The Ideological Conflict between the Criminalization of Drug Use and Harm Reduction Programming

Jessica Murray, M.A.

Submitted in fulfillment of the requirements of

Master of Arts in Criminology

Faculty of Social Science and Humanities

University of Ontario Institute of Technology

Oshawa, Ontario

February, 2019

Abstract

Policies that criminalize individuals who use drugs were first enacted for the purpose of imposing deviant identities on impoverished and racialized communities. These policies, which are disproportionately enforced, have serious social, economic, and public health implications. Harm reduction philosophies seek to alleviate these consequences, but access to such programming is impeded by the stigma, enforcement, and professionalization of service provision associated with repressive drug policies. The failed War on Drugs is in opposition to harm reduction principles, thus exacerbating the harms of drug use in addition to generating unique harms of its own. In order to achieve justice for the drug using community, the mobilization of drug policy reform advocacy at all levels is necessary. In order to contextualize the stigma faced by individuals who use drugs, this report will illustrate the social construction of drug use as immoral and subsequent labelling of people who use drugs as deviant in an examination of the historical context of drug prohibitions and harm reduction philosophies. In highlighting the empirical evidence in support of harm reduction programming, I identify gaps in service provision and assess the ways in which prohibitory drug policies act as a barrier to service delivery, and in conclusion, provide recommendations for policy reform and means for achieving structural change.

Acknowledgements

I would like to express my sincere gratitude to my supervisory committee member Amir Mostaghim, and my primary supervisor, Dr. Tyler Frederick, for their contributions and support; without you, this project could never have been complete. I would also like to thank faculty members Dr. Carla Cesaroni, and Dr. Judith Grant, for their encouragement and mentorship throughout my time at The University of Ontario Institute of Technology. Finally, this project would not have been possible without the aid of The Social Science and Humanities Research Council of Canada.

Dedicated in memory of Lara Sweet and Benjamin Comte.
You continue to inspire me.

Table of Contents

CHAPTER 1
THEORETICAL FRAMEWORK
Introduction

Policies that criminalize individuals who use drugs were first enacted for the purpose of imposing deviant identities on impoverished and racialized communities. These policies, which are disproportionately enforced, have serious social, economic, and public health implications. Harm reduction philosophies seek to alleviate these consequences, but access to such programming is impeded by the stigma, enforcement, and professionalization of service provision associated with repressive drug policies. The failed War on Drugs is in opposition to harm reduction principles, thus exacerbating the harms of drug use in addition to generating unique harms of its own. In order to achieve justice for the drug using community, the mobilization of drug policy reform advocacy at all levels is necessary.

The rationale for the present literature review is threefold; first, to systematically review Canadian harm reduction programming and thus identify gaps in existing services; second, to compare and contrast harm reduction and criminalization based philosophies, assessing their ability to coexist, and; third, to provide program and policy recommendations for exacting changes in drug policy and programming in-line with best-practices. In short, I seek to provide a comprehensive analysis of the current climate in Canada regarding substance use, and direction for growth.

In order to contextualize the stigma faced by individuals who use drugs, this report will illustrate the social construction of drug use as immoral and subsequent labelling of people who use drugs as deviant in an examination of the historical context of drug prohibitions and harm reduction philosophies. Utilizing interpretive theories of crime to assess the phenomenon of drug use and subsequent criminalization of people who use drugs, I examine these processes through a

critical lens that accounts for the impact of stigma throughout the development of North American drug laws. In doing so, I discuss the progression of these laws over the course of a century, and the consequences of such.

The efficacy of harm reduction programs as internationally recognized best practices in addressing drug use in society will be reviewed. A presentation and assessment of the principles and philosophies of harm reduction as a whole is provided, in addition to discussion of various established categories of harm reduction programming (e.g. needle exchange programs, supervised consumption sites, opioid substitution therapy). In the wake of the current opioid overdose epidemic in North America, I review how this surge of drug-related deaths has impacted Canadian harm reduction policies and programming, and vice-versa. This is particularly pertinent in regards to recent innovations in harm reduction programming. My evaluation of Canadian harm reduction programming lends itself to the identification of gaps in service provision, particularly in regards to target populations (e.g. students, prisoners, the homeless, party-goers), in addition to recent innovations in harm reduction programming, such as the expansion of supervised consumption sites, the development of drug checking programs, and the increasing accessibility of naloxone distribution programs.

In highlighting both the empirical evidence in support of harm reduction programming, and the gaps in service provision, I assess the ways in which prohibitory drug policies act as a barrier to service delivery. Assessing the success of harm reduction programs in improving public health will provide context for the detrimental impacts of drug prohibition, and its position as being ideologically opposed to harm reduction programming. Examining the harms of criminalization and elaborating on how stigma generated by drug policies, the enforcement of these policies, and the resulting professionalization of service provision, are situated as barriers

to service delivery, demonstrates a clear conflict between harm reduction and criminalization ideologies, and, by extension, this constructs a foundation on which arguments for policy reform may rest. Therefore, I provide recommendations both for policy reform, and means for achieving structural change. A presentation of the Portuguese model of decriminalization then serves as an example of alternate drug policies, supplemented by a discussion regarding the legalization and regulation of various illicit substances, and recommendations regarding social movements as a means for achieving policy reform.

Harm reduction programming began in North America in the 1980's as a grassroots movement, led by individuals who use drugs, to tackle the HIV epidemic in their communities. Now, despite its recognized efficacy and role in Canada's four pillar-approach to addressing substance use, innovations in Canada's harm reduction programs to address the opioid overdose epidemic are again being achieved via the leadership of people with lived experience. Despite decades of research, and little argument amongst scholars regarding the harms of prohibition and the benefits of harm reduction programming, real change has always occurred at the hands of these social movements. In order to achieve justice for the drug using community, the mobilization of drug policy reform advocacy at all levels is necessary, with a primacy for respecting the leadership and experiences of these communities.

The criminalization of drug use is an injustice to people who use drugs, exasperating the harms of substance use, generating harms of its own, and acting as an impediment to health and social services. This philosophical conflict between principles of harm reduction and the prohibition of drug use necessitates consideration of alternative policy frameworks for addressing drug use in society that seek to eliminate the stigma associated with substance use.

Historical Construction of Drug Use as Deviant

Although policies regulating substance use are ever-changing, they have been omnipresent in Canada for over a century. Since the beginning of the 1900's, a variety of drug prohibitions have been implemented, many of which still exist today. Since their inception, drug laws have served the primary objective of criminalizing the use of various substances, and consequently, the populations they are most commonly used by. Understanding the inequitable and racialized manner in which the criminalization of drug use was conceptualized and enforced (i.e. the historical construction of drug use as a criminal, and therefore deviant or immoral offence), is pivotal in creating a theoretical framework by which the arguments contained herein are supported.

As non-European populations began to settle in Canada in the early twentieth century, the existing populace perceived immigrants as a threat to the moral order of white hegemony. As a result, sensationalist attitudes regarding immigrant culture became prevalent, while cultural differences were quickly constructed as deviant (Gordon, 2009; Mena & Hobbs, 2009). Subsequently, policies were enacted to criminalize ethnic minorities, the earliest of which was the country's first prohibitory drug policy. The first of many drug prohibitions, the passing of the *Opium Act* of 1908 represented the initial construction of the "deviant drug user". Since then, repressive drug policies have proven to be an effective tool for criminalizing impoverished and racialized communities, with prohibition serving as a means of propagating systemic racism (Musto, 1991; Provine, 2011; Zong & Perry, 2011). This *Opium Act* characterized the earliest construction of drug use as a crime, and consequently, an act of deviance. For over a century, people who use drugs in Canada have been labelled as deviants and criminals, and have faced enormous stigma.

A once highly contested topic, there is now very little argument that the "war on drugs" has been largely unsuccessful in eradicating drug use, as promised upon its commencement in the 1970s under the Nixon administration (Wodak, 2014). Research now points to the many ways drug prohibition has exacerbated the harms associated with drug use, and created new ones of its own. To combat the injuries associated with drug use and zero-tolerance drug laws, harm reduction programs were first implemented in the 1980s during the HIV pandemic (Campbell & Shaw, 2008). However, these programs have not been prioritized by the state, which still places emphasis on the enforcement of drug prohibition. Therefore, the criminalization of people who use drugs exists as an impediment to harm reduction services (Drucker, 2013). This disregard for the wellbeing of individuals who use drugs is the result of labelling people who use drugs as deviant, and reflects an injustice to the drug using community.

Theoretical Framework

Interpretive Theories of Crime

Largely interested in utilizing the scientific method to determine cause and effect, positivist theories of crime seek to objectively understand why people engage in criminal activities (Bereska, 2014). Interpretive criminological theories, on the other hand, are subjective views of deviance that believe in the societal construction of deviance. From this perspective, it is understood that we are incapable of identifying deviant behaviour without being informed by social and legal norms what we should consider to be deviant. Interpretive theories are more symbolic, originating from an understanding that our social realities are created by our interactions with the world around us. Critical theories are also in contrast to positivism, focusing on dynamics of power and how this power plays into the construction of social and legal norms.

Together, interpretive approaches, such as labelling theory, and critical approaches, such as conflict theory, constitute a social constructionist perspective to understanding deviance.

Critical theories are also in contrast to positivism, focusing on dynamics of power and how this power plays into the construction of social and legal norms. They are largely value-oriented, and self-reflective, with a particular focus on social justice. While interpretive theories are easily tested, measuring the validity of critical theories is more challenging, as they are not a "shared body of propositions, generalizations, and supporting evidence", but an "intellectual posture around which a variety of criminological endeavours have been pursued" (Akers, Sellers, & Jennings, 2014, pp. 250). In other words, critical theories are about applying critical analysis to criminological work by examining structural and institutional inequalities and contextualizing deviance and social problems (McLaughlin & Muncie, 2013). Together, interpretive approaches and critical approaches constitute a social constructionist perspective to understanding deviance. A prominent interpretive approach, labelling theory, and one of the earliest critical approaches, conflict theory, are amalgamated herein as a social constructionist approach to understanding deviancy.

Conflict Theory. Conflict theorists argue that our socially constructed legal rules and social norms arise not from consensus of the masses, but from conflict. These rules serve to benefit society's most powerful groups, who are less likely to disobey such rules as they were created to serve their interests. The behaviours of those in society with less power are criminalized by these legal and social rules, as their creation serves to define the acts of the disenfranchised as deviant. Those with power imposed these rules on less powerful groups in society, who come into conflict with the law due to their experiences of oppression. Although there are many forms of conflict theory, its origins are traced to Karl Marx, who believed that

those with the greatest power in society own the means of production, and the less powerful include the working class, who sell their labour to the powerful. Those who come into conflict with the law do so as a result of the alienation they experience in this respect, due to factors such as poor working conditions.

In modern times, power is assessed by variables such as age, race, class, gender, sexuality, and ability, with race and class perhaps being the most prominent. In other words, racialized communities and individuals of low socio-economic status are understood as the "powerless", as these variables are what best reflects power and authority in modern society (McLaughlin & Muncie, 2013). It is for this reason that conflict theorist's contest that impoverished and racialized peoples are overrepresented in Western criminal justice systems.

Labelling Theory. Labelling theories discuss the process of being assigned a deviant label and the consequences of such. By this perspective, the assignment of a deviant label results in differential treatment and eventual adoption of this label as one's identity. Without the imposition of a deviant label, individuals may eventually transition out of the so-called deviant behaviour on their own. However, when one engages in particular deviant acts, our understanding of that person becomes primarily about that particular act. In other words, once one breaks various social or legal rules, we understand them as deviants, and nothing else. Once one is labelled as a deviant, it may become part of their identity, for which there are serious social ramifications. Those identified as deviants undergo experiences of social exclusion and stigmatization, which carry with them serious consequences (Bereska, 2014; Dotter, 2002; Goffman, 1974).

Stigma. According to Goffman (1974), the stigmatization of an individual is the social reaction to one's possession of an attribute that is widely viewed as undesirable or deviant. In

this sense, stigmatization is the consequence of the social construction and labelling of difference. Largely based on stereotypes, stigma stems from assumptions made about particular differences or traits that are viewed as undesirable by the majority, and thus characterized as deviant (Goffman, 1974; Link & Phelan, 2006). The greater society perceives the stigmatized attribute as a personal failing of the individual who possesses it, and as a result, individuals internalize this stigma and begin to view themselves as inferior. Individuals experience discrimination and victimization as a result of the stigma arising from their deviant labels, resulting in social exclusion and isolation (Goffman, 1974; Link & Phelan, 2006; Smith, 2009). The identity of an individual outside of their stigmatized trait is largely ignored, and thus, they become defined by their deviant label. Consequently, the social construction of difference and subsequent labelling of individuals as deviant cause stigmatization, the casting of individuals to the margins of society, and the compounding of consequences of their experience of difference.

Social Constructionism. Labelling and conflict theories together, constitute social constructionist theories of deviance, focusing on subjective understandings of deviant behaviour and the processes by which social problems are defined as such. Social constructionism seeks to understand how various social issues and deviant behaviours are defined, established, and reacted to (Bereska, 2014; Rafter, 1990). One way of responding to social problems is by the assignment of deviant labels that are created and assigned based on social and legal rules. Deviance may be explained as a socially constructed concept, validated by law, which serves to enhance conformity and reaffirm the social solidarity of "non-deviant" members of society. As various societal structures and systems complement one another to ensure the orderly functioning of society, "threats" to social order are regulated, and thus dictate to the public which actions are considered to be deviant. By doing so, the perceived "moral rightness" of non-deviant members

of society is augmented via the stigmatization of non-conforming individuals (Bereska, 2014; Ziyanak & Williams, 2014). Therefore, deviance is not about the qualities of an individual, but the social reaction to those who engage in behaviour that run counter to these social norms (Akers et al., 2014; Dotter, 2002). These rules, and subsequent labels, are created by those in positions of power and imposed on those with lesser social capital. Therefore, it may be understood that deviant labels are the result of a lack of power (Akers et al., 2014).

This social construction of difference exists in many aspects of identity; for example, the construction of drug use as deviant is directly related to the same phenomenon in regards to race and class. Early drug laws served the function of demonizing marginalized populations, and are known to be disproportionately enforced to this day (Fellner, 2009). Drug prohibitions have a long history of constructing moral panics around minorities and drug use, and imposing deviant labels on people who use drugs. As a crime of morality, drug use is not a deviant act in and of itself; drug use is considered to be deviant because it is illegal. The criminalization of drug use serves to increase social solidarity among those who do not use illicit substances by creating a morality of health (Bereska, 2014; Farrugia, 2014). This is accomplished by stigmatizing individuals who use drugs, inevitably leading to an atmosphere of cynicism towards the drug using community, who are subsequently labelled as deviants. As a result, the drug using community faces enormous stigma, based on stereotypes of people who use drugs as immoral, negligent, and generally inept. Consequently, people who use drugs are perceived as inferior and undeserving of the same opportunities accessed by non-users (Goffman, 1974). This perception of drug use engenders social exclusion and isolation, and can result in their internalizing of their "deviant drug user" label, thus exacerbating the social, physical, and legal detriments of their drug use (Link & Phelan, 2006; Smith, 2009). Because drug use is criminalized, those who use

drugs are stigmatized not only as “drug users”, but as criminals. The stigma of the criminal label negatively impacts an individual’s ability to gain meaningful employment, reduces educative opportunities, and lessens the likelihood that one will form various pro-social bonds (Apel, Blokland, Nieuwbeerta, & van Schellen, 2009; Windzio, 2006). Additionally, because those who experience marginalization, such as racialized and impoverished communities, are more likely to be criminalized for their substance use, this stigma is compounded for already disenfranchised populations (Fellner, 2009).

The stigma and discrimination faced by people who use illicit-drugs acts also as a barrier in accessing support services, education, treatment, and medical/social services that seek to ameliorate the harms associated with drug use (Edington & Bayer, 2013). As a result, it has been hypothesized that the prohibition of drug consumption and associated stigmatization of people who use drugs is, in and of itself, responsible for thousands of preventable overdose deaths in North American each year (Drucker, 2013). The stigma associated with drug use results in the labelling of those who use drugs as undesirable and, in turn, unworthy of health care. Subsequently, there is a general reluctance to approve the implementation of harm reduction programs (Farrugia, 2014; Mena & Hobbs, 2009). Due to the “not in my backyard” mentality, many communities prohibit the provision of these services. When services are implemented, they are scarcely funded, and hostility, pessimism, and malpractice run rampant amongst social workers and health care providers (Edington & Bayer, 2013). Consequently, the stigma that exists as a result of repressive drug policies results in people who use drugs having limited access to medical care that is rooted in evidence. When the stigma of substance use is alleviated, individuals are more likely to utilize harm reduction programing that may lessen the harms associated with their drug use (Lacquer, 2015).

Drug prohibition has been highly criticised for its exceptionally high economic and social costs, and ineffectiveness at reducing the availability of illicit substances (Drucker, 2013; Rhodes, 2011). Drug prohibition has been accused of criminalizing society's most disenfranchised communities. Individuals of low socio-economic status, immigrants, and ethnic minorities are targeted by enforcement, thus exacerbating a variety of already omnipresent social inequalities (Fellner, 2009; Gordon, 2009; Provine, 2011). By criminalizing people who use drugs, the deviant label and subsequent stigmatization is unavoidable. However, by reframing drug use as a public health concern instead of a criminal justice issue, this label may be revoked. Although the detrimental impacts of the criminalization of drug use cannot be eliminated without full drug policy reform, harm reduction initiatives exist to alleviate some of the harms of drug use and zero-tolerance drug policies.

CHAPTER 2

LITERATURE REVIEW

The History and Efficacy of Harm Reduction Philosophies

Harm reduction refers to any policy, program, or initiative that seeks to minimize the risks that are associated with drug use and/or zero-tolerance drug policies (Lushin & Anastas, 2011; McKeagany, 2011). The focus of these initiatives are primarily on adverse health effects, but also often address social and economic consequences of drug use and drug policy (Grieve, 2009; Rhodes, 2011). Pragmatic in its approach, harm reduction philosophies manifest as person-centred, public health approaches to addressing the impact of drug use on individuals and communities. This is achieved by utilizing a stance of non-judgement to accept people as they are in terms of their drug use, socio-economic status, and ability (Campbell & Shaw, 2008; Lushin & Anastas, 2011). In other words, harm reduction programs operate with a respect for individual experience and do not typically require the sobriety of the individuals accessing their services. This creates an environment in which individual identity is appreciated, and those who use drugs are understood both within, and outside of the context of their drug use. These programs seek to reframe the way people who use drugs are viewed by society by discounting their deviant labels. This erosion of stigma and empowerment of service users is associated with a number of positive outcomes for those who utilize harm reduction programs (Campbell & Shaw, 2008; McKeagany, 2011; Rhodes, 2011).

Harm reduction initiatives originated at the hands of people who inject drugs during height of the HIV epidemic in the 1980s, at a time when gay men, ethnic minorities (primarily Haitians), and people who use drugs were scapegoated for the spread of HIV. By the late 1980s, governments were well aware of the efficacy of harm reduction programs, yet refused to fund these programs out of concern for appearing to condone the use of illicit substances (Friedman et

al., 2001). In response to this lack of government intervention, people who inject drugs engaged in collective action to combat the stigmatization and lack of public health approaches to dealing with drug use, and by the late 1990s, harm reduction initiatives and drug users' alliances existed in over forty countries world-wide (Friedman et al., 2001). As a result of this collective action, gains have been made in many arenas of drug policy and service delivery in Canada. Common harm reduction initiatives include honest education, needle exchange programs (NEPs), supervised consumption sites (SCSs), and opioid substitution therapy (OST). However, in the past decade, harm reduction programming has expanded to include onsite drug checking services, safer inhalation and intranasal drug use material distribution, and naloxone administration training and distribution programs (NATDPs). Additionally, the efficacy of supervised consumption sites has been validated by the Supreme Court of Canada, and in Toronto, the first ever harm reduction workers' union is fighting to combat the professionalization of their field of work (Bazazi, Zaller, Fu, & Rich, 2010; McCann & Temenos, 2015; Piper et al., 2007; Schroers, 2002). Harm reduction programs are still scarcely funded, but the attention paid to these programs by governments across the globe has increased drastically since their advent (Edington & Bayer, 2013).

Harm reduction initiatives are now internationally recognized by health care professionals and policy experts as a best practice in minimizing the consequences of drug use within society (Drucker, 2013; Edington & Bayer, 2013; Eversman, 2014; McKeagany, 2011; Rhodes, 2011). Steeped in empirical evidence, harm reduction approaches are both cost-effective, and renowned for their ability to reduce a myriad of consequences of drug use, including blood borne illness, infection, and the social isolation that is a result of the stigma that people who use drugs face. Additionally, harm reduction programs are successful in improving

both medication adherence, and the mental health of service users (Campbell & Shaw, 2008; Drucker, 2013; Edington & Bayer, 2013; Lushin & Anastas, 2011; Rhodes, 2011). By promoting dignity and compassion, harm reduction programming integrates individuals who use drugs into the greater community; this represents a stark contrast to traditional tendencies towards dehumanizing and isolating the drug using community (McKeagany, 2011). As a result, these programs celebrate greater efficacy rates than abstinence-based approaches, which are associated with high post-treatment relapse and overdose rates. It is for these reasons that harm reduction has been prioritized in national HIV strategies in dozens of countries across the globe (Edington & Bayer, 2013; McKeagany, 2011).

Harm reduction exists in Canada as part of a four pillar approach to addressing drug use, alongside prevention, enforcement, and treatment. Common harm reduction initiatives include honest education, needle exchange programs (NEPs), supervised consumption sites (SCSs), and opioid substitution therapy (OST). Additionally, recent developments in harm reduction programming, such as naloxone administration training and distribution programs (NATDPs), and on-site drug checking (OSDC) are becoming more prevalent in the western world in response to the recent opioid overdose epidemic (Cicero, 2017; Young & Fairbairn; 2018).

Honest Education

Honest education is a primary tenet of harm reduction approaches to drug use. This approach to drug education exists to counter zero tolerance, preventative approaches used in the public school system, such as *Racing Against Drugs* or *Drug Abuse Resistance Education (DARE).* These preventative approaches are referred to as "drug education", although they typically involve the use of fear tactics in an attempt to eliminate drug use, and very little information regarding the realities of substance use is provided. These abstinence-based

"education" programs construct a morality of health that stigmatizes individuals who use drugs and privileges those who abstain (Farrugia, 2014). Educative approaches that provide health directives to reduce drug use related harm are referred to as "honest education" to distinguish them from traditional approaches to drug education (Grieve, 2009; Strang et al., 2002). These approaches are rarely utilized in public school drug education, but are an essential component of harm reduction services. Honest approaches to drug education are utilized with the understanding that minimizing the harm associated with drug use is best accomplished by providing individuals with necessary information for them to make informed decisions regarding their physical and mental health (Farrugia, 2014; McBride, Farringdon, Midford, Mueleners, & Phillips, 2004). According to Farrugia (2014) and McBride et al. (2004), harm reduction approaches to drug education have greater success in reducing substance use than traditional programs. Additionally, honest education increases safer-consumption behaviours, thus reducing the harms associated with substance use, such as overdose and the contraction of blood-borne illness (Farrugia, 2014; McBride et al, 2004).

Needle Exchange Programs (NEPs)

Needle exchange programs (NEPs) are the most extensively utilized of harm reduction services. Existing in over twenty countries worldwide, endorsed by the World Health Organization and UNAIDS, and widely recognized as a fundamental component of any effective HIV prevention strategy (Edington & Bayer, 2013; Hurley, Jolley, & Kaldor, 1997; McKeagany, 2011; Zule et al., 2018). NEPs are known, primarily, for providing individuals who use drugs intravenously with access to sterile needles. Although each facility is unique, these programs generally provide a plethora of materials to reduce the risks associated with injection drug use

(e.g. alcohol swabs, ascorbic acid, cooking spoons, filters, syringes, sterile water, and tourniquets).

While not as common, some facilities also provide materials used for non-injection routes of drug administration (Domanico & Malta, 2012; Drucker, 2013; Ivsins, Roth, Nakamura, Krajden & Fischer, 2011; Patterson et al., 2018). Although there is a growing understanding of best practices in offering services for individuals who engage in injection drug use, there is less acknowledgement of harm reduction techniques targeting inhalation drug use, particularly with crack-cocaine. The risks of crack-cocaine smoking, such as infection, blood-borne disease, and overdose, are often just as prevalent as those associated with injection drug use, and in some instances, more so, as is the case with Hepatitis C infection, and the two populations tend to overlap (Ivsins et al., 2011; Patterson et al., 2018). Many of the dangers associated with inhalation drug use are largely related to the use of unsafe equipment, or sharing materials, and there is evidence for both the willingness of individuals who smoke crack to utilize programs that distribute safer-use materials, and of the efficacy of these programs in reducing the sharing of materials and use of makeshift equipment (Cortina et al., 2018; Domanico & Malta, 2012; Ivsins et al., 2011). Pyrex stems, brass screens, rubber mouthpieces, push sticks, and lip balm are offered to service-users who, despite an awareness of the risks, would likely see no other choice but to utilize more hazardous means to smoke crack-cocaine. Despite legislative barriers, these programs have purported efficacy in reducing injury, infection, disease, and participation in the illegal economy, in addition to increasing client's health awareness and perceived personal/community safety. A growing support for safer inhalation services is building in Canada (Domanico & Malta, 2012; Ivsins et al., 2011).

Regardless of the materials distributed, NEPs typically offer counselling and support services, educational resources and referrals to medical, social, and treatment services. As the most highly researched harm reduction program, dozens of studies have confirmed the effectiveness of NEPs; they have shown to maximize the health and safety of individuals who use drugs, reduce social marginalization, and decrease global rates of blood borne illness, infection, and drug overdose (Campbell & Shaw, 2008; Bowring et al., 2013; Hurley et al., 1997; Rhodes, 2011; Striker & Miskovic, 2018). Empirical evidence also demonstrates that these cost-effective services reduce health care costs associated with the treatment of medical conditions linked to drug use (Drucker, 2013).

Supervised Consumption Sites (SCSs)

Like NEPs, supervised consumption sites (SCSs) offer honest education and equipment to reduce the risks associated with drug use, in addition to access to primary health care services, counselling, referrals to withdrawal and rehabilitation programs, and housing opportunities. (Tyndall et al., 2005; Wood et al., 2004). However, SCSs also provide private cubicles for injection and/or inhalation drug use, as well as a social space used to monitor and connect with service users, and administer medical care in the event of an overdose.

Unlike NEPs, SCSs have historically been seldom implemented and scarcely funded. Until recently, there were under one-hundred facilities located worldwide, with only one of these sites operating within North America. This facility, located in Vancouver, British Columbia, has been vigorously studied since its doors were opened as a controversial pilot project in 2003 (Bayoumi & Zaric, 2008; McCann & Temenos, 2015; Tyndall et al., 2005; Wood et al., 2004). This SCS, referred to as *Insite*, remained a pilot project for eight years, until its value was eventually proven in the Supreme Court of Canada in 2011 (Kerr, Mitra, Kennedy, & McNeil,

2017; McCann & Temenos, 2015). Since then, the empirical evidence of *Insite's* efficacy has inspired talks of program expansion, and by 2018, in response to the growing opioid overdose crisis, Health Canada confirmed dozens of projects across four Canadian provinces, and many other in various application stages (Cicero, 2017; Health Canada, 2018; Young & Fairbairn, 2018).

A stark increase in opioid overdose deaths was declared a public health emergency in the United States in the fall of 2017, and despite a staggering death toll of it's own, Canada had yet to do so by the end of 2018 (Bestha, 2018). The crisis has been attributed to an overprescribing of opioids by physicians and surgeons, and the recent emergence of more potent opioids, such as fentanyl and carfentanil, mixed into other street drugs without buyer knowledge, in order to increase drug potency (Cicero, 2017; Guevremony, Barnes, & Haupt, 2018; Makary, 2017; Vadivelu, Kai, Kodomundi, Sramcik, & Kaye, 2018; Volkow & Collins, 2017). As the opioid epidemic grew to claim tens of thousands of lives each year in North America, victims were no longer solely those belonging to society's most marginalized communities. As white, middle-class, suburban communities saw death tolls rise, the government and media alike began to take note of the epidemic (Cicero, 2017; James & Jordan, 2018; Vadivelu et al., 2018). Mainstream recognition of the opioid overdose crisis is largely credited to the advocacy work of grassroots organizations such as the Vancouver Area Network of Drug Users (VANDU). Much like the harm reduction advocacy work done during the height of HIV epidemic, people who use drugs have headed these movements through acts of civil disobedience, creating pop-up SCSs without permit or Health Canada sanction, in major Canadian cities, such as Victoria and Ottawa. Despite heavy police presence, minimal funding, and no legislative support, these volunteer run pop-sites offer services to thousands of clients and report no fatal overdoses on their premises

(Cicero, 2017; Kerr et al., 201; Young & Fairbairn, 2018). By the end of 2017, after much resistance, the city of Ottawa responded to a local pop-up site by opening a formal SCS and accelerating the approval of several more sites. Now, dozens of sites in several provinces across the country have been approved, with applications processing for dozens more. However, even in the midst of an overdose crisis, legislative barriers make these sites difficult to establish – especially those that are facilitated by people who use drugs (Cicero, 2017; Health Canada, 2018; Kerr et al., 2017).

Fifteen years after opening its doors, there have been over 40 peer reviewed studies on the beneficial impacts of *Insite*, and the lack of negative outcomes. With over three million visits and over five thousand overdoses, Canada's SCS has yet to see a single fatal overdose (Cicero, 2017; Young & Fairbairn, 2018). *Insite* now offers drug-testing services in order to attempt combat the overdose epidemic; although 80% of drugs tested at the facility tested positive for fentanyl, clients typically alter their consumption habits to accommodate for the presence of the potent drug, resulting in a reduction of fentanyl related overdoses (Young & Fairbairn, 2018). It is now widely understood that the presence of SCSs reduces public drug consumption and drug-use related litter, the sharing and make-shifting of materials and therefore the spread of infections and disease, overdose fatalities, participation in illegal economy, and stigma, in addition to increasing safer use and disposal practices, and access to treatment services, whilst remaining cost-effective and relieving financial burdens of drug-use on public health care and criminal justice systems, and without increasing the frequency of substance use. (Bayoumi & Zaric, 2008; Folch et al., 2018; Young & Fairbairn, 2018; Voon et al., 2016).

Naloxone Administration Training and Distribution Programs (NATPDs)

Naloxone is an opioid antagonist, meaning it is a medication that has the ability to halt the effects of opioids, and is especially useful in overdose situations (Bazazi et al., 2010; Piper et al., 2007). In the event of opioid overdose, an injection of Naloxone can reverse the effects of the drug taken (i.e. heroin, fentanyl) and therefore revive the individual experiencing overdose. This medication has long been used by health care professionals and emergency response units, but more recently has become accessible to the public (Piper et al., 2007). Naloxone administration training and distribution programs (NATDPs) are a more recent development in the sphere of harm reduction programming. In the wake of the opioid overdose crises, these programs dispense naloxone kits primarily to individuals at risk of opioid overdose, but increasingly, to family and friends of those who use opioids, and other members of the community (Bazazi et al., 2010; Lewis, Park, Vail, Sine, & Welsh, 2016). Many programs require that individuals take an administration training course to ensure they are well informed with regards to the procedures for administering the medication before obtaining naloxone (Bazazi et al., 2010; Lewis et al., 2016; Piper et al., 2007). Due to the criminalization of non-prescribed opioid use, individuals are often hesitant to access emergency services when witnessing an opioid overdose, and with many Canadian provinces seeing dozens of overdose deaths each week, health care resources are spread thin. Thus, NATDPs allow bystanders to respond to overdose situations without fear of police or need for medical professional involvement. NATDPs have shown to reduce drug-related mortality, in addition to increasing overdose awareness amongst individuals who use opioids and their peers (Curtis et al., 2018; Petterson & Madah-Amiri, 2017; Piper et al., 2007).

Opioid Substitution Therapy (OST)

Opioid substitution therapy (OST) is perhaps the most controversial of harm reduction programs. This medical intervention substitutes the use of illegal opioids and/or misuse of

prescription painkillers with methadone or buprenorphine, which have higher half-lives and therefore remain in the body for longer periods of time (Drucker, 2013). This means that these substances need to be consumed less frequently in order to avoid withdrawal, than other opioids. These substitutions have significantly less psychoactive effects, allowing for higher functioning than the drug which they substitute for. Opioid withdrawal syndrome at its worst may last several months, and have the potential to be deadly if not medically supervised. By preventing the occurrence of withdrawal symptoms, patients of OST may avoid this lengthy and hazardous detoxification period, and instead incrementally reduce their methadone or buprenorphine dosages. Additionally, these substances are consumed orally, which is a safer route of administration than the common method of intravenous drug use (Strang et al., 2002). OST is known to reduce adverse health effects of opioid use, such as overdose and blood-borne illness, in addition to reducing drug-related offending (Edington & Bayer, 2013; Rhodes, 2011; McKeagany, 2011). OST is rooted in empirical evidence, and when compared to abstinence based drug treatment programs, is more likely to result in eventual abstinence from opioid use. Unfortunately legislative restrictions and stigma often make these programs difficult to access (Guevremony et al., 2018). More recently, in response to the overprescribing of opioids, researchers and advocates have begun to consider alternative mechanisms for managing chronic pain, such as the substitution of opioid prescriptions with cannabis (Lucas, 2017; Volkow & Collins, 2017).

In addition to saving lives and reducing the harms associated with substance use, the aforementioned harm reduction programs place an emphasis on respect for individuals who use drugs. Therefore, they work to counteract the stigmatizing effects of criminalization by constructing a new frame of reference for understanding drug use as a social reality, instead of a

deviant act. By doing so, harm reduction rejects the deviant label so often placed upon people who use drugs by upholding principles that value individual health and safety. However, due to this ideological difference, the criminalization of drug use conflicts with harm reduction principles and serves as an impediment to service delivery.

Gaps in Service Provision

As harm reduction garnishes widespread support and is invoked as a principle tool for tackling the opioid overdose crisis, some populations fall to the wayside. As a result of the continued emphasis on enforcement over harm reduction when addressing substance use related concerns, and the stigma associated with criminalization, the potential for harm reduction programs falls short of what is necessary. Despite strides made in the funding of NEPs, and new legislative support for SCSs, the very services these programs offer are unavailable to large sub-groups of the drug-using population. The following section provides overview of four main areas which demonstrate deficits in harm reduction service provision: music festivals and night clubs (i.e. party drugs), college and university students/campuses, homeless communities (particularly, youth), and prisons.

Party Drugs

Party drugs, typically stimulants, are drugs used in a recreational context, generally at music related events, such as festivals and night clubs. Individuals using party drugs do not generally identify as having an addiction, nor do they tend to use drugs on a daily basis. Additionally, this recreational drug use involves utilizing routes of administration unlike those aforementioned (i.e. snorting, swallowing). As there are marked differences in the consumption of party drugs in comparison to that of heroin or crack-cocaine, there are also differences in harm reduction service provision for individuals who use these substances.

Harm reduction materials for these alternative routes of administration are scarcely provided via NEPs, and are generally addressed in the context of recreational or party drug use. Some similarities, however, do exist; drug checking, although more commonly utilized in SCSs, is a technique also used to reduce drug related risks at music festivals and nightclubs hosting raves (Hungerbuehler, Buecheli, & Schaub, 2011; Schroers, 2002). This service involves the on-site testing of various illicit substances to determine their content and purity. While the aforementioned harm reduction services are most often utilized by individuals with addictions to illicit substances, this sort of drug checking is a harm reduction tactic that targets recreational users. These music related events are most frequently attended by youth, who are more commonly engaging in regular recreational drug use on these occasions (Whittingham et al, 2009). Because their use is considered recreational, individuals who use party drugs generally limit their use to these events, and do not use drugs on a daily basis. As a result, they do not access substance use services, which are typically facilitated under an addictions framework, and are relatively difficult to locate without attending events at which party drugs are used. Therefore drug checking services are often facilitated by networks of individuals who actively use recreational drugs (Frei, 2010).

Stimulants, such as a cocaine or amphetamines (predominately ecstasy/MDMA) are commonly used party drugs (Panagopoulos & Ricciardelli, 2005; Whittingham et al., 2009). Drug checking services are vital to the reduction of risk associated with the use of party drugs. Because these substances are obtained via the black market, users cannot be sure of the contents or dosages or the drug they are consuming, putting them at an increased risk of overdose and/or consequences of dangerous synergistic effects (Schroers, 2002). On-site drug checking services also provide other basic harm reduction services, such as honest education, information

regarding trends in the illegal drug market, and materials associated with reducing harms related with the party scene (Frei, 2010). Examples of these materials include condoms, water, ear plugs, and intranasal drug use materials (e.g. straws, alcohol swabs, sterile water, and vitamin E capsules). Additionally, many of these services also offer counselling, consultations, and referrals to social and health care services (Hungerbuehler et al., 2011). Despite the prevalence of polysubstance use at these events, due to the illegal nature of commonly used party drugs, on-site drug checking faces many barriers in implementation (Fernandez-Calderon, Diaz-Batanero, Barratt, & Palamar, 2018). These services often involve the transfer of illicit substances from service users to service providers, which constitutes an illegal act (Schroers, 2002). This means that both parties are at risk of criminalization, resulting in reluctance to provide and access services, in addition to event venues being hesitant in allowing the provision of these services on their properties (Mohr, 2018).

Due to the risk involved in providing these services, nightlife harm reduction is often self or peer directed. Organizations such as the Toronto Rave Information Program (TRIP) and DanceSafe operate solely on a volunteer basis, using the lived experience and knowledge of individuals who use drugs to disseminate harm reduction knowledge where traditional, preventative approaches have failed (Greenspan, Aguinaldo, Husbands, Murray, & Ho, 2011; Mohr, 2018; Whittingham et al., 2009). Peers offer information on rationing and dosages, "coming down" (i.e. withdrawal), and support for individuals experiencing "bad trips" or unenjoyable highs. Although peer-led harm reduction programming in the music scene is beginning to gain support, harm reduction for party-goers is still considered controversial, and has historically been excluded from harm reduction research (Greenspan et al., 2011; Whittingham et al., 2009). However, over the past five years, an emergence of a literature on the

potential of harm reduction programs at raves and music festivals has developed, as pressure for the implementation of these programs builds alongside the opioid overdose crisis (Fernandez-Calderon, et al., 2018; Mohr, 2018; Young, Diedrich, Pirie, Lund, Turris, & Bowles, 2015).

College and University Campuses

College and university students use a variety of drugs, both legal and illicit, and campus drug use is on an incline. The university environment one of risk, both in its physical spaces (i.e. dormitories), and in its social norms (i.e. party culture) (Abelman, 2017; Wilkinson & Ivsins, 2017). Alcohol consumption and the practice of binge drinking is more than common place in these environments; it is considered a normative part of the college or university experience. With the increase in young people engaging in recreational drug use, party culture on campuses is no longer limited to dangerous alcohol consumption, but the use of party drugs as well (Whittingham et al., 2009). In addition to alcohol and recreational illicit substance use, post-secondary students make up a sub-group of individuals who use drugs that is almost solely restricted to the university campus; those who use "study drugs". Study drugs are medications typically prescribed for the treatment of attention deficit disorders, used by college and university students to increase focus and elongate working hours (Abelman, 2017). These three avenues of drug use places college and university students at an increased risk of substance-use related harms, yet harm reduction programming is not commonplace in these environments, and when they do exist, they almost solely target alcohol consumption. Additionally, many campuses have policies in place that impose academic penalties on students who are determined to have engaged in on-campus substance use (Abelman, 2017; Wilkinson & Ivsins, 2017)

Harm reduction information regarding sexual activity and alcohol consumption have become commonplace in the education of college and university aged students, and in some

regions, amongst high school aged students as well. Studies have found positive results in the use of alcohol harm reduction education in both high school and college/university settings, with a reduction in frequency and quantity of alcohol consumption noted in both groups (McBride et al., 2004; Bersamin, Mallie, Fearnow-Kenney, & Wyrick, 2007). In fact, the Nova Scotia Department of Health and Wellness (2012) endorses harm reduction practices in addressing alcohol related harms on campus, and Queens University in Ontario has both staff and students involved in alcohol harm reduction education and outreach. Despite the understanding of harm reduction as a best practice in reducing alcohol related risks on campuses, this knowledge has not translated to other areas of risk faced by college and university students, such as the use of recreational party drugs, or study drugs. Because of the dynamic nature of college and university student substance use, and the multiple avenues of drug use on which a student may embark, it is particularly important that campus harm reduction programming take a unique approach that addresses the individual needs of each campus community. As is often the case with programming geared towards young people, harm reduction services on campus must reflect the needs and experiences of the communities in which they exist (Jenkins, Selmon, & Haines-Saah; 2017).

Homeless Communities

Homelessness itself presents challenges to controlling the spread of blood-borne ailments and sexually transmitted infections, making homeless communities an important primary target for interventions (Clatts & Davis, 1999). Homeless individuals are at high risk for contracting blood-borne ailments and sexually transmitted infections, with homeless youth at highest risk, largely due to their participation in the street economy (Carmona, Slesnick, Guo, Murnan, &

Brakenhoff, 2017; Clatts & Davis, 1999; Coren et al., 2013; Hwang, Wilkins, Tjepkema, O'Campo, & Dunn, 2009).

Despite the wide support for harm reduction programming, homeless youth are still contracting blood-borne ailments at alarming rates (Clatts & Davis, 1999). Equipped with the understanding that homeless youth are one of the most difficult to reach populations, it may be speculated that this these youth are not accessing life-saving programming in their communities (Carmona et al., 2017; MacDonald, 2014). Harm reduction programming has amassed known proficiency in reducing the harms associated with high-risk behaviour, reducing the transmission of blood-borne ailments and sexually transmitted infections, and attracting youth to accessing services, yet this is not reflected in the rates of transmission among homeless youth (McDonald, 2014; Strang et al., 2012; Werb et al., 2010). Current research calls for investment in outreach programming as a vital means of connecting with homeless youth in particular, as many avoid attending shelters and drop-in centres, and do not interact with the criminal justice system (Carmona et al., 2017; Clatts & Davis, 1999; MacDonald, 2014). Outreach programming is also often more proficient in responding to trends in risk-taking behaviours and factors influencing the transmission of blood-borne ailments and sexually transmitted infections that differ in varying locales (Werb et al., 2010). The need for programming that is grounded in local research, which respects the dynamic nature of this population is emphasized (Carmona et al., 2017; Clatts & Davis, 1999; Coren et al., 2013; Hwang et al., 2009; Werb et al., 2010).

Young people without stable housing are at heightened risk of contracting blood-borne ailments and sexually transmitted infections. Despite harm reduction programming being globally recognized as best practice in reducing these risks, homeless youth are still contracting

ailments and infections at increased rates. Due to the hidden nature of this population, we must consider whether harm reduction programs are being accessed by those who need them.

Prisons

Prisons are potentially one of the most controversial of sites for implementing harm reduction programming, despite the heightened substance-use related risk that inmates and former inmates face (Curtis et al., 2017; ;Petterson & Madah-Amiri, 2017). While some harm reduction philosophies and practices are present in Canadian prisons, they generally target the promotion of safer sex and tattooing practices, and do not include NEPs (Reece, Van der Meulen, & Ka Hon Chu, 2018; Van der Meulen, 2017). In fact, of the 15 initiatives set forth by the United Nations Office on Drugs and Crime, including counselling, education, addictions programs, and OSTs, NEPs are the only one excluded in Corrections Services Canada's policies and programming (Smith & de Souza, 2018). Despite the success of prison NEPs in other countries worldwide, there is much opposition to the implementation of similar programs in Canadian facilities (Reece et al., 2018; Van der Meulen, 2017). Like much of the hostility towards harm reduction programming, this is largely based in a lack of understanding of harm reduction philosophies and a belief that providing these services acts to encourage substance use and threatens the safety of the surrounding community. Contrastingly, NEPs in prisons are known to improve workplace safety for corrections workers; in fact, prison staff were the most adamant critics of the abolition of prison NEPs in Germany in recent years (Reece et al., 2018). This indicates a dire need for training amongst corrections staff in regards to best practices in reducing harm in prisons.

Despite myths and misunderstanding, injection drug use does indeed occur inside correctional facilities. Without the availability of NEPs, the equipment needed for injection drug

use is either gained illicitly or made by inmates, is often shared, and is unlikely to be safely disposed of, despite prisoner willingness to engage in harm reduction practices (Curtis et al., 2018; Petterson & Madah-Amiri, 2017, Van der Meulen, 2017). Furthermore, harm reduction training is especially important for this population, who are at increased risk of drug-related harms upon release from prison. Seemingly decades behind the harm reduction movement occurring outside prison walls, prisons do not offer the same level of health care to inmates who use drugs as those in the community receive (Van der Meulen, 2017; Van der Meulen, De Shalit, & Ka Hon Chu, 2017).

Harm reduction has garnished widespread support since its induction some fifty years ago. Once an entirely grassroots movement, headed by people with lived experience in substance use, a variety of harm reduction programs are provided by dozens of organizations across the provinces of Canada. These efficacy of these programs, some government-funded, some peer-based, have grossed significant empirical evidence and have been invoked as a best practice in addressing both the HIV/AIDS epidemic of the 70s and the more recent opioid overdose crisis in North America. Supervised consumption sites, needle exchange programs, opioid substitution therapy, drug-checking, and naloxone distribution are beginning to shed their stigma, with networks of people who use drugs at the forefront of an ever growing movement. However, many populations remain unable to access these life-saving services, many of which remain controversial, with advocates forced to engage in civil disobedience in attempts to remove the barriers to harm reduction programing put in place by Canada's drug policies.

CHAPTER 3

POLICY ANALYSIS

The Conflict between Harm Reduction and Criminalization

Harm reduction is now well known to be a best practice in addressing substance use concerns. However, these programs are supported by philosophies of non-judgement, compassion, and acceptance, and do not actively condemn people who use drugs. In a country where drug use is focused on through a criminal justice lens, harm reduction operates ideologically opposed by the dominant systems of prohibition and enforcement. As aforementioned, not only does the criminalization of drug us have historical roots as a means of oppression of immigrant or otherwise "undesirable" populations, it hinders harm reduction programming by engraining stigma and "not in my backyard" mentalities, instilling fear and hostility in community members, property owners, and health care practitioners. As a result, programs are underfunded, with outreach programming scarce, and prisons, university campuses, and music venues hesitant to allow harm reduction services on their premises. Following a brief overview of current Canadian drug laws, this section will review in-depth three ways in which the criminalization of drug use acts as a barrier to implementing harm reduction programming; by breeding hostility in law enforcement, stigma in the community, and progressing the professionalization of harm reduction service provision.

The Current Canadian Context

In 1987 a four-pillar approach consisting of prevention, harm reduction, treatment, and enforcement tactics for addressing drug use was integrated into the *Controlled Drugs and Substances Act of Canada (CDSA*). However, the *CDSA*, like the policies that proceed it, places emphasis on the pillar of enforcement. The *CDSA* introduced stiffer penalties than those found

in the prior *Narcotic Control Act*, allowing the police to charge and prosecute a greater number of drug offenders (Gordon, 2009; Riley & Nolan, 1998). Legislation like the *CDSA* illustrates that despite a supposed four pillar approach to drug use, Canada still views drug use as a criminal justice issue, as opposed to a public health concern, and in doing so, creates massive barriers in service provision (Campbell & Shaw, 2008)**.** Despite the proven efficacy of harm reduction programs, they are most effective when implemented in combination with the decriminalization of drug use (Drucker, 2013; Eversman, 2014). Because criminalization involves the labelling of people who use drugs as deviants and the construction of drug use as immoral, it ideologically conflicts with the principles of harm reduction, which seeks to address drug use in a non-judgemental and compassionate manner. Not only do prohibitory drug policies fail to prevent drug use and its associated harms, they exacerbate these harms, and create new ones (Campbell & Shaw, 2008; Drucker, 2013; Eversman, 2014). The continued criminalization of drug use serves to impede access to harm reduction services by creating a climate of hostility from police, stigma from the public, and a professionalization of service provision (Drucker, 2013; Edington & Bayer, 2013).

Criminalization as an Impediment to Service Delivery

Stigma. As a crime of morality, drug use is not a deviant act in and of itself; drug use is considered to be deviant because it is illegal. The criminalization of drug use serves to increase social solidarity among those who do not use illicit substances by creating a morality of health (Bereska, 2014; Farrugia, 2014). This is accomplished by stigmatizing individuals who use drugs, inevitably leading to an atmosphere of cynicism towards the drug using community, who are subsequently labelled as deviants. As a result, the drug using community faces enormous stigma, based on stereotypes of people who use drugs as immoral, negligent, and generally inept.

Consequently, people who use drugs are perceived as inferior and undeserving of the same opportunities accessed by non-users (Goffman, 1974). This perception of drug use engenders social exclusion and isolation, and can result in their internalizing of their "deviant drug user" label, thus exacerbating the social, physical, and legal detriments of their drug use (Link & Phelan, 2006; Smith, 2009). Because drug use is criminalized, those who use drugs are stigmatized not only as "drug users", but as criminals. As will be expanded upon below, the stigma of the criminal label negatively impacts an individual's ability to gain meaningful employment, reduces educative opportunities, and lessens the likelihood that one will form various pro-social bonds (Apel et al., 2009; Windzio, 2006). Additionally, because those who experience marginalization, such as racialized and impoverished communities, are more likely to be criminalized for their substance use, this stigma is compounded for already disenfranchised populations (Fellner, 2009).

The stigma and discrimination faced by people who use illicit-drugs acts also as a barrier in accessing support services, education, treatment, and medical/social services that seek to ameliorate the harms associated with drug use (Edington & Bayer, 2013). The stigma associated with drug use results in the labelling of those who use drugs as undesirable and, in turn, unworthy of health care. Subsequently, there is a general reluctance to approve the implementation of harm reduction programs (Farrugia, 2014; Mena & Hobbs, 2009). Due to the "not in my backyard" mentality, many communities prohibit the provision of these services. When services are implemented, they are scarcely funded, and hostility, pessimism, and malpractice run rampant amongst social workers and health care providers (Edington & Bayer, 2013). Consequently, the stigma that exists as a result of repressive drug policies results in people who use drugs having limited access to medical care that is rooted in evidence. When the

stigma of substance use is alleviated, individuals are more likely to utilize harm reduction programing that may lessen the harms associated with their drug use (Lacquer, 2015).

Professionalization of Service Provision. Despite the proven success of harm reduction programming, the criminalized and subsequently stigmatized nature of drug use serves as a tremendous barrier in accessing these programs. Potential service users are hesitant to utilize harm reduction programs due to a general mistrust of service providers and a fear of prejudice. The stigmatization of drug use results in a general apathy among professionals in regards to the health and wellbeing of people who use drugs, with consequences for how services are provided. The hostility and discrimination that service users face when accessing harm reduction programs results in a reluctance to continue utilizing these services in the future (Aitken, Kerger, & Crofts, 2009; Edington & Bayer, 2013). This means that harm reduction programs are failing to reach the very people who may benefit from their services, largely due to the professionalization of harm reduction work.

Harm reduction initiatives originated at the hands of people who inject drugs during the HIV epidemic, but have since come to exclude people who use drugs from service provision (Campbell & Shaw, 2008; Eversman, 2014; Marshall, Dechman, Minichiello, Alcock, & Harris, 2015; Tookey, Mason, Broad, Behm, & Bondy, 2018). Harm reduction programming, particularly NEPs, have become a specialized field of social work, employing only those with educational backgrounds, and disregarding the lived experience and community ties of individuals who have engaged in drug use. The professionalization of harm reduction work not only lessens the potential impact of these programs, but takes jobs away from people who use drugs by preferencing formal education over lived experience. Exclusionary, professionalized practices in the field of harm reduction prevent many people who use drugs from gaining

employment as harm reduction workers. Those who are able to obtain employment in harm reduction programs are hired as peer workers, and are often inadequately compensated, sometimes receiving, at most, small honorariums, as opposed to the salaries and benefit packages their colleagues receive (Broadhead et al., 1998; Marshall et al., 2015). This exclusion of people who use drugs from service provision reinforces stereotypes of people who use drugs as irresponsible or incapable. Allowing for service provision by individuals who use drugs erodes their deviant labels and may work to counteract these stereotypes.

The term "peer work" refers to the inclusion of people who actively use drugs in service provision, thus counteracting the professionalization of harm reduction work. Peer work is recognized as a best practice, vital in the efficacy of harm reduction programs and practices (Tookey et al., 2018). Individuals who use drugs report being more likely to access services that are provided by people who have personal experience with drug use due to the stigma and cynicism that is so common among service providers (Broadhead et al., 1998; Edington & Bayer, 2013). Peer work, then, extends the reach of harm reduction initiatives, and therefore heightens the known benefits of harm reduction work (Latkin, Sherman, & Knowlton, 2003; Strang et al., 2002).

This is particularly pertinent when it comes populations facing intersections of marginalization's, such as homeless youth who use drugs. These young people, despite their aptitude for personal harm reduction and risk management tactics, are far less likely to seek support from formal services than adults who use drugs, and more often make changes in their lives based on their own personal experiences and those of their peers, rather than by the urging of parents and service providers (McDonald, 2014).

Peer work is also especially significant in the treatment of blood-borne ailments in people who inject drugs. As aforementioned, these individuals face a great deal of pessimism of behalf of medical service providers, thus lending itself to a sense of distrust and hopelessness that virtually eliminates the potential for medical treatment (Tookey et al., 2018). Because harm reduction programs serve a hard-to-reach population, utilizing peer networks aids in making these services accessible to a greater number of people (Aitken et al., 2009; Broadhead et al., 1998). Furthermore, involvement in peer work allows people who use injection drugs to promote safety in their communities in a way that aligns with their own moralistic standpoint; this is understood as an unlikely opportunity without the support of a harm reduction network (Barnes, Des Jarlais, Wolff, Freelemyer, & Tross, 2018).

In addition to heightening the scope of harm reduction programming, including active drugs users in service provision also has a positive impact on the lives of peer workers in many areas of their lives. By adopting helping roles in their social networks, and professional roles in their service provision networks, peer workers gain a sense of community, thus reducing their sense of social isolation. The responsibility that comes with these roles acts as an agent of empowerment for individuals who use drugs, allowing peer workers to gain a sense of confidence in a wide array of skills and experiences (Aitken et al., 2009, Latkin et al, 2003). Peer worker anecdotes as relayed by Tookey et al. (2018) demonstrate beneficial impacts of this employment experience as reaching many avenues of ones life, such as increased food and housing stability, reworking of social relationships, and marked changes in substance use practices that align with harm reduction philosophies and techniques.

Peer work provides opportunity to narrow a significant gap in steps toward recovery; vocational opportunities. Engaging in education or formal employment is often understood as an

anticipated milestone in the process of recovery, a damaging assumption to be made without regard for obstacles present for people who use drugs, or have recently become sober. Peer work allows for the smoothing of these obstacles, by offering employment opportunities in a field in which personal experience with substance use may be understood as an asset. The work environment may then be one of mutual respect, understanding, and support, and the professional role one that allows for flexibility and transition time. Peer work also supports a certain level of fluidity between the professional and personal work of an individual who uses drugs, allowing their employment to act as a conduit for their own growth in terms of their harm reduction practices (Tookey et al., 2018). For example, compensation offered for peer work acts as incentive for participation in harm reduction programming, engaging in health care opportunities, and potentially the eventual sobriety of the worker, while acting as a reminder of progress throughout the recovery process. This opportunity to give back to one's community helps to alleviate the internalized stigma that individuals who use drugs often face, thus building confidence while acquiring legitimate work experience and transferable skills (Aitken et al., 2009; Latkin et al., 2003; Tookey et al., 2018).

Regardless of demographics, literature widely illustrates a desire to engage in harm reduction practices among individuals who use drugs (Barnes et al., 2018; Curtis et al., 2018; McDonald, 2014; Tookey et al., 2018). When it comes to interacting with peers in a substance-using context, people who use drugs regulate their interactions in response to their own morals and understanding of harm reduction, largely with the desire to align themselves to helping behaviours. Decisions to offer assistance, information, or advice to other people who use drugs are grounded in the individuals belief of what would best serve to protect the safety of the person in question. In other words, people who use drugs are already working to promote the reduction

of substance-use related harms in their communities (Barnes et al., 2018; Curtis et al., 2018). By re-evaluating the required qualifications and compensation for employment in service provision, and investing in people who have, or do use drugs, within a harm reduction framework, we may welcome them into service provision and offer a framework for these helping behaviours that is grounded in research (Tookey et al., 2018). By allowing for the contributions of peer workers, harm reduction programs can be better informed, extend their reach, and have greater impact on both individuals accessing services, and those providing them.

Enforcement. The emphasis on enforcement and subsequent criminalization of individuals who use drugs philosophically conflicts with harm reduction ideology, and therefore impedes the provision of services that have been proven to be effective in reducing the harms associated with drug use in society (Drucker, 2013; Eversman, 2014; Kerr, Small, & Wood, 2005). The criminalization of drug use forces people who use drugs into hiding while doing so; hiding from police also means remaining invisible to service providers and health care professionals. Not only does this displacement make this already hard-to-reach population difficult for harm reduction outreach workers to locate, it forces people who use drugs to engage in their substance use in isolated locations, where help may be unavailable in the case of an emergency, such as accidental overdose. Furthermore, strong police presence in drug using communities deters individuals from accessing services, interacting with outreach service providers, carrying harm reduction supplies, and seeking medical assistance, all due to fear of their substance use becoming known to law enforcement officers (Kerr et al., 2005; Marshall et al., 2015; Rhodes, 2011). This fear of enforcement puts people who use drugs at an increased risk, as they experience hesitancy in accessing emergency services while in critical situations, and therefore the policing of drug using communities obstructs service access.

The enforcement of drug policies also exacerbates the harms of drug use and creates additional risks (Kerr at al., 2005; Rhodes, 2011). Individuals who have had interactions with police regarding their substance use are more likely to engage in a myriad of high risk drug use behaviours. Due to a fear of police interaction and subsequent criminalization, individuals who inject drugs rush the process of preparing for, and engaging in intravenous drug use. For example, these individuals are more likely to share needles and/or neglect to clean the site of injection or the materials they are using. Additionally, they are less likely to do a test dose, which involves taking a small dose of their drug in order to test its strength and effects before consuming a full dose. This leaves people who inject drugs at an increased risk of infection and overdose (Kerr et al., 2005).

Individuals who do become involved in the criminal justice system due to illicit drug use are often impoverished, living with concurrent mental health disorders, and potentially facing a myriad of health concerns. This results in further marginalization, as involvement with the criminal justice system brings with it even greater socio-economic consequences (Campbell & Shaw, 2008). Not only does the imposition of severe sanctions on individuals who use drugs do little to deter them from future drug use, there is a great deal of stigma associated with the criminal label that comes as a result of having a record of criminal charges and incarceration (DeFina & Hannon, 2013; Strang et al., 2002). Furthermore, because drug laws often target low-income individuals, the incarceration of non-violent drug offenders often involves the removal of primary wage earners. Even upon release from incarceration, those convicted of drug offences face stigma and restrictions to their liberty that may hinder their ability to obtain employment, and if they do, it is likely that they will earn much less than they would if they did not have a criminal record (Apel & Sweeten, 2010; Western, 2002). There are a number of reasons for this:

stereotypes associated with the criminal label, gaps in education and employment history due to incarceration, curfews, and geographical boundaries can all play a part in preventing the obtainment of legitimate employment upon release from prison (Apel & Sweeten, 2010; DeFina & Hannon, 2013; Western, 2002). As racialized and impoverished communities are disproportionately impacted by drug laws, incarceration of drug-offenders further marginalizes an already disenfranchised population.

Living with the label of "deviant" or "criminal", and facing difficulties accessing legitimate employment, are hypothesized as possibilities for the high recidivism rates associated with incarceration. Individuals who are charged and subsequently sentenced to a period of incarceration are more likely to reoffend than those who have received other sanctions. Additionally, incarceration does little to prevent future substance use for drug offenders. Therefore, the label of "deviant drug user" becomes a self-fulfilling prophecy, and only perpetuates a cycle of drug use, sanctions, and stigmatization (Cesaroni, 2014; Apel & Sweeten, 2010). Strong social bonds, however, have potential to help break this cycle. Reintegration into the community through engagement with institutions such as education, employment, and marriage is known to reduce the prospect of re-offending. However, the stigma associated with a history of incarceration diminishes the likelihood of involvement in these institutions (Apel et al., 2009; Windzio, 2006).

Repressive drug policies are said to exist with the purpose of eradicating drug use in society, but it widely acknowledged that they have failed in doing so, as such a society is unattainable (Campbell & Shaw, 2008; McKeagany, 2011). Prohibitory drug policies work to exacerbate the risks associated with drug use, in addition to generating new harms. The criminalization of drug use is, by nature, oppositional to harm reduction programming;

criminalization constructs a label of deviance to be imposed on people who use drugs, whereas harm reduction philosophies emphasize respect and compassion for those who use drugs. Because of these ideological conflict, the criminalization of drug use impedes access to life saving services (Hurley et al., 1997; Kerr et al., 2005). Alleviating the stigma associated with drug use, eliminating the detrimental impacts of drug policy enforcement, and incorporating individuals who use drugs into service delivery must be prioritized if harm reduction services are to become more widely accessible (Edington & Bayer, 2013; Marshal, 2005; Strang et al., 2002). To achieve these goals, Canadian drug policies must be revaluated and aligned with harm reduction philosophies (Drucker, 2013; Rhodes, 2011).

CHAPTER 4

RECOMMENDATIONS

Recommendations for Policy Reform

Armed with an understanding of the history of Canada's drug laws, and the efficacy of harm reduction programming, the blockade of enforcement that stands between people who use drugs and the services intended to protect them is a notable concern. It has been established that these policies directly contribute to the stereotypes associated with people who use drugs, with a myriad of consequences. With SCSs and NATDPs long battle for federal approval, the commonality of malpractice in OSTs, and the lack of services reaching students, homeless communities, prison inmates, and party goers, progress in addressing substance use during an opioid overdose epidemic is squandered by legislative barriers and law enforcement operations. While harm reductionists work to shine light on a deep-seeded societal injustice, enforcement efforts prove counter-productive, moving people who use drugs further to the margins of society, creating a climate of fear around these harm reduction services. With harm reduction programming remaining for decades as a best practice in addressing substance use related concerns, drug policy must adapt to reflect harm reduction philosophies in order to truly reap it's rewards – not only in the lives of people who use drugs, but in the community, and public health and criminal justice systems. Thus, this final section offers considerations and recommendations for legislative change that embodies principles of respect, dignity, and autonomy, via the mobilization of social movements.

Considerations in Policy Reform

When deliberating alternatives to repressive drug policies, we must consider how various policy frameworks may service the greater public good. Legal scholars have long theorized about

the purpose of law, and many believe that its primary goal should be to serve the best interests of the majority of society, and protect citizens from harm (Mill, 2010; Troyer, 2003). Due to its incompatibility with programs that reduce the prevalence of HIV, and the costs associated with health care, and the criminal justice system, the criminalization of drug use harms not only people who use drugs, but the greater population (Campbell & Shaw, 2008; Drucker, 2013). As decriminalization and the regulation of drug use in society have demonstrable ability to improve the lives of not only individuals who use drugs, but society as a whole, they are most likely to serve the public good and protect the public from harm (Lacquer, 2015; Vale de Andrade & Carapinha, 2010).

In addition to considering the public good in reforming drug policies, the autonomy and liberty of people who use drugs is also of concern. The argument may be posed that, providing no harm is imposed on others, individuals should have the right to choose what they put in their bodies, regardless of the harms it may cause to themselves (Mill, 2010). In this sense, the criminalization of drug use may be understood as impeding on the liberty of people who use drugs. Additionally, the barriers that repressive drug policies create in accessing social and medical services, the negative impacts that criminalization has on individuals and communities, and the disproportionate manner in which drug policies are enforced on already marginalized members of community, may all be understood in the context of individual liberty and autonomy.

Arguments for the criminalization of drug use have historically centred on moral issues and beliefs that condemn substance use, as opposed to focusing on the safety and liberty of individuals who use drugs. Criminal activities that are believed to run counter to dominant moral ideologies, in contrast to crimes resulting in the harm of one person by another, are referred to as

crimes of morality (Carpenter & Hayes, 2007; Hathaway & Mostaghim, 2015). This construction of morality results in the imposition of labels of deviancy and immorality upon those who engage in these activities. Crimes of morality, also known as victimless crimes, have been highly debated topics among academics, policy makers, and the general public. The criminalization of prostitution and doctor-assisted suicide exist alongside repressive drug policies, sharing many similar harms associated with drug prohibition. The criminalization of crimes of morality result in detrimental circumstances for the populations they are imposed upon, forcing them to occupy increasingly dangerous spaces in order to conduct the prohibited activity in question, thus exacerbating their associated harm (Kerr et al., 2005).

Crimes of morality are often discussed within a framework of radical non-intervention. Radical non-intervention calls for a reassessment of the way in which we think about criminality, and an understanding that the harms of criminalization far outweigh the costs (Schur, 1973). This involves the designation of policies that are steeped in empirical evidence, going beyond the rhetoric of punishment and isolation. By appreciating the ability of individuals to emerge from their drug use on their own terms, we may set the stage for policy frameworks that exist in a place of respect and dignity, thus challenging systemic inequalities (Schur, 1973; Sheldon, 2004). By ceasing to construct those who use drugs as deviant, we may allow individuals who use drugs to avoid becoming identified with a "deviant drug user" label. Additionally, we may focus on dispensing justice for more serious crimes, and providing effective intervention programs. When discussing alternative policies for regulating drug use, we may look to discussions regarding other crimes of morality for inspiration and understanding.

Decriminalization: The Portuguese Model

The regulatory framework implemented in Portugal at the turn of the twenty-first century provides us with policy directives for alternatives means of addressing drug use in society. Portugal's national drug policy involves a complete decriminalization of all drug offences that are not related to trafficking. As part of their national harm reduction strategy, all drug offences are addressed as administrative violations and are not processed through the traditional court systems (Temenos, 2016; Vale de Andrade & Carapinha, 2010; Van Het Loo et al, 2002). In doing so, those who use drugs are not labelled as criminals. Depending on the context of the violation, these individuals may be issued an oral warning, or referred to a dissuasion commission where they are either recommended for drug treatment, or have minor sanctions imposed upon them. These sanctions may include peer and location restrictions, removal of the right to practice a particular profession (i.e. childcare), or periodic reports to the commission. Upon successful completion of a treatment program, these sanctions are removed (Lacquer, 2015).

Since the decriminalization of drug use in Portugal, the country has seen a one-hundred and fifty per cent increase in drug treatment completion, and a massive reduction in the prevalence of injection drug use, overdose deaths, and HIV (Vale de Andrade & Carapinha, 2010; Van Het Loo et al., 2002). This approach has allowed medical and social services to individualize their programming, enabling those who use drugs to do so in a way that results in minimal harm to themselves and their communities, and focusing treatment efforts on those who are ready to cease their drug use entirely (Vale de Andrade & Carapinha, 2010). Furthermore, decriminalization has alleviated the immense burden placed upon the criminal justice system from prosecuting minor drug offences, allowing law enforcement efforts to focus on large scale

drug trafficking. Although there were concerns that without deterrence through legal sanctions drug use would increase, since decriminalization, Portugal has possessed the lowest rates of drug use within the European Union and has seen an increase in access to harm reduction programming (Lacquer, 2015). However, Portugal continues to be criticized for its lack of regulation of illicit drug markets; a full legalization and regulation approach would ensure that drugs are safely obtainable from legitimate markets, further alleviating the harms associated with drug use (Van Het Loo et al., 2002).

Legalization & Regulation

Although decriminalization has demonstrated the ability to alleviate some of the harms of drug use and zero-tolerance drug policies, illicit substances are still cultivated and distributed via the black market (Van Het Loo et al., 2002). This means that in order to obtain drugs, individuals have no choice but to interact with this illegal market and its associated dangers. The illegal drug trade is known for its volatility and is associated with violence. Without government regulation of drug markets, these markets are often run by street gangs, and result in violence to establish territory, combat competition from rival gangs, and enforce debt payments (Moeller, 2017; Naranjo, 2015; Reuter, 2009). Additionally, this lack of regulation causes market prices for illicit substances to fluctuate greatly (Naranjo, 2015). As providing illegal substances becomes more dangerous, due to the risk of criminalization, prices rise, and individuals who purchase drugs from the black market are unable to cope with increased costs. This results in an increase of crime to generate funds to purchase drugs, opening the door for numerous detriments associated with law-breaking, such as subsequent interactions with the criminal justice system (Greenberg, 2016; Moeller, 2017; Wodak, 2014). Furthermore, when one obtains illicit substances in the illegal market, they have no way to be sure of the contents or dosages or the

drug they are consuming, increasing the risk of overdose and side effects from dangerous drug synergies (Schroers, 2002). For these reasons, the decriminalization of drug possession and consumption alone is not enough to ameliorate the harms of drug use and repressive drug policies (Grieve, 2009).

The term "legalization" is often mistaken for a laissez-faire approach that allows for unrestricted access to once illicit substances. In reality, legalization is more synonymous with regulation. In contrast to decriminalization, full legalization of drug use involves government regulation of the cultivation and sale of drugs, much like the regulated alcohol, cannabis, and tobacco markets in Canada. Similarly, legalization would involve the imposition of age and geographical restrictions for consumption, with public intoxication and sales to minors remaining to be criminal offences (Steel, 2006). Substances sold under this framework may be labelled with health risks, as is the case with tobacco, or dosage recommendations (Mostyn, Gibbon, & Cowdery, 2012).

To date, no country has implemented a comprehensive framework for regulating drug cultivation and distribution, and it is unlikely that a one-size-fits-all approach would be effective in regulating all currently illicit drugs. For example, it is improbable that a policy model for regulating cannabis would be recommendable for regulating the use of heroin or ecstasy. Where cannabis regulation may be modeled after the tobacco and alcohol markets, purchasing drugs that are considered to be more addictive and less likely to be used recreationally, such as heroin, may require proof of a diagnosed substance dependency. This type of prescription model existed in the United States and United Kingdom as early as the 1920's, and still exists in some European countries today (Einstein, 2007). Other substances, such as ecstasy/MDMA, which have known medicinal and therapeutic effects, may require a prescription from a licenced psychotherapist

(Wodak, 2014). Substances traditionally used in spiritual or religious rituals and ceremonies, such as psilocybin mushrooms and ayahuasca, may require a licence to distribute within a controlled environment. While some substances may be sold in stores, as is the case with cannabis in some North American locations, others may be dispensed by pharmacists, and others in licenced establishments, much like bars (Toine, 2012).

Regulating the drug market is clearly not as simple as providing uniformly unrestricted access to all currently illicit substances. The suggestions provided above are intended to illustrate the complexities of creating a comprehensive regulatory framework, and demonstrate the need for a variety of approaches for regulating a variety of substances. Whatever the case, legalization and regulation of drugs must primarily take a public health approach that has been lacking under prohibition (Mostyn et al., 2012; Toine, 2012; Wodak, 2014). In doing so, funding previously used for the enforcement of drug laws may be funneled into initiatives to reduce the harms of drug use on individuals and communities (Toine, 2012). Future research on drug policy reform must work to formulate innovative regulatory frameworks that may do so.

A Vehicle for Change: Social Movement Mobilization

The scientific data regarding the value of harm reduction programming and the detriments of drug prohibition has been available to policy-makers and the general public for decades. However, change is slow to occur, and no talks of decriminalization or legalization are in the works in Canada, with the exception of the recent legalization of cannabis. Harm reduction philosophies are still considered to be a controversial subject, and programs remain scarcely funded. In order to effect real change at the policy level, more than just empirical evidence is needed. Harm reduction programs emerged first from the advocacy work of people who inject drugs, and gained footing through subsequent grassroots movements (Drucker, 2013). It was by

processes of advocacy and social mobilization that harm reduction philosophies have become normative in service provision. It is by these same processes that drug policies may be reformed and aligned with harm reduction philosophies.

Harm reduction is principally about the empowerment of individuals who use drugs and the amelioration of the stigma they face. Therefore, attempting to enact policy change based on empirical research that excludes their voices goes against the very foundation on which harm reduction rests (Campbell & Shaw, 2008; McCann & Temenos, 2015). Social movements must allow for the leadership of the individuals primarily impacted by current drug policies. Currently, much leadership within harm reduction movements are "middle class workers", such as social workers and nurses (Friedman et al., 2001). As harm reduction programming becomes increasingly coopted by professional service providers with no lived experience of the harms of drug use and repressive drug policies, we see limitations in these programs abilities to fulfill their potential. Similarly, this appropriating of the harm reduction movement and exclusion of people who use drugs will subsequently result in the professionalization of advocacy, and thus, these movements will fall short (Eversman, 2014). In addition to including people who use drugs and the working class in these movements, it is of exceptional importance that Black and Indigenous leadership be respected, as these communities are disproportionately impacted by the consequences of repressive drug policies. If drug policy reform movements are expected to be successful in addressing the harms of prohibitory drug policies, they must acknowledge the historical context of these policies, and the ethnocentrism and classism involved in their continued enforcement. By including and respecting the leadership of people with lived experience, social movements can begin to reverse the stigma faced by people who use drugs as a result of their deviant and criminal labels. Research on social movements in their application to

drug policy reform is limited, and future work on mobilizing these movements should seek direction from individuals and communities most impacted by drug prohibition.

Conclusion

Through social constructionist lens we have understood prohibitory drug policies as historically serving the purpose of casting deviant identities on already impoverished and racialized individuals who use drugs. By labelling those who use drugs as deviants, these policies create a morality of health via criminalizing marginalized communities. This criminalization results in stigmatization and thus impedes the delivery of potentially life-saving harm reduction programming. By prioritizing these programs, and aligning overarching drug policies with harm reduction philosophies, the harms of zero-tolerance drug policies and drug use may be alleviated. By extension, the harms of the enforcement and stigmatization associated with drug prohibition, in addition to the professionalization of service provision, may be addressed, in addition to alleviating the detriments of interacting with illegal drug markets and criminal justice systems. Considering the public good, and individual autonomy and liberty leads to the seeking out of frameworks by which crimes of morality have been policed around the globe. This allows for an assessment of the Portuguese Model of decriminalization of drug use and other alternative regulatory frameworks as best practices for minimizing the consequences of drug use on individuals and the greater community. In recommending these policy reforms, a discussion regarding the means for achieving legislative restructuring is necessary. Future research on drug policy reform must both work to formulate innovative frameworks for addressing substance use from a public health approach, and investigate approaches for social mobilization and advocacy work to achieve reforms. As the criminalization of drug use continues to result in the labelling and subsequent stigmatization of people who use drugs, it cannot exist alongside harm reduction

programming without impeding its provision. Therefore, drug policies must align with harm reduction philosophies in order to alleviate the harms of drug use, current drug policies, and the stigmatization of the drug using population.

References

Abelman, D.D. (2017). Mitigating risks of student's use of study drugs through understanding motivations for use and applying harm reduction theory: a literature review. *Harm Reduction Journal, 14*.

Aitken, C.K., Crofts, N., Kerger M. (2009). Peer-delivered hepatitis C testing and counselling: a means of improving the health of injecting drug users. *Drug and Alcohol Review, 21*(1), 33-37.

Akers, A.L., Sellers, C.S., & Jennings, W.G. (2014). *Criminological theories: introduction, evaluations, and application.* New York, NY: Oxford University Press.

Apel, R., & Sweeten, G. (2010). The Impact of Incarceration on Employment during to Transition to Adulthood. *Social Problems, 57*(3), 448-479.

Apel, R., Blokland, A.A.J., Nieuwbeerta, P., & van Schellen, M. (2009). The Impact of Imprisonment on Marriage and Divorce: A risk set matching approach.

Barnes, D.M., Des Jarlais, D.C., Wolff, M., Freelemyer, J., & Tross, S. (2018). A qualitative study of persons who inject drugs but have never helped others with injections: how their views of helping contrast with the views or persons who have helped with first Injections, and implications for interventions. Harm Reduction Journal, 15(43).

Bayoumi, A.M., Zaric, G.S. (2008). The cost-effectiveness of Vancouver's supervised injection facility. *Canadian Medical Association Journal, 179*(11), 1143-1151.

Bazazi, A.R., Zaller, N.D., Fu, J.J., & Rich, J.D. (2010). Preventing opiate overdose deaths: Examining objections to take-home naloxone. *Journal of Health Care for the Poor and Undeserved, 21*(4), 1108-1113.

Bereska, T.M. (2014). *Deviance, conformity, and social control in Canada.* Toronto: Pearson Canada.

Bersamin, M., Mallie, P.J., Fearnow-Kenney, M., & Wyrick, D. (2007). Effectiveness of a web-based alcohol misuse and harm prevention course among high and low risk students. *Journal of American College Health, 55*(4), 247-254.

Bestha, D. (2018). Kratum and the Opioid Crisis. *Innovations in Clinical Neuroscience, 15(5), 12.*

Bowring, A.L., Luhmann, N., Pont, S., Debaulieu, C., Derozier, S., Asoub, F., Dietze, P., Stoove, M., Toufik, A., & van Germert, C. (2013). An urgent need to scale-up injecting drug harm reduction services in Tanzania: Prevalence of blood-borne viruses among drug users in Temeke District, Dar-es-Salaam, 2011. *International Journal of Drug Policy, 24*(1), 78-81.

Broadhead, R.S., Heckathorn, D.D., Weakliem, D.L., Anthony, D.L., Madray, H., Hughes, J., & Mills, J. (1998). Harnessing peer networks as an instrument for AIDS prevention: results from a peer-driven intervention. *Public Health Reports, 113*(1), 42-57.

Campbell, N.D., & Shaw, S.J. (2008). Incitements to discourse: illicit drugs, harm reduction, and the production of ethnographic subjects. *Cultural Anthropology, 23*(4), 688-717.

Carmona, J., Slesnick, N., Guo, X., Murnan, A., & Brakenhoff, B. (2017). Predictors of Outreach Meetings among Substance Using Homeless Youth. *Community Mental Health Journal, 53*(1), 62-71.

Carpenter, B. J., & Hayes, S. L. (2007) *Crimes against morality*. In Hayes, Hennessey & Prenzler (Eds.) an Introduction to Crime (1st Ed.). Sydney, Australia: Pearson Education.

Cesaroni, C. (2014). "The Use of Prisons: Mass Incarceration in the United States". University of Ontario Institute of Technology. 8 October. Oshawa, Ontario.

Cicero, M. (2017). Ottawa's overdose prevention site defies government and gets results. *Canadian Centre for Policy Alternatives,* 24(5), 18-20.

Clatts, M.C. & Davis, W.R. (1999). A Demographic and Behavioural Profile of Homeless Youth in New York City Implications for AIDS Outreach and Prevention. *Medical Anthropology Quarterly, 12*(3), 365-374.

Coren, E., Hossain, R., Pardo Pardo, J., Veras, M.M.S., Chakraborty, K., Harris, H., & Martin, A.J. (2013). Interventions for promoting reintegration and reducing harmful behaviour and lifestyles in street-connected children and young people (Review). *Evidence-Based Child Health, 8*(4), 1140-1272.

Cortina, S., Kennedy, M.C., Dong, H., Fairbairn, N., Hayashi, K., Milljoy, M.J., Kerr, T. (2018). Willingness to use an in-hospital supervised inhalation room among people who smoke crack cocaine in Vancouver, Canada. *Drug and Alcohol Review, 347*(5), 645-652.

Curtis, M., Dietze, P., Aitken, C., Kirwan, A., Kinner, S.A., Butler, T., & Stoove, M. (2018). Acceptability of prison-based take-home naloxone programmers among a cohort of incarcerated men with a history of regular injecting drug use. *Harm Reduction Journal, 15*(48), 1-9.

DeFina, R., & Hannon, L. The Impact of Mass Incarceration on Poverty. *Crime and Delinquency, 59*(4), 562-586.

Domanico, A & Malta, M. (2012). Implementation of Harm Reduction toward Crack Users in Brazil: Barriers and Achievements. *Substance Use & Misuse, 47*(5), 535-546.

Dotter, D. (2002). Creating deviance: Scenarios of stigmatization in postmodern media culture. *Deviant Behaviour, 23*(5), 429-448.

Drucker, E. (2013). Advocacy Research in Harm Reduction Drug Policies. *Journal of Social Issues, 69*(4), 694-693.

Edington, C. & Bayer, R. (2013). When grammars collide: Harm reduction, drug detention and the challenges of international policy reform efforts in Vietnam. *Global Public Health, 8*(1), 275-291.

Einstein, S. (2007). Harm and risk reduction: History, theories, issues, and implications. *Substance Use and Misuse, 42*(2), 257-265.

Eversman, M.H. (2014). Trying to find the middle ground: Drug policy and harm reduction in black communities. *Race and Justice, 4*(1), 29-44.

Farrugia, A. (2014). Assembling the dominant accounts of youth drug use in Australian harm reduction drug education. *International Journal of Drug Policy, 25*(4), 663-627.

Fellner, J. (2009). Race, drugs, and law enforcement in the United States. *Stanford Law & Policy Review, 20*(2), 257-291.

Fernandez-Calderon, F., Diaz-Batanero, C., Barratt, M.J., & Palamar, J.J. (2018). Harm reduction strategies related to dosing and relations to harm among festival attendees who use multiple drugs. *Drug and Alcohol Review,* 1-11.

Folch, C., Lorenta, N., Majo, X., Pares-Badell, O., Roca, X., Brugal, T., Roux, P., Carrieri, P., Colom, J., Casabona, J. (2018). Drug consumption rooms in Catalonia: A comprehensive evaluation of social, health, and harm reduction benefits. *International Journal of Drug Policy, 62I, 24-29.*

Frei, M. (2010). Party drugs: Use and harm reduction. *Australian Family Physicians, 39*(8), 548-552.

Friedman, S.R., Southwell, M., Bueno, R., Paone, D., Byrne, J., & Crofts, N. (2001). Harm reduction – a historical view from the left. *International Journal of Drug Policy, 12*(1), 3-14.

Goffman, E. (1974). *Stigma: notes on the management of spoiled identity.* Harmondsworth: Penguin Books.

Gordon, T. (2009). Neoliberalism, racism, and the war on drugs in Canada. *Social Justice, 33*(1), 59-78.

Greenberg, D. (2016). Illegal drug markets and victimizing crime in New York. *Dialectical Anthropology, 40*(4), 349-354.

Greenspan, N.R., Aguinaldo, J.P., Husbands, W., Murray, J., Ho, P, Sutdhibhaslip, N., Cedano, J., Lau, C., Gray, T., Maharaj, R. (2011). "It's not rocket science, what I do": Self-directed harm

reduction strategies among drug using ethno-racially diverse gay and bisexual men. *International Journal of Drug Policy, 22,* 56-62.

Grieve, J. (2009). What do law enforcement strategies contribute to UK drug harm-reduction? *Safer Communities, 8*(1), 32-37.

Guevremony, N., Barnes, M., & Haupt, C.E. (2018). Physician autonomy and the Opioid Crisis. *Journal of Law, Medicine, and Ethics, 46,* 203-219.

Hathaway, A., Mostaghim, A. (2015). *Crimes of Morality.* In Neil Boyd (ed.) Understanding Crime in Canada: An Introduction to Criminology. Toronto: Emond Montgomery Publication.

Health Canada. (2018). Supervised consumption sites: status of applications. Retrieved from https://www.canada.ca/en/health-canada/services/substance-use/supervised-consumption-sites/status-application.html.

Hungerbuehler, I., Buecheli, A., & Schaub, M. (2011). Drug checking: A prevention measure for a heterogeneous group with high consumption frequency and polydrug use – evaluation of Zurich's drug checking services. *Harm Reduction Journal, 8*(16), 1-6.

Hurley, S.F., Jolley, D.J., & Kaldor, J.M. (1997). Effectiveness of needle-exchange programs for prevention of HIV infection. *The Lancet, 349*(9068), 1797-1800.

Hwang, S.W., Wilkins, R., Tjepkema, M., O'Campo, P.J., Dunn, J.R. (2009). Mortality among residents of shelters, rooming houses, and hotels in Canada: 11 year follow-up study. *British Medical Journal, 399,* 1-9.

Ivsins, A., Roth, E., Nakamura, N., Krajden, M., Fischer, B. (2011). Uptake, benefits of and barriers to safer crack use kit (SCUK) distribution programmes in Victoria, Canada – A qualitative exploration. *International Journal of Drug Policy, 22,* 292-300

James, K., & Jordan, A. (2018). The Opioid Crisis in Black Communities. *Journal of Law, Medicine, and Ethics, 46,* 404-421.

Jenkins, E. K., Selmon, A., & Haines-Saah, R.J. (2017). Developing harm reduction in the context of youth substance use: insights from a multisite qualitative analysis of young people's harm minimization strategies. *Harm Reduction Journal, 14*(53), 1-11.

Kerr, T., Mitra, S., Kennedy, M.C., & McNeil, R. (2017). Supervised injection facilities in Canada: past, present, and future. *Harm Reduction Journal, 14*(28), 1-9.

Kerr, T., Small, W., & Wood, E. (2005). The public health and social impacts of drug market enforcement: A review of the evidence. *International Journal of Drug Policy, 16*(4), 210-220.

Lacquer, H. (2015). Uses and abuses of drug decriminalization in Portugal. *Law & Social Inquiry, 40*(3), 746-781.

Latkin, C.A., Sherman, S., & Knowlton, A. (2003). HIV prevention among drug users: Outcome of a network-oriented peer outreach intervention. *American Psychological Association: Health Psychology, 22*(4), 332-339.

Lewis, D.A., Park, J.N., Vail, L., Sine, M., & Welsh, C. (2016). Evaluation of the overdose education and naloxone distribution program of the Baltimore Student Harm Reduction Coalition. *American Journal of Public Health, 106*(7), 1243-1246.

Link, B. G., & Phelan, J.C. (2006). Stigma and its public health implications. *The Lancet, 367*(1), 528-529.

Lucas, P. (2017). Rationale for cannabis-based interventions in the opioid overdose crisis. *Harm Reduction Journal, 14*(58), 1-6.

Lushin, V. & Anastas, J.W. (2011). Harm reduction in substance abuse treatment: Pragmatism as an epistemology for social work practice. *Journal of Social Work Practice in the Addictions, 11*(1), 96-100.

Makary, M. A. (2017). Overprescribing is major contributor to opioid crisis. *British Medical Journal*

Marshall, Z., Dechman, M.K., Minichiello, A., Alcock, L., & Harris, G.E. (2015). Peering into the literature: A systematic review of the roles of people who inject drug in harm reduction initiatives. *Drug and Alcohol Dependence, 151*(1), 1-14.

McBride, N. Farringdon, F., Midford, R., Mueleners, L., & Phillips, M. (2004). Harm minimization in school drug education: final results of the School Health and Alcohol Harm Reduction Project (SHAHRP). *Addiction, 99*(3), 278-291.

McCann, E. & Temenos, C. (2015). Mobilizing drug consumption rooms: inter-place networks and harm reduction drug policy. *Health and Place, 31*, 216-22.

McDonald, S. (2014). Managing Risk: Self-Regulation among Homeless Youth. *Child Adolescent Social Work, 31*(1), 497-520

McKeagany, N. (2011). From harm reduction to drug user abstinence: a journey in drug treatment policy. *Journal of Substance Use, 16*(3), 179-194.

Mena, F., & Hobbs, D. (2009). Narcophobia: Drugs prohibition and the generation of human rights abuses. *Trends in Organized Crime, 13*(1), 60-74.

Mill, J. S. (2010). *On Liberty*. Strand, London: Penguin Books.

Moeller, K. (2017). Debts and threats: Managing inability to repay credits in illicit drug distribution. *Justice Quarterly, 34*(2), 272-296.

Mohr, R. (2018). Preventing Drug-Related Deaths at Music Festivals: Why the "Rave" Act should be amended to provide an exception for harm reduction services. *Chicago-Kent Law Review,* 93*(3), 943-969.*

Mostyn, B., Gibbon, H., & Cowdery, N. (2012). The criminalisation of drugs and the search for alternative approaches. *Current Issues in Criminal Justice, 24*(2), 261-272.

Musto, D. F. (1991). Opium, cocaine and marijuana in American history. *Scientific American, 265*(1), 40-47.

Naranjo, A.J. (2015). Turf and illegal drug market competition between gangs. *The B.E. Journal of Economic Analysis & Policy, 15*(4), 1507-1548.

Nova Scotia Department of Health and Wellness. (2012). Reducing alcohol harms among university students: a summary of best practices. Nova Scotia: *Department of Health and Wellness, Mental Health, Children's Services & Addictions Branch.*

Panagopoulos, A., & Ricciardelli, L.A. (2005). Harm reduction and decision making among recreational ecstasy users. *International Journal of Drug Policy, 16*(1), 54-64.

Patterson, T., Bharmal, A., Padhi, S., Buchner, C., Gibson, E., Lee, V. (2018). Opening Canada's first Health Canada-approved supervised consumption site. *Canada Public Health, 109*(4), 581-584.

Petterson, A.G., & Madah-Amiri. (2017). Overdose prevention training with naloxone distribution in a prison in Oslo, Norway: a preliminary study. *Harm Reduction Journal, 14*(74), 1-6.

Piper, T.M., Rudenstine, S., Stancliff, S., Sherman, S., Nandi, V., Clear, A., & Galea, S. (2007). Overdose prevention for injection drug users: Lessons learned from naloxone training and distribution programs in New York City. *Harm Reduction Journal, 4*(3), 1-8.

Provine, D. M. (2011). Race and inequality in the war on drugs. *Annual Review of Law and Social Science, 7*(1), 41-60.

Rafter, N. (1990). The social construction of crime and crime control. *Journal of Research in Crime and Delinquency, 27*(4), 376-389.

Reece, R., Van der Meulen, E., Ka Hon Chu, S. (2018) Building Dialogue on Prison Health: Improving Access to Harm Reduction in Federal Prisons. *Canadian Journal of Criminology and Criminal Justice, 60*(3), 300-306.

Reuter, P. (2009). Systemic violence in drug markets. *Crime, Law, and Social Change, 52*(3), 275-284.

Rhodes, T. (2010). Policy resistance to harm reduction for drug users and potential effects of change. *The British Medical Journal, 341*(2), 34-39.

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

Schroers, A. (2002). Drug checking: Monitoring the contents of new synthetic drugs. *Journal of Drug Issues, 32*(2), 635-646.

Schur, E.M. (1973). *Radical non-intervention: Rethinking the delinquency problem.* Englewood Cliffs, NJ: Prentice-Hall.

Sheldon, R.G. (2004). Resurrecting Radical Non-Intervention: Stop the War on Kids. *Centre on Juvenile and Criminal Justice.*

Smith, J., & de Souza, H. (2018). Response to Building Dialogue on Prison Health: Improving Access to Harm Reduction in Federal Prisons. *Canadian Journal of Criminology and Criminal Justice, 60*(3), 314-316.

Smith, R.J. (2011). Goffman's interaction order at the margins: Stigma, role, and normalization in the outreach encounter. *Symbolic Interaction, 34*(3), 357-376.

Steel, A. (2006). Regaining control: A critique of drug legalization policies. *Drugs and Alcohol Today, 6*(1), 19-23.

Strang, J., Babor, T., Caulkins, J., Fischer, B., Foxcroft, D., & Humphreys, K. (2012). Drug policy and the public good: evidence for effective interventions. *The Lancet*, *379*(9), 71-83.

Strike, C., & Miskovic, M. (2018). Scoping out the literature on mobile needle and syringe programs – review of service delivery and client characteristics, operation, utilization, referrals, and impact. *Harm Reduction Journal, 15*(6), 1-16.

Temenos, C. (2016). Mobilizing drug policy activism: conferences, convergence spaces and ephemeral fixtures in social movement mobilization. *Space and Polity*, *20*(1), 124-141.

Toine, S. (2012). The question of regulating illegal markets: The gambling and cannabis markets in the Netherlands. *GSTF Journal of Law and Social Sciences, 2*(1), 30-37.

Tookey, P., Mason, K., Broad, J., Behm, M., Bondy, L., & Powis, J. (2018). From client to co-worker: a case study of transition to peer work within a multidisciplinary hepatitis c treatment team in Toronto, Canada. *Harm Reduction Journal, 15*(51). 1-11.

Troyer, J. (2003). *The classical utilitarian's: Bentham and Mill*. Indianapolis: Hacket Pub

Tyndall, M.W., Kerr, T., Zhang, R., King, E., Montaner, J.G., & Wood, E. (2005). Attendance, drug use patterns, and referrals made from North America's first supervised injection facility. *Drug and Alcohol Dependence, 83*(3), 193-198.

Vadivelu, N., Kai, Kodomundi, V., Sramcik, J., & Kaye, A.D. (2018). The Opioid Crisis: a Comprehensive Overview. *The Current Pain and Headache Reports, 22*(16), 15-21.

Vale de Andrade, P. & Carapinha, L. (2010). Drug decriminalisation in Portugal. *British Medical Journal, 341*(1), 1-2.

Van der Meulen, E. (2017). "It Goes on Everywhere": Injection Drug Use in Canadian Federal Prisons. *Substance Use & Misuse, 42*(7), 884-891.

Van der Meulen, E., De Shalit, A., & Ka Hon Chu, S. (2017). A Legacy of Harm: Punitive Drug Policies and Women's Carceral Experiences in Canada. *Women & Criminal Justice, 28*(2), 81-99.

Van Het Loo, M., Van Beusekom, I.V., Kahan, J.P. (2002). Decriminalization of Drug Use in Portugal: The Development of a Policy. *American Academy of Political and Social Science, 582*(1), 49-63.

Volkow, N.D., & Collins, F.S. (2017). The Role of Science in Addressing the Opioid Crisis. *The New England Journal of Medicine, 377*(4), 391-394

Voon, P., Ti, L., Bond, H., Millow, M.J., Wood, E., Kerr, T., Hayashi, K. (2016). Risky and rushed public crack cocaine smoking: the potential for supervised inhalation facilities. *Public Health, 16,* 476.

Werb, D., Kerr, T., Fast, D., Qi, J., Montaner, J.S.G., Wood, E. (2010). Drug-related risks among street youth in two neighborhoods in a Canadian setting. *Health & Place, 16*(1), 1061-1067n

Western, B. (2002). The Impact of Incarceration on Wage Mobility and Inequality. *American Sociological Review, 67*(4), 526-546.

Whittingham, J.R.D., Ruiter, R.A.C., Boiler, L., Lemmers, L., Van Hasselt, N., & Kok, G. (2009). Avoiding Counterproductive Results: An Experimental Pretest of a Harm Reduction Intervention on Attitude Toward Party Drugs Among Users and Nonusers. *Substance Use & Misuse, 44*(4), 532-547.

Wilkinson, B., & Ivsins, A. (2017). Animal house: University risk environments and the regulation of students alcohol use. *International Journal of Drug Police, 47,* 18-25.

Windzio, M. (2006). Is there a deterrent effect of pains of imprisonment? The impact of 'social costs' of first incarceration on the hazard rate of recidivism. *Punishment and Society, 8*(3), 341-364.

Wodak, A. (2014). The abject failure of drug prohibition. *Australian and New Zealand Journal of Criminology, 47*(2), 190-201.

Wood, E., Kerr, T., Lloyd-Smith, E., Buchner, C., Marsh, D.C., Montaner, J.S.G., Tyndall, M.W. (2004). Methodology for evaluating Insite: Canada's first medically supervised safer injection facility for drug users. *Harm Reduction Journal, 1*(9), 1-5.

Young, M.M., Diedrich, K., Pirie, Y., Lund, A., Turris, S., & Bowles, R. (2015). Preventing Drug and Alcohol related Harms at Music Festivals in Canada. Ottawa, Ontario: Canadian Centre on Substance Abuse.

Young, S., & Fairbairn, N. (2018). Expanding supervised injection facilities across Canada: lessons from the Vancouver experience. *Canadian Journal of Public Health, 109*(2), 227-230.

Ziyanak, S. & Williams, J.L. (2014). Functionalist perspective on deviance. *Journal of Health Sciences, 11*(2), 1-9.

Zong, L. & Perry, B. (2011). Chinese Immigrants in Canada and Social Justice: From Overt to Covert Racial Discrimination. In B. Perry (Ed.) *Diversity, crime, and justice in Canada* (pp.106-124). Ontario: Oxford University Press.

Zule, W.A., Pande, P.G., Otiashvill, D., Bobashev, G.V., Friedman, S.R., Gyarmathy, V. A., & Des Jarlais, D.C. (2018). Options for reducing HIV transmission related to the dead space in needles and syringes. *Harm Reduction Journal, 15*(3), 1-15.