MAKING UP A DRUG EPIDEMIC: CONSTRUCTING DRUG DISCOURSE DURING THE OPIOID EPIDEMIC IN ONTARIO

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Abstract

The current opioid epidemic has resulted in growing rates of overdose across the province with the introduction of fentanyl into illicit drug markets. What barriers are preventing policy makers from enacting emergency measures to save lives and how have those affected by the epidemic been categorically ignored? The following research critically analyzes drug discourse relating to the current opioid epidemic in Ontario and discusses why government responses to the epidemic have been delayed, and why they offer inferior measures to prevent growing mortality and morbidity. Using Ian Hacking's theory of *dynamic nominalism,* the work systematically deconstructs drug discourse through a number of perspectives in order to identify stakeholders and manifest relations of power that drive policy deliberation and designate key figures of authority. Research has shown that opioid dependent users are infantilized and demonized due to a history of negative perspectives on drug use that persist today in drug discourse.

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Dedication

I want to dedicate this work to those who succumbed to a drug dependence problem and everyone who has lost someone to an overdose or drug related circumstances. May they all find peace.

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INTRODUCTION

Canada is currently facing a public health epidemic of significant proportions that has killed approximately 15 393 people, and hospitalized another 19 000 since 2016. Despite the rising number of casualties and many communities sounding the alarm on the severity of the emergency, government action remains lackluster; inaction has resulted in deadly consequences. The epidemic in question is different. It is not a viral infectious disease from a distant, exotic land, nor is it making daily headlines. The young predominate case reports. People are dying right under our noses in urban centers and rural areas alike, in private homes and on the streets. Hospitals and emergency response teams are overwhelmed with the fallout, struggling to keep up with incidents and prevent people from repeatedly requiring emergency services. The epidemic cannot be cured with a vaccine, or intensive care. The body cannot heal and purge itself of what causes the epidemic. What is worse, many believe that those affected by the epidemic are somehow deserving of their fate - that this plague was sent as punishment for sins against the body, spirit and civilized society. The epidemic I am referring to is the opioid epidemic.

The opioid epidemic has plagued Canadians since the beginning of the millennium; however, it has as recently as 2016 accelerated in scope and mortality. Opioids are a class of drugs that are both licit and illicit in nature. They are often medically prescribed by doctors to help manage pain in patients (morphine, oxycodone, fentanyl), but these prescriptions end up on the black market, and exist in other derivatives on the streets (heroin). Opioids are a powerful class of depressants that can be highly habit forming. Initial use can create a sense of euphoric bliss in users that is pleasant and comforting. The initial rush of the drug may entice people to keep using, but prolonged use can lead to physical dependence that result in withdrawal symptoms after consumption has ceased (Canadian Centre on Substance Abuse and Addiction, 2020). Many pain patients prescribed opioids will turn to the illegal market after their prescription expires and their source of the drug is closed off. The introduction of fentanyl into the illegal market has increased the rate of mortality tenfold in Canada. Fentanyl is an extremely concentrated opioid that can be lethal in even trace amounts. It is used intentionally by seasoned opioid users, as well as unintentionally when it is used as a cutting agent in other drugs to increase their strength and potency. Since 2016, fentanyl has contributed to 77% of opioid related deaths (Government of Canada, 2020).

With little public health infrastructure to combat the rising death toll, communities are left in a precarious position to fend for themselves.

Who are these people? Why have they been overlooked by governing bodies and become a target deserving of malice? What cultural values, beliefs, ideologies and norms contribute to their derision in the public consciousness? Canada has long been considered a nation that supports progressive drug policy; the legalization of cannabis for recreational use in October of 2018 is a testament to our supposed liberal stance toward drug use. Yet herein lies a point of contradiction. The Federal Liberal Party of Canada's decision to legalize cannabis was in reaction to growing concerns about the health and safety of Canadians, particularly Canadian youth. To mitigate these concerns, it was decided that a public health approach to the regulation of cannabis would best serve the Canadian public and minimize the harm caused by cannabis consumption. Through regulation, the government would be more capable of intervening with a host of issues related to cannabis distribution, production and consumption: delay the age of initiation of cannabis use; reduce the frequency of use, reduce higher-risk use, expand access to treatment and prevention programs, reduce the risks involved with interactions with the illicit market and decriminalize possession resulting in incarceration and criminal records (Government of Canada, 2016). While these are commendable goals that certainly can minimize harm, the concern seems misplaced when we consider the relative safety of cannabis use - no one has overdosed on cannabis and cannabis use carries with it minimal fines and charges compared to other illicit drugs. While it is certainly the most prevalently used drug, and ubiquitous among large parts of our culture, it would be an overstatement to call cannabis use a national public health emergency in need of immediate action. Meanwhile, opioids continue to cause high overdose rates, which can often result in death. They are potent substances that are often tampered with on the illicit market, adding other powerful additives that can increase their lethality. Access to treatment and health services for opioid users remains underfunded and they struggle to accommodate higher intake rates. Young people are the largest age demographic that struggles with opioid addiction. Criminal charges for opioid possession continue to be harsh. What makes these users so fundamentally different from cannabis users and why are their pleas for assistance met with silence? Why are opioids not regulated the same way as cannabis and how has discourse surrounding opioid use influenced government response to the epidemic?

The purpose of this thesis is to investigate the field of discourse surrounding the opioid epidemic in order to determine how different interest groups and stakeholders mobilize specific communicative functions of drug discourse to influence drug policy and public opinion on drug use. To minimize the scope of research, the breadth of analysis will be confined to Ontario, which has growing rates of overdose cases and a robustly diverse field of drug discourse. Drug discourse is a signifier that describes a constellation of positions that construct our knowledge of illicit drugs and their production, distribution and consumption (Grayson, 2008). It is important to consider how the language used by claims makers to describe drug use and the opioid epidemic affects public opinion on the matter and how this translates into policy frameworks. News articles will be the primary source of text used to analyze drug discourse in popular media, but other documents such as policy proposals and secondary research essays also contribute to the research pool.

Ian Hacking's (2006) theory of dynamic nominalism will guide the research portion of this work. Hacking conceptualizes classification as a dynamic process, where scientific studies of groups of people effectively create kinds of people that were not necessarily a type of person before. Hacking refers to this process of actuality through classification "Making Up People." Models of drug addiction and dependence issues have gone through many transformations over the past century, beginning as a moral deficiency, a criminal psychopathy, slowly becoming a medical disease that requires treatment like any other illness. Depending on the historical and scientific paradigm in which discourse finds itself, certain assumptions about drug use and users become commonplace understanding for researchers, policy makers and the public, reinforcing epistemological premises and hegemonic positions that define an era. In turn, these assumptions interact with drug users, shaping their identities, how they understand their disposition, and what forms of control are imposed upon them. In regards to the opioid epidemic, I argue that a public health model of drug discourse currently informs much of our understanding on drug use and this model structures drug use through a lens of risk assessment and prevention within a neoliberal era that interpellates individuals to conduct themselves accordingly - specifically self responsibility for personal health and public good. Drug discourse is a product of historical contingency, but it is also an accumulation of all the discourses that has come before it. There is evidence that suggests that seemingly

dated notions of drug use continue to shape drug discourse today and negatively influence public response to the epidemic.

The structure of my analysis will follow Hacking's ten engines for making up people: count, quantify, create norms, correlate, medicalize, biologize, geneticize, normalize, bureaucratize, and reclaim identity. Chapter one, Conceptualizing Risk During a Drug Epidemic, will discuss how surveillance techniques are used by governing bodies to measure mortality rates and overdoses in order to track patterns in demographics as well as predict future outcomes. I will also discuss how risk assessment attempts to quantify the dangers of particular drugs that have contributed to higher mortality rates and how this has affected public spending costs.

Chapter two, Constructing a Nexus of Deviance and Enforcement, expands on notions of deviance and how society distinguishes what is normal and what is not. Deviance is a good indicator of a culture's values, beliefs and general rules of conduct, and acts as a boundary that designates one culture from another. Criminality and law enforcement discourses have long been intimately associated with drugs and one of the many ways that we have come to know and understand them is through a framework of legality/illegality. Furthermore, drug use is associated with other deviant and marginalized groups of people. Drug use not only further stigmatizes these groups but can also act as a justification for increasingly invasive means of controlling populations viewed as problematic.

Chapter three, Embodiments of Dependence, explains how medicalized approaches to drug use often function in a similar manner to criminalized approaches that seek to govern bodies through a medical lens that lead to uneven power relations between patients and professionals. Coercion remains a strong motivator for processes of normalizing drug users. The biologization and geneticization of drug use identify the site of addiction within the individual's corporeality, atomizing drug use to microscopic proportions - the very building blocks of our behaviour and personality. These discourses have strong ties to the eugenic movement and reduce social issues down to biological deficiencies that render drug users as beasts that lack developed brain formations that distinguish man from animal.

Chapter four, Widening the Discursive Field, deals with how previous engines are mobilized by institutions to justify their intervention into the lives of users and attempts to normalize them. But where there is oppression, there is also opportunity for resistance. Many advocates attempt to flip the script and

instead of accepting their subjugation, fight to change social norms and perceptions to make society more inclusive. Administration of drug users is the finalized form of institutional control and acts as both a producer of discourse, as well as a mechanism of enforcing social conduct through bureaucratic forms of governance. Ford's Progressive Conservative government will be discussed and how his party has changed the landscape of drug discourse will be considered. Lastly, after drug users have been subjected to all of these forms of classification, intervention and control, many resist their classification and fight for the right for self-determination and self-definition. Safe consumption sites (SCS) and overdose prevention sites (OPS) are geographical sites where drug users can safely use drugs, but they do more than this. They are sites where drug users can volunteer their time to their community and forge new bonds outside of traditional institutions of power.

While the scope of the research is vast, Hacking's engines offer a precise and diverse framework to explore drug discourse in the context of the opioid epidemic in Ontario. Discursive analysis requires an analysis of the entire field of discourse surrounding an issue in order to gain an understanding of how these discourses function and interact. While government action continues to lull, it is my belief that challenging discourses and analyzing how they operate offers researchers a methodology that identifies points of weakness where power can be resisted and counter discourses can be mobilized.

Chapter 1: A Review of the Literature

Introduction

Drug use and addiction studies have a long and complicated history filled with disagreement, changing definitions and prejudice. Numerous claims-makers, moral entrepreneurs and researchers have influenced beliefs surrounding the discourse of addiction, creating accepted paradigms that are historically contingent, all the while swaying public opinion on the subject, leading to specific technologies of containment and treatment. To this day, experts continue to specify through categorization where exactly the line should be drawn between recreational drug use and addiction, and what etiological factors and symptoms are defining features of 'addiction'. Current terminology used to define conceptual frameworks of addiction are telling; to use terms such as 'etiology' or 'symptoms' instantly place discourses of addiction firmly within bio-scientific epistemologies which lead to certain theoretical assumptions, mainly that drug addiction is in fact a disease. However, many theorists in the social sciences field criticize this model as being reductionist and problematic for a number of reasons (Alexander, 2014; Kalant, 2010; Weinberg, 2013; Peele, 2000). As murky and undecided as the field of addiction studies is, one thing remains clear: defining addiction is anything but clear, and how professionals choose to construct the term and the bodies that fall under its categorization are altered as a result of dominant discourses.

This literature review seeks to provide an overview of research on drug dependence and the many different perspectives of researchers involved in studying the properties of addiction. The largest rift dividing the field comes down to methodological and epistemological differences between so-called 'hard' and 'soft' sciences. Hard science is considered traditional fields of scientific study such as biology, physics, statistics and chemistry that are formulaic and based in observable reality. Hard sciences rely on empirical evidence found in nature and construct their models based on observable findings; their findings are often quantitative. Hard science methodology attempts to be objective in nature, sticking to observable phenomenon, removing any room for subjective experience or interpretation. This method is championed by current neurobiological models of drug use, most prominently supported by the National Institute of Drug Abuse (NIDA) that seeks to advance scientific research on the causes of drug use through brain imaging technology. On the other hand, the soft sciences are more socially based forms of inquiry such as

sociology, psychology, and philosophy that are more interpretive in nature. These fields of study seek to expand their focus to other social factors that may also influence habitual drug use. Social scientists prefer qualitative analysis that incorporates historical genealogies, discursive power struggles, ethnographic forms of inquiry, intersectionality, deviance and stigma, and forms of social construction, which provide a more nuanced, and contextual understanding of the phenomenon of addiction in contemporary society. Tensions felt between hard and soft science disciplines are themselves discursive power struggles over professional legitimacy and, for this reason, are in constant conversation with each other.

This literature review will therefore compare and contrast the lineage of hard and soft disciplines in the field of addiction studies in order to identify points of contention between the fields, as well as what is lacking in the conversation. Beginning with (bio) medical foundations of addiction study, the review will then move on to critiques of the brain disease model, ending with a section on the sociological turn developed within addiction studies. The field of addiction research continues to grow at a rapid rate in response to rising concerns over national drug use. Therefore, it is imperative that researchers have a strong understanding of how theories surrounding drug use have historically developed in relation to social contexts and scientific discovery. Furthermore, theories must acknowledge the high levels of variance between drug users and begin to incorporate the lived experiences and immediate concerns of those directly affected/afflicted by current models of drug addiction in order to decrease harm and increase quality of life.

(Bio)Medicalization of Drug Dependence

What exactly is addiction? How can we distinguish drug use from abuse? Who has the official right to define and diagnose people as addicts? How should drug users be dealt with? Depending on whom you ask, you may receive a number of different answers to these questions. A psychiatrist may tell you that there is a distinction between substance dependence and substance abuse. Dependence is defined as “a maladaptive pattern of substance use, leading to clinically significant impairment or distress, as manifested by three (or more) [symptoms], occurring at any time in the same 12-month period,” including: tolerance, withdrawal, increased doses, cravings, increased time spent using, lack of interest in social responsibilities, and continued use despite health issues related to drug use (American Psychiatric Association, 2013). Abuse is characterized much the same way, however, individuals must only meet *one*

of the following criteria in order to be considered suffering from drug abuse: "1. Recurrent substance use resulting in a failure to fulfill major role obligations at work, school, or home; 2. Recurrent substance use in situations in which it is physically hazardous; recurrent substance-related legal problems; and 4. Continued substance use despite having persistent or recurrent social or interpersonal problems caused or exacerbated by the effects of the substance" (American Psychiatric Association, 2013). The *Diagnostic and Statistical Manual of Mental Disorders* (DSM) has long been viewed as *the* authoritative reference for all psychiatrists, used to diagnose illnesses based on standardized definitions. Many revisions have been made to it and new editions have been released, adding to the list of disorders, fine-tuning descriptions of existing illnesses, and omitting behaviours and pathologies that are no longer defined as disorders (such as homosexuality). Disorders do not exist as an *a priori* phenomena, especially psychological ones; they are a negotiated label that is tacked on to certain behaviours that are viewed as abnormal, and are therefore problematized (Becker, 1973). Disease models of addiction are especially difficult to identify pathologically, as there is no means of telling who has the disease except by whether or not they in fact become addicted (Alexander, 1987). Furthermore, unlike any other disease, there is no identifiable pathogen directly related to addictive patterns of drug use, aside from the drug itself and its interaction with bodily chemistry. As Reinerman and Granfield (2015) have pointed out, these criteria used to characterize drug dependence and abuse are framed by drug law as much, if not more than they are by the actual effects of drug use on psychology and physiology within the user. Ethical considerations are not divorced from medical constructions of addiction (May, 2001; Netherland & Katz-Rothman, 2012). In consideration of this information, does drug dependence fit the criteria of a disease?

Prior to early-medicalized forms of addictions, alcoholics and habitual drug users were viewed as morally bankrupt individuals who possessed a weak will and a tarnished soul. In one of the most influential books on the shift to medicalizing social problems, *From Badness to Sickness: Deviance and Medicalization,* Conrad and Schneider (1980) explain how the medicalization of drug and alcohol dependence effectively releases the individual of personal responsibility which is tied to notions of free will and self control (ie. moral deficiencies) and effectively produces a victim identity where the individual is helpless to their disposition due to biological factors that require treatment, not punishment. As interest in disciplining the bodies of dependent drug users grew, physicians worked out modern

conceptions of addiction due to the very nature of their work which viewed deviance and other unnatural variations in behaviour contrary to the norm as problematic (Levine, 1978). The medicalization of addiction had begun.

Perhaps the most surprising aspect of the rise of the disease model within public discourse on addiction is medical professionals did initially not champion it. Indeed, the temperance movement of the early 20th century adopted medical terminology to gather support for abstinence within society (Conrad & Schneider, 1980).In a Western society with strong foundations in Enlightenment ideals, positivism and empiricism are propped up as an objective, and therefore, reliable and authoritative way of understanding human behaviour. By co-opting scientific language and concepts, the Temperance movement was effectively able to give their own lobbying credibility. The father of the temperance movement, Benjamin Rush, is credited with developing the first clear disease model of addiction. It was popular because it was able to accomplish what other disease models up to that point were unable to: 1. Rush *identified* a causal agent (alcohol); 2. Rush *defined* the alcoholic's condition as a loss of self-control; 3. Rush *declared* addiction a disease; and 4. Rush *prescribed* total abstinence (Levine, 1978). Rush ushered in a new paradigm in drug discourse that claimed habitual and reckless drug and alcohol use was in fact a disease that usurped the individual's free will. Interestingly, the causation of this disease did not lie within the individual's biology or psyche; rather, this disease was onset by the consumption of drugs. Due to this theory of causality, the ontology of addiction did not lie within corporeal factors that disposed certain people to drink or use drugs irresponsibly. Rush essentially identified the drugs themselves as the causal agent of addiction and for this reason called for the prohibition of all substances in order to rid society of inebriation and all of the social problems that accompanied drunkenness (Levine, 1978). Blaming drugs themselves for their addictive properties contributed to abstinence movements and ultimately prohibition of drugs and their control under the aegis of law enforcement. Early medical models of addiction were therefore not based on scientific findings; these conceptualizations were based on moral paradigms which appropriated medical language whilst also contributing to scientific inquiry.

Anderson, Swan and Lane (2010) have traced the many "institutional fads" that have constrained discourses of addiction throughout the genealogy of the term: constitutional theories, eugenics, the Human Genome Project (HGP), psychopathology, and biochemistry. In a process that decouples addiction

from drug use/abuse, medicalization essentializes addiction as a purely corporeal phenomenon, fixating on the individual body, and attempting to normalize behaviour through disciplinary apparatuses which seek to treat through therapy or other therapeutic means. The mechanisms through which medical researchers and professionals categorize and diagnose instances of drug dependence throughout history have significant effects on ontological understandings of drug and alcohol use and are influenced by popular scientific technologies of the era.

For instance, early 'constitutional theories' of the mid 1920-50's were tied to pseudo-scientific notions of phrenology, physiognomy and eugenics put forth by such theorists such as Francis Galton (1901), and Lombroso (1911) who theorized that deviancy and abnormal behaviour is expressed through individual physiology and can therefore be more readily identifiable through categorization of body type, facial attributes and other biometric markers that expose individuals as born criminals. Biometrics provided the basis of a new social science that contributed to the formation of governmentality and population monitoring that Foucault (2009) explicated within his texts on the discipline society. Early and now defunct scientific theories of biology and phenotypic representation were incorporated into the construction of criminality and addiction as co-existing constituents of deviant conditions requiring incarceration or registration into asylums that sought to protect the public from the "contagion" of drug addiction that threatened public health and societal cohesion (Grayson, 2008, p. 134). As Foucault (1988) has outlined in *Madness and Civilization,* the need to contain the mad within society in order to protect Enlightenment ideals and values of reason, and therefore order, were of particular concern for national state security: "to depart from reason with confidence and in the firm conviction that one is following it - that, it seems to me is what is called being *mad* (Foucault, 1988, p. 104). Notice how this definition of madness closely resembles a mantra espoused by Alcoholics Anonymous (a large proponent of the disease model of addiction): "the insanity of alcoholism is the alcoholic's persistent return to alcohol in the face of overwhelming evidence that it is destroying his or her life, over and over again" (Donna, 2018). It would seem that addiction is itself a disease of reason, and the addict's disposition is one that makes them unable to conform to societal expectations and reality.

Here we discover that classification and subsequent containment of deviant bodies plays a significant role in the control of population. Early models of bio-medical engineering focused on the

genetic factors that could possibly contribute to addiction and sought to prevent the continuance of the disease by controlling reproduction (Kevles, 1995). Eugenicists were obsessed with maintaining strong hereditary lines that promulgated a healthy populace and as a result resorted to tactics reminiscent of ethnic cleansing through sterilization. Eugenicists believed that those with 'bad genes' were most susceptible to developing addictive behaviours and were therefore under the purview of promoters of eugenics. Attitudes towards such problematic theories ultimately lead to the discrediting of early eugenic conceptions of addiction, but the influence of the movement remains in current discourses of addiction. For example, the notion that addicts are predisposed to addiction or 'have an addictive personality' are common tropes found in current discourse of addiction. While there is some validity to the hereditary components involved with problematic drug use, there are numerous other contingencies to consider in drug abuse; rather, these notions are an effective means to control behaviour through fear of susceptibility. Alarmingly enough, remnants of eugenics movements continue to survive in practice today. Project Prevention is a current example of sterilizing addicts, "offer[ing] cash incentives to women and men addicted to drugs and/or alcohol to use long-term or permanent birth control" (Balzer, 2015). Barbara Harris, the founder of Project Prevention, claims her motives are humanitarian, however, to coerce vulnerable people with limited income to withdraw their reproductive rights with promises of monetary supplication is ethically dubious to say the least.

Despite the problematic early medical frameworks of addiction, the disease model of addiction continued to hold a considerable amount of support amongst clinical researchers and therapeutic groups; what caused the disease is where debate continued to develop. B.F. Skinner's (1976) psychological theory of behaviourism introduced a new scientific paradigm within addiction studies, resulting in psycho-pathological frameworks of addiction that shifted the site of addiction from genetic components or a person's general constitution to behavioural conditioning through positive reinforcement as well as metabolic factors of drug dependence. This new model of addiction promulgated amongst clinical practitioners in the 1950's-1970's and marked a therapeutic shift in the treatment of drug users away from a criminalized lens that had informed policy from the times of prohibition in the early 20th century (Anderson, Swan & Lane, 2010). One of the most well known researchers from this era is E. Morton Jellinek, who brought medicalized conceptions of addiction into the mainstream with his work, *The*

Disease Concept of Alcoholism (2010). This work, and others like it, promoted a "new approach" to alcoholism that took the notion that addiction was in fact a disease seriously, and centered their working hypotheses on this foundation. This work differed from earlier movements previously discussed (such as the temperance movement) that rested on the crux that addiction was a disease; for this era marked a time of institutional acceptance of the disease model of addiction where increasing research was being funded by organizations such as the Yale Center of Alcohol Studies as well as endorsement from high level government officials, including John F. Kennedy. After years of scientific aversion to taking addiction seriously as a disease, medical institutions gradually presided over a larger portion of control on the issue and became an integral facet of addiction discourse.

Scientific, empirical research on the disease model of addiction has only developed further with time and with vast leaps in biological understanding of the human body. The advent of neurological scientific research has contributed significantly to current conceptualizations of addiction, culminating in the brain-disease model of addiction championed by Nora Volkow, the current director of the National Institute on Drug Abuse (NIDA) in the United States. According to this theory, those who are prone to drug dependence suffer from chemical imbalances within the brain. This deficiency can be attributed to genetics (Blum, Oscar-Berman, Demetrovics, Barh & Gold, 2014) or caused by environmental factors such as trauma (Maté, 2008) but more striking, drugs themselves are claimed to change the neural networks of users after extended periods of use (Volkow, Wang, Fowler, Tomasi, Telang & Baler, 2010). In order to retain normal levels of dopamine and serotonin in synaptic pathways, drug users must continue to use a drug. Drugs then become positive reinforcers of behaviour, resulting in a vicious cycle of hedonia and dysphoria where the individual seeks to pursue the rewarding aspects of drug use (euphoria) while simultaneously avoiding the negative reinforcers of drug use (withdrawal) (Koob, 2000). Anhedonia refers to the decreased capacity for the user to experience pleasure after discontinued use (Weinberg, 2013, p. 83). This conceptual model of drug dependence has gained acceptance within institutions due to the empirical evidence provided by advancements in brain imaging technologies such as Magnetic Resonance Imaging (MRI) and Positron Emission Tomography (PET) (Courtwright, 2010). Finally, it would seem, the existence of a pathology of addiction that has for so long evaded clinical analysis has been located and observed.

Critical Addiction Studies

The brain-disease model of addiction has undoubtedly gone mainstream in today's discourse of addiction and has become the foundation upon which claims to truth and objectivity rest for continued neurobiological research of addiction. However, alongside the rise of disease models of addiction that focus on observable fluctuations within the bodies and minds of drug users, social scientists have utilized their own frameworks in order to explain drug use phenomenon, looking outside of an individual's biological disposition and instead focusing on the societal factors that shape our understanding of addiction, seeking societal causes for deviant behaviour, focusing on an ontology of addiction that exists outside of the individual. It would seem that the nature versus nurture dichotomy continues to shape our knowledge of addiction, and remains a major contestation between academic fields relating to addiction.

This socially based research on addiction can be referred to as Critical Addiction Studies, coined by Reinerman and Granfield (2015); they state that:

> "the scientists and scholars working in this tradition have interrogated the fundamental concepts and categories of the field and found far more fluidity and far less solidity than others had supposed. In this tradition, the new neuroscientific narrative of addiction as a "chronic relapsing brain disease" is only the most recent in a long and ever-shifting line… whatever progress has been achieved, each model of addiction reflects the taken-for-granted premises, prejudices, and politics of institutions, the epoch, and the culture in which it was born" (pp. 16-17).

Some of the pioneers of this field of critical studies include Alfred Lindesmith (1949), who studied opiate addicts and found that social contingencies influence addictive outcomes in individuals more than merely biological determinants; Howard Becker's (1973) research on deviance and drug use has contributed to our understanding of how deviance is culturally negotiated and therefore constructed based on cultural norm creation and enforcement, known as labeling theory; Stanton Peele (1975) has been one of the more outspoken critics of the medical model of addiction, claiming addiction is not an illness but rather the result of a dependency on experience and the interrelationships that can develop between an individual and the object of their desire - he goes so far to say that mistaken notions of addiction can effectively do more harm than good, creating expectations of involvement that ultimately determine how addiction is experienced, and this experience is most often viewed negatively (Peele, 2000); Thomas Szasz (1972)

rejects the disease model of addiction altogether, arguing that drug use is an ethical - not a medical - problem as its categorization depends on definitions of the proper and improper uses of drugs in certain cultural contexts.

For Critical Addiction Studies scholars, addiction is not merely the result of chemical imbalances within the brain and a damaged neuronal rewards circuit catalyzed by the intake of drugs; rather, addiction is indeterminate in that how it is defined, and what values are embedded within the description of deviant behaviour are ultimately culturally and historically contingent. For example, Harry G. Levine (1978) has traced the "discovery" of addiction within Western civilization, which began in the late 18th and early 19th century. His work mirrors Foucault's (1988) genealogy of madness in the Middle Ages, deconstructing historical records through a lens of shifting ideologies and advancements in knowledge leading to an episteme which acts as the ground that represents the conditions of possibility for a given discourse within a certain epoch. Prior to industrialization, consuming large amounts of alcohol was commonplace amongst European settlers and was imbibed often to invigorate colonizers through the toil of their day and grease the wheels of social interaction and bonding. However, with a modernizing society that required specialized skills in dangerous work environments overindulgence of alcohol was leading to a loss of production and idleness. Paired with a rising Puritanical population and social disorder, the setting was ripe for the Temperance movement to advocate for abstaining from alcohol and the perceived social evils that it encouraged amongst the drinking populace. Excessive drug or alcohol use was soon transformed from a relatively mild social nuisance into a dangerous, criminal activity that threatened social security and national identity (Grayson, 2008).

In a Canadian context, Malleck (2015) has written a comprehensive account of the birth of drug laws in Canada. Canada is often viewed as taking a more progressive approach to drug policy (Grayson, 2008), however, the very first drug regulations were enacted in Canada, specifically with the Pharmacy Act of 1871. This law effectively put controls on the distribution of pharmaceuticals, which had previously been available over the counter, most notably opium. Prior to the establishment of set laws on distribution, many social actors were lobbying for authoritative control over the management of distribution, manufacturing, and sales of these drugs, empowering one professional group to define what is a dangerous drug and how it should be handled; pharmacists, physicians, and patent medicine

producers were all stakeholders in the initial battle for institutional legitimacy. Ultimately, the pharmacy became a self-regulated entity, establishing an "epistemological colonialism" and forming governance aimed to conduct the conduct of professionals in order to strengthen the profession's social status and maintain a gatekeeper's role (Malleck, 2015, p. 82). Therefore, drugs, and the perceived social problems that they were causing at the time were not merely regulated for social goods but were a point of advantage for professional medical practitioners to create institutional legitimacy within a negotiated field of power and knowledge production.

Of course, the medical community did not solely produce drugs and the laws that regulate them and the subsequent enforcement of these laws brought other social actors into the fold, specifically criminal justice systems. Drug laws continued to expand and include a vast array of drugs and classifications that were scheduled to aid in proper punishment for the possession, trafficking or consumption of drugs, creating larger police task forces to monitor drug trade. Those who are involved in the drug trade are not only social deviants but de facto criminals. Moore (2007) notes that 80% of people in Canada's federal penitentiaries have some sort of substance abuse problem that correlates with their criminality, creating a cause and effect line of reasoning that links drug use to other criminal behaviour. Critical criminology studies of drug use claim there is no reason to believe that drug use is linked to crime, and rather, an amalgamation of social, physical, mental, law and material conditions all contribute to crime and social control apparatuses such as legal, medical and judicial systems only further oppress those who are already marginal (Moore, 2007). Dollar (2018) asserts that race, class and neoliberal politics have a significant impact on which side of the medical-criminal nexus of punishment a drug user falls on. They claim that criminalizing drug use is a way for lawmakers to control and exclude people defined as a threat to social order, providing a scapegoat for increased surveillance of certain demographics. This phenomenon can be illustrated when drug epidemics and socio-political responses to them are compared. For example, the rise in prevalence of crack-cocaine in black, low-income communities in the late 1980's was framed as a security risk that was threatening the safety of neighborhoods. Users were described as unpredictable, violent, desperate for their next fix, and willing to pay for it by any means necessary. Government response to this drug scare was rhetorically represented as a drug war, where violence was met with violence through direct police intervention that found

justification through media sensationalism and the fear of the Other in white middle class consciousness. This situation has been characterized as a state of exception, in Agamban terminology, by Snoek and Fry (2015) to describe a time of increased security measures that would be deemed unconstitutional or invasive under normal circumstances. Mass incarceration of black men skyrocketed at this time and police budgets increased to protect the law-abiding citizens from the ravages of crack use. On the other hand, the current drug crisis that has caught the attention of the media is an opioid epidemic. Prescription drugs like oxycontin, morphine, and fentanyl have risen in popularity and have led to many deaths across the nation. A portion of opioid users are from white, middle-class backgrounds that have access to good health care in order to initially obtain the prescription and can then afford rehabilitation once their habit has become unmanageable. For this reason, the opioid epidemic has been called a health crisis, rather than a war on drugs where therapeutic treatment is promoted over incarceration. This disproportionate doling out of punishment/treatment depending on the drug in question has pervaded the media; Anderson, Scott, and Kavanaugh (2015) have displayed in their analysis of documentary films on drug addiction that films that are meant to be educational are often biased and perpetuate stigmatization and racial inequality based on the differing narratives that criminalize minority communities while presenting stories of white addiction in an empathetic tone. It would seem that race, socio-economic position and geographic location can all have an impact on how a government frames drug use in communities and how they choose to respond to it.

Critiques of the Biological Brain Disease Model

If it has not become apparent already, there are clear methodological separations between biomedical models of addiction and critical drug studies. While biomedical models that focus on the diseased individual are more concerned with empirical data gathered from controlled lab settings using animal testing, EEG and other brain mapping technology, the field of critical drug studies has a wide variety of methods in obtaining and analyzing data that include ethnographic studies, discursive and rhetorical analysis, historical accounts and critical theory. Not only are the disagreements of epistemology inherent between these two fields of study a point of contention; they lead each field to view addiction through completely different ontological frameworks that can lead to oversights in methodological

verification. For instance, Alexander, Coambs, & Hadaway's (1978) famous Rat Park experiment challenged traditional methods of observing a drug's impact on behaviour on rats in testing labs. While it was commonplace for rats to be isolated in individual Skinner Box style cages in order to exclude any unpredictable variables that could affect the drug's pharmacological properties and effects, Alexander realized that rats, like humans, are social creatures who depend on interaction. What Alexander found when rats were put together in an environment that promotes social cohesion was that the majority of rats no longer sought out drug infused sustenance and mostly preferred the saline solution. Alexander (2001) has gone on to expand his social psychological approach to addiction, maintaining that the structural precarity of free market societies is the cause of the dislocation and isolation that drives people to escape into habitual drug use.

Another common criticism against the medical model of addiction is that with all of the scientific and technological advances made, research has not come any closer to providing adequate treatment options for those afflicted, nor has it been able to identify any meaningful markers of predisposition (Courtwright, 2010). In response to this, Kalant (2010) has cited Wallner and Olsen (2008) to argue that that neurological research "may also suggest pharmacological interventions to prevent the production or function of some of the gene products that contribute to vulnerability to addiction or relapse, and thus help to maintain treatment-induced abstinence" (pp.77); albeit, these are helpful, but ultimately limited approaches to a larger social problem. Condon (2006) claims that medicalization can only be achieved with a cure-all pharmaceutical that curbs craving or nullifies euphoric effects of drugs - so-called "magic bullet drugs" that Balter (1996) has conceptualized based on his research on dopamine control in cocaine addicts. Despite the growing market for drug inhibitors and antagonists such as methadone, buprenorphine, naloxone, naltrexone and varenicline, these drugs only target specific drugs such as opioids or nicotine, and are not long-term solutions to behaviour modification. Perhaps the most unsettling charge against these forms of therapeutic intervention is the increased presence of state mandated control over deviant bodies who reject social norms of sobriety and economic activity (Bourgois, 2000; Vrecko, 2016), as a cure-all drug for drug use could be forcibly imposed on high risk populations in order to eliminate any chances of risky substance use.

This individuation of a social problem is yet another problematic aspect of the disease model of addiction that is often mentioned in critical drug studies. Current criminalized and medicalized policy addressing addicted people both reflect neoliberal agendas that relegate responsibility to the individual, rather than to the state, distracting people from systemic societal issues, effectively scapegoating distinct groups of people deemed risky in the eyes of the state (Dollar, 2018). This may seem counterintuitive, as many claim that medicalization has shifted blame away from addicts by the assertion that their affliction is a disease, thus rendering them as helpless and sick (Conrad & Schneider, 1980; Levine, 1978). However, stereotypes continue to survive, and an over exaggeration of drugs and users as dangerous people unable to show self-restraint leads to further stigma, ultimately creating a rigid category of "addict" that all drug users fall into and are judged as such (Fraser, Pienaar, Dilkes-Frayne, Moore, Kokanovic, Treloar, & Dunlop, 2017). Medicalization can lead to modes of social control seeking to stop the spread of a foreseen contagion that are not as explicit and forceful as criminal modes of control, but just as coercive, placing individuals who refuse to conform into apparatuses of social engineering (Kaye, 2012). Of the users who are able to quit their habit based on "natural recovery" (without a treatment program), they often possess more social capital and are therefore in a position that allows them to depend upon their interpersonal relationships while recovering, which gives them moral and economic support in a stable environment (Granfield & Cloud, 2001). Upon recovery, these individuals then perpetuate a narrative that everyone is able to overcome their struggles with drugs if they simply have the drive to quit, further entrenching self-reliant values that are promoted by neoliberal propaganda, relieving social safety nets of the burden of caring for the individual. "Within the climate of risk, susceptibility, and surveillance created by the convergent processes of biomedicalization, health has become a moral obligation to take on individual or personal responsibility for the maintenance of health" (Netherland & Katz-Rothman, 2012, pp. 21).

Critical Addiction Studies does not work to invalidate the medical/disease model of addiction; rather, researchers in this field work to progress discourse of addiction and challenge dominant institutional discourses that maintain that understanding the human brain is the key to unlocking the mystery of addiction. Critical Addiction scholars do not deny the psychological or neurological factors

that influence addictive tendencies, however they argue that neurobiology essentializes an issue that is also socially constructed.

Harm Reduction Approaches to Public Health

While theoretical criticisms of medicalization and law enforcement can expand the discursive field of drug use, these criticisms must be grounded in practice and an approach that can offer an alternative to traditional drug policy authorities while actively challenging preconceived notions of drug use that act as the ideological base of dominant institutions of drug policy. Harm reduction models achieve this goal through direct action, and evidence based findings that directly oppose many of the epistemological assumptions that inform medicalization and law enforcement based approaches to drug control.

While there is no all-encompassing definition of harm reduction, harm reduction models operate under key tenets that many view as radical shifts away from previous models of drug policy that privilege medicalized or law enforcement approaches. In many ways, harm reduction models function to dismantle institutions that advocates claim are misguided in theory, and oppressive in practice, leading to unintended consequences that have only exacerbated social issues related to drug use in communities. While there is space for medical and police approaches in drug policy, these institutions must undergo serious restructuring and relinquish their dominant position of authority within the field of drug discourse in order to accommodate progressive policies that are based in harm reduction. Dominant institutions of drug discourse remain obstinate in their epistemology and the consequences of their position continue to contribute to drug use issues in society. Criminalization has increased stigma attached to drug use, forcing users to withhold their disposition from society, isolating them and acting as a deterrent to seeking help for fear of legal consequences or public shame. Medicalization has classified drug use as an illness that requires professional intervention, conflating all drug use as harmful and essentializing a complex issue as a biologically determined phenomenon that ignores social factors and power relations. The harm reduction model calls for a complete overhaul of drug policy that privileges public health, seeking to minimize harm associated with drug use rather than attempting to eradicate it completely.

What are the principles of harm reduction? Bierness (2008) identifies three central features of a harm reduction approach: pragmatism, humane values, and focus on harms. Pragmatism refers to harm

reduction's view that drug use is inevitable in today's society and therefore operates under the assumption that the goal of drug policy should be to provide users with options that meet the needs of individuals to ensure they can maintain their health and wellbeing. "Harm Reduction is an evidence-based, client-centred approach that seeks to reduce the health and social harms associated with addiction and substance use, without necessarily requiring people who use substances from abstaining or stopping" (Thomas, 2005). Humane values are concerned with personal autonomy and upholding individual dignity. Drug policy should not be invasive, coercive or judgemental, rather, it should be open to acknowledging an individual has needs and providing them with the necessary resources to address those needs in an environment that is welcoming. "Harm reduction practitioners accept people who use drugs as they are and are committed to meeting them "where they are" in their lives without judgement…Stigmatizing language perpetuates harmful stereotypes, and creates barriers to health and social services" (Harm Reduction International, 2020). Lastly, focusing on harms claims an "individual's substance use is secondary to the potential harms that may result in that use" (Canadian Mental Health Association, 2020). It is impossible to help a drug user if they are dead. Harm reduction states that keeping drug users alive and healthy are the most important priorities in dealing with substance abuse. These features of harm reduction are integral to informing how harm reduction should be practiced.

What are some examples of harm reduction in practice? In the context of the opioid epidemic in Ontario, Overdose Prevention Sites (OPS) and Safe Consumption Sites (SCS) are key harm reduction sites that offer drug users a safe space to consume drugs, offering clean needles, needle disposal, and drug testing kits, information on drug use and abuse, and naloxone that is administered in the event of an overdose. It has been argued, however, that OPS are more representative of harm reduction philosophy (Watson, Kolla, van der Meulen, & Dodd, 2020). Unsanctioned OPS operate autonomously, apart from the auspices of medical authority; they were implemented by community-based organizations, advocates, and drug users to fill in a gap in public services during the rise in opioid deaths. The Moss Park OPS in Toronto is perhaps the best example of this form of organization. SCS, on the other hand, are apparatuses of medical authority, government regulation and bureaucratic stipulation that offer drug users a more limiting experience that remains clinical in nature. Watson et al. (2020) note that a "key strength of the Moss Park model has been that the group of volunteers running the site largely consisted of people with

lived experience who have championed low-threshold service delivery with few rules or regulations in place." Involving people from the community in public health projects remains an important feature of harm reduction models as it promotes a space of familiarity that is less threatening for users and empowers marginalized communities. OPS have been proven to reduce or outright eliminate overdoses on site, reduce the rate of HIV transmission in drug using communities, connect people to treatment options and healthcare, and reduce public use (Addictions & Mental Health Ontario, 2018). These sites have been met with criticism from law enforcement, the public, and government officials who claim that they threaten public safety, encourage drug use and do more harm than good. These criticisms are unfounded; ideological attacks on harm reduction sites are based in partisan appeals to dated views on drug use while ignoring the evidence that proves otherwise. Harm reduction will continue to grow in application and influence drug policy, but will also continue to struggle for acceptance within a field of discourse that it often stands in opposition of.

Making Up Drug Use

Of particular concern in this thesis is the construction drug discourse and how established and accepted conceptions of drug use influence social policy and surveillance practices on risky populations. These policies and practices disproportionately affect people who use drugs depending on their class, race, involvement, geographic location and visibility. Quite a few scholars already mentioned have taken a discursive approach to drug use and addiction such as Levine, Malleck, Moore, and Grayson, which all provide a thorough account of the origins of addiction within society based on the political, economic, medical, technological, judicial, and international relations that effectively created the notion of addiction that we are familiar with today.

At this time, a scholar worth noting is Toby Seddon, Senior Research Fellow in the School of Law at the University of Manchester. Seddon has written extensively on drug use, crime and social exclusion through a legal lens. In Seddon's (2016) work entitled, "Inventing Drugs: A Genealogy of a Regulatory Concept," he argues that "the drug label is an invented legal-regulatory construct closely bound up with the global drug prohibition system… To move beyond prohibition, radical law and policy reform may require us to abandon the drug concept completely" (pp.1). This work claims that the current

meaning of drugs is highly influenced by liberal subjectivity and freedom from enslavement in an era of modern state formation and industrialization.

Seddon (2010) has another essay entitled, “What is a Problem Drug User?” Seddon uses Ian Hacking’s concept of “dynamic nominalism”, or “making up people” to trace the shifting developments in drug use categorization in the UK and Europe from the term addict to problem drug users (PDU). While he provides an excellent discursive analysis of PDUs in the UK, his work using Hacking’s framework is incomplete and only three of Hacking’s nine engines of categorical production are applied to PDUs in the UK. My work aims to expand upon Seddon’s work in a Canadian context, particularly in the era of the opioid epidemic. It is my hope that applying Hacking’s dynamic nominalism to opioid users in contemporary Canadian society will elucidate how neo-liberal subjectivity has further shaped our understanding of addiction and the practical policies that have formed as a result of this construction.

By turning our attention to the discourse and language that constructs drug use, we are given an insight into the epistemological struggle for meaning that institutions persistently participate in when defining addiction. As dominant interpretations of drug use directly impact how governments choose to delegate funding for research and these studies directly inform policy considerations based on expert opinion, it is necessary to investigate how our current political and economic epoch has shaped drug discourse and those categorized as drug users, and for what ends. Current drug discourse seems to be trapped in an either/or conundrum between medicalization and criminalization that twists drug dependent ontology to fit within each institution’s authoritative position. Only after the concept is deconstructed down to its essence in a contemporary context will new policy options and opportunities for community building present themselves.

Chapter 2: THEORETICAL FRAMEWORK

Introduction to Social Constructionism

With a concept so fluid, elusive and divisive, where does one even begin to deconstruct the multi-faceted enigma that is drug dependence? As the literature has demonstrated, understandings of drug use and addiction have undergone drastic shifts in meaning and pathology throughout the course of its existence within society and continue to morph as new institutional and political complexes progress and vie for authoritative legitimacy. Furthermore, the particular site of addiction has emigrated from the soul, to the body, to the drug itself. Presently, addiction is apparently stationed in the molecular building blocks of human biology, our DNA - the unique blueprint of an individual. It would seem that addiction is simultaneously everywhere, and nowhere, existing in time, but lacking a specific space that would imbue it with a materiality that reveals its observable essence, allowing itself to be studied without pesky sociological variables interfering. How does one study something that science cannot even prove is "real" - in an empirical sense of the word?

Perhaps the best mode of action would be to turn our attention from the objective, material world to the symbols and signs that colour it. The discursive turn to language, often credited to the works of philosophers such as Wittgenstein, and de Saussure, systematically analyzed language, rather than the objects that language supposedly signified. The result of such inquiries lead to the establishment of the structuralist tradition of thought that rejected long-held Western conceptions of meaning, which assumed that language was merely a reflection of reality. Instead, supporters of this movement claimed that language itself constituted reality and created meaning in the world (O'Reilly & Lester, 2017). Based on this framework, the apparent truth of a phenomenon lies in the language used to define it, and the other phenomena used as a point of reference to differentiate it from other things. Constructionism, especially post-constructionism, posits that knowledge is an interactive process based on shared meaning and cultural practice that is not universal in scope and is relative to particular geographies and historical epochs (O'Reilly & Lester, 2017). If this line of reasoning is followed, the practices, social relations, and classifications of a society are not simply "just the way things are" but are negotiated forms of acceptable conduct that are historically and culturally contingent and subject to change. Applying this framework to

drug use allows researchers to study the *process* involved in classifying certain behaviours or experiences as deviant. The object of study is not the illness itself but the surrounding social context that shapes the illness and the mechanisms that are used to measure and refine its definition.

Where a researcher chooses to direct their attention can have drastic effects on their methodology and can skew the results of their study. Gusfield's social problems theory attests to this fact. "The construction of any social problem is the product of choices, choices about what the claims maker–or the analyst—decides to notice, and what to ignore" (Best, 2017, pp. 17).For example, in Gusfield's (1980) study of drunk drivers he questioned the taken for granted assumptions that until then had directed studies on the subject, particularly that deviant drunk drivers were the main culprits in most traffic accidents. But when other factors, such as accessible transit, poor automobile design, and bar location are considered, we can see that social planning and cultural norms can in fact alter understanding and lead to better solutions to social problems. In much the same way, to simply focus on drug use as a medically determined disease is myopic as it ignores other social factors and pushes a discourse of blame on the individual when there are social conditions that are in need of improvement.

Room (2003) suggests that addiction may be considered a "culturally-bound syndrome" that can only exist within certain cultures due to cultural values. For example, within a liberal society that privileges self-reliance and self-responsibility, habitual drug use would certainly be frowned upon as it signifies a lack of self-control within the individual and an inability to conform to societal norms and customs (Room, 2003). Paired with an industrialized society that demanded citizens to manage and maintain their bodies in order to increase their productive value (Seddon, 2016), the social setting from which conceptions of addiction sprouted from were rife for the reformation of drug policy. The policies that are enacted by authorities in turn create new legal, normative and material conditions that may have unexpected consequences on the populations they set out to administer and manage. As Reinerman and Granfield (2015) state:

> In short, over time our drug control policies are in some measure self-ontologizing, that is, they bring into being the very outcomes that are then invoked to justify those policies. Any full understanding of addiction requires understanding how drug control laws and policies feedback,

often in unanticipated ways, upon the behaviors they set out to control" (Reinerman & Granfield, 2015).]

One important disclaimer to note before proceeding: when I say that drug addiction is "constructed", I do not mean to say that it does not exist. I recognize the struggles of substance dependence and the extremely harrowing experiences that those who are afflicted must face on a daily basis - this is not up for debate. Drug addiction is correlated with physical and mental abuse, emotional trauma, community dislocation, and a host of mental illnesses such as depression, bipolar disorder, and antisocial personality disorder - among others. To state that drug dependencies do not exist is not only incorrect but ignorant and downright dangerous as it erases the many struggles that these people deal with on a daily basis. The goal of my study is to demonstrate how drug dependence as a concept can inform public perception on drug use and influence policy. It is time that we discard archaic, morally inept opinions of drug users and replaces them with understanding, compassion and truly progressive policy that is incorporative rather than dislocative.

Making Up People

This notion of "feeding back" is crucial to Ian Hacking's conception of *dynamic nominalism*. In his celebrated work, "Making Up People", Hacking (2006) posits that scientific inquiry does not lead to the discovery of classifications of people, *per se*, instead the very act of classification in effect brings categories of people into existence. From a constructionist point of view, we could say that the classification constitutes the group in question rather than merely naming a pre-existing condition that was previously not recognized by medical authorities. Hacking (2006) illustrates the distinction in defining human kinds with a rather banal statement in reference to multiple personality disorder (now referred to as Dissociative Identity Disorder),:

A. There were no multiple personalities in 1955; there were many in 1985.

In many ways, this is true; until medical authorities acknowledged the existence of and created a label for multiple personalities, there was no language or category available for practitioners to work with in a diagnostic sense - even if people had experienced multiple personalities prior to it being named. Patients who exhibited symptoms of multiple personality disorder prior to its inauguration in the psychiatric community were given other labels, such as schizophrenic. However, once the distinction was made and

given a name, the term captured the imagination of the public and soon many psychiatrists were diagnosing patients with the syndrome. This did not mean that all doctors accepted the existence of multiple personalities; even today, the acknowledgement of its existence is contested and said to be the result of public intrigue and professional self-interest. Whether or not this is true, however, doesn't matter because the term is now ubiquitous in public consciousness.

What is important, in Hacking's view, is how the classification interacts with those who are classified. In the second statement we find a more nuanced explanation of how a label can affect the identity of the labeled:

> B. In 1955 this was not a way to be a person, people did not experience themselves in this way, they did not interact with their friends, their families, their employers, their counselors, in this way; but in 1985 this was a way to be a person, to experience oneself, to live in society.

Let us swap multiple personality disorder for drug dependence in these statements and see how it affects what it means to be a drug-using person. Before we do so, it is important to note that there have been multiple iterations of addiction throughout its genealogical history. As stated in the literature, the earliest conceptions of addiction can be traced back to Benjamin Rush in the late 18th century and its endorsement by early temperance movements of the mid-19th century; however, this model of addiction is not the focus of this project because it was still firmly grounded in moral and religious foundations and lacked the institutional backing from medical authorities that legitimize addiction as a biological disease. Instead, we turn our attention to the addict that is "substance dependent" in a more secularized society. This modern understanding of drug addiction was established in the 1960's by the World Health Organization and coincided with the emergence of "new public health" which was "characterized by a focus on population health, the development of preventive approaches and the targeting of high-risk groups with the poorest health outcomes as part of strategies to reduce health inequalities" (Seddon, 2010, pp. 337). This brief genealogy already demonstrates that addiction was always a moving target that defied static classification. Now, let us consider Hacking's statements in regards to addiction.

> A. There were no drug dependent addicts in 1959; there were many in the 1960's.

This statement is resoundingly false. Problematic drug use has been prevalent in society and public policy created in the early 20th century reflects this. In Canada, the Opium Act of 1908 was the first drug policy in the developed world and paved the way for other countries to follow suit (Malleck, 2015). Clearly, there would be no need for legislating drug use if it were not a social issue. The only point that this statement claims to make is that the construct of the drug dependent addict did not exist prior to the WHO's declaration of it.

This statement does not address the dynamic interaction between the classification and the classified in creating shared meaning; this is where the value in Hacking's theory lies. Let us consider statement B:

> B. In 1959 this was not a way to be a person, people did not experience themselves in this way, they did not interact with their friends, their families, their employers, their counselors, in this way; but in 1960 this was a way to be a person, to experience oneself, to live in society.

This statement compared to statement A, rings true. Up until relatively recently, drug users were still considered immoral, criminal, and lacking self-restraint; their behaviour was characterized by moral judgements and was ridiculed by authority. However, with changing models of addiction that rooted the etiology of addiction within human biology instead of the soul came a decrease in personal responsibility for the disease. The reframing of the disease affirms the way an individual perceives their lifeworld. Much like the relief a hypochondriac feels after finally having their suspicions confirmed, the creation of addiction as a disease provides addicts with a new identification marker that undoubtedly changes their daily lives, routines and interactions. Furthermore, medicalization often leads to the softening of stigma surrounding deviant behaviours because it replaces moral judgements with biological causes that are out of the individual's control (Conrad & Schneider, 1980). In effect, those who are given a medical classification may feel more candid in explaining their illness to others, more emboldened to justify certain actions when they are questioned, and more willing to seek help when services are provided. In effect, an addict's understanding of their behaviours and actions change when presented with new concepts that seek to define their particular disposition and provide them with an overarching identity that they can coalesce under.

As a result of an increasing amount of dialogue contributing to the knowledge of addiction, more refined definitions of its classification are possible, continuously re-shaping the discourse surrounding it. As Hacking (1985) puts it, “making up people changes the space of possibilities for personhood” (pp.107). The very act of investigation changes the defining properties of addiction and shifts the boundaries that envelope it. Hacking refers to this interaction as a “looping effect” - where classifications directly influence those classified and vice versa. The target of study is always a “moving target” that defies exact categorization due to the reverberating feedback between channels. The feedback chain could be described as such: a certain behaviour is problematized by the general population, exposing a certain portion of the population to scrutiny, both publicly and professionally. This particular population is observed by the medical gaze in microscopic detail, meticulously measuring actions and updating definitions to reflect collected data. The research obtained from studies is compiled to construct a generalized representation of observable symptoms and primary characteristics, ultimately leading to the invention of a new diagnostic type. A shift happens, however, once the new terminology is applied to the population it is meant to represent because people have agency, and meaning is also created through interactions - not simply from the top-down. As individuals either accept or reject the label, and adjust their self-identification and self-awareness accordingly, the classification must accommodate for this shift in order to account for changing perceptions found within the original population of study. We see how the distinctions made about a person’s identity or biology constitutes changes in the way they view their experiences and reality as a result of classification. This cycle continues indefinitely as populations struggle for self-determination and institutions try to exercise their right to govern populations through classification. We also see how this process of refining classifications can function as a form of social control, where “categories are often designed and defined as to make it easier to count - and thereby control - the family of human kinds, subjecting them to more focused descriptions” (Sparti, 2001, pp. 342).

The question remains - how do we go about breaking down the factors that contribute to the formation of distinct types of people? How are addicts ``made up”? Hacking identifies ten engines of discovery, practice, administration and resistance that work to construct kinds of people through technologies of power and governance: count, quantify, create norms, correlate, medicalize, biologize,

geneticize, normalize, bureaucratize, and reclaim our identity. These engines provide a conceptual template that is useful for discursive inquiry. A more refined explanation of these engines will be provided in the methodology section of this work. For now, the direction will turn to some other key theoretical frameworks that are embedded within Hacking's engines in order to lead to richer analysis.

Foucault's Contributions to (Post)-Structuralism

Hacking (1979, 2004) often credits Foucault with influencing his work: "there is a currently more fashionable source of the idea of making up people, namely, Michel Foucault, to whom both Arnold Davidson and I are indebted (2002, pp.103). This is no surprise, as the constant renegotiation of a classification's defining features found in dynamic nominalism mirrors Foucault's own theories relating to knowledge and power as a contested field. Furthermore, Foucault (1980) was deeply interested in the ways in which subjects were constituted "gradually, progressively, really, and materially through a multiplicity of organisms, forces, energies, materials, desires, thoughts, etc" (pp. 97). Foucault has researched a number of types of people that's very existence is viewed as threatening to social norms and challenges dominant hegemonic realities of morality, epistemology and ontology including the mentally ill, criminals, and homosexuals. In doing so, Foucault has made immense contributions to the constitution of the subject, or how types of people and ideas about them are constructed.

Foucault's repertoire is so vast that it is difficult to choose a point of entry to begin to introduce his theoretical base. Perhaps a good starting point would be from the beginning, with his work in *History of Madness* (1988), and as an extension, *The Birth of the Clinic* (1994a). In these texts, Foucault traces the changing conceptions of, and reactions to, madness throughout the Middle Ages into the 19th century. This archeological work sought to excavate the dominant discursive formations, or epistemes, operating in these distinct historical eras. His conception of the episteme, which he explicates in his work *The Order of Things* (1994b), is similar to Kuhn's (1962) notion of a paradigm; Foucault claims that at any given point in history, there are historically contingent conditions of truth that determine the horizon of accepted knowledge. An episteme is the culmination of a multiplicity of moving factors, specifically the organic, the economic, and the linguistic, which bound humanity to a finite pool of conceivable thought, representing all possible discursive events in any given epoch. Madness, according to Foucault, has undergone an evolution that was not an inevitable trajectory following rational thought and practice, but

was rather the result of the era's zeitgeist; for example, "the Renaissance idea that the mad were in contact with the mysterious forces of cosmic tragedy or the seventeenth-eighteenth-century view of madness as a renouncing of reason" (Gutting & Oksala, 2018). We can see how the defining characteristics of an historical period project their defining features onto the mad subject. The public's reaction to madness also depended on the era, ranging from passive affection in the Middle Ages to hostile, enforced imprisonment during the Enlightenment period. The shift to a medical model of madness has been viewed by many as an improved humanitarian approach to treating the mentally ill that has led to more humane treatment and therapeutic methods. Not Foucault. In his view, the notion that madness is a medical disease that is judgement-neutral and based in objective reality is disingenuous because it was instituted to protect bourgeois values and morals. Individuals subjected to medical treatment are still under mechanisms of control that strive to suppress or relinquish their abnormality for the sake of social integration. Untreatable instances are confined for an indeterminate amount of time away from the public eye where they cannot corrupt social cohesion.

In other words, medical institutions resemble prisons. Foucault turned his gaze to the disciplinary power of modern institutions in *Discipline and Punish* (1995). Whereas earlier methods of law and punishment relied on spectacular displays as a deterrent to undesirable behaviour, modern forms of discipline function to work on the individual, the criminal body. New techniques of control were invented to encourage proper conduct that were woven into the very fabric of human relations. Through the establishment of norms subjects were now doubly surveilled - externally by law enforcement and the general public, as well as internally through self-surveillance practices where subjects monitor their own conduct. Foucault identified Bentham's model of the panopticon as an ideal representation of the logic of disciplinary power. In a circular prison with a single watchtower planted in the center, the supervisor has a 360 degree view of the inmates, but furthermore, the glass that encloses the viewing center is one directional, preventing the inmates from knowing for certain whether or not they are indeed being watched. This uncertainty of surveillance acts as an effective metaphor for the paranoia that subjects feel within society, that their every move may be recorded and scrutinized and pressures subjects to act accordingly. In addition, with opaque windows the identity of the supervisor ceases to matter because their authority is maintained by anonymity, nebulizing power relations. The goal of such a project was to

correct deviant behaviours through more subtle means of coercion that reformed subjects into docile bodies: biometrically recorded bodies that could be optimized for increased productivity and easier to manipulate and control. This notion of social engineering through population surveillance, maintenance and administration is further extended through biopolitics, found in Foucault's *Introduction to the History of Sexuality* (1990) as well as *The Birth of Biopolitics* (2010). This form of power exerts a positive influence on the lives of a population, attempting to manage and govern subjects through the promotion of life rather than through the promise of death. New techniques of social control were developed through the use of statistical analysis and data collection that record birth and death trends in order to calculate probable trends in populations. Any actions or events that fall outside of statistical norms are seen as deviations that could possibly threaten the equilibrium of the population are thus labeled as deviant and risky. Within a neoliberal model of governance, that displaces responsibility onto the individual rather than the state, risky behaviour is viewed as immoral as it is a danger to the self and others. For this reason, we must turn our attention to theories of deviance within public health models as they pertain to drug use.

Theories of Deviance

Much of the earliest sociological research involving drug use and addiction was concerned with how those who partake and are involved in drug communities are given a deviant status within society. What is so inherently wrong with drug use? How do cultural values create limits to acceptable behaviour? Who is deserving of the label and who is exempt? When is it appropriate for disciplinary action to be applied to abnormal bodies?

Deviance itself is socially constructed and defined differently at each level of collectivity. On a micro level, personal norms of conduct are relative to the intimate relations shared between people, and the response to an action is dictated by one's tolerable limits and whether or not they have been transgressed. On a more macro level, deviance in communities is positioned as a boundary marker, the absolute limit that a community is willing to tolerate in order to maintain a cohesive group identity (Erikson, 1962). In this way, deviance is a useful lens to view cultural identity through because it reveals what values and customs a community actively encourages its members to embody with their conduct and beliefs. Durkheim points out that increased social integration requires increased conformity from citizens. Without a sense of belonging based on shared values, anomie will set in, disincentivizing the benefits of

remaining with the group, leading to social disintegration. Any action or behaviour that is outside the norm is a threat to collective identity and therefore must be punished in order to protect the status quo. In their analysis of Canadian drug policy's relation to its national identity and security, Grayson (2008) found that "security discourse surrounding the issue of illicit drugs/users defines what can be considered legitimate approaches to drugs by constructing the very objects it speaks of as security issues" (p.39). Grayson goes on to claim that state action constructs national identity in an attempt to fix boundaries of conduct which distinguishes a collective, localized self from the foreign other; the goal of these actions is to protect this national self from becoming amorphous. In the case of Canada, Grayson claims that Canada's more liberal approach to drug policy is one of its defining features that differentiate Canada from the United States. It is viewed as a point of pride, a position that is seen as more civilized and humane compared with the harsh cruelty of the American justice system. However, it must be noted that drug use is still condemned as an unsavory action that contradicts liberal Canadian values such as self-control, determination and productivity. In viewing drug policy in this way, we can say that deviance may be responded to differently depending on the values of a specific nation-state, even when the behaviour in question transgresses those same values.

More than anything, deviance is a moral enterprise that determines what a society views as right and wrong. Becker (1973) refers to those involved in the campaign to shape public morality in regards to a certain behaviour as "moral entrepreneurs" pushing for a moral crusade. In order to convince the public that a problem exists and that measures must be taken to prevent it from spreading, these moral entrepreneurs distribute propaganda, hold public demonstrations, speak with high ranking officials, and create petitions to ultimately reform existing laws in order to ban morally reprimandable actions with legal sanctions. Howard Becker has made a lasting impression on theories of deviance and addiction in his classic text, *Outsiders.* Compiled of a series of essays on cannabis smoking and jazz musicians, Becker's work reframed how deviance was constructed in society, claiming that "social groups create deviance by making the rules whose infractions constitutes deviance, and by applying those rules to particular people and labeling them as outcasts" (Becker, 1973, pp.79). Based on this interpretation, the deviant act is not inherently so; it is the result of an interaction between the actor and audience and how the audience chooses to react to the action. Synthesizing social construction and symbolic interaction, this

perspective is called labeling theory. The theory posits that the labels used to define and categorize people who are charged with deviancy have lasting effects on an individual's identity and self-perception as well as their status within society (we can see how this relates to Hacking's theory of dynamic nominalism). How a person chooses to self-identify based on the labels that have been attached to them contributes to how deviant actions are realized within their interactions and behaviours. For example, McIntosh and McKegany (2000) highlight the importance in creating non-addict identities for drug users on the road to recovery; creating positive self-images and identifying with professionally produced narratives of addiction help ex-users envision a new life for themselves that does not include drug use. Much like a self-fulfilling prophecy, the categories that people belong to can influence their self-image and behaviour in response to their label. If this is true for recovering addicts, it is also important to research the narratives and identities that are consonant with active drug use to understand how these discourses can be destructive and actively work to change what it means to be a drug user or addict.

One of the main forms of advocacy for drug use has been reducing stigma attached to it. While medicalizing addiction has been said to decrease the stigma directed at drug users, if we take into account Goffman's theories of stigma, we can come to the conclusion that stigma towards addiction can never be fully extinguished if it remains a disease. According to Goffman (1963):

> The attitudes we normals have toward a person with a stigma, and the actions we take in regard to him, are well known, since these responses are what benevolent social action is designed to soften and ameliorate. By definition, of course, we believe the person with a stigma is not quite human. On this assumption we exercise varieties of discrimination, through which we effectively, if often unthinkingly, reduce his life chances. (pp.5)

Negative social identities that are ascribed to individuals based on perceived "blemishes of individual character" (Goffman, 1963, pp.4) such as addiction, alcoholism, or mental disorder are the second type of stigma identified by Goffman - along with abominations of the body and tribal stigma. Stigmas of this type differ from the others mentioned because they are not immediately apparent, or visible, upon contact with normal groups; whereas the physically deformed or coloured person is immediately sold out by their appearance, the drug addict may be completely unidentifiable (aside from telltale signs such as track marks from intravenous use, or hippy stereotypes including disheveled appearance and choice in

clothing). The condition is one that is possible to keep secret, to be managed; Becker (1955) even claims that this ability is one of the defining traits of habitual use in cannabis smokers - to be able to use a substance without close members of a social circle being suspicious of use. This secrecy also leads to a sense of betrayal or mistrust when an habitual user is outed, contributing to stereotypes that all drug users are liars that cannot be trusted. This stereotype often pressures users to keep their use a secret for fear of being reprimanded and acts as a barrier to seeking professional help. Furthermore, the concealed nature of the stigma in question leads to judgements that are inherently value-based and morally influenced regardless of medical legitimacy. Mental illness continues to be stigmatized - consider schizophrenia, bipolar disorder or antisocial personality disorder. These disorders are heavily stigmatized and the daily lives of those who are diagnosed are dominated by the medical and pharmaceutical industry. The disease model leads to different implications oscillating between sympathy and dangerous modes of social control that are invoked to stop the spread of a foreseen epidemic, or "contagion" (Kaye, 2012).

Stigma, then, is itself an unsavory label that is constructed in particular cultures and social settings. Hacking showed interest in Goffman's work in relation to his looping effect:

> Goffman wrote that in our kind of society, total institutions are places of coercion that change people – not at all necessarily in the intended directions, such as the cure of the patient, the reform of the criminal or the sound education of the schoolboy at boarding school. Goffman truly offered an analysis of making up people. (Hacking, 2004, pp.294)

Considering this, we can see how institutions can create dominant discourses of mental health that label, categorize, diagnose and reify problematic behaviour through their very practice.

The relationship between deviance and stigma must be explained in the context of drug use and addiction. While the two terms are related, Goffman (1963) makes the distinction that the deviants are "the folk who are considered to be engaged in some kind of collective denial of the social order; they are perceived as failing to use available opportunity for advancement in the various approved runways of society" (pp.144). It would seem that Goffman suggests that deviance is motivated by civil disobedience whereas stigma is the resultant chastisement that these actions warrant within a value-laden society. Stigma acts as the barrier to admission into particular social groups within society, the tainted mark on

individual identity that displays a character flaw for all to see, a mark of Cain. Deviance is relishing this demarcation.

Due to the complex relationship that drugs share with the law, morality and health, the discourse surrounding drugs and their illicit use is very political. Canada has recently legalized cannabis for recreational use; however, it is important to note that the framework that this legal sanction operates under is a public health model, within a larger neoliberal form of governance. The legalization of cannabis is normalizing use within Canadian culture, but stigma remains. What this means for cannabis users is although their actions may be legally admissible, the surrounding stigma is still able to function to deter habitual use, as chronic cannabis use is still connected to respiratory issues as well as mental health issues, suggesting that the law and social stigma work reciprocally even when they seem to be in contradiction. Within this legal framework, there are degrees of stigma and deviance at play within acceptable uses of cannabis: the patient that is prescribed cannabis faces little stigma and is not labeled a deviant as their drug use is medically prescribed and therefore seen as a necessary component of health maintenance; the recreational user faces stigma but is not necessarily considered a deviant so long as they follow the guidelines of use set out by the Canadian government, only use at appropriately deemed social settings and buy from approved vendors; finally, there is the chronic user that uses frequently throughout the day (even at work), often buys from illegitimate sources that do not contribute to sales tax, and face increased risk of detrimental health effects - this group still faces high levels of stigma and are considered deviant based on their disregard for the medically based goals of legalization. The legal status of cannabis can also increase the stigma and perceived deviance of other drugs because users continue to use illicit drugs instead of legal options (Hathaway, Comeau, & Erickson, 2011). The paradox of the public health model for cannabis legalization is that cannabis is considered the least harmful drug in regards to death toll, social harm, and black market violence. If the motivation for legalization was to reduce these harms, then why not legalize cocaine, heroin or methamphetamine, which pose far greater risks to the population and account for far more harm?

Drug Use in a Risk Society

> *The 'portfolio' of risks changes markedly over time. The choice of risks to worry about is rarely determined by what experts assure us are the 'objective,' 'real' probabilities and disutilities of the*

> *dangers. No general theory about what determines a choice of risks can be offered, for too many contingent facts and local stories affect the choice.* (Hacking, 2003, pp.22)

Much in line with Foucault's conception of biopolitics and governmentality, our current technologies of governance rely on acute data collection and statistical analysis to calculate areas of risk within a population and preemptively intervene with possible issues before they have the chance to spread. Mary Douglas' work in risk theory is considered foundational to our current understandings of maintaining health and purity in a secular world:

> The modern risk concept, parsed now as danger, is invoked to protect individuals against encroachments of others. It is part of the system of thought that upholds the type of individualist culture, which sustains an expanding industrial system. This is why risk is such an important subject for America. The expansion has been enormous; there is some retrenchment; more expansion beckons. The dialogue about risk plays the role equivalent to taboo or sin, but the slope is tilted in the reverse direction, away from protecting the community and in favor of protecting the individual. (Douglas, 1990, pp. 7)

The need to protect the individual speaks to current neoliberal forms of conduct and responsibility within modern society. While there is a need to consider populations as a whole that must be managed, each individual is expected to minimize their chance of coming into contact with risky situations and behaviours for the good of themselves, as well as the prosperity of their community members.

The need for self-preservation goes deeper, however. This need to preserve purity is concomitantly built into the fabric of our cultural constellation, and individuals are the ground soldiers that uphold narratives of cultural identity. Deviant and risky behaviour are metaphorical dirt, a virus, a contagion that must be quarantined and targeted in order to maintain a cultural homogeneity (Meylakhs, 2009; Hacking, 2003; Douglas, 1990). From this perspective, it is not so much the real, inherent danger to human life that determines a phenomenon's risk status, but rather its capability or possibility of reaping moral decay on a nation and its citizens. Normalcy is reliable. Normal denotes a certain objectivity of human behaviour in a statistical sense - any deviations from a norm upset the balances in social relations and conduct and signal a risk that is a threat to liberty, to the values of Western democracy and selfhood (Ericson & Doyle, 2003).

Surveilling practices directed at high-level risk groups has led to new forms of policing subjects. Valverde (2003) has coined the term "targeted governance" to describe a new biopolitical logic of control that directs surveillance resources to specific communities based on risk potentials. Surveillance is used economically through data collection that identifies more problematic individuals based on geographic location, income levels, race and occupation, among other categories. Unsurprisingly, the data disproportionately targets low-income neighborhoods, ethnic minorities and the unemployed. The gaze of the risk society is constantly atomizing - breaking phenomenon and subjects into more refined categories in order to concentrate attention on the roots of risk and prevent their branching out. According to Rose (2003), the rise of bio-medical technology - particularly neurochemistry, mapping the human genome, and psychopharmacology - is concurrently molecularizing the site of addiction and other problematic behaviours, magnifying the properties and functions within the body to microscopic levels of specificity that can be targeted for manipulation and recession. Genetic research continues to seek out an "addiction gene" that can account for risky drug using behaviour. The possibilities of such technology are far-reaching; those who inherit a risky genetic predisposition are viewed as susceptible to developing problematic diseases or illnesses; as a preventative measure, those individuals will experience advanced scrutiny from governing bodies based on their genetic makeup; this predisposition takes on a master status, overtaking the individual's very identity and creating a new ontology of sickness based on the subject and their microbiology; pharmaceuticals are developed to interact with specific genetic abnormalities and correct them. Here, we can see how biomedecine mirrors the operations of biopolitics and feeds into the discourse of population control. As Rose (2001) points out:

> social and vital norms of individuals and populations have always been inextricably intertwined at the very heart of medical knowledge. It was in the universal and compulsory practices of schooling that the idea of 'normal development' in the child was formed and the techniques of weighing, measuring, and assessing were invented: they solidified the idea… that deviations… were biomedical abnormalities. (pp.22)

It would seem that a paradox exists in risk governance, where risk is both individualized and totalized across the population. Hunt (2003) argues that modern governance oscillates between the individual and the population, facilitating novel forms of control through responsibilization of population health

management. The general idea is that it is the individual's responsibility to avoid risky behaviour for the greater good and prosperity of the community, moralizing conduct and making one liable to public scrutiny when someone fails to comply with public standards of health. What is good for the individual is good for the population as a whole. Medicalization and medical discourse mask the moral dimensions of a social problem, providing empirical evidence that are presented as objective and therefore amoral statements on proper conduct; however, our current regime of truth implicitly informs what values need protection from threats to social order and production. But are drugs the cause of moral degradation and economic uncertainty, or merely a convenient scapegoat to displace blame onto?

Drug epidemics never fail to evoke mass panic within the population. The pandemonium is charged with moral and safety concerns that grab the attention of citizens and instill within them a deep-seated fear of drug users. Reinerman (1994) claims that this moral panic is ideologically constructed to construe street drugs as the core cause of pre-existing public problems. Based on their research, Reinerman demonstrates that drug scares are usually coincidentally in vogue at times of societal upheaval or restructuring. For example, the prohibition of alcohol was in many ways a battle of morality in America between the Protestant settlers and Catholic immigrants of early America. Alcohol was the vice of choice for many Catholics, while such indulgence was frowned upon by the Protestants because production and self-control were both virtues of Protestant ethics. As a means of asserting social control and moral integrity (and therefore national sovereignty) over the Catholics, Protestants created the temperance movement to chastise and regulate Catholics into submission (Reinarman, 1994). Another example would be the crack epidemic that closely followed the proceeding major recession of the early 1980's. After the boom of the 1970's where many elites were enjoying cocaine, the austerity of the 1980's bred a new, cheaper alternative - crack-cocaine. Used predominantly by low-income, black communities, the drug invaded the imagination of the public and was heavily demonized. The increases in theft, violent crime, and home invasion were pinned on the influx of crack use in black neighborhoods, leading to higher incarceration rates. Rather than consider the surrounding social conditions and economic struggles that would spur increased crime rates, crack was strategically framed as the main culprit, ignoring systemic contradictions that were causing social distress and desperation. The drug policies put in place by Reagan's administration would give permission to law enforcement agencies to arrest thousands of

black men at the behest of the DEA. Not only were drugs a useful scapegoat for social upheaval and hardship, they were also an effective means of targeted governance, albeit a racially motivated and state coordinated operation.

It is clear that drugs are depicted in many different forms within the risk society: as a dirty substance; as a force of moral destruction, as a risk to health, and as a scapegoat for social ills. How drugs and those who use them are rhetorically presented in news and in policy directly contribute to the acceptable forms of knowledge that construct public discourse. However, it is important to note "that [although] risks are socially constructed makes them no less real, but it does mean that they can be magnified and dramatized in the public imagination, as projections of a structure of personal anxieties created by the new uncertainties of social life" (Garland, 2003, pp. 78).

Chapter 3: METHODOLOGY

Introduction

How is it that the language employed to mediate knowledge on drug use comes to represent contradicting meanings? It would seem that addiction sits in a liminal space of meaning, torn between morality and instinct, perceived as both a matter of autonomous free will and biological determinism. These two contradicting philosophical concepts negate each other, yet simultaneously facilitate the construction of drug discourse in the public and ultimately form opinions of drug users that are extremely polarizing. On the one hand, addicts are viewed as junkies that have *chosen* a life of drug use and refuse to adhere to societal standards. No sympathy is afforded to this category of people because their circumstances are depicted as entirely of their own making, and for this, they are relegated to an abject status within society. On the other hand, addicts are framed as helpless victims who's suffering is due to an external source (drugs) that they are at the mercy of. They simply cannot help themselves; they were born susceptible and continued drug use has hardwired their brain circuitry to seek out reward. Of course, there are other discursive forms that shape our understanding of drug use, however, medicalized and criminalized discourses continue to be the most dominant. While this distinction has already been made repeatedly, and the reduction of moral stigma through medicalization has been outlined in Schneider's theory of medicalization, we have not considered why some drug users are deemed junkies and others labeled patients in the eyes of the public and institutions and what accompanying language tells us how to differentiate between the two. How does the audience know or decide "what kind" of addict any particular person is? And why does it matter? These questions are especially pertinent in the case of safe injection sites where temporary health care sites attempt to accommodate users who would ostensibly fall under a "junkie" category, raising issues of access to public health and identity. But what methods can be used to critically analyze terminology and how it functions in knowledge production and maintenance of hegemony?

What is Discourse?

In order to investigate how language in media constructs the identity of opiate users and the site of treatment, this study will utilize a critical discourse analysis methodology. “Discourse” has been mentioned in passing throughout this study, however, now time must be taken to explain what exactly is meant by this term. In simple terms, discourse can refer to processes of speech and writing: conversations, news articles, lectures, speeches, memes, videos, all of these are acceptable forms of discourse. This is a gross simplification of the term, yet it identifies the source of data collected and analyzed in this methodology: language acts. In particular, discourse analysis is concerned with “interrelated set of texts, and the practices of their production, dissemination, and reception, that brings an object into being" (Parker, 1992). According to researchers who use a discourse analysis methodology, language has a strong bearing on social reality and for this reason, can be said to embrace a strong social constructionist epistemology (Gergen, 1999). As we have discussed, social constructionism holds that social meaning is mediated through language, and rather than being a reflection of objective reality, language largely constitutes the way we interact with the world around us and make sense of it.

Furthermore, if language has the ability to constitute our reality, then it is a hot commodity and harnesses incredible power. As Habermas (1977) has noted, “language is also a medium of domination and social force. It serves to legitimize relations of organized power. In so far as the legitimations of power relations . . . are not articulated . . . language is also ideological” (in Wodak & Meyer, 2001, pp. 259). In this way, the functions of discourse can be related to Althusser’s (1970) conception of Ideological State Apparatuses (ISA), which are institutions such as schools, hospitals, churches, and the media that are conduits used to transmit dominant values to the populace. These can be understood as “superstructural” institutions from a neo-Marxist lens. Due to their authority and reputable claims to knowledge production and dissemination, these institutions effectively distinguish truth from falsehood based on distinctive worldviews, establishing dominant discourses that become commonplace in daily life. In doing so, worldviews that critique or are outside the scope of dominant discourse are diminished in public discourse and exist on the frays of consciousness. Foucault (1994b) has referred to this demarcation of acceptable truth statements as the episteme of an era existing within a specific milieu. However, we must be careful not to “imagine a world of discourse divided between accepted discourse

and excluded discourse, or between the dominant discourse and the dominated one; but as a multiplicity of discursive elements that can come into play in various strategies" (Foucault, 1990, pp.100). Anything said to be knowledge exists within a particular social, technological and historical time and place that is the result of a constant battle over discourse where spoils go to the victor. Any number of possible discursive formations may present themselves throughout an arc of events, yet it is neither inevitable, nor random in how these formations come to be; rather, it is how involved parties negotiate their proposed truth and their motivations for doing so. Whichever truth wins out (that which gathers the most endorsement from dominant political and governing bodies), is then able to reify and replicate itself within public discourse through tangible changes to public policy, research funding and public acceptance. Changes to policy then further entrench commonly held truths, as the successful lobbying of these policies depend upon it; therefore, discourse is tautological because it both provides the necessary mechanism for the transmission of truth-claims, while also forming as the result of a successful campaign that brings about social progression - it can be both a cause and an effect. That being said, "where there is power, there is resistance… and [the] existence [of power relationships] depends on a multiplicity of points of resistance: these play the role of adversary, target, support, or handle in power relations" (Foucault, 1990, pp. 95). For this reason, language is political. Knowledge is power and it is used as a means of controlling perceptual reality by effectively silencing any positions that threaten dominant hegemony.

The goal of discourse analysis, then, is to investigate how ideas and objects that shape our worldview are created, and how they are propped up and maintained over time (Phillips & Hardy, 2002). Studies that use this methodology are invaluable because they provide insight into how dominance is injected into language, forcing researchers to question how politically charged statements function and discretely mask power relations in plain view. Reflexivity cannot be ignored when doing discourse analysis because as researchers we must acknowledge that our studies are informed by discourse and universities are institutions that sustain powerful ideologies and power relations to truth claims. As Ball (1995) notes, good practice in discourse analysis involves a "theorising that rests upon complexity, uncertainty and doubt and upon reflexivity about its own production and its claims to knowledge about the social" (p.269).

Discourse as Paradigm: Dogma and Reflexivity

In addition to the grander conception of discourse as a force that shapes knowledge/power relations within a given society as a whole, there are also distinct discourses that are particular to specific fields or disciplines of knowledge. These forms of discourse constitute differing perspectives and establish one group of social actors from another. Esoteric terminologies are coveted and co-opted by these different professions and signify a shared knowledge paradigm that effectively creates cultural capital through shared understanding, separating the in-group from the out-group. Every profession has a discourse: medicine, law enforcement, education, corrections, therapy etc. Each of these professions have a rich historical foundation built upon specific epistemological assumptions that cultivate a strong sense of tradition within those initiated into its ranks. As a result, these firmly held beliefs and values become ingrained into professional opinion and come to embody their professional status. Bourdieu (date) refers to these beliefs as *doxa*, dominant views that go unchallenged to the point of dogma within a field. Furthermore, the status of these professions is constantly in a state of struggle for dominance with each other within a discursive arena. Bourdieu (1993) refers to this arena as a *field*, a social space where actors and institutions compete for capital. In the ideological battle for hegemony, institutions and professions battle for cultural capital to establish legitimacy over other disciplines through claims to truth, and these claims to truth are enveloped in discourse.

Due to the dogmatic nature of commonly accepted truths within disciplines, researchers are liable to favour their own world views, while diminishing views that run counter to, or contradict their views. The impulse is natural, as competing views threaten to undermine the perspective of a group, diminishing their credibility or even leading to their complete dissolution. Furthermore, members of a group have complete faith in their discipline's ability to solve societal issues and they project this confidence onto subjects that fall under their jurisdiction; the issue with such devotion lies in an inability to acknowledge that their perceived objectivity extends beyond the limits of their own subjectivity. Claims to objectivity are then reduced to expressions of consensus among social, disciplinary, and political groups." Law enforcement agencies are convinced that drug users are criminals and the best solution to reducing drug consumption is prohibition through severe policing tactics that disrupt distribution and consumption of

illegal substances. Therapists are convinced that problem drug use is a reaction to deep-seated trauma that must be treated with intense therapy. Pharmacologists are convinced that addiction can be cured with a "magic bullet" drug that alleviates all cravings (Condon, 2006). Drug users have borne the brunt of all of these behaviour modification social experiments in the name of discursive supremacy, and are often worse off for it.

For this reason, researchers must practice reflexivity diligently in order to combat the dangerous trappings of doxa in their research. What this means is consciously surveying one's own biases throughout the research process, identifying prejudices that may contribute to faulty conclusions. Our position as researchers is a place of privilege and the conclusions we come to can have far-reaching effects on the groups of people we are researching because we are contributing to discourse on subjects. In this way, not only are we critiquing discourse, we are constantly existing within and through discourse. A discursive methodology is inherently reflexive because its analysis relies on recognizing language used by institutions of power, and determining how this language affects social reality. Furthermore, the very notion of objective, neutral research is called into question when considering the constructive role of language in creating meaning (Wodak & Meyer, 2001, pp.11). Discourse analysis is a qualitative method of research that relies on interpretation, which is in itself a subjective endeavor that will yield differing results based on a researcher's biases and dispositions. Acknowledging this fact is a key component of practicing reflexivity in qualitative studies. To overlook how the academy itself functions discursively as a transmitter of knowledge would be a massive oversight. Even worse, to deny the fact that our own worldview is the consequence of discourse is both academically dishonest and ethically unsound.

Critical Discourse Analysis

Within the field of discourse analysis methodology, there is a variety of subsets of discourse analysis that can be differentiated according to two dimensions: "the degree to which the emphasis is on individual texts or on the surrounding context and the degree to which the research focuses on power and ideology as opposed to processes of social construction" (Wodak & Meyer, 2001, pp.18). Here we can see that there are two primary resources that can be analyzed to collect data: specific texts, or specific contexts. This distinction can be a cause for confusion, as discourse analysis is commonly associated with textual analysis - how specific texts function to communicate coded meanings. However, depending on

the interests of the researcher, the social, political historical and cultural contexts in which specific texts are found may also be a useful source for mapping out the distribution of ideas and the contingent factors that make a specific text a more powerful conduit for the transmission of meaning. Fairclough (2013) defends that discourse should be understood as "an element or 'moment' of the political, political-economic and more generally social which is dialectically related to other elements/moments" (pp.178). While textual discourse analysis is concerned with how a specific package of discourse functions, contextual discourse analysis is more concerned with the conditions that have made specific texts a necessary vehicle for knowledge claims on a given subject at a specific point in time. For this reason, we can view the textual/contextual spectrum as a micro/macro (respectively) framework of discourse. Conceptualized another way we can understand the distinction as one on the specific *form* of discourse being investigated and analyzed.

The other dimension that Wodak & Meyer (2001) identify is more concerned with how the text *functions*. In particular, how does the discourse contribute to the construction of social reality (constructivist) or how does the discourse reflect relations of power and ideological perspectives (critical). These different perspectives should not be viewed as a binary system, but rather as a spectrum where a researcher can anchor their analysis. Based on these four axes of theoretical perspectives, Wodak & Meyer (2001) identify four corresponding types of discourse analysis, depending on where they sit on the table: Interpretive Structuralism, Critical Discourse Analysis, Social Linguistic Analysis, and Critical Linguistic Analysis. These perspectives are not pure categorizations that a researcher must stay within the confines of, they are merely categories that assist researchers in grounding their methodological perspective through a useful criteria.

With this in mind, my research ostensibly falls within a Critical Discourse Analysis (CDA) format. My scope is most concerned with the unequal distribution of power relations between users, medical practitioners and major news sources within the social and political context of the neoliberal era. However, my research undoubtedly includes the analysis of specific texts in order to ground the study and advance my claims with specific examples, and deals with the social construction of safe injection sites and the patients who frequent them. Let us explore what exactly Critical Discourse Analysis is, what it's objectives are, and how to effectively use it as a methodology.

First, what do we mean by 'critical'? Much like the term "culture," as Raymond Williams was able to showcase, "critical" is a word used to define multiple things and is attached to many words (critical theory, critical hit, critical feedback, critical mass) but its meaning is polysemous and indirect in a sense. It is used to define other words and concepts but is difficult to define itself - especially in the context we are using it. It would seem that the term "critique" is itself a discursive formation forged out of dialectic opposition. Locke (2004) provides an excellent overview of the subject in their text on CDA and devotes an entire chapter to unpacking the many different nuanced meanings ascribed to the critical tradition of research. Locke (2004) highlights three "headings" that each defines "critical" based on the basic tenets of the critical tradition: critique as revelation; critical practice as self-reflexive; and critical practice as socially transformative. Critique as revelation refers to the work of Foucault, specifically how he "located the 'critical' in the systematic, analytical endeavor to reveal the nature of systems of rules, principles and values as historically situated bases for critique" (Locke, 2004, pp. 26). Furthermore, it relates to the process of revealing taken for granted assumptions, institutions, traditions and social conventions are not merely the natural order of things, but are instead the result of a complex interrelationship of power structures and discursive formations that have normalized socio-economic inequalities, reproducing dominant discourses through apparatuses of force and ideology, resulting in hegemony. Critical scholars hold those with power accountable for actions and deconstruct their language in order to express how language functions to manipulate meaning, creating rigid dichotomies of deserving/undeserving, good/evil, safe/dangerous etc. that inform an object or subject's value. Critical practice as self-reflexive describes the post-modern tendency to oppose grand narrative in favour of a multiplicity of discourses that interact and are interwoven, creating a pastiche of truth that is not absolute, but rather, is ambiguous and relative to cultural and historical contingencies. Based on this understanding of knowledge, critical scholars are behooved to be self-reflexive and critical of their own subjectivity and claims to objectivity. Finally, critical practice as social transformation posits that it is the duty of the critical scholar to subvert dominant discourse in the public sphere and open up a space for marginalized voices. Critical research methodology acknowledges the existence of power inequalities, encourages researchers to be aware of their own biases, and mobilizes the perspective of marginalized groups of people in order to transform dominant discourses in the social world.

At its core, CDA "should describe and explain how power abuse is enacted, reproduced or legitimated by the talk and text of dominant groups and institutions" (van Dijk, 1996, pp.84). In doing so, CDA often *problematizes* language that reaffirms power relations, exposing how language functions to expand the supremacy of one group at the expense of another, silencing certain opinions, or erasing them outright. "Problematization", as Fairclough (2013, pp.186) explains, "links negative critique to positive critique: in positing a cause of difficulties as a problem and explaining these difficulties as effects of this problem, one is identifying… what needs to be changed, what needs a solution. A problem is simultaneously what explains difficulties and what demands solutions." In this way, critical researchers are able to transform discourse by identifying problematic terms and categories, explaining how this language functions negatively and as a result are capable of replacing oppressive terms with others that are more inclusive and empowering. Because discursive resistance is a strategy to subvert dominant power relations, critical theorists can exercise power through a critical discourse methodology. More than anything, CDA explores how disciplinary and repressive actions against underprivileged peoples are justified through discursive strategies that function to normalize invasive policy and state action while seeking to upend disproportionate power relations through revelation and subversion.

Method

The subject of study in this paper is the discursive language and terminology employed in policy and news articles about safe injection sites, and the people who frequent them, in Ontario from 2010-2019. Due to Covid-19, I was forced to change my primary source of data from an archival study of CAMH documents to a media/policy study. While the possibility of pursuing my original plans for this study remains open, following the containment of the novel virus, the original intent of my work remains intact. This study utilizes a critical discourse analysis methodology paired with rhetorical reading of the primary sources in order to discern how power is distributed amongst claims makers that argue for or against safe injection sites, how they frame their respective arguments, and how this has affected policy decisions for public health and safety. The overarching question for which I seek answers for is: why, in an era of relaxed drug prohibition in Canada, have programs that benefit intravenous users been dismantled while government bodies claim to be taking a public health approach to drug use? The reason for terminating temporary safe injection sites, I hypothesize, is a combination of anti-drug discourse,

neoliberal rhetoric of personal responsibility for health, sensationalized news articles, and public health gate keeping that discourages community-based programs of wellness.

I intend to investigate my question and these claims through systematically gathering news articles using the Factiva database of Ontario based news outlets. Keyword searches using the terms “safe injection site”, “intravenous drug use”, “harm reduction strategies”, “drug policy”, “drug regulation” and “legalization” will yield a strong compilation of news articles pertaining to my subject of inquiry. As Stringer and Maggard (2016) have noted, “the media has great impact on public opinions, plus it has the ability to influence vast numbers of individuals and is conducive to influencing the collective definition of a situation” (pp.429). Furthermore, the average citizen’s only direct knowledge of illicit drug use comes from mass media, as they do not often come into direct contact with drug use, making news stories a powerful medium of influence and propaganda (Gelders, Patesson, Vandonick, Steinberg, Malderen, Nicaise, & Laenen, 2009). In addition to media sources, drug policy relating to drug regulation and safe injection sites will be reviewed to contribute to the breadth of analysis and compare trends in public opinion and public policy.

In order to focus my analysis, Hacking’s twelve engines for making up people (discussed in the theory section) offers a useful heuristic device to organize and process discursive strategies found in the text and in contextual trends. Johnstone (2017) emphasizes the need for an analytic heuristic in discourse analysis because it is a useful frame of reference that keeps research precise and manageable. Therefore, Hacking’s engines will be a constant point of reference throughout the coding stages of my research that, paired with my theoretical framework, will orient my analysis, producing cases of social construction and sites of struggle for self-definition. These engines have the added bonus of framing discourse through different lenses of theoretical analysis. I will be dividing these engines into three sections based on their theoretical application: statistics and risk, medicalization, and institutionalization. While this method may seem unorthodox, this layered approach to discourse analysis is comprehensive and enables an even analysis of many working variables in social construction.

There is no proper way “to do” discourse analysis from a methodological standpoint due to the qualitative, hermeneutical nature of the method:

> It is for this reason that those using discourse analysis with Foucault shy away from prescribing method, for no matter how standardised the process, the analysis of language by different people will seldom yield the same result.This is not seen as problematic for the aim of poststructural analysis is not to establish a final 'truth' but to question the intelligibility of truth/s we have come to take for granted. (Graham, 2013, pp. 666)

The freedom of analysis that CDA provides as a methodology makes it an invaluable tool for being critical of accepted truths related to drug use and harm reduction programs and encourages novel analysis of media phenomenon and subsequent policy plans in order to identify who has discursive power to define and intervene, how discourse functions and for what purpose. Paired with rhetorical analysis, my method seeks to deconstruct discourse and the linguistic strategies employed to establish and maintain dominant discourses of discipline and control. Finally, a neoliberal lens of critique of expected norms of health and wellness for individuals in the era of risk and responsibility grounds my critical scope on rhetorics of public health.

Chapter 4: CONCEPTUALIZING RISK DURING A DRUG EPIDEMIC

Biopolitical Surveillance of Risky Bodies: Counting an Epidemic

Hacking's first engine of discovery in 'making up people' is counting. When categorizing a distinct group within a population, it is important to measure the prevalence of this group. Upon reading news stories on the current opioid epidemic, one of the most common facts reported in news stories is the rising overdose rate across the nation. This is no surprise. The numbers are worrying and automatically speak to the gravity of the situation at hand. More people are dying in their homes or in the streets; emergency calls are becoming more frequent; more hospital beds are being reserved for overdose patients. This obsession with reporting statistics and mortality rates reaffirms the emergency state of Ontario's opioid problem. These numbers are something tangible and accessible to the public. Despite the rising numbers, however, the government of Ontario has been apprehensive in declaring the opioid epidemic a public health emergency due to the ongoing, long-term nature of the epidemic (Howlett & Giovannetti, 2017 August 30). Coinciding with the rise in deaths, more state run surveillance measures have been established to more accurately track the rate of people who are being admitted to emergency treatment as well as who is accessing services. These techniques of surveillance provide state services with precise metrics that allow careful allocation of resources, the ability to project future casualties, and to demarcate areas of risk within the province as a means of containing the spread of opioid related deaths throughout the province. While these justifications for increased surveillance of a vulnerable population of people are benevolent in intent, we must be wary of the unintended consequences of how they are practiced within a state of exception that has the potential to further oppress vulnerable populations in the name of public health.

One of the defining characteristics of the modern era is the advancement of tools of classification, identification and monitoring of public health risks. Consider the AIDS epidemic of the 1980's or the current Covid-19 outbreak that has spread globally, necessitating a very sophisticated level of data collection to track cases within a community. Now more than ever, state bodies and institutions are capable of collecting rich, detailed data on its citizens in an effort to track birth and mortality rates that can predict future complications in real time. The obsession with data collection in modern society is one of absolute necessity, as it functions to maintain production relations within society, working to govern

from afar through invisible regulatory and corrective mechanisms of power (Foucault, 1990). Without statistical data, specialized institutions such as medical, law enforcement and judicial systems would have no point of reference to systematically concentrate their available resources toward particular populations and the individuals that comprise them; efficiency is tantamount to organizing effective measures of surveillance and intervention, especially within a neoliberal framework of public health provision. This is especially the case when services are on limited budgets and resources are scarce. Health care sites that provide access to essential harm reduction tools like sterile needles, naloxone, and drug use information are underfunded and often rely on volunteer labour and public donations to stay afloat. Why is it that these services must struggle to acquire the necessary supplies to treat a group of people in desperate need of social assistance and why is the right to life of these people becoming a political matter in current discourse surrounding opioid use? “Biopolitics is an active and reactive process that politicizes life by locating it within the polarizing paradigm of normality and abnormality and thus [categorizes] life as either productive or unproductive and therefore worthy or risky” (Saltes, 2013, pp. 61). Risk has become synonymous with abnormality in that national security and identity are performatively dependent upon normality (Grayson, 2008). Abnormal groups are seen as a threat to social cohesion and the biological integrity of a population and for this reason must be watched closely, intervening when it is appropriate. The opioid epidemic is no different. Although there have been efforts to de-stigmatize people who are opioid users, and many white, middle-class people are also dying - a convincing reason to explain the moral shift in drug discourse toward a medicalized lens - the majority of victims are homeless, and without employment (Public Health Ontario, 2019). The epidemic has made marginalized groups increasingly visible to the scrutinizing view of institutions. While it is the state’s task to uphold and promote the right to life of the population they oversee, health outcomes are dependent upon a criterion of normality that is inherently classist, racially motivated and exclusive.

While the gathering of data is necessary to assist in public health policy and distributing resources accordingly, it is important to critically analyze surveillance practices because they can be inherently biased and further alienate subordinate groups. Lyon’s (2003) contributions to surveillance studies point out these inherent biases and claim that surveillance should be understood as systematic attention to personal details with the goal of managing the groups concerned. Lyon (2003) has theorized what has

been termed “social sorting”, a “system of surveillance which seeks to obtain personal data to classify people according to varying criteria to determine who should be targeted for special treatment, suspicion, eligibility, and access to resources” (pp.20). In regards to the opioid epidemic, it is imperative that we consider the demographics that are disproportionately affected by, and therefore targeted by instruments of data collection, reinforcing long-term social differences through value-driven metrics of categorization. According to Public Health Ontario (2019), “nearly one-third of deceased persons lived in the fifth ON-Marg quintile of neighbourhood material deprivation (most deprived) and the majority (62.0%) of deaths occurred among people who resided in large urban centres.” Furthermore, 46.8% of individuals were unemployed. The fact that the target group of interest in tracking opioid consumption often lacks employment and a stable address complicates modern methods of data collection. Modes of registration such as licenses, property taxes, social assistance application and a host of other bureaucratic documents are integral tools of state management of populations and proof of citizenship (Breckeridge & Szreter 2012). Therefore, those who lack proper documents of registration are stuck in a catch-22 situation: without proper documentation, these individuals are essentially non-existent in the eyes of bureaucratic surveillance and are ineligible for the benefits of citizenship, yet - because of their invisible status - these individuals are subjected to increased monitoring by law enforcement agencies, making them hyper visible. In a position paper distributed by the Ontario Association of Chiefs of Police (Taverner, 2012) in regards to supervised injection sites, there is an assertion that the success of Vancouver’s Insite program was not due to the supervised injection facility’s presence in the community, but rather, an increased police presence that monitored the area more vigilantly. This is an example of “targeted governance”: a site-specific point of contact between law enforcement and problematic populations (Valverde, 2018). How and why certain groups of people situated within geographically defined boundaries are strategically subjected to heightened security measures is a question of biopolitical control.

Biopolitics have directly reinforced societal norms because normal characteristics, behaviours and societal phenomena can now be statistically verified with the help of data science, which compares and contrasts population trends with the ultimate goal of establishing averages within the population; these averages are then correlated with ideal types of people. Adolph Quetelet found that the distribution of traits can be graphed as a bell curve that calculates mean values within a population (Eknoyan, 2007).

Francis Galton, another pioneer in the field of what was to be named biometry, was also influential in establishing this new mode of social science that utilized population analytics. Natural selection and eugenic undertones informed his work, justifying Eurocentric values of white supremacy and social hierarchy that constituted and reproduced societal norms:

> The forms by which distribution is expressed in the new method are excellently fitted to bring to light any *survivals of a less advanced type*...Also they quickly indicate incipient changes, through their power of *isolating aberrant forms,* and then measuring the degree in which any of these may be favoured by natural selection. (Galton, 1901, pp. 10 emphasis added)

Those who fall outside of Quetelet's bell curve of human characteristics are viewed as abnormal outliers who possess certain variable traits, which fall outside of normal distribution. Soon, this theory was being applied to social values of a moral persuasion such as criminality and other deviant behaviours deemed problematic by society. In Quetelet and Galton's time, "dangerous classes" of petty thieves, drunks, vagabonds, and prostitutes became a daily concern in the lives of the civilized classes in early 19th century France and the carceral system continuously failed to normalize and rehabilitate these repeat offenders (Beirne, 1987). Quetelet sought to apply his theories of distribution in order to calculate regularities over time in criminal conduct within a given population living in specific conditions.

These practices continue today, albeit in new forms and toward different ends. The opioid epidemic has forced the federal and provincial governments to monitor drug use more vigorously, relying on data collection from a number of different public services such as hospitals, safe injection sites, first response reports and police surveillance to constantly update rates of mortality, the drugs involved in incidents and the demographics of the individuals that comprise their data sets. For Rose (2001), biopolitics is no longer a strategy of social engineering that actively seeks to classify, identify, and eliminate deviant bodies, but rather functions to manage these populations perceived as problematic, or risky, with the ultimate goal of normalizing behaviour in order to correct deviance. This conceptualization mirrors Foucault's (2003) assertion that functions of biopolitical power can be "a positive technique of intervention and transformation to a sort of normative project (pp.50). In response to the opioid epidemic, the government of Canada has created a publicly available interactive opioid surveillance tool that provides real time data on the epidemic, including key findings, maps and graphs that tally deaths,

hospitalizations and medical emergencies related to the epidemic as a means to monitor and mitigate possible risk through statistical models of prediction. Since the government has begun collecting data in 2016, there have been 15 393 total deaths, 19 377 hospitalizations and 21 000 emergency medical service calls. In 2019 alone, 1535 people died of apparent opioid-related deaths in Ontario (the most in any province), which is approximately 10.5 deaths per 100 000, making Ontario the third worst province behind British Columbia and Alberta (Government of Canada, 2020). Ontario also has their own interactive opioid tool, which gives even more specific numbers on the crises, including mortality and morbidity trends based on area and time periods, the age and sex of overdose victims, infographic maps, and types of drugs present at death. Of all public health sectors in the province, the North Simcoe Muskoka LHIN had the highest rate per 100 000 at 114.9 cases (Public Health Ontario, 2020). To put this into perspective, in 2017 more people died of overdoses than motor-vehicle and homicides combined (Woo & Hager, 2018, March 28).

Prior to the rise of the epidemic, Ontario did not have any system that monitored overdoses in real time (Howlett, 2016, October 12). It was not until May of 2017 that an online surveillance system was unveiled with a backlog of cases going back to 2003, and even then, there was no real-time monitoring in place that could track deaths province-wide (Howlett, 2017, May 24). Without baseline data to track trends in drug use, future projections of drug mortality are impossible to account for (Howlett, 24 May 2017). Hindsight has left Ontario in a position where state institutions are struggling to bail out a ship that is already sinking rapidly, focusing on establishing regulation measures and surveillance infrastructure while overlooking the structural inconsistencies that contribute to risky drug use such as inaccessible health care, unaffordable housing, and an unregulated drug trade.

An issue with constructing a provincial-wide census on drug use is that it is notoriously difficult to collect all-encompassing data on drug use. In his own construction of problem drug users in the United Kingdom, Seddon (2010) acknowledges the difficulties in counting drug use, and states “we can and do count those who come into contact with treatment services but to assess the total population we have to rely on estimates” (pp. 340).. Drug use is highly stigmatized in society - not to mention still criminalized - and a user’s distrust in authorities is hyper-sensitized as a result, making it very difficult to collect data from a population unwilling to divulge private and possibly illegal information to state authority. In a

possible move to address this issue, Toronto Police Services launched a voluntary information database under the guise of a tool to help officers better assess a situation when dealing with certain vulnerable people. “The information - which could include behaviours that officers might encounter, de-escalation strategies and emergency-contact details - can be entered either by the registered person themselves or a caregiver or power of attorney” (Hayes, 2019, December 6). Someone who wanted it known that they struggle with addiction was one of the first submissions they received was from. The issue with such a strategy is that citizens may feel coerced into sharing this information under the fear of police violence in routine check-ins. Jennifer Chambers, executive director of the CAMH-funded Empowerment Council points out that “sometimes things that are voluntary are not coercion-free” and instead pleads for “universal caution” in all situations when dealing with the public (Hayes, 2019, December 6). Drug users are a marginalized group that is difficult to count because of the paranoia and fear of authority that they may harbour. To expect this vulnerable group to voluntarily provide private information to public censuses is naive and paternalistic. If the recording of patient visits is made mandatory in hospitals and safe injection sites, users may be more apprehensive to use the service out of fear of being outed to law enforcement authorities. Therefore, anonymity must be promised and respected in order for users to feel safe using services, while also contributing to data collection of drug incidents.

After reviewing nationwide data on the growth of the opioid epidemic, what is most frustrating with Ontario’s inaction is that there was always an awareness of the possibility that the epidemic would eventually spread eastward. British Columbia has long been the locus of opioid related social issues in Canada, and the province was quick to declare a state of emergency to respond to the growth of the issue in an immediate fashion. Granted, British Columbia already had a public health infrastructure in place to accommodate opioid trends - Insite, the nation’s first safe injection site, is a testament to the province’s commitment to addressing the problem - while Ontario has continued to deny the magnitude of the matter based on their refusal to address the crisis for what it is: a public health security threat. The Ontario government, however, has failed to address the emergency nature of their own opioid crisis, despite the increase in deaths and ER visits due to opioid related overdoses and an open letter from over 700 health care workers pleading for bolstered support (Howlett, 2017, August 29). Officials have instead rejected the request, as Ontario Health Minister Eric Hoskins made clear when he claimed “emergency powers are

typically used for situations lasting no more than 14 days" (Howlett & Giovannetti, 2017, August 30). Not only would an admittance of the emergency situation provide increased funding to frontline health workers, it would also symbolically communicate to those affected that their lives have value. By stopping short of such action, the Ontario government inadvertently reveals that their commitment to the public health of vulnerable groups is only rhetorical, rather than transformative.

Risky Business: Drug Potency and its Costs

Quantification has a distinct definition according to Hacking. It is not simply counting prevalence. Quantification refers to how a divergent characteristic that defines a categorical type is measured in comparison to the norm. Hacking uses weight as the prime indicator of obesity, in particular, body mass index. When considering the harmful potentiality of drug use, many factors contribute to the conceptualization of deviant drug use and how it is quantified. Duration of use, the potency of a drug, physical, emotional and financial harms, and associated costs of drug use are all viable variables associated with the quantification of opioid use. In any case, the metric by which we quantify opioid use is through risk assessment. At what point does recreational opioid use transform into dependence? What is at stake in this distinction? Quantifying the harms and risks associated with habitual opioid use are a useful tool in conceptualizing public response to the opioid epidemic.

Precisely what is risk? In our daily lives, we often encounter situations where we must make a decision whether or not to engage in particular actions based on their possible outcomes. We may find ourselves making a mental list of pros and cons - does the reward outweigh the perceived consequences that could result from the action? What we are contemplating in these situations is risk assessment. "Risk is the calculating concept that modulates the relations between fear and harm" (Hacking, 2003, pp. 27). Now, there are many factors that could deter one from choosing to engage in a risky action: physical harm, social stigma, significant losses to prestige, income or health, punishment, or moral retribution. Notice that each of these deterrents are possible outcomes involved with drug use. Risk is inseparable from drug use in common drug discourse. This reflects the "all or nothing" trope in the Just Say No or Not Even Once anti-drug campaigns that reinforce the dangers of drugs in public consciousness and perpetuate the notion that illicit drug use is inherently harmful to both the user and society (Dollar, 2018). By corrupting their own body, drug users are threatening the sanctity of a neoliberal society that values

the responsibility of self-preservation and reproductive labour. For Hunt (2003), risk and morality are inextricably tied together and function at both an individual and totalizing level:

> On the one hand, risk assessment serves as a factor in the calculative discourses of individual life chances. We change our patterns of activity and consumption to avoid risks and to promote some conception of our 'well-being.' On the other hand, 'risk' discourses, especially in their technical forms (statistics, actuarial tables, and epidemiology), totalize aggregated populations (pregnant women, middle-aged men, drug users).

The tug-of-war between personal and social ethics that functions as a disciplinary mechanism of risk discourse - within a neo-liberal milieu - effectively situates personal choice within acceptable forms of conduct, inculcating a collective gestalt within social relations of autonomy. Wellness has become a moral demand in a neoliberal free market economy (Cederstrom & Spicer, 2015). It becomes the duty of the individual to avoid risk in order to manage one's ability to contribute to the reproduction of social values. In a secularized world, risk is synonymous with sin - a damnable offense that threatens a community's salvation from rapture (Douglas, 1966).

Drug use, and particularly opioid use, violates many of our society's cardinal sins. Moore (2007) theorizes that every drug has a unique "personality" that effectively organizes the way a drug is scheduled in the criminal code and translates into specific practices of risk management. While most public agencies frame drug consumption through an "all use is use" lens (Moore, 2007, pp. 70), cultural opinions pertaining to different drugs can undoubtedly be placed on a gradual scale of harm (i.e. cannabis vs. heroin). Opioids are Canada's original demon drug, and are responsible for Canada's very first drug laws, specifically the Opium Act of 1908. Undoubtedly, the cultural aversion to opium and its many modern day derivatives has become deep-seated in the Canadian psyche after over 100 years of prohibition. Many of the initial concerns that spurred opium's heavy regulation are mirrored in the anti-opioid discourse of today (Malleck, 2015; Grayson, 2008). Opioids are depressants. Their pharmacology causes users to exhibit a lack of energy - a sluggish, relaxed state of euphoria that is at odds with current demands of production that value quick and efficient labour in a (post)industrial society (Room, 2003). This lends itself to the commonly held belief that opioid users are unemployed criminals that must support their habit by any means necessary, while also being a drain on public health services. A common method of

administration for opioids is intravenous injection - a dangerous practice that can spread disease amongst users who share needles, mounting risk of epidemiological outbreak, literally infecting society. Opioids also threaten the perceived authority of our respected institutions and professionals; drugs that were prescribed by physicians have led to iatrogenic diseases of dependence in patients, discrediting the pharmaceutical field's expertise and discretion. Pharmaceutical companies have over-prescribed opioids to patients, recommending high dosages over prolonged periods that outlast the initial needs of pain management (Howlett, 2016, October 12). Which leads us to the worst offense of all in a moralized world: prolonged opioid dependence manifests itself as physical craving and withdrawal symptoms in its users. Pain management is viewed as a lack of self-control, an inability to resist primal urges that are not becoming of a civilized human. Opioid dependence defies the moral values of the nation, and because of this, is framed through a discourse of risk that functions to discourage risky drug use by making an example of those who are incapable of conforming to societal standards of personal responsibility, as if they are deserving of their abjection.

At what point does drug use behaviour transition from a harmless or troubling habit into a risky, dangerous addiction? Two key variables that Public Health Ontario (2019) identified in their surveillance report that significantly contributed to high mortality rates were the duration of substance use and preferred method of administration. Due to the difficulty in collecting precise data on drug use, as discussed earlier, almost half of deceased people had unknown histories of drug use. However, of the half that did have records of drug use, 39.1% had more than a five-year history of substance use. The longer someone uses a substance, the more at-risk they are of health related complications due to substance use. This pattern of behaviour over a long period is one of the most reliable measures of risk when quantifying the harms of drug use. Injection drug use - arguably the most efficient method of drug administration because it introduces a concentrated dose of the drug directly to the user's bloodstream - is undoubtedly accountable for considerable risks associated with drug use. Thirty-three percent (410 deaths) of deaths from July 2017 to June 2018 had indications of injection drug use and could possibly be much higher, as some reports had missing information that prevented conclusive findings (Public Health Ontario, 2019). Imagery of self-injected drug use is often romanticized in the media such as movies like Trainspotting, or Requiem for a Dream; scenes in these movies are disturbing, visceral representations of self-harm and

overindulgent decadence that are unsettling to viewers, causing many to look away in disgust. A fear of needles and bodily desecration have furthered social disapproval of intravenous drug use and those who have graduated to this method of drug administration are said to have hit rock bottom - fully giving themselves in to their rapacious desire and giving up on normal social relations. Possibility of infection also rises gradually through needle sharing and unsterile environments that lead to discourses of bodily pollution and social infection. The AIDS epidemic of the 1980s was in large part proliferated through increased intravenous drug use. AIDS was viewed by many religious moralists as a plague sent to punish homosexuals and drug users, a purging force of social purification that demonized those afflicted, stigmatizing marginalized groups further, and justifying the condemnation of certain lifestyle choices that countered national values of conduct and morality (Avert, 2019). Douglas (1966) asserts that pollution functions as a mechanism for maintaining society's collective identity and defense of its moral boundaries – every society has rules for maintaining its purity by excluding various 'polluting' substances, phenomena, and types of action. Paired with an actual public health risk requiring epidemiological intervention, intravenous drug use is viewed as a threat to both social morality and public health. A contagion effect occurs in drug discourse where they are a symbolic representation of pollution - social, personal, and spiritual - that dirties a nation's purity. Meylakhs (2009) notes that in media representations in Russia, "drugs are perceived to be polluting substances that 'corrupt the morals of our children', and defile their purity (and, consequently, the purity of the society itself). Drugs and drug users pollute children and make them crazed zombies" (pp. 385). Intravenous injection, therefore, contributes to high risk potentials in quantifying risk in society.

What exactly is being injected also shapes discourses of risk surrounding drug use. Perhaps the most significant factor contributing to the rise in current discourse of risk surrounding opioid overdoses in Ontario is the increased distribution of fentanyl - and its more potent derivatives - within the illegal drug trade. The drug is used both intentionally and unintentionally by drug users, and is difficult to adequately dose. Seasoned opioid users miscalculate appropriate dosages as the drug is more potent than heroin or prescription drugs such as oxycodone; recreational users of cocaine and other drugs are overdosing after unwittingly ingesting drugs cut with fentanyl without first developing a tolerance to the powerful opioid. Here, quantification of the potential risks of opioid use is measured through potency. In Public Health

Ontario's Opioid Mortality Surveillance Report (2019), fentanyl contributed to 66.3% of all overdose deaths total from 2017 Q3 to 2018 Q2. Mortality trends over the past decade have shown significant increases in death and hospitalizations in 2016, which coincides with the introduction of fentanyl into black market drug trades in Ontario. Fentanyl - a prescription drug used for chronic-pain maintenance - "is roughly 100 times more potent than morphine and about 40 times stronger than heroin" (Mehta, 2017, January 9). Comparing the powerful potency of fentanyl with heroin - a highly demonized drug in its own right - communicates the inherent dangers of ingesting the substance. "A dose of just two milligrams of pure fentanyl - the weight of seven poppy seeds - can be lethal" (Mehta, 9 January 2017). What amounts to a speck of sand has the power to arrest a user's cardiac system. Notice the dark power the drug itself is imbued with in this language; an unassuming, microscopic amount of fentanyl - the size of mere poppy seeds - is capable of delivering death and despair throughout an entire community. This is a curious use of synecdoche; fentanyl has come to signify the deadly disposition of those who use drugs in socio-economically disadvantaged areas, acting as a scapegoat for the myriad of other constraints, which leave these communities abject and struggling. Fentanyl becomes the sole explanation for abysmal health conditions found within these communities. This phenomena is nothing new; drugs are utilized by apparatuses of neoliberal politics to obscure actual social and systemic inequalities through the scapegoating of distinct groups (consider the crack epidemic and the violent struggle of black neighbourhoods) as means of individualizing issues that are systemic in nature (Dollar, 2018). Lethal doses of fentanyl are undoubtedly the culprit of a large majority of opioid overdoses, and its ubiquity as a common cutting agent in other drugs such as cocaine, ecstasy and methamphetamine (Katawazi, 2017, August 4) only further contributes to the drug's infamy in mainstream media. Risk is applied, then, to all drug use during the rise of fentanyl in drug trade. The miniscule, unassuming nature of the drug masks its powerful potential for harm and obfuscates its detection in street drugs, contributing to a heightened risk factor in all drug use. Furthermore, the possibility of accidental transmission furthers public paranoia, and renders drug users as a class to be avoided, like a leper that harbours death. The discovery of carfentanil - a tranquilizer used on elephants and other large mammals - increases this hysteria tenfold. It is reported that carfentanil is "100 times more powerful than fentanyl" and "a dose as small as a grain of salt can be deadly" (Gray, 2016, December 7). The presence of carfentanil in drug batches has made even

recreational drug use a game of "Russian roulette" (Zwarenstein, 2019, April 6) or a "roll of the dice", where even seasoned drug users have no idea what they are getting and the odds are increasingly stacked against their favour. Drug use is now equated with holding a gun to your temple and pulling the trigger, and those who are caught in the crossfire of dependence are left with little to no shielding from the subterfuge because their risky behaviour violates norms of social and bodily health.

The costs of the epidemic are not only fatal; they have led to increases in public health spending in order to account for the rising mortality rate and increased burdens on medical care. The number of deaths in Ontario due to opioids remained somewhat stable over time before the massive uptick in 2016; public health expenditure was then more or less stable as well. Where we see a substantial increase, however, is in ED visits, which have put enormous strains on the health department to keep up with intake. In 2017, 7512 people were admitted to emergency services and stayed for an average of 8 days (Addictions & Mental Health Ontario, 2018). While exact figures of public expenditure have not been released, according to Home Care Ontario (n.d.), the average per diem for a hospital bed is $842. Rough estimations of total public expenses for emergency visits for overdoses in Ontario would then sit around $50 000 000 - a massive hit to public spending. In addition, "public drug programs spent $93-million on medications used for addiction to prescription and illicit opioids in 2014" nationwide (Howlett, 2016, October 12). The irony is that Ontario's failure to create a real-time database of overdose incidents prior to the uptick prevented them from properly preparing for this contingency which has cost lives and dollars. The sudden concern for opioid related incidents by government officials can be interpreted as a need to account for expenses in the public health sector, rather than a duty to protect life through preventative measures. A defining feature of neoliberal governance is evaluating free market enterprise as an ethic in itself, and in order to compensate for market demand, the state must restructure public welfare sectors through deregulation and privatization in order to stay competitive, and therefore, more cost efficient (Harvey, 2005, pp. 65). In order to relieve the state of unnecessary burdens on public health expenditure, citizens absorb the responsibility of maintaining their own wellbeing (Harvey, 2007, pp.65). Risk assessment, again, is a mode of mitigation that disciplines individual conduct through the virtue of personal enterprise and individualism. Those who engage in risky behaviour are viewed as a drain on public welfare programs that are increasingly deregulated and threaten the equilibrium of carefully

planned budgets. Self-monitoring through the assessment of risk and reward is a strategy of governmentality: a development of personal ethics that is tied to building populations and maintaining power structures through particular social relations (Moore, 2007, pp. 137). Opioid use is therefore not only perceived as a threat to public health - it challenges social cohesion and defies the social contract of neoliberal governance. In an environment that continues to displace risk management and stress onto the individual, while willfully ignoring the systemic contradictions in political economy that accelerate these stresses, a rise in “healthism” has instilled a belief in the public that maintaining a healthy lifestyle is the key to cope with ever-increasing stress while reducing preventable burdens on publicly funded health care (Schuster, Dobson, Jauregui & Blanks, 2004). Through methods of quantification, the opioid epidemic has been inextricably linked to risky behaviour that inadvertently affects all levels of social ontology: the self, community, and state.

Chapter 5: CONSTRUCTING A NEXUS OF DEVIANCE AND ENFORCEMENT

(Il)licit Deviance: Criminalization and Stigma

When constructing and categorizing a group of people, what we are doing is distinguishing and comparing them from others. What sets this group apart? Deviation from the norm is what alerts state actors to the existence of a group - their deviance comes to define their existence - for the better or worse of those being categorized. Norms within society function as a shared agreement of conduct that maintain cohesion between members in any given society, and these norms are culturally specific and historically contingent. In constructing tolerable limits within a community, Erikson (1962) maintains that communities strive to find universality in social organization through commonality of customs, values, and proximity that come to define the essence of a particular nation or community, synthesizing a collective weltanschauung for people to follow and abide by. Norms maintain boundaries around a culture, and effectively act as a means to distinguish in-groups and out-groups. "Boundaries remain a meaningful point of reference [for new members] only so long as they are repeatedly tested by persons on the fringes of the group and repeatedly defended by persons chosen to represent the group's inner morality" (Erikson, 1962, pp. 13). It would seem, then, that not only is deviance a feature of all societies, but that it also plays an important role in constructing a culture's identity, and maintaining national hegemony.

In Canada, there is often a sense of identity crisis that arises when considering what demarcates Canada from our southern neighbours. Aside from using the proper spelling of neighbours, Grayson (2008) asserts that Canadian security discourses of drug use reflect relations of power that produce Canadian identity and political representation. Whereas the United States of America has historically been the driving global force behind strict prohibition and punitive measures to deter the production, distribution and consumption of drugs, Canada has presented a more liberal approach to drug policy that is said to reflect our softer views of drug use. This may be true to an extent - Canada has legalized cannabis for recreational use - however, it can also be argued that these postures of progressive drug policy are purely performative in nature. Drug discourse is practically inseparable with law enforcement discourse, to the point that law enforcement constitutes a large portion of acceptable conversation on the subject in the public sphere. Canada has a long tradition of prohibiting opioids and were in fact the first

nation to pass drug regulation laws. Canadian leaders used drug prohibition as a launching point to establish Canada as a world leader and gave them a seat at the table with other powerful nations like the United States, and the United Kingdom, governing morality globally in developed nations (for a full account of Canada's history of drug regulation, *see* Malleck, 2015). The regulation of drugs contributed to shaping Canada's identity and global political position as an authority that upheld virtuous values and moral integrity.

Drug scheduling is one tool used by legislative powers to place different drugs on a scale of deviancy. Health Canada and the National Association of Pharmacy Regulatory Authorities both have roles related to drug scheduling in Canada, determining the status of a drug (controlled substance, prescription drug, non-prescription drug), evaluating a drug's safety, efficacy and quality, and placing restrictions on the sale of drugs (National Association of Pharmacy Regulation Authority, 2019). Opium and all of its derivatives including codeine, morphine, oxycodone, heroin and fentanyl are registered as schedule 1 drugs, meaning that those who are apprehended for producing, distributing or possessing these drugs face the harshest punishments. In the context of the current opioid epidemic, it is important to investigate the range of licit and illicit drugs being consumed that are contributing to increased mortality rates. Canada's current opioid epidemic traces its roots to the mid-1990's, with the introduction of OxyContin (Howlett, 2019, May 16). Pharmaceutical companies underplayed the addictive properties of the drug, even boasting that the drug was less habit forming than other opioids on the market for pain management. OxyContin was monetarily incentivized, doctors began overprescribing the medication and keeping patients on prescriptions for long periods - longer than necessary (Grant, 2018, March 27). A Toronto law firm has sued 28 pharmaceutical companies for damages caused by their "reaping obscene profits through a false and deceptive marketing campaign" (Howlett, 2019, May 16). Iatrogenically induced dependence on opioids has led to an influx of patients hooked on drugs that were meant for pain management, but are now consumed to stave off withdrawal symptoms. To combat this frenzied over prescription of pain medication, the College of Physicians and Surgeons of Ontario (CPSO) adopted new guidelines of prescribing opioids that set far more austere limits to dosing and prescribing (Grant, 2018, March 27). The CPSO also investigated 84 high-prescribing doctors and meted out punishments for overprescribing including mandatory courses, suspensions and revoking licenses. One doctor, Robert

Cameron was forced to give up his license due to his continuing to prescribe at levels deemed too high in defiance of the recent guideline changes (Grant, 2018, March 27). One of the major concerns with the CPSO's reactive guideline changes to address over prescription is that the sudden change has neglected patient's needs and has inadvertently directed them to purchasing illicit drugs on the street in order to prevent withdrawal symptoms. "People who abuse or are dependent on prescription drugs are much more likely to transition to street drugs such as heroin" (Woo, 2016, August 30). Drug regulation finds itself in a quandary. Who is to blame for the opioid epidemic? Negligent doctors? Pharmaceutical companies? Patients abusing the system? What is clear is that pharmaceutical regulation is now retroactively pursuing damage control measures in order to save authoritative face for the mismanagement of prescription standards, which has had astronomical public health repercussions. The fact that a licit, Health Canada approved prescription drug is mostly responsible for the current drug epidemic definitely changes the discourse surrounding the opioid epidemic, compared to previous drug epidemics that were illicit in nature (cannabis, cocaine, heroin, crack, methamphetamine). Drug offenders are now framed as victims of the pharmaceutical and medical industry, patients who were treated as consumers rather than people in need of care.

Who then, holds an authoritative position to properly deal with the crisis? Increasingly, public health models of care have spread through drug discourse in the news media. The establishment of Safe Injection Sites (SIS) in Toronto and other hotspots for opioid use throughout the province of Ontario has presented a harm-reduction model of drug monitoring aimed at preventing overdoses. These sites save lives and offer a new alternative to traditional forms of rehabilitation that minimize the harms associated with drug use rather than attempting to minimize drug use itself. It is a novel approach to drug policy that has promising potential. While SIS may offer a radical approach to drug use that directly opposes the criminalization of drug use – providing a space for users to use illicit substances – we must also be critical of their clinical setting and the bureaucratic hoops that must be jumped through in order for their permits to be approved. SIS are often audited and must provide full record of all of their visitors and the services provided to them in order to maintain their funding. Those who wish to remain anonymous may be denied service or avoid the site altogether. While harm reduction developed as an alternative to medicalized approaches to drug treatment, SIS is often still bound to the standards of clinical practice and authoritative

oversight. Fischer, Turnbull, Poland & Haydon (2004) have shown that SIS 'house rules', such as sharing drugs, assisted injection, and location of injection on the body, can exclude and deter users who would otherwise use the site to use drugs safely. These regulations attest to the medical and government oversight that can act as a barrier to true access and harm reduction principles, whereas Overdose Prevention Sites are largely unsanctioned, autonomous, and independent services that are community organized, accepting input and encouraging involvement from the community that is directly affected by the epidemic. Those supervising injections at Moss Park were paired on shift, one medical volunteer was paired with a volunteer with lived experience, as a way to equalize medically dominant perspectives and power relations on drug use (Watson et al., 2020). The issue with physicians and other medical professionals adopting such an approach without community input is that they remain doctors over harm reduction practitioners:

> This 'band-aid' approach is popular because its rhetoric adheres to and further legitimizes those discourses propagated by those in institutions of power which act to preserve the population in a governable state. In other words, public health advocates can be accused of leaving unexamined and intact the power relations that these narratives both reproduce and help to sustain. This leads to the conclusion that harm minimization is a safety net, not a strategy, representing a convergence of economic rationalism and social policy. (Miller, 2001, pp. 177)

While harm reduction measures are progressive services, appointing medical practitioners and public health experts to positions of authority can perpetuate medicalized norms that are disproportionate and ignore the experiences of experienced drug users that make OPS so successful. In a field that is already strongly directed by the medical gaze, theorists must remain aware of how medical and harm reduction models can overlap because doctors and physicians play a role in harm reduction and their management of SIS may be susceptible to the same trappings as other medical institutions.

This is not to say, however, that policing plays no active role in controlling this public health problem. The construction of deviance is a moral enterprise, one that involves both rule creating, and rule enforcing (Adler & Adler, 2016). Police play an important role in enforcing social norms and punishing deviance. Funding for police activity has continued to rise during the time span of the crisis, often in direct response to SIS and OPS opening. For example, one such OPS in Moss Park had seen that "police

presence in the area [had] increased, putting some drug users on edge" (Gray, 2018, March 10). There is a symbiotic relationship between law enforcement and medical authorities as the epidemic continues to spread and grow in intensity. Rather than seeing these two authorities as diametrically opposed responses to opioid use, we should instead view them as sitting on a nexus of power relations that work in tandem to strengthen the state's power to monitor and intervene with the epidemic at a number of different levels of operation, from the distribution, production and consumption of opioids. However, a contest of authoritative power still exists between the two. In an effort to bolster each respective field's position and power to define drug use, hegemonic control of knowledge production remains the goal in each field's shaping of drug discourse. "Many of the institutions designed to discourage deviant behaviour actually operate in such a way to perpetuate it" (Erikson, 1962, pp. 14).

This can be seen in the Ontario Association of Chiefs of Police's (OPS) position paper on SIS. The report's communicative function seems to be an attempt to discredit SIS as a viable option for reducing drug related incidents in communities. It claims that SIS will only lead to increased deviance and criminal behaviour in areas that are already crime-ridden, attracting all types of vagrants, addicts and criminals to the area, leading to increased violent episodes, looting and drug use in public areas (Taverner, 2012). These claims were reaffirmed in a more recent statement made by the OPS when SIS were approved for construction in Toronto (Ontario Association of Chiefs of Police, 2017.

As harm reduction discourses of drug use continue to gain support in public policy and mainstream discourse, the police apparatus must continue to affirm their position as protectors of public safety from dangerous drug use and the actions of drug users. A doubling down on police presence in communities where SIS are located seeks to discredit the effectiveness of SIS and reframe success in decreasing numbers as the work of increased police monitoring. Minor drug offenses account for a large portion of arrests, and to remove drug use from the jurisdiction of law enforcement would mean heavy cuts to police funding. Therefore, perpetuating certain stigmas around drug use are employed in order to maintain law enforcement's authoritative position as experts on drug prevention strategy. This issue is particularly prescient in today's political climate, where Black Lives Matter and calls to defund the police are gaining traction in public discourse, police forces find themselves struggling to maintain their funding and position of power, rather than have their departments dissolved and replaced with public health and

social services departments which would also leach funding from police operations. In addition to losing supremacy over drug discourse, current calls for decriminalization of drugs are another blow to the police's reign over drug intervention measures.

> Treating drug users as criminals isn't working, especially those in the cold grip of substance-use disorders. It's expensive to arrest people, put them on trial and send them to prison. The return on investment appears to be nil, or negative. A stint in jail does nothing to help a drug user deal with their problems - health care in jail is lacking, for one - and a criminal record weighs heavily on efforts to get a job and rehabilitate one's life. And the looming threat of criminal prosecution for drug possession scares people away from seeking help, while also encouraging dangerous behaviour, such as doing drugs alone. (The Globe and Mail, 2019, April 26)

Through a discourse of law enforcement and illicit drug use, all drugs are inherently harmful to public health and safety and for this reason are not tolerated in any capacity. Deviant drug use is characterized by being low income, because these "users living in the area still do not possess the economic means to purchase their drugs. Instead, they continue to commit crimes… [as a] means to support their illegal habit" (Taverner, 2012, pp.12). Other deviant behaviours, such as injecting in public, further this discursive problematization of low income and homeless people, as they do not have a home where they can use drugs safely. "Drug scares expand the quantity and quality of social control, particularly over social groups perceived as dangerous or threatening" (Reinarman, 1994, pp.151). It becomes clear that deviant drug use is not a matter of drug use itself, but who in particular is using drugs and the social position that they inhabit.

Stigmatization continues to negatively affect drug users in a number of ways, and this is in part due to a criminalized discourse of drug use that is morally driven and functions to discourage drug use through direct (arrest and incarceration) and indirect (loss of social standing, breaking social norms and mores, shame) forms of punishment. "The greatest barrier to stigma is the criminalization of substance use. And until we make the difficult and maybe not politically popular decision with some sectors of society (to decriminalize personal possession), it's really hard to get people to come out and seek help" (Woo & Hager, 2018, March 28). Stigma is a mark of deviance on one's social identity, and "refer to an attribute that is deeply discrediting, but it should be seen that a language of relationships, not

attributes, is really needed" (Goffman, 1963, pp. 13). Stigma comes from the Ancient Greek term *stigmata*, which is a mark or blemish made by an instrument. This branding, or labeling of a particular characteristic as undesirable can act as a barrier to acceptance in social situations and programs. While stigma can often refer to features of the body that are highly visible and therefore easy to spot, Goffman (1963) also identifies stigmas related to individual character that come to signify weak will, moral corruption, radical beliefs or other blemishes of conduct that can equally discriminate against those who possess the deviant trait. Drug users may be able to conceal their disposition in face-to-face interaction but for those whose status has been made public, the identity can be difficult to evade as criminal records, health documents and gossip can all effectively out the drug user as a deviant to employers, law enforcement officials, family, friends and health care providers. Becker (1973) notes that stigma and deviance are not deemed offensive or inhuman by the behaviour itself, but rather mediated through the "interaction between the person who commits an act and those who respond to it" (pp. 80). Becker's labeling theory demonstrates the way that looping effects occur in the process of classifying a group of people as Hacking (2006) theorizes. Nominalism based on the classification of a deviant group first must acknowledge that certain behaviour is undesirable and therefore something that must be defined and managed within a population. In doing so, those who fall under that classification internalize their deviance and come to identify with the label. Stigma in society will further hostilities directed at opioid users, leading to social barriers to access and demonization that push users further to the margins of society where they may congregate as a counterculture. A form of self-fulfilling prophecy then becomes a reality; people who are unemployable due to drug charges or drug related problems have trouble finding housing and lack access to medical care; in order to afford basic necessities, they may resort to petty crime or begging to subsist; the stigma and stereotypes surrounding drug use reaffirm and perpetuate cycles of use and abuse that only dole out punishment and harm, while offering no exit point or olive branch out of the cycle. Health officials are now acknowledging how stigma only accelerates the rise in opioid abuse. B.C. provincial health officer Bonnie Henry

> suggested decriminalization and says it would reduce the stigma around drug use. In many cases, people who die of opioid-related overdoses use drugs alone because they fear social or criminal

repercussions. Removing that can help them out of the shadows and connect them with social services that can help them (Weeks, 2019, April 11).

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More work needs to be done to reduce stigma - even in hospitals. While medicalized discourses of deviance are meant to diminish stigma within the public, relinquishing blame from victims of disease (Conrad & Schneider, 1980), those within the medical profession still hold their own prejudices against opioid users. Stigma can often result in blockages to health services and - due to medical histories - deny patients medications because of questionable motives (Fraser, et al., 2017) The failure to empathize with repeat patients of overdose has led to recidivism. A hospital in Oshawa is working to change this and connect with their patients and giving them the tools they need - like medication, treatment options, and registering them into the system to track progress- to improve their chances of using drugs safely and preventing them from walking through the revolving door (Gee, 2018, October 31). Rather than referring to these individuals as “frequent fliers”, they are now referred to as “familiar faces” which hopes to change the stigmatizing discourse of drug using patients (Gee, 2018, October 31). The stigma that drug users face from medical professionals has made many opioid users resist seeking out traditional medical help from institutions. During my own time spent in Narcotics Anonymous, many people in the group expressed their distaste of medical authorities based on the many negative experiences they had under their care. They were treated as an inconvenience, as helpless addicts who were just going to die of an overdose, who were referred to in derogatory ways. One individual in particular said he was called “a fucking junkie” and that the doctors told him he was “going to lose his leg because he couldn’t take care of himself.”. In a professional setting, such conduct is unacceptable and violates the code of ethics that all physicians must adhere to. In response to the negative effects of stigma in the opioid using community, the Canadian government has earmarked $18.7 million dollars in the budget for public campaigns to reduce stigma and change stereotypes (Omand, 2018, March 27). While this is a step in the right direction, stigma will only be decreased through radical changes to drug policy, such as decriminalization, and increased spending on public services that will assist marginalized communities affected by opioid use.

Guilt by Association: Finding Correlation

Correlation is said to be "the fundamental engine of the social sciences" (Hacking, 2006, pp. 5). In making up the opioid epidemic, social scientists look for connections between a number of different factors or subsets that a large portion of the opioid using population are said to possess. Associating particular traits or other classifications with opioid users "serves to reinforce the idea that they represent a distinctive class or category of person" (Seddon, 2010, pp. 340). While correlations may be useful in gaining further insight into demographics involved with opioid use, they may also reinforce harmful stereotypes due to proximity. Much like a judge determining the character of an offender based on the company that they keep, opioid use takes on a number of stigmas that may transfer over from other groups that are said to be correlated with opioid use: criminal behaviour, homelessness, sex work, unemployment, mental illness, addiction, blood borne illness and ethnicity are all groups associated with opioid use and the stereotypes attached to each of these groups amalgamate in to a particularly powerful nexus of stigma. Notice that each of these associated groups face endemic prejudice in modern society that is deeply rooted in neoliberal hegemony. Crime is seen as a violation of property rights and barbaric violence; the homeless are characterized as vampires that suck funding through social assistance without contributing anything to society; sex work threatens the nuclear family unit and is too hedonistic for a society that values sexual restraint; unemployment is a sign of laziness; mental illness makes one erratic and illogical; addiction is a weakness of will power; blood borne illness threatens public health and purity; and ethnicity is othered and suspicious. These negative connotations all contribute to the negative perception of opioid users in the general public and paints every user with the same brush of guilt.

These stigmas not only isolate people struggling with opioid dependence, they are actively weaponized in rhetorical arguments against harm reduction policies such as SIS and OPS. Law enforcement discourse claims that SIS and OPS are a hotbed for criminal activity, attracting addicts, thieves and other dangerous individuals.

> Numerous communities across North America have been devastated as the violence associated with illicit drugs forces people and businesses to move out. Thus, the consumption of illicit drugs at supervised injection sites will inevitably lead to a general degradation of the social and economic life of communities in which these facilities are situated. (Taverner, 2012, pp. 3).

From a rhetorical standpoint, Taverner's words betray his opinion of the opioid using community. He claims that the violence associated with illicit drugs is the doing of organized crime groups and turf wars, and that SIS will only encourage more drug use and therefore the stakes are higher for these crime syndicates. "Organized crime groups" can be a euphemism for "gangs" and are often associated with racial groups that are non-white. Furthermore, the term "degradation" has strong linguistic ties to fascist rhetoric that has been employed by far-right leaders as a dog-whistle for social purity and the demonizing of unwelcome groups of people. With this in mind, we can see that the presence of SIS or OPS is perceived by law enforcement as a threat to social order and uses an emotional appeal to fear and danger, scapegoating opioid users as the cause of social ills. Economic prosperity is also at stake according to Taverner. The claim that drug use has forced businesses to leave at the cost of a growing economic life in the community furthers the argument that SIS and OPS are harmful to communities. Police forces have always been a state tool of legitimate violence protecting the economic interests of the upper class by arresting disaffected minority groups and throwing them in prison as part of the prison-industrial complex (Davis, 2003). The public may fear that their property values will decrease due to the presence of OPS or SIS in the area, or that their stores are not secure, emphasizing the need for increased police presence to combat the gathering of vagrants that regular SIS and OPS.

Gentrification of dilapidated neighborhoods continues to grow across Ontario, pushing out lower income communities that can no longer afford increasing property taxes and rent in rejuvenated areas. Not only has gentrification contributed to the displacement of people resulting in growing numbers of homeless people, but the aesthetic of gentrification - making a diamond out of the rough - seeks to maintain the "urbaness" of an area while doing away with the communities that comprise its history. In Barrie, downtown projects have cleaned up areas, however, the juxtaposition of gentrified areas with low-income areas demonstrates the economic disparities and inherent contradictions of gentrification:

> Barrie's downtown is looking up. Boutiques selling yoga wear, chocolates, crepes and cappuccinos welcome customers strolling along the once-rundown main drag, Dunlop Street East. But walk a minute or two down Dunlop, and you may see a different side of this growing city an hour's drive north of Toronto: doorways full of garbage and used syringes, sex workers patrolling

> to support a drug habit, a poster on a store window proclaiming in big letters: “Naloxone Kits Available Here.” (Gee, 2018, October 27)

This comparison blatantly illustrates the dirty, debaucherous and decaying state that is associated with opioid use, something that is swept under the rug and out of sight from the idyllic, picturesque downtown streets that are healthy, renewed and energized. It would seem that the gentrification of opioid affected neighborhoods represents a new life for a dying space filled with people that are literally dying in the streets. But this is the inherent contradiction of gentrification - a new layer of paint and some boutique shops do not solve structural problems that are contributing to homelessness and lack of medical access for those living in the area, in fact they accelerate them, and continue to displace as quickly as they rejuvenate. The presence of SIS and OPS in these gentrified neighborhoods threatens to undo all of the work put into, and many trendy, upper-middle class people stand in opposition to including them, as district of Barrie Conservative MP Alex Nuttall expressed in a tweet supporting a candidate “who will NOT put an illegal drug injection site in Barrie’s beautifully revitalized and historic downtown” (Gee, 2018, October 27). Anti-SIS rhetoric often emphasizes that the drugs being consumed at SIS are illegal. This appeal to the law is a rhetorical move that discredits the work being done at these sites and accuses all clients who use the service of criminality. Drugs have become synonymous with crime, directing the intention and attention of the audience, displaying the immorality of those who partake and the inherent evil of the substance, while deflecting attention away from the fact that these people are humans that deserve compassion and public health services. For many conservative-minded people, the law is a sacred contract that must be abided by - which is ironic, as SIS are legal in Ontario. The inherent criminality of illicit drugs and their contribution to the prevalence of crime lead to hasty generalization and correlation/ causation fallacies that frame all drug use as harmful and criminal in nature, while stating that drugs are directly the cause of high crime rates. When we consider that a large portion of arrests are *for* drug possession or drug dealing, it is no surprise that there are higher crime rates, simply because of the illegal status of drugs and their ubiquity in these areas.

In turn, SIS is blamed for not treating opioid users, and perpetuating harm that users are doing to themselves:

> Evidence pertaining to the general deterioration of the quality of life in areas adjacent to the injection site, however, did show a clear trend. Most residents likely did not possess the financial ability to buy heroin or cocaine prior to the facility's opening. Yet, they probably financed their addictions by committing various crimes. We know the Insite injection site has had a poor record in helping drug users with their addictions. Users living in the area still do not possess the economic means to purchase their drugs. Instead, they continue to commit crimes at a similar rate as existed prior to the facility's opening. (Taverner, 2012, pp.12)

Based on this statement, it can be gathered that drug use is not so much the problem that the police are taking issue with, but rather the poor economic means of drug users. It would seem that opioid dependence is only problematic when the individual is poor and unable to secure their daily doses through traditional forms of labour and they must be punished for their economic position and frivolous spending on drugs. Apparently, the poor do not deserve to be idle. Taverner's position on the issue places drugs as the prime cause of a poor area's abjection rather than acknowledging a host of other structural issues that have contributed to the current state of these areas. A strange form of transference is at play here, which can be traced through correlation. Drug dependence acts as a conduit through which low income and homelessness are in effect criminalized based on their correlation to drug dependence. The assumption is that any poor drug user must be acquiring their drugs through nefarious means, as they could not possibly be able to support their habit any other way. SIS are accused of facilitating these poor financial decisions and stable crime rates, while what they are supposed to do - prevent overdoses, minimize harm, and provide opioid users with sanitized needles, health care and information - is not even recognized for the good that these sites do. For a population that has limited access or an aversion to the healthcare system, SIS and OPS offer clients a comfortable, non-judgemental setting for accessing services and receiving referrals compared to traditional healthcare settings (Addictions & Mental Health Ontario, 2018, pp.6).

The only correlation that does not negatively impact views on opioid users is the growing number of middle-to-upper class Caucasian people that are becoming dependent on opioids (Case & Deaton, 2015). This is of course a tragedy as well, and is not meant to diminish the damages done to many families from all lifestyles; but what is interesting is how drug discourse has shifted as a result of this demographic's inclusion in the opioid epidemic. Anderson, Scott & Kavanaugh (2015) found evidence of

symbolic inequality by race in both the representation of addicts and explanations of their addictions in documentary films on addiction and drug use. In particular, they found that films dealing with white middle class addiction to prescription pain medications “conveyed a diminished sense of responsibility for prescription painkiller addiction among these suburban, white and middle class teens. Addiction was constructed as a sort of “accident” or something that “happened to” unsuspecting teens” (pp.325). Portrayals of white suburban drug users were sympathetic in nature, and presented these users as “model kids” who were corrupted by drug use and “estranged from their normal lives” (pp.326). Mirroring the same sentiments that lead to the Opium Act in 1908, state authorities were concerned that drugs were corrupting the youth and there was a need to medicalize addiction in order to explain a behaviour that was only associated with uncivilized foreigners. Rather than conclude that white teens were morally defective, scientific discourse replaced moral explanations of drug dependence. Currently, appeals to scientifically proven biological changes in neural pathways are offered as a means to absolve these users of guilt and frame them as victims in need of treatment. In comparison, black crack and heroin users were profiled as criminals and focused more on the drug trade and other criminal activities. This patient/junkie dichotomy greatly affects responses to drug epidemics based on race and social class. Because the opioid epidemic was in a large part spurred by overprescribing pain medication, it is more accessible to middle-class people who have good access to healthcare, are seen as trustworthy, and have the financial means to afford prescription medication. Rather than treating the current epidemic purely as a criminal matter, discourses of medicalization are now becoming more pronounced in media portrayals of drug dependence due to changing demographics.

Chapter 6: EMBODIMENTS OF DEPENDENCE

Prescription Handcuffs: Medicalizing Opioid Dependence

Drug use has a long history of medicalization that has been the result of changing discourses as scientific and medical paradigms continue to progress, becoming arbiters of reality in the public sphere. Conrad (2005) explains medicalization as a "definitional issue": "defining a problem in medical terms, usually as an illness or disorder, or using medical intervention to treat it" (pp.3). From a social constructionist view, the creation of medical categories expanded medical jurisdiction as problems that were once under the purview of law enforcement, the church, or private residences. Conrad (2005) identifies three factors that contributed to the ascension of medical discourse: 1. The power and authority of the medical profession consolidated influence amongst the general populace; 2. Social movements and interest groups would apply scientific lingo and concepts to their own message as a way to strengthen their own position, solidifying medical professionalism as a rhetorical appeal to authority (à la the temperance movement); and 3. Directed organizational and professional activities promulgated medicalization through the establishment of bureaucratic institutions that standardized practice, founding an autonomous entity with its own rules, customs and ethics. Foucault (1980) argues that academic, medical and juridical fields of study and practice emerged historically as central components of social control through the construction of epistemological frameworks defined as legitimate science and health discourses. Medicalization has had a lasting impact on drug discourse. The "disease model" of addiction is now popularized in discussions of drug dependence as it pathologized deviance as an illness, rather than as a sin of the spirit, which makes it an amoral issue that encourages rehabilitation rather than punishment (Conrad & Schneider, 1980). For the past century, people suffering from drug dependence have been caught in a tug-of-war between criminalized and medicalized models of addiction that have influenced the ontology of drug use, how users are to be treated, and which institutions hold authoritative legitimacy to produce knowledge on the matter. Currently, we are experiencing a shift away from criminalized models of drug use and a return to medicalized forms of intervention for treating drug users – as is evident in growing interest in the neurochemical brain disease model - but both models continue to vie for supremacy over acceptable drug discourse. Standing in opposition to this dichotomy, harm reduction services are also growing in fashion. This is evident in public policy proposals written by the

City of Toronto (2018), the Registered Nurses' Association of Ontario (2019), Addictions & Mental Health Ontario (2018), HIV & AIDS Legal Clinic Ontario (2016) and the Canadian Harm Reduction Policy Project (2017). Despite rhetorical support for harm reduction models, Hyshka et al. (2017) have found that harm reduction policy frameworks are conceptually weak overall and often play lip service to supporting the model, while neglecting to offer defined criterion to adhere to and actual service suggestions. This is troubling, because:

> public policy documents, like other formal government texts, have communicative functions…by endorsing harm reduction in name, but not in substance, provincial and territorial documents may be communicating a general lack of support for key aspects of the approach to a diverse array of policy stakeholders, and thereby indirectly to a broader public. (Hyshka et al., 2017, pp. 11)

Medical authorities have also attempted to incorporate harm reduction models into their practice, and while there are similarities between the two, and they can work cooperatively, it should be noted that harm reduction developed as an alternative to medicalization and the two are ideologically incompatible at their foundations. That being said, a public health approach nevertheless attempts to conflate harm reduction approaches with medical authority.

Some of the key aspects of a public health approach to the opioid epidemic include decriminalizing all drug possession for personal use, scaling up prevention measures, and funding harm reduction and treatment services (City of Toronto, 2018). Perhaps the most significant policy recommendation that these organizations support is constructing more supervised injection sites, with the goal of making better connections to treatment and improving health outcomes in substance use behaviours, preventing overdose and death, reducing public use, and preventing the spread of infectious disease (Addictions and Mental Health Ontario, 2018). Doug Ford's rebranded Consumption and Treatment Services (CTS) demonstrate a more obvious conflation of harm reduction and medicalization where treatment takes precedence over saving lives, creating a more coercive structure of public service that is ultimately "an effort to dismantle the low-threshold OPS model that had been developed by people who use drugs, with significant input from frontline workers, and replace it with a highly bureaucratic approach" (Watson, 2020). Furthermore, CTS reviews have been increasingly negative due to heightened

surveillance and monitoring requirements and the strict adherence to rules and treatment based rehabilitation goals (Pagliaro, 2018) that signal a return to medicalized approaches to drug policy.

The struggle for dominance in the field of drug discourse involves many real world, material outcomes. Funding for drug programs is in short supply. Law enforcement receives considerable financing from the provincial and federal governments. It costs approximately $2 billion a year to enforce drug laws, based on the cost of police and court salaries, and prison expenses (City of Toronto, 2018). Public health models of drug use prevention are said to be evidence-based and better equipped to confront the complex nature of drug use. The tension resulting from the medical/corrections power struggle is apparent in drug programs and jurisdictional powers:

> Under Ontario's naloxone program for municipal public-health units, only clinics that hand out clean needles to addicts can give the first-aid treatment, which reverses the symptoms of an overdose in minutes, to members of the public to take home… A plan to distribute naloxone to released prison inmates ground to a halt over the past six months in a jurisdictional row between officials with the Ministry of Community Safety and Correctional Services and the Ministry of Health… The rift between the two ministries dates back to at least Jan. 11, when the correctional ministry's senior medical consultant, Lori Kiefer, wrote to the province's regional medical officers of health proposing a take-home naloxone program for all Ontario inmates returning to the community… When word of Dr. Kiefer's plan reached the Ministry of Health… staff there refused to take action on it, complaining that corrections staff had overstepped their authority…" (Howlett & White, 2016, July 3).

Even when a program could benefit a marginalized group of people, in this situation inmates, arguments over red tape prevent the rolling out of beneficial naloxone distribution to newly released inmates, who are 56 times more likely of overdosing than the general population in the two weeks following release (Howlett & White, 2016, July 3). We can see how this is not just an issue of discourse, but of bureaucracy and maintaining a position of authority on matters that fall under an institution's jurisdiction. Any attempts to encroach upon the territory of another institution can be interpreted as a threat to the institution's autonomy, authority, and power. Obsolescence or dissolution of a department or an institution are becoming possible future realities with calls for defunding, or even abolishing police forces, and the

medical perspective's call for decriminalization or even legalization of drugs would be a heavy blow to the dominant role that law enforcement plays in drug discourse and policy.

The opioid epidemic presents an unusual case of medicalization because medicalization inadvertently caused the problem through overprescribing pain medication. There's no question that the pharmaceutical industry has developed a business model that capitalizes on preventing, rather than curing, illness. Dunnit (2012) notes that the "notion of health [is] driven by market forces" (pp.11) and the survival of a company relies on keeping patients and health consumers on stable, long-term prescription plans that are a continuous source of revenue. Unfortunately, this market logic has had disastrous results in pain management. It could be said that drugs like Oxycodone work too well in this model of distribution, leading to dependence rates that would be a salesman's wet dream - if it were not for the fallout and harm caused by opioids. The pharmacological properties of opioids are inherently habit forming compared to other licit and illicit drugs as they lead to physical dependence and withdrawal symptoms that cause nausea, aching, profuse sweating, vomiting, diarrhea and a host of other nasty symptoms that users will avoid at all costs, which reinforces their drug use as a new form of pain management. In this way, opioids are a very paradoxical substance that both treat pain while having the potential to cause pain after prolonged use. Opioid dependence is an inevitability under market driven pharmaceutical practice.

To reactively account for the disaster, new drug antidotes are now being distributed to counteract opioid overdoses. Naloxone is a non-selective and competitive opioid receptor antagonist. It works by reversing the depression of the central nervous system and respiratory system caused by opioids. Ontario has made naloxone publicly available at any pharmacy as long as the customer presents a health card, and it is free of charge. Public servants are now equipped with naloxone, even public librarians who "find themselves resuscitating patrons who have suffered fentanyl overdoses in their branches" (Galt, 2019, October 2). First responders, including police, are tasked with reviving victims of overdose, a task they claim is not part of the job description and is hindering their ability to do routine patrols. "It takes away from our response time. Maybe we couldn't get to a burglary [in time] because we were on an overdose," said Chief Collins of Marion, Cincinnati (Woo, 2016, August 30). With little other resources, such as SIS

or OPS where users can administer drugs safely and in a professional environment, first responders will be expected to continue doing a job that medical professionals would be better suited for.

The most popular medicalized program for dealing with opioid dependence is undoubtedly methadone clinics. Methadone is an opioid that is used in maintenance treatments for those who are detoxing off of other opioids. Methadone is a long-acting opioid drug used to replace the shorter-acting opioids that someone may be addicted to, such as heroin, oxycodone, fentanyl or hydromorphone (Centre of Addictions and Mental Health, 2020). Due to its slow metabolic rate, methadone counteracts withdrawal symptoms without giving users the full rush of other opioids and keeping them functional in their daily lives. Doses are gradually tapered off until the individual is drug free. "Methadone maintenance is a long-term treatment. The length of treatment varies from one or two years to 20 years or more" (CAMH, 2020). Again, methadone is not meant to cure drug dependence, merely to treat it and this can lead to problematic doctor-patient relationships. "A number of Ontario's highest billing physicians are methadone providers. They charge, not only for prescribing the drug and for addiction counseling, but also for the frequent urine tests that are required by their patients, who must turn up weekly to stay in the program" (Galloway, 2019, May 28). The life of a methadone user is incredibly regimented, and their failure to comply by the strict rules that the program enforces can lead to disciplinary measures such as reduced prescription. "Methadone dosages are at the mercy of doctors and are not pharmacologically determined variables. Dosages fluctuate when recalcitrant addicts disobey clinic rules, sending them into pain or stupor" (Bourgois, 2000, pp. 180). Codes of conduct include urine tests to prove abstinence, returning packaging to prove it has not been sold, arriving at the appointed time, and frequent counseling visits. In this way, the lives of opioid users are are policed through forms of medical biopower that discipline users by holding their dependence hostage, and making the user indebted to them in order to receive their next dose; for this reason, on the streets, methadone is referred to as "liquid handcuffs" (Galloway, 2019, May 28). Armstrong (1995) claims that there has been a rise in "surveillance medicine" where factors of illness such as lifestyle are encoded in risk assessment as a means of determining precursors of future illness in populations. By using the carrot, instead of the stick, methadone clinics effectively surveill their patients through a number of techniques in order to confirm that they are following orders and conducting themselves in the appropriate way. Methadone, then,

"represents the state's attempt to inculcate moral discipline into the hearts, minds and bodies of deviants who reject sobriety and economic activity" (Bourgois, 2000, pp. 172).

When arguing for a more medicalized approach to opioid dependence and the current epidemic, we must be wary of the coercive techniques of control that patients, like criminals, are subjected to. Framing drug dependence as a disease can be an even more oppressive model of classification because a disease is a life-long, chronic illness that is incurable. Like an AA member being encouraged to keep coming back, medicalizing drug use creates an ontology of illness that is eternal and definitive. The only option is management through self-surveillance and institutional oversight. Under a medicalized model, drug users could become lifelong patients under the medical gaze, and coerced into action through disciplinary mechanisms of biopower that make them reliant on their doctors in order to stay well. While there is an application of certain medicalized practices in confronting the opioid epidemic, it is not a panacea, and should only be an aspect of drug policy going forward. Furthermore, medicalization may reduce stigma associated with drug use, but it will never relinquish it fully. As Goffman (1963) has shown, medical conditions are stigmatized as they deviate from the norm and for this reason, will continue to be considered different and non-human.

Marks of the Beast: Biogenetic Surveillance and Engineering

Medical studies of addiction have now progressed to new levels of intensity that are able to scrutinize even the microscopic building blocks of our corporeal makeup. Clarke, Shim, Mamo, Fosket, and Fishman (2003) argue that medicalization is being transformed into "biomedicalization" where technoscientific biomedicine is quickly reconstituting medical practice and social forms. The medicalization of addiction has reached this new paradigm in technological discovery that targets human biology and genetics. Neurobiology has mapped out neuronal pathways in our brains and determined the functioning of the brain's many components - how they relate to substance use. The complex mysteries of the brain are slowly being revealed through advanced techniques of imaging. Meanwhile, the field of genetics has exploded within the scientific community and promises new frontiers of medical treatment that can selectively inhibit genes of susceptibility and edit the human genome to full optimization. Increased scientific-biological technology, such as EEG and CAT scans have opened a new world of phenomena to discover and investigate at microscopic levels that were once undetectable. This has

translated into research that can empirically verify how biology is involved with drug reactions and dependency issues; however, this has not necessarily resulted in successful treatment options, but rather progressive technologies have been major selling points in securing continued funding of research (Courtwright, 2010). Ludwik Fleck conceptualizes shifts in objective fact as historical events, which only come into existence within a style of thought or reasoning that engenders a collectively accepted way of perceiving the world, mirroring Foucault's conceptualization of the episteme (Wojciech, 2019) . We see then, that scientific inquiry in a technologized age is yet another discursive formation that claims objectivity through empirically verifiable data. This obsession with materialism in science can lead to unintended ethical dilemmas (we can do this, but should we?) as well as a tendency to overlook or directly downplay qualitative, socially structured factors that contribute to drug dependence issues. Science-fiction is quickly becoming reality in an increasingly technologized world that often outpaces the ethical concerns of bodily autonomy and neurodivergency, yet biomedicine's fixation on individual bodies is in line with neoliberal logics of control that individualize social issues. The "rational" nature of neurobiological understandings of addiction are meant to denote that it is a politically-neutral stance (Vrecko, 2010), however, when we consider its function in discourse it is clear that biomedicalization continues to push a worldview that positions scientific understandings of addiction as a dominant model of addiction.

Neuroimaging technology gave researchers a window into the inner-workings of the brain and allowed them to identify chemical receptors that act as information pathways in the brain, sending messages to different areas of the brain and reacting to stimulus. These receptors are referred to as neurotransmitters and there are trillions in every single person's brain, forming complex pathways and associations between brain centers that enable our bodies to function physically, emotionally and psychologically. Out of these discoveries, a new field of addiction study was conceived: the neurological brain disease model of addiction; a chronic, relapsing brain disease that is characterized by neurochemical changes and imbalances in the brain resulting from long-term drug use (Courtwright, 2010). While this model can show "information about biological mechanisms of tolerance or physical dependence, these are not the same as addiction" because they cannot show direct causation between drug use and habit forming tendencies due to the fact that everyone's neurobiology is unique and is greatly affected by environmental

factors such as upbringing, social circles, education, trauma and life opportunities (Kalant, 2010). Furthermore, the biological determinism of the brain disease model is problematic, as it can further stigmatize, exploit and even exterminate minority groups (Courtwright, 2010). Paired with an increasing focus on genetic risk factors and susceptibility, drug dependence is now encoded directly within a person's genetic makeup, comprising essential components of an individual's biology and personhood. It can be said that deviance now exists within our genetic makeup.

Rose (2003) connects inherited deviant pathology with the eugenics movement:

> As we know, in the late nineteenth century and into the age of eugenics, alcoholism had a dual role in the inheritance of pathology. On the one hand, alcoholism was one among many manifestations of an inherited tainted constitution. Its passage down the generations could be visualized in a genealogical table whose blacked out squares and circles -marking the affected men and women in the lineage - indicated the defective germ plasm. On the other hand, alcohol abuse had a deleterious effect on the germ plasm, and so was a factor that led those with already weakened constitutions to breakdown. Pedigree charts of alcoholism and its links with feeble-mindedness, sexual immorality, criminality, and the whole catalogue of manifestations of degeneracy were common in eugenic advice up to the outbreak of the Second World War. (pp. 425)

If genetic sequencing becomes freely available to the public for medical reasons, this concern with maintaining pure genealogical lines that are free of degenerative genetic qualities could negatively affect an individual's procreation options with mates and through processes of selection could ultimately lead to the extinction of risky genes in society. Furthermore, children who are born with these genetic predispositions may be subjected to heightened clinical surveillance as an early preventative measure. Ornoy, Finkel-Pekarsky, Peles, Adelson, Schreiber and Ebstein (2016) have conducted studies on ADHD risk alleles associated with opiate addiction and found that children born to opioid addicted parents often have higher risks of ADHD. Here we see how opioid dependence is seen as a risky behaviour for parents and that their life choices can put their own children at a disadvantage, solidifying notions that drug use can taint family lineages and breed deviance generationally. Logics of anatomo-politics establish direct chemical control over biological mechanisms that are associated with future medical problems (Vrecko,

2016). These faulty mechanisms mark individuals as different, as somehow tainted, like the mark upon Cain, representing his guilt in the eyes of God. Clearly, eugenic discourse is riddled with ethical issues, but when it is packaged in scientific rhetorics of wellness, it promises a new age of pharmacology that is tailor made based on each individual's unique genetic makeup (Barton, 2015, May 30). The goal of biological and genetic research is to produce a magic bullet cure-all drug that can curb cravings, nullify the effects of a drug, or remove or manage genetic factors that predispose people to drug dependence (Condon, 2006). However, the result of increased medical research on addiction also expands the medical surveillance gaze of the human body, strengthening biopolitical monitoring to minute factors of genetic and neurological variance through advanced forms of medical technology.

Articles in the news media on the neurological and genetic determinants of drug dependence were in abundance from 2010 until 2016. The sudden drop in interest coincides with the rise in fentanyl deaths that were of immediate concern for the public. This shift is telling. The crisis called for immediate action which involved public health care initiatives such as SIS and OPS centers as well as distributing naloxone and other opioid antagonists to flatten the curve. Neurological and genetic science does not have immediate application at this stage in their development and for this reason, its place in drug discourse within the media has dwindled. However, this field of study continues to dominate in academic circles and receive the majority of funding for research. Upon review of these research papers, one thing remains clear: the scientific field is highly specialized and professionalized, resulting in esoteric terminology and knowledge that is unintelligible for the average person. The content is specifically directed at fellow peers that are in the field and the knowledge that is produced is of little use to the nonprofessional. For example, Nestler and Lüscher's (2019) study of epigenetics and drug addiction is nearly incomprehensible without a vast understanding of brain structure and chemistry:

> CREB activation also contributes to drug-induced synaptic plasticity in NAc by mediating cocaine induction of the GluN2B subunit of NMDA glutamate receptors and associated changes in dendritic morphology. (pp. 55)

While these findings undoubtedly mean something to someone with an education in neuroscience, they only alienate readers who are not involved with the field. Language can act as a gatekeeper to certain professions and elevates the prestige of the profession. This charge is often directed at qualitative fields of

theory that include esoteric terminology of their own, yet scientific papers can be just as - if not more - impenetrable for casual readers and struggle to translate in news media, leading to confusion on the topic and uninformed conclusions and relying on authority figures in the profession to act as interpreters of meaning affirming their expertise on the subject. Furthermore, scientific language aims to be objective and value-free, however, medical discourses in neurology and genetics have a tendency to subjugate their test subjects for the sake of impartiality and disinterest, which rhetorically transforms human subjects into lab rats that lack emotions and dehumanizes marginalized groups of people.

Drug dependence has long been theorized through discourses of moral puritanism and the liberal subject that prizes self-restraint and conquering our more base instincts - our desires, our carnal needs - that demonstrate our personal sovereignty over our will. While medicalized models of addiction are understood to transfer sin and deviance into disease and illness (Conrad & Schneider, 1980) - thereby relieving individual's of moral chastising - notions of free will continue to influence neurological and biological discourse of addiction; albeit, the locus of addiction has shifted from deficits of the spirit into deficits of the body, in particular the brain and its functioning. Dopamine deficiency and how it reacts with drug consumption now explains desire and craving through material chemical reactions:

> It is dopamine's flame of desire, Dr. Lewis writes, unleashed by the ahhh of opioids, that causes animals to repeat behaviours that lead to satisfaction… yet there's a downside: the slippery slope, the repetition compulsion, that constitutes addiction… addiction may be a form of learning gone bad. (Brown, 2011, October 1).

In other excerpts, Dr. Lewis, psychologist and writer of *Memoirs of an Addicted Brain*, refers to drug dependence as a brain that has been "corrupted" through ongoing drug use, and that drugs have "hijacked" certain brain mechanisms to reinforce drug-seeking behaviours (Brown, 1 October 2011). The language used to conceptualize the brain disease model of addiction employ concepts of morality and the user's inability to control their behaviour due to habitual drug use. Drugs have effectively robbed the individual of freewill and their actions are reduced to biologically determined behaviour that are purely driven by desire and primal urges existing within our brain chemistry. Without the faculty to free will, what does this make a drug dependent user? For one of the defining features of man after the age of

Enlightenment has been the suppression of subconscious animal desire and civilization's dominance over nature.

Qaadri (2014, July 3), MPP and family physician, claims "the very same brain pathways that prompt us to seek the basics like food, water, and sex" are responsible for drug cravings and drug seeking behaviour. "A brain on hard drugs is flooded with a cocktail of chemicals" and "it's hard to reproduce that kind of overflowing chemical excitement in our day-to-day, working world" (Qaadri, 3 July 2014). "So addicts and their brains substitute chemical life for real life… The brain's pleasure centres do the talking and give the orders" (Qaadri, 3 July 2014). Upon analysis, it can be argued that these claims rhetorically equate drug users with animals, where action is purely driven by biological needs that renounce humanity's high order brain functioning that enables individuals to use reason and logic to assess risk and reward, set goals, and prepare for the future. Human evolution, specifically in the development of the brain, is considered integral to the development of the species:

> But the only way to get an animal to act is to motivate it. Emotion, motivation - these were evolutionary experiments that started around the time mammals first got up off their bellies. If mammals were going to learn from their experiences - unlike their coldblooded forebears - they would need a more flexible operating system than the fixed action patterns responsible for the flinching of the worm and the darting of the frog's tongue. (Lewis, 2015, August 9).

Biological discourse of addiction dehumanizes the addicted subject, not intentionally, but as a consequence of its field of study.The concern for the body and its functioning and how it compares to other species is the foundational basis of biological research, and will undoubtedly influence the theoretical scope of their model of addiction. We can see that biological discourse is not divorced from morality at all, and is a product of its age and therefore privileges a way of being that is aligned with modern conceptualizations of humanity. The mutilated brain of a drug user betrays logic and reason and leads to regression - not to an earlier stage of human development - but to an earlier stage of evolution where desire determines intent.

Biological studies of addiction further this discourse of regression through the very methods employed to measure drug response and neurochemical reactions. Animal testing is commonplace in drug studies and close attention is paid to the links in brain chemistry and drug seeking behaviour:

> Their second contribution was a formula for the growth of desire for specific goals with the rise of addiction, a formula that describes how drugs (and sex, and food, and other attractive things) end up triggering impulsive behaviour. Their work was mostly done with rats and mice, but our brains aren't much different when it comes to the accumbens. The more the rodents were exposed to cues that predicted getting addictive drugs, or even sugar, the more those cues commandeered the accumbens. (Lewis, 2015, August 9).

Or in Belluck (2016, April 9):

> It clearly involves the dopamine system and these areas of the brain, and in addicts, as in risky rats, the same receptors produce weaker signals. Dr. Deisseroth said optogenetic manipulation is too invasive to be done in humans, but findings from optogenetic studies in animals are now being used to identify brain areas to target with noninvasive brain stimulation for problems like cocaine addiction.

Notice that rat brains are said to be similar to human brains and that drugs elicit the same responses in both species. Addicts are compared to "risky rats" that are slaves to defective neuronal receptors and reinforced brain pathways. The relationship that researchers treat rat test subjects with can be transferred to human subjects in a field that demands detached objectivity, which can lead to harmful discourses of drug use that dehumanize patients in need of treatment and reinforce this animality within the user's mind. A looping effect (Hacking, 2006) occurs where the classification of addiction and the professional practice that defines, measures, and furthers understanding on addiction have influenced how professionals interact with certain categories of people, and how these interactions are experienced and internalized by the drug user.

In earlier eras - prior to medicalization - criminal discourses of addiction also employed dehumanizing language to legitimate the incarceration and poor treatment of crack users. The mythos of the crack user is inflected with a character of walking death, threatening the very stability of life itself. In "I felt like my brain died…" one user interviewed says "I was a zombie." (Fine, 1989, A1). Images of an insatiable thirst, like a vampire's lust for blood - simultaneously sustaining life while threatening mortality - are evoked in passages like "addicts spoke of their unquenchable desire for more, even though they knew the drug was killing them" (Fine, 1989, A1). Addiction and drug use is personified into the

ghoulish characters of nightmares, rendering users into beings that are neither living nor dead - inhuman yet mortal. Considering Foucault's (1990) explanation of biopolitics, the very existence of the addict is threatening to the administration of life because the addict embodies a state of being that is liminal. The drive to continue chasing euphoria to the detriment of health and wellbeing results in a regression back to primal urges that are not entirely human.

> "Rats will chew through wood to get at cocaine, Monkeys, given the chance to press a bar that sends a caress to their pleasure-centre, will not eat or sleep. They will keep returning to that bar until they die. And humans? Humans will put their infants at mortal risk, steal and sell the possessions of their loved ones, and wish for death to end their habit." (Fine, 1989, A15)

Excessive drug use, then, is a behaviour that cannot be reconciled with the demands of life and bodily autonomy. Being unable to be held responsible for themselves, and incapable of meeting the demands of modern living, crack users were viewed as a drain on public resources and a threat to the stability of the population. It is no surprise that crack users are thrown in prisons, like animals that must be kept in cages, "disallowing life to the point of death" (Foucault, 1990, pp.138). The dominant discourse of the crack crisis dehumanized drug users to justify their subjection to aggressive techniques of power. In much the same way, the biological and genetic discourse of the opioid epidemic claims that drug use is biologically and genetically determined, legitimating invasive methods of biopolitics that dissect and question the humanity of the individual in an effort to reprogram their brains and genes, restoring them to normal human beings.

Chapter 7: WIDENING THE DISCURSIVE FIELD

Introduction

The previous chapters of analysis all dealt with what Hacking (2006) refers to as "engines of discovery." These sections dealt mainly with the development of drug use through classification. Specific institutions are involved in constructing a category or group of people that deviate from the norm: statistics, social science, law enforcement, and medical authority. For this reason, the previous chapters deal specifically with how discourse is *constructed* by institutions that produce knowledge and the *relations* between these different fields of study. The subject of this chapter differs from previous chapters. The following chapter deals with how dominant institutions *apply* discourse and how counter discourses can effectively resist power.

In Hacking's (2006) work on making up people, his final three engines are referred to as an engine of practice (normalization), an engine of administration (bureaucratization) and an engine of resistance (reclaiming identity). Normalization is a form of practice in the sense that it can be mobilized as both a repressive means to socially engineer deviant people back into regular citizens, or as a counter discourse tool used by marginalized groups to remove stigma. I will discuss both applications of normalization in the section *Fallen Angels.*

Bureaucratization functions to administer and manage drug users through various mechanisms of state sanctioned public services. Applying for a Safe Consumption Site in Ontario involves a long and arduous application process that is at odds with the immediate needs of those directly affected by the epidemic. Red tape inadvertently spawned non-sanctioned Overdose Prevention Sites that eschewed state exemption and bureaucratic oversight and instead organized marginalized communities. Bureaucracy created the conditions necessary for grassroots initiatives to take control of a crisis that government officials continued to ignore. This will be discussed in the section *Red Tape and Blue Politics*.

Finally, I present an example of how dominant discourse and institutions can be resisted through direct action and shifts in paradigm in the section entitled *Space to Breathe.* OPS pop ups in Toronto demonstrate the power of reclaiming identity, definition and public space. These sites operate under a harm reduction ideology that directly opposes dominant discourses of drug use and continue to provide

services despite barriers to funding and legal exemption. Here we discover how a group can redefine themselves by creating their own knowledge and institutions that exist outside of hegemonic control.

Fallen Angels: Reformative Measures and Humanizing the Subject through Normalization

Hacking conceptualizes normalization as the reformative measures that institutions and the state imprint on deviant classes of people - the means taken to bring them back to a normal state. While this is certainly an aspect of the normalizing process of drug users (incarceration, rehabilitation, drug courts, medications), there have also been efforts pursued by activists and positive drug campaigns that seek to flip this script and bring about changes in society to widen the horizon of acceptable standards of conduct and normalize drug use itself within society. Each of these forms of normalization will be discussed in the following section to illustrate that discursive formation is a malleable substance that can be a site of struggle for changing social consciousness. Foucault (1990) asserts that power does not necessarily exist in centralized institutions that merely exert power unilaterally upon subjects in a top-down fashion, but can be conceptualized in a fragmented, micro-political form that offers actors opportunities to exercise power to challenge hegemony through cleavages and fractures in discourse where wars of position (in a Gramscian sense) can be waged. Discourses of drug prohibition have morphed in recent times as the result of pro-drug and harm reduction campaigns instigated during the counterculture of the 1960's that have called attention to the hypocrisy of prohibitive drug measures that have subjected millions to systems of criminal reformation, that have failed to prevent the distribution and consumption of drugs and that have arguably only accelerated drug related issues and led to further stigmatization of drug users. State efforts to reform deviant bodies are in conflict with oppressed groups that struggle for their humanity to be validated.

The state's position on drug use continues to foster models of drug intervention that are coercive and invasive in nature; this is evident in state-approved drug policies and legislation. Hyshka et al. (2017) note the significance of the communicative functions of policy:

> Formal policy documents are also government communication tools, which convey underlying normative assumptions and conceptual logics of policy problems. In deliberately presenting specific knowledge, values, and beliefs, these texts reinforce to an audience of diverse

> government and societal actors preferred understandings of illegal drug use, harm reduction, and other policy responses. (pp. 3)

Hegemonic control of drug discourse in public policy reifies acceptable reactions to drug use in documentation and crystallizes the opinion that drug dependent users are: 1) a danger to themselves and others; 2) in need of disciplinary action to reform behaviour; and 3) incapable of facilitating this change on their own. These assumptions have led to a number of coercive treatment measures, which are state sanctioned and discursively function to reaffirm the beliefs and values of the state. Incarceration has been the most popular method of reforming drug users. Drug offenses are written into the Criminal Code in Canada and are enforced relentlessly by law enforcement agencies. This has previously been discussed at lengths in the chapter on deviance and law enforcement and therefore will not be discussed further. Other disciplinary mechanisms of control utilized by the state to correct deviant behaviour in drug users include drug courts and mandated treatment. Drug treatment courts are defined as "a blend of judicial supervision, sanctions for non-compliance and incentives for reduced drug use to motivate offenders to successfully complete addiction treatment" (House of Commons Canada, 2002). Drug courts are an alternative to incarceration; however, the threat of incarceration is the main source of motivation for offenders in drug courts to comply with official orders. Suitability for the program determines who is admitted into the program based on an offender's perceived ability to comply with orders and successfully complete the program. Furthermore, the identity of addiction is not contested in the court - those applying to the program must self-identify as addicts as an act of subjectification and exhibit a wish to change, accepting governing from a state body (Moore, 2007). This surrendering to the authority of the court may or may not be sincere, as coercion is a central characteristic of drug courts as it forces offenders to stay in the program and sets a precedent for the expansion of the role of the courts in the recovery process, promoting a "desire to keep [drug users] under the supervision of the courts" (Tiger, 2011, pp. 193). Drug courts offer a method of monitoring offenders that is all encompassing in the daily lives of those under its supervision. Reports from treatment providers, mandatory drug testing, curfews, random police check-ins and no contact orders are all mechanisms of control that seek to engineer the social lives of offenders, instilling within them a sense of panoptical oversight that is present at all times in any space. Whereas in a prison, control is limited to the confines of the prison - drug courts expand control into public and private

life that is not limited by a confined geographical location and significantly increases the reach of judicial jurisdiction. The pressure to comply is internalized in the conduct of the drug offender as they may conclude that remaining in the program still affords them the incentive of completing their sentencing in the public, outside of prison where their movement would be far more restricted. However, the restrictions placed on those under the purview of the drug courts function to imprint on its subjects a sense of compliance that will extend beyond the length of their sentence, as they continue to relate their public and private life in society to their experiences within the drug court, instilling within them a conduct of compliance long after the coercive pressures of the program have been lifted. This is the ultimate goal of the drug courts: molding deviants into docile subjects through long-term maintenance measures that target "a constellation of behaviours believed to contribute to drug use and its outgrowth to criminal activity" (Tiger, 2011). This is the strength of the drug court model; reforming offenders in the social environment they inhabit, rather than removing them from it, fosters transformative change in the offender that seeks to rehabilitate rather than simply punish behaviour. But the threat of punishment is never absent and acts as a strong motivator to coerce compliance.

A more medicalized approach to normalization that also relies on coercive measures is involuntary hospitalization or mandatory treatment. Involuntary psychiatric hospital admission in Ontario rose almost 90% between 2008 and 2017 (Paperny, 2019, August 10). While many of these admissions involve other psychiatric disorders and mental health issues, the correlation between drug use and mental health disorder is known. More than 50 per cent of people with substance use disorders have also had mental health problems at some point during their lifetimes (Centre for Addictions and Mental Health b, 2020). The law in Ontario regarding involuntary commitment for drug addicts is the same as the laws concerning people with mental illness. If their addiction has impaired their ability to give consent, they may be admitted to care under a certificate of Involuntary Admission (Trafalgar Addiction Treatment Centre, 2018). Paperny (2019, August 10) argues that rather than being the exception, involuntary hospitalization is quickly becoming the rule for people who are deemed a threat to themselves and others in the community. They also suggests that certain populations are discriminated against; race and class influence rates of involuntary admittance possibly due to subpar access to mental health care which leads to complete mental deterioration or prejudice renders these bodies more dangerous and violent which

leads clinicians to “rob them more readily of autonomy as a result (Paperny, 2019, August 10). These arguments are reminiscent of Foucault’s work on madness and confinement in the birth of clinical medicine and the institutionalization of undesirables. While these institutions were conceived of to cure the mad of their illness, they also functioned in an extra-judicial sense that enabled the state to confine the mad when there was no evidence of criminal wrongdoing, stripping them of their freedom, imposing strict boundaries that separated them from the public, and presenting a growing medical field of knowledge a subject to be examined through a medical gaze that viewed mental illness as a natural object of study (Foucault, 1994a). While drug laws set a precedent to incarcerate drug users, growing medicalized shifts in treatment are indicative of new forms of social control that use discipline through varying mechanisms of institutionalized power. A discourse of treatment is viewed as a more humane, evidence-based practice of normalizing drug users, yet its techniques of control and coercion are masked by this sense of benevolence. “Power is tolerable only on condition that it masks a substantial part of itself. Its success is proportional to an ability to hide its own mechanisms” (Foucault, 1990).

Decriminalized models of drug policy, such as Portugal’s approach, have taken a treatment, rather than a punitive approach to drug laws. The driving force behind this change in policy can be attributed to the country’s own opioid epidemic, particularly heroin, in the early millenia. While drugs remain illegal, and distribution is still punishable as a criminal offense, drug possession is no longer a crime and users are instead given a citation and ordered before a commission that assesses their drug dependence and determines whether they are in need of treatment. The commission is comprised of one official from the legal arena and two from the medical or social services field. “Police contacts with drug users changed little in Portugal following decriminalization” (Laqueur, 2014), as they are still tasked with detecting incidents involving drug use and apprehending those possessing or selling drugs. Committees take a number of things into consideration before deliberating on whether an individual is deserving of non-criminal sanctions or treatment: employment, duration of use, drug of choice, prior offenses, and where the drug was used all affect a decision. Sanctions can be monetary or non-monetary measures such as fines, provisional suspensions, treatment, or reporting to health services offices.

While the Dissuasion Commissions are not authorized to mandate treatment, they can make suspension of sanctions conditioned on the offender’s seeking treatment. This is typically what is

done, though in practice, there are very few ways to enforce the condition, since violations of a commission's rulings are not, themselves, infractions of any law. (Greenwald, 2009, pp. 3)

We see that while treatment cannot be enforced upon offenders, sanctions can act as a motivation to accept treatment, but are difficult to enforce. When mandated treatment is not an option, sanctions can act as a coercive measure if the offender is unable to pay a fine, or the offender is unaware of the committee's limited power to enforce treatment. The authoritative position of the committee and the setting of the hearing can be powerful representations of force that can intimidate offenders, manufacturing consent through susceptibility - like a child being sent to the principal's office. Many praise Portugal for their progressive global drug policy measures, and are eager to apply their model in a [redacted] context. Decriminalization in Portugal may offer a more caring, less violent form of drug regulation that minimizes the role of police in punishing drug users; however, shifting authoritative control from judicial to health institutions is merely performative in nature, as the torch of power and social control is passed from one disciplinary mechanism to the next, ultimately maintaining oppressive and corrective techniques of discipline that are endemic in drug policy. Treatment can have many benefits and has the ability to change lives for the better, but it must be facilitated through non-coercive means that respect drug user's autonomy and volition. A truly progressive harm reduction model of decriminalization would include people with lived drug use experience on the commission to ensure balanced representation, guaranteeing definitions of harm are not classified solely by legal and medical practitioners.

Normalization can be a politically transformative process that influences societal change. Where decriminalization succeeds is in normalizing drug use within public discourse and opinion. Normalization of drug use functions to promote an atmosphere of tolerance in societal views and values, encouraging individuals with drug dependence problems to seek help without fear of stigma. "Before decriminalization [in Portugal], addicts were afraid to seek treatment because they feared they would be denounced to the police and arrested, now they know they will be treated as patients with a problem and not stigmatized as criminals" (Economist, 2009). Decriminalization has contributed to improved biopolitical surveillance and data collection, as self-reporting increases in a group that may be hesitant to divulge their drug use, as shown in increased reporting of drug use in censuses in Portugal (Institute for Drugs and Treatment, 2009). Harrison and Hathaway (2010) note that "the normalization thesis shifts the focus from subcultures

as an explanation for illicit substance use, [therefore] it is essential to amass more population-level data about who the users are and where they are located" (pp. 138). Reports from drug users of all demographic categories may show that drug use is prevalent in all social groups, rather than just a characteristic of underprivileged and marginal groups of people, which may lead to further normalization in society. While this shift is undoubtedly due to racial biases that privilege white lives, it nonetheless can progress drug policy and benefit racialized drug users. Paired with a harm reduction model of drug policy, normalization can invoke positive change in society, freeing drug users from harmful stigmas that are barriers to social inclusion.

Normalization can be achieved through many mediums. The news media holds considerable power over the opinions of its readers and has the ability to influence public perceptions of drug use. Throughout my research, I came across many sympathetic pieces that humanized drug users through stories of loss and hope. Many of these stories follow a common story arc: a young, bright child with aspirations, possessing creative and athletic talents faces struggles during high school or in home life that turn them to drugs; their use quickly spirals into decay - selling drugs, panhandling, binge drinking, theft, and prostitution to support their habit - often leading to arrest; they die alone, in homes or in the street - leaving their families to mourn. Parents give anecdotes of their children that are heartfelt and filled with affect that describe their children the way they wish to remember them:

> Tyson was quite a little devil as a boy. Right from when he could barely speak he was cracking jokes and making you laugh, Mrs. Allen says. He would always be climbing the highest tree and loved his Spider-Man outfit. I think he wore that costume for about three years. Artistic and musical, Tyson learned to play a mean guitar and could perform Led Zeppelin's Stairway to Heaven without a hitch. (Gee, 2019, July 19)

> Your dad and I fell in love with you immediately… so tiny, so beautiful, so perfect, with a full head of platinum blonde hair and sparkling blue eyes. (Gee, 2018, 27 March)

> "Mom," said the six-foot, 300 pound foundry worker, handing Michele McPherson a copy of Green Eggs and Ham, "this is the first book I ever read"... He'd struggled with illiteracy his

> whole life, just like he'd struggled with drug use and mental health problems. If he could learn to read, perhaps sobriety and serenity were not far off. (White, 2018, March 12)

Stories like these remind readers that these people who died from drug dependence were sons and daughters who had loving parents. They invoke strong pathos that achieves a sympathetic response from the audience and remind readers that their identity consisted of more than their struggles with drugs. Perhaps the realization that this could happen to the audience's loved ones also effectively humanizes drug users and encourages the audience not to be so quick to judge and to reduce any prejudices they may hold against drug users. The stories are also rhetorically deliberative in nature and attempt to persuade the audience to support increased public health awareness and services that can save the lives of drug users and prevent unnecessary deaths. Campaigns and interest groups have formed, composed of people who have lost a loved one to an overdose. Moms Stop the Harm is one of these groups and they have been instrumental in affecting policy change and advocating for de-stigmatizing drug use and providing better health services. Their campaigning helped make naloxone more accessible, were an important voice in passing Canada's Good Samaritan overdose law - which protects people from criminal charges if they call emergency services, and have been able to connect other grieving parents around the nation, giving them a space to collectively grieve and support each other (Weeks, 2018, November 19). Advocacy groups such as Moms Stop the Harm communicate a message to action for people across the nation and their campaigning has collectively organized citizens to exert pressure on legislators and government officials to effect change in law and in policy, proving that citizens possess the power to challenge institutions on issues that are not being properly addressed or handled.

Another project that attempts to reduce stigma by normalizing drug users is the Opioid Chapters, a multimedia project that shares personal experiences of those affected by the epidemic. The project uses video, audio, photographs and text to tell the stories of 11 individuals, including those with chronic pain that requires opioid prescriptions, people struggling with addiction, and health care workers on the front lines (Leung, 2018, 10 September). Tara Gomes, an epidemiologist and the creator of the project said:

> By putting all these different experiences together in this project, we thought it would provide everybody with an opportunity to understand and experience all those different pathways that

> people have had in using opioids and maybe help people have a broader appreciation of how complex this issue is. (Leung, 2018, September 10)

The work changes the narrative of addiction, forcing the audience to rethink who a drug user is - what they look like, and how their lives have been affected by drugs - providing a point of view that may be foreign to those who are not in contact with drug users. Media pieces, advocacy groups and art projects work to change the culture of drug discourse in order to inform people, evoke emotion and de-stigmatize drug users through rhetorical devices that humanize them.

Normalization is a two-way street where dominant powers can exert force upon individuals to correct behaviour and make them "normal," or people can work to change culture so that these people do not seem so different after all. This cultural struggle in the face of coercive forms of control illustrates the flexible nature of drug discourse, acting as a site of conflict where claims to knowledge vie for attention and legitimacy within the public. Persistent calls to action and solidarity through collectively mobilizing counter discourses operate as tools of resistance to dominant hegemony and state actors. With enough pressure, the material conditions and laws that maintain them can be transformed to treat marginalized groups more humanely.

Red Tape and Blue Politics: Bureaucratic Barriers to Public Health Space

"Some schools of thought speak of bureaucratic power as if it were always a bad thing. So let me emphasize the positive. Most prosperous nations have quite complex bureaucracies that pick out children with developmental problems in the early years of schooling, and assign them to special services" (Hacking, 2006, pp. 6). Hacking's optimism toward bureaucracy is interesting, given Foucault's influence on his work; albeit, many have charged Foucault with supporting neoliberalism in his later career (Zamora & Behrent, 2015). While Foucault's later work, such as *Society Must Be Defended*, may be seen as an introduction to neoliberal policy, we must remind ourselves that these works were translated from his lectures at the Collège de France and were critical in nature, providing Foucault with a space to further his research on biopolitics, the discipline society and security through governmentality. Bureaucratic oversight is perhaps the hallmark of modernity, embodying forms of classification, organization, and logistics that optimize mechanisms of power within the state, governing bodies through centralized entities of authority. Bureaucratic forms of governance are systematically logical in nature,

and devoid of affect; their function within modern forms of governance is mechanical - a complex formation of agencies, institutions and actors that is specially designed to perform specific tasks of governance over distinct populations. The impersonal, mechanical nature of bureaucracy manifests itself as an apolitical entity that is indifferent to the political whims of a society; its robustly diverse structure is believed to be a safeguard against politicking. However, no institution lives outside of discourse and its functioning is determined by discursive boundaries. Bureaucratic institutions are a culmination of every engine of discovery that has previously been discussed, and are bound to the discourses that construct meaning through the study of a classification of people. For example, Hacking's previous quote refers to the administration of autism in early childhood, and in this context, it is a passable assertion because autism is a developmental disorder that needs to be addressed at an early age in order to provide children with necessary services that fit their needs. Unfortunately, this is not always the case with drug dependent individuals and bureaucracy has hindered the progression of social services that are designed to both mitigate risk and treat individuals during a drug epidemic. The opioid epidemic has exposed how political parties can commandeer bureaucracy as a means to inhibit progressive policies, while simultaneously exhibiting a stance of benevolent gesture and intent.

June of 2018 marked a seismic shift in drug policy in Ontario. Doug Ford's Progressive Conservative government was elected as Ontario's provincial government, much to the malaise of many citizens. Ford's campaign centered on balancing the books through a number of cuts to taxes and public spending in education, health care, and energy that appealed to high-income voters with traditional values that also wanted to shrink government oversight. In other words, Ford's campaign catered to neoliberal values that supported increased privatization, decreased government oversight and allowing the free market to dictate economic pursuits. In regards to the opioid epidemic and safe injection sites, Ford's position was clear: "if your son, daughter or loved one ever had an addiction, would you want them to go in a little area and do more drugs? I'm dead against that" (Weeks, 2019, April 1). Ford's position was framed as a call to stop enabling users, as well as claiming that "if I put one beside your house, you'd be going ballistic" (CBC News, 2019, April 1). Ford's stance on SIS catered to businesses and property owners in the area that worried that the presence of an SIS would interfere with business and decrease

property values. Right wing media applauded Ford's objection to the sites, using nonequivalent comparisons and virtue signaling that demonized drug use:

> Providing needles and drugs to prisoners is like giving an alcoholic another drink. He, or she, will keep coming back for another one. It also creates another bureaucracy. And in the end, bureaucracy needs the addicts for their employment, more than the addicts need the bureaucracy! (Gifford-Jones, 2018, July 14)

The article went so far as to claim that the death penalty should be brought back to deter drug use, following Singapore's austere and draconian policies. The mention of bureaucracy is also telling of the aversion to launch another government institution to oversee a necessary service. This line of logic completely discounts reverting funding and services from police forces and broadcasts negative attitudes toward big government and increased oversight. Ironically, Ford's campaign utilizes bureaucratic red tape to create barriers to SIS and has revived a discourse of drug use that had been lying dormant for quite some time in Ontario's drug policy: there is a War on Drugs that must be combated.

Kathleen Wynne's Ontario Liberal Party preceded Ford's premiership. Faced with a growing opioid epidemic, the Ontario Liberal Party struggled to allocate resources and public health infrastructure to combat the crisis. Over 700 health-care workers across Ontario signed an open letter to Premier Wynne to declare the opioid crisis a provincial emergency (Jivani, 2017, September 29). Eric Hoskin, Ontario's Health Minister declined the plea, stating that "harm-reduction activists and Toronto health officials are mistaken in their belief that a state of emergency would speed the flow of funding or ease regulations around illegal pop-up supervised injection sites" (Giovannetti & Gray, 2017, September 25). For the many people involved in the harm-reduction community, the government's toe-dragging on the issue was resulting in death and decided to take measures into their own hands. A pop up tent referred to as an Overdose Prevention Sites was erected in Moss Park, Toronto by the Toronto Harm Reduction Alliance in August of 2017.

> Overdose prevention sites (OPSs) are places – tents, trailers, vans, shipping containers, and spaces within existing community-based organizations and housing facilities (Blythe, Chapman, Dodd, Gagnon, Hobbs, & Westfall, 2017) – where people who use drugs can inject, smoke, and/or snort drugs under the supervision of trained volunteers or staff, often but not always including

> a regulated health professional. In Canada, OPSs are designed to be a low budget overdose prevention intervention that can be rapidly implemented and adapted to diverse settings. While most sites also distribute and dispose of drug equipment and offer information about health and social services, they generally do not offer the extensive range of services that are typical of supervised consumption services (SCSs) (e.g., counseling or HIV testing). (Foreman-Mackey, Bayoumi, Miskovic, Kolla, & Strike, 2019)

The Moss Park OPS was not a sanctioned site, and for this reason, are not federally protected from drug related charges and convictions, putting volunteers and the clients who use the service in a precarious legal situation.

After a lengthy application process, Toronto opened its first permanent supervised consumption site (SCS, aka SIS) in November 2017 at the edge of Dundas Square, on Victoria St. across from the Ryerson University campus. As early as 2012, reports had recommended that Toronto open three SCS to confront the rising overdose rates in the city; however, "implementation was slow given that sites were required to obtain municipal endorsement, provincial funding, and federal approval, as well as complete construction, hiring, and inspections before opening" (Foreman-Mackey et al., 2019). Application processes for permanent sites must pass through many hands and await approval from many departments, delaying a service that needed immediate implementation to offer care to a marginalized community that was in the throes of a drug crisis. OPS bypassed these barriers, setting up temporary structures where drug users could safely consume drugs, have their drugs tested and even be provided with a meal. The success of OPS like in Moss Park beckoned Federal Health Minister Ginette Petitpas-Taylor to approve new harm reduction initiatives that would streamline the permission process for provinces to open temporary OPS in emergencies (Woo, 2017, November 17). While the protocol change seems like an olive branch for OPS, Marilou Gagnon, a core organizer of Overdose Prevention Ottawa, said:

> the new process adds a layer of bureaucracy to what was born as an emergency measure taken without seeking federal permission because the formal application process was taking too long. They were created for a system that was failing to begin with. Now suddenly there's a protocol, we have to demonstrate a need, and they are being framed as temporary. The language to me is concerning" (Woo, 2017, November 17).

Clearly, during an emergency (that the state refuses to acknowledge as such), the structure of bureaucratic protocol and paper shuffling is at odds with immediate material conditions that require services for those most in need. While setting up a portal for OPS to apply for legal sanction of their temporary site is a step in the right direction, the state's delayed and procedural response to the crisis only demonstrates their disconnect from the realities of the situation.

These procedural roadblocks were only exacerbated with the inauguration of Ford's Progressive Conservative government. Ford immediately froze the opening of any new SCS facilities until a formal review was completed by the new Health Minister, Christine Elliot (Giovannetti & Hayes, 2018, August 16). Ford stated that his government will be focused on rehabilitation and law enforcement, saying "This is a major, major crisis. It's all hands on deck. We have to work with our police to stop these drugs, these killer drugs. It's terrible. I can assure you we will be listening" (Giovannetti & Hayes, 16 August 2018). Ford's drug policy works to shift drug discourse back to reactionary perspectives that diminish the need for SCS and OPS. This is evident by the provincial government's decision to rebrand SCS as "consumption and treatment services;" after completing the three month review - while people continued to die awaiting a conclusion - the Ontario government planned to overhaul policy on overdose prevention, "forcing existing centres to reapply and meet a new set of requirements while moving to strictly limit the number of new sites that are allowed to open" (Weeks & Stone, 2018, October 22). The government capped the amount of sites that can exist across Ontario to 21, when there were already 18 existing, leaving little wiggle room for distributing sites according to need across the province. Furthermore, Ford's policies underhandedly targeted existing sites, such as The Works, which is across from Ryerson University. Following complaints of increased vandalism and crime in the area, the university blamed The Works for their inability to monitor or control their clientele. In response, Ford proposed a provision that would prohibit sites from being located within 600 meters from postsecondary institutions (Gray, 2018, November 6). As SCS struggle for funding and increased intake numbers, they have been bombarded with long, precarious reapplication processes that jeopardize their ability to serve clientele. The future of OPS seemed even grimmer, as the government demanded that must reapply under the new consumption-and-treatment model, which forbids the use of pop-ups or tents, as well as enforcing regular reports on access numbers, community consultations and random audits in response to complaints (Weeks & Stone, 2017,

October 22). Pop-ups are a defining feature of OPS as they are by definition temporary sites that do not operate in permanent residence, due to the lengthy application process, as well as gaining permission within the community and infrastructural issues. Ford's policy attempts to phase out these sites that continue to save lives by imposing strict rules and regulations that strategically single out defining features of existing sites in order to halt their sanctioning, without outrightly calling for their closure.

It is crucial that the province supports these services because they rely on provincial funding to operate. Throughout the long reapplication process, the economic stability of established sites was jeopardized. The federal government stepped in to offer support to these sites in times of uncertainty, promising to "work with municipalities and not-for-profit organizations to ensure they receive the money to operate" (Weeks, 2018, December 14). Thomas Kerr, a professor of medicine at UBC, accused the Ontario government of "putting up ideological barriers to the implementation of a lifesaving intervention" (Weeks, 14 December 2018). Justin Trudeau also denounced the actions of conservative governments across Canada that have opposed SCS, stating:

> We know the evidence is very clear: safe injection sites save lives. And the fact that the conservative government in Ontario and indeed conservative politicians across the country are putting vulnerable people at risk by shutting down consumption sites, really makes you wonder where their priorities are. (Stone, 2019, April 6)

Ford's priorities seem to be in line with a voter base that views the sites with suspicion, even outright disdain. "There's four safe injection sites within a kilometer, Mr. Ford said. And they don't want them down there" (Weeks, 2019, April 2). Who is the "they" in this statement? Ford's governments stopped funding several sites in the province, claiming that they were too close together and were becoming a hotbed of crime and property damage. In a gentrified city like Toronto, with dense populations in urban areas, it would seem that Ford's concern is how SCS interferes with business and public security. The issue is not that these sites are too close together - the sites should be located where need has been determined based on levels of use in the area - the issue is that one is too many in gentrified areas that decrease property values and detract from business. "We know that supervised injecting sites are most effective when they're placed in neighborhoods with high concentrations of people who use drugs," said Dr. Kerr (Weeks, 2019, April 2). Ford's clear disdain for the provincial capital and a penchant to support

business interests has left many sites in a state of limbo, where they are allowed, technically, to operate with federal consent, yet are unable to afford operating costs without provincial funding that has been denied to them. Kapri Rabin, the executive director Street Health Clinic, claimed the site costs "roughly $20 000 a month to run, but under the province's new model, it would cost them three times that because of increased staffing and renovation requirements" (Hayes, 2019, April 1). On top of these increased costs, the province rejected their application for funding, leaving them struggling to stay afloat. As Picard (2019, April 2) so eloquently put it: "the cut-the-bureaucracy Conservatives decided to choke supervised consumption programs to death slowly with the red tape instead of just killing them outright."

Ford's political maneuvering through bureaucratic barriers has strangled public health services that provide essential services to populations in need. His calls for a treatment based model overlooks the validity and lifesaving work that SCS and OPS provide for drug users and only stigmatizes drug use further, which may deter those who are seeking help for their drug use from using facilities. The Conservative government has resurrected reactionary discourses of drug use into the public sphere, dismantling progressive policy and promoting dated perspectives of drug use that privilege law enforcement and medicalized discourses that are reminiscent of the failed War on Drugs from the 1980's onward. It is in these times that advocates and citizens must continue to struggle for legitimacy and promote their position through public disobedience.

Space to Breathe: Reclaiming Identity Through Grassroots Initiatives

After being subjected to various techniques of control and surveillance that ultimately contribute to constructing a defined classification of personal type, there will undoubtedly be resistance from the group in question. "Kinds of people who are medicalized, normalized, administered, increasingly try to take back control from the experts and institutions, sometimes by creating new experts, new institutions" (Hacking, 2006, pp.6). Hacking points to the struggles of the homosexual population and their resistance to medicalized, biologized and geneticized models of oversight and definition that sought to cure a behaviour dominant institutions deemed deviant and in need of correcting. Gay pride reclaimed a sense of control within the community to define the classification under which they fell. Drug dependence is experiencing its own ontological becoming within communities that struggle for the right to self define and care for the people that comprise them. In response to the mismanagement of the opioid

epidemic, communities have taken it upon themselves to step up and create novel ways to combat the epidemic - outside of the purview of dominant institutions of control. The process of classification and making up people has come full circle; the classified respond to their classification and challenge definition, feeding back into the process of knowledge production, changing problematic misconceptions of their identity and presenting alternatives more representative of their disposition. In doing so, harm reduction communities and advocates are strategically wrestling for legitimacy at particular nodes of power within the field of drug discourse, boldly inserting themselves into conversations and spaces they were never welcomed into.

In defiance of Ford's move to halt the opening of new SCS in Toronto, the Toronto Overdose Prevention Society opened an unsanctioned OPS in Toronto's Parkdale neighbourhood in August of 2018. Much like the Moss Park OPS that opened a year earlier to intervene with increases in mortality due to opioid overdoses, the Parkdale site filled in a service that the government would not act on. From a lawful perspective, the site's existence disobeyed zoning regulations and had not been given approval by any governing bodies for exemption status; therefore, the site was considered illegal and those involved could be subject to criminal charges. A Toronto police statement claimed officers will "use the discretion which the law gives them" in regards to the site (Giovannetti & Hauen, 2018, August 20). It should be noted that the Moss Park OPS was not closed, yet the Parkdale site existed within a new political context that was openly in opposition to harm reduction services and drug strategies that are modelled on public health. While the Mayor of Toronto pledged his support to SCS - having visited the Moss Park location firsthand and "appeared to soften his stance [on OPS] after his visit, which he described in an interview as moving" (Gray, 2017, September 15) - he still voiced his concerns about setting up sites in public parks, stating "there should be no need for a site such as this in a park and the planned site could be open soon" (Giovannetti & Hauen, 20 August 2018). This contradictory stance on OPS reveals an apprehension to have a public health service in a public space. Governing bodies want drug users off the street, but they also do not want sites that alleviate this issue in plain view in public settings.

The precarious situation that many of these sites face has been met with unwavering support from certain neighbourhoods that they call home. One example is St. Stephen's Community House, an SCS that lost its funding after Ford's overhaul on SCS approval. The centre is situated in historic Kensington

Market. Contrary to Ford's assertions that neighbourhoods do not want these services in their backyards, "many business owners and residents… are rallying to support the local site. They are raising money to keep it running. They are writing protest letters and signing petitions" (Gee, 2019, April 22). Rallying behind a cause is a strong social building practice, and signifies solidarity amongst the community. While Kensington Market has a long history of fighting oppression and it is certainly one of Toronto's quirkiest areas, the resistance to gentrification in the area and the welcoming of essential services for drug users demonstrates that rather than being a threat to public security, safe injection sites can foster community growth and empathy among residents, developing a space of acceptance for marginalized people where fear of stigma is alleviated, encouraging harm reduction practices that have been proven to save lives.

There is much talk of harm reduction in the news media and in policy proposals, yet very little discussion of developed conceptual frameworks that can be translated into practical goals for public health providers. Harm reduction discourse continues to grow in Canada, but studies have accused drug policy administration of only paying lip service to the radical paradigm shift. In a comparative analysis of current Canadian policy frameworks of harm reduction, Hyshka, Anderson-Baron, Karekezi, Belle-Isle, Elliott, Pauly, Strike, Asbridge, Dell, McBride, Hathaway & Wild (2017) found that "current harm reduction policy texts are dominated by rhetorical support for unspecified "harm reduction" services, in place of detailed discussion of any number of distinct interventions typically included under this approach" (pp.9). As a result, "by endorsing harm reduction in name, but not in substance, provincial and territorial documents may be communicating a general lack of support for key aspects of the approach to a diverse array of policy stakeholders, and thereby indirectly to a broader public" (Hyshka et al., 2017, pp. 11). Key aspects of harm reduction directly challenge many dominant discourses of drug use that have historically been the foundation upon which drug policy has been built upon in Canada: licit and illicit drug use are inescapable aspects of society and the goal should be to minimize harm rather than condemning drug use entirely; drug use is a continuum and some ways of using drugs are safer than others; providing non-judgemental and non-coercive provision of services to drug users to prevent harm; including those with a history of drug use in the development of drug policy that directly affects them; recognizing how social factors (poverty, race, trauma, sexism, isolation) can contribute to harmful drug use; and supplying drug users with services and counseling that seek to minimize harm, rather than

correcting behaviour (HealthLinkBC, 2020). Strategies based on reducing harm have received only 2% of the federal drug strategy's budget (Jeffries, 2019, January 1). Historically, drug policy in Canada has operated under the assumption that drug use can be eradicated through prohibition and the enforcement of violent and oppressive measures to disincentivize drug production, distribution and consumption through punitary systems of control and discipline. The War on Drugs is widely considered an abject failure by a number of agencies and studies (Public Health Toronto, 2018; Alexander, 1990; Martel, 2006), and have called for drastic shifts in drug discourse and policy that call for new drug laws in order to direct resources and modes of intervention to a host of social issues that contribute to widespread drug dependence issues within the population. The existence of pop up overdose protection sites not only defy laws and the institutions that uphold them - they directly challenge dominant discourses of drug use that have pervaded Canadian culture and policy guidelines for the better part of the past century, acting outside of medical and law enforcement jurisdictions, creating new institutions that are comprised of community members viewed as illegitimate experts on the subject and non-accredited health care workers.

Grassroots organizations are leading through example, demonstrating what these new measures can look like in practice, with or without government approval. The Toronto Harm Reduction Alliance organizes many pop-up tents that can be found in parks throughout Toronto. The alliance consists of health care workers, actual drug users, and community members that volunteer their time to a cause they see as an essential service that does more than simply prevent overdoses and provide clean drug paraphernalia. Councilor Joe Cressy stated:

> I understand that for some activists, they sought to fill a void. And while the city cannot break the law to fill that void, I can't blame the activists for stepping in… The long-term solution is not to have unsanctioned sites in parks, but adequate and sustainable and funded sites throughout the city. (Gray, 2017, August 14)

While permanent sites may promote better public health access for many, it is naive to consider them more effective than pop ups that operate outside of medical authority and oversight. Organizer Matt Johnson said that:

> The pop-up wasn't meant as a publicity stunt to shame the city into action. It was meant to serve the drug users of Moss Park. It has also benefited from the help of many volunteers who are drug-users themselves. If moving inside means professionalizing and potentially shutting them out, it's not worth it. (Gray, 2017, September 15)

For many volunteers that also happen to be drug users, the work they do at the pop-ups is important to them for a number of reasons, filling them with purpose, forging bonds within their community, and even helping them with their own drug use or road to sobriety. Furthermore, the sites offer visitors a public health service that is devoid of traditional medicalized health service infrastructures that can be intimidating and unwelcoming to many drug users that have had bad experiences with hospitals and other oppressive institutions. The people who volunteer for pop-ups are like them; they have shared experiences, which build trust; they do not feel judged for their drug use; they will most likely continue to frequent the site, ultimately decreasing the possibility of harm when using alone. Professional settings are a clinical environment where power is distributed unequally within a doctor-patient relationship. Patients are burdened with complying with orders in order to maintain working relations with their doctor, which can be an exercise in futility for a demographic that is rebellious in nature and already suspicious of the gaze of institutional power. Pop-up sites do away with barriers to access that are rooted in uneven distributions of power that are inherent in professionalized medical infrastructure that privilege accredited knowledge over experience, which is discredited by medical authorities as amateur or even dangerous.

The need to enforce standardized practice upon pop-ups and the volunteers who work within them is becoming a reality for law enforcement. The legally precarious situation of pop-ups can lead to a heightened police presence and underhanded strategies to target the community through iniquitous means. One such example is the arrest of Mark Baratta, a peer ambassador who reaches out to drug users for the Parkdale Community Health Centre. Baratta, an "off and on user for 24 years," has saved seventeen people from overdosing on opioids. Instead of receiving praise, Baratta is facing criminal charges for trafficking heroin and with possession of property obtained by crime. After posting a warning that a bad batch of heroin was circulating in the area - in response to a recent overdose he helped reverse - Baratta received a call from someone claiming to be an acquaintance in need of heroin. "When a person is an addict," said Baratta, "they don't want you to do them the favour of helping them abstain. They want you

to do them the favour of helping them get dope so they can get well, because they're in hell while they're in withdrawal" (Contenta, 2017, April 30). Baratta turned to a friend who might have a safe supply of heroin, and delivered it himself, walking right into a police sting. While his actions were technically illegal, they were done with good intentions for someone he perceived to be in pain and in need of help; he only wanted to make sure that this person would receive untainted drugs that were not laced with fentanyl. The fact that Baratta was specifically targeted by the police is strange, but not totally surprising. Baratta's arrest could be an attempt to discredit OPS and SCS and the people who work with the sites. Proving that criminal behaviour is associated with the sites could be a heavy blow to their legitimacy and discredit claims that they do not supply drugs to their clients, only supplying a safe place to use and clean drug paraphernalia. As pop-ups continue to establish themselves as an alternative public health service for drug users - operating under principles informed by a counter discourse of harm reduction that challenges traditional views and the institutions that uphold them - the more we may see medical and law enforcement groups attempt to attack or discredit the sites. For if, these sites continue to succeed, the discourse that they espouse will strengthen and may contribute to the dismantling of dominant interest groups and institutions that depend upon hegemonic control of drug discourse for their legitimate claims to authority over knowledge production and state approved violence. More is at stake than merely sharing resources and funding across different interest groups; the battle over discourse can have widespread implications for many entrenched institutions of control in our society. We may see that with increasing threats to hegemony, these institutions may increasingly rely upon each other to maintain their position of authority. While criminal and medical discourses of drug use are at seemingly at odds, they each exist within a shared matrix of drug discourse that punishes drug use and functions to control drugs and those who use them; medical intervention and law enforcement coexist on a continuum that is dependent on the belief that all drug use is inherently wrong and dangerous. Safe injection sites and harm reduction models are mutually exclusive to this logic of control that permeates established drug policy and criminal law.

When drug users determine their own identity and existence, they propose different values and social relations with public health providers. The power to self define can offer radical potentials for a group that has been systematically classified based on a criteria of deviance and risk, affirming their own right to identify and exist within society. Jeffries (1 January 2019) refers to Henri Lefebvre's conception

of the right to the city in relation to grassroots organizing of urban infrastructure to claim that safe injection sites are engaged in transformative politics that exemplify the “struggle of people devoting themselves to improving life in an increasingly inhospitable urban landscape, in the face of entrenched stigma, criminalization and official neglect.” For Lefebvre, “the right to the city… means much more than a formal right to be present in the city. It is an affirmation of the need to participate in the making and remaking of our cities” (Jeffries, 2019, January 1). For a group of marginalized people that many view as a hindrance to city development, resulting in their exclusion - even eradication - from public life and space, safe injection sites symbolically affirm their right to inhabit both public life and space and actively contribute to its progress. During a crisis that lacks government leadership, the very people affected by the crisis have stepped in to take control over their own lives and wrestle from institutions the right to self determination and autonomy through community based action, transforming the public health landscape, dismantling structures of power, countering discursive constructions and reclaiming the right to exist as they are.

CONCLUSION

The opioid epidemic in Ontario is not just a public health crisis; it is a situation that has developed out of neglectful policies that have marginalized a group in desperate need of social assistance who must struggle for visibility in a social setting that would rather them stay invisible. An analysis of the discursive field in which the epidemic is situated has shown that compassion for these people is mostly performative in nature, and public health policy is still deeply embedded in dated views of addiction that continue to discipline drug users and punish them for transgressing law and order and societal expectations of conduct. Many of the dominant discourses that envelope the public sphere of acceptable limits of drug discourse function to perpetuate power relations and solidify figures of institutional authority.

The opioid epidemic provides an excellent case study for mapping out discourse and analyzing discursive interaction as a process where competing ideologies struggle for legitimacy and engage in political posturing for position as producers of knowledge within a social milieu. I have discussed at length many of these competing discourses: risk assessment, surveillance, law enforcement, medical, corrections, rehabilitation, neoliberalism, advocacy, and counter discourses. My hope is that over the course of my analysis, the reader will notice that these discourses do not exist in a vacuum, and they frequently interact and overlap. Oftentimes these separate discourses are employed by state actors and other claims makers in unison as a means of strengthening positions of power that perpetuate dominant social relations and structures. For example, risk assessment and law enforcement discourses are often present alongside each other as a rhetorical technique that first makes law enforcement synonymous with preventing risk and protecting citizens, and secondly suggests that drug users are risky and law enforcement is the state's most useful apparatus for dealing with drug users. Another example would be Ford's claim that the drug epidemic must focus on a dual approach to the crisis that supports increased law enforcement and medical intervention, and discounts overdose prevention and other safe injection practices and services that are framed as enabling further drug use. Here we see that two discourses that are often viewed as diametrically opposite policy responses to drug use are instead joined in a union that represents traditional responses to drug use, in opposition to harm reduction models of drug use that are not compatible with fixed, deeply rooted norms, laws and social values. Harm reduction discourse

radically shifts society's relationship with drug use and would require removing many of the foundational assumptions that our current political epistemology is based upon. So we can see that faced with a new enemy, law enforcement and medical discourses are not mutually exclusive after all, in fact they comprise each face of the drug policy coin, sharing more in common than policy makers would care to admit. We can see this marrying of each discourse in actual drug response initiatives, specifically in drug courts and other apparatuses of drug control that seek to synthesize professional authority: for law enforcement, the ability to coerce drug users into treatment through state sanctioned forms of violence and incarceration; for medical professionals, a more finely tuned set of tools to rehabilitate and correct behaviour that is viewed as benevolent and nurturing, rather than disciplinary and oppressive. We must remind ourselves that unequal power relations are just as present under medical supervision, albeit, in more relaxed, and subtle forms of manufactured consent. Dominant institutions will restructure themselves and remain elastic as discourses continue to morph and change, in an attempt to sustain their political reach in the face of counter discourses that threaten the very foundations upon which they rest.

What is most striking is that policy makers remain hesitant to acknowledge the evidence-based success of harm reduction models; many autonomous entities - even within dominant fields of discourse (like Registered Nurses' Association of Ontario) - support SCS and concede that "the consensus is that the evidence supports SCS as being effective in meeting public health objectives including reducing overdose-induced mortality and morbidity" (Registered Nurses' Association of Ontario, 2019). Here we see that objectivity is relative and negotiated through discourse and claims to knowledge. Language is malleable; by changing language, you can alter or delegitimize acknowledged truisms, objective truth and reality. In this case, Ford and other state actors' aversion to harm reduction models can easily delegitimize SCS by offering contradicting narratives that utilize language steeped in *pathos* that convince the public of the dangers of the sites and appeal to traditional values, reiterating the moral degradation of drug use and an intolerance to all forms of drug use. Regardless of the evidence, harm reduction is effectively disregarded in a public sphere that opposes all drug use, ignoring the positive outcomes of harm reduction and remaining steadfast in their beliefs despite the inevitability of drug use within society. This is not a question of objective reality, but rather a symptom of morally charged discourse that affords no leeway for progressive drug discourse within their ideological boundaries.

Yet, for the people directly affected by the opioid epidemic, this is not merely an argument over semantics; this is a life or death situation. After being subjected to forms of discipline, surveillance, scientific research and normalization, it would seem that these endeavors meant to classify drug users in order to gain a better understanding of their disposition has only furthered their oppression without devising a plan to truly assist them. SCS and OPS present drug users with an opportunity to contribute to a service that directly serves them and to share their knowledge with policy makers and medical personnel in order to create services that are inclusive, welcoming, and non-judgemental - truly working as intended. Instead of suppressing these voices and their experiential knowledge on the realities of opioid dependence, service providers must make a conscious effort to offer drug users a place at the table in creating policies specifically designed to meet the needs of the population and reach realistic goals to begin flattening the curve. It is clear that after years of imposing treatments and regulating bodies, the epidemic has not abated and new methods and treatment options must be considered and implemented.

This thesis is not all encompassing, nor does it claim to be. Drug discourse features a constellation of voices that matches the infinite multitudes in the night sky. Hopefully, my work traces but a small portion of the endless assemblages and formations that characterize drug discourse, and partially materializes the power relations that construct them. Future work would do well to expand upon these ideas with ethnographic research that includes personal opinion of the many aspects that have been outlined. While news media certainly alludes to the many different voices that construct drug discourse, it is a limited resource to draw from because of the political leanings of specific news outlets and the journalistic duty to present objective fact (whether or not this is accomplished is another concern entirely). Fieldwork and direct interviews with the many actors involved in the opioid epidemic would undoubtedly reveal more interesting points of micropolitical discourse, filling in gaps in knowledge - while also seeking to include oppressed groups in research in a more meaningful, direct way. What my work has accomplished is not deliberative in nature, nor does it seek to prove or disprove the validity of statements in regards to drug use and policy. What my work has hopefully demonstrated is that language is always politically charged and is deployed by interest groups to support specific goals to their program - sometimes self-serving, sometimes emancipatory, but always spoken from a position of relative power.

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