nineteenth century, urban diseases and the complications of poverty had come to be seen as a collective phenomenon and therefore a collective threat (Boyer, 1983, 26). Early urban planners and welfare institutions sought not to help the people condemned to tenement cores, but to protect the

rest of society from the disorder that threatened to escape from within the city perimeter (Boyer, 1983, 16). While current city planning is no longer explicitly concerned with moral pathologies and social "ills," planning and other related interventions continue to have spatial implications regarding social control and desirable "traits" or bodies. The Toronto Drug Strategy is not overtly an urban planning document, yet it has several spatial dimensions that directly seek to control a particular kind of urban drug use. The Toronto Drug Strategy has emerged as a new technique for exerting social control over urban "disorder" at a time where cities are actively trying to market "place" while interacting directly with global flows of capital.

A new form of boosterism shaped in large measure by Richard Florida's ideas about "creative classes" has emerged at the end of twentieth century and into the twenty-first. The context of this emergence is the growing competition among cities for global capital. This competition transcends conventional political spaces, at once realigning the salience of the nation state as the point of interaction with global circuits while also reinforcing local spaces as key economic centres. This realignment has placed an increased focus on place marketing and urban boosterism. The physical urban environment itself has become the main attraction of a new urban economic order. Richard Florida's "creative class" ideas are emblematic in this regard. Taking hold in many Western cities as governments and policy makers look for a post-industrial urban plan, Florida's central thesis is that the role of place has changed significantly as economies continue to transition from traditional industries (such as manufacturing) to high-tech and advanced services. While people once followed jobs in the traditional industries, Florida argues jobs and industry are what move now, shifting to where clusters of a particular kind of person are found. Capital follows a group of highly mobile, creative people who increasingly base their location decisions not on where job opportunities are located, but rather on what urban

amenities and cultural environments a city has to offer (Donegan and Lowe, 2008, 46). The economic prosperity of a city is dependent on how well it attracts and retains this creative talent

The City of Toronto has embraced Florida's work and has released its own "creative" policy. In 2003 the City released its *Culture Plan for the Creative City*, a "ten year strategy to position Toronto as an 'international cultural capital' while 'placing culture at the heart of the city's *economic and social agenda*'" (emphasis added), followed up by the 2008 *Creative City Planning Framework*, a document that states "in order to compete for the talent in the international labour market, Toronto must gain a competitive advantage by maintaining robust cultural and creative industries" (City of Toronto, 2010). These "culture plans" released with numerous other reports and initiatives send a message about what kind of bodies are valued in the city. As Richard Florida's "creative class" is occupationally defined, not everyone can be creative in the way that is understood and sold to cities by Florida.

The Toronto Drug Strategy: A Comprehensive Approach to Alcohol and Other Drugs (2005), the first attempt by the City of Toronto to create a comprehensive municipal approach to the "drug problem," follows Florida's vision. The physical urban environment is an essential component of boosterism practices, which is where the public nature of drug use becomes problematic. Public drug use creates an issue both because of its visible nature and because of its economic threat to local businesses and larger associated health care costs. Public drug use almost always implies poverty, as the user is unable to afford private space to conduct private actions in, instead, conducting them in public. Poor urban drug users are also devoid of the kind of cultural and creative capital so valued by Florida. In this "creative economy" framework one's actions become a sort of goods. Drug users, and the poor and "fallen" more generally are perceived as incurring a debt to their "benefactors" (the "state", social institutions, etc.), which is

to be paid in moral, not economic currency (Valverde, 1992, 3-5). As drug users also lack the kind of creative currency that is currently valued, the way they pay back what they receive is with "moral fibre" (ibid). Moral regulation is its own distinct mode of regulation which now uses the language of biomedical science and social work (ibid). Moral regulation is aimed at the production of "individual ethical subjectivity and the reproduction of the nation's moral capital", that is, ensuring the drug user self-regulates in a way that is palatable to the larger population, which often focuses on decreasing the public nature of poor urban drug use (ibid).

The Toronto Drug Strategy's aim is "the improved quality of life of individuals, families, neighbourhoods and communities in Toronto by creating a society increasingly free of the range of harms associated with substance use" (City of Toronto, 2005, 7). The Toronto Drug Strategy proclaims to be a comprehensive strategy to address both alcohol and drugs at varying levels of uses, from recreation to addiction. The document even recognizes that "we are a drug using society", an important acknowledgement for implementing harm reduction procedures (City of Toronto, 2005, 2). The strategy also acknowledges: "people of all economic, social and cultural backgrounds use both legal and illegal substances" (City of Toronto, 2005, 27). The City also recognized, from public consultations, that Torontonians wanted the strategy to treat substance use as a health issue (City of Toronto, 2005, 27). However, despite these early assertions, the strategy defines and focuses on a very particular kind of user. In the opening pages of the report, it states: "most use is harmless and accepted as part of everyday social interactions, some even provide health benefits. But, "*not everyone uses safely or without causing harm*" (emphasis added) (City of Toronto, 2005, 2). It is those drug users who do not use safely and cause harm that the report focuses on.

The Strategy hinges on a particular understanding of the drug problem, which is highlighted in two chapters: Chapter 4, entitled "People Who Use Substances", and Chapter 5, "Neighbourhoods and Communities." These chapters and their associated recommendations set out how the problem of drug use is defined in Toronto and what the proposed solutions are. They formally lay out who uses drugs in Toronto and the associated effects on the city.

As a problem, Toronto's drug strategy defines drug use in much the same manner as already discussed with respect to Insite, as a harm reduction and public health matter. While the Toronto Drug Strategy borrows heavily from Vancouver's drug policy framework, it also defines the "drug problem" somewhat differently. Toronto does "not have large, concentrated, open drug scenes like the Downtown Eastside of Vancouver." Rather, the city has several smaller spaces where drug use is highly visible. Also unlike Vancouver, Toronto has "not had to declare a health emergency amongst its injection drug using population" (City of Toronto, 2005, 2-3). While crack cocaine has been identified as a larger issue than heroin in Toronto, unsafe consumption and disposal practices are still potential issues for police officers not trained to properly approach and interact with drug users.

The report identifies alcohol and crack cocaine as the drugs of most concern for Toronto (City of Toronto, 2005 3). Chapter 4, "People Who Use Substances", outlines, as the title suggests, people who use substances in Toronto. Recommendations 4.1 to 4.3 deal with alcohol, prescription drugs, and decriminalizing cannabis. Recommendations 4.4 to 4.16 explicitly and implicitly deal with crack cocaine usage. Crack cocaine is not typically a recreational drug, so the report is addressing people with what can be considered serious addictions. Under Section 4.5, which discusses the need for expanded harm reduction, the report does acknowledge that crack is not an exclusively "poor" drug, explaining that "people from all income brackets use

crack cocaine, including well off and privileged people. However, this kind of use is largely ignored and rarely profiled" (City of Toronto, 2005, 31). This kind of "well off" and "privileged use" is also ignored by the report, without an explanation. This section of the report does serve to identify and profile the most marginalized users though, as people "who use crack cocaine, in particular people who are homeless or otherwise street involved" (City of Toronto, 2005, 31). The issue that arises here is the dichotomy between public and private spaces, and the ability to afford a private space. The "well off" crack cocaine user is not considered a problem because they most often conduct their drug use in a private space, and are likely "functioning bodies" or have another source of monetary support. The "marginalized" crack cocaine user, who the report identifies as most often homeless or street involved, is a problem because they do not have a private space and therefore conduct private actions, such as drug use, in public spaces. This serves to define public crack cocaine use by poor users as the "problem" the report is seeking to regulate.

There is also an associated spatial dimension to the problematizations of drug use. The report identifies "pockets of open use, of both alcohol and other drugs, most notably in parts of the downtown core. People in these areas of the city tend to be more marginalized because of poverty, homelessness, mental health issues and prostitution" (City of Toronto, 2005, 32). This downtown sentiment is repeated further on in Section 5, Neighbourhoods and Communities:

> Residents of neighbourhoods with concentrations of illegal drug use and drug dealing, such as those in the downtown core of Toronto, sometimes feel unsafe and angry about the crime and disorder that is happening in their communities. This includes related crime such as prostitution, property theft, violence and vandalism (City of Toronto, 2005, 43).

The strategy considers drug use to be an urban issue, something that occurs most often in the downtown core. It recognizes the drug user as a spatial threat to downtown communities, spaces

that are becoming increasingly more economically valuable. These statements also identify the criminal and spatial implications of the addicted body. There is not only an assumption that the drug user's body will behave criminally and attract criminal behaviour, but that the drug user makes a space dangerous, even after they have gone. This assumption is addressed in recommendation 5.5 Reduce Drug Related Litter, which identifies as an outcome of public drug use:

> ...the discarding of paraphernalia such as needles and crack pipes. Some neighbourhood areas and city parks are struggling with ways to deal with this litter, which can cause health and safety concerns for children and adults who want to use these public spaces (City of Toronto, 2005, 46).

The understanding from this then is that the "problematic" drug user in Toronto can then be conceptualized as one whose drug use is public, is urban and centralized in nature, and has both criminal and spatial implications that produce risk.

Homelessness and mental health issues are other recurring themes in identifying who drug users are in Toronto. Recommendation 4.7 specifically deals with homeless drug users, as it seeks to provide more harm reduction in shelters, and identifies alcohol and other drug use issues as significant among people who are homeless (City of Toronto, 2005, 33). Recommendation 4.6 addresses developing a 24 hour crisis centre for short term crisis and care support, because homeless shelters have become the "de facto" support system for "people abandoned by every other part of our health and social safety net" (City of Toronto, 2005, 32). Recommendation 4.8 seeks to increase case management services, which are "particularly helpful for vulnerable groups such as youth, or people with multiple health and/or mental health issues" (City of Toronto, 2005, 34).

Poverty is also particularly prevalent in defining drug use in Toronto. Section 4.10 discusses the need for increased day programming, as

> ...financially stable people tend to have a wide range of pursuits and activities to occupy their work and leisure time. People who are not working and/or who are struggling to on a limited income have fewer resources for such activities to engage their time (City of Toronto, 2005, 36).

Section 4.14, which discusses improving income security for "vulnerable groups", makes a stronger statement about the connections between unemployment, poverty and drug use, declaring that

> ...the resulting combination of poverty and addiction and/or mental health issues make people more vulnerable to substance use and to engaging in prostitution, drug dealing and other crimes in order to support their drug use (City of Toronto, 2005, 39).

The vision then that comes out of this document is not of an all-encompassing approach to drugs, spanning from recreation to addiction, across socio-economic statuses. Rather, the Toronto Drug Strategy defines the drug user (and therefore the problem to be regulated) as most likely to be a poor, urban crack cocaine user who uses in visible, public spaces, most likely experiences concurrent addiction and mental health issues, has a high probability of being homeless and most likely has engaged in criminal activities, including theft and prostitution. From a biopolitical stance, we see how the Toronto Drug Strategy is constituting the drug using subject as means to make it a space for better governance.

In terms of proposed solutions, the Toronto Drug Strategy makes recommendations based on four principles that align with *The Vancouver Agreement* (2000) and the *Framework for Action: A Four Pillar Approach to Vancouver's Drug Problems* (2000, adopted by City Council

in 2001): prevention; harm reduction; treatment and enforcement. Despite overtures to a health promotion model, the "criminal" aspect of drug use is not divorced from proposed health-oriented approaches. The most frequent recommendation in the Toronto Drug Strategy was increased police presence and police involvement, yet there were no recommendations for harm reduction training for police. While the four guiding principles of the Toronto Drug Strategy are prevention, harm reduction, treatment and enforcement, to be applied in tandem, the continuance of prohibitionist type enforcement and policing challenges the ability of the document to address harm reduction and treatment, and a more general idea of "health". What emerges here is the application of a "health" or "harm reduction" discourse that enables continued policing under the umbrella of the discourse.

One of the biggest health concerns of a drug user is the quality or purity of the drug they are consuming. The Toronto Drug Strategy recognizes this concern under section 4.4, noting that users are at an increased risk of serious illness and overdose because they are unaware of the quality of drug they are using (City of Toronto, 2005, 30). However, the recommendation for this issue is to increase surveillance and police involvement to develop "a local drug and drug use surveillance system with protocols to issue broad-based alerts about potentially dangerous substances" (City of Toronto, 2005, 31). This proposal does nothing to address the associated health concerns. Increased police involvement is called for three more times in Chapter 5. Section 5.1 Support Neighbourhood Based Solutions, which calls for increased police presence in neighbourhoods. Section 5.2 Address Drug-Related Crime in Rental Housing, advocates for "enforcement options such as blanket trespass orders that allow police to act on behalf of landlords, which should be considered to enable police to better assist landlords," which would

effectively increase police presence in social and private rental housing and allow the police to enter private units, as if they were landlords (City of, Toronto, 2005, 44).

Section 5.3, "Support Police Efforts to Enforce Drug Laws," calls for the continued enforcement of prohibitionist drug laws (ibid). This recommendation for increased police presence raises concerns for two reasons. The first is that there are no recommendations in the entire document about training police officers to properly approach drug users while they are consuming. While increased police involvement can succeed in reducing the visible aspects of street drug use, they are also associated with negative public health consequences, including reductions in needle exchange utilization, increases in syringe sharing, unsafe injecting and improper syringe disposal. The second issue that arises from increased police presence in a document that calls for harm reduction measures is a contradiction of costs. One of the economic appeals of harm reduction is that it is cheaper to prevent new infections than to pay for a lifetime of treatment. Insite, for instance, estimates that the long term cost of a new HIV infection is about $500,000 per infection (Insite Numbers, 2009). The Toronto Drug Strategy discusses the economic costs of drug use in section 4.9, stating that "the reality is that injuries and illness related to alcohol and other drug use have a serious financial impact on the primary health care system and therefore must be considered, especially within the context of preventing illness" (City of Toronto, 2005, 35). However, the single largest cost related to drug use is policing. The Toronto Drug Strategy, which denounces the cost of drug use to the health care system and advocates for harm reduction, is still prescribing an increase in police presence, which has been proven to be costly, ineffective in terms of stopping drug use, and potentially hazardous to the health of drug users. This example is indicative of how the rubric of health sometimes enables continued policing.

5. Supervised Injection Sites and the Toronto Print Media

The Toronto print media, specifically newspapers, have been a major site of knowledge generation informing these discussions about the merits/demerits of a supervised injection site. More specifically, newspaper editorials and coverage have been the predominant source of information for the "general public" regarding a supervised injection site. These media sources draw heavily upon legal and scientific expertise.

This section offers a discourse analysis of editorials from three Toronto based newspapers, ranging in their social and political leanings – *The Toronto Star*, *The Toronto Sun* and the *Globe and Mail*. I chose articles from the late 1990s through to 2010 based on the key words "supervised injection sites", "safe injection sites", "drug use" and "Toronto." I read the articles with the following questions in mind. 1) How were drugs and drug users perceived? 2) Was drug use considered a criminal or a health problem? 3) How were SIS facilities perceived, as a solution or a problem? Based upon these questions, I read over 50 articles and formulated a thematic table that highlighted three key governmental sensibilities: 1) risk, which has become the new point of intervention for harm reduction under the umbrella of health; 2) the loss of the productive body, articulated as a social cost borne by the general public, and 3) the spatial and criminal implications of the addicted body, in which the physical presence of supervised injection sites and drug users in space has a perceived negative impact on the surrounding environment. In this section, I examine each of these discourses in turn.

Thematic 1: Risk

One of the main languages taken up in official attempts to rationalize and implement controls over substances is the language of risk. Historically, risk was most often used to embed substances in the drug/crime nexus, justifying criminal justice responses to drug use. Risk is now being mobilized in the harm reduction movement, particularly around opiates (Moore, 2007, 62). Heroin specifically is the drug most often associated with injection drug use and supervised injection sites in media discourses. The harm reduction movement, which began in the 1980's around the 'discovery' of the HIV/AIDS connection to injection drug use, lent to heroin the language of risk, in particular a risk to health (Moore, 2007, 83). Harm reduction as a technique emphasizes voluntary treatment rather than punishment of users and tries to minimize the stigma of the criminalization of drug users (O'Malley, 1999, 196). Thus, harm reduction has emerged as a movement that is in opposition to criminal justice and prohibitionist models of responses to drug use, emphasizing the mitigation of harms and the importance of "health." However, harm reduction still seeks to govern drug users. Health and risks to health have become the new point of intervention for governmental stakeholders. Health risks are articulated as both a risk to an individual's health and a risk to the greater public's health, both physiological and economic. Instead of carceral responses, harm reduction recruits intravenous drug users in their own project of care, instilling regimes of self care and responsibilization. That is, the good drug user has the responsibility of practicing their use in a way that reduces the harms or risks to others.

Risk is discussed in two ways in the editorials – risk to the drug users themselves, such as overdose and disease, and the risk of drug users to others, through exposure to live drug use, used paraphernalia left in public spaces, etc. However, notions of risk go beyond these discussions. An inherent component of discussions of risk is the possibility of prevention, and in

these editorials risk speaks to a larger project at hand, that is, instilling regimes of self-care. Many of the editorial discussions revolved around the risk associated with drug use and the ability of supervised injection sites to manage risk. Editorials adverse to Supervised Injection Sites objected to the ability of such facilities to manage risk and drug use on the idea that these sites actually perpetuate and encourage drug use.

> The intent is to reduce the risk to addicts, but to us it's all part of enabling them, instead of focusing on treatment and law enforcement (Toronto Sun, December 12, 2002).

> 'Harm reduction' sites and services encourage illegal drug users and alcoholic street people to continue to ingest their poisons using clean equipment in a safe environment. The theory is that it will eventually lead to fewer overdoses and less open use of drugs on the street (Toronto Sun, October 18, 2005).

Editorials that advocated for supervised injection sites did so on the basis that these sites reduce the risk (or harms) associated with drug use both to the drug user and to the population at large. By attempting to limit drug use to one geographic location in which it can be brought under surveillance, these editorials advocated physically concentrating the "locus of harm" because would be easier to limit the negative outcomes. The biggest emphasis on risk reduction focused on health related risks. Specifically, concerns with stopping the spread of diseases like AIDS, HIV and Hepatitis C among drug users, and stopping death from overdoses.

> ... provides compelling evidence that initiatives targeting illicit drug users such as supervised injection sites have been effective in reducing overdose deaths, HIV and other infections; improving safety and order in the community; and saving costs for emergency services (Toronto Star, September 7, 2006).

> What is killing addicts? Some die of overdoses, because they are buying street drugs and using them in uncontrolled conditions. Others die of diseases linked to sharing of needles, such as AIDS of hepatitis C. (Globe & Mail, February 1, 2005).

The second largest emphasis was on reducing the risk to the general public from drugs. In particular the concern was with the open, visible and public nature of drug use. One of the intentions of supervised injection sites is to bring public drug use inside and under the supervision of medical professionals, which serves the dual function of bringing drug use under surveillance while also decreasing the visibility of drug use. The concern from the editorials was that the population at large should not be exposed to live drug use, nor should they be exposed to used paraphernalia left in public spaces, and by extension crime related to drug use.

> It is a logical progression from safe-injection sites: an attempt to bring hard-core addicts under medical supervision, in the hope they will be less dangerous to society, and will live long enough to accept help (Globe & Mail, February 1, 2005).

> Hey, we can see why they'd want to expand that great crack kit program [to include Supervised Injection Sites]. After all, its [sic] apparently so popular, the remains of the kits (complete with syringes) are turning up in places like a downtown park next to a school (Toronto Sun, October 19, 2005).

The danger of public drug use, which in this context is more appropriately read as poor urban public drug use, is particularly prevalent throughout all of the editorials. Discourses of risk have become the predominant forum in which urban drug use is discussed. Part of framing drug use as an issue of risk is that it opens drug use up to calculated intervention. There has been a transfer in the language and in the way medical professions discuss drugs and drug use, from a discourse of dangerousness to a discourse of risk (Castel, 1991, 287). Drugs are dangerous, but

danger cannot be predicted, it is not quantifiable in a way that can be bench marked. Risk, however, can be determined, calculated and predicted. Risk is a way in which problems are constructed, viewed or imagined and dealt with. It is a probalistic technique where events are sorted into a distribution and the distribution is used as a means of making predictions to reduce harm (ibid). In the editorials, harm and risk can be read almost uniformly as interchangeable. Risk is a combination of abstract factors which render more or less probable the occurrence of undesirable modes of behaviour, in this case, spread of disease, death, and public drug use (Castel, 1991, 288). Harm reduction and supervised injection sites are in theory all about the reduction of risks. The emphasis surrounding supervised injection sites on reducing risk and reducing harm presents the possibility for a new mode of surveillance – systematic prevention (ibid). Supervised injection sites can be considered a form of surveillance in that the intended objective is to anticipate and prevent the emergence of undesirable events (illness, deviant behaviour, death) (ibid). Plainly put, they are intended to manage and prevent risk.

Part of the normalization project of harm reduction, and supervised injection sites, is to transform drug users into appropriate consumers (that is, users who only consume inside SIS facilities). In the harm reduction movement "risk" implies that the locus of harm creation lies neither in the properties of drugs, nor in the characteristics of the user, but in the variable yet calculable relationship between them (O'Malley, 1999, 197-198). One of the core principles of harm reduction is that risk probabilities can be calculated and thus known and governed (O'Malley,1999, 198). Risks and harms are recognized as not being an inherent quality in the drug or the user, but rather in the situations in which they are brought together (O'Malley and Valverde, 2004, 36). Governing the physical space in which the action of drug use happens, the site of risk, has become the focus of harm reduction and has provided the rationale for the

implementation of supervised injection sites. In earlier discourses of drug use, the intravenous drug user was depicted as a 'slave' to addiction, incapable of rational decision making and as living only for the next injection. In more recent discourses, particularly harm reduction, the intravenous drug using subject is a health-conscious citizen capable of rational decision making and self-regulation in keeping with risk-avoidance regimes and techniques (Moore, 2004, 1549). The changing "drug user" as a disorder is both created and maintained through current modalities and discourses of treatment, a process that now currently requires the individual's docile commitment to the treatment regime (Johncke, 2009, 16). In this, the drug user is charged with managing risks to the self.

The larger project of supervised injection sites is to install risk management as an "everyday practice of the self", backed by a moral responsibility or duty to the self "to be well", and the belief that each individual can acquire a personal preventative capacity (O'Malley, 1996, 200). Health becomes the responsibility of the private individual. In the last 100 years there has been a shift in emphasis from controlling the dangerous individual, through face to face interventions and confinement, to anticipating and preventing the emergence of undesirable events, such as illness, abnormality and deviant behaviour (Petersen, 1997, 192-193). Since the mid-1970's there has been a clear ideological shift away from idea that the state should protect the health of individuals to the idea that individuals should take responsibility to protect themselves from risk (Petersen, 1997, 194). This ethos can be read as part of the larger co-emergence of neoliberalism. The neo liberal rationality emphasizes the "entrepreneurial individual", who has freedom and autonomy and the ability to properly care for themselves (ibid). What emerges is a duality that the individual must strive for that consists of the responsible (moral) and of the rational (calculating) individual. The rational individual strives to

become responsible for the self, the most effective provision for security against risk. The responsible individual will take rational steps to avoid and to insure against risk, in order to be independent rather than a burden on others (O'Malley, 1996, 199-200). As Petersen puts it, "neo-liberalism calls upon the individual to enter into the process of his or her own-self governance through processes of self-examination, self-care and self-improvement", and the care of the self is inextricably bound with the project of moderating the burden of individuals on society (1997, 194). If one is unable to regulate one's own lifestyle and risky behaviour, it is a failure of the self to take care of one's self.

Thematic 2: Loss of the Productive Body (the Dying Body)

With supervised injection sites, users are encouraged to appreciate the "realities of their health" and to take responsibility for the care of their bodies while at the same time limiting potential to harm themselves or others by undertaking preventative actions (Fischer et al., 2004, 361). With SIS facilities drug users have become increasingly normalized as a responsibilized agent whose prime responsibility and "right" is to manage risk to themselves and others associated with drug use (Fischer et al., 2004, 358). 'Normalization' in the lexicon of harm reduction takes on the meaning of rendering illicit drug taking subjects as normal subjects of government (O'Malley, 1999, 196). The object of normalization is to make illicit drug use a self-governing activity that does not, for the most part, require expert intervention. The goal of normalization is undertaken in order to more effectively govern drug users, to align "the wills of subjects" with the project of harm reduction, and to arrange the distribution of risks and harms with the objectives of government programs (O'Malley, 1999, 196). It is the drug user who is responsible for accessing the SIS facilities and ensuring that they only conduct their drug use on premises. In this context,

the drug user is made up as a "citizen subject", the product of a regime of discipline that secures normalization by embedding a pattern of norms "disseminated throughout daily life and secured through surveillance" (Fischer et al., 2004, 362). The primary goal is to manage risk/harm, which in part requires drug users to consume only within supervised injection sites. The extension of this goal of risk/harm management is a responsibility for health management, implicit in which is an economic imperative regarding a body's productivity.

While the actual goal and outcome of supervised injection sites can be understood as managing the spatial realm of drug use, the productivity, and the loss of productivity of the drug using body has increasingly become a focus. Loss of productivity is understood as a physical state due to decreased health functioning, but has also been extended to encompass a socio-economic perspective, that is, decreased participation in the work force, and as a further extension, the "societal" economic and monetary costs of drug use. Loss of productivity ties into the larger economic and monetary costs of drug use. In the editorials, the loss of productivity and the productive body due to drug use was often discussed as a social cost. This "cost" was understood as one borne both by the individual drug user (loss of physical health, loss of the ability to participate and contribute in the workforce) as well as the population (healthcare costs, decrease in labour pool). In the editorials it was measured in both economic terms of money spent and money lost, as well as the loss of life and functioning and decreased health.

> The social cost of substance abuse in Canada is $40 billion a year…This dollar amount represents a terrible toll of tens of thousands of deaths, hundreds of thousands of years of productive life lost, and millions of days spent in hospital... (Toronto Star, September 7, 2006).

> No single method of trying to reach heroin users will work. Treatment usually means methadone – a substitute high – which at up to $5000 a year is a cost-

> effective way of reaching addicts for whom the costs in health, policing and lost productivity have been estimated at $50,000 annually [per user] (Globe & Mail, September 19, 2003).

Supervised injection sites and other harm reduction techniques resonate in the editorials on the level of cost-effectiveness. The loss of productivity is both physical and economic, and supervised injection sites are appealing in that they can potentially decrease the health care costs associated with drug use. Advocates in the editorials also cited supervised injection sites as desirable because they are seen as a technique that will help to restore and regain lost productivity, noting the decreased functioning capacity of drug users and the potential to increase health.

> Further there are benefits arising from the inclusion of previously marginalized members of society into mainstream life. The improved health and functioning of individuals and the net impact on harm in the community are notable indicators of the success of harm reduction (Toronto Star, September 7, 2006).

> Harm reduction is rooted in a pragmatic approach that focuses on improving overall health and well-being of individuals. It's meant to focus on a problem that is causing a harm (Toronto Star, August 19, 2008).

The idea that supervised injection sites are a panacea for the social, economic and health issues associated with drug use is somewhat troubling. The expectation that SIS facilities will improve the functioning and health of addicts and that the goal of these sites is to include those previously considered marginalized into mainstream society, with the intention of transforming such marginalized and disenfranchised individuals into cured, choice-making, self-regulating subjects, is a misunderstanding of how SIS facilities function. When discussing notions of freedom under liberalism there is an obligation to maximize one's life. This is an obligation that is borne solely

by the individual (Moore, 2007, 62). In this sense, supervised injection sites can be considered a technology that is both autonomizing and responsibilizing, in that the creation of a SIS facility responsibilizes the drug user for making sure they use the site, use clean instruments and exercise so called safe injection practices. However, unlike other governmental institutions, like the prison or the factory, supervised injection sites do not seek to rehabilitate bodies or to make them productive again (Philo, 2001, 482-483). The purpose of these sites is simply to mitigate harms associated with drug use. They do not maximize life and do not enable individuals to do so. That is not to say that it is impossible for a SIS client to successfully access rehabilitation services, in fact almost all SIS facilities have connections or access to such programs. However, it is up to the user to seek out and participate in such programs. The main function of Supervised Injection Sites is simply to provide a supervised space for consumption.

Thematic 3: Criminal and spatial implications of the addicted body

While governmental approaches are starting to transition away from explicitly using the criminal identity for governance, it continues to persist in the media and public opinion. This transition is coupled with the emergence of "new public health", which has resulted in the broadening of the focus of health promotion to include the 'environment', which is conceived broadly as spanning the local through to the global and including social, psychological and physical elements, such as the regulation of urban space (Petersen, 1997, 195). This new understanding has multiplied the number of sites for preventative action and has given rise to numerous "at risk populations and risky situations" (ibid). Supervised injection sites have emerged in the context of the advancement of globalization, in which cities have surpassed nation states to compete directly

for global capital, in which the physical spaces of cities have taken on a new importance. The dominant rationale for urban order is no longer linked to the demands of the industrial city but to the role of cities as competitive nodes within the global economy (Gandy, 2006, 508). Intravenous drug users in western industrialized nations have traditionally been a phenomenon located in urban environments (Fischer et al., 2004, 358). With the advent of "global cities", urban agendas have increasingly focused on the facilitation of economic activity and emphasizing the city as a space of consumption (Fischer et al., 2004, 359). Within this context, supervised injection sites have become appealing as a measure against the "contamination" of urban space by drug users who would disturb "neo-urban functionality, safety and aesthetics" (Fischer et al., 2004, 361). The body of the drug user in public space represents a threat to urban economic order and aesthetics. While previous criminal justice approaches have failed to eliminate public drug use, supervised injection sites seek only to take the public nature out of drug use, bringing it into a regulated and enclosed space.

Regulation of the modern subject is connected with the strategic needs of the nation state (Gandy, 2006, 499). Since cities are surpassing the nation-state in this reorganization of global capital, citizens-as-subjects are being regulated in accordance of the needs of the urban jurisdiction. Since the 18th century the human body has become progressively incorporated into a nexus of architectural and regulatory structures to produce a new spatial order in the modern city (Gandy, 2006, 503). The politics of public health have involved a shift from a preoccupation with death to a focus on life in which "the health and physical well being of the population in general emerges as one of the essential objectives in political power" (ibid). With this recognition that the health of the population at large was profitable, and necessary to invest in and protect, the need to invent new kinds of control for the "dangerous" classes emerged (ibid).

Intravenous drug users are seen as representing a threat not only to consumption practices and economic activities, but also to the health of the population at large. In this context the drug user becomes a "disabled body" in urban space. Within space "disabled" people are forced to account for their different bodily performances, often shunned or formally excluded, and constantly feel pressure to perform as "normally" as they possibly can (Hansen and Philo, 2007, 496). The "non-disabled body" is established as the "natural" way of appearing, being and doing. Everyday spaces (streets, parks, offices, etc) are "naturalised" as ones to be inhabited and used by non-disabled people. Many bodies, such as the drug user (the dying body), do not "belong" in these spaces and their presence is treated as a form of trespass (ibid). The very presence of a drug user in space is regarded as creating a potential criminal element. There are two facets to this. First, addiction has become conflated with crime in many editorials. Second, the "criminal" element has a spatial implication and dimension. Several of the editorials objected to supervised injection sites because they felt having a known space in the city dedicated to drug use would bring a concentration of drug users into a neighbourhood, and as a result of this would attract crime and drug dealers, compromising neighbourhood safety.

> One area resident told her drug dealers love to hang around the places where the city gives out the kits…instant customers! (Toronto Sun, October 19, 2005).

> That strategy proposes, among many other things, providing more, safer crack-use kits to addicts to ingest their illegal poisons – but safely. It also suggests looking at safe sites where drug users can smoke or shoot up while the pushers wait at the door to sell them their substances (Toronto Sun, October 25, 2005).

Some editorials felt that the crime they associated with SIS facilities and drug users also presented as a threat to local businesses, creating a dichotomy between legitimate and

illegitimate economies. “Many area merchants fear the sites will attract more addicts to their area and intimidate their customers.” (Globe & Mail, November 15, 2002). The editorials presented discussions about both the criminalization of the drug use and the criminalizing effect on space that the presence of drug users causes.

> Gilroy added that safe crack kits and injection sites are the ‘most ridiculous idea’ she’s ever heard of. ‘It’s preposterous to think there wouldn’t be violence outside of an injection site when drug dealers know where they are (Toronto Sun, October 25, 2005).

> First, who in Toronto, Montreal or Vancouver would want to live near a ‘safe’ injection site’ – an oxymoron if we’ve ever heard one – as proposed by a Liberal-dominated parliamentary committee? Such a site would by definition attract drug users and dealers and prevent the police from enforcing the law (Toronto Sun, December 12, 2002).

Drug users, and by extension Supervised Injection Sites, are depicted as presenting a threat to public space because there is no way of guaranteeing that drug use is conducted solely in the facility and no way of guaranteeing continued facility usage. Thus there is a perceived threat of drug use occurring in the neighbourhood around the supervised injection site. For these editorials, supervised injection sites are simply enabling criminal actions. However, the sites were also advocated for in some editorials on the advantages on having such a concentration of drug users from a law enforcement perspective. “Campbell and others argue that harm reduction efforts help police...” (Toronto Sun, October 25, 2005). SIS facilities were advocated for on the basis that it would make it easier to police and manage drug users, while at the same time addressing the spatial element of drug use by taking it out of highly visible public spaces. Supervised injection sites as a technique for dealing with drug addiction presents a useful entry point for authorities to govern other issues (Moore, 2007, 49). As previously discussed,

substance abuse is a "problem" that is very scientifically accessible and can be read as an exclusively individual behaviour (Moore, 2007, 50). The drug addict and addiction are not natural truths; they are modern discoveries and identities that were exposed in order to facilitate a practice of governing (Moore, 2007, 125). Drug users, once identified, could be subject to appropriate interventions, guided by socio-economic status, race, gender, etc. (Moore, 2007, 126). This identification and association has particular relevance for supervised injection sites. Appropriate interventions for upper class people have usually meant rehabilitation clinics (ibid). For "others" (poor people), it has meant criminalization, forcible confinement, incarceration and disenfranchisement (ibid). Supervised injection sites are a technology/tool that are aimed at a very particular kind of drug user. In these editorials it is addiction, not social inequality, which is at the root of criminalization. Addiction and drug use are also presented as the product of individual choice, thus implying that there is no socio-economic or structural explanation or "cure" for crime, because crime is a product of individual choice rather than social ills (ibid). The "crack addicted stock broker" mentioned in one editorial encapsulates who the subjects of supervised injection sites are.

> While some of society's 'marginalized' users could indeed be contacted, many crack users, perhaps a majority, would remain out of reach. A crack-addicted stock-broker, for example, isn't likely to seek out a city-supplied safe kit, much less go to a public inhalation room to get high (Toronto Star, October 24, 2005).

Supervised injection sites are not intended to reach the crack addicted stock broker; these sites are aimed at poor urban drug users who are not considered "high functioning" and do not have a private space to do drugs in, and thus practice drug use in public spaces. Supervised injection

sites can essentially be considered a management tool for addressing the intersection of poverty and drug use in cities.

Conclusion: Prolonging an inevitable death

Supervised injection sites emerged out of the harm reduction movement at a time when governments started to publicly acknowledge that prohibitionist techniques failed to address the "drug problem." This acknowledgement precipitated a transition to "health" based harm reduction techniques. This shift from punitive schemes to the government of drug users as a form of regulated risk consumption and socio-spatial ordering articulated under the rubric of health has provided a new point of access for the governance of drug users. As a mode of bio-power, health has become the new truth discourse that justifies supervised injection sites as the appropriate strategy to address intravenous drug use. SIS facilities enable the promotion of forms of subjectivity that align with larger governmental goals through the assigning of the "good drug user" identity. This subjectivity has coincided with and is closely linked to the increasing social and economic importance of urban space that positions supervised injections sites as a key governmental space. In the quest for order in the city, supervised injection sites are sites of bio-political struggle for urban space. They are a measure against the contamination of increasingly valuable urban real estate. As demonstrated by The Toronto Drug Strategy and the discourse analysis, there is a spatial and economic imperative for the creation of supervised injection sites in Toronto. All of these debates hinge on a notion of health, but supervised injection sites are not about health care. They are access points in which the drug using body can become accessible to governance. "Health" has become a way to assign responsibility for a personal preventative capacity, essentially allocating to the drug user responsibility to conduct drug use in a way that

protects larger societal social and economic imperatives. This is not strictly nor necessarily in the best interests of the personal health of the person using drugs. Serious consideration needs to be given to what it means when "health" and "health care" are used to describe and justify supervised injection sites, as these facilities do not maximize life and do not enable individuals to do so. That is not their purpose. Yet this "misunderstanding" continues to perpetuate, further facilitating the ability of supervised injection sites to govern drug users. For the majority of drug users, all that supervised injections sites will ever do is briefly prolong the inevitable: an early death. This is a profound declaration regarding what kind bodies are valued in the city and what kinds of lives are worth protecting (see also Murray 2011). Before any supervised injection sites are deployed in Toronto, consideration needs to be given to who and what interests these facilities actually serve, and what real health care would mean for drug users.

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