# Social Psychology of Drug Policy:

# Dislocation and Dissonance Theory

by

Carmen Wilson

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APPROVED BY

Glen Grigg, Ph.D., R.C.C., Thesis Advisor, Counsellor Faculty

Colin Sanders, Ph.D., R.C.C., Faculty Reader, Counsellor Faculty

Abstract

The war on drugs is, arguably, a failed social policy, and yet it persists. This thesis uses scholarly review and analysis to ask: What is the social and individual psychology that accounts for the endurance of a demonstratively failed drug policy? From there, this inquiry goes on to ask what is the social and individual psychology that informs change in appropriate drug policy? This study finds that there is a relationship between addiction and dislocation due to stigma, and that one of the main driving forces behind the continuation of drug prohibition is cognitive dissonance. Two empirically validated treatments for addiction are reviewed. Family therapy is connected to the theory of dislocation, and motivational interviewing is connected to dissonance theory.

*Keywords: drug policy, addiction, social psychology, decriminalization, drug prohibition, war on drugs, cognitive dissonance, dislocation theory*

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# Social Psychology of Drug Policy: Dislocation and Dissonance Theory

## Chapter One: Introduction

This thesis begins with the premise that the war on drugs is a failed social policy (Boyd, 2017; Boyd, Carter & Macpherson, 2016; Buchanan & Young, 2000). From the premise of failed social policy follows the proposition that dislocation theory (Alexander, 2012; Alexander 2010; Levine, 2009) and dissonance theory (Tavris & Aronson, 2016), considered in combination, have potential to give new understanding to this policy failure, and to go further by pointing to new possibilities in contextualized, effective help for those oppressed by problematic substance use. Dissonance theory and dislocation theory are well-validated conceptual frames of reference in social psychology, and thus take an analysis of the war on drugs well outside conventional policy analysis (Csete, Kamarulzaman, Kazatchkine, Altice, Bailcki, Buxton, & Beyrer, 2016; Domostawski, 2011; MacCoun, 2011, Spapens, Müller & Bunt, 2014), and beyond conventional sociological analysis and attributions of psychopathology (Barry, McGinty, Pescosolido & Goldman, 2014; Eaton, Ohan & Dear, 2014, Linnemann & Wall, 2013; Lloyd, 2013). The literature review, analysis, and thematic synthesis in this inquiry will elucidate dislocation and dissonance theory as explanatory frameworks for the failure of the war on drugs. This thesis will show how dislocation theory accounts for the interpersonal and psycho-social dimensions of problematic substance use, while dissonance theory complements this perspective by accounting for the intra-personal dimensions of motivation and emotion known to accompany problematic substance use. The analysis and synthesis methodology will also generate ideas for psychologically-informed policies and evidence-based, theory-grounded alternatives to current professional strategies.

In creating a thesis based on the integration of two theoretical perspectives, I am aware that the results of this study are not facts. The results of this study are a set of propositions (Kuhn, 1970; Popper, 2013). These propositions are grounded in theory, consistent with logical analysis, and are, within the limits of my literature review, consistent with the current body of known facts. Such results are, technically and philosophically, heuristics (Cresswell, 2014). The results point to, but do not conclusively validate, policy alternatives and treatment strategies. Validations of social policy are questions for historians and policy analysts and validation of treatment strategies are empirical questions in applied psychology, both of which will be informed by, but beyond the scope, of this thesis.

**The British Columbia Context of the War on Drugs**

In British Columbia, "the war on drugs was an expensive failure and linked prohibitionist policies to overdose deaths in the province" (Boyd, Murray & MacPherson., 2017, p. 2). Despite a large amount of evidence demonstrating that drug prohibition does not accomplish what it is meant to, and successful examples of substance decriminalization such as in Portugal, drug prohibition remains in most places across the world. As discussed by Wilson (2017):

> The war on drugs made it a difficult and slow process to set up heroin-assisted treatment programs, allowed unnecessary overdose deaths, and marginalized illicit drug users (Boyd et al., 2017), worsening the problem. The war on drugs does not achieve the goal of reducing drug consumption (Domostawski, 2011).

This writer found it challenging to find a definition for the Canadian war on drugs. For the United States, the following definition was found:

> War on drugs is a series of actions tending toward prohibition of illegal drug trade. It is a campaign adopted by the U.S. government along with the foreign military aid and with

> the assistance of participating countries, to both define and to end the import, manufacture, sale, and use of illegal drugs.. This initiative includes a set of U.S. drug policies that are proposed to discourage the production, distribution, and consumption of illegal psychoactive drugs. The term "War on Drugs" was first used by President Richard Nixon on June 17, 1971, during which he described illegal drugs as "public enemy number one in the United States (US Legal, Inc., n.d.).

It could be argued that it is easier to find an American definition of the war on drugs over a Canadian one because Canada is strongly influenced by American policy changed and has followed suit throughout moments in history, which will be discussed below.

Drug policy history will further be discussed in the next chapter. However, this is an extensive topic, and as such it will be limited to give a general idea of historical events in drug policy that are relevant to this study, with a focus on Canada.

This thesis aims to understand the social and interpersonal psychology behind this resistance to change. In terms of the methodology for this study, there will be no participants or original data being collected. The following is a scholarly examination of practice; a literature review of non-original data. Answers to the research questions will be sought through analyzing various sources, and synthesizing and interpreting this data in a new way. This analysis will seek to discover patterns of thinking and behaviour that will help explain resistance to change despite evidence against the current drug policy.

This thesis reviews the history of Canadian drug policy including the opioid crisis, steps towards decriminalization, and stigmatization and discrimination of drug users. Dislocation theory is reviewed and connected with stigmatization of drug users. These two factors are argued to be closely tied and to detrimentally affect each other. Response to policy failure is then

reviewed. The multiple social psychological factors of dissonance theory are discussed and connected to drug policy decisions and discriminations. It is argued that decriminalization has not been accomplished because of cognitive dissonance, in which policy makers cannot admit that the war on drugs has been a failure. Different viewpoint of drug addiction and drug use are then discussed, considering the moral model, medical model, and critical addiction studies. The critical addiction model is argued to be the way forward. Lastly, two counselling approaches that are well-known for being effective for addiction treatment are reviewed. The efficacy of motivational interviewing and family therapy are explored, and are connected to dissonance theory and dislocation theory.

Seen from afar, and thinking in terms of practical logic, it seems strange that even for something as important as drug policy, logic and evidence appear to be overtaken by emotions and personal biases. This may not be sensible, yet it is, as this thesis will demonstrate, something like what has happened in the field of policy on the use of illicit substances. Whereas much has been written from the perspective of social policy, political science, and criminology, little has been said about the basic psychology underpinning a non-rational and, arguably, ineffective response to a serious social problem. Social psychology concepts within dissonance theory, including self-justification, confirmation bias, sunk costs, the power of irrevocability, and blaming the victim, will be explored and connected to the persistence of the war on drugs.

Alexander (2010) sees the issue of addiction not lying with the individual who is using substances, but with society. In an individualistic society such as Vancouver, people are being dislocated, causing some individuals to turn to addiction to cope (Alexander, 2010). A literature review by Lloyd (2013) defines stigma as a “long-lasting mark of social disgrace that has a profound effect on interactions between the stigmatized and the unstigmatized” (p. 85). This

review demonstrates that stigma has a significant impact on problem drug users, and that stigma acts as a significant barrier to recovery and the social reintegration of users (Lloyd, 2013). The integration of literature further documents the different ways that problem drug users are stigmatized against, including by the public, health professionals, pharmacies, policies, and self-stigma (Lloyd, 2013). The stigma towards drug users, as well as how this stigma affects policy and supports for people with addiction, will be further discussed in the next chapter.

Social psychology will be linked with attitudes towards drug users and drug policy, pulling from multiple sources. In their summary of the effects of psychological dissonance on social behaviour, enigmatically titled *Mistakes were made (but not by me),* Tavris and Aronson (2015) state "most people, when directly confronted by evidence that they are wrong, do not change their point of view or plan of action but justify it even more tenaciously" (p. 2). Self-justification is a concept discussed, which is the behaviour of people unconsciously lying to themselves to convince themselves that they did they best they could, or that what they did was the right thing to do (Tavris & Aronson, 2015). Could it be that changing drug policy is not nearly as difficult as the psychological task of admitting to one's self, and to others, that behavior of long-standing was not just misguided, but actually counter-productive? And it is possible that such dispassionate examination of evidence is rendered difficult, if not nearly impossible, by the presence of justifying thoughts and rationales? Tavris and Aronson (2015) argue that the presence of self-justifying thoughts is essential to avoiding dissonance, the psychological distress of holding incompatible thoughts. This could be an example of how the war on drugs has continued on for so long. Dissonance theory posits that, to abandon the policy, people at all levels of society would have to abandon the self-comforting and ego-sustaining belief that the current policy is the best option (Tavris & Aronson, 2015). Self-justification "...allows us to

create a distinction between our moral lapses and someone else's and blur the discrepancy between our actions and our moral convictions (Tavris & Aronson, 2015, p. 5). Cognitive dissonance drives self-justification (Tavris & Aronson, 2015), and this concept among with many others will be discussed further in the following chapter.

> I feel that a major barrier to the decriminalization of substances is people's views on drug use and drug policy that have been conditioned into them through decades of the war on drugs. I believe that developing an understanding of what causes people to resist considering other perspectives and alternatives to the war on drugs could help us find a way to move forward past this barrier. This would help us move towards policy change that will save the lives of people overdosing every day, save societies huge amounts of money that they are spending on enforcing the war on drugs and on medical care for those who overdose, and could improve societies through using that money to support people to quit their addiction through social support systems, rather than punishing them and taking away their opportunities. I wish to find a way to help people understand a more nuanced perspective of drug users and drug policy, to make a better world for everyone (Wilson, 2017).

The thesis will argue through the data analyzed that the stigmatization of drug users caused by drug prohibition leads to dislocation of drug users, which may in turn cause drug users to continue using drugs. It is also concluded that one of the reasons drug prohibition has continued for so long besides contradictory evidence is cognitive dissonance. The importance of facing ones dissonance and having connection are highlighted again when discussing family therapy and motivational interviewing, two empirically validated treatments for addiction.

## Problem Statement

The issue at hand is drug policies being based on pathology, criminalization, and interdiction. The reasons behind this method of drug control needs to be better understood in order to be able to shift from a way of thinking and approaching drug policy that has proven ineffective. In addition to understanding the psychology behind why drug policies are as they are currently, it is valuable to also increase understanding of the psychology that can inform progressive substance use policy.

## Nature of the Study

The research objective of this thesis is to develop a deeper understanding of the psychological reasons that individuals and societies have been able to ignore clear data that drug prohibition is ineffective, and continue to support the war on drugs. Discussions of decriminalization and legalization of substances tend to be quite controversial, with most people having strong opinions despite not necessarily having a strong knowledge base. The intention behind this thesis is to find out the behavioural patterns and thought patterns that lead to this type of thinking. How do individual and social psychology combine to underpin the persistence of a failed public policy? The data being reviewed for this thesis will be analyzed in a different conceptual framework of social psychology to discover what underpins this persistence, in addition to ways we can create positive policy change using social psychology.

The methodology of this thesis will be analysis and synthesis of two social-psychological frames of reference, dissonance theory and dislocation theory. The analysis and synthesis is aimed at articulating a non-pathologizing, non-criminalizing frame of reference. A satisfactory analysis and synthesis must simultaneously provides a rigorous account of substance use as a

phenomenon; account for the "war on drugs" as a failed policy; and articulate logical steps founded on theory and data that provide possible alternatives in policy and treatment.

## Purpose of the Study

The purpose of this study is to understand the social psychology that underlies the persistence of the war on drugs, even in the face of objective failure of this policy. This thesis aims to learn how people have come to the beliefs that they have regarding drug use, drug users, and drug policy, how that influences drug policy, and why individuals tend to be highly resistant to learning about or considering views that oppose their own. Drug policy does not seem to be well informed by psychology, and this thesis aims to change that. A goal of this study is to find new connections to create a deeper understanding of the reasons for resistance to change of something that has been deeply bred into the moral ideology of society- drug prohibition.

## Scholarly Context

One of the conceptual frameworks being followed in this thesis is Bruce Alexander's concept of dislocation and the opposite of addiction being connection. His work is viewed as an example of a nuanced and scientific view on addiction, it's predisposing and precipitating factors, and policy. Another main conceptual framework is Elliot Aronson and Carol Tavris' discussions of social psychology in the book *Mistakes were Made (but not by me).* This book delves into theories such as cognitive dissonance that are of vital importance for this study. Aronson's views and explanation of dissonance theory provides a framework for how non-rational and destructive patterns endure in social contexts. Dissonance theory has been particularly powerful in providing an explanatory frame of reference for why people tend to continue to hold opinions that are unsupported by objective facts, and tend not to assimilate

certain kinds of facts. Fundamentally, dissonance theory posits that when an opinion is formed based on an attribution about a person, such as “that person takes drugs because they are weak and immoral”, contrary facts based on causes found in context, such as “that person uses illicit substances because they are socially isolated and economically oppressed” tend to have no impact. Dissonance theory predicts that when two reasonings are incompatible, such as psychological versus contextual explanations of substance use, the effect is to motivate the opinion-holder to defend their original position and to ignore or discredit the contrary opinion so as to reduce the psychological distress associated with dissonance. This thesis will, among many other things, explore how research on substance use that is dissonant with respect to the ‘war on drugs’ tends not only to be discounted, but actively rejected, in ways that dissonance theory predicts.

Drug policy is defined as “an overarching set of guidelines, policies and laws that shape the decisions that governments and other groups make about how to spend public monies, the types and levels of services to offer and the laws and criminal justice activities to be undertaken by police, courts and correctional systems” (Boyd, Carter & MacPherson, 2016, p. 2). When the method is drug prohibition, punitive measures are the main focus (Boyd, 2017). In Canada, a drug strategy approach, the four pillars, was developed in 2001. While the four pillars were prevention, treatment, harm reduction, and law enforcement, roughly three-quarters of funding was used for enforcement (VPD, 2016). Seeing someone struggling with an addiction as a criminal marginalizes the person and creates a barrier to accessing treatment and recovery (Boyd, 2017). It is also important to note the inherent racism and classism within Canada’s drug policy history, which will be expanded upon further in chapter two.

## Definitions

The following is a collection of definitions for salient terms in this literature. Many definitions are quoted from Bruce Alexander and Susan Boyd, experts in the field of addiction.

***Addiction:*** "Addiction is an intense involvement with any habit or pursuit that, in extreme cases, may become harmful to the addicted person and to society (See Oxford English Dictionary, 2010 edition, definition 1a)" (Alexander, 2012, p. 1481).

***Decriminalization:*** "...refers to the removal of criminal penalties for possession of small amounts of currently criminalized drugs. Possession would remain a criminal offence "subject to civil or administration sanctions" such as fines (Transform 2014: 83). Critics argue that prohibition-related harms would remain intact, such as illegal drug markets and organized crime. Further, they argue that drug users would remain at risk because the quality of the drugs bought would remain unknown..." (Boyd, Carter & Macpherson, 2016, additional sidebar for chapter 5).

***Dislocation:*** "Rupturing of the complex linkages that normally connect people with their societies on a local, national, and international level. These include links to family, neighborhood, church, ethnic groups, work groups, regional and national identity, identity with global humanity, and spiritual awareness. Dislocation is the absence of psychosocial integration" (Alexander, 2012, p. 1481).

***Cognitive Dissonance:*** "state of tension that occurs whenever a person holds two cognitions (ideas, attitudes, beliefs, opinions) that are psychologically inconsistent..." (Tavris & Aronson, 2015, p. 15).

***Drug Policy:*** "an overarching set of guidelines, policies and laws that shape the decisions that governments and other groups make about how to spend public monies, the types and levels

of services to offer and the laws and criminal justice activities to be undertaken by police, courts and correctional system" (Boyd, Carter & Macpherson, 2016, p. 2).

***Harm Minimization:*** "seek to improve the health and longevity of drug users even if those measures lead to an overall increase in use" (Manderson, 2011 in the drug effect, p. 225).

***Legalization:*** "refers to removing all criminal penalties for the possession of currently criminalized drugs. These drugs would be legally regulated by the state (just as alcohol and prescription drugs are). Furthermore, policies for the production, sale and taxation of some drugs such as cannabis would be enacted.." (Boyd, Carter & Macpherson, 2016, additional sidebar for chapter 5).

***Problem Drug Users:*** "people who are dependent socially, psychologically and/or physically upon a substance of substances, to the extent that they experience problems and/pr present problems to others. Most problem drug users are poly users, have been dependent for many years, and will have made numerous unsuccessful attempts to give up, or regain control of their drug use" (Buchanan & Young, 2000, p. 414).

## Assumptions, Limits, and Scope

The assumption that I am bringing into this study is that the war on drugs is an unsuccessful strategy to prevent drug use. I will be collecting data to discover patterns behind why people choose to support the war on drugs, while a large amount evidence demonstrates that this strategy has made things worse. As I am strongly against the war on drugs, I will have a preference to interpret the data in a way that supports drug decriminalization and legalization, but will keep these biases in mind as I interpret data on both sides (Wilson, 2017). This ties into the assumption in this thesis that legalization of illicit substances would be a beneficial change.

Another fact assumed is that Bruce Alexander's theory of the opposite of addiction being connection is factual and accurate. The importance of connection for a person with addiction will be treated as fact, but will not be deeply delved into with evidence in this study.

The validity of social psychology concepts such as dissonance theory, attribution theory, and bystander effect will be treated as evidence-consistent and valid. To keep this study concise, evidence will not be provided to support this but to a small extent. However, the resource list will provide opportunity for further learning of these theories.

## Significance

This study will provide a psychology view of drug policy, an area which I believe is currently lacking. "It is not generals, police officers, or criminal court judges, but rather doctors, social workers, and researchers who need to address drug-related issues" (Domostawski, 2011, p. 16). This study will provide an opportunity for social change, in which we can better understand why drug policy is how it currently is from a psychological perspective. In better understanding this, we can find ways to move forward to a more effective drug policy that will be better for society as a whole. Importantly, the conceptual dimensions that inform better drug policy, originating as they do out of social psychology, also show strong potential as heuristic for more effective treatment strategies.

A literature review will be conducted in the next chapter, expanding on the concepts mentioned above as well as bringing in additional ideas and information, to best understand the issue at hand.

## Chapter Two: Literature Review

The review utilizes a multitude of sources from various researchers to best address the research question: what are the individual and social psychology that account for the enduring failed “war on drugs”?. Internet databases were used to collect the following data, including google scholar, SFU library, and City University library. Relevant books were also used to explore this issue.

This literature review begins with a timeline of the history of drug criminalization, to understand the context in which Canada’s drug policy has been created and the viewpoints behind that. This timeline will demonstrate that this sequence of events and the social-psychological responses to drug policy lead to the present-day opioid crisis which is, arguably, a further consequence of this policy. It is important to consider that this review of Canada’s history of drug policy will be limited, as it is a vast topic with many important historical moments. Next, the history of decriminalization will be discussed. This will include the end of alcohol prohibition in North America, decriminalization in the Netherlands and Portugal and how that has impacted each country, as well as steps towards decriminalization in Canada. The next topic addressed in this review are the consequences of criminalization. This will include an in-depth discussion of the stigmatization and discrimination of drug users, how this impacts society as a whole, as well as how this stigma has come about and how it has been maintained. It will be argued that the sociopolitical, sociocultural, and socioeconomic factors that lead to a person behaving in a way that negatively impacts their lives has been disregarded in Canada’s current drug strategy, instead being punitive and stigmatizing. This brings in the previously mentioned viewpoint of Alexander and his dislocation theory. Dislocation theory will be connected to public health including social capital, racism and classism. The consequences of criminalization

will also contain a discussion of links to mental health. Ensuingly, the response to policy failure will be delved into. This section of the review will analyze Aaronson's dissonance theory and argue a connection to the maintenance of drug prohibition. Lastly, arguments currently being used against drug decriminalization will be discussed, connecting social and individual psychology to these arguments. After a thorough examination of the previously mentioned topics, policy alternatives will be explored. This includes the moral model, the disease model, and critical addiction studies. Lastly, treatments of addiction in terms of counselling methods will be analyzed. The validity of motivational interviewing for addiction will be examined, and will be linked to dissonance theory. The validity of family therapy as an effective treatment for problematic substance use will also be reviewed, and connected to dislocation theory. Throughout the literature review, social and individual psychology concepts and theories will be linked to the various topics being discussed to create a deeper understanding of the psychology behind Canada's drug policy and our views on drug use.

It is important to highlight that dislocation theory and dissonance theory, both as psychological and social conceptual frames of reference, are guides for this work. Dislocation is the lack of psychosocial integration, where links that normally connect people with society have been ruptured (Alexander, 2012). Addiction is viewed as an adaptation for the "breakdown of psychologically sustaining culture under the global influence of a free market society" (Alexander, 2012, p. 1475). Dissonance is a feeling of discomfort tense state that occurs when one holds two psychologically inconsistent cognitions (Tavris & Aronson, 2015). People relieve this dissonance by adjusting one of their cognitions to be in line with their idea, attitude, or belief (Tavris & Aronson, 2015).

For the purposes of this review, there is a focus on the historical and social unfolding of Canada's government's policy initiative, and its impact on individuals, groups, and organizations. Therefore, I have selected peer-reviewed and edited scholarly reviews and empirical summaries that are organized around substance use policy, and the historical context and consequences of the "war on drugs". When I write about the theories that, according to my thesis, respond to and explain the consequences of this policy, I have selected references from the founders and researchers of those theories, prominently Aaronson on dissonance theory and Alexander on dislocation theory. Other scholarly selections were based on their close affiliation with these theories and the empirical studies that validate them.

## Understanding Context: History of Criminalization

### Timeline of Drug Policy in Canada

Drug policy is defined as "an overarching set of guidelines, policies and laws that shape the decisions that governments and other groups make about how to spend public monies, the types and levels of services to offer and the laws and criminal justice activities to be undertaken by police, courts and correctional systems" (Boyd, Carter & MacPherson, 2016, p. 2). Drug policy decisions influence a multitude of domains, including law-making, use of military force, policing, justice, interpretation of law, and public policy domains including housing, health, social assistance, immigration, and education (Boyd et al., 2016). How drug policies are determined is usually through a process of problematization (Boyd et al., 2016). A specific issue is identified as a problem, then, depending on how the problem is portrayed, solutions are proposed (Boyd et al., 2016). For example, using illicit substances is often seen as a problem, regardless of the amount or type (Boyd et al., 2016). "People who use illegal drugs are often

portrayed in simplistic terms as either lacking personal discipline or as victims as ‘evil’ drug pushers” (Boyd et al., 2016, p. 3). Canada’s drug policies are based on the formulation of a “drug problem” (Boyd et al., 2016), rather than diagnosing drug use as a societal problem or any other possibility.

Drugs are defined as “chemical compounds that affect activity in the brain and body” (Here to Help 2013: 1, as cited in Boyd et al., 2016, p. 3). This includes prescription drugs, nicotine, alcohol, caffeine (Boyd et al., 2016), in addition to substances that have been criminalized. “There is a tendency to lump all illegal drugs together as somehow more dangerous than drugs that are available over-the-counter in pharmacies or by prescription” (Boyd et al., 2016, p. 5). For example, prescription opioids carry the risk of dependency or overdosing (Boyd et al., 2016). In the last decade, use of prescribed opioids has increased significantly, resulted in an increased demand for dependency treatment as well as increased overdoses (Boyd et al., 2016).

The following summary paragraphs of Canada’s history of criminalization and decriminalization follow closely from Boyd (2017), and so additional references, as well as page citations, will be provided as appropriate. Before Canada was colonized, Indigenous populations were virtually alcohol free. After colonization in the 1700s, alcohol was consumed for pleasure and medicinal purposes, and was embedded in Western culture. However, this began to change as moral reformers began advocating for the temperance movement. Moral reformers are “vocal individuals and groups that identify a ‘social problem’ and then propose solutions which correspond with their own priorities” (Boyd, 2017, p. 2). These reformers promoted the idea that drug prohibition will lead to lower addiction rates, drug consumption, and drug trafficking. The temperance movement was calling for the prohibition of alcohol (Black, 1884). The Protestant

Christian mission movement advocating temperance is demonstrated by a quote from the 19th century: “our day of deliverance from this most prolific source of evil seems near…” (Black, 1884, p. 6). Temperance reformers aimed to convert Indigenous peoples to the morals, religious, and values of Western Christians, including sobriety. Colonization and this movement contributed to the racialization of drug policy. The Indian Act of 1876 banned alcohol sales to Status Indians until 1955. This racist act “...encouraged covert and dangerous drinking practices, illegal consumption and selling, and discouraged social drinking” (Boyd, 2017, p. 13)

There was no categorization of illegal and legal drugs in the 18th and 19th century. Drug use has been a part of human society for thousands of years (Boyd et al., 2016). During this time, opiate-based drugs were used for medicinal purposes and were not regulated. Opiates were not seen as a social problem in Canada until Protestant ethics regarding sobriety and morality changed attitudes. Drug use became more suspect at this time, particularly when being used by foreigners. “The increased power of medical professionals, and their growing concerns about unregulated patient medicines, and colonial discourse about outsiders to white, middle-class morality also influenced this change” (Boyd, 2017, p. 27).

The opium wars in the 19th century gave Christian missionaries an opportunity to spread their ideas about opium use being evil, particularly in smoking form by non-white people. Many supporters of this movement were also part of the temperance movement. “Both movements highlighted the physical and moral decline of users and called for prohibition” (Boyd, 2017, p. 29). Christian missionaries did not believe it was possible to use a moderate amount of opium. This could be compared to today’s perspective on drug use, considering the assumption of many that legalization and heroin-assisted treatment would lead to a large increase in drug use**.** Racism continued to be a theme in Canadian drug policy, as the Chinese head tax and Chinese opium

licensing fees were put in place in the late 1800s. The media also influenced perspectives on smoking opium being something to fear. In the early 1900s, the Chinese Anti-Opium league described opium as a "social evil" that should be suppressed. In 1908, Mackenzie King met with the league and declared goals to make it impossible to manufacture opium in Canada. "In the course of three days, government policy regarding psychoactive substances effectively changed in Canada" (Boyd, 2017, p. 40). With the fear of "yellow peril" and the 1907 race riot in British Columbia intensifying the discrimination against Chinese immigrants, there was a strong fear of foreign others associating with innocent white women, thereby fuelling opium legislation. The Opium Act of 1908 was enacted in Canada (Riley & Nolin, 1998), creating a major shift in drug policy "without a shred of hard evidence to support [King's] claim that smoking opium equals harm and degradation" (Boyd, 2017, p. 43). King began drug prohibition in Canada, and was a leader in this method of drug control. In the late 19th and early 20th century, physicians advocated that addiction was in their domain of expertise (Boyd et al., 2016). As the self-proclaimed "experts" of addiction, physicians "...contributed to misinformation about addiction, especially their theory that withdrawal from drugs and continued abstinence leads to a cure for drug addiction" (Boyd et al., 2016, p. 13).

In the 19th century, cannabis was used often for medicinal purposes such as treating migraines, asthma, and ulcers, as well depression and insomnia. In 1908, Canada attempted to regulate tobacco by prohibiting the importation, manufacturing, and sale of cigarettes, but this bill was defeated and an age limit of 16 for selling cigarettes was set instead.

Coca was used in everyday medicines and drinks like Coca Cola, until "newspaper articles in Quebec depicted crazed cocaine demons and criminal enterprises trafficking the substance" (Boyd, 2017, p. 45). The media was a large influencer on views of various drugs.

There was little stigma associated with using drugs during the late 1800s and early 1900s, as drug use, including cannabis, cocaine, and opiates, was seem as a personal matter. Doctors even wrote about the benefits of these substances, and they were consumed as medicines. This changed in the early 1900s when Canada adopted a drug control system. In 1911, the Opium and Drug Act passed in Canada (Riley & Nolin, 1998). Cocaine and morphine were criminalized by this act for possession, as well as for being used for non-scientific and non-medical purposes. People became guilty until proven innocent, as police powers expanded. While tobacco and alcohol were legal for production and sale at this time, specific drugs like opium were criminalized for non-medical purposes. Narcotic convictions skyrocketed at this time, going from 342 convictions in 1908 to 1,375 in 1915. Over 3 million people have been arrested in Canada for a drug offence since prohibition began over a century ago.

During World War I, "illegal drugs were depicted as a threat to the war effort and the morality of the nation" (Boyd, 2017, p. 47). Foreign others were also connected to illegal drug use. Since the early twentieth century, how we understand substance use as a society and how we approach curbing its use has changed significantly (Boyd et al., 2016). Over the past century, "...the predominant means that many Western nations have used to curb substance use is through prohibition and criminalization, entailing the extensive use of the criminal justice system and international cooperation to detect and suppress drug trafficking" (Boyd et al., 2016, p. 1).

In the 1920s and 1930s, reefer madness took place (Stringer & Maggard, 2016). In 1921, Mackenzie King was elected as Prime Minister of Canada, and a Narcotic Division was established. "Unlike the preceding decade, these changes centralized institutional power, legal authority and law enforcement through the Narcotic Division to expand prohibition in Canada. Thus, the 'father of drug prohibition,' Mackenzie King, took the lead once again in forming

prohibitionist policy" (Boyd, 2017, p. 49). People who were addicted to drugs like morphine or heroin, which were now criminalized, were not provided drug substitution treatments, nor were government-funded drug treatment programs provided. The Narcotic Division primarily controlled addiction and drug policy, and they were strongly against drug maintenance programs. Instead, abstinence and imprisonment were advocated for by the division.

Emily Murphy was a moral reformer who largely contributed to viewpoints of addiction in the 1920s. Murphy wrote articles claiming that "every drug fiend is a liar", linked opium smoking to sexual immorality for women as well as crime, and claims that people 'addicted' to marijuana "become raving maniacs and are liable to kill or indulge in any form of violence to other persons" (Boyd, 2017, p. 53). Due to fears created by Murphy and others, the Opium and Narcotic Act was strengthened in 1922, and in 1923 marijuana was criminalized without any evidence stating it was a dangerous drug, or any debate in Parliament. The Canadian Narcotic Division expanded its power in the 1930s, claiming that drugs and drug users were threats to Canada, despite few people using illicit substances at this time. These moments in history can be used to demonstrate that our views on drug use and drug policy have been fabricated with little to no evidence, utilizing fear-mongering for people to forward their personal agendas. "Criminalized drugs are most often those substances that a variety of institutionally based groups condemned in a specific historical era..." (Boyd et al., 2016, p. 7). Another example of this is anti-marijuana morality films and articles being released during the Great Depression to distract from the failed economy and difficulties of those that are unemployed. Anslinger, the Commissioner of the U.S. Federal Bureau of Narcotics, wanted to criminalize marijuana so created exaggerated fictional stories to support prohibition, including claiming that marijuana leads to youth committing "sex attacks", crime sprees, murder, and going insane.

From 1928 to the early 1970s, The Narcotic Division maintained thorough files of people they labelled as “addicts”, “traffickers, and “doctors”, known as the addict files. Unlike people who used legal drugs such as alcohol or tobacco, people who used illegal drugs were constructed by the Division as people lacking morality. Drugs such as heroin, opium, and cocaine were still used for medicinal-purposes, however, doctors could not use these substances to treat addiction.

After World War II, fear of “criminal addicts” increased as the government focused more fully on the “drug problem”. The Royal Canadian Mounted Police were important contributors to the concept of the “criminal addict” (Boyd 2013, 2014, as cited in Boyd et al., 2016). While people whom used substances that were newly criminalized were viewed as criminals, those who suffered from alcoholism were seen as having an illness, and it being a public health problem.

> The concept of the criminal addict implied that criminal behaviour preceded addiction. Therefore, it purported that even if abstinence were achieved, these individuals would still be criminals and a risk to society. It was believed that there was no cure for the criminal addict; thus treatment, including drug substitution treatment, was unnecessary, with abstinence being the preferred goal (Boyd, 2017, p. 64).

At this time, psychiatrists claimed addiction to illicit substances to be a psychiatric disorder as well as a criminal activity. More fear-mongering movies were released in the 1940s and 1950s, with a focus on heroin use. In 1955, it became illegal to import heroin into Canada, causing there to no longer be a legal source of heroin as it was not produced locally.

During the 20th century, alcohol and tobacco were used much more than illicit substances. Attempts to criminalize alcohol failed in Canada as the commercial interest was strong, and it was highly common for consumption by Caucasian people. As alcohol could not be tied to a marginalized or racialized population, racism could not be used to create fear of this

substance. There was a brief period of alcohol prohibition in Manitoba, Nova Scotia, Alberta, and Ontario from 1916-1919 (Riley & Nolin, 1998). Alcohol prohibition led to illegal trade, increase in unregulated alcohols which could be deadly, less respect for laws, and police corruption.

How tobacco was presented in the media impacted its regulation, as it was associated with leisure and pleasure. Cigarettes were even provided to soldiers in WWI and WWII. In 2014, tobacco smoking prevalence in Canada was 15% of the population. This is the lowest rate ever recorded, which could be used to argue that legalization and regulating a substance does not increase use. “Public education, rather than criminalization, is responsible for Canada’s decreased smoking rates” (Boyd, 2017, p. 95).

The 1961 Narcotic Control Act created punitive penalties, harsher drug laws, and legal discrimination (Riley & Nolin, 1998). In the 1970s, cannabis smoking became common among white, middle-class people. The counterculture movement defied conventional notions of drug use among other topics, and led to increased rates of illegal drug use and arrests. In 1960, there were 21 arrests for cannabis possession, but in 1977, there were 50,168 arrests.

The Neoliberal movement at the end of the 20th century influenced drug policy as “neoliberals saw individuals as solely responsible for how their lives turn out” (Boyd, 2017, p. 127). This led to governments cutting social supports such as welfare, unemployment protection, and spending on education, health, and housing.

The war on drugs was first initiated in 1971 by U.S. President Richard Nixon, and Canadian politicians and law agents followed suit soon after (Boyd et al., 2016). President Reagan renewed the war on drugs in 1986 in the U.S., by signing a bill to expand law enforcement and increase punishment. As Canada is often influenced by actions in the U.S.,

Canada's Prime Minister Mulroney announced "drug abuse has become an epidemic that undermines our economic as well as our social fabric" (Boyd, 2017, p. 128) two days after Reagan's actions. This action was taken without evidence to support Mulroney's claim, as drug use was actually decreasing in the 1980s in Canada. In 1987, Mulroney created Canada's first five-year National Drug Strategy (Riley & Nolin, 1998). The dominant policy for illicit drugs in Canada remained as criminal prohibition (Riley & Nolin, 1998). By 1992, harm reduction was included in this strategy but a large portion of funds supported abstinence-based programs. Criminalizing drug users and focusing on prohibition has led to "...the costs, both financial and human, of licit drug use [to] remain unnecessarily high while the costs of criminalizing illicit drug use continue to rise, steadily, predictably and avoidably" (Riley & Nolin, 1998, p. 6).

The marijuana scare increased during the 1990s and 2000s. "With little substantial evidence, the RCMP, local police, media and moral reformers linked both licensed medical and illegal cannabis growing to racialized gangs, organized crime, violence and public safety" (Boyd, 2017, p. 150). This demonstrates again how groups of people with certain motivations can use fear to make changes in Canada without proper evidence or discussion. In the context of a panic, substantial evidence does not appear to be necessary to create opinions and change policy.

In 2001, the four pillars approach was developed in Vancouver (Boyd, Murray & MacPherson., 2017). The four pillars are prevention, treatment, harm reduction, and law enforcement (VPD, 2016). The treatment pillar was least supported due to limited implementation and lack of funds (VPD, 2016). Roughly three-quarters of the four pillars funding is used for enforcement (VPD, 2016).

While harm reduction practices became available in some countries around the globe like the Netherlands and Switzerland, a new National Anti-Drug Strategy was introduced in 2007 by

Prime Minister Stephen Harper (Cavalieri & Riley, 2012). Research findings on the benefits of these services were ignored, as Harper's strategy opposed harm reduction and supported law enforcement. "Stephen Harper, leader of Canada's former Conservative government, strongly fought against harm reduction initiatives and heroin-assisted treatments, instead waging a 10-year war as he created more discriminatory policies and punitive drug laws (Boyd et al., 2017, as cited in Wilson, 2017, p. 6).

**The Opioid Overdose Crisis**

Nowhere in British Columbia is the issue of problematic substance use more apparent to even a casual viewer that Vancouver's Downtown Eastside. Wilson (2017) states:

> The Downtown Eastside of Vancouver is currently experiencing the worst opioid overdose crisis in its history (Boyd, Murray, & MacPherson, 2017). The rise of fentanyl being cut into other drugs has been a large driver behind the steep rise in overdose deaths since 2012 (Boyd, Murray & MacPherson., 2017). The lethal dose of fentanyl is two milligrams (Vancouver Police Department, 2016). As this is such a small amount, it is impossible to know how much is in a substance that has been cut with fentanyl. Users often don't know that they're getting fentanyl, but dealers are cutting it in for greater profits. 931 people overdosed in 2016 in British Columbia (Boyd et al., 2017), but action is not being taken quickly enough to match the severity of the situation. A public health emergency was declared in April 2016 (Vancouver Police Department, 2016). A comprehensive report by the BC Centre of Disease Control found that:
>
> > While there has been an incredible amount of work and resources put into the overdose response over the last year, we still face a serious health emergency that shows no signs of slowing. The overdose crisis continues to marginalize people

> who rely on an unregulated drug market to deal with their addiction, pain, trauma, mental illness and social isolation (BCCDC, 2017, p. 5).

One large contributor to the overdose epidemic is fentanyl, a highly potent opioid that has been found to be mixed with other illegal drugs. A report by the British Columbia Coroners Service (2018), provides statistics on fentanyl-detected deaths from 2012-2018 in British Columbia. In 2017, 1,210 people died of overdose wherein fentanyl was fully or partially involved (British Columbia Coroners Service, 2018). This is nearly double the amount of 2016, with 667 fentanyl-detected overdose deaths (British Columbia Coroners Service, 2018). In 2017 and 2018, approximately 83%-84% of illicit drug overdose deaths detected fentanyl, alone or in combination with other drugs (British Columbia Coroners Service, 2018). This demonstrates well the epidemic of unregulated drugs, as many people do not know what substances they are really taking, and therefore can't properly regulate the amount they ingest. Below is a graph created by the British Columbia Coroners Service (2018), that well illustrates the urgency and danger of this epidemic:

**Fentanyl-Detected Deaths by Month, 2012-2018[3]**

| Month | 2012 | 2013 | 2014 | 2015 | 2016 | 2017 | 2018 |
|---|---|---|---|---|---|---|---|
| January | 0 | 5 | 5 | 20 | 46 | 107 | 112 |
| February | 0 | 3 | 5 | 8 | 29 | 106 | 82 |
| March | 0 | 6 | 9 | 8 | 48 | 117 | 129 |
| April | 1 | 8 | 8 | 12 | 48 | 130 | - |
| May | 1 | 3 | 8 | 8 | 37 | 112 | - |
| June | 1 | 2 | 6 | 11 | 42 | 104 | - |
| July | 0 | 1 | 3 | 14 | 41 | 107 | - |
| August | 1 | 4 | 8 | 15 | 38 | 105 | - |
| September | 1 | 2 | 9 | 15 | 43 | 76 | - |
| October | 0 | 4 | 13 | 16 | 53 | 78 | - |
| November | 4 | 6 | 6 | 12 | 111 | 90 | - |
| December | 3 | 6 | 11 | 13 | 131 | 78 | - |
| Total | 12 | 50 | 91 | 152 | 667 | 1,210 | 323 |

According to Boyd (2017), “this crisis stems from prohibition: lack of access to safe, legal, unadulterated drugs, effective opioid maintenance such as HAT [heroin-assisted treatment], stimulant programs, and safer injection and smoking sites” (p. 141).

## Understanding Context: History of Decriminalization

### Steps Forward in Canadian Drug Policy

While the movement of criminalization continued in Canada, there were some moments of opposition where the nation took steps towards a more nuanced view on drug policy and drug users.

After World War II, the treatment movement emerged as medical professionals asserted their place in the addiction field (Boyd, Carter & MacPherson., 2016). “As a result of medical influence, publicly funded drug treatment services were established from the 1960s on for people who used illegal drugs” (Boyd et al., 2016, p. 14). LSD was not illegal in the 1950s and was used in experiments to treat alcoholism and schizophrenia. These LSD trials supported the theory that “mental illness was both biological and social in origin” (Boyd, 2017, p. 78). During this time, there was also an anti-colonialism movement in Canada. Indigenous people fought against the Indian act and discriminatory laws. The 1950s were a time in which advocates in Vancouver defied drug prohibition and its punitive policies. The Narcotic Addiction Foundation of British Columbia (NAFBC) was founded in 1955, funded by the Provincial Government. The goals of this organization were research, rehabilitation, treatment, and education. NAFBC opened a community clinic and residence in 1958 which provided in-patient and outpatient services. In 1959, a 12-day methadone withdrawal program was created. Methadone programmes expanded

across Canada in the late 1980s and early 1990s, with a somewhat liberal nature (Cavalieri & Riley, 2012).

In the 1960s, the counterculture movement was an era of political and social activism. Conventional notions of politics, drug use, human rights, and other important topics were challenged. Rates of illicit substance use rose sharply during this time, despite increased criminalization and enforcement (Riley & Nolin, 1998). The 1961 Narcotic Control Act created harsh drug laws and punitive penalties, but also allowed doctors to prescribe methadone as a treatment to people dependent on narcotics. In 1969, the counterculture movement led to an increase rate of illegal drug use as well as arrests for youth. Otherwise law-abiding youth being sentenced for possession, particularly cannabis, in addition to strain on the courts, created pressure for Canada to liberalize their drug laws (Riley & Nolin, 1998). A clause was therefore added to the Narcotic Control Act which decreased penalties for possession. In 1972, judges were given the power to discharge first-time cannabis offenders, and in 1978, the National Organization for the Reform of Marijuana Laws was established. NORML argued that cannabis civil and criminal law is harmful to society in Canada as well as costly. In 1989, the International Anti-Prohibitionist League was founded. By 1992, harm reduction was included in Canada's drug strategy. However, a large portion of funds went to abstinence-based programs. By the end of the twentieth century, prohibition was being challenged as the best and only method of addressing substance use (Boyd et al., 2016).

The U.K. and the Netherlands began utilizing harm reduction practices in the 1980s. It can be argued by the literature reviewed above that a common opinion by those who oppose harm reduction is that harm reduction enables drug users and provides them with easy access to illicit substances, perpetuating addiction. However, with some education, people can learn that

this is not the case. “Harm reduction does not reject abstinence, but it is not the sole objective of services or treatment. Rather, harm reduction advocates assert that non-judgmental and practical integrated services can reduce harms” (Boyd, 2017, p. 129). From 1987-1989, the first needle exchanges opened in Canada in defiance of federal law. In 1992, the Portland Hotel Society was founded, which organized many drug policy and harm reduction events in Vancouver. 1995 was the year of the first 4/20 celebration in Vancouver. This celebration occurs annually across Canada in defiance of cannabis prohibition. In 1997, the Vancouver Area Network of Drug Users (VANDU) was established, fighting for the rights of its members and advocating for safer injection sites (Cavalieri & Riley, 2012). In the same year, a public health emergency was declared due to the large amount of illicit drug overdoses and HIV infections in British Columbia. The House of Commons recommended in 2002 to decriminalize cannabis, stating that its prohibition is a failure. Senator Pierre Claude Nolan stated that “billions of dollars have gone into law enforcement with no great effect on drug use rates and trafficking” (Boyd, 2017, p. 150).

Wilson (2017, p. 6-7) explains:

> NAOMI, the first North American Opiate Medication Initiative, was the first heroin-assistance therapy clinical trial in Canada (Boyd et al., 2017). This 2005 trial in Vancouver proved HAT to be an effective, safe treatment for those suffering from chronic heroin addiction (Boyd et al., 2017). The study resulted in improved psychological and physical health, less money spent on drugs, less use of illicit street heroin, and less criminal activity (Boyd et al., 2017). SALOME, the Study to Assess Longer-term Opioid Medication Effectiveness, was a 2011 Vancouver study that proved successful as well (Boyd et al., 2017). The study compared use of hydromorphone and

diacetylmorphine for long-term illegal opioid users (Boyd et al., 2017). However, neither of these trials had an ethical exit strategy, leaving the participants with no heroin-assisted treatment after the trial (Boyd et al., 2017). In 2011, the research participants of these trials created an organization in response to this failure, the SALOME/NAOMI Association of Patients (SNAP) (Boyd et al., 2017). SNAP advocated for change with the goal to improve the lives of those who use illicit drugs (Boyd et al., 2017).

Despite the need for more funding during this overdose crisis, health authorities and municipalities in Canada have had to continue to work without more financial support from the federal government (Boyd et al., 2017). One meeting attendee from the 2017 BC Overdose Action Exchange II stated:

> Urge the incoming government to reiterate the scale of the emergency and the impacts it has on our friends and families. These deaths are preventable and there is no one that can't be helped. Stigma. Decriminalization. Connection. Rebuilding lives. (BCCDC, 2017, p. 4).

In September of 2016, activists set up two unauthorized injection tents in the Downtown Eastside of Vancouver in response to a lack of action from the federal government (Boyd et al., 2017). The BC Ministry of Health announced a few months later that more overdose prevention sites would open in Vancouver and around BC, rather than waiting for federal approval (Boyd et al., 2017). It took until February of 2017 for the federal government to announce it has designated $10 million in health care funds to address the crisis, but it is unclear how these funds will be delegated (Boyd et al., 2017).

In 2002, a nurse-supervised injection site was opened without federal approval. The federal government ignored some of the policies of the four pillars, and it took until 2003 for Canada's first safer injection facility, Insite, to open in the Downtown Eastside (Boyd et al., 2017 as cited in Wilson, 2017). In 2003, Health Canada established a federal medical marijuana program (Boyd, 2017). In 2005, heroin-assisted treatment trials were opened in Vancouver and Montreal, and "HAT proved to be a safe and effective treatment for long-term illegal opioid users who had not benefited from conventional treatments…" (Boyd, 2017, p. 140). Prime Minister Stephen Harper introduced a new National Anti-Drug Strategy in 2007, which opposed harm reduction and supported law enforcement (Cavalieri & Riley, 2012). "Disregarding research findings on the effectiveness of the services, including the fact that not one person had died from a drug overdose at Insite…" (Boyd, 2017, p. 136), there have been multiple attempts to shut it down by the federal government (Cavalieri & Riley, 2012). Despite Harper's attempts to shut down Insite, in 2011, the Supreme Court of Canada ruled that this would be a violation of the Charter of Rights and Freedoms.

In 2010, the Vienna Declaration called for a full shift of drug policy, as well as the incorporation of scientific evidence into these policies. This declaration stated that criminalization of illicit drug use has had major consequences in health and society, in addition to increasing the HIV epidemic. In 2011, the Salome/Naomi Association of Patients (SNAP), a group of people whom had been part of the HAT trials, advocated for heroin-assisted treatment. In 2015, a second safe injection site was formally authorized in Vancouver (Boyd et al., 2017 as cited in Wilson, 2017). By 2017, there was only one clinic in Vancouver that provided heroin-assisted treatment.

In 2015, the Canadian government established a Task Force for the legalization and regulation of marijuana. In 2016, the Access Cannabis for Medical Purposes Regulations (ACMPR) allowed for a limited production of cannabis for personal use and by designated growers. As it is difficult and costly to acquire a license for a cannabis dispensary, many illegal dispensaries opened across Canada. Insite was the only authorized safer injection site in Canada in 2016, but eight other sites received approval as of May 2017. "Health Canada also announced a new process that will allow the importation and use of medications not yet authorized in Canada, such as legal heroin, to help stem the overdose crisis" (Boyd, 2017, p. 161). The Good Samaritan Drug Overdose Act was created in 2017. This act allows people to call 911 during an overdose emergency without fear of criminal charges of possession of an illegal drug. The 2018 Cannabis Act will be legalizing marijuana in Canada beginning October 17, 2018 (Government of Canada, 2018). This new framework is taking a public health approach, aiming to reduce the illegal marijuana market, protect the health and safety of the public by regulating the product, and better preventing underage people from accessing the substance (Government of Canada, 2018). This is a significant moment in Canada's drug policy history, that has been advocated for by many for decades.

**The Alcohol Prohibition Era in North America**

The influence of the temperance movement gave support to anti-alcohol groups, leading to all Canadian provinces prohibiting alcohol to some extent during the First World War (Riley & Nolin, 1998). As previously mentioned, prohibition led to many problems in Canada, including a growing illegal trade, disrespect of laws, police corruption, and an increase in unregulated alcohol products of which some were deadly. Even though alcohol was associated with more health and social related harms than criminalized drugs, in 1929, all provinces with

the exception of Prince Edward Island chose to regulate the alcohol trade, rescinding alcohol prohibition (Riley & Nolin, 1998).

As explained by Boyd (2017):

> ...Canada's history with [alcohol], the social acceptance for moderate and pleasurable use, the negative impact of prohibition, commercial interests, and people's readiness to ignore the laws in order to continue drinking during prohibition and (for some) to participate in the illegal trade, led to legal regulation, taxation and public education, rather than prohibition (p. 106).

This account of how Canada came to legalize alcohol is a strong example of the benefits of and reasons behind regulating a substance rather than fighting a battle that causes harm for everyone involved.

**Regulation in the Netherlands**

In 1976, through the Dutch Opium Act, the Netherlands implemented de facto decriminalization of cannabis possession and sale up to 30 grams. The Netherlands were able to regulate substances by distinguishing between "soft" drugs, like marijuana and hashish, and "hard" drugs (Spapens, Müller & van de Bunt, 2014). The Netherlands saw the considerable disadvantages of criminalization. As stated by van Duyne and Levi (2005), "as long as substantial customer demand for these products and services remains, criminalization creates huge illegal markets" (as cited in Spapens et al., 2014, p. 191). In addition, drug criminalization strains the criminal justice system, as there is an increased need for police, judicial authorities, and prison systems to invest their resources in this area (Spapens et al., 2014). The goals of regulating were to have customers buy from legal suppliers therefore decreasing criminals' profits and decreasing police workload, and regulating the quality of the product (Spapens et al.,

2014). The Netherlands looked at their drug policy with a public health perspective, aiming to prevent drug users from associating with dealers who also sold "hard" drugs, by providing the opportunity to buy regulated "soft" drugs without punitive risk (Spapens et al., 2014). Evaluations of the Dutch drug policy found that this goal was succeeded (Van Laar & Van Ooyen-Houben, 2009, as cited in Spapens et al., 2014).

A perspective change towards cannabis in the 1960s and 1970s led to the drug policy changes in the Netherlands (Spapens et al., 2014). "In 1969 and 1970, for example, media articles appeared that portrayed cannabis use as harmless in comparison to cocaine and heroin, and that reframed hashish and marijuana as non-addictive 'soft drugs'" (Spapens et al., 2014, p. 193). Some of the public did not believe middle class youth smoking cannabis were criminals, and that it would be unfair to imprison them and jeopardize their futures (Cohen, 1994, as cited in Spapens et al., 2014). In 1969, the Board of Procurators General stated that action would no longer be taken against soft drug possession up to 30 grams. In 1971, Hulsman, an expert in penal law, concluded that "the use of cannabis was mainly a subculture phenomenon and that moral factors rather than objective dangers had been the drivers behind its criminalization" (Leuw, 1994 as cited in Spapens et al., 2014, p. 193). In the 1970s, Dutch parliament agreed unanimously that those struggling with drug addiction should not be targets for law enforcement, but should be provided with support and treatment (Spapens et al., 2014). With a focus on harm reduction and separating the markets for soft and hard drugs, avoiding stigmatization was vital for soft drug users (Spapens et al., 2014). "Rather than seeing an inexorable psychopharmacological link between marijuana and hard drugs, the Dutch hypothesized that the gateway mechanism reflected social and economic networks, so that separating the markets would keep cannabis users out of contact with hard-drug users and sellers" (MacCoun, 2011, p.

1899). Through these policy changes, marijuana use has decreased and overall drug use appears to be declining (Staley, 1993).

In the 1970s, the first ‘coffee shops’ opened in the Netherlands (Spapens et al., 2014), which are known for selling cannabis in various forms. “The authorities found it difficult to respond to this development at first, but in the end they saw it as positive that the coffee shops now served most of the soft drug customers and had largely replaced the house dealers and street dealers” (Spapens et al., 2014, p. 194). While there was a concern for this policy impacting other countries, the level of drug tourism remained low and it was not seen as a serious problem by the Dutch (Spapens et al., 2014).

As demonstrated in the scholarship reviewed above, there is widespread opinion that is demonstrably at odds with scientific evidence, that decriminalizing drugs would lead to increased use. However, “using the most recent drug-use statistics available, cannabis rates have not increased in the Netherlands, and cannabis use is much lower there” (Boyd, 2017, p. 159). As mentioned above, a large benefit to this policy change is that customers can buy from legal providers, which will reduce drug dealers market share and their profits (Spapens et al., 2017). “...drug prohibition leads to huge profits and the creation of criminal enterprises determined to maintain those profits” (Staley, 1993, p. xvi). Regulation also allows the authorities to have better control of the product or service, and reduce risks such as exploitation and addiction (Spapens et al., 2017). Staley (1993) states that the Netherlands have successfully regulated substances by focusing on harm reduction. The Dutch emphasize treatment by providing medical and social services, making these programs accessible for drug users, promoting the social rehabilitations of people with addictions, and providing comprehensive health education (Staley, 1993). One study conducted in 2004 compared cannabis use in Amsterdam and in San Francisco,

two cities with strongly differing approaches to regulating cannabis (Csete et al., 2016). This study "showed that the partial decriminalisation of cannabis in Amsterdam was not associated with increased use of possession, and the rigorous criminalisation in San Francisco was not associated with reductions in use or possession" (Csete et al., 2016, p. 1444).

**Decriminalization in Portugal**

Portugal made a historical change in 2001 by decriminalizing the personal possession and use of all "hard" and "soft" substances (Domostawski, 2011). In 2000, 1% of the population in Portugal was addicted to heroin (Hari, 2016). A panel was created involving scientists and doctors to address the drug problem (Hari, 2016). This panel recommended decriminalizing all drugs and putting the money that was spent on enforcing prohibition towards drug treatment, secure housing, and jobs for those with addiction (Hari, 2016). This reconnected people with addiction back to society.

As stated by Wilson (2017, p. 13-14):

> Portugal is taking the money that they were using to fight the war on drugs, and instead putting that money towards harm reduction programs to reduce drug consumption (Domostawski, 2011). So much money is wasted on imprisoning drug users instead of supporting them in fighting their addictions (Domostawski, 2011). The decriminalization movement in Portugal has reduced drug consumption, recidivism, addiction, and HIV and Hepatitis infection (Domostawski, 2011). This policy change has disproven concerns of drug use increasing with decriminalization, as drug use has even fallen in some categories (Domostawski, 2011), which will help save many lives and decrease healthcare costs. "Trying to create a 'drug-free' society was an illusion that would never become reality-

like creating a society where drivers will not exceed the speed limit" (Domostawski, 2011, p. 22)

The benefits of decriminalization are clear. Organized crime can decrease, there are less overdoses due to drugs being regulated and safer as well as less diseases, users are not afraid to be punished for seeking help (Domostawski, 2011), and they are not stigmatized to the point of feeling totally dislocated from society... In Portugal in 2000, 52% (1430 people) of newly diagnosed HIV-infections were of drug users (Domostawski, 2011). In 2008, 7 years after decriminalization, only 20% (352 people) of new HIV-infections were of drug users (Domostawski, 2011). It is clear that harm reduction works and that programs like these need to be supported globally.

**Considering Global Drug Policy Changes**

A common theme in the changing of drug policy appears to be how individuals, societies, and influential leaders view particular drugs. Racism appears to be another driver, with people in different eras developing negative stereotypes against certain populations and the substances they use to create legal discrimination. For whatever reason, leaders appear, in the main, not to take into account the scientifically validated fact that drug criminalization increases crime, while the Netherlands has realized this and have opted for a public health approach to drug abuse (Staley, 1993).

When a group of people start to challenge viewpoints, they can help change how others view drug use and drug policy, and make real change. People who view decriminalization as the appropriate method for drug policy have realized that the "policy of repression would result in an endless negative spiral" (Spapens, Müller, T., & Bunt, 2014, p. 193).

The media is a large influencer on how drugs are viewed, which then influences policy. As marijuana was being used by middle-class men, it was portrayed as a leisurely pasttime, thereafter leading to less punitive measures involving this substance.

> In Canada, the categories of good and bad drugs are not fixed. Consider how the drug tobacco is framed today in comparison to fifty years ago. Although it is not illegal for adults to buy or possess legal tobacco products, recent public health efforts have inadvertently helped to stigmatize long-term useds. Or consider the ups and downs of alcohol in Canada. It has been framed as an acceptable social practice and at other times as an evil to be rooted out. Drugs were not entities with a fixed meaning: our ideas about them are framed by the era we live in (Boyd, 2017, p. 84).

## Consequences of Criminalization

### Stigmatization and Discrimination of Drug Users

As demonstrated by the review of the history of drug policy in Canada, stigmatization and discrimination have long played a role in how drug users are perceived and treated, therefore affecting drug policy. For the past century, the media and law enforcers have supported harsh, punitive drug policies as they linked drugs such as cocaine, cannabis, and heroin, and the people who use and sell these substances, to crime and violence (Boyd, 2017). This stigmatization toward drug users is a worldwide social phenomenon (Mora-Ríos, Ortega-Ortega & Medina-Mora, 2017). How drug users and particular drugs are portrayed plays a large role in the amount of support or punishment they receive. “Drug users are socially perceived as persons incapable of self-control, who are responsible for their own behaviour” (Corrigan, Kuwabara, & O’Shaughnessy, 2009, as cited in Mora-Ríos et al., 2017). As mentioned in chapter one, stigma

is defined as a "long-lasting mark of social disgrace that has a profound effect on interactions between the stigmatized and the unstigmatized" (Lloyd, 2013, p. 85). Mora-Ríos, Ortega-Ortega, & Medina-Mora (2017) explain that stigma and discrimination practices include hostile looks, judging, inappropriate comments, and mockery. Goffman's (1963) classic definition of stigma is "an attribute that discredits the individual who bears it" (as cited in Mora-Ríos et al., 2017). Drug users are often stigmatized as "junkies" with illicit substances being the main importance in their life. Society appears to fear that if drug users have access to free, safe heroin, they will only use more and drug use will increase in the general population. Determining factors of the level of stigma that is placed on a person are the extent to which they are seen as at fault for the stigma, and the perceived danger the person poses (Lloyd, 2013).

The sociological conceptualization of stigma, as demonstrated by Scheff's labelling theory for example, "largely focus[es] on the effects of labelling on the stigmatized individual" (Eaton, Ohan & Dear, 2014). This viewpoint sees a power imbalance between the "in-group", which is socially dominant, and the "out-group" (Eaton et al., 2014). The person in the "out-group" is labelled as devalued and different, and if the stigmatized person internalizes this label, it can be harmful to their wellbeing (Eaton et al., 2014). Another conceptualization is the modified labelling theory of stigma, created by Link, Struening, Cullen, Shrout, and Dohrenwend in 1989 (Eaton et al., 2014). This theory still sees social power imbalances as an important contributor to stigma, but believes stigma is more multifaceted, including not just labelling, but also separation, stereotyping, discrimination, and status loss (Link & Phelan, 2001; Tjafel & Turner, 1979 as cited in Eaton et al., 2014). "Such definitions situate stigma at a micro-level, in which one group devalues another group with whom they do not identify, and rejects them based on this differentness" (Eaton et al., 2014, p. 20). As argued by Buchanan and Young

(2000), problem drug users are experiencing isolation and detachment due to societies general disapproval of drug taking and drug users. The hostile climate that has been created due to this stigmatization makes it difficult for drug users to integrate and can leave them feeling isolated and uneasy, as it appears separate 'worlds' have been created, with little interconnection between them (Buchanan & Young, 2000).

Addiction, as a concept, is produced by the times (Fraser & Moore, 2011 as cited in Boyd, Murray & MacPherson, 2016), and is a recent invention (Reinarman & Granfield, 2015 as cited in Boyd et al., 2016). In the first half of the twentieth century, for example, the RCMP largely promoted the idea of the "criminal addict", implying that all illicit drug users are criminals (Boyd 2013, 2014 as cited in Boyd et al., 2016). "The stigmatization of drug users, the fear of police repression and the risk of criminal persecution made access to treatment much more difficult" (Domostawski, 2011, p. 4). Many people see drug users as being personally responsible for their addiction, and assume that they can make a choice to not take drugs (Lloyd, 2013). However, research evidence demonstrates that those struggling with addiction feel they are being driven to use and do not have a choice (Lloyd, 2013). "Again, research evidence seems to be out of step with public understanding" (Lloyd, 2013, p. 92).

"Addicts" tend to be lumped into one homogeneous group of people. Research demonstrates that some of the population carry assumptions that drug users would like substances to be legalized so that it is easier for them to access and less likely to endure punitive action. A study by Darke and Torok (2013) interviewed intravenous drug users regarding their opinions on legalization, decriminalization, and criminalization of illicit substances. Despite intravenous drug users being defined as a population, they did not act like one (Darke & Torok, 2013).

As stated by Wilson (2017):

> Nearly everyone supported legalization of cannabis as it was viewed as the least harmful, but legalization of heroin had the same level of support as continued prohibition (Darke & Torok, 2013). There was also little support for changing drug policy on MDMA, methamphetamine, and cocaine (Darke & Torok, 2013). ...this study [can be used to] demonstrate that one should never assume they know what a person believes in or their values based off one aspect of their life. Drug use does not define someone, but is a small part of who they are. The study concluded that drug user's expressed nuanced views on different substances, and that their opinions should be valued in debates on drug policy, and not assumed to be for legalization (Darke & Torok, 2013).

### *Stigma in treatment*

Stigma towards drug users has further been demonstrated by a qualitative study conducted to explore the stigma and addiction connected to addiction in treatment centers in Mexico city (Mora-Ríos, Ortega-Ortega, & Medina-Mora, 2017) . 35 in-depth interviews were analyzed of drug users, health care personnel, and family members, to learn about their experience with stigma related to drug use (Mora-Ríos et al., 2017). The most common forms of stigma and discrimination experienced by drug users came from family, other users, self help treatment, and people on the street, school, or at work (Mora-Ríos et al., 2017). The treatment received by these drug users led to mistrust, sadness, irritability, and importantly the internalization of stigma, including feeling guilty and ashamed, withdrawal, and fear of being singled out (Mora-Ríos et al., 2017). Family members of drug users received stigma from other family members, health care personnel, and neighbours, while health care personnel received stigma from family, the media, society, and treatment centres (Mora-Ríos et al., 2017). The

statements made by this studies participants "provide evidence of varied conditions of social and gender inequality, as well as experience of violence abuse, that refer to the structural context of discrimination surrounding addiction, and that constitute obstacles to treatment" (Mora-Ríos et al., 2017, p. 594).

Research, exemplified by von Boekel, Brouweers, van Weeghe and Garretsen (2013), have supported the general conclusion that medical personnel's negative attitudes towards drug users affects their diagnosis, treatment, and rehabilitation (as cited in Mora-Ríos et al., 2017). The burden of illness falls onto drug users and their families (Mora-Ríos et al., 2017).

Stigma not only affects drug users in treatment, but also impacts the workers providing treatment. This has been demonstrated by a literature review in which seven studies were systematically analyzed within search criteria regarding stigma experienced by people working in the alcohol and other drug (AOD) field (Eaton, Ohan, and Dear, 2014). This study found that for people who work in the alcohol and other drug field, stigma leads to high turnover, low job satisfaction, and difficulty attracting qualified workers to the field (Eaton et al., 2014). The stigma received by AOD workers also impedes occupational functioning (Eaton et al., 2014), therefore affecting the quality level of treatment drug users receive. Multiple studies analyzed in this literature review demonstrated difficulty to fill AOD worker roles with qualified candidates, with one of the main reasons being the stigma attached to these roles (Eaton et al., 2014). A study surveying 1,345 front line AOD workers stated that 73% of participants thought about quitting due to stigma (Duraisingam, Pidd, Roche and O'Connor, 2006 as cited in Eaton et al., 2014). According to Eaton, Ohan, and Dear (2014), AOD work may be seen as having a "moral taint", likely leading to these workers experiencing "dirty work" stigma. When these workers are stigmatized, the devaluation they experience impacts the individual's social identity and self

concept (Baran et al., 2012 as cited in Eaton et al., 2014). According to Gray (2010), stigma within the AOD field led to workers intentionally avoiding agencies that carried more stigma (as cited in Eaton et al., 2014). Due to these difficulties for workers supporting drug users, it is not surprising that there is a high burnout rate and that it can be difficult for drug users to receive quality, non-judgmental care. The stigma placed on AOD users negatively affects those who receive treatment. Another study found that for doctors treating patients who had contracted HIV through intravenous drug use, 14% agreed or strongly agreed that treating this population was futile, and 9% of doctors agreed that they would rather not treat this population if given the choice (Ding et al., 2005 as cited in Lloyd, 2013). HIV-positive drug users who received care from doctors with negative attitudes received significantly less exposure to antiretroviral therapy than those with doctors with a positive attitude (Ding et al., 2005 as cited in Lloyd, 2013).

### *Stigma from within the stigmatized group*

Mora-Ríos, Ortega-Ortega & Medina-Mora's (2017) study demonstrates that discrimination also comes from the stigmatized group, as there is a hierarchy between drug users. For example, steroid users view themselves as better than people addicted to heroin (Mora-Ríos et al., 2017). Such stigmatization from multiple groups leads to social exclusion (Mora-Ríos et al., 2017). Lloyd (2013) conducted a narrative literature review of 185 papers, and found that drug users stigmatize among themselves, with the main reasons being because a person is older, uses heroin, uses methadone or is on too much methadone, or is chaotic. "Stigma is being used as a mechanism… to displace acknowledgement of their own risky behaviour… by focusing on the behaviour of others - others not like them but worse in definable ways" (Simmonds & Coomber, 2009 as cited in Lloyd, 2013, p. 90).

### *Self-stigma*

Stigma that is directed towards the self occurs through the individual becoming aware of the stigmas places on them, then agreeing with them, followed by applying the stigmas to their self (Eaton, Ohan & Dear, 2014). Lloyd (2013) reports that in some cases, "felt stigma can precede and exceed any enacted stigma from others" (p. 86). Therefore, even if drug users don't directly experience the stigma, they are aware of the stereotypes and can internalize that, stigmatizing themselves. In Mora-Ríos, Ortega-Ortega & Medina-Mora's (2017) study, many drug user participants reported internalizing the negative stereotypes of addiction, and experience feelings of shame and inferiority in regards to their substance use. "Marginalized groups who are subject to individual and institutional discrimination can internalize the ascribed identity and come to believe that the discrimination is somehow warranted and justified" (Buchanan & Young, 2000, p. 415). This internalization reinforces poor self-confidence and low self-esteem for many drug users, and may lead to continued drug use to mask a sense of inadequacy (Buchanan & Young, 2000).

### *Social stigma*

Many drug users are trapped in a cycle of chronic relapse, as being continuously stigmatized and socially excluded can lead to difficulty reintegrating into the wider economic and social community, thereby hindering recovery (Buchanan & Young, 2000). This issue is well illustrated by the *Steps to Reintegration* and the *Wall of Exclusion* (Buchanan & Young, 2000). The steps to reintegration include: chaotic phase, ambivalent phase, action phase, control phase, re-orientation phase, and re-integration phase (Buchanan & Young, 2000). The wall of exclusion prevents many drug users from passing the control phase (Buchanan & Young, 2000). "...a barrier has been constructed to separate and isolate problem drug users. This discriminatory

action is legitimized and indirectly supported by a drug strategy that portrays all problem drug users as dangerous addicts and criminals, people not to be trusted or associated with" (Buchanan & Young, 2000, p. 420). While many people doubt the motivation of drug users to change, studies find that it's not a lack of motivation that is the issue, but a lack of opportunities intensified by discrimination (Buchanan & Young, 2000).

Ormston et al. (2010) found that 29% of surveyed participants agreed that most people who use heroin come from difficult backgrounds, and 45% of participants agreed that people who become addicted to heroin only have themselves to blame (as cited in Lloyd, 2013). This study demonstrates that while one may think people wouldn't agree with both of these statements, people's attitudes towards drug users is complex, and they are "able to blame users while also recognizing their damaged backgrounds" (Lloyd, 2013, p. 87). Blame appears to be a central issue, as another study demonstrates that when watching videos of people who contracted AIDS either through blood transfusion or intravenous drug use, more empathy and personal distress was reported for people who had been infected through blood transfusions (Lloyd, 2013).

### *Mental health versus drug addiction stigma*

Barry, McGinty, Pescosolido, and Goldman (2014) surveyed 709 participants, comparing attitudes about mental illness versus drug addiction. This article found that public views about people with addiction are more negative than about people with mental illness (Barry et al., 2014). The negative outlook on people with addiction translates into attitudes towards support programs (Barry et al, 2014). For example, there is less support from the public for better insurance coverage as well as increased government funding for treatment, housing, and job support for addiction than for mental health (Barry et al., 2014). "Less sympathetic views may

result at least in part from societal ambivalence about whether to regard substance abuse problems as medical conditions to be treated… or personal failings to be overcome" (Barry et al., 2014, p. 1271). People with psychiatric conditions such as anxiety and depression do not experience as much social rejection as substance users (Mora-Ríos, Ortega-Ortega & Medina-Mora, 2017). This rejection may lead to social exclusion for drug users, possibly preventing them from seeking treatment (Mora-Ríos et al., 2017).

### *Racism, classism, and sexism in drug policy*

"Throughout prohibition history, people who use illegal drugs have been framed as immoral, criminal, pathological and out of control" (Boyd, 2017, p. 4). Social status, including gender, sexuality, class, and race, largely influences how different groups interact with the criminal justice system (Boyd, Carter & MacPherson, 2016). As discussed in the review of Canadian drug policy, many of "Canada's drug laws are based on racial, class and gender prejudices and are aimed at controlling these groups of people. Drug prohibition has also been intricately tied up with colonization" (Boyd, 2017, p. 2). Ones experience with drug use as well as outcome depends on their environment and social status (Boyd, 2017).

Racism, as has been discussed, has been a major theme in Canadian drug policy. In the early 1900s, opium was associated with Chinese men, who were viewed as foreign "Others" who would corrupt moral white people (Boyd, 2017). These negative stereotypes were reactivated for drug scares and to increase support of prohibitionist policy (Boyd, 2017). An enduring stereotype was created for Indigenous people due to drug policy, leading to legal discrimination (Boyd, 2017). Thousands of people in this population were arrested and imprisoned because of alcohol prohibition policies (Boyd, 2017). In fact, drug prohibition led to the U.S. having the highest rates of incarceration in the world (Boyd, Carter & MacPherson, 2016). There is an increasing

amount of evidence that drug laws undermine some groups of people's human rights (Boyd et al., 2016).

Sexism is present in stigmatization for drug users. Women who use criminalized drugs are often viewed as more deviant than men, and as "outside these norms of proper moral and gendered female behaviour" (Boyd, 2015 as cited in Boyd et al., 2016, p. 11). This perception came from medical and social work professionals, law enforcement, and others (Boyd, 2017). Poor, Indigenous, racialized, and non-heterosexual women who use drugs are seen as dangerous to their children and society in comparison to white women and men in the middle- and upper-class (Boyd et al., 2016). Women who are stigmatized for drug use have been double or triple stigmatized, leading to social exclusion (Mora-Ríos, Ortega-Ortega & Medina-Mora, 2017). These women are perceived as abandoning gender norms and being sexually immoral (Boyd, 2017). "Women who used drugs such as heroin or cocaine were framed as immoral and unfit mothers, and child apprehension was the norm for poor and Indigenous women" (Boyd, 2017, p. 135).

### *Media influence on stigmatization*

The media is a large influencer on how individuals and societies view particular drugs and drug users. "Policies that criminalize drugs have contributed greatly to the exclusion of those who use them by promoting fear and social rejection, particularly toward young people" (Mora-Rios et al., 2017, p. 595). Some well known campaigns are "This is your face on meth", "D.A.R.E,", and "above the influence", as well as the articles and movies produced during "reefer madness". The "this is your face on meth" campaign and its effects will be discussed.

Linnemann and Wall (2013) discuss the 'this is your face on meth' campaign and its portrayal of meth users as 'white trash'. This campaign in the U.S. showed a collection of

mugshots of people before and after using meth, with the common theme of black, broken teeth and damaged, decaying skin. It illustrates "...how Faces of Meth and similar programs, further embed the individual rational conception that drug use within dominant criminal justice discourses, reaffirming the disparate racialized and classed contours of penal spectacle and abject Others" (Linnemann & Wall, 2013, p. 4). This *pedagogical policing project* supports a viewpoint in which meth users are at fault for their drug use, are socially disposable, and are ungrievable (Linnemann & Wall, 2013). This discounts the importance of economic, social, and political context, only focusing on the assumed crimes of the meth users (Linnemann & Wall, 2013).

Stigmatization against drug users causes a significant barrier to recovery and social reintegration (Lloyd, 2013). Being a drug user impacts greatly how one interacts with others, including doctors, police officers, and the public (Lloyd, 2013). "It is a status that frequently incites disgust, anger, judgement and censure in others. No wonder then that stigmatization has a profound effect on drug users: on their sense of self-worth and their ability to escape addiction" (Lloyd, 2013, p. 93).

**Dislocation Theory**

Dislocation is defined by Alexander (2012) as the:

> "rupturing of the complex linkages that normally connect people with their societies on a local, national, and international level. These include links to family, neighborhood, church, ethnic groups, work groups, regional and national identity, identity with global humanity, and spiritual awareness. Dislocation is the absence of psychosocial integration" (p. 1481).

The concept of dislocation will be delved into here, as it is important in understanding the experience of stigmatized drug users. Addiction is currently viewed in a very individualistic manner, either as an individual's disease or an individual's moral breach (Alexander, 2012). Alexander (2012) has a more nuanced viewpoint on addiction, arguing that it needs to be understood socially. He views addiction as an adaptation for people who are dealing with a "...breakdown of psychologically sustaining culture under the global influence of a free market society" (Alexander, 2012, p. 1475). Many social psychologists agree on the social causes of addiction, with Karl Polanyi being one of the founders of this new paradigm (Alexander, 2012). Vancouver is an excellent example of the spread of addiction in a globalizing planet (Alexander, 2010). People are being pushed away from close ties to family and culture and towards individualism and competition in a free-market society (Alexander, 2010). This dislocates them from social life, and many have turned to addiction to cope with this dislocation (Alexander, 2010).

Free-market society is "a social system in which virtually every aspect of human existence is embedded within unregulated, competitive markets" (Alexander, 2012, p. 1477). Free-market society can also be referred to as neoliberalism, casino capitalism, or crony capitalism (Alexander, 2012). Neoliberals views individuals as "solely responsible for how their lives turn out" (Boyd, 2017, p. 127). Due to this viewpoint, the Canadian government opted to cut funding for social supports, including education, health, welfare benefits, unemployment protection, and spending on housing (Boyd, 2017). The power of this society is held by industrial corporations, international media, multinational banks, and a small amount of highly wealthy individuals that protect and expand global markets (Alexander, 2012). Free-market society mass-

produces dislocation, which leads to people who are chronically dislocated experiencing hardships such as anxiety, depression, suicide, violence, and irresponsibility (Alexander, 2012).

Polanyi traced the evolution of modern free-market society back to the 16th century in England, and he noticed psychological externalities from the beginning (Alexander, 2012). “FMS fragments culture of every sort, breaking the social, and economic links that have traditionally given people a sense of belonging, meaning, purpose, and identity. People find long-term dislocation from cultural support unbearable” (Alexander, 2012, p. 1476). An example of this is the colonization and breakdown of aboriginal societies causing a permanent dislocation of this population (Alexander, 2012). Polanyi sees dislocation as having no class bias and can cause suffering even in rich capitalists, although dislocation does often occur alongside material poverty (Alexander, 2012). Polanyi also clarifies that dislocation refers to a lack of psychological integration, not only geographical separation (Alexander, 2012). “Neither food, nor shelter, nor the attainment of wealth can restore them to well-being. Only psychosocial integration itself can do that. In contrast to material poverty, dislocation could be called 'poverty of the spirit'” (Levine, 2009, p. 3).

Alexander (2010) states that there is extensive evidence throughout history that proves that dislocation is connected to the spread of free-market society, and addiction is connected to the spread of dislocation. There is a cycle of addiction and dislocation that makes it difficult to bring addiction under control (Alexander, 2012). People continue to become dislocated in free-market societies, which can lead to adaptation through addiction, consequently, an increased amount of addiction leads to an increase in societies addiction, as people who suffer from addiction may damage their communities and families (Alexander, 2012). This cycle is well illustrated through Alexander’s (2012) figure 1. A Dislocation View of Addiction (p. 1477):

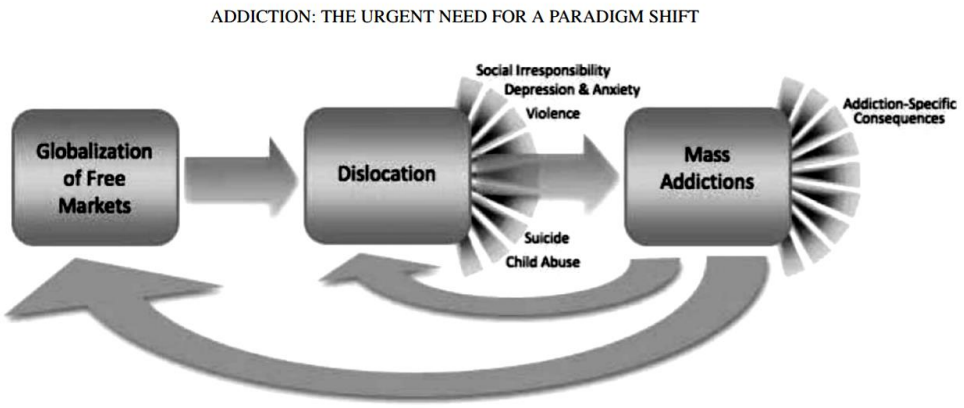


FIGURE 1. A Dislocation View of Addiction.

"Addiction is an individual and social response to 'dislocation' - especially severe social, economic, and cultural dislocation" (Levine, 2009, p. 3). Alexander sees the opposite of dislocation as "psychosocial integration" (Levine, 2009). Psychosocial integration is defined by Erikson as a "complex interdependence of individuals and their societies" (Alexander, 2012, p. 1478). This integration gives people a sense of belonging and creates a sense of individual identity (Alexander, 2012). This is well illustrated by Alexander Beyerstein, Coambs, and Hadaway's 'Rat Park' experiment in the late 1970s (Alexander, 2010). Two environments were created- one with rats in individual cages with nothing but two drinking bottles, one with water and one with morphine (Alexander, 2010). The second environment, rat park, was created as a natural environment for a group of rats with lots of space and things for the rats to play with (Alexander, 2010). The morphine was at the end of a tunnel that could only fit one rat in this environment (Alexander, 2010). The rats who lived in isolation had much more desire for morphine than the rats in rat park, with consumption being almost 20 times as much in some conditions (Alexander, 2010). This demonstrates how people who are psychosocially integrated are able to resist opioids, and if they use recreationally or medically, they rarely become addicted

(Alexander, 2010). Psychosocial integration is a major factor in ones relationships with drugs, and this factor is no different for rats (Alexander, 2010).

As discussed, many people see those with addiction as only having themselves to blame, and that they are making a deliberate choice to use drugs. This can be connected to the idea of free-market society, as people in modern business need to think for themselves, and this level of individualism cannot be accomplished if one is distracted by loyalty to family, friends, customs, or religion (Alexander, 2012). This level of individualism leads to feeling disconnected from others, and feelings of loneliness often are compensated for with various addictions, whether that be drugs, shopping, gambling, or power. This sustained dislocation can be unbearable, and "the human psyche is anything but self-sufficient" (Alexander, 2012, p. 1478). People who experienced dislocation desperately try to "find themselves", and those who are not successful adapt by finding substitutes for psychosocial integration (Alexander, 2012). People who adopt "substitute lifestyles" are labelled and stigmatized, with names such as junkie, religious zealot, workaholic, or anorexic (Alexander, 2012). The harms of labelling are well illustrated by Buchanan and Young (2000), as in a study of 200 illicit drug users:

> Many recognized the low status they were ascribed as a 'smackhead' and were acutely aware of the negative stereotypical roles attributed to them: 'They see me as a drug addict, a smackhead and they think I'd rob them'. Such was the degree of isolation (perhaps initially self-imposed because of its illegal nature), but which was now so severe and long lasting, that many now felt uneasy or even unable to cope in the company of non-drug users (p. 415).

"Addiction is neither a disease nor a moral failure, but a narrowly focused lifestyle that people may use to compensate for inadequate psychosocial integration" (Alexander, 2012, p.

1479). Addiction is harmful to the addicted individual and to society, and only provides a partial compensation for dislocation (Alexander, 2012). Alexander (2012) does not see addiction to drugs as any different to the adaptive value of any other addiction. Everyone has addictions of one kind or another, but some are judged more harshly than others, like taking illicit drugs. Individuals cling to their addictions, often denying the harm that follows as it is their best substitute they can achieve to compensate for dislocation (Alexander, 2012). "A reasonable conclusion after more than a century of futile searching is that hidden, individual causes of addiction play a relatively minor role" (Alexander, 2012, p. 1480). In short, Alexander does not believe addiction stems only from medical or moral individualistic reasons, but from society. Alexander (2012) does not disregard the individual factors that can lead to addiction like trauma, genes, or brain damage, but states that psychosocial factors should be in the foreground as powerful determinants.

**The Impact of the War on Drugs**

As stated by Wilson (2017, p. 6):

> Many across the world see the "war on drugs" as failed, and believe it's time to discuss new methods to address the issue (Domostawski, 2011). When we punish drug users, we are fighting the patients instead of the disease (Domostawski, 2011). The war on drugs has made us view drug users as criminals; as bad people. We see drug users are choosing to be addicted and that they don't deserve the support systems that others with health problems receive. For example, we support programs for alcoholics and see it as positive when someone seeks treatment for alcoholism, because alcohol is legal and widely accepted. Because we've been socially conditioned to associate illicit drugs with bad people, we are judgmental of those who use it and look down on them rather than

offering a helping hand. Stephen Harper, leader of Canada's former Conservative government, strongly fought against harm reduction initiatives and heroin-assisted treatments, instead waging a 10-year war as he created more discriminatory policies and punitive drug laws (Boyd et al., 2017).

The messages communicated by the war on drugs create a divide between illicit drug users and the rest of society, and there are many divides beyond this. The portrayal of drug users and particular drugs over the past century in Canada has led to deeply embedded opinions in our society that lead to discrimination and negative outlooks on 'addicts'. This contributes to stigmatization and dislocation, creating a fracture in society. "...thousands of otherwise 'law abiding' citizens are criminalized for recreationally using 'soft' drugs, while problem drug users, who tend to be dependent on 'hard' drugs such as cocaine and heroin, are stigmatized and kept isolated within drug sub-cultures" (Buchanan & Young, 2000, p. 419). The stigmatization and rejection from society of drug users comes from the general population, the government, law enforcement, other drug users, and drug users stigmatizing themselves. This stigmatization dislocates people, as they feel ashamed and unwanted due to their addiction, leading them to isolate themselves further. This divide of 'us' and 'them' is preventing psychosocial integration, as we don't see drug users as possibly having other qualities that are similar to us, but as a completely separate type of person, with drugs being the primary importance in their lives. Therefore, the war on drugs have been a major driver behind the stigmatization of drug users, as well as their dislocation, which has in turn worsened the spread of addiction.

## Response to Policy Failure

Arguably, the war on drugs is an objective failure based on three robust and consistent empirical findings: (a) where the war on drugs is prosecuted, crime and substance use increase,

(b) societal responses that treat substance use as criminality or pathology are generally ineffective, and (c) in jurisdictions where simple possession of substances is decriminalized, a host of positive social and psychological outcomes are routinely observed. Yet, prohibition has continued to be the method for drug control in Canada for over a century. This brings into question how policy makers and influencers are able to ignore vast amounts of evidence that what they are doing is not helpful, and is in fact harmful. The social psychology behind this resistance to change will be explored, along with arguments against decriminalization discussed and dissonance connected to these arguments.

The following is a review of the social and individual psychology that influences how people think and behave, and how these influences impact Canada's drug policy. The theory of cognitive dissonance will be explained, along with the behaviours it drives such as self-justification and confirmation bias. The facts reviewed regarding dissonance theory will be expanded upon by providing examples of moments in Canada's drug policy history that have demonstrated cognitive dissonance. This review of policy failure will be concluded with arguments against decriminalization of substances, with psychological theories being tied to these arguments as well. The purpose of this section of the literature review is to argue and demonstrate that dissonance theory accounts for the paradoxical response to Canadian drug policy by advocating for a failed policy.

It should be noted that for the following discussions of dissonance theory and dislocation theory, these theories were selected on the basis of my thesis. These theories arguably account for the dynamics of the war on drugs, as well as to have explanatory power with respect to treatment efficacy.

**Dissonance Theory**

Cognitive dissonance is an unpleasant feeling or "state of tension that occurs whenever a person holds two cognitions (ideas, attitudes, beliefs, opinions) that are psychologically inconsistent..." (Tavris & Aronson, 2015, p. 15). This discomfort ranges in how distressing it is depending on the inner conflict, regardless, people feel uncomfortable until they find a way to reduce the dissonance (Tavris & Aronson, 2015). Cognitive dissonance was a theory created by Festinger, and the theory was studied and expanded by Festinger and Aronson at Stanford University in 1956 (Tavris & Aronson, 2015). Festinger's dissonance theory explores "...how people strive to make sense out of contradictory ideas and lead lives that are, at least in their own minds, consistent and meaningful" (Tavris & Aronson, 2015, p. 16). These psychological mechanisms are hardwired into our being, and protect individual's self-esteem, tribal affiliations, and certainties (Tavris & Aronson, 2015). As human beings, we do not process information logically (Tavris & Aronson, 2015).

Behaviourisms theory of actions being governed by rewards and punishments has been challenged by cognitive dissonance theory (Tavris & Aronson, 2015). This behaviourist theory gathered evidentiary support from studies involving lab animals. However, the human mind is more complex than that of a rat or a puppy, so this theory isn't necessarily transferable to human behaviour. Many people assume that a punitive drug policy will deter people from using illicit drugs. However, dissonance theory has shown that "...our behaviour transcends the effects of rewards and punishments and often contradicts them" (Tavris & Aronson, 2015, p. 18). Therefore, under the viewpoint of dissonance theory, sending someone to jail for using drugs will not necessarily deter them from future use. As many can observe, those who are punished for drug use are highly likely to 'reoffend'.

Despite vast evidence that drug prohibition has not been successful, policy makers have been able to continue focusing on punitive measures for drug use, while not delegating enough funding to social assistance programs. A policy maker or enforcer may be resistant to admitting that drug prohibition has been a failure due to cognitive dissonance. In fact, Tavris and Aronson (2015) state that the more famous and self-confident experts are, the less likely they are to admit their mistakes. For example, people who influence drug policy will likely impulsively deny any mistake when challenged, in order to protect their job, reputation, and colleagues (Tavris & Aronson, 2015). Dissonance would also threaten an individual's internal perception, as one may see themselves as capable at what they do, but when what they do is questioned, they can feel threatened and need to defend their actions, even if there is evidence to the contrary (Tavris & Aronson, 2015).

### *Self-justification*

Cognitive dissonance is "the engine that drives self-justification" (Tavris & Aronson, 2015, p. 15). Many people, when confronted with evidence that they are wrong, choose to justify their belief tenaciously rather than adjust their point of view or course of action (Tavris & Aronson, 2015). Everyone holds the capability to follow beliefs we know to be false, and when proved wrong, to twist the facts until we feel we have been proven right (Tavris & Aronson, 2015).

Self-justification occurs when people lie to themselves that they did the best they could, or that what they did was the right thing to do (Tavris & Aronson, 2015). People tell themselves these lies to help avoid admitting that they ever make bad decisions or mistakes (Tavris & Aronson, 2015). Self-justification may stand in the way of even seeing our mistakes, leaving no chance of correcting them (Tavris & Aronson, 2015). Tavris and Aronson (2015) explain:

> It distorts reality, keeping us from getting all the information we need and assessing issues clearly. It prolongs and widens riffs between lovers, friends, and nations. It keeps us from letting go of unhealthy habits. It permits the guilty to avoid taking responsibility for their deeds. And it keeps many professionals from changing outdated attitudes and procedures that can harm the public (p. 12).

A popular form of self-justification is minimizing ethical violations (Tavris & Aronson, 2015). An example of this could be allowing drug users to die unnecessarily from unregulated, illicit substances. One would face discomfort if they faced the fact that drug prohibition is causing overdoses, and may justify prohibition by arguing that drug users are at fault for 'choosing' to use drugs, or that decriminalization would lead to an increase in drug use.

There is also the matter of pride, in that we have do some things subconsciously, and in the aftermath may have no idea why we are clinging onto a belief but are too proud to admit this (Tavris & Aronson, 2015). In addition, when someone is unsure about a decision they have to make, and there are pros and cons to each, the decision maker will feel a strong pressure to justify their choice (Tavris & Aronson, 2015). Tavris and Aronson illustrate this well:

> Often, when standing at the top of the pyramid, we are faced not with a black-or-white, go-or-no-go decision but with gray choices whose consequences are shrouded. The first steps along the path are morally ambiguous, and the right decision is not always clear. We make an early, apparently inconsequential decision, and then we justify it to reduce the ambiguity of the choice. This starts as a process of entrapment -- action, justification, further action -- that increases our intensity and commitment and may end up taking us far from our original intentions or principles (p. 45).

The war on drugs could be argued to be a strong example of this process. Apparently inconsequential decisions are made, as one substance after another is prohibited, and stereotypes are created through propaganda. Albeit, there is often a religious or racial motivation behind these decisions in drug policy. Justifications had to be made for these decisions, such as reefer madness to justify prohibiting marijuana, despite a lack of evidence to support this movement (Boyd, 2017). Now, a century since prohibition began, Canada is entrapped in taking punitive actions in drug policy, and justifying their decisions. For example, Stephen Harper lobbied against harm reduction sites despite their success in Vancouver. Propaganda by Harper influenced Canadian society's viewpoint on drug users and drug policy, as he portrayed them as dangerous criminals (Boyd, 2017), and this helped Harper justify his actions.

### *Confirmation bias*

Confirmation bias is another powerful example of dissonance theory. Confirmation bias occurs when someone is faced with disconfirming evidence, and they find a way to distort, dismiss, or criticize the information so that they can continue without adjusting their current belief (Tavris & Aronson, 2015). Individual's may also selectively ignore and take in certain information that will reaffirm their beliefs (Tavris & Aronson, 2015). Tavris and Aronson (2015) explain that confirmation bias is especially present in political observation, as individuals only see the positive attributes of their side, and the negative attributes of others. Our biases have been demonstrated by neuroscientists to be built into our brains wiring, in how we process information (Tavris & Aronson, 2015). One study demonstrated this well, by doing fMRI scans while people attempted to process conflicting or dissonant information about one of two political candidates-Bush and Kerry (Tavris & Aronson, 2015). This study found that "...the reasoning areas of the brain virtually shut down when participants were confronted with dissonant information, and the

emotion circuits of the brain were activated when consonance was restored" (Tavris & Aronson, 2015, p. 25). This demonstrates why it can be challenging to change one's mind once it is made up, as there is a neurological basis under these decisions. This could be argued as one of the driving forces behind some peoples refusal to consider decriminalization or legalization of substances. When individuals hear the term 'legalize', the reasoning portion of their brains may 'shut down', and the information against their beliefs will not be considered or processed. Subconsciously, people may be choosing to be ignorant to evidence that support beliefs that go against their owns, because it would cause dissonance. One's viewpoint can be even more solidified by reading information that goes against their beliefs (Tavris & Aronson, 2015).

> 'Whereas criminalization fails to stop people from using and selling illegal drugs, police and others sometimes claim that policy makers have failed to provide sufficient public resources to support police, courts and prisons (Boyd & Carter, 2014)'. Thus, they argue that harsher laws, longer prison sentences and more policing resources will lower drug use rates and drug production and trafficking (as cited in Boyd, Carter & MacPherson, 2016, p. 12).

This is a strong example of confirmation bias, as police and others are claiming that criminalization has been unsuccessful, not because the policy is wrong, but because they don't have enough funding to enforce it. For the people who worked to support drug prohibition, it would be very uncomfortable for them to accept what they had dedicated their time and money to had been a total failure. It is more comfortable to dismiss the possibility that decriminalization is a better option, to ensure their sense of self and beliefs are protected.

This reaction may also be due to sunk costs or the power of irrevocability (Tavris & Aronson, 2015). When a decision is made that cannot be changed, the power or irrevocability

leads people to confidently stand by their decision to reduce dissonance (Tavris & Aronson, 2015). “The more costly a decision in terms of time, money, effort, or inconvenience, and the more irrevocable its consequences, the greater the dissonance and the greater the need to reduce it by overemphasizing the good things about the choice made” (Tavris & Aronson, 2015, p. 29). Sunk costs is a similar concept, in which people are reluctant to accept that the things they have invested time or money into have been a mistake, and instead continue to throw money after bad decisions “...in hopes of recouping those losses and justifying their original decision” (Tavris & Aronson, 2015, p. 29). Drug prohibition has been an extremely expensive failure, with a century of effort put in and a large amount of effort around the world (Boyd, 2017).

Another way to reduce dissonance is blaming the victim (Tavris & Aronson, 2015). When an individual behaves in a way that negatively impacts or harms another person, they may experience dissonance. In order to reduce this dissonance, this person will attempt to convince themselves that the victim is not a good person (Tavris & Aronson, 2015). For example, a policy maker may experience dissonance when they face evidence that drug criminalization has contributed to a sharp rise in overdose deaths. This person can either look at themselves as to blame for this, or they can look at the drug users as criminals who ‘chose’ to do drugs, and ‘deserved’ whatever consequences occurred from that. If they blame the drug user, they do not need to question themselves or their beliefs, and consonance is restored.

**Arguments Against Decriminalization**

The following literature on arguments against decriminalization follows closely from Boyd, Carter, and MacPherson, 2016, and additional references, as well as page citations, will be provided as appropriate. Boyd et al. (2016) argue that “social problems, such as the ‘drug problem’ are socially constructed” (p. 6). A social constructionist analysis conducted by Boyd et

al. (2016) highlights the influencers who shape how we understand drugs, as a social problem. These institutionally based claim-makers include politicians, researchers, physicians, and the police. These individuals can influence how the "drug problem" is defined, and subsequently offer solutions to the problem as they define it, which aligns with the priorities of their institutions. Various media sources are also influential claim-makers, such as websites, TV, social media, newspapers, and the radio.

"How we understand what a drug is and how it affects people are products of cultural and social systems that shape the meaning and experience of a substance" (Conrad & Barker, 2010 as cited in Boyd et al., 2016, p. 7). Therefore, our opinions on substances, whether we think they're good or bad, are more likely to be biased claims made about that substance throughout history rather than on actual facts regarding social or health harms. Many socially constructed ideas regarding illicit substances have been organized into laws, which in turn govern how people in Canada may use and access these drugs.

Bacchi, a researcher of drug policy in Australia, explains that there is typically a set of binary ideas that guide drug policies, such as moral/immoral, addicted/non-addicted, legal/illegal drugs, and good/bad drugs. Policy makers often frame the war on drugs as being a war mainly against drug traffickers. When the "drug problem" is framed as being an issue of supply, there is an assumption that the solution is to reduce supply. "...this approach completely ignores both the reasons why people use substances and the harms that stem from prohibition itself" (Boyd et al., 2016, p. 10). Bacchi argues that these policies give shape to problems, but don't address them. The language of drug policy can be a large contributor to the problems that are produced. In fact, Boyd et al. (2016) argue that Canada's drug policies are central to and give shape to the problem of illegal drugs.

It is argued by some sociologists that no act is inherently deviant, but that specific behaviours are labelled as criminal due to the influencers that shape certain problems. An interplay between politics, social phenomena, and laws that influence what constitutes "deviancy" and our theories of why crime occurs. Addiction is a recent invention (Reinarman & Granfield, 2015 as cited in Boyd et al., 2016) and is produced by the times (Fraser & Moore, 2011 as cited in Boyd et al., 2016). How we view addiction, substances, drug users, and drug policy is socially constructed through a complex interplay of various sources with ulterior motives.

One of the common arguments against drug decriminalization is a fear that drug use rates will rapidly increase if punitive drug policies are not in place (Boyd, 2017). However, recent history has demonstrated that this assumption is inaccurate (Boyd, 2017), such as in Portugal. Wilson (2017, p. 10-11) discusses some researchers arguments against drug decriminalization:

> Darke and Farrell (2014) researched if changing the legal status of opioids would reduce overdose mortality and morbidity. Some of the main arguments for heroin legalization are that it could then be safer due to impurities being avoided and dose and strength being regulated. Darke and Farrell (2014) refer to studies that have found little to no relationship between heroin purity and heroin overdose. They say that tolerance does not have a clear connection to overdose, as most overdoses are by long-term, dependent, daily injecting drug-users, not the young new users who would have a lower tolerance (Darke & Farrell, 2014). They argue that overdoses are due to concomitant drug use, not drug purity (Darke & Farrell, 2014). "Known dose and purity do not protect and any such provision, we argue, would not reduce overdose rates, but actually increase rates due to wider availability and more widespread, unsupervised use of these drugs" (Darke &

Farrell, 2014, p. 1241). The researchers conclude that any support of legalization is based on false assumptions (Darke & Farrell, 2014).

Trafton and Olivia (2014) argue that there are legislative policies besides legalization that can better reduce overdoses, such as the good Samaritan 911 laws and Overdose Education and Naloxone Distribution programs. While these programs are helpful, I do not believe they are even close to sufficient. Trafton and Olivia (2014) claim that "targeted legislative approaches, along with public health and health-care system efforts to improve overdose recognition and response, show far greater promise for reducing overdose mortality than heroin legalization" (p. 1243).

The possibility of bias and cognitive dissonance dictating the outlook of these arguments should be considered. Darke and Farrell's (2014) study was funded by Australian drug control officials and the American organization National Institute of Drug Abuse (NIDA).

In addition, some individuals view drug users as being to blame for their addiction, and see drug users and drug distributors only as criminals. This outlook may encourage the idea of once a criminal, always a criminal. A pattern could be assumed that drug users would 'take advantage' of decriminalization to commit more crimes and that law enforcement would lose control over this population.

## Policy Alternatives

Three theories about drug use and addiction will be discussed- the moral model, the medical model, and the critical addiction studies model. These models discuss why people use drugs, and why this use translates into dependency (Boyd, Carter & MacPherson, 2016). Currently, the dominant viewpoint is that addiction is either an individual moral breach, or an individual disease (Alexander, 2012). These viewpoints are labelled as the moral model and the

medical model (Alexander, 2012). These individually oriented paradigms have arguably failed (Alexander, 2012). However, this paradigm is supported by NIDA, the mainstream media, governments, and many addiction professionals (American Society of Addiction Medicine, 2012; Hoffman & Froemke, 2007 as cited in Alexander, 2012).

**Moral Model**

The model model believes that "all illegal drug use is bad and using drugs to alter one's perceptions is the result of poor decision making and lack of person discipline" (Boyd Carter & MacPherson, 2016, p. 11). Since illicit drug use is viewed as a choice and a bad habit, this model encourages punitive measures to decrease drug use (Boyd et al., 2016). Punishment and abstinence are viewed as the cure for the personal failures of drug users (Boyd et al., 2016).

The punishment encouraged by the moral model can be argued to be ineffective as history has demonstrated that punitive measures does not stop people from using drugs. This was seen during the alcohol prohibition era, in which consumption continued and became more dangerous, an underground criminal system began, and disrespect for the law increased (Boyd et al., 2016).

The moral model also led to marginalization and discrimination against drug users (Boyd et al., 2016). Many assume that drug use and criminality have an inevitable relationship (Boyd et al., 2016). Illicit drug users have to obtain substances illegally, so they are quickly labelled as criminals. This model supports the notion that "drugs all by themselves pose public safety threats to communities, individuals and nations" (Boyd et al., 2016, p. 12). Drug users fear being judged as criminals and being discriminated against, so often avoid seeking support for their drug use (Boyd et al., 2016). This leads to unnecessary harmful social and health outcomes (Boyd et al., 2016).

**Medical Model**

The medical model, also known as the disease model or NIDA model, is justified by neuroscience (Alexander, 2012). “The origins of drug dependency lie in the biological and neurological processes of the body and brain, rather than in the failures of the soul” (Boyd et al., 2012, p. 12). However, the underlying ideas of it don’t come from neuroscience, but from the temperance movement (Alexander, 2010, 2011 as cited in Alexander, 2012). As the medical model views addiction as a biological issue, it is seen as a progressive and permanent disease, with relapse being a normal part of recovery (Boyd, Carter & MacPherson, 2016). There is a decline in the use of the disease metaphor for drug addiction, but this viewpoint still has a strong presence in some treatment communities (Sanders, 1998).

This model has existed since the 18th century, and became more prominent in the 20th century. “Particularly in North America there exists a tendency to medicalise certain social problems, such as substance misuse, locating the origins of this concern within the person’s biochemistry” (Hubbard & Wald, 1993 as cited in Sanders, 1998, p. 144). In the late 19th and early 20th century, physicians were advocating that the field of addiction was their domain of expertise (Boyd et al., 2016). This excluded traditional healers and other new professions from the field (Boyd et al., 2016). “Physicians also contributed to the misinformation about addiction, especially their theory that withdrawal from drugs and continued abstinence leads to a cure for drug addiction (Boyd et al., 2016, p. 13).

Framing addiction as a ‘disease’ helped blame be shifted from the drug user, instead having society view those with drug addiction as people who deserve treatment (Boyd et al., 2016). However, this model also detaches the brain from social contexts in which the body and brain develop (Boyd et al., 2016). “Research has not illustrated conclusively that there is a

genetic basis for drug addiction, nor have the biological determinants been conclusively defined (Boyd et al., 2016, p. 13). While relapse is common and viewed as a part of the process to recovery in this model, a disease label can be a trap as it is challenging to overcome such a label once placed on an individual (Boyd et al., 2016). The medical model takes away human agency as it prevents drug users from understanding their addiction in any other way than as a disease (Boyd et al., 2016). Social and cultural contexts of addiction are not considered in this model (Boyd et al., 2016). It is more difficult to establish harm reduction support under this model, because it is portrayed as 'enabling' drug users and worsening their addiction (Boyd et al., 2016). "How can punishment be effective if addiction is a health concern characterized as a permanent biological disease and relapse is integral to the disease?" (Boyd et al., 2016, p. 14).

**Critical Addiction Studies**

Reinarman and Granfield developed critical addiction studies, which provides a multi-disciplinary, holistic approach through sociological analysis of addiction (Boyd, Carter & MacPherson., 2016). "A critical perspective acknowledges that illegal drug use is also mediated by race, class, gender and the law. Thus, not all drug use is viewed equally, nor are the consequences of drug use experienced equally" (Boyd et al., 2016, p. 15). This model argues that drug use can be influenced by a multitude of factors, including biological processes, individual traits, and key issues in the social environment (Boyd et al., 2016). Sanders (1998) explains that "social problems such as substance misuse, often occur within the matrix of a sociocultural context from which the person's experience cannot be divorced, or decontextualized" (p. 147).

This viewpoint supports the notion that there are a variety of reasons people use drugs, and there are a variety of outcomes of drug use (Boyd et al., 2016). Drug use, legal and illegal, can have spiritual, social, mental, physical, and emotional benefits (Boyd et al., 2016). This

model aims to normalize some drug consumption, viewing drug use as possibly pleasurable, and as a popular cultural practice (Boyd et al., 2016). “Popular culture representations of illegal drug use has moved from the sub-cultural to the mainstream” (Boyd et al., 2016, p. 15). This model differs greatly from the medical or moral model of addiction that views use of illegal drugs as criminal or problematic (Boyd et al., 2016).

While this model states that all drugs carry risks, it explains that the level of risk depends on the dosage, history of other drug use, and context of use, among other factors (Boyd et al., 2016). Most people that use drugs don’t experience significant problems (Reinarman & Granfield, 2015 as cited in Boyd et al., 2016). Some individuals do develop drug problems, but others may experience benefits (Reinarman & Granfield, 2015 as cited in Boyd et al., 2016). Boyd et al (2016, p. 16) state:

> ...harms and benefits of drug use can be compounded and in some cases wholly created by drug policy. The unique pharmacology of any drug is only part of the story. As the principles of critical addiction studies suggest, a user’s mindset and the environment of use also shape the effects of drugs; drug policies and drug laws are key components that also shape the environment of use. Social factors like homelessness, imprisonment, and encounters with law enforcement have been found to exacerbate the harms of drug use.

## Counselling Treatments for Addiction

### Motivational Interviewing

The treatment approach of motivational interviewing (MI) has been used widely as a tobacco dependence intervention, and is recommended in clinical practice guidelines (Hettema & Henricks, 2010). MI uses common therapeutic methods such as supporting self-efficacy and

being empathetic, as well as unique methods such as evoking change talk (Glynn & Moyers, 2009). Motivation to change substance use is seen as a fluctuating and dynamic state (Malat, Morrow & Stewart, 2011). Colby et al. conducted the first MI trial for smoking cessation in 1998 (Hettema & Henricks, 2010). MI is different to a traditional behavioural intervention for smoking, which typically focus on information provision, skill building, and advice giving (Fiore et al., 2008 as cited in Hettema & Henricks, 2010). "Instead of trying to convince individuals of the need to change or insert motivation or skills, MI holds the implicit assumption that clients have inherent motivation and ability to engage in positive change and consequently discourages the use of direct persuasion and unsolicited advice" (Rollnick & Miller, 1995 as cited in Hettema & Henricks, 2010, p. 868). MI consists of direct and client-centered strategies (Miller & Rollnick, 2002 as cited in Hettema & Henricks, 2010), focusing on supporting clients in resolving ambivalence (Glynn & Moyers, 2009). It also "encourages the active and strategic elicitation of intrinsic motivations to change" (Amrhein, Miller, Yahne, Palmer, & Fulcher, 2003; Moyers, Miller, & Hendrickson, 2005 as cited in Hettema & Hendricks, 2010, p. 868). Motivation is seen as a transactional and interpersonal process (Malat et al., 2011). MI targets motivation, which is a precursor for beginning and progression of behavioural change (Hettema & Hendricks, 2010). "MI has been widely applied to a range of problem behaviors and has demonstrated efficacy in treating alcoholism, substance abuse, medication compliance, diet and exercise, safe sex practices, and treatment engagement" (Hettema et al., 2005 as cited in Hettema & Hendricks, 2010, p. 869). Confrontational or prescriptive approaches are avoided (Prochaska & Norcross, 2001 as cited in Malat et al., 2011). "Instead, patients are gently guided through selective reflective listening to develop discrepancy between their substance use and other values and goals" (Malat et al., 2011, p. 560). MI aims to elicit 'change talk', which involved self-

motivational statements (Malat et al., 2011). This includes ‘recognizing the disadvantages of the status quo’, ‘recognizing the advantages of change’, ‘expressed optimism through change’, and ‘expressing either a direct or implicit intention to change’ (Malat et al., 2011). Once this change talk has occurred, the therapist supports the client in setting goals and committing concretely to change (Malat et al., 2011). Motivational Interviewing has had a far-reaching impact on addiction treatment (Malat et al., 2011), with empirical support of this (Glynn & Moyers, 2009). MI aims to help evoke change talk, allow counsellors to avoid resistance, and create long lasting behavioural change (Glynn & Moyers, 2009).

Hettema and Hendricks (2010) conducted a comprehensive meta-analysis of motivational interviewing for smoking cessation, through 31 controlled trials with an abstinence outcome variable. 23 groups were nonpregnant, 8 groups were pregnant (Hettema & Hendricks, 2010). This study found that MI generally performs better or as well as other conditions for tobacco dependence treatments (Hettema & Hendricks, 2010). Effects were greater among nonpregnant groups (Hettema & Hendricks, 2010). The results may demonstrate a small effect size for smoking intervention, but this can make a large impact at the population level, considering the large amount of people that are addicted to tobacco (Hettema & Hendricks, 2010).

Malat, Morrow and Stewart (2011) conducted a study which explored using MI principles in Modified Interpersonal Group Therapy. This was unique in that participants did not have to be abstinent, and were in the precontemplative and contemplative stages of change (Malat, Morrow & Stewart, 2011). This study involved 8 patients with comorbid mental illness and addiction, in an open-ended, modified interpersonal group (Malat et al., 2011). This group was co-led by a psychiatrist and a social worker (Malat et al., 2011). While MI for addiction is still being explored, this study demonstrated that comorbid participants appreciated being able to

explore their substance use in a group, without the pressure of abstinence (Handmaker, Packard & Conforti, 2002 as cited in Malat et al., 2011). Through change talk, participants realized a discrepancy between their values and their substance use (Malat et al., 2011).

Hettema et al. (2005) state that MI has performed well compared to wait-list control, no treatment, and when added to other treatments, demonstrating its efficacy for addiction treatment (as cited in Glynn & Moyers, 2009). This effectiveness of treatment has been especially noticeable for alcohol misuse and street drug use (Glynn & Moyers, 2009).

### *Dissonance theory and motivational interviewing*

Motivational interviewing for addiction can be argued to be connected to dissonance theory. Clients notice a developing discrepancy in their behaviour, which means they can see the differences between their deeply held values and their behaviours (Glynn & Moyers, 2009). Dissonance theory involves a discomfort between one's behaviour conflicting with one's values. One of the four principles of MI is developing discrepancy, meaning supporting clients to see the differences between their deeply held values and their behaviours (Glynn & Moyers, 2009). Motivational Interviewing supports clients in facing their dissonance and overcoming it by changing their behaviour rather than their values. This treatment, which is known to be effective for addiction, draws on the same psychologies as dissonance theory.

## Family Therapy

Kaufman and Yoshioka (2004) state that family can be a traditional family, elected family, or extended family, defined by the client's closest emotional connections. Family therapy involves a multitude of therapeutic approaches, which all believe in family-level assessment and intervention being effective (Kaufman & Yoshioka, 2004). Therefore, a change in one part of the

system may create change in other parts of the system (Kaufman & Yoshioka, 2004). In addiction treatment, family therapy aims to decrease the impact of drug dependency on the client and their family and to use the strengths and resources of the family to find ways to live without substance abuse (Kaufman & Yoshioka, 2004). The validity of this method as an effective treatment for problematic substance use will be discussed.

The client is seen as a subsystem within the family, and their symptoms have a large impact on the family system (Kaufman & Yoshioka, 2004). The relationships within the family and client are a point of focus in this intervention (Kaufman & Yoshioka, 2004). Some of the goals of family therapy for addiction include supporting family members in realizing their own needs, providing healing for family members, improving communication in the family, and shifting power to the parental figures (Kaufman & Yoshioka, 2004). In addition, there is a goal to support the family in making environmental, interpersonal, and intrapersonal changes affecting the client, and to stop substance abuse from continuing in future generations (Kaufman & Yoshioka, 2004).

It has been recommended by a panel for substance abuse treatment agencies to include family therapy methods in their approaches, based on effectiveness data (Kaufman & Yoshioka, 2004). A small body of data also suggests that family therapy for substance abuse may have better cost benefits than other approaches like 12-step programs or individual family (Kaufman & Yoshioka, 2004). Bulkstein (2000) found that 68% of youth with substance abuse disorder also had a behaviour disorder (Kaufman & Yoshioka, 2004). Bulkstein found strong empirical support for family-focused interventions for youth with these comorbid disorders, and highlighted that focusing on environmental factors that promote both these disorders can be done through family therapy (Kaufman & Yoshioka, 2004). Catalano et al. (1999) provided family-

focused treatment for 144 methadone-treated parents and 78 children with 33 sessions of family training over a year (as cited in Kaufman & Yoshioka, 2004). Significant improvements were found in better family management, parenting skills, having fewer deviant peers, and less parental drug use (Kaufman & Yoshioka, 2004). Stanton and Shadish (1996) compared treatment for substance abuse that focused on family or non-family approaches (as cited in Kaufman & Yoshioka, 2004). They found that family therapy improves engagement and retentions of participants, and that family therapy led to clearly better results than methods that do not involve the family (Kaufman & Yoshioka, 2004).

Liddle, Dakof, Turner, Henderson and Greenbaum (2008) compared CBT and multidimensional family therapy (MDFT) for cannabis and alcohol abuse, with 224 participants. While both treatments had good results, MDFT was found to have significant treatment effects on substance use problem severity, minimal use, and other drug use, with these effects continuing 12 months post-treatment (Liddle et al., 2008). This demonstrates the sustainability of the treatment effects of MDFT (Liddle et al., 2008).

Rowe (2012) reviewed the efficacy of multidimensional family therapy, which integrates family therapy, drug counselling, individual therapy, and multiple systems-oriented intervention approaches, in an outpatient format. Changes are aimed for in the family environment, the extrafamilial systems that influence the family, the parent(s), and the adolescent (Rowe, 2012). In recent studies, adolescent-focused family-based models show the strongest and most consistent findings when focusing on the ecology of the teen and their family (Rowe, 2012). Models for adults, which are based on systems and behavioural theories, also show strong effects for drug abusers and their families (Rowe, 2012). Family-based models are now recognized

consistently as one of the most effective approaches for treatment of drug problems in both adults and adolescents (Rowe, 2012).

### *Dislocation theory and family therapy*

According to Alexander (2010), one of the reasons people turn to addiction is due to dislocation from society. This is furthered when drug users are discriminated against and stigmatized, creating a wall of exclusion. Addiction can break families apart, leading to the drug user feeling even more dislocated. Family therapy is an effective method to begin reintegrating the drug user into their families. Both family therapy and dislocation theory recognize the importance of relationships and connection, demonstrating how vital it is to focus on reintegrating drug users to decrease the drug problem.

## Chapter Three: Methodology

As has been discussed, the purpose of this thesis is to review and analyze a portion of the existing data on drug policy and the individual and social psychology that drives it. Drug prohibition has persisted in Canada and many other places throughout the world, despite this policy being an objective failure. This study aims to create a deeper understanding of this resistance to change and the ability to disregard multitudes of evidence proving the failure of drug prohibition. This chapter will discuss how this study was conducted, through a literature review. The collected data was synthesized and interpreted into original concepts and new patterns were discovered and discussed.

## Literature Review

For this study, a literature review was conducted. The data collected aimed to address the research questions mentioned previously. There are several major researchers whose writings were utilized for this thesis. Several sources from Boyd were used to create a literature review of drug policy and various aspects of the psychology behind it as well as the history. Boyd is an expert in the field of drug policy, particularly in Canada, and professor at the University of Victoria. Aronson's writings on cognitive dissonance were explored to develop a deep understanding of the social psychology that influence individuals and societies thoughts and behaviours. Alexander's literature on dislocation and the opposite of addiction being connection were also a key aspect in this review, utilizing this viewpoint to support the argument that drug

prohibition is a failed policy. A large variety of researchers are cited in this thesis to ensure validity of the conclusions made. This study is qualitative, with some quantitative data included. Therefore, the purpose of this literature review was to conduct scholarly research of non-original data, and to analyze and synthesize this data into a new ways of thinking and original concepts.

A scholarly examination of research was the method chosen for this thesis. This writer chose not to create original data, but to focus on the rich history of drug policy and social psychology literature that was pre-existing. Through this method, decades of research and different viewpoints can be analyzed in the framework mentioned above. While there is no official sample for this study, the focus is on Canada. Drug use and drug policy affects everyone, whether they are a drug user or not. While the focus is on Canada's experience with drug policy, data is also considered from other countries such as the United States, Portugal, and the Netherlands. This supports the thesis in better understanding alternative means of action and ways of understanding to Canada's approach.

To collect data, several different databases were used. This includes: City University of Seattle library, Simon Fraser University library, and Google Scholar. The following terms were used to search for the literature used in this thesis: "addiction", "stigma", "stigmatization", "dislocation", "heroin-assisted treatment", "harm reduction", "drug policy", "prohibition", "decriminalization", "Portugal", "cognitive dissonance", "dissonance theory", "legalization", "war on drugs", "reefer madness", "social psychology", "social values", "discrimination", "opioid crisis", "drug addict", "injecting drug user", "illicit drug use", "Canada", "drug policy

history" and "Netherlands". Most articles were restricted to being published within the past 10 years. However, some older articles were used to gain different perspectives on drug use and drug policy from different times in history.

A number of books were used as well, found on www.amazon.com, which can be viewed in the reference list.

# Chapter Four: Results

## Purpose

The purpose of this study is to examine the individual and social psychology of drug use to understand why we are continuing the use of a demonstratively failed drug policy. The information gathered and conclusions argued will be used to find pathways forward for drug policy in terms of applied psychology and social policy.

## Research Question

Two research questions were addressed in this study. Firstly, what is the social and individual psychology that accounts for the endurance of a demonstratively failed drug policy? Secondly, what is the social and individual psychology that informs change in appropriate drug policy?

An important proposition of this study is that drug prohibition, also known as the war on drugs, is a failed policy. It has been concluded that there have been detrimental results from the war on drugs. The following analysis follows closely from arguments made by Boyd, Carter, and MacPherson (2016), and so additional references, as well as page citations, will be provided as appropriate. The negative effects of prohibition have been well documented in regards to making it difficult to improve public health services for drug users. There is also evidence that these drug laws undermine some groups human rights, enabling racism and classism. The moral model,

which acts as one of the justifications of drug prohibition, has led to marginalization and discrimination of drug users, especially for people of lower socioeconomic status. There is sound evidence that "prohibition has failed to deliver on its promises, including curbing drug use and its harms and ensuring increased public safety and national security" (Boyd et al., 2016, p. 1-2). There is also evidence that the war on drugs is actually partially responsible for the harm associated with drugs for communities, individuals, families, and nations.

> Drug availability, drug use, and cost of prohibition have all increased due to the war on drugs. Canada spends enormous amounts of public funds annual to prevent the illegal purchase and/or distribution of prohibited drugs both inside Canada and beyond its borders. Drugs continue to be available despite these efforts. Indeed, the availability and purity of many common drugs has increased in the last thirty years (Boyd et al., 2016, p. 3).

Opioid use and overdose has also increased drastically in the past decade, as well as requests for addiction treatment.

> It is now well documented that prohibition has not stopped the use of drugs, but it has worsened the health and well-being of not only those who use them but also those who do not use them. Drug prohibition results in increased imprisonment, child apprehension and human rights violations. Moreover, prohibition undermines health services such as prevention and treatment services that effectively counter HIV and hepatitis C epidemics and drug overdose deaths. The harms stemming from drug

> prohibition are not limited to illegal drug users and traffickers: families and communities also bear the brunt of our drug policies. Drug prohibition is a multi-billion dollar experiment that has utterly failed (Boyd, 2017, p. 3).

The war on drugs has become a war on drug users, emphasizing criminalization and punitive measures, further dislocating drug users and putting them at a large disadvantage (Buchanan & Young, 2000). “Illicit drug taking has been presented as an ‘enemy’ within, that can, and will be eradicated” (Buchanan & Young, 2000, p. 410). Drug users are caught in a vicious cycle of discrimination, stigmatization, and social exclusion (Buchanan & Young, 2000). Drug users are heavily stigmatized, which effects their health care, social support, how others view and treat them, and how they view themselves (Mora-Ríos et al., 2017). In addition, criminalizing drugs increases drug crime because it gives underground drug dealers full control of the market, with drug users being unable to get their supply from safe, regulated, and legal resources. The points summarized here have been thoroughly reviewed in chapter two of this thesis.

## Method

The method used to develop the argument in this thesis was to analyze reports on the war on drugs and the results of it, and synthesizing this data in terms of individual and social psychology, which can be seen in detail in chapter two. Data was tracked by creating lists of themes and organizing data collected into the appropriate heading and subheadings, thereby

having multiple sources supporting each section. A pattern emerged through the analysis of the data in chapter two, which will be discussed below.

## Analysis

### Results of Stigmatization and Discrimination of Drug Users

Drug users are heavily stigmatized due to drug prohibition. The "criminal addict" (Boyd, 2017) concept portrayed in drug prohibition shows drug users as dangerous criminals and addicts who should not be trusted or associated with (Buchanan & Young, 2000). Drug users are seen as making a choice to use drugs, and that the addiction is simply a lack of willpower (Mora-Ríos, Ortega-Ortega & Medina-Mora, 2017). The amount of stigma a person experiences depends on how at fault they are seen to be at for their issue, and if the person seems to pose danger (Lloyd, 2013). This stigmatization can make drug users feel isolated and as if they are in "separate worlds" from others, leading them to feel disconnected from the rest of society (Buchanan & Young, 2000).

Drug users receive discrimination and stigmatization from a multitude of sources. In a study by Mora-Ríos, Ortega-Ortega, & Medina-Mora (2017), it was found that drug users experiences stigma from family, treatment centres, school, work, other users, the self, and people on the street. Family members of drug users also experience stigmatization. In addition, workers who provide treatment for drug users can receive stigma (Eaton, Ohan & Dear, 2014). This stigmatization results in low job satisfaction for alcohol and other drug workers, leading to high

turnover and difficulty attracting qualified workers (Eaton et al., 2014). It can be argued that the stigma these workers endure could affect the quality of their work and even their attitude towards the people they are supporting. A study by Ding et al. (2005) found that for people receiving treatment for HIV due to intravenous drug use, 14% of doctors found these efforts futile, and 9% of doctors would prefer not to treat this population (as cited in Lloyd, 2013). This can result in lower quality care, as proven by the study result that HIV-positive drug users received significantly less exposure to antiretroviral therapy from doctors with negative attitudes compared to doctors with positive attitudes (Ding et al., 2005 as cited in Lloyd, 2013). People struggling with addiction also receive less sympathy than those with mental illness, and this view translates into attitudes towards support programs. (Barry et al., 2014).

The stigma placed upon drug users due to drug prohibition causes more harm than good. It negatively affects their quality and accessibility of treatment, their interactions with general society, their relationships, and their views of themselves and their own capabilities. Criminalization is counterproductive in that it creates a barrier between drug users and others. This barrier makes recovering from addiction more difficult as there is less support for programs for drug addiction, and coming forward for support comes with the risk or fear of persecution. The self-doubt instilled in drug users due to the labels they may internalize can consequently decrease their feeling of self-efficacy in terms of whether or not they believe they can overcome their addiction.

Criminalizing drugs is meant to stop people from using drugs, yet drug use and drug crime have not decreased due to the war on drugs (Boyd, 2017). In fact, as reviewed and argued in chapter two, this drug policy has dislocated drug users from the rest of society. Discrimination due to drug prohibition creates paradoxical effects. This dislocation creates a void that drug users may choose to fill by continuing to take drugs (Alexander, 2010). This policy punishes drug users rather than supporting them to overcome their addiction. The fear of persecution due to the illegality of a drug users addiction may stop drug users from seeking help. This is another paradoxical effect, in which drug users need to keep their addiction private in order to not be punished, demonstrating how drug prohibition creates a barrier to treatment. A parent who comes forward for help may have their children away, and a user who may be selling or possessing heroin could arrested or fined for coming forward. The war on drugs is expensive, and is creating a larger struggle for everyone involved.

It can be particularly harmful when a drug user internalizes the labels placed upon them (Eaton et al., 2014). Drug users can feel inferior to others, and can come to find the labels placed on them as justified (Buchanan & Young, 2000). This shaming and judgment that comes from almost all facets of the drug users life can create a feeling of rejection and isolation, leading to dislocation. The stigma and perceived danger of drug users can also affect their closer relationships negatively, leading to further isolation. This stigma can cause low self-esteem and self-confidence, which may lead drug users to continue using illicit substances to mask their feeling of inadequacy (Buchanan & Young, 2000). Many see drug users motivation to change as

lacking, but studies show that the issue is lack of opportunities enhanced by discrimination, not lack of motivation (Buchanan & Young, 2000).

As reviewed in chapter two, one's social status plays a large role in how one interacts with the criminal justice system. This includes race, class, gender, and sexuality. Boyd (2017) states that prejudice is a foundation to Canada's drug laws, and that these laws are aimed at controlling certain racial, class, and gender groups. It can be argued that the war on drugs is moreso a war on poor and marginalized people, and is a thinly veiled rationale for racism. This point has been reviewed in chapter two, demonstrating this through important points in Canada's drug policy history. The fight against opium in Canada began because this drug was associated with Chinese men, who were seen as foreign "Others" who would corrupt white people (Boyd, 2017). Legal discrimination continued to prevail for Indigenous people due to Canadian drug policy, including an alcohol ban for this population (Boyd, 2017). These policies created an enduring stereotype for Indigenous people (Boyd, 2017) which has caused major dislocation and long-term harm.

**Cognitive Dissonance and Drug Policy**

As argued in chapter two, dissonance theory accounts for the continuation of Canada's failed drug policy. Cognitive dissonance is a conflict between two cognitions a person holds that causes tension or discomfort (Tavris & Aronson, 2015). The inconsistency between a person's attitudes or beliefs causes distress, leading the person to find a way to reduce this dissonance

(Tavris & Aronson, 2015). Canada's current drug policy is based on behaviourisms idea of rewards and punishments governing actions (Tavris & Aronson, 2015). There is an assumption that punishing a drug user will deter them from using illicit drugs. However, human behaviour often contradicts the effects of rewards and punishments (Tavris & Aronson, 2015). Viewing addiction from a dissonance perspective seems more logical, as policy makers and drug users can alleviate the contradiction between their actions and their values this way, rather than changing their behaviour.

Using reefer madness to prohibit marijuana is an example of self-justification. One can convince themselves and others that marijuana turns people into "sex criminals", despite this being based on no evidence (Boyd, 2017), in order to justify their actions of prohibition. Self-justification can even stop us from seeing our own mistakes, as reality becomes distorted (Tavris & Aronson, 2015). It can be argued that confirmation bias is another way drug prohibition has continued. When evidence contradictory to one's beliefs is presented, one may distort or criticize the information so they can continue their behaviour without changing their current belief (Tavris & Aronson, 2015). When participants in a study were presented with dissonant information while receiving an fMRI scan, it was shown that the reasoning areas of the brain were virtually shut down (Tavris & Aronson, 2015). More information on how cognitive dissonance has influenced Canada's drug policy can be seen in chapter two.

Drug prohibition provides a "law and order" rationale, which many accept as an effective policy despite contradictory evidence. This rationale allows policy makers and the general

population to rationalize retribution as fairness. Viewing addiction as a choice, and drug users as dangerous and simply lacking motivation, can help justify the decision to punish this population rather than provide support. If drug users are seen as at fault for their addiction, feelings of discomfort can be alleviated that may come from punishing drug users if addiction is seen as a mental health issue. If drug users were seen as not at fault for their addiction, punitive measures would appear nonsensical and would therefore create cognitive dissonance. The law and order rationale assumes that drug users want to do drugs, therefore if drugs were decriminalized, drug use would increase catastrophically. The rationale is that drug prohibition can actually stop someone who is addicted to drugs from doing drugs. As demonstrated by a century of prohibition and no evident decrease in drug use or drug crime, this is not the case.

**Addiction Models**

Three models of addiction were reviewed in chapter two- the moral model, the medical model, and the critical addiction studies model. The dominant models are the moral and medical models, seeing addicting as either an individual disease or an individual moral breach (Alexander, 2012). These models view addiction as an individual's problem, not as part of a larger network of issues.

The moral model sees abstinence and punishment as the cures for drug users "choices", leading to marginalization and discrimination against them. They are seen as immoral and making a choice and therefore are criminal and pose dangers to others. The medical model sees

addiction as a permanent, progressive, biological disease, with a normal part of recovery being relapse. This shifts the blame from the drug user, but places a label on them that is hard to overcome, taking away human agency.

These two models can be connected to dislocation theory and dissonance theory. Both models dislocate drug users from the rest of society as they are viewed as immoral or as having a permanent "disease" that may pose a threat to others. The medical model may also lead drug users to dislocate themselves as they lose power to overcome their addiction and are seen permanently as the "other". The stigmatization that comes along with this label comes from society and the drug user themself. The drug user may pull further away from society due to this stigma, further dislocating themselves. As the drug user is viewed as criminal in the moral model, they are rejected from general society as dangerous and as choosing to use illicit substances. The stigmatization and marginalization of drug users due to the moral and medical model lead to dislocation, which in turn can cause drug users to further turn to drugs to fill the void that has been created by the lack of psychosocial integration.

The moral and medical model can also be connected to dissonance theory. The moral model sees "addicts" as criminals, therefore justifying punitive measures. If this model viewed and portrayed addiction as a mental health issue rather than as a choice, it would create an unpleasant dissonance, as it would call into question why people are being punished for a mental health issue. The concept of the criminal addict alleviates this dissonance. It gives a law-and-order rationale that helps people feel safe as "dangerous" criminal addicts are punished for their

illegal behaviour. As the medical model takes away a drug user's human agency and labels them with a permanent disease, it may help justify drug users not having much say in drug policy. Drug users have the most experience in what supports would be best for addiction, yet are rarely asked. As the medical model views addiction as a disease, it could alleviate dissonance of excluding drug users from important discussions, as a disease should be "treated" by experts. As the drug user is not seen as in control or able to fully get rid of their addiction, it is not seen as unfair to exclude them from contributing to important policy discussions.

Critical addiction studies provide a sociological analysis of addiction. Drug use is not viewed as solely bad, and it is argued that people can have various outcomes of drug use including many benefits. This is a holistic, multidisciplinary approach that sees the pharmacology of a drug as one part of a larger story, also considering factors such as drug policy, environment of use, and the user's mindset. As this model considering multiple viewpoints and factors, it is less likely to face dissonance. The non-rigidity of this model allows a understanding of various situations without it conflicting with one's values or beliefs. It can also be argued that this model does not dislocate drug users as it is a non-judgmental viewpoint, seeing that there can be many benefits to drug use in addition to risks, depending on the environment and other factors. If drug users do not feel stigmatized or marginalized for their drug use, it is likely that they were not feel dislocated and will not feel the need to hide their addiction or feel ashamed of it. They can therefore receive more support and feel more capable of overcoming their addiction.

**Addiction Counselling Methods**

As discussed in chapter two, motivational interviewing and family therapy are empirically-based, effective treatments for substance use. Motivational interviewing can be argued to be based on dissonance theory and is arguably the most effective substance use treatment. Family therapy can be viewed as applied dislocation theory, focusing on healing and strengthening connections.

Motivational interviewing (MI) uses typical counselling methods like empathy and supporting self-efficacy, but also uses unique methods like evoking change talk (Glynn & Moyers, 2009). MI assumes that there is an inherent ability for positive change and motivation in clients, therefore MI avoids giving unsolicited advice or directing persuading a client (Rollnick & Miller, 1995 as cited in Hettema & Henricks, 2010, p. 868). There is a focus on supporting clients in resolving ambivalence (Glynn & Moyers, 2009). This resolving of ambivalence can be seen as addressing cognitive dissonance to make positive change. Developing discrepancy, one of the four principles of MI, helps clients see the conflicts between their behaviours and their deeply held values (Glynn & Moyers, 2009). An example of this would be a drug user who deeply values supporting their family, but spends a bulk of their income on illicit substances. This method is arguably the most effective substance use treatment, demonstrating the importance of cognitive dissonance in addiction.

Family therapy uses multiple therapeutic approaches, and believes family-level intervention and assessment is important for treatment (Kauman & Yoshioka, 2004). The client's

addiction is seen as having a large impact on their family system, and changing one part in the system can create changes in other parts of the system (Kauman & Yoshioka, 2004). Significant improvements have been found in studies utilizing family therapy methods for addiction treatment, as reviewed in chapter two. The effectiveness of family therapy for addiction treatment demonstrates that, as Alexander (2010) states, the opposite of addiction is connection. When relationships are healed and the drug user's support system is expanded and strengthened, it is likely that they will have more resources and motivation to overcome their addiction. As argued throughout this writing, acceptance and support are much more effective than stigmatization and punishment. The importance of psychosocial integration in healing for a drug user cannot be understated, with family therapy demonstrating the importance of connection for recovery.

The analysis and synthesis above connects a series of key connections that point to a comprehensive understanding of drug policy, the socio-cultural context of problematic substance use, and the psychology underpinning empirically-validated approaches to substance use problems. Policy appears to have been informed by the untested assumptions of users of illicit substances as socially criminal and psychologically pathological. Treatments have, in many cases, been built on ideas of pathology and social deviance, relying heavily on psychological concepts like denial, unrealistic needs for control, and unresolved inner neurotic conflict. When seen through a relationship lens, like dislocation theory, and a cognitive-motivational lens, like dissonance theory, problematic substance use takes on an entirely different character. Concepts like marginalization, stigma, rejection, and social isolation become the social explanatory ideas,

and treatments like family therapy, therapies that focus on relatedness, and motivational interviewing, therapies that emphasize a productive relationship with the self and its complexities, become obvious alternatives. The fact that these therapies are among the best-validated treatment modalities (Duncan, Miller, Wampold & Hubble, 2010) is a conspicuous support for this analysis and synthesis.

## Chapter Five: Discussion

The problem being researched in this thesis is the implications of drug policies being based on criminalization, pathology, and interdiction, and the reasons why this strategy has continued for over a century despite evidence demonstrating the war on drugs as arguably being a failure. This thesis also aimed to gain understanding of how people develop their perspectives and beliefs regarding illicit substances and drug users, and how this influences policy. The social psychology of this matter is analyzed to demonstrate why individuals and societies may have difficulty accepting information that is opposed to their beliefs or policies. This thesis seeks answers to what the social and individual psychology are that account for the endurance of a demonstratively failed drug policy. Thereafter, this thesis addresses the inquiry what is the social and individual psychology that informs change to appropriate policy.

This thesis addressed these questions through an extensive literature review. Data was collected from multiple online platforms, including SFU Library, CityU Library, and google scholar, as well as through books found on www.amazon.ca, and articles provided by thesis advisors. This data was synthesized and interpreted into original concepts, and new patterns have been discovered and discussed. The analysis was done in a social psychology framework in order to discover what underpins the persistence of the war on drugs, as well as ways we can create positive change for drug policy using social psychology. The following discussion chapter will explore the implications of the outcomes detailed in chapter four.

Considering all that has been discussed in this study, I have several policy change recommendations as well as practice and professional recommendations that are intended to address some of the issues discussed. It is clear from this review that how drug users and drugs are viewed is a major contributor to drug policy as well as how drug users are treated. Stigmatization and marginalization of drug users arguably exacerbated by Canada's current drug policy strategies created a barrier between drug users and others, making drug users lives more difficult and recovery harder to achieve.

## Policy Changes

So far, this thesis has show that there is a depth of data and analysis of that data showing that drug users, under current Canadian policy, are subject to marginalization and to objectification as persons who are wrong, immoral, damaged and deficit. The chapters above have shown that marginalization can be expected, according to dislocation theory, to exacerbate, if not cause, substance use problems. Therefore, it is reasonable to assert that not only stopping practices of marginalization, but actively reversing them with policies that emphasize social inclusion, is indicated. The chapters above have also shown that ascription of characterological causation, such as moral weakness, to those who use substances as a way of coping, creates the conditions of cognitive dissonance that justify the marginalization of those caught in a cycle of problematic substance use. Therefore, representations of substance users need change in order to make active and socially inclusive treatments, such as the abandonment of practices of isolation

and punishment in exchange for non-dissonant and consequently socially acceptable and supportable practices. The following points of policy analysis and recommendation will demonstrate the consequences of rejecting dislocation and characterological attribution with inclusion practices and humanizing perceptual sets.

**Anti-Stigma Programs**

Rather than focusing on portraying drug users as people with loose morals and as criminals, they should be portrayed in a way that elicits empathy and understanding. As demonstrated by the “this is your face on meth” campaign, portraying drug users in a negative way furthers the concept of drug users as the “Other” (Linnemann & Wall, 2013). This campaign supports the viewpoint that drug users are socially disposable, ungrievable, and at fault for their drug use (Linnemann & Wall, 2013). This sort of portrayal further dislocates drug users and creates a barrier to social reintegration and recovery (Lloyd, 2013).

It is my conclusion, based on the review of theory and evidence above, that there would be a significant and measurable change in the treatment of drug users and their opportunities for recovery if the government focused more on anti-stigma programs and campaigns. To understand the complex path that may lead one to problematic substance use rather than putting drug users into socially stigmatized categories such as a "criminal" or "addict" would not only be more humane, but can be predicted to magnify the cost-effectiveness of treatment efforts.

This movement has already began being put into action by the Ministry of Mental Health and Addictions and the Vancouver Canucks hockey team. Judy Darcy, Minister of Mental Health and Addictions states:

> Stigma around addiction is killing people... Addiction is often a response to deep pain or trauma, and stigma drives our loved ones to act and live in dark silence. We need to knock down the walls of silence and encourage courageous conversations between friends, family and co-workers struggling with substance use, so they feel supported in seeking treatment and recovery (Ministry of Mental Health and Addictions, 2018, p. 1).

This campaign aims to raise public awareness in regards to false stereotypes and the fact that addiction can affect anyone (Ministry of Mental Health and Addictions, 2018). It also aims to encourage seeing addiction as a health issue that deserves support, rather than as a moral failure (Ministry of Mental Health and Addictions, 2018). Stigma discourages people from reaching out for help, therefore, reducing stigma can help break the vicious cycle of silence and isolation in addiction (BC Ministry of Mental Health and Addictions, 2018) that is contributing to the overdose crisis. $322 million has been invested by the BC government to end stigma, save lives, and improve access to addictions services (Ministry of Mental Health and Addictions, 2018). Part of this campaign is Stop Overdose BC, a movement which has utilized methods such as bus stop ads to demonstrate that “people who use drugs are real people” (Ministry of Mental Health and Addictions, n.d.). The website, www.stopoverdose.gov.bc.ca, provides important

information on overdose awareness, support services, opportunities to get involved such as naloxone training, and anti-stigmatization (Ministry of Mental Health and Addictions, n.d.).

Programs such as these are vital in making a difference in Canada's drug policy and treatment of drug users. My considered conclusion is that in order to make steps forward, we need to change our outdated views on drugs and drug use, and focus on harm reduction and support rather than punishment and abstinence being the only option.

**Social Justice Programs**

"Worn out tropes about people who use and/ or sell drugs have promoted social injustice" (Boyd, 2017, p. 157). Drug prohibition is increasingly being understood as a human rights and social justice issue (Boyd, 2017). Therefore, I believe that social justice and social equality programs will yield better results that law enforcement in drug policy. Mora-Ríos, Ortega-Ortega and Medina-Mora (2017) recommend policies that are based on human rights and inclusion, focusing on treatment and prevention. "Decriminalization in Portugal co-exists with other measures, such as expanded prevention, treatment, harm reduction services and social supports. Rather than criminalization, pragmatism, humanism and social integration are key to Portugal's drug policy" (Boyd, 2017, p. 160). The money that Portugal put towards the war on drugs is now being used for hard reduction programs aimed at reducing drug consumption (Domostawski, 2011). In Canada, illicit drug use continues to be presented as both a criminal issue and a health issue, creating a contradiction within drug policy (Boyd, Carter & MacPherson, 2016). Drug

maintenance programs and publicly funded treatments were deemed unnecessary by prominent doctors and law enforcement, stating that “criminal addicts” continued to be criminals even once they stopped using drugs (Boyd, 2014 as cited in Boyd et al., 2016). In the 1950s, rather than offering public treatment, prison programs were created in Canada to treat prisoners (Boyd et al., 2016). By the end of the 20th century, many prisons would not provide methadone maintenance or needle exchange programs (Riley, 1998). Instead, visitors were searched and urine tests for prisoners increased, a costly and invasive alternative to harm reduction (Riley, 1998). As we continue to fight to step away from the medical and moral model and towards a more holistic model of addiction, punitive measures do not make sense. If illegal drug use is understood as a health issue, then the establishment of treatment and support programs appears appropriate (Boyd et al., 2016). If social factors such as drug prohibition were seen as contributing to harms related to drug use, perhaps a different approach would be used, such as removing some drug policies and setting up a variety of services in addition to decriminalizing drugs for regulation (Boyd et al., 2016).

This thesis has demonstrated that the war on drugs has not been effective in decreasing drug use, and that harm reduction and social justice measures have had far more success. This writer suggests focusing on several movements to forward our support of drug users, some of which are already in action in Canada or other countries.

As will be discussed, housing first has had success in Vancouver (Patterson et al., 2013). Rather than punishing drug users, ostracizing them, than them continuing to use drugs, we

should provide them with opportunities to better themselves. This starts with having their basic needs met. Homes are needed in order for drug users to not feel marginalized and discriminated against, and to feel like they are accepted as part of general society. In addition, if people struggling with addiction do not have jobs, it is very difficult to apply for a job without a home. In saying that, there should also be more job opportunities for substance users. Having a job provides one with a sense of purpose and productivity. Supporting drug users in obtaining homes and jobs, if they do not already have these things, can help with psychosocial reintegration and therefore lessen their need for illicit substances. Illicit drug users also need social justice programs to help them fight for their rights. Even if a person did save up enough to start renting a home or was qualified for a job, how they present may deter others from giving them a chance. It would be meaningful to have programs that provide drug users with knowledge on their rights and support in fully obtaining these rights. As previously mentioned, current drug policy is a human rights issue.

As discussed by Boyd et al. (2016), the integration of substance-use and mental health services be focused on to a greater degree than it is currently. There is strong evidence that many people who experience problematic substance use also experience challenges with mental health (Boyd et al., 2016). A 2012 study found that 1.2% of Canadians age 15 to 64 concurrently experienced substance use and mental health disorders in the past year (Khan, 2017). People dealing with these challenges are often bounced from one service to another due to the lack of integration into a more holistic approach (Boyd et al., 2016). Those who have concurrent

disorders may receive subpar health care, in addition to often having worse physical health and psychological distress than those with a single disorder (Khan, 2017).

> This lack of coordination is most acutely felt at the service level when mental health services do not accept clients who use drugs, including clients on methadone, while some addiction services do not accept clients on certain types of prescription medications, including antipsychotic drugs (Boyd et al., 2016, p. 93).

For individuals who do have concurrent disorders, there is a high relapse rate if the disorders are not treated at the same time (Khan, 2017). “Integrating the delivery systems to treat concurrent mental health and substance use problems is a recognized challenge” (Khan, 2017, p. 3). It is important, however, to note that mental health issues and problematic substance use are not always connected, and in fact the majority of problem drug users do not have co-occurring disorders (Rush, Fogg et al., 2008 as cited in Boyd et al., 2016). There are many different factors that can contribute to substance use, which have been discussed throughout this study. So while it is important to create some programs that integrate drug use and mental health, it is also important to protect current services that provide support for one or the other (Boyd et al., 2016). While there are some free counselling services in BC, there are many limitations to accessing this. Some programs have an age limit, some do not take on comorbid disorders, and some have a long waitlist. I recommend focusing more funding on programs such as these rather than on policing and punishment of drug users.

**Problematic Substance Use as a Health Care Problem**

Given the lack of empirical or theoretical defense of marginalization and criminalization, a defensible change in policy should include that it is far more likely to be beneficial to treat problematic substance use as a health care problem at an individual level, and a public health problem at a societal level, and not as a criminal justice problem. As discussed, drug policies are determined through problematization, as a specific issue is identified as a problem, solutions are proposed depending on how the problem is portrayed (Boyd, Carter & MacPherson, 2016). Viewing drug use as a choice and a moral failure is problematic because the logical solution to a "crime" appears to be punishment.

Treating drug use as a criminal justice problem is expensive. Roughly three-quarters of the funding for the four pillars model, which addresses illicit substances in Vancouver, was used for law enforcement (VPD, 2016). Meanwhile, the treatment pillar was least supported due to lack of funds and limited implementation (VPD, 2016).

The success of treating addiction with support rather than punitive measures can be seen in Portugal, where personal possession of all "hard" and "soft" substances was decriminalized in 2001 (Domostawski, 2011). Instead of spending money on policing and punishing people for possession, money was put towards secure housing, drug treatment, and jobs for those with addiction (Hari, 2016). This change has successfully reduced addiction, recidivism, drug consumption, and HIV and Hepatitis infections (Domostawski, 2011). Drug users experienced less of a barrier to accessing treatment (Domostawski, 2011), and decreased dislocation.

It is important to note that the Portuguese model is embedded in its history and its particular socio-cultural milieu. For example, Portugal's system mandates one must attend treatment if they are identified by law enforcement as users of substances that bring about criminal sanctions if possessed for sale. Dimensions of the Portuguese model, such as mandatory treatment, would be outside of the constitutional and social traditions of civil rights in Canada.

One study noted in this thesis found that the public did not support social programs for people struggling with addiction as much as they did for mental health issues (Barry, McGinty & Pescosolido, 2014). As mentioned in chapter two, this lack of sympathy for addiction may come from confusion about whether addiction is a personal failing, a medical condition to be treated (Barry et al., 2014), or a complex outcome of social policies that essentially makes those who are racialized, poor, or otherwise marginalized vastly more vulnerable to problematic substance use. "Social rejection of drug use is greater than that directed at other psychiatric conditions, like depression and anxiety, which may lead to social exclusion of substance users and prevent them from seeking treatment" (Mora-Ríos et al., 2017, p. 594).

As demonstrated for addressing addiction, putting funding towards health care and support programs is far more humane and cost-effective than focusing budgets on law enforcement. If we as a country are able to see addiction as a mental health issue rather than through the lens of the moral or medical model, these changes would arguably seem like an obvious step to take.

**Harm Reduction Education**

Another recommendation for policy change in regard to addiction is providing more harm reduction education. Rather than simply advocating for abstinence, it would be beneficial to provide more public information on ways to engage with substances safely. For example, knowing the interaction between different drugs, appropriate doses depending on the individual and their environment, and where to access supplies or environments to take substances safely.

Individuals may experience harm because they did not know enough about a substance or how to safely take it. It is well known and told by doctors that certain prescription antibiotics should not be mixed with alcohol. Because both of these substances are legal, people are able to safely take them and know they should not be mixed. Unfortunately, with illegal substances, it would be difficult for drug users to ask about how different substances interact without fearing judgment or punishment,such as how a depressant and a stimulant interact. It would be beneficial for users to be able to easily access information about where to go to exchange needles. This benefits users in decreasing the spread of needle-born diseases, and benefits society in general as it is likely less used needles would be left in public spaces. Awareness about harm reduction resources has begun to be implemented by the www.stopoverdosebc.gov.bc.ca website, with a section providing information on overdose prevention, drug checking services, and supervised consumption (Ministry of Mental Health and Addictions, n.d.).

Substance use, whether problematic or not, should be made safe. People should not have to risk or lose their lives due to addiction or recreational use. Just as people who are addicted to

smoking are providing with information on how to quit, alternative methods such as patches and gum, and apparently cleaner methods like vaping, so should people who use drugs that happen to be illegal.

Criminalization and stigmatization are major barriers to harm reduction. As discussed, drug users may be reluctant to reach out for support and information due to fear of punishment or judgment. If discussions about harm reduction became more mainstream, it is likely drug users would experience less hesitation in regards to reaching out for resources, and the general public would be able to use substances more safely and ask many questions to use as safely as possible.

This harm reduction information should also be taught in school. Abstinence is not the common method taught for sex in Canada, as safe sex is. Open conversations are generally encouraged about sex in schools, allowing youth to make educated and safe decision when they do choose to engage in sexual behaviour. Coyle et al. (2001) demonstrated the success of an educational program, *Safer Choices,* in increasing protective behaviours to prevent pregnancy and STD's, and reducing risky sexual behaviours among high school students (Coyle et al., 2001). Due to education about safe sex, the students whom were studied "were 1.68 times more likely to have used condoms (P=0.04), and 1.76 times more likely to use an effective pregnancy prevention method (birth control pills, birth control pills plus condoms, or condoms alone) (P=0.05) at last intercourse than were students in the comparison school" (Coyle et al., 2001, p. 87). The example of safe sex school programs demonstrates the benefits of harm reduction rather

than advocating abstinence without education. Educating youth on safe drug use could reduce overdoses and increase protective behaviours.

**Treatment Research**

As discussed in chapter two, motivational interviewing and family therapy are empirically based successful treatment methods for addiction. Motivational interviewing addresses cognitive dissonance, and family therapy addresses dislocation. I believe it would be beneficial to conduct applied research on treatments that include applications of cognitive dissonance and relational inclusion beyond the traditional methods we use at this time. To combine the aspects of two clearly effective methods to treat addiction in a unique way is worth researching to find more effective methods for substance use treatment. A treatment that addresses dislocation and cognitive dissonance could be very useful for a drug user in improving psychosocial integration and addressing their dissonance in using drugs, to overcome their addiction with longer-term effects . This would get to the root of the issue, addressing the context of the drug use. This is considering that drug use is a secondary behaviour in reaction to an issue in a person's life. I believe this would have better effects than simply working on reducing drug consumption through advice and tools.

## Practice and Professional Recommendations

The following is a discussion of steps mental health professionals can take to best support clients who struggle with addiction. This includes focusing on context, attending to critical developmental events, working on one's own history and biases, and providing education on risks of drug use.

### Focus on Context

When counselling a client who struggles with substance use, fifty years of integrated research, articulated by Wampold (2015), shows that effective counselling and psychotherapy focuses on context, and contextualizes substance use as a secondary behaviour that is a reaction to context. Changes in context lead to changes in psychology and behaviour, and context transformation includes relationships, marginalization, and basic self-care needs being met.

As discussed, dislocation theory posits that drug use can be seen as an attempt to fill a void left by lack of psychosocial integration and dissonance theory posits that, without deliberate changes in attribution, drug users will be assigned the blame for their own victimization. One of the first things that should be considered when treating a client struggling with addiction is their support system. It is valuable to see what their relationships are like with their family, friends, and community, and if any of these relationships have been effected or even ruptured before or during drug use. A person may use drugs due to losing someone close to them, or their

relationships may be affected due to drug use and push them to further uses drugs due to increasing dislocation.

People who use drugs tend to be marginalized. Some populations, races, and classes are marginalized further than others, as discussed in chapter two. Drug users may be ostracized for their actions, seen as having low morals and being dangerous (Lloyd, 2013). Addressing marginalization for a client could improve their environment and support systems, therefore leading to reduction of drug use.

Meeting basic needs, such as for people who are street-entrenched, can also be a large factor in amount of involvement with illicit substances. For homeless people who use illicit drugs, it can be assumed for many of them that they are ostracized from society, and that drug use can be used as an escape from the difficulties of homelessness. An example of the importance of basic needs being met in addressing problematic substance use can be seen in the success of the Housing First movement in Vancouver. A randomized control trial studied the changes in subjective quality of life of homeless adults with mental illness due to Housing First (Patterson et al., 2013). The study found that participants who were assigned to Housing First had a significantly greater overall quality of life compared to the treatment as usual (TAU) group (Patterson et al., 2013). This result occurred regardless of type of supported housing or need level, at 6 and 12 months post-baseline (Patterson et al., 2013). "...Housing First (HF) provides homeless individuals with SMI [serious mental illness] immediate access to permanent housing as well as services and supports that are flexible and consumer-driven. Research on HF has

documented improved residential stability, community integration, and high levels of client satisfaction" (Patterson et al., 2013). A higher proportion of this study's participants qualified as being substance dependent (Patterson et al., 2013). Another study found that there was a significantly larger reduction in alcohol problems for participants in the Housing First intervention compared to than the TAU group (Kirst, Zerger, Misir, Hwang & Stergiopoulos, 2015). There was not a significant reduction in illicit drug use between the two groups, demonstrating that for people experiencing mental illness, drug problems, and homelessness, additional supports may be needed to reduce drug use (Kirst et al., 2015).

**Attending to Critical Developmental Events**

Considering the theory and evidence analyzed throughout this thesis, it is my conclusion that it is also important to attend to critical developmental events when supporting a client with problematic substance use. As discussed, drug use should be seen as a secondary behaviour in reaction to an event or environment. When a client is wanting to reduce their drug consumption, critical events such as traumas and relationship disconnections should be considered.

For example, the assimilation policies and residential schools for aboriginal societies led to dissonance and dislocation. The colonization and breakdown of these societies led to permanent dislocation (Alexander, 2012), which in turn caused a portion of First Nations people to turn to drugs to cope with the trauma of their experiences and the lack of psychosocial integration.

It can be argued that drug use would be decreased if the issues that led to drug use are attended to during counselling. Working through traumatic experiences and damaged relationships could increase the clients protective factors, and thereafter their ability to further benefit from tools that can support them in overcoming addiction.

**Work on one's own History and Biases**

I also recommend that clinicians take the time to reflect and work on their own history and predilections to make judgments. An important part of being a counsellor is being aware of one's biases, worldview, and values. These biases are large unconscious, and should be brought into consciousness to best support clients. If a clinician has an internal bias that drug addiction is a moral failure, for example, they may subconsciously look down on their client. They may see the addiction as a lack of motivation, and therefore might have less hope for progress with the client, which could come across in treatment quality.

Being aware of your biases that could lead to countertransference or judgment is vital in becoming an ethical and effective counsellor. Taking the time to reflect on our development, culture, and values is something counsellors should work on continuously. We may not be able to get rid of our biases, but we can bring them into consciousness so we don't allow them to negatively affect our clients.

Due to the moral and medical model, drug prohibition, and the viewpoint of the "criminal addict" (Boyd, 2017), it is likely that many people have looked down on drug users at some point

in their lives, if not currently. Getting to know people who struggle with addiction, and seeing them as real people with addiction being one aspect of their being, rather than seeing them simply as an addict, is important. People with problematic substance use should not be put into a box, but seen as unique individuals. These individuals should have unique treatment plans considering their developmental history, yet if we think of "addicts" as all the same due to our biases, we will limit our treatment methods to simply focusing on drug use.

**Provide Education about Risks**

Lastly, I recommend that clinicians be knowledgeable about, emotionally neutral about, and prepared to provide education about risks of drug use. Safe use should be supported even if the ultimate goal is abstinence. If a client using heroin, for example, there should be an open discussion with them about needle-borne diseases and where to get clean needles, how drugs interact, resources for drug testing due to possible contamination, and safe places to use heroin.

I advise counsellors to take it upon themselves to get educated on drugs, drug use, stigma around drug use, and harm reduction. I believe that it is unrealistic for drug users to benefit from being told to aim for abstinence right away. Drug users may be able to reduce their drug use gradually, but should be provided with information for how to use safely while they do so. Open dialogue should be encouraged around this topic, in a judgment-free environment, so drug users can feel comfortable discussing the details of their drug use without fear of punishment or judgment. This open dialogue can also lead to a feeling of acceptance in a society where drug

users often feel stigmatized and ostracized, thereby decreasing dislocation by strengthening the client-counsellor relationship.

## References

Alexander, B. K. (2012). Addiction: The Urgent Need for a Paradigm Shift. Substance Use & Misuse, 47(13/14), 1475-1482.

Alexander, B. K. (2010). The Globalization of Addiction: A Study in Poverty of the Spirit. Oxford: Oxford University Press.

Barry, C. L., McGinty, E, Pescosolido, B. A., & Goldman, H. H. (2014). Stigma, discrimination, treatment, effectiveness, and policy: Public views about drug addiction and mental illness. Psychiatric Services,65(10), 1269-1272.

BC Centre for Disease Control. (2017). BC Overdose Action Exchange II. Vancouver, BC.

Black, J. R. (1884, Dec 04). THE TEMPERANCE MOVEMENT IN CANADA. The Independent ...Devoted to the Consideration of Politics, Social and Economic Tendencies, History, Literature, and the Arts (1848-1921), 36, 6.

British Columbia Coroners Service. (2018, May 10). Fentanyl-Detected Illicit Overdose Deaths. Retrieved May 27, 2018, from https://www2.gov.bc.ca/assets/gov/public-safety-and-emergency-services/death-investigation/statistical/fentanyl-detected-overdose.pdf

Boyd, S. C. (2017). Busted: An illustrated history of drug prohibition in Canada. Winnipeg: Fernwood.

Boyd, S., Murray, D., & MacPherson, D. (2017). Telling our stories: heroin-assisted treatment and SNAP activism in the Downtown Eastside of Vancouver. Harm reduction journal, 14(1), 27.

Boyd, S. C., Carter, C. I., & MacPherson, D. (2016). More harm than good: Drug policy in Canada. Halifax, Nova Scotia: Fernwood Publishing.

Buchanan, J., & Young, L. (2000). A war on drugs- a war on drug users? Drugs: Education, Prevention and Policy,7(4), 409-422.

Cavalieri, W., & Riley, D. (2012). Harm Reduction in Canada: The Many Faces of Regression. In *Harm Reduction in Substance Use and High‐risk Behaviour: International Policy and Practice*(p. 1-20). London: Wiley-Blackwell.

Coyle, K., Basen-Engquist, K., Kirby, D., Parcel, G., Banspach, S., Collins, J., . . . Harrist, R. (2001). Safer Choices: Reducing Teen Pregnancy, HIV, and STDs. *Public Health Reports,116*(1), 82-93.

Creswell, J. W. (2014). *Research Design: Qualitative, Quantitative, and Mixed Methods Approaches*. Thousand Oaks, CA: SAGE Publications.

Csete, J., Kamarulzaman, A., Kazatchkine, M., Altice, F., Bailcki, M., Buxton, J.,... Beyrer, C. (2016). Public health and international drug policy. The Lancet Commissions,387, 1427-1480.

Darke, S., & Farrell, M. (2014). Would legalizing illicit opioids reduce overdose fatalities? Implications from a natural experiment. *Addiction, 109(8),* 1237-1242.

Darke, S., & Torok, M. (2013). Attitudes of regular injecting drug users towards the legal status of the major illicit drugs. *Drug and Alcohol Review*.

Domostawski, A. (2011). Drug policy in Portugal: The benefits of decriminalizing drug use. *Open Society Foundations,*1-58.

Duncan, B. L., Miller, S. D., Wampold, B. E., & Hubble, M. A. (2010). *The heart & soul of change: Delivering what works in therapy*(2nd ed.). Washington, D.C: American Psychological Association.

Eaton, K., Ohan, J. L., & Dear, G. (2014). The stigmatisation of the provision of services for alcohol and other drug users: A systematic literature review. *Drugs: Education, Prevention and Policy,22*(1), 19-25.

Government of Canada. (2018, September 28). What you need to know about cannabis. Retrieved from https://www.canada.ca/en/services/health/campaigns/cannabis/canadians.html

Glynn, L. H., & Moyers, T. B. (2009). Motivational Interviewing for Addictions. In *Evidence-Based Addiction Treatment*(pp. 175-188). Academic Press.

Hari, J. (2016). *Chasing the scream: The first and last days of the war on drugs*. London: Bloomsbury Publishing.

Hettema, J. E., & Hendricks, P. S. (2010). Motivational interviewing for smoking cessation: A meta-analytic review. *Journal of Consulting and Clinical Psychology,78*(6), 868-884.

Kaufman, E. F., & Yoshioka, M. R. (2004). *Substance Abuse Treatment and Family Therapy: A treatment Improvement Protocol*. Rockville, MD: U.S. Department of Health and Human Services.

Khan, S. (2017). Concurrent mental and substance use disorders in canada. *Health Reports, 28*(8), 3-8. Retrieved from http://proxy.cityu.edu/login?url=https://search-proquest-com.proxy.cityu.edu/docview/1933112410?accountid=1230

Kirst, M., Zerger, S., Misir, V., Hwang, S., & Stergiopoulos, V. (2015). The impact of a Housing First randomized controlled trial on substance use problems among homeless individuals with mental illness. *Drug and Alcohol Dependence,146,* 24-29.

Kuhn, T. S. (1970). Logic of discovery or psychology of research. *Criticism and the Growth of Knowledge*, 1-23.

Levine, H. G. (2009). Review of "The Globalisation Of Addiction: A Study In Poverty Of The Spirit" By Bruce K. Alexander. *Harm Reduction Journal,6*(1), 12.

Liddle, H. A., Dakof, G. A., Turner, R. M., Henderson, C. E., & Greenbaum, P. E. (2008). Treating adolescent drug abuse: A randomized trial comparing multidimensional family therapy and cognitive behavior therapy. *Addiction, 103*(10), 1660-1670.

Linnemann, T., & Wall, T. (2013). 'This is your face on meth': The punitive spectacle of 'white trash' in the rural war on drugs. *Theoretical Criminology,17*(3), 315-334.

Lloyd, C. (2013). The stigmatization of problem drug users: A narrative literature review. *Drugs: Education, Prevention and Policy,20*(2), 85-95.

MacCoun, R. (2011). What can we learn from the Dutch cannabis coffeeshop system? *Addiction, 106*(11), 1899-1910.

Malat, J., Morrow, S., & Stewart, P. (2011). Applying Motivational Interviewing Principles in a Modified Interpersonal Group for Comorbid Addiction. *International Journal of Group Psychotherapy,61*(4), 556-575.

Manderson, D. (2011). Possessed: The unconscious law of drugs. In *The drug effect: Health, crime & society* (pp. 225-239). CUP.

Ministry of Mental Health and Addictions. (2018, January 29). New campaign aims to save lives by eliminating stigma. Retrieved from https://news.gov.bc.ca/releases/2018MMHA000-000113

Ministry of Mental Health and Addictions. (n.d.). Get involved. Get Informed. Get Help. Retrieved from https://www.stopoverdose.gov.bc.ca/

Mora-Ríos, J., Ortega-Ortega, M., & Medina-Mora, M. E. (2017). Addiction-Related Stigma and Discrimination: A Qualitative Study in Treatment Centers in Mexico City. *Substance Use & Misuse,52*(5), 594-603.

Patterson, M., Moniruzzaman, A., Palepu, A., Zabkiewicz, D., Frankish, C. J., Krausz, M., & Somers, J. M. (2013). Housing First improves subjective quality of life among homeless adults with mental illness: 12-month findings from a randomized controlled trial in Vancouver, British Columbia. *Social Psychiatry and Psychiatric Epidemiology,48*(8), 1245-1259.

Popper, K. (2013). *Realism and the aim of science: From the postscript to the logic of scientific discovery*. Routledge.

Riley, D. M., & Nolin, P. C. (1998). *Drugs and drug policy in Canada: A brief review and commentary.* Senate of Canada.

Rowe, C. L. (2012). Family Therapy for Drug Abuse: Review and Updates 2003-2010. *Journal of Marital and Family Therapy,38*(1), 59-81.

Sanders, C. (1998). Substance misuse dilemmas: A postmodern inquiry. *Praxis: Situating discourse, feminism and politics in narrative therapies*, 143-162.

Spapens, T., Müller, T., & Bunt, H. V. (2014). The Dutch Drug Policy from a Regulatory Perspective. *European Journal on Criminal Policy and Research,21*(1), 191-205.

Staley, S. (1993). *Drug policy and the decline of American cities*. New Brunswick, NJ, U.S.A.: Transaction.

Stringer, R. J., & Maggard, S. R. (2016). Reefer madness to marijuana legalization.*Journal of Drug Issues, 46*(4), 428-445.

Tavris, C., & Aronson, E. (2016). *Mistakes were made (but not by me): Why we justify foolish beliefs, bad decisions, and hurtful acts*. London: Pinter & Martin.

Trafton, J. A., & Oliva, E. M. (2014). Legislative strategies other than legalizing illicit opioids may help to reduce overdose fatalities. *Addiction,109*(8), 1243-1244.

Vancouver Police Department. (2017). *The Opioid Crisis: The need for treatment on demand. Review and recommendations.* Vancouver, BC.

US Legal, Inc. (n.d.). War on Drugs Law and Legal Definition. Retrieved from https://definitions.uslegal.com/w/war-on-drugs/

Wampold, B. E. (2015). How important are the common factors in psychotherapy? An update. *World Psychiatry*, *14*(3), 270–277.

Wilson, C. W. (2017). *The opioid overdose crisis of Vancouver.* Unpublished manuscript. City University of Seattle, Vancouver, Canada.