

Counselling in the Midst of an Overdose Crisis:
Immediate Changes to Practice are needed to Save Lives

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ABSTRACT

The recent increase in fatal opiate overdoses in British Columbia has been declared a public health emergency by the provincial government. Across Canada, overdose numbers are also increasing significantly and the topic of opiate overdoses has begun to be discussed publically and politically. This manuscript style thesis first presents an examination of the history of opiates in Canada focusing on the effects of prohibition over the last century and its current impact. The history of colonization and its ongoing impacts on the Indigenous peoples of Canada is outlined, including the disproportionate effect the overdose epidemic has had on Indigenous communities. Current practices of psychotherapy in the realms of addiction and opiate use are then critically examined and emerging best practices are identified through a literature review. Finally, this thesis outlines immediate changes to psychotherapy practice that are aimed at reducing opiate overdose-related fatalities. A critical theoretical lens is applied to current psychotherapy practices in an effort to encourage harm reduction and life-saving practices.

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DEDICATION

This manuscript and my entire graduate school completion are the result of the support and love of my wife Dawn Emery and my wonderful boys Maxim and Emmanuel. I always knew I was coming home to a house full of love at the end of a long Saturday, or after a morning of thesis work, and this allowed me to keep going. Thank you, this achievement is as much yours as it is mine. When I realized that I did not want to be the man I thought I wanted to be, you stood beside me. Then I became something more than I dreamed that I could be, all because of you.

CHAPTER 1: INTRODUCTION

The rise in drug overdose deaths in British Columbia (BC), from 369 deaths in 2014 to 1,422 deaths in 2017 has been declared a public health emergency by the provincial government (Woo, 2017). This overdose epidemic has turned public and government attention towards the area of substance use and opiate use across the country. The overdose crisis has established the need to immediately examine the social contexts that have given rise to this public health emergency. This manuscript style thesis seeks to investigate the reasons behind the rise in overdose deaths and outlines some paths forward for drug users, counsellors, and therapists who work with drug users, and for society at large. Understanding the social and historical context of the overdose epidemic, this thesis then examines the current practices of psychotherapy in the realms of addiction and opiate use. Literature is reviewed and emerging practices are identified. This introductory chapter outlines the need and purpose for conducting such a review, defines the scope of the review, and outlines the structural framework for this manuscript style thesis.

Purpose

The purpose of this thesis is to contribute to the discussion surrounding practices of psychotherapy with clients using substances, focusing on opiate use as it is most directly associated with the overdose epidemic. By consolidating the literature and critically assessing current psychotherapy models and practices this thesis aims to outline emerging best practices in psychotherapy in light of the overdose epidemic. This thesis also encourages psychotherapists to engage with wider discussions of social change to advocate for those they serve. This work is intended to inspire increased discussion around how psychotherapy will address the overdose crisis as well as encourage practitioners to critically evaluate their practice in light of emerging

research and the overdose crisis. This work highlights the need for continued research into effective treatments for substance use disorder, as well as counselling strategies and public policies to reduce overdose deaths.

Significance

This work is currently significant as the overdose epidemic in Canada is generating increased discussion around opiate use, substance use, and social policies. As funding and support for substance use treatment programs increases in Canada, it is imperative at this time to critically evaluate counselling practices and models for their ability to effectively address the overdose epidemic. This thesis evaluates current practices and argues that an expansion of current practices will not effectively address the overdose crisis; immediate changes are needed.

Literature Review

Current research is discussed in this paper from a critical theoretical lens. This critical theoretical approach stems from the belief that drug users, specifically opiate users, are a marginalized and oppressed group in North America. In North America and most of the world, drug users face high rates of imprisonment and lack access to housing and health care (Levine, 2009). Further to this, members of this population may face multiple oppressions based on class, race, culture, or gender identity among other factors (Alexander, 2010).

Any research or discussion of abstinence from drugs must also acknowledge that there are overt pressures to maintain abstinence placed on drug users from law enforcement and government with the very real possibility of homelessness or imprisonment for drug users who do not achieve abstinence (Levine, 2009).

Literature regarding abstinence-based counselling perspectives is discussed including the limitations of this approach. Emerging harm reduction-based counselling practices are discussed

following this. Throughout this discussion, Indigenous perspectives on substance use counselling will be highlighted.

Theoretical Framework

Current practices and approaches are evaluated through the theoretical framework of Bruce Alexander's dislocation model of addiction. This thesis is guided and inspired by Alexander's work in critically examining the theoretical underpinnings of the psychological and social understanding of addiction and substance use.

Method

The method for this thesis is to first conduct a thorough review of the existing literature on the historical context of the current overdose crisis to re-orientate attention from the singular drug user to the historical, social, and political contexts of the overdose crisis. Current clinical practices in substance use counselling are then critically examined. Finally, emerging research and theory is discussed in light of the overdose crisis. Recommendations are made for immediate changes to clinical practice to prevent overdoses and save lives.

Definitions of Terms

Fentanyl:

An opioid: a class of painkillers that also includes oxycodone, heroin, and morphine. Prescription-grade fentanyl; however, is up to 100-times stronger than morphine (Stanley, 1992). Developed in 1959 by Belgian chemist Dr. Paul Janssen, it was quickly adopted as a pain reliever and anesthetic in medical settings. It came into widespread use in the late-1980s with the introduction of the transdermal patch that releases the drug into the patient's bloodstream over two or three days (Stanley, 1992).

Carfentanyl:

A synthetic opiate with similar properties to fentanyl, first synthesized by Janssen laboratories in Belgium in 1974 (Stanley, 1992). It is a much more potent form of synthetic opiate, up to 100-times stronger than an identical amount of fentanyl. It has also been used as a chemical weapon, most notably in Moscow in 2002 when the Russian army used it in an aerosol form to subdue Chechen hostage takers (Howlett, 2017). When either fentanyl or carfentanyl is processed in unregulated laboratories with no quality controls, it is difficult to get the dosage right, making it potentially very dangerous (Beletsky & Davis, 2017).

Heroin:

Heroin, also known as diamorphine among other names, is an opioid most commonly used as a recreational drug for its euphoric effects (Stanley, 1992). Medically, it is used in several countries to relieve pain or in opioid replacement therapy. Heroin is typically injected, usually into a vein; however, it can also be smoked, snorted, or inhaled (Stanley, 1992). Heroin was first made by C. R. Alder Wright in 1874 from morphine, a natural product of the opium poppy (United Nations Publications, 2010).

Opiate overdose:

Opiate overdose refers to a decreased level of consciousness and respiratory depression as a result of high opiate levels in the human body (Stanley, 1992). This leads to respiratory cessation and death as a result of high opiate levels in the body (Stanley, 1992). For the purposes of this thesis, opiate overdose refers to a complete cessation of respiratory function that results in death without medical interventions.

Limitations and Scope

Several limitations exist in the scope of this thesis. First, while I have attempted to give a historical context to the current overdose epidemic, it is by no means a thorough examination of the subject. The historical analysis is limited to a Canadian perspective and is based largely on written accounts by European colonialists. This thesis contains a section on the Indigenous experience in Canada and the ongoing effects of colonization. This is a limited discussion and does not fully examine the depth and severity of the effects of colonization. This discussion is also largely based on written documents by European colonialists and therefore excludes Indigenous oral history as well as a fully developed Indigenous perspective. This thesis is also based in a euro-centric understanding of history and scholarly literature and therefore does not engage in de-colonializing practices around knowledge or language.

This thesis focuses almost exclusively on the Canadian experience, and predominately on the current overdose crisis in BC. Therefore, the analysis contained within this thesis and any conclusions drawn from it are limited in the scope of their application. There has been a global increase in overdose deaths, most notably in the United States and this thesis does not address the historical or societal contexts surrounding those instances.

Situating the Author

I identify as a 39-year-old cisgender male. My heritage is European, and I am Canadian born and identify as Canadian. I have worked in the downtown eastside of Vancouver as a community worker and shelter program manager since 2003. During this time, I have worked for an organization that places harm reduction at the center of its programming. I have supervised injection drug use and I have intervened in over 40 overdoses. I am trained in the use of naloxone and am a naloxone training facilitator.

The majority of my career has been spent working with active substance users, many working towards changing their relationship with substances, but critical of the substance use counselling options available to them. It is their experiences that initially began my critical examination of current substance use counselling practices.

In early-2015, I realized that something significant was changing in the number of overdoses and the severity of those overdoses among opiate users. Fentanyl-related overdoses began to increase substantially within the shelter program where I was the manager. Individuals would inject opiates, and then lose consciousness and stop breathing within minutes. Community workers began to respond to overdoses daily and sometimes hourly. CPR and naloxone were administered to those who overdosed and paramedics were called to attend.

At the same time, I began to receive news that old friends or coworkers had died from overdoses, usually alone in their homes. I began to read newspaper stories about young couples dying of overdoses in condominiums, or young indigenous women dying in tents alone in wooded areas in Vancouver suburbs. I read about the overdose epidemic sweeping North America and about important cultural figures such as musicians Prince, Whitney Houston, and Tom Petty, or actors such as Phillip Seymour Hoffman, Heath Ledger, or Cory Monteith all dying of overdoses alone.

I began to investigate how fentanyl had come to be present in illicit opiates, and I critically examined the impact of prohibition on drug-related harm and overdose deaths. I read Bruce Alexander's book "The Globalization of Addiction" and began to develop what a connected and compassionate approach to the overdose epidemic might be.

This thesis is intended to put some of these ideas into concrete actions and strategies. I hope this thesis contributes to the ongoing dialogue around preventing overdose deaths and other drug-related harms.

Organization of the Remaining Chapters

The second chapter of this thesis examines the Canadian historical context of the overdose crisis with a specific focus on the effects of prohibition. A part of Chapter 2 is also dedicated to briefly detailing the history of colonization in BC and the ongoing effects of colonization on Indigenous communities in the province, specifically in regards to the overdose crisis. Chapter 2 is intended to reorient attention from singular drug users, or singular opiates such as fentanyl, towards the historical, social, and structural contexts that surround the current overdose epidemic in Canada.

The third chapter of this thesis focuses on the current practices of psychotherapy and counselling most often applied to substance use and opiate use specifically. This chapter briefly examines the history of these approaches and critically evaluates their ability to address the current overdose epidemic in Canada.

The fourth chapter of this thesis outlines Bruce Alexander's dislocation theory of addiction and its application to harm reduction psychotherapy practices with opiate users. This chapter outlines specific practices that could increase psychotherapy's ability to reduce the harms of opiate use, specifically reducing fatalities as a result of opiate overdose. This chapter includes a discussion of the role of psychotherapists in social change.

Finally, the thesis concludes with a review of the implications and recommendations, a discussion of the limitations of this thesis, proposals for future research, and the sharing of the

author's personal reflections on the research process and his work during the current overdose epidemic in BC.

CHAPTER 2:
THE HISTORICAL, SOCIAL, AND STRUCTURAL CONTEXTS OF
THE OVERDOSE CRISIS

In this chapter, I will examine the historical and social contexts surrounding the prohibition of opiates in Canada. A review of the literature will demonstrate how the prohibition of opiates has contributed to the current overdose epidemic in BC. I will discuss the disproportionate impact of the overdose epidemic on Indigenous communities and examine the historical and social contexts for this. This discussion is intended to reorient attention from singular drug users, or singular opiates such as fentanyl, towards the historical, social, and structural contexts that surround the current overdose epidemic in Canada.

Statistics of a Health Crisis

British Columbia is in the midst of a public health crisis, with 914 documented overdose deaths in 2016, and 1,422 deaths in 2017 (Woo, 2017). This is an increase of 43% from 2016 to 2017. While there has been a steady increase in overdose deaths over the past two years in BC, December 2016 had the highest monthly total of deaths ever recorded in the province at 128 deaths (Woo, 2017). Eight months later, there were 113 suspected drug overdose deaths in August 2017. This is a 79% increase over the number of deaths occurring in August 2016. This is particularly alarming as it is happening despite a public health emergency announcement in April 2016 and a massive scale-up of the take-home naloxone program that has been used in over 3,000 overdose reversals (Howlett, 2017). Despite an announcement by the provincial government in April 2016 calling the overdose epidemic a health crisis, it seems we are no closer to addressing this epidemic than we were when it was declared a health crisis.

Prohibition and the Overdose Epidemic

British Columbia's overdose epidemic is the result of drug and opiate prohibition and criminalization over the last century in Canada. Through a review of literature, I will illustrate how the criminalization of opiate use in Canada has led to substantial harms including disease spread and death. The emergence of fentanyl and the current overdose epidemic is the direct and somewhat predictable result of over 100 years of drug prohibition in Canada (Beletsky & Davis, 2017).

Marginalized Communities and Racial Discrimination

The overdose epidemic in Canada continues to have its most devastating impacts on substance users who are already marginalized in Canadian society through poverty, physical or mental illness, or racial discrimination. This is starkly illustrated by the disproportionate impact the overdose crisis is having on Indigenous people and communities in Canada. The ongoing impact of colonization on Indigenous people's health in Canada has led to their overrepresentation in overdose statistics (Russell, Firestone, Kelly, Mushquash, & Fischer, 2016).

Fentanyl as a Symptom, Not the Root Cause

The recent overdose epidemic has led to public awareness and attention turned towards the synthetic opiate fentanyl as the cause of the overdose crisis (Howlett, 2017). The BC Coroners service reported that fentanyl was present in 83% of overdose deaths in the province from January to October 2017 (Woo, 2017).

Some politicians, members of the public, and media outlets in Canada have called for more resources to prevent the importation and distribution of fentanyl in Canada (Howlett, 2017). This call for increased opiate prohibition in light of the emergence of fentanyl and the

current overdose crisis fails to see the emergence of synthetic opiates in the historical context of opiate prohibition. Opiate prohibition in Canada has led to the conditions that created a market for synthetic opiates and increased prohibition may create more harm just as historical prohibition has (Beletsky & Davis, 2017).

It is necessary to reorient attention from the singular drug user or the toxic substance fentanyl toward the historical, social, and structural contexts that surround the overdose epidemic. Although the potent synthetic opioids fentanyl and carfentanyl are responsible for people overdosing according to toxicology reports, the current overdose crisis is the result of years of criminalizing opiates and opiate users with an increasing demand for opiates through increased prescriptions of medical opiates.

The Prohibition of Opiates

The overdose epidemic in BC has arisen in the last two years and left government, health, and law enforcement officials scrambling for solutions (Howlett, 2017). To understand the recent spike in overdose numbers; however, it is important to analyze how substances like opium and heroin came to be criminalized and the causal relationship between drug prohibition in Canada and the societal harms related to opiate use.

Opium is a paste made from the dried and concentrated nectar, or milk, from the seed pod of a poppy plant (Brook & Wakabayashi, 2016). Opium first appeared in BC in the 1880s as men from China immigrated mainly to work on the railroad or in industry (Giffen, Endicott, & Lambert, 1991). Opium had been widely used in China for thousands of years and there are references to its use in Greek and Latin literature (Brook & Wakabayashi, 2016). At first, opium was not illegal and opium smoking establishments existed in Vancouver and New Westminster

(Giffen et al., 1991). Alcohol was considered more of a concern at the time due to its association with violence (Giffen et al., 1991).

In September 1907, tensions that had been growing between European settlers and Asian and South Asian settlers came to a head. European settlers rioted in Vancouver and nearby Bellingham in Washington State, smashing Asian settlers' storefronts and lighting fires (Giffen et al., 1991). The riots were clearly racist in nature with rioters protesting for a "white Canada" (Giffen et al., 1991). The riots of 1907 commenced a number of Canadian federal government policies to restrict Asian immigration to Canada including imposing quotas on Japanese immigration, restricting voyages from India, and various enforcement laws against the Chinese such as an immigration or "head tax" on each Chinese immigrant (Barman, 1991). The enforcement laws against Chinese immigrants included the criminalization of opium. Labour Minister William Lyon Mackenzie King brought in the Opium Act in 1907, which made importation, sale, and distribution of opium illegal for non-medical purposes (Giffen et al., 1991).

The initial criminalization of opium was done for racist and economic reasons to discriminate against and discourage Chinese workers from coming and settling in Canada (Carstairs, 2006). The fact that it was introduced by a labour minister highlights that it was criminalized for economic reasons rather than for health concerns as substance prohibition is not normally a concern of a labour minister (Giffen et al., 1991). The prohibition of opium was intended to slow the arrival of Chinese immigrants and discourage their settlement in Canada (Carstairs, 2006).

While opium was made illegal, its use continued and was accompanied by regular police raids of establishments, seizure of drugs, and arrests (Carstairs, 2006). Between 1923 and 1932,

more than 700 Chinese men were deported for drug-related violations (Carstairs, 2006). In part because of this continued police pressure, opium use began to drop in BC in the 1920s and 1930s being replaced in part by the use of heroin (Giffen et al., 1991).

The Emergence of Heroin

Heroin was developed by Bayer Pharmaceuticals in 1895 and first marketed to be as safe as and less addictive than morphine or opium (Gross, 2013). While opium consisted of plant material smoked by users, heroin was sold in a more potent powder form with users increasingly injecting it intravenously (Giffen et al., 1991). Heroin users moved towards injection of the substance as it was more efficient than smoking it and it did not require a large pipe or produce smoke, which made injection use easier to conceal from law enforcement (Carstairs, 2006). Heroin could be imported in much smaller quantities to yield the same profits due to its powdered form and increased potency. By the 1950s heroin was the opiate most available to users while opium became much rarer in BC (Giffen et al., 1991).

The Iron Law of Prohibition

The historic shift from opium to heroin use in BC is an example of what Richard Cowan called the iron law of prohibition (Cowan, 1986). Cowan describes how “imposing substantial barriers and costs to the illicit drug supply chain creates direct pressure to minimise volume while maximising profit. More bulky products become more expensive relative to less bulky ones, incentivising increases in potency” (Cowan, 1986, p. 6).

The iron law of prohibition phenomenon was developed out of an analysis of the alcohol prohibition period in the United States. From January 1920 to December 1933, the United States criminalized alcohol sale and production. During this time, beer and wine production and sales plummeted while the sale of spirits increased substantially. Beer and wine increased 700% in

price during prohibition while spirits increased 200% (Cowan, 1986, p. 22). In efforts to maximize profits, alcohol producers switched to smaller and more potent forms of alcohol that were easier to conceal and transport (Cowan, 1986). The increase in potency and lack of regulation of alcohol resulted in numerous poisonings and illnesses. In one notable incident in New York City, 60 people became ill and 16 died during one night in 1926 (Blum, 2010).

In BC, following the 1907 Opium Act, the iron law of prohibition was seen by the increased scarcity of opium and the move to importing and using heroin due to its smaller size and higher potency (Carstairs, 2006). Increased law enforcement efforts saw heroin becoming more scarce and heroin use becoming more hidden (Carstairs, 2006). The increased scarcity led to an increase in price and more users. Having access to smaller amounts of heroin, users began to use the drug intravenously to maximize the effects (Giffen et al., 1991). The increase in intravenous heroin use led to a scarcity of syringes available to substance users and syringe sharing became a more common practice (Wood, Lloyd-Smith, Strathdee, Small, Tyndall, & Kerr, 2007). In the 1980s, as HIV began to spread in BC, intravenous drug use and syringe sharing became a major factor in the increase in HIV cases (Wood et al., 2007). In 1997, the Vancouver Health Authority declared a public health emergency as HIV rates in the downtown eastside of Vancouver were the highest in the world outside of sub-Saharan Africa (Fayerman, 2015). Vancouver reacted with a number of harm reduction measures including a syringe exchange and safe injection sites. These measures resulted in a significant drop in HIV transmission rates as well as overdoses (Fayerman, 2015).

The iron law of prohibition saw increased law enforcement efforts following the 1907 Opium Act, leading to the importation of smaller and more potent opiate heroin to decrease the risk of detection and seizure by law enforcement and to maximize profits (Cowan, 1986).

Increased law enforcement efforts aimed at heroin users saw the substance increase in price and scarcity (Carstairs, 2006).

Increase in Prescription Opiates

In the 1990s, as harm reduction measures were being implemented in some cities in Canada to prevent overdose deaths and HIV spread from the use of illegal opioids, physicians in Canada were prescribing greater amounts of synthetic opioids such as fentanyl and oxycodone for pain management (Gomes, Mamdani, Paterson, Dhalla, & Juurlink, 2014). Oxycodone was marketed under the trademarked name OxyContin by Purdue Pharma and was advertised to physicians as a non-addictive drug with few side-effects (Fischer, Jones, Krahn, & Rehm, 2011). Until this time, doctors were mostly prescribing opiates for severe pain such as bone fracture, cancer treatment, or palliative care (Fischer et al., 2011). The shift in prescribing practice was partly related to medical research that informed doctors that prescription opiates were appropriate for a wide variety of pain management purposes and were essentially not addictive (Gomes et al., 2014).

In 2007, Purdue Pharma, the makers and marketers of OxyContin settled criminal and civil charges in the United States for the company's deceptive promotion of the medication (Howlett, 2017). Purdue Pharma acknowledged that it had fraudulently and misleadingly marketed OxyContin as less addictive, less subject to abuse, and less likely to cause withdrawal symptoms than other pain medications (Meier, 2007).

Health Canada changed prescribing guidelines for opiates in 2010, and physicians across Canada began to recognize the impact that prescribing opiates was having on patients (Fischer, Gooch, Goldman, Kurdyak, & Rehm, 2014). Many physicians stopped giving opioids to patients

for chronic pain or began working with them on alternative pain management (Fischer et al., 2014).

In 2012, Purdue Pharma's patent on OxyContin expired and generic versions of the brand entered the market place. Purdue Pharma replaced its OxyContin pills in Canada with a new form, OxyNeo, which was more difficult to misuse by crushing, injecting or snorting. OxyNeo now has a patent that will expire in 2037 (Howlett, 2017).

The Effects of Restricting Opiate Prescriptions

The efforts by Health Canada to restrict the supply of medical opiates to Canadians did not take into account the numbers of patients who had come to rely on these medications. Unfortunately, the demand for opiates did not simply dissipate as the supply of medical opiates diminished. A number of people who had been using medically prescribed opiates now had to purchase their opiates from the illegal market (Howlett, 2017). Statistics for this increase in illegal opiate sales are difficult to determine exactly due to the clandestine and illegal nature of opiate importation and sale. The government of Canada; however, realized that the increased prescription of opioids in Canada had led to growth in the number of opiate users in Canada both legal and illegal. Starting in 2012, as prescribing guidelines tightened and OxyContin was taken off the market, the illegal market for opiates grew (Howlett, 2017).

The United States was also seeing an increase in opiate use during this time, which they attempted to counter by increasing enforcement. This is significant to Canada because it interrupted the supply of illicit opiates to Canada from the United States and South America (Beletsky et al., 2017). Federal agents along the Mexico-United States border increased their seizure of opiates from 500 kilograms in 2008 to 2,250 kilograms in 2012 (Drug Enforcement Agency, 2016) This is almost a fivefold increase in the amount of opiates seized. Opiate seizures

within the United States increased from 2,700 kilograms in 2010 to 6,300 kilograms in 2014 (Drug Enforcement Agency, 2016, p. 41).

The increased drug enforcement by the DEA in the US imposed substantial barriers to opiate importation. In Canada and the US, opiate importers were forced to find new ways of importing illegal opiates due to the increased enforcement (Beletsky et al., 2017). As the iron law of prohibition indicates, increased pressures on supply chains will create a need to minimize volume and maximize profit (Cowan, 1986). Fentanyl became the answer for drug importers to continue to supply the market while avoiding the barriers of importation of bulkier heroin (Beletsky et al., 2017; Cowan, 1986).

Fentanyl is synthesized in laboratories from chemicals unlike heroin, which requires plant-based alkaloids (Drug Enforcement Agency, 2016). Fentanyl can be imported in very small but potent quantities or it can be synthesized domestically by importing the necessary ingredient chemicals (Howlett, 2017). Fentanyl is very potent and small in volume. Depending on how fentanyl is synthesized it can be up to 100-times more powerful than heroin (Stanley, 1992). A small amount of fentanyl can be mixed with other substances such as talcum powder or sugar to make larger quantities of powder to be sold for injection, smoking, or snorting (Drug Enforcement Agency, 2016). The fentanyl powder mix can also be pressed into a pill form of opiates (Drug Enforcement Agency, 2016). The danger of illicit fentanyl is that it is difficult to know the potency of the fentanyl used or the percentage of the fentanyl in a specific pill or small amount of powder (Howlett, 2017). The illegal production of fentanyl is not regulated in any way and attempts by importers or sellers to build more scientific laboratories in Canada to analyze their product would put them at risk of being discovered and charged by law enforcement (Beletsky et al., 2017). The majority of fentanyl production therefore takes place in kitchens or warehouses

where the set-ups are quickly put together and often moved to avoid detection (Howlett, 2017; Drug Enforcement Agency, 2016).

The pill forms of illicit fentanyl are a direct attempt by illicit opiate importers and sellers to address the needs of former prescription OxyContin users who may no longer be able to access OxyContin due to changes in prescribing practices. Following changes to prescribing practices and the discontinuation of OxyContin, users were seeking the drug on the illegal market, and the supply chain adapted to the demands (Beletsky et al., 2017). A number of Canadian provinces have made it illegal to possess pill pressing machines in the hopes that this will reduce the number of overdose deaths (Howlett, 2017). Unfortunately, from studying the history of drug prohibition in Canada, it is clear that further restrictions on drug production will not reduce demand but rather force suppliers to find new ways to fill the demand for the product in the marketplace (Cowan, 1986).

The Indigenous Experience and the Overdose Crisis

Proportionately, those most affected by the overdose epidemic in BC are people of Indigenous ancestry. Indigenous people make up about 3.4% of BC's population but make up 10% of the province's overdose deaths for 2016 (Linkins, 2017). These figures exclude people who are not registered as Status Indigenous people or those who are Inuit and Metis, so the figures are undoubtedly an undercount. Indigenous people were five-times more likely to have a non-fatal overdose than non-Indigenous people in BC in 2016 (Linkins, 2017).

Solely focusing on the toxicity of fentanyl does not explain why the overdose epidemic has disproportionately affected Indigenous people. The root causes of the overdose epidemic's disproportionate effect on Indigenous communities rests in the ongoing impact of colonization on Indigenous people (Russell, Firestone, Kelly, Mushquash, & Fischer, 2016). An in-depth

account of colonization in BC is needed to understand and do justice to the experience of Indigenous peoples in this province and its lasting impact, including the disproportionate effect of the overdose crisis on Indigenous peoples.

The overdose epidemic is a health crisis. It is a health crisis disproportionately affecting Indigenous peoples and to fully understand the overdose crisis we have to understand the ongoing impact of colonization on Indigenous people's health. Indigenous historian Mary-Ellen Klem summarizes this point in her statement, "When we talk about the poor health of our people, remember that it all starts with the white man" (Klem, 1999, p. 3). Non-Indigenous commentators have also looked at Indigenous health, often through mortality and morbidity rates as clear indicators of the state of cross-cultural relations (Klem, 1999). Viewing the overdose crisis through this lens, it is clearly a crisis irrevocably linked to the continuing process of colonization.

Vancouver's history of colonization.

The impact of colonization on the current overdose crisis is illustrated in an in-depth look at the history of Vancouver, BC's largest city. The area now called Vancouver has been the site of Indigenous inhabitation for at least 3,000 years (Alexander, 2010). Areas along Vancouver's inlets were the sites of Indigenous fishing villages (Harris, 2011). The land accommodated villages, beautifully decorated communal houses, ancestral burial grounds, and places of significant cultural and spiritual importance for the Indigenous groups that lived there (Alexander, 2010). The Skwxwúmesh lived on what are now called Howe sound, False Creek and Burrard inlet. The Xwayxway occupied much of what is now called Stanley Park and the Senakw occupied what is now called north False Creek (Harris, 2011).

These traditional settlement areas for Indigenous people in Vancouver all encircle the area which is now the epicenter of BC's overdose crisis, Vancouver's downtown eastside (Howlett, 2017). The geographic proximity of the center of the overdose crisis to the traditional and unceded territories of the Indigenous population is significant.

Contact and colonization.

The first documented contact between settlers and Indigenous peoples in BC was in 1791 with Spanish Explorers (Barman, 1991). The discovery of gold in the Fraser Canyon area brought a rush of European settlers and the colony of BC was formed in 1858, which proclaimed all lands in BC to belong to the British Government, or Crown, and those lands were parceled out to individuals (Harris, 2011). Lands were reserved for Indigenous peoples and they were forced to reside there. This forced confinement brought a scarcity of resources and intertribal conflict. The Indigenous peoples on the reserved land began to die of starvation and from intertribal conflicts over resources (Harris, 2011).

New diseases brought to BC by European settlers were also having a serious impact on Indigenous peoples (Barman, 1991). Forced confinement and starvation had led to living conditions where diseases spread quickly and lethally. Smallpox, tuberculosis, and measles began to spread among the confined and malnourished Indigenous communities (Harris, 2011). Although these illnesses were lethal in part due to Indigenous peoples having no history of contact with them, their spread and impact were due to the forced confinement and lack of resources imposed on Indigenous people by colonization (Klem, 1999). Indigenous communities had well developed medical systems that relied on resources they gathered from the surrounding land. Forced confinement meant that the Indigenous peoples did not have access to their medical resources and practices while their populations suffered and died from communicable diseases

(Klem, 1999). Such diseases have spread throughout history and continue to spread when people are displaced from their homes and forced into confinement as evidenced in refugee camps and most notably in the concentration camps in Nazi Germany in occupied areas during the second world war (Klem, 1999).

Upon finding Indigenous villages empty due to the deaths of their inhabitants, further European settlers began to encroach on the small areas to which Indigenous communities had already been confined (Harris, 2011). Thus, the reserve system for Indigenous people was established in BC with most of the current reserve lands being established in the last quarter of the 19th century (Harris, 2011).

They were fixed geographical points of reference surrounded by clusters of permissions and inhibitions that affected most Native opportunities and movements. Once put in place they had a long life. Only now after more than a hundred years after most of them were laid out are they perhaps breaking down somewhat (Harris, 2011, p. 11).

Residential schools.

With the introduction of the Indian Act in 1876, the Canadian government required Indigenous children to receive a government prescribed education and to integrate into Canadian society (Miller, 1996). Some Indigenous parents allowed their children to attend residential school because they wanted them to learn English and other skills highly valued in the quickly changing environment of BC (Klem, 1999). Although the motives expressed by Indigenous families for attending residential school were authentic, the motives of school administrators were not (Klem, 1999). The goal of residential schools was not to teach Indigenous children new and valuable skills but rather to convert them to Christianity and to eliminate their language and culture (Klem, 1999).

Mistreatment at residential schools was common and the use of corporal punishment was universal (Klem, 1999). Children were punished for speaking their Indigenous languages or discussing Indigenous culture. Reports of sexual misconduct by school administrators and staff were not followed up on and were generally ignored. Former students reported being punished for reporting sexual misconduct (Klem, 1999). Much of the abuse went unreported or undocumented at the time and is only now coming to the attention of the Canadian public (Truth and Reconciliation Canada, 2015). The history of reports of abuse being silenced or undocumented means that we may never know the full extent of the abuse that took place at residential schools in Canada and we may never know the level to which the Canadian government was complicit in this abuse by allowing it and ignoring it.

Outside of residential schools, on reservations and Indigenous communities across BC, the provincial and federal governments began oppressing and outlawing expressions of Indigenous culture. The most significant examples are the outlawing of the potlatch and spirit dancing from 1884 to 1951 (Sommers & Bromley, 2002).

A number of residential schools began to close in the 1950s and the federal government began to transfer some Indigenous services to the provincial governments. A 1951 Indian Act amendment enabled the provinces to provide services to Indigenous people where none existed federally; child protection was one of those areas of service (De Leeuw, Greenwood, & Cameron, 2010). The implementation of child protection services provincially represented the next wave of colonization taking Indigenous children away from their communities and culture (De Leeuw et al., 2010).

Thousands of Indigenous children were apprehended by the Ministry of Children and Families and the Indian Affairs Department and put into foster care between 1951 and 1980

(Johnson, 1983). Patrick Johnson first used the term “sixties scoop” to describe this process in his 1983 report, “Native Children and the Child Welfare System”. During the period of 1960 to 1980, over 20,000 Indigenous children in Canada were apprehended from their families and placed for adoption with mainly White, middle class families across the country, while some children were adopted out to families in the US and Europe (Johnson, 1983).

The apprehension of Indigenous children happened swiftly in BC. In 1951, 29 Aboriginal children were in provincial care in BC; by 1964, that number was 1,466. Aboriginal children, who had comprised only 1% of all children in care, came to make up just over 34% by 1964 (Hansen, 2017).

The reasons given by the Canadian government for these apprehensions were varied and in some cases unclear. Government records indicate that the main reason cited for apprehension was that it was “in the best interest of the child” with few other details listed. When other details were listed they included allowing children to access schools and to learn English and job skills (De Leeuw et al., 2010). The stark reality was that Indigenous communities had been confined to areas that were often far away from schools, and now they had their children apprehended due to not being able to access schooling (De Leeuw et al., 2010).

Child apprehension was a deeply flawed process rooted in racism and ideas of cultural superiority (De Leeuw et al., 2010). The Kimelman Report published in 1985 outlined how the term “best interest of the child” had been wrought with cultural bias in a system dominated by White, middle class workers, boards of directors, administrators, lawyers, and judges (Kimelman & Manitoba, 1985).

In February 2017, Superior Court Justice Edward Belobaba ruled in favor of a group of Indigenous plaintiffs represented by Chief Marcia Martel Brown in a class action lawsuit against

the Canadian Government for its child apprehension policies of the 1960s. Justice Belobaba found that Canada breached its common law duty of care to “take reasonable steps to prevent on reserve aboriginal children, who had been placed in the care of non-aboriginal foster or adoptive parents, from losing their aboriginal identity” (Brown v Canada, 2017).

In his decision, Justice Belobaba addressed the impact of child apprehension on Indigenous communities:

The Sixties Scoop happened and great harm was done... The uncontroverted evidence of the plaintiff’s experts is that the loss of their Aboriginal identity left the children fundamentally disoriented, with a reduced ability to lead healthy and fulfilling lives. The loss of Aboriginal identity resulted in psychiatric disorders, substance abuse, unemployment, violence and numerous suicides (Brown v Canada, 2017, p. 6).

The effects of the large-scale apprehension of Indigenous children by government child protection agencies are widespread and only beginning to be documented (Reder, 2007). As expressed in Justice Belobaba’s verdict, the loss of Indigenous identity as a result of the Canadian government’s child apprehension policies has led to substance use, psychiatric diagnoses, violence, and suicide in Indigenous communities (Brown v Canada, 2017). Justice Belobaba’s verdict clearly links the effects of Indigenous child apprehension to substance use. There is a clear connection between the legacy of child apprehension in Canada and the opiate use that has led to the emerging overdose epidemic in BC.

Despite government reports such as the Kimilman report and judicial verdicts in cases such as Brown v Canada (2017) detailing the systemic racism and cultural superiority inherent in the child apprehension process in Canada, Indigenous children are still over-represented in child apprehension cases (Hansen, 2017). Statistics Canada figures from 2011 indicate that Indigenous

children under the age of 14 represent 7% of the children in Canada but represent 48% of children in foster care (Hansen, 2017).

A 2016 ruling by the Canadian Human Rights Tribunal found that the federal government had discriminated against Indigenous people by providing less money for welfare services on Indigenous reserves than what is available elsewhere in Canada (Hansen, 2017). This systemic discrimination led to conditions of poverty, which were then cited as a reason for child apprehension and placement in foster care (Hansen, 2017). Although the “sixties scoop” has passed, the systemic discrimination and disproportionate child apprehension rates for Indigenous people in Canada continues.

The cumulative effect of over 100 years of forced confinement, illness, death, child apprehension, and a lack of both economic and social opportunities has led to many Indigenous people in BC living with the effects of poverty, substance use, and diagnosed mental health issues (Hansen, 2017).

As outlined earlier in this thesis, medical prescriptions of opiates such as OxyContin have steadily increased since the 1990s and this has led to increased numbers of people using opiates both legal and illegal. Indigenous peoples in Canada saw the highest increase in opioid prescriptions. Between 2011 and 2015, the overall dispensation rate for opioids was nearly two-times higher for Indigenous people in Canada (Howlett, 2017). Indigenous peoples averaged 187 prescriptions per 1,000 population while non-Indigenous peoples averaged 98 per 1,000. The difference in dispensation rates was greatest at the ages of 25 to 49 years, where it was nearly three-times higher for Indigenous peoples (Howlett, 2017).

There are multiple explanations for this discrepancy in prescription rates between Indigenous and non-Indigenous peoples. Many Indigenous communities may lack access to

alternative pain management such as physiotherapy as the reservation system in Canada has left many Indigenous populations geographically removed from accessing such services (Webster, 2013). While lack of services may be a reason for the high prescription rates of opiates to Indigenous peoples, Vicky Stergiopolous, chief physician at the Canadian Center for Addiction and Mental health in Toronto suggests that many Indigenous patients are coping with emotional trauma, which manifests itself in physical pain (Gupta, 2017). Stergiopolous suggests that trauma, anxiety, and depression may be presenting as physical pain, which is then treated by an opioid prescription from their physician (Gupta, 2017). The current health of Indigenous peoples in Canada is inexorably linked to the history of colonization in Canada and its continuing effects (Klem, 1999). This is very clearly illustrated in opiate prescription and illicit opiate use rates for Indigenous peoples in Canada.

A situation has been created in BC where Indigenous communities, profoundly affected by the ongoing impact of colonization, are dealing with collective emotional trauma that manifests itself in physical and mental pain. The Canadian medical system has prescribed opiates at nearly twice the rate to Indigenous people compared to non-Indigenous people.

At the same time, the historical trajectory of the prohibition of opiates has led to the emergence of fentanyl through the iron law of prohibition, which sees increased enforcement met with drug suppliers who find ways to supply smaller and more potent forms of drugs to increase their profit and keep up with market demand. This has led to Indigenous communities being disproportionately affected by the overdose epidemic.

Summary

A historical, social, and structural analysis of the overdose epidemic in BC shows how the current situation is a result of over 100 years of drug prohibition in Canada. This historical

and structural perspective is meant to reorient attention from singular drug users, or singular opiates such as fentanyl, towards the historical, social, and structural contexts that surround the current overdose epidemic in Canada. The prohibition of opiates has led to increasingly potent forms of illicit opiates being introduced to the market, with the emergence of fentanyl being the most recent, significant, and deadly.

An examination of the history of colonization in BC shows how colonizing practices such as the establishment of the reserve system and residential schools has led to inter-generational trauma within Indigenous communities. A symptom of this collective trauma is increased opiate use, both through prescriptions and illicit means. This has resulted in the overdose epidemic having a disproportionately high effect within Indigenous communities.

A historical, social, and structural analysis of the overdose epidemic in BC reveals how the current situation has emerged. From such a perspective, current approaches to address the opiate overdose epidemic can be better understood and critically evaluated regarding their potential effectiveness.

CHAPTER 3:

SUBSTANCE USE COUNSELLING AND THE OVERDOSE CRISIS

In this chapter of my thesis, I will discuss the historical and social contexts that surround psychotherapy and counselling for opiate use disorder in Canada. I will discuss the history, evolution, and current practices of psychotherapy and counselling for opiate users and the area of addictions treatment in Canada. For the purposes of this discussion, I will use the Diagnostic and Statistical Manual, 5th edition (DSM-5) criteria for opiate use disorder as a guide. The DSM-5 states that the clinical criteria for “drug dependence” (or addiction) includes compulsive drug use despite harmful consequences; inability to stop using a drug; failure to meet work, social, or family obligations; and sometimes (depending on the drug), tolerance and withdrawal (American Psychiatric Association, 2013).

BC psychotherapy practice for opiate use disorder includes, but is not limited to, the work of publically and privately funded treatment facilities, addictions counsellors, registered clinical counsellors, and physicians (Luce & Strike, 2011). I will also examine the work of support groups in the community such as Narcotics Anonymous. This discussion will focus on the ability of current psychotherapy and addictions counselling approaches to address the opiate overdose epidemic.

To analyze the ability of current substance use treatment models to address the overdose epidemic, I will examine the history of substance use treatment in Canada and the current, dominant, substance use treatment models. First, I will discuss the moral model of addiction treatment and how opiates and ideas around the loss of morality became inexorably linked. Then, I will discuss the emergence of the medical model of addiction and its focus on opiate use

disorder as a brain disease. Following this I will look at the emergence and influence of 12-step treatment models such as Narcotics Anonymous.

I will examine how effectively these dominant addictions treatment models are able to address the overdose epidemic and examine what practices may engage those using opiates, and which may push them away. I will also investigate whether the three dominant models of addictions treatment are addressing the needs of Indigenous people in BC or whether they are a continuation of colonialist practices.

Can our current psychotherapy practices significantly reduce overdose numbers and save lives? What dominant approaches of our current psychotherapy and counselling practices in Canada need to be addressed in light of the overdose epidemic?

Calls for Increased Substance Use Treatment

Discussions regarding substance use treatment have increased in conjunction with the current overdose epidemic (Karstens Smith, 2017). Various levels of government are encouraged to fund and support more substance use treatment programs as a way to reduce the number of deaths related to opiate overdose in BC. Increased access to psychotherapy and counselling is seen by many as a way to reduce the impact of the overdose epidemic in BC.

In BC, the overdose epidemic has been met with calls from city mayors, police chiefs, and religious leaders for increased access to opiate use disorder treatment for opiate users. Gregor Robertson, Mayor of Vancouver, the city with the highest overdose death numbers in the country, called upon federal and provincial leaders to increase access to substance use treatment facilities to “create a system in which opiate users seeking treatment can access it immediately and 24/7” (Robertson, as cited in Woo, 2017). J. Michael Miller, Archbishop of the Roman Catholic Church of Vancouver, called for “more treatment and residential care for those addicted

to opiates” in an open letter published online (Miller, 2016). Dr. Evan Wood, director of the BC Centre on Substance Use, said expanding access to treatment is the key to addressing the overdose crisis (Karstens Smith, 2017). BC Premier John Horgan responded to calls from mayors and community leaders by announcing on September 27, 2017 that the province will spend more than \$31 million over the next 3 years to increase access to treatment programs for opiate users. With increased focus and funding for substance use treatment programs as a tool to address the overdose epidemic, it is important to understand the history of treatment programs for substance use in Canada and to evaluate whether or not our current approaches are able to address the overdose epidemic and ultimately save lives.

Historical Rise of the Moral Model

Approaching addiction and opiate use from a moral perspective has the longest history of any perspective in Canadian and Western European thought and its influence on addictions treatment continues currently (Alexander, 2010). The moral model of addiction has its roots in Christianity and Christian thought. The writings of St. Augustine (354-430), Bishop of the Church of Rome, form the foundation of the moral model of addiction treatment (Warner, 1963; Alexander, 2010). St. Augustine wrote of his own addictions issues in his youth and how his imploring of god for assistance and help led to his sobriety and salvation (Alexander, 2010). The core of the moral model’s treatment for addiction is the practice first written about by St. Augustine of asking god for assistance and finding the moral strength to overcome addiction (Russell, Davies, & Hunter, 2011).

The moral model states that addictions are the result of human weakness, and are defects of character, so that addiction is a moral failing. Those who advance this model believe either that a person with greater moral strength could have the force of will to break an addiction, or

that the addict demonstrated a great moral failure in the first place by starting the addiction (Alexander, 2010). The moral model of addiction dominated addictions treatment in Western Europe and North America until the mid-20th century. Addictions treatment was the domain of the church and the state and addicts were cured by religious conversion or punished for sin in correctional institutions (Russell et al., 2011).

The moral model in Canada.

Early 20th century concerns about substance use in BC, specifically opiate use, were moral and criminal in nature (Erickson, 2013). Government officials and members of the public were worried that substance use and especially opiate use was contributing to the moral decay of Canadian society. Media reports from the period indicate that opiate use was seen to increase sinful behavior, namely crime and prostitution. Throughout these discussions, concerns were expressed about Caucasian Canadians sharing space with Asian Canadians (Carstairs, 2006).

One of the social policy innovators in this area was Emily Murphy (1869-1933), the first female magistrate in Canada and the British Empire (Tooley, 1999). She is memorialized on the back of the Canadian fifty dollar bill. Emily Murphy is best known for her contributions to Canadian feminism, specifically to the question of whether or not women were “persons” under Canadian law (Tooley, 1999). Her contributions to the criminalization of substances and her focus on the moral impact of substance use in Canadian society; however, are of interest in this discussion. Her book, *The Black Candle*, was published in 1922 and was a best-seller in the 1920s, being reprinted until the 1970s by Coles Bookstores (Erickson, 2013). In *The Black Candle*, Murphy outlines her belief that immigrants from Asia are conspiring to erode the moral fabric of Canadian society and even enslave Caucasian Canadians through opiate use (Erickson, 2013).

In 1923, the federal government, prompted by Emily Murphy, made marijuana illegal and took further steps to restrict Chinese immigration and increased sentence lengths for drug use and possession (Tooley, 1999). The moral views of addiction that were rooted in racist ideas about European superiority clearly informed the criminalization of opiates and other substances (Erickson, 2013).

The belief that the use of substances such as opiates was a moral issue in society was also supported by many medical professionals at the time. Emily Murphy's *The Black Candle* quoted Dr. James Warnock from *The Journal of Mental Sciences* for January 1903: "The moral degradation of these cases is their most salient symptom; loss of social position, shamelessness, addiction to lying and theft, and a loose, irregular life makes them a curse to their families" (Murphy, 1922, p. 7).

The predominance of the moral model in early 20th century Canadian public policy is mirrored by the process of colonization at the time. The language and framework used in descriptions of the moral healing of addictions is very similar to the language and frameworks used in the process of colonization. Indigenous cultural practices and lifestyles were seen as immoral by government officials, and many European settlers at the first half of the 20th century (Russell et al., 2016).

Criminalization of opiates and the moral model.

With the increased criminalization of opiates in Canada, treatment of opiate addiction became the responsibility of Canadian jails and reformatories (Solomon & Green, 1982). Those found to be using illegal substances including opiates were given prison sentences. The aim of the Canadian prison system in the early 20th century was to protect the public from criminality and punishing offenders (Solomon & Green, 1982). Each prison also had a variety of Christian

religion-based programs and religious conversion was seen as a solution to the moral failing of criminality (Tooley, 1999).

In 1901, the Salvation Army, a Protestant Christian non-government organization with its origins in England, recommended to the Canadian federal government that a prisoner probation system be adopted, which led to Canada's first parole program (Fischer, Roberts & Kirst, 2002). An early focus of the Salvation Army's prisoner probation system was substance use treatment and counselling based on the moral model of addiction. In BC, the Salvation Army established substance use treatment programs connected to the criminal justice system in Vancouver and rural areas surrounding Vancouver (Fischer et al., 2002).

Opiate use is treated from a moral standpoint by working towards an individual taking sole responsibility for their substance use and not blaming others. This includes not looking at their personal history or society as a source of addiction (Alexander, 2010). The person in treatment is encouraged to take a moral inventory of their selves and to ask god, or a higher power, to take control of their lives of which they have lost control (Alexander, 2010). The moral model focuses on strict abstinence from substances as the only way to overcome addiction. An addict is an addict for life and cannot ever use substances again (Alexander, 2010). Early opiate addiction treatment from a moral model perspective was focused on daily or even hourly prayer and penance, or working for the church to atone for one's sins (Fischer et al. 2002).

The current influence of the moral model and eclectic spirituality.

The moral model of addictions treatment still has a prominent place in addictions and opiate use disorder treatments in BC. The Salvation Army runs one of only two adult detoxification facilities in Vancouver, often the first place for those struggling with addiction to turn for assistance (<https://www.salvationarmy.ca/>). The Salvation Army operates six drug

treatment facilities in BC and the Union Gospel mission operates four. Many other smaller treatment facilities or recovery-based residences, or recovery houses, are affiliated with religious or spiritual organizations (Luce & Strike, 2011).

While drug treatment programs organized and funded by religious organizations are clearly still connected to the moral model of addictions treatment, other treatment approaches also have strong connections to the moral model of addictions. The moral model's influence on addictions and opiate use treatment is evident in the inclusion of eclectic spirituality in addictions treatment and counselling. Eclectic spirituality has no agreed upon universal symbol, deity, or organized religious affiliation (Alexander, 2010). Central to eclectic spirituality is the idea of universal compassionate love. "Eclectic Spirituality starts with the belief that one's own serenity is the primary, achievable goal in an imperfect world" (Alexander, 2010, p. 300). Many 12-step programs incorporate the serenity prayer in their practice, where participants ask a higher power for serenity (Flanagin, 2014). While an eclectic spirituality approach to addictions treatment does not explicitly judge the substance user as morally deficient, it does seek to remedy substance use by connecting the substance user to a larger understanding of their place in the universe and acceptance of this (Alexander, 2010). In essence, the approach seeks to support the substance user through a moral connection to the world. By seeking to remedy opiate use disorder through moral growth or healing, I would argue that eclectic spirituality is essentially restating the moral model's assertion that the root cause of addiction is moral in nature. Eclectic spirituality continues the legacy of the moral model of addiction by viewing the treatment of substance misuse or addiction to lie in the moral healing and growth of the substance user.

The Disease Model

While the moral model of addiction was the primary model of addictions treatment in the first half of the 20th century, modern psychology and medicine were developing theories of addiction and substance misuse that viewed substance use as a disease, specifically a brain disease (Levy, 2013). The disease model of addiction currently describes addiction as a progressive disease and a psychiatric disorder. The claim that addiction is a brain disease is almost universally accepted among scientists who work on addiction (Levy, 2013). The American Society of Addiction Medicine defines addiction as

a primary, chronic disease of brain reward, motivation, memory and related circuitry. It is characterized by the inability to control behavior, it creates a dysfunctional emotional response, and it affects the user's ability to abstain from the substance or behavior consistently (National Institute of Drug Abuse, 2009, p. 7).

According to the DSM-5, the clinical criteria for "drug dependence" (or addiction) includes compulsive drug use despite harmful consequences; inability to stop using a drug; failure to meet work, social, or family obligations; and, sometimes (depending on the drug), tolerance and withdrawal (American Psychiatric Association, 2013).

Medical physicians in Canada in the first half of the 20th century concentrated on the physical and measurable effects of substances such as opiates on the brain and sought to deal with addiction through pharmaceutical remedies (Levy, 2013). Those who support the disease model of addiction note that neuroscientists embrace the brain disease model of addiction, because they have made great progress in uncovering neural mechanisms and neuroadaptations that are correlated with, and undoubtedly causally involved in, addiction (Leshner, 2001; Levy, 2013). Opiate use disorder treatment from a medical model perspective is based on the idea that,

if brain chemistry and structure have rendered the opiate user unable to control impulses to use opiates, then a pharmaceutical remedy could be found to remedy these changes in the brain (Levy, 2013). While brain chemistry was being addressed with medications, opiate users could engage in psychotherapy to better cope with life stressors (Leshner, 2001).

The Adaptive Model

Early psychotherapists, like Sigmund Freud, who experimented with the use of cocaine himself, developed a theory that addiction and substance use were a way for people to self-regulate their emotions (Hopper, 1995). Freud believed that those who had diminished capacity to regulate negative emotions and cope effectively with stress would become addicted to substances (Hopper, 1995). Freud asserted that psychoanalysis treatment would assist people in dealing with their addictions by uncovering their unconscious thoughts and emotions (Hopper, 1995). Freud's work laid the foundation for the adaptive model of addiction in psychotherapy that postulates that addiction is the result of issues such as poverty, abuse, faulty upbringing, or past trauma. These may develop into a situation where people are unable to handle stressors and control substance use (Alexander, 2010). The adaptive model subscribes to the idea that when someone is unable to handle life stressors, they will turn to substances to relieve the stressors (Alexander, 2010).

Combining the disease model and the adaptive model.

Many scholars and counselling practitioners have begun to combine elements of the disease model and the adaptive model into how they view and treat substance use issues (Alexander, 2010). By combining elements of both the disease and adaptive models problematic substance use is seen as an adaptive practice that results from a genetic predisposition combined

with faulty upbringing, abuse, trauma, or other harmful experiences that cause the person's brain chemistry to adapt and change to crave or be addicted to substances (Alexander, 2010).

The disease model in practice.

Several medications for opiate use disorder are instrumental to the medical model of addiction treatment and are currently in use in Canada. Methadone, a synthetic opiate, developed in Germany in 1937, is an opiate replacement therapy that seeks to replace the use of other opiates with methadone use, and then to gradually taper the patient to lower doses and eventual cessation of methadone (Luce & Strike, 2011). Buprenorphine, sold under the brand name Subutex, is used as an opioid receptor antagonist; it binds to opioid receptors in the body and brain and prevents opioid withdrawal symptoms and cravings (Luce & Strike, 2011). Buprenorphine is often combined with naloxone to treat opiate use disorder, as naloxone blocks the effects of opiates, leaving the opiate user less likely to use opiates as they will have little to no effect. All three of these medications are used as maintenance therapy to allow the opiate user to limit, or stop, use of other opiates and to eventually work towards opiate abstinence (Luce & Strike, 2011).

Effectiveness of the disease model.

While the disease model has developed several medications that assist opiate users in moving away from non-prescribed opiates, it explains little about the phenomenon of addiction and does not address the increased use other than to focus on an individual genetic predisposition or individual trauma or negative life experiences (Alexander, 2010). The largest challenge in the administration of maintenance therapies such as methadone and buprenorphine is the retention of patients (Luce & Strike, 2011). Many opiate users may choose to not engage in maintenance

therapies, end maintenance programs early, or choose abstinence-based approaches instead (Luce & Strike, 2011).

Methadone maintenance therapies also increase the risk of opiate-related deaths for many patients. A 2015 study by the Canadian Drug Safety and Effectiveness Research Network found that psychotropic drugs were associated with an increased risk of opioid-related death among patients prescribed methadone for opioid use disorders. The report also found that new initiation of methadone increased the risk of opioid-related mortality 16-fold (Leece, Cavacuiti, Macdonald, Gomes, Kahan, & Srivastava, 2015).

A review of methadone programs across Canada in 2011 for the Canadian Executive Council on Addictions found that

the stigma of addiction is very prevalent and affects every level of the addiction treatment system. As a substitution treatment, methadone maintenance therapy is judged to be less effective and often morally wrong as compared to abstinence-based treatment by both doctors and patients. The common perception that methadone just substitutes one drug for another drug is pervasive and impacts everything from clients choosing to go on methadone, to physicians seeking exemptions, to governments and regulatory bodies establishing policies and funding for methadone maintenance therapy (Luce & Strike, 2011, p. 3).

Maintenance therapies for opiate use disorder have so far failed to deliver the promise of a universally effective and safe treatment for opiate users. This may be due in part to the stigma of maintenance therapies as simply replacing one drug for another as well as the risks involved in undertaking the therapy. Patients have often identified abstinence as a goal, and have seen maintenance therapies as not supporting this goal (Mueller, Walley, Calcaterra, Glanz, &

Binswanger, 2015). For those not identifying abstinence as a goal, maintenance therapies have pushed for abstinence by focusing on reducing methadone amounts and working towards cessation of methadone use (Mueller et al., 2015).

Maintenance therapies in Canada have also focused on addiction as a brain disease, and focused on addressing the effect of opiates on the brain, though this individual, medical approach has failed to engage opiate users or retain them in treatment (Luce & Strike, 2011). Maintenance therapies in Canada have also been infrequently provided in conjunction with psychotherapy programs or counselling programs and have focused on a medical relationship between doctors and patients. Little social or psychological support is available for those entering methadone programs in Canada (Luce & Strike, 2011).

Finally, the arguments over ‘brain disease’ should be put behind us. Our real challenge is to understand addiction and devise better ways to help.

12-Step Models of Addictions Treatment

While the moral model of addiction saw substance use as a moral failing, remedied by a stronger connection to god, and the disease model saw addiction as a result of genetic disposition and upbringing, remedied through psycho-pharmacology and psychotherapy, the Alcoholics Anonymous movement, and later, Narcotics Anonymous and related community meetings combined elements of both of these models into a new social model of addictions treatment. While the Narcotics Anonymous model borrows from both the moral and medical models of addiction, I believe it represents its own model of addiction treatment. Its historical and current influence on drug treatment in Canada are important to consider.

History of the Narcotics Anonymous Model

The Alcoholics Anonymous model, or 12-step model, of addiction treatment was first developed by Bill Wilson and Dr. Robert Smith (Wilson, 1957). In 1935, Bill Wilson hosted the first Alcoholic Anonymous meetings in his New York home (Wilson, 1957). Prior to the founding of Alcoholics Anonymous, Bill Wilson had been a part of The Oxford Group, an American Christian organization founded by the American Christian minister Frank Buchman (Khantzian & Mack, 1994). The Oxford Group was part of the Religious Society of Friends movement in America that had its roots in mid-17th century Lancashire, England. Members are informally known as Quakers (Khantzian & Mack, 1994). The Oxford Group had several practices that appear to have influenced the Alcoholics Anonymous model and Bill Wilson himself, who outlined those connections in his 1957 “A Brief History of AA” (Wilson, 1957). The Oxford Group saw themselves as a group with shared beliefs, not a religion. Both NA and AA clearly express that they are fellowships and not religions (Khantzian & Mack, 1994). The Oxford Group encouraged group meetings where individuals would confess their sins and the Oxford Group had four absolutes, or practices, that were similar to steps. The Oxford Group published three books in the 1930s describing their approach to treatment for alcoholism (Khantzian & Mack, 1994).

The Alcoholics Anonymous model, or 12-step model, has been applied in many different ways since its advent; however, some core practices and beliefs define the model. The 12-step model is primarily a group model of addiction treatment with scheduled meetings. Many members also have individual support persons, or sponsors, to mentor them through the 12-step program. Those who attend meetings identify themselves as addicts, admit to be powerless over addiction, and recognize that a higher power can provide strength and guidance (Khantzian &

Mack, 1994). The following steps are a combination of self and spiritual development including admitting and making amends for past errors, developing new behavior and practices, and finally, helping others with addiction issues (Khantzian & Mack, 1994). The final step has in part helped 12-step models of addiction recovery to become so widespread in addiction treatment.

The 12-step approach to substance use and opiate use treatment is the dominant approach in Canada and its influence can be seen across many communities. Most counselling treatment centers and recovery houses in Canada are based on the 12-step recovery model that originated in Alcoholic Anonymous and later in similar groups such as Narcotics Anonymous, Cocaine Anonymous, and others (Denning, Glickman, & Little, 2003). The 12-step abstinence-based model has been the strongest influence on substance use counselling services in North America (Cunningham & Breslin, 2004).

Abstinence as a Dominant Theme in Substance Use Treatment

The dominant models of opiate use disorder psychotherapy or treatment in Canada, the moral, medical, adaptive, and 12-step approaches, focus on complete abstinence from substances as the goal of treatment. For many of the treatment facilities that practice these models, abstinence from substances must be reached for a short period, usually 72 hours, before even gaining access to the substance use therapy (Olsen & Sharfstein, 2014). Practical reasons are given for this, including the safety of the person entering treatment, as rapid cessation of opiate use can carry physical side-effects and risk (Olsen & Sharfstein, 2014). Clearly, however, substance use treatment and psychotherapy in BC is overwhelmingly focused on abstinence from substances. For those not identifying abstinence as a goal, the abstinence-based programs have a message: You must hit your “rock bottom” before you will change (Cunningham et al. 2004). Opiate users are left to purchase opiates illegally and are discouraged from seeking counselling

or treatment unless they identify abstinence as their goal. An abstinence-based approach does not welcome into their programming those who are currently using substances. Some abstinence programs even see connecting or supporting individuals who use substances as “enabling” them to continue to use substances (Cunningham et al., 2004). Often, clients entering abstinence-based treatment programs are required to cease all contact with friends and relatives who are currently using substances for a period of time (Olsen & Sharfstein, 2014). Abstinence-based programs account for 93% of all drug and alcohol treatment programs in North America (Denning, Glickman, & Little, 2003). The goal of abstinence is often measured in the length of time that someone has not used substances.

Dominance and dangers of abstinence.

The dominant focus on abstinence in opiate use disorder treatment in Canada has created a system of treatment options that either exclude opiate users who do not identify abstinence as their goal, or endanger the lives of opiate users by focusing on rapid opiate cessation and abstinence. The reliance on opioid detoxification treatment needs to be reduced in light of strong scientific evidence that it is ineffective and possibly harmful (Nosyk, Anglin, Brissette, Kerr, Marsh, Schackman, & Montaner, 2013). A 20-month study of 137 patients in a 28-day opiate detoxification and treatment program in London, England found that patients who “successfully” completed inpatient detoxification (i.e., they had completely stopped using opiates for the 28-day period) were more likely than other patients to have died within a year. Conversely, no patients who failed to complete detoxification died (Strang, McCambridge, Best, Beswick, Bearn, Rees, Gossop, 2003). These startling findings; however, were limited by the relatively small size of the cohort studied.

A 2007 study of 10,454 Italian heroin users found that overdose deaths were greatly reduced while opiate users participated in treatment; however, high death rates occurred after they left treatment, particularly within the first 30 days (Davoli, Bargagli, Perucci, Schifano, Belleudi, Hickman, & Faggiano, 2007). This suggests that programs that rapidly detoxify dependent heroin users and place them quickly back into their communities put these users at high risk of overdose death (Davoli et al., 2007).

Similar findings were reported for cohorts of opiate using prisoners who had been recently released from correctional institutions. The 2013 study, “Mortality after Prison Release” looked at post-release mortality for male inmates between 1999 and 2009 across Washington State in the US (Binswanger, Blatchford, Mueller, & Stern, 2013). Opiate overdose was the leading cause of death for inmates in the six-month period following their release. The authors believed that the loss of tolerance to opiates was the cause of many of these overdoses, though suicide and the emergence of fentanyl were also factors (Binswanger et al., 2013). While in correctional facilities, prisoners reported having limited or no access to opiates, and the forced abstinence lead to a lowered tolerance for opiates. A return to pre-incarceration opiate use levels often leads to opiate overdose and death (Binswanger et al., 2013).

What these studies all indicate is that rapid opiate cessation and abstinence from opiates for a short period increases the risk of overdose and death for opiate users. Abstinence models of treatment must be re-examined as it appears that the treatment they offer results in higher overdose numbers and deaths.

Focus on Individualism: Bio-Psychological Self vs the Social Self

Opiate use disorder treatment in Canada has historically been an individually-based practice and the three dominant models of addictions treatment continue to treat addiction as an

individual problem. The moral model of addiction treatment focuses on opiate use disorder as a moral failing of the individual. The disease, or medical model, views opiate use disorder as a brain disease centrally located in the functioning of an individual's brain. 12-step programs, while often social in nature, locate addiction within the individual, going so far as to define the individual by their substance use. 12-step meetings often begin with individual introductions by group members of "Hello, my name is _____, and I'm an addict" (Khantzian & Mack, 1994). The three dominant models of opiate use disorder treatment focus on the individual's understanding of self, as a bio-psychological, or particle self, which excludes an understanding of the self as a nexus of relationships (i.e., the social self) (Adams, 2016).

Dangers of Solitary Opiate Use and Overdoses

The risks of using opiates alone are clearly documented in overdose statistics. Those who overdose fatally are usually using opiates alone with no-one to assist or to call paramedics if they overdose. In a December 2017 press release, BC's chief coroner Lisa Lapointe urged all substance users to not use substances alone, pointing to the importance of calling paramedics as soon as an overdose occurs and also using the opiate overdose reversing medication naloxone (Woo, 2017). Throughout the overdose epidemic in Canada, not one death has occurred at a supervised substance injection site (Woo, 2017).

The message to not use alone is in stark contrast to the message that substance use treatment has developed about substance use being an individual problem. The dominant models of substance use treatment have constructed substance use as an individual problem, rooted in moral, neurological, or adaptive issues. Those who use substances may have internalized these ideas that substance use is an individual problem and therefore using substances alone fits this view. Those who have identified abstinence as their goal may not want to disclose to anyone that

they are currently using substances; therefore, they use alone and are at greater risk. This group of individuals, many of whom have recently left a substance use treatment program, are most at risk of overdose and most likely to use alone (Davoli et al., 2007).

Indigenous Perspectives and Treatment

Indigenous populations have been disproportionately affected by the overdose epidemic and are particularly underserved by the dominant models of addiction treatment. Western perspectives imposed on Indigenous populations through colonization treat substance use as an illness or disease rooted in the individual (Browne, Varcoe, Lavoie, Smye, Wong, Krause, & Fridkin, 2016). Western colonization has treated substance use as a problem that affects a disproportionate number of Indigenous peoples without addressing the relationship between the effects of colonization and increased substance use (Browne et al., 2016). Western colonization has categorized certain drugs as acceptable and others as unacceptable and problematic. Opiates, marijuana, and cocaine are all substances that do not have a long history in Western European countries, and consequently, they are illegal, socially unacceptable, or seen to be more problematic than other substances, such as alcohol that has a long history in Western Europe (Lavalley & Poole, 2010). Colonization led to the criminalization of opiates, and colonialist practices and attitudes continue to view opiate use as being more problematic than other substances (Browne et al., 2016).

The moral model was developed mainly from Christian theology and its progression mirrors that of colonization. The early history of moral model-based addictions treatment in Canada and its connection to the criminalization of opiates shows a pattern of racist policies against non-European Canadians, forced incarceration, and forced moral treatment (Carstairs, 2006). The similarities between the early practices of the moral model and the early practices of

colonization, including residential schools, must be considered. The moral model's focus on individual spirituality and individual moral failing are concepts that are not part of most Indigenous perspectives in North America (Gone & Calf Looking, 2011).

The medical model is based on a western, scientific understanding of the individual and western medical concepts of brain function and mind/body connection. This understanding of the self as a bio-psychological being does not take into account the social self (Adams, 2016). Maintenance therapies such as methadone have focused on the neuroscience of individuals, while excluding the social factors associated with substance use (Levy, 2013) (Adams, 2016).

The 12-step model is based on western religious traditions, and concepts like steps that are undertaken by individuals and focused on individual recovery (Khantzian & Mack, 1994). This individual approach does little to incorporate an Indigenous understanding of community or social identity (Browne et al., 2016).

All of these factors have created an opiate use disorder treatment system that has not addressed the social factors of addiction. The approach has been particularly alienating to Indigenous communities in Canada.

Summary

An analysis of the dominant opiate use disorder psychotherapy treatment models and their historical significance reveals significant gaps in the ability of the current substance use treatment system in Canada to engage opiate users who are at risk of overdose. An analysis of common treatment practices such as rapid detoxification and a focus on abstinence suggests that such practices may actually be endangering opiate users lives and unintentionally contributing to the overdose epidemic. The current dominant models of opiate use disorder treatment also appear to not be engaging Indigenous communities in Canada, while those communities are

disproportionately affected by the overdose epidemic. While a greater call is being made for expansion of the current treatment models in response to the overdose epidemic, further analysis suggests that the current approaches to opiate use are largely ineffective. An expansion of such models will not likely significantly address the overdose epidemic.

CHAPTER 4:
DISLOCATION THEORY AND CONNECTION THROUGH HARM
REDUCTION

In this chapter, I will outline Bruce Alexander's dislocation model of addiction and look at how it can inform psychotherapy practice. I will connect the theory of the dislocation model to specific practices in counselling and psychotherapy in light of the overdose epidemic. Specific recommendations for practice are outlined, including immediate changes to practice that could save lives. Finally, I will discuss the role of counsellors as activists in social change, specifically relating to the prohibition of opiates and the harmful and deadly effects of that prohibition.

The overdose crisis in Canada has created an urgent need to change the practices and theory of psychology and psychotherapy surrounding opiate use in Canada. Therapists and counsellors must immediately consider changing how they engage and support those using opiates as well as the families and communities where opiate use exists. In 2017, 1,422 individuals died of a drug overdose in BC, a 43% increase from 2016, which saw 993 deaths, and more than triple the 369 deaths from overdose in 2014 (Woo, 2017). This incredible increase in overdose deaths represents a crisis where psychotherapists are actively involved. During this period, counsellors and therapists were connecting with opiate users across Canada at health clinics, hospitals, in private practice, and at numerous substance use treatment facilities. For many years, academic research and counselling theory has outlined changes that are needed in psychotherapy with regards to addictions (Alexander, 2010). The overdose epidemic is increasing the urgency for changes to theory and the approach and practices of addiction treatment in Canada to save lives.

Expanding the Adaptive Model

Opiate use treatment must be re-orientated from looking at the singular drug user to examining the historical and societal contexts of opiate use. This entails viewing opiate use from an adaptive model standpoint while expanding the scope and breadth of the adaptive analysis. While an individually-focused adaptive approach would look at a single person's upbringing, including traumas, and personal grief and loss, for example, an expanded adaptive approach would examine opiate use in the historical and current context of communities, cultures, and economic systems (Alexander, 2010).

Such an approach is discussed in detail by Bruce Alexander in "The Globalization of Addiction" (2010). Alexander (2010) expands the definition of addiction far beyond problematic substance use to include the pursuit of power, money, dysfunctional relationships, and time spent on computers among many other things. Alexander (2010) describes a social perspective on addiction that does not deny individual differences in vulnerability to addiction, but removes them from the foreground of attention. Attention is then focused on the social determinants of addiction, which Alexander (2010) argues are more powerful than individual vulnerabilities. Alexander (2010) refers to this perspective as the dislocation theory of addiction.

Alexander (2010) focuses on the disconnection between individuals in society as being at the root of addictive behavior. The dislocation theory of addiction was formulated through a historical analysis of addictive behavior and social determinants of that behavior. The core of the theory is that psychosocial integration is vital to preventing addiction and in people moving away from addiction. If a person feels connected to others and to society, they are less likely to engage in repetitive and harmful behaviors (i.e., addiction) (Alexander, 2010).

The dislocation theory of addiction may present a challenge for therapists and health professionals working in the field of substance use since it makes clear the need for profound social change rather than simple strategies for counselling practice (Levine, 2009). The dislocation theory of addiction encourages a profound change in how therapists and health professionals engage and work with those with addictions.

I believe that a counselling approach to addressing the overdose epidemic informed by the dislocation model could bring about important and immediate changes to practice, which could save lives. The dislocation theory requires those working as counsellors or therapists to re-orientate their perspective from the individual to the societal and historical contexts surrounding individuals and their community. Such a re-orientation is detailed in Chapter 2 of this thesis. I believe that the dislocation theory asks therapists to not only look at how to work with individuals on positive change but also on how to work with communities and society as a whole.

Moving Away from the Disease Model

While neuroscientific debate continues over whether or not substance use or substance dependency is a brain disease, the dislocation model encourages psychotherapists and health care professionals to widen their analysis from looking at the individual only to looking at the wider social context. Bruce Alexander (2010) advocates for abandoning the disease model of addiction and moving towards an adaptive framework informed by his dislocation theory of addiction. He points out that medicine has made many great successes in many domains but has made little progress in understanding and treating addiction.

Those who advocate for a social response to addiction rather than a medical one, point out that addiction increases and decreases throughout history depending on the social conditions

at the time (Alexander, 2010; Levy, 2013). The experience of the Indigenous peoples of BC outlined earlier in this thesis is an example of how addiction increases along with certain social conditions. Prior to colonization, no mention was made of addictive behavior or substance use among the Indigenous peoples of BC, either through Indigenous oral histories or through early accounts of colonialists (Alexander, 2010). The effects of colonization were the root cause of increased substance use and addiction among Indigenous people across Canada (Beletsky & Davis, 2017).

Neil Levy (2013) believes that, though addictive behavior may change neuropsychological functioning, it is not caused by it, and it is not the primary reason for the existence of addiction.

Addiction is not best understood as a brain disease, though it certainly involves pathological neuropsychological dysfunction. Addiction is a disorder of a person, embedded in a social context. The neuroscientists and their allies have mistaken some necessary conditions of the disorder with the disorder itself (Levy, 2013, p. 2).

Looking for Oblivion

The addiction was all about looking for oblivion, for forgetting the contortions we go through just enough to be ourselves for a few hours (Keith Richards, 2016).

I would suggest that counsellors and psychotherapists should put aside the debate over whether or not addiction is a brain disease, particularly in light of the overdose epidemic. It seems that a pharmaceutical solution for opiate addiction, or opiate use in particular, is not a reality at this moment. I would argue that even if a highly effective medication could be developed to take away all physical cravings for opiates from individuals, substance use and opiate use would persist in Canada. For many who use substances, a drive exists to escape

reality, to control emotions, and to step outside of them. It is doubtful that these drives and urges can be medicated away completely (Alexander, 2010).

Psychotherapy practice must embrace the idea that substance use and the reasons behind it are as varied as the people who access services. The overdose epidemic makes clear that as a society we need to stop trying to “cure” substance addiction by focusing on abstinence, and rather, learn to include substance users in our social connections while reducing the levels of harm and death related to substance use.

Health care, including psychotherapy for substance users, should be about reducing harm, saving lives, and empowering communities to do the same. I believe that this shift in approach will result in a better sense of psychosocial integration and acceptance for those who use substances or struggle with addiction. This integration will lead to less of a sense of dislocation with society, particularly within marginalized communities. The increased psychosocial integration may lead to a decrease in substance use and addiction, but this is not the intended focus. The focus of psychotherapy practice, particularly in light of the overdose epidemic, has to be to engage and connect those who use opiates with health and community services to reduce drug-related harm and death.

Harm Reduction

Psychotherapy and counselling practices across Canada must immediately take a harm reduction approach to opiate use in light of the overdose epidemic. Such an approach takes into account the therapist’s professional responsibility to do no harm and to preserve human life. The BC Clinical Counsellors Code of Ethics and Standards makes clear the need to focus on preserving life and specifically “to do everything reasonably possible to stop or offset the consequences of actions by others when those actions are likely to cause serious physical harm

or death” (BCACC, 2014, p. 6). I believe this places harm reduction at the center of any counselling or treatment for opiate users.

In counselling or psychotherapy practice, when a client expresses that they are considering taking their own lives, therapists have a professional duty to immediately intervene to keep them safe and preserve life (BCACC, 2014). Various risk assessments are used in practice to ensure that therapists check in with clients and assess their risk of self-harm. In the treatment of opiate users, therapists cannot encourage abstinence while doing little to ensure that the client in question is safe, as doing so could create a potential for harm to clients.

Harm Reduction in Practice

The current overdose epidemic increases the need for overdose prevention to be a mandatory part of all substance use counselling. This requires individual practitioners and agencies to incorporate overdose prevention and safety discussions into all approaches, including discussions of abstinence (Beletsky & Davis, 2017).

When working with individuals, safety planning and overdose prevention must be part of the initial discussions. A variety of individuals, from those who may be actively using substances and not considering change, to those who have maintained abstinence for long periods of time, may benefit from overdose prevention planning and training (Hawk, Vaca, & D’Onofrio, 2015). The immensity of the overdose epidemic in BC has meant that anyone can encounter someone overdosing, and therefore, overdose prevention and Naloxone training would be of value to anyone (Banjo, Tzemis, Al-Qutub, Amlani, Kesselring & Buxton, 2014).

I believe that when working with families or communities, discussions around substance use must include safety planning. In a family, for example, many of those involved may desire complete abstinence for the individual or individuals using substances. Discussions around

strategies for abstinence may dominate the discourse, but a discussion of harm reduction and safety planning would also be needed. Discussions around safety and harm reduction are the professional duty of therapists to do everything reasonably possible to preserve life and offset harm. This desire for abstinence can be valued while also opening up a dialogue about harm reduction measures to possibly save lives (Hawk et al., 2015).

Counsellors can encourage families to have more open discussions about substance use and substance use safety. One harm reduction strategy would be having at least one person in the family who the substance user can inform when they are going to use substances. The person using could then be monitored for signs of an overdose. Overdose statistics are clear; solitary drug use leads to fatal overdoses, because no-one is present to intervene (Woo, 2017).

Those who use together should be encouraged to not use at the same time. Allowing a time interval between individuals using will allow for an intervention in case an overdose occurs (Hawk et al., 2015). The danger of two people using at the same time and both overdosing was seen in the deaths of Hardy and Amelia Leighton of North Vancouver (Woo, 2017). Their families shared their story with the media in hopes that other families could learn from it and prevent similar overdose deaths (Woo, 2017). The young couple, Amanda and Hardy, were both found dead on their kitchen floor after smoking opiates including fentanyl. Both had successful careers, Amelia managed a fitness facility and Hardy was a carpenter. By all accounts they were attentive parents to their two-year-old son and were packing for a move to a new apartment with a backyard for their son to play in at the time of their deaths. Amelia's mother called the police after she could not contact them; she had been taking care of their two-year-old son for the afternoon (Woo, 2017). Both Hardy and Amelia had attended psychotherapy, Amelia for post-partum depression and Hardy for his use of physician-prescribed oxycodone. Their families said

that they were unaware that Amelia used opiates and believed that Hardy no longer did (Woo, 2017).

If Amelia and Hardy had engaged in a harm reduction approach to substance use by not using at the same time, having naloxone on hand, or calling a trusted friend or family member to monitor them, they may still be alive today. Although we do not know the content of the psychotherapy they received, and whether or not harm reduction strategies were part of the therapy, their story makes clear the need to include harm reduction discussions in therapy and to open the dialogue with families and communities about overdose prevention strategies.

Therapists as Naloxone Trainers

I believe that naloxone training should also become a mandatory part of all substance use counselling in light of the overdose epidemic. Therapists can become naloxone trainers in approximately two hours, and complete naloxone training with clients can be accomplished in approximately 30 minutes (Banjo et al., 2014). Naloxone training should be provided to the substance user, and as many of their friends and family members as possible. If the substance user informs someone that they are about to use, and is then monitored by someone, preferably with naloxone training, the risk of death or serious physical harm from an overdose is greatly diminished (Banjo et al., 2014). This is supported by the fact that not one death has occurred at a supervised consumption site in BC (Woo, 2017).

For communities discussing substance use or the impact of the overdose crisis, counsellors should work to establish overdose prevention plans including reducing the number of people using substances alone, and increasing the number of people trained in using naloxone (Banjo et al., 2014).

The collaborative community harm reduction approach seeks to have people work together to prevent overdose deaths. By positioning community members as allies in overdose prevention, regardless of whether or not they use substances, the overdose epidemic is identified as a social concern. This brings the overdose epidemic outside of substance users and re-orientates attention towards the social and structural elements of the overdose epidemic.

Harm Reduction Reducing Stigma

One of the key focuses of harm reduction strategies is to reduce stigma surrounding a behavior, disease, or substance and to encourage dialogue (Smye, Browne, Varcoe, & Josewski, 2011). Harm reduction strategies surrounding HIV in Canada, for instance, have encouraged health care providers to discuss HIV prevention and encourage HIV testing with as many of their patients as possible. In this way, the discussions about HIV were not limited to those groups statistically most at risk, but rather the discussion about reducing instances of HIV transmission was expanded to locate HIV transmission as a social issue affecting the whole Canadian society (Smye et al., 2011).

Harm reduction discussions about overdoses should follow a similar framework as the harm reduction discussions about HIV. Health care providers, including counsellors, should discuss overdose risk and prevention with as wide a variety of people as possible. The discussions should not be limited to those who use substances currently, or those with a family member who uses. By expanding the discussion of overdose harm reduction, overdose deaths can be discussed as a social problem rather than as a problem only of the substance users (Smye et al., 2011).

Engaging Hidden Substance Users

Many researchers agree that health care providers, law enforcement, and government agencies do not have a clear idea of the number of substance users in Canadian society (Levy, 2013; Beletsky & Davis, 2017). The prohibition of many substances in Canada including opiates makes the collection of data on substance users and the amount they use difficult to measure (Beletsky & Davis, 2017). The overdose epidemic has made it clear that opiate use is much more widespread than previously believed, and is not restricted to the most visible drug users in urban settings or troubled communities (Woo, 2017). By introducing discussions about overdose prevention with all of their clients, therapists may begin to engage substance users who have previously not engaged with any health care provider regarding substance use. This type of engagement could be invaluable for preventing overdoses. As medical doctors discuss HIV transmission prevention with a wide variety of patients, therapists should discuss overdose prevention with a wide group of clients (Smye et al., 2011).

Moving Away from Abstinence Only Discussions

Researchers have found that many substance users do not seek out any form of health care or substance use counselling (Beletsky & Davis, 2017). This is often due to their reluctance to stop using substances completely (Denning & Little, 2011). Drug users may have a desire to discuss their drug use but may feel excluded from substance use counselling as it requires abstinence (Denning & Little, 2011). Drug users may also feel that abstinence is unachievable, and can be reluctant to enter counselling programs that have abstinence as the main and almost exclusive focus (Denning & Little, 2011).

Moving Away from Rapid Detox for Opiate Users

Connected to discussions of total abstinence is the process of rapid detox. In rapid detox, the substance user completely stops taking opiates and spends 3-5 days abstaining from opiate use. In Canada, various health authorities fund and support detox centers that engage in the process of rapid detox. Lengths of stay may vary, but they are usually less than two weeks (Beletsky & Davis, 2017).

The rapid detox process usually involves the opiate user feeling very ill, with symptoms including fever, vomiting, stomach upset, or physical pain. The rapid detox process can also include psychiatric symptoms including depression, anxiety, and insomnia (Beletsky & Davis, 2017).

Studies of the fatal overdose rates of opiate users following rapid detox programs have shown that opiate users are at a higher risk of a fatal overdose following a rapid detox program compared to opiate users who are in the community and have not undergone rapid detox (Nosyk et al., 2013). Similar results were found for opiate users who underwent rapid detox in prison in Washington State. The fatal overdose rates increased following release from prison, again suggesting that rapid detox from opiates increases the risk of a fatal overdose (Binswanger et al., 2013). Dr. Evan Wood, director of the BC Center for Substance Use recognizes the dangers of rapid detox. For opioid addictions, Wood says “rapidly detoxing without being admitted to follow-up treatment is more dangerous than taking no action because the risk of relapse and overdose is greater after a patient’s tolerance for drugs is reduced” (Wood, 2017, p. 1).

For psychotherapists working with opiate users, the dangers of rapid detox and abstinence are important to understand and discuss with opiate users and their support networks. Opiate users may identify immediate detox as their plan; however, the risks of rapid detox should

also be discussed. For therapists working within institutions, such as substance use treatment facilities, the institutional practice of rapid detox should be re-examined. Therapists must work with opiate users and those around them to ensure that safety plans are in place during this period of increased overdose risk.

Indigenous Peoples and Abstinence

Abstinence-based approaches also appear to not be engaging Indigenous communities (Gone & Calf Looking, 2015). Western perspectives imposed on Indigenous populations through colonization treat substance use as an illness or disease that is rooted in the individual (Browne, Varcoe, Lavoie, Smye, Wong, Krause & Fridkin, 2016). Western colonization has treated substance use as a problem that affects a disproportionate number of Indigenous peoples without addressing the effect of colonization on substance use (Browne et al., 2016). Western colonization has categorized certain drugs as acceptable and others as unacceptable and problematic. Opiates, marijuana, and cocaine do not have a long history in western European countries, and consequently, they are illegal, socially unacceptable, or seen to be more problematic than other substances in Canada (Browne et al., 2016).

Indigenous research into the effectiveness of substance use counselling has found that the current abstinence-based models built around the 12-steps (Alcoholics Anonymous traditions) have a low success rate with Indigenous populations (Gone & Calf Looking, 2015). Qualitative interviews summarized in Gone and Calf Looking's (2015) article, "The Blackfeet Indian Culture Camp" found that many Indigenous drug users do not seek treatment partly because of the overwhelming focus on abstinence. Indigenous substance users also have shorter lengths of stay in treatment facilities, and attend fewer treatment facilities, compared to non-Indigenous

substance users (Gone & Calf Looking, 2015). A research participant in Gone and Calf Looking's (2015) study described the experience in abstinence-based substance use treatment as:

Its a room full of Indians all trying to see who can hold out the longest against the need to drink. Like some kind of contest. We are all white knuckling it. No one talks about the pain in the community, other than to blame it on alcohol. Alcohol didn't do this to us. Alcohol didn't take away our farm land and build an oil rig. The army, then the government, now our own leaders are doing this, and no one wants to talk about that (Gone & Calf Looking, 2015, p. 35).

The participant's comments highlight the need to address substance use in Indigenous communities by looking at substance use from a historical and societal perspective rather than the individual's perspective. The history of colonization and its ongoing impacts cannot be ignored when working with Indigenous peoples.

Moving Away from the Moral Model and Its Influence

This thesis suggests that the moral model of addiction and eclectic spirituality should be relegated to community groups like Narcotics Anonymous and spiritual groups of various religious faiths. The moral model should have little influence in professional psychology or counselling. The harm caused by a moral approach to opiate use is well documented. They include the stigmatization of opiate users as morally deficient. Moral ideas around substance use contributed to the criminalization of substances and substance users. The criminalization of opiates has contributed to the emergence of fentanyl in the illicit opiate supplies as outlined by the iron law of prohibition (Cowan, 1986). Moral approaches to substance use are rooted in the racist policies of the early 1900s when the prohibition of opium was closely tied to restrictions against immigration from Asia, specifically China. Moral treatment models grew out of

colonialist ideas that Christianity should be spread among communities, specifically Indigenous communities, to improve them. The historical trajectory of this forced moral colonization has led to incredible suffering among Indigenous communities and carries with it a legacy of racism, and cultural and moral superiority. A historical analysis of the moral model of addiction makes clear that it has caused immeasurable harm and that its effectiveness has been limited. Elements of programming surrounding opiate use, which are informed by the moral model of addiction, should be discarded from professional psychotherapy practice due to the harm they may cause.

Psychotherapists as Activists for Social Change

In Canada, many health care professionals including psychotherapists working with marginalized populations acutely affected by substance use and the overdose epidemic, such as opiate users and Indigenous communities, are doing so as part of large health authorities or social service agencies (Woo, 2017). Such therapists are employed by the government or agencies that receive direct funding from the government. This puts therapists in a unique position of being integrated into, and part of, systems that may be contributing to the marginalization and harm experienced by their clients. Such a unique position requires an analysis of the role of psychotherapists as agents of change within the systems and society in which they are embedded (Cornish, Montenegro, Van Reisen, Zaka, & Sevitt, 2014). Can psychotherapists be employed by the government, essentially as government agents, while also acting as agents of change in regards to government policy?

A historical analysis of the effect of the prohibition of opiates in Canada makes clear the connection between the harms experienced by opiate users and the continued prohibition of opiates in Canada. The iron law of prohibition outlines how the emergence of fentanyl and the overdose epidemic is a direct result of opiate prohibition in Canada (Beletsky & Davis, 2017).

For psychotherapists working directly for a government health authority, or funded by a government agency, can they play a role to advocate for changes to government policy while being embedded in a government-funded program?

An analysis of the ongoing impact of colonization in Canada suggests that government policy towards Indigenous communities continues to marginalize members of those communities. The marginalization includes limited access to health care, over-representation in child apprehension by the state, and over representation in the criminal justice system (De Leeuw et al., 2010; Reder, 2007). Indigenous health, measured through mortality and morbidity rates, clearly indicates the state of cross-cultural relations (Klem, 1999). From this perspective, the overdose epidemic becomes a political and social justice issue.

Therapists may choose to position themselves as allies to those advocating for social change by supporting appreciative inquiries into the strengths and resiliencies of communities affected by social inequities (Cornish et al., 2014). In reaction to the overdose crisis this could entail creating space for community dialogue around the root causes of substance misuse or the emergence of the overdose epidemic. By creating space for dialogue and building upon the strengths and resiliencies of the communities most affected by the overdose epidemic, therapists can ally themselves with movements for social change.

Therapists may also choose to adapt their practice to include direct action towards social change. Ideas and theory can be put into action, and that action can support social change. One such example in Vancouver was the establishment of an unsanctioned, “illegal” supervised injection site by the Vancouver Area Network of Drug Users (VANDU) in 1998 to reduce drug-related harm (Boyd, MacPherson, & Osborn, 2009). The establishment of an unsanctioned supervised injection site proved that a supervised injection site could reduce overdoses and

reduce public drug use. Through the establishment of the unsanctioned program, the idea of a sanctioned injection site gained support from politicians, police, and the public (Boyd et al., 2009). In light of the overdose epidemic, therapists in communities without a supervised injection site can support the creation of unsanctioned supervised injection sites by creating dialogue around harm reduction and by providing space for activists to meet.

Once a safe injection site begins operations, therapists can support the program by providing counselling services directly to clients using the site. Housing programs for those using substances also provide a venue for harm-reduction counselling. Addictions counsellors cannot simply wait in their offices for people to walk in the door; rather, they must engage and understand the community in which they work.

Further research and discussion is needed to fully examine the role that psychotherapists can play in changing government policy and social awareness around substance use and harm reduction. Therapists can encourage and support social change as part of their engagement with individuals and communities, and in light of the overdose epidemic, I believe this facet of psychotherapy needs to be highlighted and encouraged to save lives.

Summary

The overdose crisis in Canada has created an urgent need to change the practices and theory of psychology and psychotherapy surrounding opiate use in Canada. Therapists and counsellors must immediately look to change the way in which they engage and support those using opiates as well as families and communities where opiate use is present.

In this chapter, I have taken a critical theoretical approach to challenge many of the current perspectives and practices of psychotherapy as they relate to opiate users and substance use treatment. This approach belies the urgency of the current overdose epidemic; immediate

changes must be put into practice to save lives and we must be critical of current practices and approaches. January 2018 saw 125 people die in BC from opiate overdoses, which puts 2018 on pace to at least equal the 1,422 deaths from overdose seen in 2017 (BCCDC, 2018).

I have outlined Bruce Alexander's dislocation model of addiction and showed how it can inform psychotherapy practice. I have connected the theory of the dislocation model to specific harm reduction practices in counselling and psychotherapy in light of the overdose epidemic. Recommendations for practice have been outlined including immediate changes to practice that can save lives. I have examined the role of counsellors as activists in social change, specifically relating to the prohibition of opiates and reducing the harmful and deadly effects of substance use. This chapter is intended to be a call to action.

CHAPTER 5:

DISCUSSION

Through a historical analysis of the emergence of the overdose epidemic in Canada, a critical discussion of the current practices of psychotherapy and a literature review of emerging research and practices, this thesis has critically examined the role of psychotherapy in the overdose epidemic. In this final chapter, clinical implications and recommendations are reviewed, the limitations of this thesis, and proposals for future research are discussed. I also present my personal reflections on the research process and on my work with opiate users and their communities during the current overdose epidemic.

Clinical Implications and Recommendations

In Chapter 4, several clinical implications were suggested for psychotherapists working in the midst of the current overdose epidemic. The suggestions included the immediate implementation and expansion of harm reduction strategies for opiate users, families, support networks, and communities to reduce fatalities from opiate overdoses. Harm reduction discussions around opiate use must become a part of all clinical work to engage opiate users who may not have disclosed their substance use. These harm reduction strategies are part of a larger process of ensuring that counselling services are inclusive of opiate users, drawing inspiration from Bruce Alexander's (2010) theoretical approach of furthering social connectedness as a reaction to increased addiction, including substance use, in Canadian society. Therapists are also encouraged to challenge the dominant discourses around abstinence from substances as the preferred treatment approach, because the abstinence-focused approaches may exclude substance users who do not identify abstinence as a goal. Professionals in the field are also encouraged to critically evaluate how they can facilitate and participate in social change to create more safety

and inclusion for opiate users in Canadian society. Above all, this thesis encourages psychotherapy practitioners to be critical of the status quo in regards to how opiate users have been viewed in therapy and within society as a whole. Significantly reducing the number of overdose deaths in Canada will require a paradigm shift in terms of how opiate users are viewed both as clients and as fellow human beings. The dislocation theory of addiction suggests that significant social change is needed to reduce the prevalence of addiction in society. Psychotherapy must engage in this process by critically examining and changing many of the current underpinnings of substance use treatment.

Limitations and Future Research

This thesis is limited in its geographical scope, with a focus on the overdose epidemic in a Canadian, and specifically, BC context. Future research could include a historical analysis of the overdose epidemic while focusing on other communities and geographic areas. Similarities and differences between areas could then be compared and contrasted.

This thesis does not address the role of gender in overdose fatalities. Of the 1,436 overdose deaths in BC in 2018, 253 were identified as female, and 1,183 were identified as male (BCCDC, 2018). The BC coroners service data does not distinguish individuals who identified as transgender, gender fluid, or non-binary persons. Based on the data, males accounted for 82% of the fatal overdoses in BC in 2017. This is a significant discrepancy that warrants further research both qualitatively and quantitatively. If gender is playing a role in overdose deaths, further research is needed to determine the main contributing factors.

This thesis is written from my perspective as a European settler in Canada. It is also written in a western European-based academic tradition. It adheres to the guidelines of the American Psychiatric Association in its format and structure. While I have attempted to include

Indigenous perspectives in the literature review and critical analysis, this work does not represent Indigenous perspectives on the overdose crisis. This thesis does not contribute to the process of decolonization in academia. Future research into the disproportionate impact of the overdose crisis on Indigenous communities could be undertaken by Indigenous scholars from a critical theoretical perspective to include the viewpoints of Indigenous peoples more thoroughly.

Personal Reflections

The process of researching and writing this thesis was an emotional one for me. I work with opiate users, and I realize that they are all at risk of overdose. When I write about overdoses or fentanyl, I often picture the people with whom I have worked having an overdose, with their faces turning blue and breathing becoming shallow or non-existent. When summarizing the overdose fatality data, I realized that of the 1,436 people who overdosed in 2017, I knew a few of them. I mourn their loss and I am angry at the conditions that contributed to it. I also feel a connection to each of the 1,436 overdose deaths in this province because I feel a connection to all those who use substances. Some may use substances to escape pain, trauma, loneliness, social anxiety, or a host of other conditions, called suffering. Suffering seems to be part of the human condition and I know of no-one who has escaped it. I have compassion for those who suffer. Overdose deaths are preventable, but many of the harms and forms of suffering that accompany substance use are also preventable. In recognizing that suffering may be preventable, I have a desire to engage in social change to prevent this form of suffering and death. Even with the desire; however, I am overwhelmed with a frustration about the lack of action by the government and society as a whole. This thesis discusses not only changes to psychotherapy practice but also about engaging in practices to save lives. As such, the process of researching and writing this thesis has been a personal, emotional, and urgent one for me. As each month passed, while I was

researching and writing this thesis, news reports about overdose deaths in the province continued. In January 2018, 125 people died of opiate overdoses in BC (BCCDC, 2018). This crisis requires immediate attention and action. It is unacceptable for this to continue in Canada – change is needed now.

Conclusion

This thesis presented an investigation of the reasons behind the rise in overdose deaths and outlined some paths forward for drug users, counsellors, and therapists who work with drug users, and for society at large. With regards to the social and historical context of the overdose epidemic, this thesis critically examined the current practices of psychotherapy for addiction and opiate use. This thesis asserts that an expansion of current practices will not effectively address the overdose crisis, and immediate change is needed. The current, abstinence-focused practices of psychotherapy for opiate users are not engaging opiate users for whom abstinence is not a goal. Practices like focusing on rapid detox and complete abstinence may endanger opiate users by exposing them to an increased risk of overdose if they use opiates in the future. The literature review identified emerging best practices for psychotherapists and counsellors in light of the overdose epidemic. The dislocation theory of addiction was applied to therapy work with individuals and communities affected by the overdose epidemic through harm reduction discussions and practices. This thesis critically examined the history of opiate use, prohibition, and psychotherapy with opiate users in Canada. It is imperative that changes to psychotherapy work with opiate users begin to occur immediately. This is not simply a discussion of the most effective psychotherapy practices, but rather an urgent call for change. Immediate changes to practice are needed to save lives.

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