AUTHOR'S DECLARATION FOR ELECTRONIC SUBMISSION OF A THESIS

I hereby declare that I am the sole author of this thesis. This is a true copy of the thesis, including any required final revisions, as accepted by my examiners. I authorize Ryerson University to lend this thesis to other institutions or individuals for the purpose of scholarly research. I further authorize Ryerson University to reproduce this thesis by photocopying or by other means, in total or in part, at the request of other institutions or individuals for the purpose of scholarly research. I understand that my thesis may be made electronically available to the public.

i

Making Up a Drug Epidemic: Constructing Drug Discourse During the Opioid Epidemic in Ontario Master of Arts 2020 Travis M. Sidak Communication and Culture Ryerson University & York University

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.

Acknowledgements

Many people come to mind whom I owe unfathomable amounts of gratitude. They have been indispensable throughout my academic journey and have directly and indirectly supported me through many anxious days and sleepless nights. First of all, I would like to thank my supervisor, Stephen Muzzatti, for agreeing to oversee my project, even when it was still incubating, allowing me the freedom to follow my academic interests, and reigning me in when I got ahead of myself. I appreciate that he supported my decisions throughout my project and let me work at my own pace.

I want to extend my thanks to my committee members, Rob Heynen and Claudio Colaguori, who reassured me that the work was doable and encouraged me to keep at it. There were times I was ready to throw in the towel but your motivation truly gave me the confidence to continue.

I would like to thank the faculty members at Ryerson University, particularly Sarah Edmonds, who assisted me in setting deadlines and replying to my many questions about how to navigate through the labyrinth that is higher education administration. Everyone in my cohort is undoubtedly indebted to your expertise.

A big thank you to the SSHRC and OGS funding agencies for making my postsecondary education possible. Without this funding, I would not have been able to afford a move to Toronto and a life of relative comfort.

Of course, I can't forget my fantastic parents who have always supported me emotionally, intellectually and unconditionally. Thank you for all that you have done and continue to do for me. I love you.

Last, but never least, thank you to my wonderful girlfriend, Shay, who persistently urged me to keep working and to always be the best man I can be. You are my inspiration and my person.

iii

iii

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.

Table of Contents

Introduction	1
Chapter 1: Review of the Literature	6
Introduction	6
(Bio)medicalization of Drug Dependence	7
Critical Addiction Studies	13
Critiques of the Biological Brain Disease Model	
Harm Reduction Approach to Public Health	20
Making Up Drug Use	

Chapter 2:	: Theoretical Framework	25
Int	troduction to Social Constructionism	25
Ма	aking Up People	27

Chapter 5: Constructing a Nexus of Deviance & Enforcement7	0
(II)licit Deviance: Criminalization & Stigma7	0
Guilty by Association: Finding Correlation7	9

Chapter 6: Embodiments of Dependence	.85
Prescription Handcuffs: Medicalizing opioid dependence	85
Marks of the Beast: Biogenetic Surveillance & Engineering	91

Chapter 7: Widening the Discursive Field	100
Introduction	.100
Fallen Angels: Reformative Measures & Humanizing the Subject	101
Red Tape & Blue Politics: Bureaucratic Barriers to Public Health Space	.109
Space to Breathe: Reclaiming Identity Through Grassroots Initiatives//	.116

Conclusion

Works Cited127

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

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

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

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

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 al cohol 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 psychopathological 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

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

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

producers were all stakeholders in the initial battle for institutional legitimacy. Ultimately, the pharmacy

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

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

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, clientcentred 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

Chapter 2: THEORETICAL FRAMEWORK

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 (prove) 2 (. F) -0(oc) 0.2 (n (t) 0.2 (t) 0.7r0 -0.2 (or7)t) 0.2 (t) 0.7r0s r0sc at tmocar

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

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.

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

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

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

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.

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?

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.

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

Discourse as Paradigm: Dogma and Reflexivity

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.

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

neoliberal rhetoric of personal responsibility for health, sensationalized news articles, and public health

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

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- 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

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

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

administration for opioids is intravenous injection - a dangerous practice that can spread disease amongst

overindulgent decadence that are unsettling to viewers, causing many to look away in disgust. A fear of

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 socioeconomically 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

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

Chapter 5: CONSTRUCTING A NEXUS OF DEVIANCE AND ENFORCEMENT

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

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.

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

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

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, relinguishing 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

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).

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 MPAlex 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

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.



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

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

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

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 genera2 (dow) 0.2 (e) 8ur

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 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 1 0 0 1n rey n()] TJET2 (rugs)-2(a) 0.2. 11 0 (oi) 0.2ouay a& o2 (. D) 9gve f6n ree. Dhee, and t20.20.2(

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 manipulatihetsrot

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 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 (normalizati(2 ((i) 0.2 (he)0.2 (22.7(In H)22.7(In H) pra) 0.(I) 0.2 d82 Tm /TT2 1(he)0.2

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

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 indica (w) -0.rsdof sese fore tolnracuot roac(w) -0.rate ser ic enpasstohough avrryng aedha

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

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. u62.2(i) 0.(i) 0.. u6BT 11 0.2 (s) (, no i u6BT 0.2(i)).

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

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

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

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

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 drugusers 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 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

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.

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 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.

Works Cited

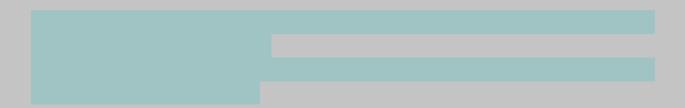
- Addictions & Mental Health Ontario. (2018). Overview of the effectiveness of supervised consumption services: What does the evidence and the Ontario experience tell us? https://amho.ca/wp-content/uploads/AMHO-Submission-to-MOHLTC-Overview-of-the-Effectiveness-of-Supervised-Consumption-Services.pdf
- Adler, P. & Adler, P. (Eds.) (2016). *Constructions of Deviance: Social power, context and interaction*. Cengage Learning.
- Alexander, B.K., Coambs, R.B. & Hadaway, P.F. (1978). The effect of housing and gender on morphine self-administration in rats. *Psychopharmacology* 58, 175–179. https://doi.org/10.1007/BF00426903
- Alexander, B. K. (1987). The Disease and Adaptive Models of Addiction: A Framework Evaluation. *Journal of Drug Issues*, 17(1), 47–66. https://doi.org/10.1177/002204268701700104
- Alexander, B. K. (1990). *Peaceful measures: Canada's way out of the 'war on drugs'* University of Toronto Press
- Alexander, B.K. (2001). *The Roots of Addiction in Free Market Society*. Canadian Centre for Policy Alternatives.
- Alexander, B. K. (2014). *Rise and Fall of the Official View of Addiction*. Bruce K. Alexander. https://www.brucekalexander.com/articles-speeches/277-rise-and-fall-of-the-Official-view-of-addiction-6

Althusser, L. (1970).

Barton, R. (2015, May 30) In pursuit of mental health's holy grail. The Globe and Mail. Proquest.

Becker, H. (1955). Marihuana Use and Social Control. Social Problems, 3(1), 35-44. doi:10.2307/798741

- Becker, H.S. (1973). *Outsiders: Studies in the sociology of deviance*. The Free Press.
- Beirne, P. (1987). Adolphe Quetelet and the Origins of Positivist Criminology. *American Journal of Sociology*, *92*(5), 1140-1169. www.jstor.org/stable/2779999
- Belluck, P. (2016, April 9). Risk-taking rats offer insights into addiction. *The New York Times International Weekly.* Proquest.
- Best, J. (2017). Joseph Gusfield and Social Problems Theory. *Am Soc* 48, 14–22. https://doi.org/10.1007/s12108-015-9295-4
- Bierness, D. (2008) Harm Reduction: What's in a name? Canadian Center on Substance Abuse National Policy Working Group. Retrieved from: http://www.ccsa.ca/Resource%20Library/ccsa0115302008e.pdf
- Blum, K., Oscar-Berman, M., Demetrovics, Z., Barh, D., & Gold, M. S. (2014). Genetic Addiction Risk Score (GARS): molecular neurogenetic evidence for predisposition to Reward Deficiency Syndrome (RDS). *Molecular neurobiology*, 50(3), 765–796. https://doi.org/10.1007/s12035-014-8726-5
- Blythe, S., Chapman, L., Dodd, Z., Gagnon, M., Hobbs, H., & Westfall, J. (2017).



https://academic.oup.com/ndt/article/23/1/47/1923176

Foucault, M. (2010). The Birth of Biopolitics: Lectures at the Collège de France, 1978--1979. Vintage.

Fraser, S., Pienaar, K., Dilkes-Frayne, E., Moore, D., Kokanovic, R., Treloar, C., & Dunlop, A. (2017).

theoretical framework, Government Information Quarterly, 26, 349-357

Gergen, K.(1999). An invitation to social construction. Sage.

- Gifford-Jones, W. (2018, July 14). Doug Ford is dead right, injection sites are wrong. *Toronto Sun.* https://torontosun.com/life/relationships/doug-ford-is-dead-right-injection-sites-are-dead-wrong
- Giovannetti, J. & Gray, J. (2017, September 25). Ontario resists calls for state of emergency on opioid overdoses. *The Globe and Mail*. Factiva.
- Giovannetti, J. & Hauen, J. (2018, August 20). Activist group opens unsanctioned overdose prevention site in Toronto. *The Globe and Mail.* Factiva.
- Giovannetti, J. & Hayes, M. (2018, August 16). Advocates voice concern over Ontario government's freeze on overdose prevention sites. *The Globe and Mail*. Factiva.

The Globe and Mail. (2019). An overdose epidemic, and a radical idea. The Globe and Mail. Factiva

Goffman, E. (1963). Stigma: Notes on the management of spoiled identity. University of Michigan.

- Government of Canada. (2016). A framework for the legalization and regulation of cannabis in Canada. marijuana-grupe-etude/framework-cadre/alt/framework-cadre-eng.pdf
- Government of Canada. (2020). *Opioid-Related Harms in Canada.* https://health-infobase.canada.ca/substance-related-harms/opioids/
- Granfield, R., & Cloud, W. (2001). Social context and "natural recovery": the role of social capital in the resolution of drug-associated problems. *Substance use & misuse*, 36(11), 1543–1570. https://doi.org/10.1081/ja-100106963
- Graham, L. J. (2013). The product of text and 'Other' statements: Discourse analysis and the critical use of foucault. *Educational Philosophy and Theory*, *43*(6), 663-674. doi:10.1111/j.1469-5812.2010.00698.x

Grant, K. (2018). Ontario doctor gives up license as physicians's college grapples with opioid crisis. The

Globe and Mail. Factiva.

Gray, J. (2016, December 7). Deadly opioid carfentanil found in Toronto for first time. *The Globe and Mail*. Factiva.

Contemporary practices of moral regulation. *Criminology & Criminal Justice*, *11*(5), 451-469. Hayes, M. (2019, April 1). Supervised drug use sites in city scramble to find funding after cuts announcement. *The Globe and Mail*. Factiva.

Hayes, M. (2019, December 6). Police launch Vulnerable Persons Registry. *The Globe and Mail.* Factiva. HealthLinkBC. (2020). Understanding Harm Reduction: Drug use.

- Hyshka, E., Anderson-Baron, J., Karekezi, K. *et al.* Harm reduction in name, but not substance: a comparative analysis of current Canadian provincial and territorial policy frameworks. *Harm Reduct J* 14, 50 (2017). https://doi.org/10.1186/s12954-017-0177-7
- Institute for Drugs and Treatment. (2009). National Report to the EMCDDA by the REITOX National Focal Point: Portugal Institute for Drugs and Drug Addiction. In New Development, Trends and In-Depth Information on Selected Issues. Lisbon: Institute for Drugs and Drug Addiction.
- Jeffries, F. (2019, January 1). The right to safety in the city. *Canadian centre for Policy Alternatives. https://www.policyalternatives.ca/print/14695*
- Jellinek, E.M. (2010). The Disease Concept of Alcoholism. Martino Publishing.
- Jivani, J. (2017, September 29). Money alone can't solve Ontario's opioid crisis. *The Globe and Mail*. Factiva.
- Johnstone, B. (2017). Discourse Analysis. Wiley-Blackwell.
- Kalant, H. (2010). What neurobiology cannot tell us about addiction. *Addiction (Abingdon, England)*, *105*(5), 780–789. https://doi.org/10.1111/j.1360-0443.2009.02739.x
- Katawazi, M. (2017, August 4). Toronto's fentanyl threat 'very real,' harm reduction advocate says. *The Globe and Mail. https://www.theglobeandmail.com/news/toronto/torontos-fentanyl -threat-very-real-harm-reduction-advocate-says/article35883796/*
- Kaye, K. (2012). De-Medicalizing addiction: Toward biocultural understandings. *Advances in Medical Sociology*, *14*, 27-51. DOI: 10.1108/S1057-6290(2012)0000014006.
- Kevles, D.J. (1995). In the Name of Eugenics: Genetics and the uses of human heredity. University of California Press.
- Khun, T. (1962). The Structure of Scientific Revolutions. University of Chicago Press.
- Koob, G. F. (2000). Neurobiology of addiction: Toward the development of new therapies. In S. D. Glick
 & I. M. Maisonneuve (Eds.), Annals of the New York Academy of Sciences: Vol. 909. New medications for drug abuse (p. 170–185). Necysrsc2 (a) 0.Tm Y2 (BT -0.n2 (rb0.) 0Bg-0n Tm /TC

Lindesmith, A. (1949). Opiate Addiction. *Journal of the American Pharmaceutical Association, 38*(9), 534. https://doi.org/10.1002/jps.3030380924

Locke, T. (2004). Critical discourse analysis Continuum.

Lombroso, C. (1911). Criminal man. Putnam.

- Lyon, D. (2003). Surveillance as Social Sorting: Privacy, risk and digital discrimination. Routledge.
- Maté, G. (2008). In the realm of hungry ghosts: Close encounters with addiction. Knopf Canada.
- Malleck, D. (2015). When Good Drugs Go Bad: Opium, medicine, and the origins of Canada's drug laws. UBC Press
- Martel, M. (2006). *Not this time: Canadians, public policy, and the marijuana question, 1961-1975* University of Toronto Press.
- May, C. (2001). Pathology, Identity and the Social Construction of Alcohol Dependence. *Sociology*, *35*, 385-401. 10.1177/S0038038501000189.
- McIntosh, J. & Mckeganey, N.. (2000). Addicts' narratives of recovery from drug use: Constructing a non-addict identity. *Social science & medicine 50*. 1501-10. 10.1016/S0277-9536(99)00409-8.
- Mehta, D. (2017, January 9). Toronto mayor urges joint response as opioid crisis moves east. *The Globe and Mail*. Factiva.
- Meylakhs, P. (2009). Drugs and Symbolic Pollution: The Work of Cultural Logic in the Russian Press. *Cultural Sociology*, *3*(3), 377–395. https://doi.org/10.1177/1749975509105538
- Miller, P. (2001). A critical review of the harm minimization ideology in Australia. *Critical Public Health, 11*, pp. 167-178.
- Moore, D. (2007). Criminal Artefacts: Governing drugs and users. UBC Press
- National Association of Pharmacy Regulatory Authorities. (2019). Drug Scheduling in Canada General Overview. https://napra.ca/drug-scheduling-canada-general-overview
- Nestler, E.J. & Luscher, C. (2019). The molecular basis of drug addiction: Linking epigenetic to synaptic and circuit mechanisms. *Neuron*, *102*, 48-59.
- Netherland, J. & Katz-Rothman, B. (Eds.) (2012). *Critical Perspectives on Addiction, Vol. 14*. Emerald Group Publishing.
- Omand, G. (2018, March 27). Ottawa to reform drug treatment laws. The Globe and Mail. Factiva.
- Ontario Association of Chiefs of Police. (2017). OACP Statement on Supervised Injection Sites. F http://www.oacp.on.ca/news-events/news-releases/oacp-statement-on-supervised-injection-sites
- O'Reilly, M. & Lester, J. (2017). Examining Mental Health through Social Constructionism: The Language of Mental Health. 10.1007/978-3-319-60095-6.

Seddon, T. (2016). Inventing Drugs: A genealogy of a regulatory concept.

- Woo, A. (2017, November 17). Advocates say federal moves to curb opioid crisis are just a start. *The Globe and Mail*. Factiva.
- Woo, A. & Hager, M. (2018, March 28). Opioids claim more lives than road crashes. *The Globe and Mail*. Factiva.

Zamora, D. & Behrent, M.C. (Eds.) (2015). Foucault and Neoliberalism. Polity.