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Inside Insite: How a Localized Social Movement Led the Way for North America's First Legal Supervised Injection Site

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Donna Harati
Law and Social Change

Inside Insite: How a Localized Social Movement Led the Way for North America's First Legal Supervised Injection Site

ABSTRACT

This paper explores the connection between law and social change by looking at Insite, North America's first legal supervised injection site, as a case study. The paper focuses on how the Canadian Supreme Court was primed to grant legal status to the site. By examining the deep, grassroots, addict-led movement that set the foundation for the site to exist, the paper looks at how local movements coupled with evidence-based statistics can help inform judges in making decisions that affect social change. The paper looks closely at how advocates drew on both the social movement and the law in defending the legality of Insite.

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Introduction

Every year, approximately 12,000 individuals enter a building located at 139 East Hastings Street in the Downtown Eastside of Vancouver (DTES).¹ They check in with a receptionist, fill out a short form, proceed to a back room, sit at one of twelve booths outfitted with mirrors, and then inject themselves with an illegal drug, usually heroin. Because they are at Insite, North America's only supervised injection facility, they do all of this legally. Since it opened in 2003, Insite has helped make the DTES a safer place for intravenous drug users (IDUs) by reducing the number of overdoses and the rate of injection drug related diseases.² As such, it has been hailed as a public health success story.³

This paper will explore how Insite emerged and how it came to retain its legal status in the Canadian judicial system. In order to understand Insite's practical and legal success, I will discuss the history and activities of the DTES harm reduction movement. The grassroots, addicted movement that developed in response to the dire public health crisis in the DTES played an especially critical role in making Insite a reality by humanizing addicted individuals and influencing public officials. Although many unquantifiable factors might have influenced the courts in deciding Insite's fate, I will focus on the local harm reduction movement's sustained activism and commitment to acknowledging, protecting, and politicizing the rights of addicted individuals in the DTES. This, coupled with evidence-based research lauding Insite's success, allowed the Canadian courts to view Insite as a legitimate localized public health strategy worthy of a legal exemption from drug laws.⁴

¹ INSITE USER STATISTICS

http://supervisedinjection.vch.ca/research/supporting_research/user_statistics (last visited Apr. 15, 2013).

² E. Wood, M.W. Tyndall, J.S. Montaner, T. Kerr, *Summary of findings from the evaluation of a pilot medically supervised safer injecting facility* 175 (11) CMAJ 1399–404 (2006).

³ Matthew Power, *The Vancouver Experiment*, SLATE (Feb. 1, 2010, 9:35 AM), http://www.slate.com/articles/news_and_politics/dispatches/features/2010/the_vancouver_experiment/welcome_to_insite.html

⁴ This paper was inspired by Amy Kapczynski and Jonathan Berger's analysis of the TAC decision in SOUTH AFRICA IN THE STORY OF THE TAC CASE: THE POTENTIAL AND LIMITS OF SOCIO-ECONOMIC RIGHTS LITIGATION IN SOUTH AFRICA. Kapczynski and Berger's contention that the story of the TAC case "is less about a judgment or a doctrine than it is about a movement. More specifically, it is about the power that an organized movement can have if it makes strategic use of constitutionally entrenched and justiciable human rights, lays the

Background on Insite

The Context of The Epidemic

“See, the buses come and go down here, and you see people looking. But they don’t see nothing. All they see is the dope. People can hide in plain sight. They can be this far from you... The thing is these people, they’re invisible to society.”⁵

- Cree female injection drug user resident of DTES

In order to understand the story of Insite, the socioeconomic, political and neo-colonial standing of the neighborhood that prompted Insite’s inception must be explored. In fact, the first line of the Supreme Court of British Columbia’s decision addressing Insite’s legality stated, “The character of the DTES and the context in which Insite emerged are central to an understanding of the issues raised by these actions.”⁶ Insite is a product of a specific geographic community: Vancouver’s Downtown East Side (DTES). One of Vancouver’s oldest neighborhoods⁷, the DTES comprises an area that is six square kilometers large,⁸ sandwiched between the commercially prosperous Chinatown and Gastown neighborhoods.⁹ The DTES, oft-cited as Canada’s poorest postal code¹⁰, is home to “a large, open drug scene; a large homeless population; deteriorating housing, including dozens of single-room occupancy (SRO) hotels; and an active sex trade.”¹¹ Although traces of the area’s original Coast Salish indigenous inhabitants were “long ago overlain by the rapid urbanization that took place in the late nineteenth

groundwork necessary to give those abstract guarantees meaning, and energetically builds broad public support for its cause” applies to the story of Insite as well.

⁵ LESLIE ROBERTSON & DARA CULHANE, IN PLAIN SIGHT: REFLECTIONS ON LIFE IN DOWNTOWN EASTSIDE VANCOUVER 60 (2005).

⁶ PHS Community Services Society v. Attorney General of Canada at 7.

⁷ SCOTT BERNSTEIN AND KATRINA PACEY, INSITE EVIDENCE IDEOLOGY AND THE FIGHT FOR HARM REDUCTION Pivot Legal Society.

⁸ HESTER LESSARD, JURISDICTIONAL JUSTICE, DEMOCRACY AND THE STORY OF INSITE. Constitutional Forum constitutionnel, at 95.

⁹ CITY OF VANCOUVER, DOWNTOWN EASTSIDE COMMUNITY MONITORING REPORT, 10TH EDITION (2007).

¹⁰ Canada (Attorney General) v. PHS Community Services Society [2011] S.C.R. 44 (Can.) at 7.

¹¹ WILL SMALL, JEAN SHOVELLER, DAVID MOORE, MARK TYNDALL, EVAN WOOD & THOMAS KERR, *Injection Drug Users’ Access to a Supervised Injection Facility in Vancouver, Canada: The influence of Operating Policies and Local Drug Culture*. Qual Health Res 2011 21:743 (Mar. 4 2011), <http://qhr.sagepub.com/content/21/6/743> citing E. WOOD, & T. KERR, *What do you do when you hit rock bottom? Responding to drugs in the city of Vancouver*. Int’l Journal of Drug Policy, 17(2), 55-60, (2006).

century,”¹² the “cultural memories of dispossession live on”¹³ given that an estimated 10% to 40% of the roughly 16,500 DTES inhabitants are indigenous peoples.¹⁴ Approximately 45% of DTES residents are first-generation immigrants to Canada,¹⁵ and 40% rely on transfer government payments for support.¹⁶ Proportionally, the DTES has twice the seniors and half the children and youth than the rest of the city.¹⁷ The neighborhood has three times the number of persons living alone than the rest of Vancouver, and the unemployment rate of 22% is three times the rate in the rest of the city.¹⁸ Violence has permeated daily life in the DTES.¹⁹ Finally, approximately 5,000 Injecting Drug Users (IDUs) reside in the DTES while thousands more visit the neighborhood regularly to “purchase and consume drugs.”²⁰

In 1988, there were 39 deaths by overdose in British Columbia. In 1995, the number had risen to 331. By 1998, the worst year on record, 417 individuals died by drug overdose in British Columbia.²¹ The majority of these deaths were concentrated in the DTES.²² A death by overdose is especially jarring; timely intervention can easily prevent these fatalities.²³

¹² Lessard, *supra* note 8, at 95.

¹³ NICHOLAS BLOMLEY, *UNSETTLING THE CITY: URBAN LAND AND THE POLITICS OF PROPERTY* 34 (2004).

¹⁴ See J CAIN, *REPORT OF THE TASK FORCE INTO ILLICIT NARCOTIC DEATHS IN BRITISH COLUMBIA* (Victoria: Ministry of the Attorney General, 1994), cited in LARRY CAMPBELL, NEIL BOYD AND LORI CULBERT, *A THOUSAND DREAMS: VANCOUVER’S DOWNTOWN EASTSIDE AND THE FIGHT FOR ITS FUTURE* 55 (2009). See also ADRIENNE BURK *SPEAKING FOR A LONG TIME: PUBLIC SPACE AND SOCIAL MEMORY IN VANCOUVER* xi (2010) (noting that the DTES is “widely acknowledged in Canada as having one of the largest off-reserve concentrations of Aboriginal people of various First Nations”).

¹⁵ City of Vancouver, 2005/06 Downtown Eastside Community Monitoring Report, 10th ed, online: (2006) <http://vancouver.ca/commsvcs/planning/dtes/pdf/2006MR.pdf>

¹⁶ *Id.* at 13.

¹⁷ 22% seniors in DTES as opposed to 11% in Vancouver and 2% children and 8% youth. See *Id.* at 8.

¹⁸ *Id.* at 12.

¹⁹ See Lessard *supra* note 8 at 95-96 (detailing the epidemic of “missing women” in the DTES and ultimate conviction of serial murderer Robert Pickton).

²⁰ *Id.* at 745.

²¹ See J CAIN, *REPORT OF THE TASK FORCE INTO ILLICIT NARCOTIC DEATHS IN BRITISH COLUMBIA* (Victoria: Ministry of the Attorney General, 1994), cited in LARRY CAMPBELL, NEIL BOYD & LORI CULBERT, *A THOUSAND DREAMS: VANCOUVER’S DOWNTOWN EASTSIDE AND THE FIGHT FOR ITS FUTURE* 51, 127 (2009).

²² T. KERR, D. MACPHERSON, E. WOOD, *Establishing North America’s first safer injection facility: lessons from the Vancouver experience*, in: Stevens A., editor. *CROSSING FRONTIERS:*

Not only was Vancouver's DTES confronted with steadily rising overdose death rates, but rates of HIV and Hepatitis C infections among IDUs also reached alarming rates as 17% of the IDU population in the DTES were found to be HIV positive, and over 80% were found to be infected with the hepatitis C virus.²⁴ Development of a "constellation of associated conditions" such as septicaemia, endocarditis, aggravated mental illness, and foetal exposure to narcotics also began to reach "epidemic proportions".²⁵ In response to these numbers and at the urging of community activists, Vancouver's chief medical officer declared a public health emergency in the DTES in 1997.²⁶

Typical of the slow-moving timeline of responses to addiction problems, the municipal government finally responded decidedly to the crisis in 2000 with the publication of "Framework for Action: A Four Pillar Approach to Vancouver's Drug Problems." In this report, the government outlined an integrated approach to the drug problem built on the four pillars of prevention, treatment, enforcement and harm reduction.²⁷ Although the first three pillars are standard practice in government responses to drug addiction, the fourth pillar of harm reduction is much less frequently seen in government strategies and is the subject of widespread controversy.²⁸ This paper now turns to an exploration of the harm reduction model, first generally, and then specifically on how the harm reduction movement developed in the DTES and influenced the government.

Harm Reduction

While traditional drug control policies focus primarily on restricting access to illegal drugs, harm reduction approaches instead emphasize preventing and mitigating "negative

INTERNATIONAL DEVELOPMENT IN THE TREATMENT OF DRUG DEPENDENCE 109-29 (A. Stevens, ed., 2008).

²³ Russ Maynard, program director at Insite, analogizing death by drug overdose to a drowning, personal communication, August 2010. And "If you reach a drowning person in a few seconds or a minute, chances are very good they will do well. That is what is occurring at injection sites all over the world." VANCOUVER'S SUPERVISED INJECTION SITE PROVIDING SAFE PLACE CHANGING LIVES, Streetroots <http://news.streetroots.org/2010/07/21/vancouver-s-supervised-injection-site-providing-safe-place-changing-lives> (last visited Apr.20, 2013).

²⁴ See Small et. Al *supra* note 11.

²⁵ 2008 BSCS 661, 293 DLR (4th) 392 (PHS Community Services Society (BSCS))

²⁶ Bernstein *supra* note 7.

²⁷ *Id.*

²⁸ GUYTANO VIRDO, *Harm Reduction Policy, Political Economy, and Insite 1 HEALTHY DIALOGUE* 3 (2012).

consequences associated with risky activity.”²⁹ In contrast to the traditional punitive approach, the harm reduction approach operates under the basic premise that there has never been and will never be a drug-free society³⁰ and that people who use drugs are “complex, multi-faceted individuals who are more than their behaviors.”³¹ As such, instead of promoting the criminalization of drugs, which often only serves to push IDUs further underground,³² harm reductionists instead focus on reducing the negative public health consequences of drug use by supporting approaches that allow for safer and more regulated drug activity.³³

Harm Reduction and Insite

“Crack cocaine, which can produce paranoid and violent behaviours among its users, is illegal for a reason. Its effects are far more intense than those of ordinary cocaine. Some users report that they’ve been addicted since the first time they tried it. It is a scourge on society.”

- Vancouver Province, 16 August 2004: A:16

“Drug Users are People Too! They deserve compassion and a place in the Community!”

- VANDU protest sign

The first quote above, from a newspaper article denouncing the opening of Insite, embodies many of the pervasive beliefs surrounding addiction that render resistance to harm reduction models so entrenched. First, by noting that crack cocaine is more dangerous than regular cocaine, the quote reinforces the notion that “each subsequent drug is worse than the previous one.”³⁴ Second, it straightforwardly states that drugs are illegal for the reason that they are dangerous. Third, it emphasizes the supposedly inherently addictive nature of the drug itself

²⁹ A. Wodak & L. McLeod, (2008). *The role of harm reduction in controlling HIV among injecting drug users*. 22 AIDS 81-92.

³⁰ REDUCING HARM. DRUG POLICY ALLIANCE, <http://www.drugpolicy.org/reducing-drug-harm> (last visited Apr. 15, 2013).

³¹ DRUGS & DRUG USE. HARM REDUCTION COALITION, <http://harmreduction.org/issues/drugs-drug-users/> (last visited Apr. 15, 2013).

³² GUYTANO VIRDO, *Harm Reduction Policy, Political Economy, and Insite* 1 HEALTHY DIALOGUE 2 (2012). YTANO VIRDO, HARM REDUCTION POLICY, POLITICAL ECONOMY, AND INSITE.

³³ For a more complete discussion of the harms of a punitive approaches to drugs See e.g. Mauer, Mark and Ryan S. King, *A 25 Year Quagmire: the War on Drugs and its impact on American Society*, SENTENCING PROJECT, (2007).

³⁴ See Dan Small, Anita Palepu, Mark W. Tyndall, *The establishment of North America’s first state sanctioned supervised injection facility: A case study in culture change*, 17 Int’l Journal of Drug Policy 73,74 (2006).

in accounting for addiction rather than “the mental pain of the drug user.”³⁵ Implicit in the quote but perhaps the most persistent and insidious idea about addiction that works against harm reduction models is the notion that addiction is a choice made by a blameworthy individual. When the addict is seen as an independent agent making a deliberate and conscious decision to engage in harmful behavior, it is easier to apportion blame on him or her and thus easier to justify non-intervention. Within the individual responsibility mentality, the onus for recovery or rehabilitation falls on the individual who made the choice to engage in the harmful behavior rather than on the society that might have facilitated that individual’s choice through its failure to provide a decent quality of life for him or her.

Much of the success surrounding Insite and its subsequent legal victory rests in the ability of the movement surrounding Insite to successfully reframe the narrative around addiction and addicts in the DTES.³⁶ The normalization of the harm reduction approach to drug addiction in the DTES was perhaps the most vital component of this reframing. Although harm reduction approaches implemented as part of a government drug policy regime are typically combined with enforcement strategies focusing on trafficking and abstinence models, the harm reduction approach “is premised on the recognition that social factors such as homelessness, poverty, gender inequality, colonialism and racism must be factored into the understanding of addiction.”³⁷ Thus, the harm reduction model invites a more flexible set of approaches to

³⁵ *Id.* at 74. Small et al. suggest an *addiction* habitus in the vein of Bourdieu to reflect “the enduring set of narrative responses pertaining to addiction.” They summarize this habitus as including the following elements: 1- People choose to be addicts; therefore addicts are to blame for their addiction and corrupt lifestyles. 2- Services for addicts attract addicts, promote and spread addictive behavior. 3- Drugs promote violence. 4- Drugs are seen as inherently addictive and the inherent properties of the drug itself, rather than the mental pain of the drug user, account for addiction. 5- Addicts should be made more uncomfortable to prevent and not enable addiction. 6- Drug addiction exists in a large part because drugs are widely available. 7- Harm reduction addiction services (supervised injection facilities and needle exchanges) promote addiction and keep people on drugs. 8- Drugs are illegal for a reason: they are dangerous. 9- All resources spent on enforcement are justified. Each new drug is dramatically worse than the preceding focus of the addiction habitus: people are made more violent, more mentally ill and more morally bankrupt.”

³⁶ *Id.* at 74.

³⁷ Lessard *supra* note 8, at 96.

“treatment” because its focus is on reducing death and disease and achieving stability “rather than to reduce addiction.”³⁸

Harm reduction was technically endorsed, at least on paper, by the Canadian government in 1987 when it adopted the model as part of its National Drug Strategy (CDS).³⁹ The CDS defined harm as “sickness, death, social misery, crime, violence and economic costs to all levels of government,”⁴⁰ and this definition “became the initial step in its transition towards a ‘four pillars’ approach to drugs.”⁴¹ However, the majority of funds earmarked for harm reduction went to police drug education programs that reinforced the traditional criminal model of addiction response.⁴²

Although the government slowly adopted and endorsed harm reduction policies in the background, it was left to community groups and activists in the DTES to engage in the tangible, on the ground work of bringing harm reduction services to the neighborhood and to influence the government to do the same. It was this movement that both laid the groundwork for Insite’s opening and allowed the Canadian courts to frame Insite as a legitimate response to a public health crisis.

In 1988, DTES social activist John Turvey “started single-handedly giving out three thousand clean syringes a month” when the government failed to proactively set up a needle exchange program.⁴³ He opened the first official needle exchange in Canada in 1989 after receiving a government grant.⁴⁴ In 1991, a group of primarily indigenous women and mothers set up a weekly support group called Drug and Alcohol Support Group for Women (DAMS) after they were unable to obtain funding “because they pursued a harm reduction rather than

³⁸ Lessard *supra* note 8, at 97.

³⁹ D. Zilkowski *Canada’s National Drug Strategy*. Forum on Corrections Research Focusing on Alcohol and Drugs 13(3) *available at*: http://www.csc-scc.gc.ca/text/pblct/forum/e133/133a_e.pdf.

⁴⁰ *Id.*

⁴¹ Aidan MacDonald, *Insite or Outside the Law: Examining the place of safe injection sites within the Canadian legal System* 1 Onati Socio-Legal Series (2011).

⁴² See Small et al, *supra* note 34 at 73-75.

⁴³ Donald MacPherson, Zarina Mulla, Lindsey Richardson, *The Evolution of Drug Policy in Vancouver, Canada: Strategies for Preventing Harm from Psychoactive Substance Use* 17 *International Journal of Drug Policy* 127, 127 (2006).

⁴⁴ *Id.* at 127.

abstinence approach.”⁴⁵ In 1995, Back Alley, an illegal injection site, was opened by a lobby group of drug users called IV Feed. Back Alley received informal support from the B.C. Centre for Disease Control in the form of free syringes and occasional visits by a nurse.⁴⁶ The police “unofficially tolerated” the site because it reduced drug use in open-air and unsafe locations.⁴⁷ Larry Campbell, a former drug cop, City Coroner at the time, and a key player in the coming struggle for Insite, visited Back Alley to encourage the IDUs running the facility and to express his support for such community-based harm reduction approaches.⁴⁸ Campbell initially viewed harm reduction approaches as “honey pots” that would only serve to attract more addicts to the area and increase crime.⁴⁹ However, by visiting the harm reduction sites and conversing with the IDUs who ran them, Campbell came gradually to believe that these sites were health facilities and that abstinence policies did not work. He explains,

I had to be taught. I had no problem with the idea that this was a medical problem, but I hadn’t come to grips yet with looking at it as a wide-open problem that required many different solutions. It finally occurred to me that drug addiction was no different than being an alcoholic, but drinking was socially acceptable, and you couldn’t get the same help for an addict. If you work through this in a logical fashion, then you realize it’s a healthcare issue- nothing more. It’s not the same as condoning the use of drugs.⁵⁰

Unfortunately, Back Alley had to shut its doors after only a year of operation due to a lack of funding.⁵¹ Yet, in that one year, Back Alley had no fatalities on site.⁵² Thus, the DTES’ ad-hoc, community-based harm reduction solutions to the neighborhood’s drug crisis allowed the government to gather data on the effectiveness of such approaches before having to formally commit to them.

⁴⁵ LARRY CAMPBELL, NEIL BOYD & LORI CULBER, *A THOUSAND DREAMS: VANCOUVER’S DOWNTOWN EASTSIDE AND THE FIGHT FOR ITS FUTURE* 10 (2009).

⁴⁶ *Id.* at 62.

⁴⁷ SUSAN BOYD, DONALD MACPHERSON & BUD OSBORN, *RAISE SHIT! SOCIAL ACTION SAVING LIVES* 29 (2009).

⁴⁸ *Id.* at 29

⁴⁹ LARRY CAMPBELL, NEIL BOYD & LORI CULBERT *A THOUSAND DREAMS: VANCOUVER’S DOWNTOWN EASTSIDE AND THE FIGHT FOR ITS FUTURE* 119 (2009).

⁵⁰ *Id.* at 129-130.

⁵¹ *Id.* at 62-63.

⁵² *Id.* at 29.

One of the most remembered and salient community based responses to the lack of services for addicts in the DTES was staged by a group called the Political Response Group, who organized eighty demonstrations demanding better services. In 1997, the group planted 1,000 crosses in Oppenheimer Park, a prominent park in the DTES often referred to as “our park” by community activists, to physically symbolize and commemorate the lives lost to drug addiction in the area.⁵³

Oppenheimer Park in 1997 also served as the birthplace of the Vancouver Area Network of Drug Users (VANDU), one of two organizational plaintiffs in the Insite case, when a number of advocacy and support groups in the neighborhood met⁵⁴ to discuss the formation of a drug user organization to cope with the epidemic of addiction-related deaths and health issues.⁵⁵ In the first few months, VANDU’s membership grew from 20 to 100 and eventually reached more than 2,000.⁵⁶ Although anyone can join VANDU, only addicts or former addicts have a vote at meetings or can be elected to the board.⁵⁷ Further, the membership is composed of 1/3 women and 1/3 indigenous persons, roughly paralleling the make-up of the DTES itself.⁵⁸ This governing structure and demographic makeup reflects VANDU’s commitment to “empower people who use drugs to design and implement harm reduction interventions.”⁵⁹ This commitment is part of an explicit strategy to maintain a sustainable social movement to “shift

⁵³ “Traffic on a main artery running through the neighborhood was blocked, leaflets were handed out detailing the epidemic of overdose deaths, and while indigenous elders drummed and sang, a thousand crosses were planted in Oppenheimer park.” See SUSAN BOYD, DONALD MACPHERSON, AND BUD OSBORN, RAISE SHIT! SOCIAL ACTION SAVING LIVES 19 (2009).

⁵⁴ Thomas Kerr et. al, *Responding to an Emergency: Education, Advocacy and Community Care by a Peer-Driven Organization of Drug Users* Health Canada 6 (2001).

⁵⁵ “It commenced with a meeting in Oppenheimer Park in September 1997 organized by Ann Livingston, a non-user and harm reduction activist who had been instrumental in setting up Back Alley, and Bud Osborn, a DTES former heroin addict, social activist, poet, and member of the Vancouver-Richmond Health Board. Osborn and Livingston plastered the neighborhood with flyers inviting people to take a ‘community approach’ to a list of five issues, none of them specifically about addiction, but all of them imbricated in the experience of addiction in the DTES. The five issues were: ‘police conduct, ‘is this your home?,’ neighbor relations, violence and safety, washroom facilities.” See Lessard *supra* note 8 at 97.

⁵⁶ Kerr et. al *supra* note 55, at 9.

⁵⁷ *Id.* at 17.

⁵⁸ *Id.* at 17.

⁵⁹ VANDU, ABOUT VANDU, www.vandu.org (last visited Apr. 28, 2013)

social attitudes and public policy simultaneously and dialectically.”⁶⁰ From the beginning, VANDU identified “the distance that users are from society” as a key obstacle⁶¹ and defined as its first objective “ [changing] the demonizing rhetoric they endured using community meetings, demonstrations, education and fearlessness in the face of repression.”⁶² To achieve this goal, VANDU members organized to directly confront and challenge the dominant discourse condemning the DTES as “deviant and beyond repair.”⁶³ For example, VANDU activists circulated a poster that asked, “Why don’t you just kill us?” when home and business owners in the area asked for more law enforcement as a direct challenge to harm reduction.⁶⁴ Further, VANDU staged demonstrations to respond to Constable Mark Tonner of the Vancouver Police Department’s portrayal of DTES IDUs as ‘vampires’ and ‘werewolves’ in a weekly column he wrote for a Vancouver newspaper.⁶⁵ VANDU also invited key government players such as the aforementioned Larry Campbell and Libby Davies, MP for the district, to meetings to listen to concerns and share solutions.⁶⁶

Beyond direct action, VANDU served as a structured and tangible space for community members to discuss issues such as police violence against indigenous resistance, harm reduction approaches pursued in Europe “as well as...larger systemic issues- the role of poverty, the effects of criminalization, and the absence of any political voice or credibility for injection drug users in the face of ‘war on drugs’ rhetoric” in regular meetings.⁶⁷ The need for a legal, user-controlled, and adequately funded safe injection site was a constant topic of conversation.⁶⁸ In addition to its tangible programmatic achievements over the years⁶⁹, VANDU has served to

⁶⁰ *Id.*

⁶¹ Kerr et. Al. *supra* note 55, at 9.

⁶² Boyd et al. *supra* note 38 at 108-10.

⁶³ Lessard *supra* note 8, at 98.

⁶⁴ Boyd et al. *supra* note 47, at 102.

⁶⁵ *Id.* at 84-85.

⁶⁶ Boyd et al. *supra* note 47, at 98-99.

⁶⁷ Lessard *supra* note 3, at 98.

⁶⁸ Boyd et al. *supra* note 47, at 45-52.

⁶⁹ “VANDU’s programmatic achievements over the years have included creating peer support and mentorship relationships; obtaining CPR training for addicts; inviting guest speakers; creating support groups for people on methadone, women with HIV, and those with Hepatitis C; patrolling back alleys to reach high risk drug users; creating used syringe recovery and syringe exchange programs; lobbying for, and then supervising, night-time public toilets, creating drop-

render the “invisible” community of the DTES visible as conscious, politically active agents of change. By creating a physical space where DTES IDUs could come together to collectively address their problems, VANDU enabled individual addicts to realize that they were not alone in the health and social problems they faced and empowered them to take deliberate action to directly address the stigma associated with their neighborhood and the failed governmental actions taken to respond to the problems that plague the DTES.

The other institutional petitioner in the Insite court cases, the Portland Hotel Society (PHS), was formed by the Downtown Eastside Residents Association and shared many members with VANDU.⁷⁰ Unlike VANDU, PHS ran a residence “for adults with mental illnesses, addictions and other problems” with funds from the Vancouver Coastal Health Authority and the B.C. Housing and Mortgage Corporation.⁷¹ Thus, PHS often served as a bridge between the DTES community and government bodies while still remaining of the community.⁷² In 1998, PHS organized a conference in Oppenheimer Park that brought “politicians, government bureaucrats, harm reduction experts from Europe and neighborhood drug users” together.⁷³

This sustained community activism was critical in prompting the local government to formally endorse the four pillars approach in 2001. Phillip Owen, Vancouver’s mayor from 1993 to 2002, had earlier in his tenure been an opponent of harm reduction strategies, but the DTES community activists’ sustained efforts to render themselves as visible political stakeholders worked to sway Owen to adopt the four pillars approach and become a “strong and articulate promoter” of it.⁷⁴ Owen, who spent every Saturday during his childhood in the DTES at his grandfather’s store, convened a Coalition for Crime Prevention and Drug Treatment in 1996 as a response to the drug epidemic in the DTES.⁷⁵ Owen was originally motivated by a fear of the “social decay” that drug addiction caused.⁷⁶ However, he began making rounds in the DTES at

in centers; visiting hospitalized drug users; and engaging in educational activities including participating in local, national and international conferences.” Lessard *supra* note 8, at 98.

⁷⁰ Lessard *supra* note 3, at 98.

⁷¹ SHARED LEARNINGS ON HOMELESSNESS, PORTLAND HOTEL SOCIETY, <http://www.sharedlearnings.org/index.cfm?fuseaction=Prof.dspProfileFull&profilesId=18131194-83ff-4f31-aea0-37e8756b3d0e>.(last visited Apr. 20, 2013).

⁷² Lessard *supra* note 8, at 99.

⁷³ Campbell et. al. *supra* note 45, at 127.

⁷⁴ Lessard *supra* note 8, at 99.

⁷⁵ Campbell et. al. *supra* note 45, at 125.

⁷⁶ *Id.* at 125.

night and came to know many addicts personally that way. He realized the people he met were “open, honest, and not the least bit frightening.”⁷⁷ Owen’s self-proclaimed “watershed” moment occurred at the International Forum on Drug Treatment and Crime Prevention that he convened in Vancouver in 1998.⁷⁸ In an effort to learn more about harm reduction, Owen invited experts on the topic from a variety of countries. However, he failed to extend an invitation to any actual drug users to speak. During the first panel, three VANDU members made the oversight clear to the mayor when they approached the microphone and explained that they were drug users and that their perspective was not represented at the conference. Harm reduction advocates in the crowd cheered, and drug users, mostly from VANDU, were included in most government-sponsored events focusing on drugs from that point forward.⁷⁹ Another example of VANDU’s impact on Owen occurred in 2001 when Owen decided to institute a 90-day moratorium on new services for drug users while government debate on the issue continued. At that time, approximately one person a day was dying in the DTES, so VANDU presented Owen with a coffin at his office with a check payable to the City of Vancouver for 90 human beings. Owen lifted the moratorium within three weeks.⁸⁰

However, Owen’s change of heart cost him politically as his party chose another candidate to run in the 2002 mayoral elections, in part to distance the party from Owen’s support of harm reduction policies.⁸¹ The strategy backfired for the party as Larry Campbell, still Chief Coroner of British Columbia and at that time also leader of the Committee on Progressive Electors (COPE), won in a landslide victory with almost twice as many votes as his leading opponent.⁸² Given Campbell’s first hand exposure to the increasing number of addiction related deaths in his capacity as Chief Coroner and his engagement with the DTES community, his election platform focused significantly on addressing the plights of the DTES and explicitly advocated for the opening of a supervised injection site in the neighborhood.⁸³ Campbell’s victory demonstrates not only the influence the DTES community’s harm reduction movement

⁷⁷ *Id.* at 125.

⁷⁸ *Id.* at 126.

⁷⁹ *Id.* at 127.

⁸⁰ VANDU, VANDU TIMELINE, www.vandu.org (last visited Apr. 28, 2013).

⁸¹ Neil Boyd, *Lessons from INSITE: Vancouver’s supervised injection facility: 2003-2012*, DRUG EDUCATION, PREVENTION AND POLICY (2012).

⁸² *Id.* at 7.

⁸³ *Id.* at 7.

had on government officials,⁸⁴ but also the inroads the community had made in rendering itself visible in Vancouver's collective consciousness. Vancouverites began to realize that harm reduction approaches were not "a fundamental disregard for the morality of prohibition."⁸⁵ By their votes for Campbell, the citizens of Vancouver demonstrated that the DTES was a community worthy of attention, one that they cared about. The opening of North America's first supervised injection facility went from being a distant pipe dream to an impending reality.

SIFs worldwide

Currently, there are 92 supervised injection facilities (SIF) in 61 cities worldwide.⁸⁶ Fifty-four of these cities are located in Europe.⁸⁷ Most of the European sites are operated by local social services while the sites in Norway, Canada and Australia have operated as pilot scientific studies.⁸⁸ The SIF in Australia, much like Insite, opened in large part due to community-based activism, and much like Insite, it faced opposition stemming from "supporters of prohibition" who saw the establishment of the SIF as a symbol of "the failure of punitive policy."⁸⁹ Also similarly to Insite, the Australian site's establishment was conditioned on the promise of extensive evaluation and research on the SIF's impact on addiction and public health. As the research results came in, it was noted that, "ironically, evidence from this evaluation will probably assist efforts to establish [SIFs] in other parts of the world."⁹⁰ This statement is all too relevant to Insite because the research results came to play an integral role in the court cases that decided Insite's future. Before delving into the reasoning in the court decisions, this paper will explore the events surrounding Insite's actual opening.

Insite

⁸⁴ Ken Higgins, a former Vancouver deputy police chief, Dr. John Millier, the provincial health officer, and Libby Davies, the New Democratic Party MP for Vancouver East all became "outspoken supporters of harm reduction" during this time period. Lessard *supra* note 8, at 99.

⁸⁵ Boyd *supra* note 79, at 6.

⁸⁶ D. Hedrich, T. Kerr & F. Dubois-Arber, *Drug consumption facilities in Europe and beyond*, in Rhodes T., Hedrich D., editors. HARM REDUCTION: EVIDENCE, IMPACTS, AND CHALLENGES 306-331 (T. Rhodes & D. Hedrich eds., 2010).

⁸⁷ Audio recording: Hester Lessard, *Jurisdictional Justice and the "Dream of Democracy": Missing Voices in the Struggle for Insite* held at University of Victoria, Faculty of Law in Allard Hall at the University of British Columbia (Jan. 26, 2012), https://circle.ubc.ca/feed/atom_1.0/2429/33755.

⁸⁸ *Id.*

⁸⁹ Wodak et al. *supra* note 29, at 621.

⁹⁰ Wodak et al. *supra* note 29, at 621.

raise shit

*we have become a community of prophets in the downtown eastside
rebuking the system
and speaking hope and possibility into situations
of apparent impossibility
to raise shit is to actively resist
and we resist with our presence
with our words
with our love
with our courage*

-Bud Osborn, DTES “poet activist”

The primary obstacle to legally opening a SIF in Canada rested in the federal Controlled Substances and Drug Act, which prohibits the possession and trafficking of controlled substances.⁹¹ In order to legally open Insite, the federal government would have to grant Insite an exemption from the CSDA. Mayor Campbell initially hoped to have Insite up and running by the end of 2002. However, negotiating the exemption with the Liberal federal government took almost a year after he was elected.⁹² It is critical to note that the DTES community groups remained in the frontlines despite the unprecedented governmental support they were enjoying. In fact, while the municipal elections for mayor were still contested, PHS went ahead and set up an unapproved SIF under the guise of a hair salon.⁹³ Once it became apparent that Campbell would win, PHS retreated from the plan in “hopes that an approved site would soon follow with better staffing and programming.”⁹⁴ When the negotiations between Campbell and the federal government dragged on, the founders of Back Alley opened another illegal SIF that operated until Insite finally opened its doors in September of 2003 at the “hair salon” location that PHS had prepared earlier.⁹⁵

Insite formally opened as a three-year pilot project. It received legal status through a federal exemption under Section 56 of the CSDA which allows the Minister of Health to exempt individuals and/or illegal substances from the application of the Act when “in the opinion of the Minister, the exemption is necessary for a scientific purpose or is otherwise in the public

⁹¹ Controlled Drugs and Substances Act, R.S.C. 1996 c. 19 4(1) and 5(1)

⁹² Boyd *supra* note 81, at 8.

⁹³ Lessard *supra* note 8, at 99.

⁹⁴ Campbell et. al. *supra* note 45, at 173-174.

⁹⁵ Lessard *supra* note 8, at 100.

interest.”⁹⁶ The scientific research was to evaluate Insite’s “impact in relation to overdoses, its impacts upon the health of those injecting at the facility, the extent of involvement with health and social services in responding to these injection drug users, and the relative health, legal and correctional costs associated with injection drug use within the community.”⁹⁷

Insite began operating as a partnership between PHS and the Vancouver Coastal Health Authority, a government agency. PHS’s significant partnership role in running the facility demonstrates that the government understood that as an idea that originated from within the DTES community, Insite could not come to fruition without continued involvement from key DTES players such as PHS. These were the people who knew the community most intimately and who had already taken a stab at harm reduction approaches, learning best practices along the way through first-hand trial and error.

Since its opening, Insite has been open 365 days a year and has seen an average of 700-800 visits a day.⁹⁸ Insite is a three-story building. The first floor serves as the supervised injection site with twelve injection booths.⁹⁹ The second floor is a detox program that serves 12 people at a time, and the third is an 18-bed, long-term drug recovery program called Onsite. Insite was deliberately designed this way to make it, “as easy as going up a flight of stairs” for IDUs to begin the recovery process.¹⁰⁰

As soon as Insite opened, the B.C. Centre for Excellence in HIV/AIDS set up the scientific evaluations. In the first five years, over thirty studies were published in peer-reviewed journals “demonstrating that the facility was associated with a range of health and social benefits

⁹⁶ Controlled Drugs and Substances Act, Section 56.

⁹⁷ Boyd *supra* note 79, at 7.

⁹⁸ VANCOUVER’S SUPERVISED INJECTION SITE PROVIDING SAFE PLACE CHANGING LIVES, Streetroots <http://news.streetroots.org/2010/07/21/vancouver-s-supervised-injection-site-providing-safe-place-changing-lives> (last visited Apr.20, 2013).

⁹⁹ The booths are fitted with large mirrors. The mirrors serve a dual function. First, they help the staff and nurses monitor the IDUs and look for signs of overdoses. Second, they allow the IDUs, who are often homeless without access to mirrors, to see the physical effect the drug is having on them. This physical and visual confrontation with the self often serves as the first step in the road to recovery. Interview with Russ Maynard April 15, 2003.

¹⁰⁰ VANCOUVER’S SUPERVISED INJECTION SITE PROVIDING SAFE PLACE CHANGING LIVES, Streetroots <http://news.streetroots.org/2010/07/21/vancouver-s-supervised-injection-site-providing-safe-place-changing-lives> (last visited Apr.20, 2013).

and not associated with adverse effects.”¹⁰¹ Despite the almost unanimously positive results of the scientific evaluations,¹⁰² Insite was about to face its toughest challenge yet.

History of Legal Battle

“The decision of the PHS to launch the legal case to protect the SIF was an attempt at preventing this group from being further neglected, forgotten and pushed into the shadows of society.” Dan Smalls¹⁰³

“On the first day and the last day of this legal case, people wept.” Dan Smalls¹⁰⁴

After 13 years of Liberal rule, the Conservative party of Canada secured a minority government in January of 2006 with the election of Prime Minister Stephen Harper. Harper expressed opposition to Insite during his campaign, stating, “We as a government will not use taxpayers’ money to fund drug use.”¹⁰⁵ In 2006, as the expiration date for the three year exemption quickly approached, Harper was equivocal about whether or not his government would grant an extension of the exemption, stating, “we are undertaking some evaluations, but this government’s concentration in the fight against drugs in the next few years will be on enforcement, prevention and treatment.”¹⁰⁶ In September 2006, Health Minister Tony Clement advised Insite that the exemption would be extended for 15 months but that the government would no longer provide funding for the evaluations.¹⁰⁷ In December 2006, Clement created an “expert advisory committee” to gather scientific advice on Insite’s effectiveness. Further, the Conservative government put out a call for research on Insite’s impact on crime and public order. In February 2008, the commissioned report concluded,

In sum, there is no compelling evidence to suggest that Insite has had a negative impact on public order, and, more specifically, there

¹⁰¹ E. Wood, M.W. Tyndall, J.S. Montaner & T. Kerr, *Summary of Findings from the Evaluation of a Pilot Medically Supervised Safer Injecting Facility* 175 CMAJ 1399 (2006).

¹⁰² One study of Insite attempted to debunk all of the positive results found in the other studies. Colin Mangham, *A Critique of Canada’s INSITE Injection Site and its Parent Philosophy: Implications and Recommendations for Policy Planning* JOURNAL OF GLOBAL DRUG POLICY AND PRACTICE (2007). However, this paper has been widely denounced, especially because it was published in a non-peer reviewed, online-only journal. See e.g. Thomas Kerr & Evan Wood, *Misrepresentation of Science Undermines HIV Prevention* 178 CANADIAN MEDICAL ASSOCIATION JOURNAL 964 (2008).

¹⁰³ Small et. al *supra* note 34, at 9.

¹⁰⁴ Small et. al *supra* note 34, at 10.

¹⁰⁵ Boyd *supra* note 81, at 8.

¹⁰⁶ *No Aids Announcement during ‘politicized’ week: Ottawa*, CBC NEWS, August 17, 2006.

¹⁰⁷ Boyd *supra* note 81, at 8.

is no evidence to suggest that Insite has had any significant impact on either the rate or spatial distribution of criminal activity within the neighbourhood. There is evidence, however, that a clear majority of our sample of people who live and/or work in the neighbourhood view Insite as making a positive contribution to public order, and would like to see the services expanded, retained, or modified.¹⁰⁸

However, in late 2006, the Royal Canadian Mounted Police privately commissioned the director of a group called the Drug Research Network to write a report “critical of Insite’s effectiveness, and the research conducted to date.”¹⁰⁹ The report was published in a non peer reviewed journal and widely criticized,¹¹⁰ yet Clement seized on this single report to signal that the government would not be extending Insite’s exemption. He stated, “There has been more research done, and some of it has been questioning of the research that has already taken place and questioning of the methodology of those associated with Insite.”¹¹¹ Clement referred to Insite as an “abomination” at the International AIDS conference in 2008.¹¹²

Realizing that Insite would have to permanently shut its doors without an exemption, PHS, along with two IDUs, Dean Edward Wilson and Shelly Tomic, filed suit in the British Columbia Supreme Court, arguing that Insite’s closure would violate section 7 of the Canadian Charter of Rights, which states, “Everyone has the right to life, liberty and security of the person and the right not to be deprived thereof except in accordance with the principles of fundamental justice.” VANDU joined PHS in claiming that the doctrine of interjurisdictional immunity shielded Insite from the CSDA.¹¹³ It is critical to note that the Vancouver Coastal Authority

¹⁰⁸ NEIL BOYD, BRIAN KINNEY & CARLA MCLEAN, FINAL REPORT: PUBLIC ORDER AND SUPERVISED INJECTION FACILITIES- VANCOUVER’S SUPERVISED INJECTION SITE, Ottawa, Health Canada (2008).

¹⁰⁹ Boyd *supra* note 81, at 11.

¹¹⁰ *Id.* at 11.

¹¹¹ Monte Paulsen, *Tory MPs Met with RCMP Officers Who Commissioned Anti-Insite Research* THE TYEE, (October 8, 2008) <http://theyee.ca/Blogs/TheHook/RightsJustice/2008/10/08/MPsMetWithRCMP/>

¹¹² Boyd *supra* note 81, at 11.

¹¹³ “Simply stated, this doctrine applies to circumstances in which provincial laws may encroach upon federal laws, or put differently, circumstances in which a provincial jurisdiction of legislation clashes with a federal jurisdiction of legislation. In this instance section 91(27) of Canada’s Constitution Act gives the Canadian government exclusive powers to legislate in relation to criminal law and procedure. In turn, Section 92(7) of the Constitution Act gives each of Canada’s provinces (in this case, British Columbia) exclusive authority over ‘the

(VCA) strongly advised PHS not to bring suit, fearing antagonizing the government.¹¹⁴ But PHS, as opposed to the bureaucratic government office that was VCA, was intimately invested in the DTES community given its sustained, long-term, grassroots efforts to make Insite a reality; as such, it had no intention of risking the possibility that Insite would be permanently shut down. If the decision had been left to VCA, an entity that was not borne out of a DTES social movement, the government might very well have closed Insite down in 2008 without much of a fight.¹¹⁵ In fact, VCA was making active plans to close Insite just days before the final Supreme Court judgment.¹¹⁶ Thus, this story serves as an example of a situation where a social movement benefitted from legal intervention in order to continue to work toward its social change goals.

In the court cases,¹¹⁷ PHS centered the stories of individual IDUs in an attempt to humanize them while simultaneously emphasizing the robust evidence-based research that lauded Insite's effectiveness. Both Wilson and Tomic gave moving testimonies at trial, detailing their decades long battles with addiction. Wilson began using heroin when he was twelve while Tomic was injected with speed by a relative when she was seven.¹¹⁸ Their testimonies highlighted that they experienced addiction as a prolonged illness. A number of health professionals also testified on behalf of Insite. Of these, the British Columbia Nurses Association and British Columbia Nurses Union brought a significant degree of legitimacy to Insite as a public health institution given that the Canadian population holds the two groups in high esteem.¹¹⁹

The Decision

The most favorable ruling for Insite came at the trial level, where Justice Ian Pitfield found that Insite should remain open even without an exemption from the CSDA and that the

establishment, maintenance and management of hospitals, asylums, charities and eleemosynary institutions in and for the province, other than marine hospitals' The claim of the plaintiffs was that interjurisdictional immunity should be upheld in this conflict- that the operation of Insite was a valid use of the provincial power to legislate in relation to public health institutions. As such, it was immune from the operation of the federal criminal law power." See Boyd *supra* note 79, at 13.

¹¹⁴ Interview with Russ Maynard, April 15, 2013.

¹¹⁵ *Id.*

¹¹⁶ *Id.*

¹¹⁷ There were three decisions since the case was appealed twice.

¹¹⁸ PHS Community Services Society et al. v. Attorney General of Canada, [2008] BCCA at 25.

¹¹⁹ Interview with Russ Maynard, April 15, 2013.

federal government should rewrite federal law to allow the medical use of illegal drugs. As applied to Insite, Justice Pitfield found the prohibition on illicit drugs to arbitrarily limit “the management of addiction and its associated risks” and thus it violated an individual’s right to “life, liberty and security of the person.”¹²⁰ Justice Pitfield reached his decision by decidedly viewing addiction as an illness and after a thorough review of the evidence, concluding, “The risk of morbidity and mortality associated with addiction and injection is ameliorated by injection in the presence of health professionals.”¹²¹ Justice Pitfield focused his analysis on the Charter framework and rejected the interjurisdictional analysis.

The government appealed the decision to the B.C. Court of Appeal. In 2010, in a 2 to 1 ruling, the court upheld Justice Pitfield’s decision that “Insite should continue to operate” free from federal prohibition.¹²² The government had argued before the court that Justice Pitfield’s decision would “require Parliament to carve out an exception to the laws of possession and trafficking for addicts, the most frequent offenders of the drug laws.”¹²³ Writing for the majority, Justice Rowles squarely rejected that reasoning, finding that it “simply ignores...the effect of addiction on the downtown eastside.”¹²⁴ This statement indicates that the justices were moved by the localized, specific, contextual addiction situation of individuals in the DTES and that the history of the dire situation in the DTES and the successes of the harm reduction movement in mitigating death and disease in the area justified an exception to the CSDA in this geographic location. The court again promoted a localized response to local problems by using the interjurisdictional immunity doctrine to further shelter Insite from the federal government, finding that “law-making is often best achieved by the level of government closest to the citizens affected and thus most responsive to local distinctiveness and population diversity.”¹²⁵ Justice Huddart cemented the point by concluding,

The crisis that brings the issue to this Court is a local one. Their practical response to ‘one of the worst, if not the worst, health outcomes for injection drug use of any city in the developed world in the last 25 years’ is to permit supervised self-injection of illegally obtained drugs in a carefully-controlled health care

¹²⁰ PHS Community Services Society et al. v. Attorney General of Canada, [2008] SCBC at 89.

¹²¹ *Id.*

¹²² *Id.*

¹²³ Boyd *supra* note 79, at 15.

¹²⁴ PHS Community Services Society v. Canada, [2010] BCCA at 76.

¹²⁵ *Id.*

facility...the application of the doctrine does not amount to a form of provincial paramountcy. The doctrine's application, as I understand it, is available only to enable the operation of an essential part of a provincial undertaking that would not negate the federal law or undermine its goals. It is a surgical immunity- it attaches only to a small part of the power, precisely defined and narrowly circumscribed.¹²⁶

The government appealed the decision to the Supreme Court of Canada. The DTES movement immediately protested Prime Minister Harper's decision to appeal, organizing a 150 person rally that prevented Harper from attending a pre-Olympic event.¹²⁷ The rally focused on the message that Insite "saves lives." Nevertheless, the government proceeded with the appeal, and the Supreme Court handed down a unanimous decision of the nine-person bench in 2011.

Not wanting to "disturb settled competencies and introduce uncertainties for new ones" the court rejected the interjurisdictional argument.¹²⁸ In its Charter analysis, the court focused not on the blanket prohibition against possession of illegal substances, as Judge Pitfield had, but instead specifically on the Minister of Health's decision under Section 56 not to grant the exemption. The court emphasized that addiction was a disease and as such, "there is no reason to conclude that the deprivation the claimants would suffer was due to personal choice rather than government action."¹²⁹ Since the Minister of Health's decision would have threatened the health and lives of addicted individuals by cutting them off from services, the court found it would simultaneously limit their Section 7 rights and undermine the purpose of the CDSA- the protection of health and public safety. The court continued, "the effect of denying the services of Insite to the population it serves and the correlative increase in the risk of death and disease to injection drug users is grossly disproportionate to any benefit that Canada might derive from presenting a uniform stance on the possession of narcotics."¹³⁰ The court concluded by counseling the Minister of Health to weigh possible negative impacts on public safety against

¹²⁶ *Id* at 174-175.

¹²⁷ *Supporters rally to defend Insite from Feds.* (Feb. 12, 2010) <http://cupe.ca/communications/supporters-rally-support-insite>.

¹²⁸ *Canada (Attorney General) v. PHS Community Services Society* [2011] S.C.R. 44 (Can.) at 70.

¹²⁹ *Id.*

¹³⁰ *Id.*

possible deprivations to a person's life and security when determining whether or not to grant a Section 56 exemption.

Conclusion

The decisions in the Insite cases were predicated on two fundamental premises. First, that addiction is an illness, and second, that harm reduction is an appropriate response to this illness. The court would not have so readily accepted these two ideas had it not been for the sustained efforts of the DTES community-based, harm reduction movement. That movement humanized the addicted individuals of the DTES and rendered them into visible, politically active agents of change. They implemented harm reduction approaches when the government would not, and in doing so and achieving successful results, they steadily gained support from key institutional players, culminating in the election of an ardent Insite supporter to the office of mayor. That institutional support was buttressed by evidenced-based studies that confirmed what the DTES community had known for years- harm reduction works. This context enabled the courts to frame the denial of such an effective and popular local solution to be a denial of basic constitutional rights. Undoubtedly, it helped that the Insite plaintiffs had “good law” on their side in the form of Section 7 of the Canadian Charter.¹³¹ But for the justices to accept a human rights/public health justification for granting the exemption, they had to first see IDUs as Canadian citizens whose being and health were worthy of full Charter protections instead of as lesser citizens relegated to the margins. Perhaps the justices held pre-existing sympathetic views toward IDUs- it is impossible to know. But justices do not operate within a vacuum, and PHS and VANDU's approaches toward the case deliberately humanized IDUs by focusing on their personal stories and their constitutional rights along with the history of IDU-led harm reduction activism in the DTES. The justices emphasized the localized nature of the harm reduction response to addiction in the DTES, signaling that they respected that movement's effective response to the drug problem in the DTES. The justices essentially found that the federal government has no right to interfere with this local movement designed to protect individuals' Charter-guaranteed rights. The Insite story demonstrates that sometimes, sustained, focused, effective and localized movements can successfully respond to problems plaguing their communities despite seeming legal obstacles. In fact, such movements can even enjoy significant legal victories.

¹³¹ See e.g., Michael McCann and George Lovell, *Executing “Good” Civil Rights Law: A Political History of Wards Cove v. Atonio (The 1980s-90s)*.

