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Zoned Out: "NIMBYism", addiction services and municipal governance in British Columbia

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ABSTRACT

In Canada, Provincial Governments have jurisdiction over delivery of healthcare including harm reduction services and Methadone Maintenance Therapy (MMT). While policy directives and funding come from the provincial capital, individuals' access to these services happens in neighbourhoods and municipalities spread out across the province. In some cases, public health objectives targeted at people living with addictions and the rights to equitable access to healthcare are at odds with the vision that residents, business associations and other interest groups have for their neighbourhood or city.

This paper looks at the cases of four British Columbia municipalities, Mission, Surrey, Coquitlam and Abbotsford, where local governments have used zoning provisions to restrict access to harm reduction services and drug substitution therapies including MMT. This paper will contextualize these case studies in a survey of zoning and bylaw provisions related to harm reduction and MMT across British Columbia, and examine the interplay between municipal actions and public discourses that affect access to healthcare for people living with addictions. Finally, this paper will explore possible legal implications for municipalities that use their zoning and permitting powers to restrict access to health care for people with addictions, as well as public engagement strategies for healthcare advocates that have the potential to reduce resistance to health services for people living with addictions in communities across the province.

Introduction

As one of the most thoroughly studied medical treatments for addiction, Methadone Maintenance Treatment (MMT) has a proven track record in stabilizing the lives of people with opioid addiction. MMT is correlated with reduced use of illicit opioids and with a reduction in illegal and risk-promoting behaviours (Murray, 1998). MMT has also proved cost effective for the public health system (Jamieson, Beals, Lalonde, & Associates Inc., 2002). However, access to MMT for stabilizing opioid addiction remains a global problem. Despite being around for over 40 years, less than 10% of those in need of treatment are able to receive MMT (World Health Organization, 2008). Further, MMT remains outright illegal in some countries with extensive opioid dependency problems, notably the Russian Federation. In countries where it is widely available, only 40–50% of drug users receive treatment (World Health Organization, 2008).

MMT access may be limited by any number of factors, including governmental control measures targeted at narcotic drugs (World Health Organization, 2008) or the lack of funding, physicians and pharmacists to carry out an effective programme (Health, 2011). Policy decisions around MMT availability, however, are often influenced more by the stigma and contempt for drug users than the data and evidence about effectiveness of the treatment (Wodak, 2002).

Following a "turbulent history" (Fischer, 2000), MMT has been available in all provinces in Canada since 2005. MMT is currently prescribed to approximately 51,000 Canadians (Luce & Strike, 2011). In British Columbia, where there is a higher rate of heroin and other opioid use than in other Canadian provinces, MMT is prescribed to approximately 10,000 individuals (Reist, 2010).

Despite the empirical evidence supporting low-barrier access to MMT as an important tool for stabilizing and improving health outcomes for people with opioid addictions, availability of this treatment in Canada is threatened by the growing number of municipalities, particularly in the provinces of Ontario and British Columbia, that have restricted access to methadone and other harm reduction services through zoning bylaws. In many cases, these municipal restrictions on access to methadone and harm reduction services are an acquiescence to "Not in My Backyard" (NIMBY) organized community opposition. While there have been many cases of NIMBY organizing by residents and business associations in Canadian municipalities that have resulted in reduced

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access to MMT and other harm reduction services, scholarly debate around this phenomenon has been lacking (Smith, 2010). This commentary aims to provide a survey of the use of zoning bylaws to address NIMBY opposition to harm reduction health strategies in the Lower Mainland of British Columbia, the geographical area surrounding the city of Vancouver, and explores the legal and human rights impacts of these developments for marginalized drug users.

Zoning against harm reduction

In Canada, zoning is a mechanism by which municipalities, through authority conferred on them by provincial statute, are empowered to regulate land use through bylaws. Although not consistent across Canada, some stated statutory purposes of zoning are "to control the use of land for providing for the amenity of the area within the council's jurisdiction and for the health, safety and general welfare of the inhabitants of the municipality" (The Planning and Development Act, 2007) or, more simply, to "prohibit, regulate, and control the use and development of land and buildings in a municipality" (Municipal Act, 2002).

Exclusionary zoning – using zoning bylaws to exclude certain socio-economic groups from parts of a municipality – is nearly as old as the implementation of zoning itself (Kinnally, 1999). Zoning developed in Europe in the mid-1800s, and its first application in North America was in 1885 in California, when zoning provisions were used to exclude Chinese laundries from certain areas (Bish & Clemens, 2008). Zoning has been used to restrict access to land use based on race, ethnicity, and social class, both overtly and covertly through bylaws that are neutral on their face, but discriminate in effect.

Courts have, on occasion, been asked to examine the purpose of zoning laws and have settled on some ground rules for valid exercise of zoning powers. In order to be deemed valid, "a zoning ordinance must be reasonably related to the police power – that is, it must further the public health, safety, morals, or general welfare" (Rohan, 2007). It is important to consider, however, that communities are rarely unanimous in their estimation of whether a particular service or land use decision contributes or detracts from safety, morals or general welfare. In that context, the needs of marginalized community members may be undermined if zoning powers are used to deny access to necessary social and health services provided by higher levels of government or to "zone out" groups of people rather than manage land uses.

Typically, zoning bylaws define a set of "uses" that the municipal government wants to regulate, such as retail store, library, or retirement home. The bylaw generally sets out geographical "zones" within the municipality, which might, for example, be designated residential, commercial, industrial, or mixed use, and then ties the uses to the zone, either permitting certain uses outright or with conditions, or prohibiting them entirely.

Since 2000, several municipalities in the lower mainland of British Columbia have passed amendments to their zoning bylaws that restrict access to methadone and other harm reduction services. These amendments typically create new uses such as "methadone clinic" or "methadone dispensary" as distinct from other health care or social service uses, as well as new restrictions on the zones in which these services may be located or how they may be distributed throughout the municipality or the zone. What follows is a brief survey of some changes to zoning bylaws that restrict access to methadone or other harm reduction services and the process through which the bylaws came into being.

Mission, BC

Mission is a British Columbia district municipality with a population of 34,505 (Statistics Canada, 2007). A number of unincorporated semi-rural and rural districts are closely linked to Mission and the area has a low volume of new local employment opportunities (District of Mission, 2012).

In August 2012, the Council of the District of Mission amended its zoning bylaw to remove two uses from the zone identified in the bylaw as "Core Commercial Downtown One Zone". The amendment removed "Pharmacy" and "Medical Clinic" from the bylaw (District of Mission, 2009). This amendment came on the heels of an application for a building permit by Life Pharmacy Inc. in April 2012 to open a general-purpose pharmacy which would include dispensing methadone. The apparent purpose of the amendment was to prohibit this business from establishing in the downtown area.

Following the purchase and permit application by Life Pharmacy, unsubstantiated rumours began to surface that the pharmacy would be not only dispensing methadone, but also offering a needle exchange programme, operating a medical cannabis clinic, and prescribing methadone. On May 2, 2012, at a special Council meeting, Mission Mayor Walter Adlem asked Council to consider an amendment to remove "pharmacy" and "medical clinic" as permitted uses for the zone in question. The resolution was passed by Council and the bylaw was subsequently made the subject of a public hearing, at which Council staff reported receiving 78 signed form letters in support of the amendment from individuals identified as members of the Mission Downtown Business Association (MacNair, 2012). Some people who wrote letters in support of the amendment stated that they did not want a business in downtown Mission that would attract "the wrong type of people."

A representative of Life Pharmacy spoke against the amendment and attempted to clear up rumours, noting that their pharmacy business would not be providing cannabis, needles or prescriptions for methadone. The pharmacy would, however, be dispensing methadone to patients with valid prescriptions in accordance with the law. The representative of the pharmacy suggested that opposition to the business may have arisen from the fact that they would be providing services to marginalized people who were already accessing social service agencies in the vicinity of the intended site for the pharmacy. Other than the business owner himself, there were no clear opponents to the amendment present at the public hearing, particularly any person who supported the rights of MMT patients to receive unfettered access to treatment (District of Mission City Council, 2012).

In passing the amendment, the Mayor and some Councillors cited the City's incomplete and developing "revitalization plan" as the rationale for prohibiting Life Pharmacy from opening their business. In support of the amendment, Councillor Jeff Jewell stated, "we have to respond to the overwhelming concerns of the people who are directly affected, specifically the businesses of Mission" (MacNair, 2012). Councillor Jenny Stevens, the only councillor who voted against the amendment, said she couldn't support a bylaw that prohibited certain businesses based on their legal activities, and suggested that the City of Mission might be in contravention of the *Canadian Charter of Rights and Freedoms*.

Surrey, BC

With a population of nearly 500,000, Surrey is British Columbia's second most populous city. Surrey is just 35 km from Vancouver, and is characterized by large number of commuters and low population density (City of Surrey [COS], n.d.). Surrey's efforts to restrict methadone services in the city began in 2000 with a move to amend its zoning bylaw to add a definition for "Methadone Clinic" (City of

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Surrey, 1993). The City also amended the list of *Permitted Uses* for all zones to exclude Methadone Clinic except as an "accessory use to a hospital." City staff forwarded a report to Council on October 25, 2000 that outlined the rationale for this bylaw change, which would restrict methadone clinics to a single site, Surrey Memorial Hospital, and which included comment from interested parties (City of Surrey, 2000). That report noted that the South Fraser Health Region had some concerns about the bylaw change, namely that a methadone clinic was not currently located at the Surrey Memorial Hospital site, and it was neither planned nor feasible to locate a clinic there. The health region representative further noted that in the absence of a comprehensive and integrative alcohol and drug treatment plan, enacting the bylaw "may further limit or restrict the community's access to a necessary service" (City of Surrey, 2000).

During the public hearing on the bylaw, Dr. Roland Guasparini, Medical Health Officer for the health region, noted that there were approximately 2300 addicted people in the Region, 800 of whom were in methadone treatment. He recommended that the municipality consider alternate ways to manage methadone clinics such as size and design (City of Surrey Council, 2001). Those recommendations were ignored by the City of Surrey, which passed the bylaw changes.

In July, 2008, the municipal council of Surrey proposed further amendments to its zoning bylaw targeting methadone dispensing pharmacies. The 2008 zoning changes reportedly resulted from a discussion between the City and the B.C. College of Pharmacists concerning "the need to address the proliferation of methadone dispensing pharmacies in City neighbourhoods, and in particular the rapidly gentrifying City Centre, due to the adverse impacts to neighbourhoods that such a proliferation is causing" (City of Surrey, 2008). The City created new definitions of "methadone dispensary", "small-scale drug store" and "drug store", and legislated minimum distances of 400 m between small-scale drug stores and drug stores. Amendments were also proposed to Surrey's *Methadone Dispensing Bylaw* (City of Surrey, 2003) that reflected the new definitions of the zoning bylaw and also stipulated that methadone dispensaries could not locate within 400 m of an existing methadone dispensary, small-scale drug store, or drug store (City of Surrey, 2008). These changes built upon the 2001 zoning changes that prohibited new methadone dispensing drug stores being established in a retail zone.

In media reports about the proposed amendments, Jay Redmond, president of the Downtown Surrey Business Improvement Association stated of the 400 m rule, "It will be a good first step. Obviously we're not going to solve all the world's problems, especially the drug problems in this area, but by reducing the concentration it will hopefully reduce the impact on the businesses in that area." He further noted that the concentration of the methadone dispensaries serving addicts also attracts "undesirables" to the gentrifying Whalley core and merchants complain they scare away customers (Surrey Now, 2008).

Coquitlam, BC

Coquitlam is a largely suburban city near Vancouver, BC, with a population of 126,456 (Statistics Canada, 2012a). On July 27th, 2009, the mayor of Coquitlam signed the *Adult Oriented and Undesirable Business Bylaw No. 3864, 2009* into effect (City of Coquitlam, 2009). This bylaw added several new definitions into the city's zoning bylaw, including "Methadone Clinic" and "Methadone Dispensary".

The amended bylaw prohibits a broad range of businesses which it describes as "adult oriented" in all zones of the city: pawnbrokers, massage parlours, methadone clinics, escort services, and exotic dancing (City of Coquitlam, 2009).

This amendment also restricted the location of certain new permitted "adult or undesirable" businesses including methadone dispensaries, to no closer than 1 km from other existing businesses, and restricted the locating of a new methadone dispensary to no closer than 1 km from existing adult entertainment use, adult video store, cheque cashing business, methadone dispensary, tattoo parlour, massage parlour, pawnbroker, pawnshop, escort service, exotic dancing use, or scrap metal dealer (City of Coquitlam, 2009).

The explicitly moral tone of the bylaw and the diverse businesses captured by the bylaw drew the attention of the Canada-wide newspaper, the Globe and Mail. Al Boire, president of a local Residents' Association, told the Globe and Mail that the area was struggling with drug problems, vandalism, graffiti and prostitution after a neighbourhood pawnshop opened a couple of years prior. Boire said it was becoming an adult-entertainment zone, and that was not acceptable in a family-oriented community.

City Councillor Mae Reid, who spoke to the Globe and Mail, said that the City could not provide the number of complaints it received about businesses classified as undesirable, but was cited as saying: "we got it before we ended up having hundreds of these businesses" (Sandhu Bhamra, 2009). At the time the bylaw was passed, Coquitlam had three pawnshops, and did not actually have an existing methadone clinic (North Shore News, 2009). Bars, liquor stores and the large local casino, all of which serve only adults, were not affected by the bylaw change and continue to operate as they had previously.

Abbotsford, BC

Abbotsford is located 74 km east of Vancouver. It is the fifth largest municipality in British Columbia and home to approximately 133,497 people (Statistics Canada, 2012b). It also has British Columbia's most sweeping anti-harm reduction zoning bylaw. In 2005, Abbotsford City Council amended their zoning bylaw to add "harm reduction use". For the purpose of the bylaw, harm reduction use included, (1) the growing, production, manufacture, sale, distribution and trade of drugs listed in Schedule 1 of the *Controlled Drugs and Substances Act*, including cannabis, or any by-product of cannabis, or any substance held out to be cannabis; (2) Methadone treatment clinics and dispensing facilities, except where administered by a Provincially registered pharmacist; and (3) Needle exchanges, mobile dispensing vans, safe injection sites, and any other similar uses.

The zoning bylaw was further amended to prohibit "harm reduction use" in any zone of the City (City of Abbotford, 1996). In comments in support of his City's anti-harm reduction policies, Abbotsford Mayor Bruce Banman made his position on harm reduction clear: "you are, if you are a drug user, a criminal. You're not a helpless victim. You are, and choose to be, a criminal. It is an illegal activity that you are doing. If you are a paedophile, you are a criminal. And how we deal with criminals is we lock em up" (Bellrichard, 2012).

The bylaw runs contrary to plans outlined by the Fraser Health Authority to implement harm reduction strategies in the community. As noted by the regional health authority, the bylaw has an impact on their provincially mandated health provision work (Fraser Health Authority, 2012). Abbotsford currently faces escalating rates of infectious disease higher than both provincial and national averages (Fraser Health Authority, 2012). However, Fraser Health Authority public health director, David Portesi, noted, "If we institute harm reduction services in a hostile environment their effectiveness is diminished considerably" (Bellrichard, 2012).

Some groups in Abbotsford are flouting the restrictions in the bylaw and distributing clean needles to injection drug users, either through surreptitious distribution at a location where other services are offered or through operation of a mobile van. However, the

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bylaw has created a chilling effect and community organizations wishing to operate overt services are unable to secure approval and funding from the health authority, which has stated explicitly that the bylaw is an obstacle to providing service.

Abbotsford officially continues to "review" the bylaw, and there are indicators that the tide is changing. In some venues, the Mayor has supported needle exchange to combat the spread of hepatitis C and overdose death, and the provincial Minister of Health has come out in support of needle exchange in Abbotsford (Baker, 2012). On April 22, 2013, Council directed City staff to create both an amendment to the bylaw that would remove the reference to "harm reduction" and a "good neighbour" policy to which needle exchange services would have to adhere. However, any amendment to the bylaw would be subject to public hearing and both that and the policy would be dependent on Council approval (City of Abbotsford Executive Committee, 2013).

Discussion

Zoning can be used as a tool to increase opportunities and improve access to services for marginalized groups, such as people with disabilities. As evidenced by the above examples, however, it can also be misused, "zoning out" necessary services for vulnerable communities, with dire public health and human rights implications.

In Canada, authority for providing healthcare rests with provincial governments. In British Columbia, municipalities cannot specifically legislate with respect to public health unless such legislation is authorized by regulation, agreement or with approval of the responsible minister. As a result, a municipality cannot legally tread on the authority of the province to deliver healthcare through its zoning unless it has provincial authority to do so. When municipalities attempt to legislate access to healthcare, such as methadone or harm reduction, through their zoning bylaws, they are likely exceeding their jurisdiction. This is especially true where municipalities have banned a particular mode of healthcare outright.

In the case of Abbotsford, for example, the health authority would provide harm reduction services, were it not for the municipal bylaw standing in the way. The tensions between the exercise of the municipal powers and the aims of public health present possibilities for legal interventions on behalf of those denied access to healthcare through zoning laws. One example of such an intervention into the bylaw amendment process on behalf of marginalized people occurred in the Province of Ontario. The Ontario Human Rights Commission (OHRC) looked at a case in London, Ontario involving bylaw amendments to restrict the provision of methadone in that city. In a letter to London's Mayor and planning staff, who were evaluating the amendments to restrict methadone clinics and pharmacies in all zones of the city, the Commission noted that public hearings reinforce the incorrect assumption that neighbourhood residents have the right to make decisions about the availability of housing and medical care (Hall, 2012). A similar letter was sent to the Ontario town of Northeastern Manitoulin and the Islands (NEMI) in February 2013 noting possible human rights violations of restricting methadone access on the basis of discriminatory stereotypes of methadone patients (Hall, 2013). While the Human Rights Tribunal in British Columbia does not take a proactive stance in voicing concerns about potential human rights infringements as the OHRC does, the Ontario example raises the possibility that human rights claims could be brought challenging the public process that leads to restrictive bylaws as well as the content and effect of the bylaws themselves.

In a recent similar case in the United States, a Pennsylvania District Judge ruled on August 17, 2012 that the City of DuBois' zoning ordinance barring a methadone clinic from establishing in the downtown was unconstitutional and ordered the City to pay the clinic $132,801 (US$) in damages. The City had enacted the ordinance after a federal appeals court struck down as unconstitutional a state law that restricted where methadone clinics could be located. Addressing the key question of the case – whether city officials intended to treat drug treatment facilities differently from other medical offices and facilities – U.S. District Judge Kim Gibson concluded, ". . .the plain language of the ordinance – which specifically prohibits methadone and drug treatment facilities, and no other medical uses. . .speaks for itself and demonstrates the City's intention to do just that" (Ray, 2012).

That municipal governments feel emboldened to engage in managing health care accessibility through zoning results not only from the failure of higher-level of governments to exert their own legal authority in constraining municipal powers in this realm, but perhaps also from the failure of the harm reduction movement to engage municipalities more effectively. When the harm reduction movement focuses on individuals, programmes and high-level drug policy directives without effectively engaging mid-level decision-making bodies, such as municipal councils, in the planning and collaboration of harm reduction services, it is natural that a gap in policy-making will emerge. That gap is as likely to be filled by public opinion as by evidence, and could result in exclusionary zoning decisions that limit access to health care.

However, exclusionary zoning decisions will continue to raise questions about human rights infringement of marginalized persons, as exemplified in London, Ontario, DuBois, Pennsylvania and elsewhere. These bylaws, as well as the complicity of the province in choosing not to challenge them, may constitute discrimination against people with disabilities or an infringement of the *Canadian Charter of Rights and Freedom* protected rights to life and security of the person of people who are prescribed methadone. These bylaws may also constitute discrimination on the basis of geography given that in Vancouver methadone and needles are readily available to drug users as provincially supported medical care.

Conclusion

The stigma around drug use and even around recognized and effective methods of stabilizing and treating opioid addiction such as MMT are driving zoning policy and healthcare delivery in several Canadian municipalities. Despite the fact that methadone is a provincially sanctioned, funded and regulated form of healthcare in British Columbia, the motivation for this legislative action seems to be to move people prescribed methadone elsewhere.

Yet, municipal governments do have other alternatives and, in fact, can use their zoning powers to strengthen access to MMT and other health services in their communities. The City of Saskatoon in Saskatchewan Canada, responded to NIMBY pressure about a needle exchange programme that has been operated by a service group in the community for three and a half years by commissioning a report that looked into the impacts of the service. The report, tabled on December 3rd, 2012, found that despite claims to the contrary, the needle exchange has not increased crime in the area and it was correlated with a reduction in new cases of HIV infection (Grauer, 2012). The definition of a "medical clinic" in Saskatoon's land use and zoning bylaw did not, however, specifically mention needle exchanges, and so these facilities were at risk of falling outside of lawful use. Based on the recommendations of the report, the City will now undertake a review with the intention of "clarifying" the definition of "medical clinics" to include needle exchanges to ensure that its zoning bylaws do not stand in the way of sensible and effective responses to a public health crisis and do not undermine

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public health goals. Undoubtedly, a culture in the local government recognizing the stigma faced by drug users and the importance of evidence-based decision-making paved the way for a municipal response supporting public health. Positive media portrayals of drug users and the complexity of drug dependency and health interventions also likely shape public opinion in support of harm reduction approaches (Adam, 2013) and support non-exclusionary planning and zoning decisions that do not "zone out" health care options for marginalized persons.

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