Psychoactive Substances & Society (2nd Edition)

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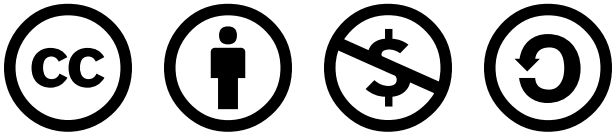
Jacqueline Lewis and Jillian Holland-Penney

Jillian Holland-Penney; Nobuko Fujita; Jackie Durocher; Brandon Bernardon; and Christine Miller



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Land Acknowledgement

The University of Windsor sits on the traditional territory of the Three Fires Confederacy of First Nations, which includes the Ojibwa, the Odawa, and the Potawatomie. As settlers, we acknowledge and thank the traditional custodians of this place.

2

Psychoactive Substances & Society (2nd Edition)

This is the 2nd edition of *Psychoactive Substances Use & Social Policy* by Jacqueline Lewis & Jillian Holland-Penney (link to original eBook). It has a revised and abbreviated title, *Psychoactive Substances & Society*. The 2nd edition is updated and enhanced. There are a number of changes, additions and updates including:

- Two new chapters:
    - Chapter 2: The Social Construction of Drugs, Users & Policies.
    - Chapter 12: The Cannabis and Emerging Psychedelic Industries.
- Chapter 1.2 Infographic: Psychoactive Drug Classifications.
- Chapter 12.1 Infographic: Canadian Medical Cannabis Policies & Key Court Decisions Infographic: Historical Timeline.
- Chapter 2.4 video by one of the authors: Social constructionism – Claims-makers & Audiences.

- An updated syllabus
- An updated assignment rubric.
- Updated content includes material from over 100 resources from 2022-2023 .

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Adopting or Adapting the Book

Citation & Attribution

The suggested citation for this book in APA format is:

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The suggested attribution for this textbook is

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open educational resources are customizable to meet a wide range of learning needs, and we invite instructors to review and adopt the resources for use in their courses.

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Instructor Materials

Course Syllabus

Psychoactive Substances & Society Syllabus

Grading Rubric

Psychoactive Substances & Society Assignment Evaluation Rubric

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Acknowledgements

Jacqueline Lewis

Project Funding

This project was developed with funding from the Government of Ontario and eCampusOntario Virtual Learning Strategy (VLS).

Project Team Members

A number of people contributed to the completion of this eCampus Pressbook. I would like to thank them for their tireless efforts.

Jillian Holland-Penney, MA, worked for the duration of the project while completing her MA degree at the University of Windsor. After completion of her degree in January 2022, she moved into a full-time role for the last 3 months of the project. Her various contributions include serving as project manager, research and development of Pressbook content, co-editor of all materials, and co-author of most chapters. The successful completion of the project would not have been possible without her hard-work and dedication.

Nobuko Fujita, PhD (Office of Open Learning, University of Windsor), played an integral role in the

development of the eCampus funding application and bringing the project through to fruition. Throughout the project she provided technical and administrative support, including her expertise with the Pressbook platform, helping to implement my vision for this book.

Jacqueline Durocher and Brandon Bernardon both worked on the project as research associates while completing their MAs at the University of Windsor. As part of their contributions to the project, they conducted research, developed audio-video resources, and co-authored chapters.

Dave Cormier, Patrick Carnevale, Madelyn Poulin and Mikayla Paesano (Office of Open Learning, University of Windsor), through their expertise with the Pressbook platform, helped to implement my vision for this book.

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Shreyas Tambe (Office of Open Learning, University of Windsor) provided support for video post-production.

Alicia Higgison provided essential administrative and accounting support for the project.

I also want to acknowledge the tireless efforts of my spouse Minde Lawson, who during the pandemic provided me with at home technical and IT services, and who assisted with the creation of audio/visual materials for this course.

Chapter Reviewers

University of Windsor students and recent graduates reviewed and provided feedback on chapters in this eCampus Pressbook. I would like to thank them for their invaluable contribution to the project.

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Olivia Mirisola holds a BA(H) in Combined Criminology and Family Social Relations from the University of Windsor.

Bridget Nicholls holds a BA(H) in Labour Studies and a MA in Social Justice Studies from Brock University, where she also served as a humane jobs fellow. She is in the final stages of completing her PhD in Sociology at the University of Windsor.

Alyssa Woodbridge holds a BA(H) in Psychology and Criminology from the University of Windsor.

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Attributions

In Chapter 1, An Introduction to Psychoactive Drugs, we have adapted content from in 8,8 Psychoactive Drugs in *Human Biology* by Christine Miller. This work is licensed under a Creative Commons Attribution-NonCommercial 4.0International License, except where otherwise noted. The authorship indicates the relative contributions to each subchapter.

Note: The book *Human Biology* by Christine Miller is an adaptation of the CK Foundation textbook, *College Human Biology* by Jean Brainard and Rachel Henderson.

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Accessibility Statement

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- The colour contrast on the Pressbooks Theme Malala header and footer does not meet guidelines, and there is a redundant link in the footer.

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- Use the Previous and Next links found at the bottom of each page to navigate through the sequence of pages in the site. To access these links most easily, use your screen reader's landmarks list to navigate to the content info region, then press Shift+Tab to back up to the Next links.
- Depending on the operating system and browser being used, font size can be adjusted by pressing a key combination including the plus (+) and minus (-) keys. On Windows systems the key combination is typically "Ctrl+" and on Mac it is "Command+".
- Alt text has been provided for images that are not decorative.
- Videos developed for this project contain closed captioning and also offer downloadable transcripts.

Course & e-Book Introduction

Psychoactive Substances & Society

This course provides a critical exploration of social factors affecting our understanding of psychoactive substances (e.g., alcohol, tobacco, cannabis, opiates, cocaine, psilocybin, club drugs, etc.), their use and relevant social policy, and how these have changed over time. In the course, students will analyze the social factors influencing the origins and maintenance of prohibitionist policies at both the national and international levels, as well as the costs and consequences of such policies. They will also explore the movement for health and human-rights oriented policy change, including recent efforts at decriminalization, legalization and the introduction of innovative harm reduction efforts. While the course has a predominately Canadian focus, other countries are used as examples of policy alternatives.

Each chapter requires students to read and watch course material and then do an assignment based on what they have read and watched. There are a series of questions at the start of each chapter designed to facilitate student engagement with the materials.

Understanding Text Font Colours & Style

FONTS		MEANING
Bolded Red Font		Content warnings
Bolded Royal Blue Font		Required reading and/or video course content. Instructions for students
Black underlined titles or hyperlinks	inside	Required reading and/or video course content.

shaded boxes	
Black underlined or **Bolded underlined** words	Supplementary information (hyperlinks or definitions). Not required course content.

I

Chapter 1: An Introduction to Psychoactive Drugs


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1.0 Introduction

Jacqueline Lewis

Chapter Introduction

A myriad of substances exist that can have a psychoactive effect, ranging from natural plant-based (e.g., THC/cannabis, psilocybin/magic mushrooms, opium) to synthetic substances (e.g., LSD, MDMA/ ecstasy). This chapter is an introduction to the study of psychoactive substances, providing important foundational knowledge for the course. In order to engage with future social-science oriented course topics, it is important to have an understanding of psychoactive substances, including: what they are; how they are classified; their impact on the human body; and reasons they are used.

Chapter Objectives/Learning Outcomes

After completing the chapter materials, you should have an understanding of:

1. How psychoactive drugs are defined from a psychopharmacological perspective.
2. Drug classifications.
3. Why various substances are used.
4. The effects of various substances, the risks associated with using them and how to minimize those risks.
5. The importance of factual, accurate, non-judgemental drug education materials.

Questions to Think About When Completing Chapter Materials

1. What are the different psychoactive drug classifications? How do different substances covered in the course material fit into these classes? What are the limitations of this classification system?
2. What are the issues tied to relying on a legal versus illegal way to categorize psychoactive substances?
3. What are some characteristics of good drug education material? Using the Canadian Institute for Substance Use Research “Learn About…” readings, provide some examples of these characteristics. How do these compare with those detailed in the video by Students for Sensible Drug Policy (2007)?
4. What are the different ways that drugs are used? What is an example of each?

1.1 What are Psychoactive Drugs?

Jacqueline Lewis and Christine Miller

Drugs Sign.

Psychoactive drugs are substances that influence the functioning of the human brain, altering mood, feeling, emotion, sensation, thought, perception, and/or behaviour. They may be used for many purposes, including therapeutically, ritually, or recreationally. Caffeine, the most widely consumed psychoactive substance in the world (CAMH, 2011), is a nervous system stimulant. In moderation, it can make you more alert and/or improve your level of concentration, but in larger doses it can cause restlessness, insomnia, headaches, heart palpitations and anxiety (CISUR, 2015a). Other examples of psychoactive drugs include alcohol, tobacco, cocaine, ketamine/special K, MDMA/ecstasy, LSD and opiates.

1.2 Psychoactive Drug Classifications & Effects

Jacqueline Lewis and Christine Miller

Psychoactive drugs are divided into different classes based on their pharmacological effects. Several classes are listed in the infographic below, along with examples of commonly used drugs in each class.

PSYCHOACTIVE DRUG CLASSIFICATIONS

Depressants

Drugs that calm the brain, reduce anxious feelings, and induce sleepiness. Examples include: ethanol (in alcoholic beverages) and opioids, such as codeine and heroin.

Hallucinogens

Drugs that can cause hallucinations and distorted perceptions, changes in thoughts, emotions, and consciousness. Examples include: LSD, mescaline, nitrous oxide, and psilocybin.

Stimulants

Drugs that stimulate the brain, increase alertness and wakefulness. Examples include: caffeine, nicotine, cocaine, and amphetamines (such as Adderall).

Opiates/Opioids

Drugs that suppress the central nervous system. They slow breathing, heart rate, thoughts, actions, and alter perceptions of pain. The term opiate is generally used to refer to natural versions of the drug derived from the opium poppy. The term opioid refers to products that are synthetic or manufactured.

Tetrahydrocannabinol (THC)

The primary psychoactive component found in the cannabis plant. THC products (e.g., cannabis dried leaves, extracts, edibles, etc.) can have various effects including: relaxation; euphoria; impaired concentration, coordination and memory; changes in sensory perception, blood pressure and appetite.

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Allies Interactive. (n.d.). B&W illustration of blade with cocaine icon [Element]. Canva.com.
Clker-Free-Vector-Images from Pixabay. (n.d.). Pill bottle illustration. [Element]. Canva.com.
Financial Crime. (n.d.). Narcotics [Element]. Canva.com.
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Orathai Yingyoud. (n.d.). Inject a drug [Element]. Canva.com.
Ruslannesterenko. (n.d.). Peyote cactus color icon [Element]. Canva.com.
Trendify. (n.d.). Organic handrawn textured wine bottles [Element]. Canva.com.
Trendily. (n.d.). Psychedelic mushroom illustration [Element]. Canva.com.
Vectortradition. (n.d.). Poppy dried flowers with seeds. [Element]. Canva.com.

Access the Word file containing text for the Drug Classifications infographic

Many psychoactive drugs have multiple effects, so they may be placed in more than one class. An example is MDMA (see image below), which may act as both a stimulant and a hallucinogen. MDMA's efficacy as a treatment for post-traumatic stress disorder (PTSD) and other types of anxiety disorders, is showing promise in some recent studies (Stone, August 14, 2019). THC is another substance that is hard to classify, as it can act as a stimulant, a depressant, and/or an hallucinogen. This is why THC is often placed in a category of its own.

Ecstasy (MDMA) is most commonly taken in tablet form, like the tablets shown here.

VIDEO: *Overview of Psychoactive Drugs*

The following video provides an overview of the different classifications of psychoactive substances.

One or more interactive elements has been excluded from this version of the text. You can view them online here: https://ecampusontario.pressbooks.pub/psychoactivesubstanceuseandsociety2nded/?p=35#oembed-1

1.3 Legal Versus Illegal Drugs

Jacqueline Lewis and Christine Miller

Psychoactive drugs may be classified as legal prescription medications (codeine and morphine), legal non-prescription drugs (alcohol, tobacco and cannabis), or illegal drugs (cocaine, LSD). The definition of substances as legal or illegal varies historically and cross-culturally according to existing legislation. For example, cannabis (or marijuana) is a psychoactive drug that is illegal in many countries, but legal for medical purposes in others, and in some countries it is regulated for recreational use (e.g., in Canada since the introduction of the *Cannabis Act*, 2018).

An interactive H5P element has been excluded from this version of the text. You can view it online here: https://ecampusontario.pressbooks.pub/psychoactivesubstanceuseandsociety2nded/?p=38#h5p-1

Some legal drugs are readily available, as illustrated by the images above.

Whether a substance is classified as legal or illegal is often dependent on how the substance in question is used. For example, although some opioids can be legally prescribed to people (e.g., codeine, morphine), these drugs can also be used illegally. This occurs if a prescribed substance is used by someone other than the person to whom it is prescribed, if legal prescription medicine is diverted to the illegal market (CCSA, 2020), or if opioids are specifically manufactured for the illegal market.

The problem with relying on notions of "legal versus illegal" is that such distinctions tend to be associated with assumptions of harm posed to the individual and society, with illegal psychoactive drugs being viewed as more harmful than legal ones. However, when one considers harm, it is actually the two most commonly used legal drugs, alcohol and tobacco, that cause the majority of drug-related harm (see CSUCH infographic below)(CSUCH, 2020). For example, harms associated with alcohol consumption include: injury and death tied to accident, impaired driving, violence, suicide, birth defects, and alcohol poisoning (APHA, 2019). A less commonly known harm related to alcohol consumption is the link between the alcohol-based beverage use and cancer (CCSA, January 2023; Roumeliotis & Witmer, January 8, 2022; Stockwell, 2019).

Click the link below to learn more about the new Canadian guidelines on alcohol and health from the Canadian Centre on Substance Use and Addiction (CCSA):

Canada's Guidance on Alcohol and Health, Public Summary: Drinking Less Is Better (Infographic)

PROFILE:

Ontario

In 2017, substance use cost Ontario more than

$17 BILLION

which amounts to $1,235 per person regardless of age

Compared to almost $46 billion or $1,258 per person in Canada

Overall cost of substance use in 2017 (in milli

$6166
35%

Alcohol

Tobacco

Other CNS d

Cocaine

Canadian substance use costs and harms 2015–2017. ©Canadian Institute for Substance Use and Addiction (2020).

In addition to the harms tied to tobacco and alcohol use, are the health risks associated with both legal over the counter and prescription pharmaceuticals. Have you ever read the information sheet that come with every prescription drug or the warning labels on over-the-counter medication? While many of these pharmaceutical substances may not be psychoactive in nature, the interaction between them and other medications, or use of other legal and illegal psychoactive substances can lead to an array of health problems (Holland, 2017). As noted in the Drug Education Network (2019) video (below), "just because it is legal doesn't mean it doesn't cause harm."

VIDEO:*Facts About Drugs: What is the Difference Between Legal and Illegal Drugs*

In the following video Maurice Dawe, from the Drug Education Network, talks about the problems with classifying drugs as legal and illegal.

One or more interactive elements has been excluded from this version of the text. You can view them online here: https://ecampusontario.pressbooks.pub/psychoactivesubstanceuseandsociety2nded/?p=38#oembed-1

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1.4 Uses of Psychoactive Drugs

Christine Miller and Jacqueline Lewis

Psychoactive substance use is prominent in North American society. You may have been prescribed psychoactive drugs by your doctor. For example, your physician may have prescribed you an opioid drug, such as codeine for pain. Chances are you also use nonprescription psychoactive drugs (like caffeine) for mental alertness and alcohol and/or cannabis recreationally as part of social activities. These are just a few of the many possible uses of psychoactive drugs.

Medical Uses

General anesthesia is one use of psychoactive drugs in medicine. With general anesthesia, pain is blocked and unconsciousness is induced. General anesthetics are most often used during surgical procedures and may be administered in gaseous form. General anesthetics include the drugs halothane and ketamine. Other psychoactive drugs are used to manage pain without affecting consciousness. They may be prescribed either for acute pain in cases of trauma (such as broken bones) or for chronic pain caused by arthritis, cancer, or fibromyalgia. Most often, the drugs used for pain control are opioids, such as morphine and codeine.

Many mental health conditions are also managed with the use of psychoactive substances. Antidepressants like sertraline, for example, are used to treat depression, anxiety, and eating disorders. Anxiety disorders may also be treated with anxiolytics, such as buspirone and diazepam. Stimulants (such as amphetamines) are used to treat attention deficit disorder. Antipsychotics (such as clozapine and risperidone) — as well as mood stabilizers, such as lithium — are used to treat schizophrenia and

bipolar disorder.

As you will learn in this course, the growing recognition of opiate use disorders (OUDs) as medical issues has resulted in better access to a wider array of legally available treatments, including Opioid Agonist Treatment (OAT). As part of OAT, patients are prescribed opioid agonist medications (e.g., methadone, buprenorphine/naloxone, slow-release oral morphine, etc.) to help prevent withdrawal symptoms (BC Mental Health & Substance Use Services, n.d.).

Ritual Uses

The peyote cactus used by some Indigenous groups for religious rituals.

Certain psychoactive drugs, particularly hallucinogens, have been used for ritual purposes since ancient times. For example, in regions where the mescaline-containing peyote cactus grow (pictured on left) some Indigenous groups have used it for religious ceremonies for as long as 5,700 years. In Europe, the mushroom *Amanita muscaria*, which contains a hallucinogenic drug called muscimol, was used for similar purposes. Various other psychoactive drugs — including jimsonweed, psilocybin mushrooms, and cannabis — have also been used for millennia, by various peoples, for ritual purposes.

Recreational Uses

The recreational use of psychoactive drugs is generally engaged in for the purpose of altering one's consciousness and creating a feeling of euphoria or a "high." Commonly used recreational substances include cannabis, alcohol, opioids, and stimulants (such as nicotine). Hallucinogens are also used recreationally, primarily for the alterations they cause in thinking and perception. Some investigators have suggested that the urge to alter one's state of consciousness is a universal human drive, similar to the drive to satiate thirst, hunger, or sexual desire. They think that this instinct is even present in children, who may attain an altered state by repetitive motions, such as spinning or swinging. Some nonhuman animals also exhibit a drive to experience altered states. They may consume fermented berries or fruit and become intoxicated. The way cats respond to catnip is another example.

Cat enjoying the psychoactive effects of the catnip plant.

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1.5 Learning About Psychoactive Drugs

Jacqueline Lewis

The Importance of Evidence-Based Drug Educational Materials

Drug education campaigns have historically been “anti-drug” and sensationalist in nature (Werb et al., 2011). The typical messages provided are that “drugs are bad” and “people who use drugs are bad” or “bad things will happen to them.” The campaigns are often factually inaccurate, heavily moralistic and judgemental in their messaging, lacking evidence/science in terms of their design and the information provided (Fishbein et al., 2002; Kirkey, 2018; Rosenbaum, 2014). Abstinence from substance use/”just saying no” is typically put forward as the only option.

Moralistic and abstinence-only messaging has been found to lack credibility and be ineffective (Fishbein et al., 2002; Kirkey, 2018). Despite all the money spent on such education efforts over the years, there is scant evidence that they dissuade substance use (Fishbein et al., 2002; Werb et al., 2011). In fact, research has found that some drug education materials can encourage drug use or at least contribute to a healthy skepticism from the target audience, who are typically youth and young adults (Dejong & Wallack, 1999).

People (including teenagers and young adults) consume psychoactive substances (legal and illegal). The question is how can we provide educational materials that explain how to reduce the harms associated with substance use, and that model behaviour, that also resonate with the intended audience? Removing the moralism and judgement is part of the answer. The other part is producing evidence/ science-based materials, with credible messaging and behaviour modelling (Dejong & Wallack, 1999; Kirkey, 2018; Werb et al., 2011), that are also culturally sensitive (Maina et al., 2020).

VIDEO: *Current TV Bashes "Anti-Drug" Propaganda Campaign*

The following video provides a critical and humorous look at past televised drug education campaigns/ public service announcements (PSAs). **(Watch to 3:20 minute mark)**

One or more interactive elements has been excluded from this version of the text. You can view them online here: https://ecampusontario.pressbooks.pub/psychoactivesubstanceuseandsociety2nded/?p=44#oembed-1

Evidence-Based Educational Materials

The Canadian Institute for Substance Use Research (CISUR) has developed a series of informational brochures that take an evidence-based approach to drug education. Instead of the usual labelling of psychoactive substances as bad and all substance use as dangerous, the "Learn About…" series provides information that helps people better understand substances they may want to learn more about (see links below). This information includes: what the substances are; why people use them; how one can expect to feel after using the substance; the risks tied to use; and how to reduce those risks and make healthier choices.

Click the links below to "learn about" psychoactive substances:

Learn About Alcohol

Learn About Caffeine

Learn About Cocaine

Learn About Hallucinogens

Learn About MDMA (Ecstasy or Molly)

Learn About Methamphetamine

Learn About Opioids

Learn About Tobacco

Learn About Tripping

Safer Tripping: Magic Mushrooms, LSD, & Other Hallucinogens

The critical orientation to drug education introduced in this section is important for this course, as it provides an orientation you are expected to use throughout the semester. As you progress through the weekly course materials, you will be challenged to critically engage with common (mis)perceptions regarding drugs, people who use drugs/substances (PWUD/PWUS), and drug policy (regulation and control policies). The goal is to enhance critical thinking skills and in doing so, encourage you to critically reflect on your own views and attitudes – the first steps toward facilitating progressive social change.

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1.6 Chapter Summary

Jacqueline Lewis

Key Summary Points

1. Psychoactive drugs are substances that influence the functioning of the human brain, altering mood, feeling, emotion, sensation, thought, perception, and/or behaviour.
2. Classifying drugs is complicated. Although there are 5 basic psychoactive drug classifications based on their pharmacological effects (depressants, hallucinogens, opiates/opioids, stimulants, THC), many substances can be placed in more than one class.
3. People use substances for a variety of reasons including: medical, ritual and recreational.
4. There are issues with using the labels of "legal versus illegal" to categorize drugs. Definitions of legal and illegal change over time. Some substances can be categorized as both legal and illegal, and even that categorization is complicated. The concept of illegal is often equated with harm, despite legal drugs also being harmful.
5. Effective educational materials on psychoactive substances need to be non-judgmental, evidence/science-based materials, with credible messaging and behaviour modelling.

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1.7 Required Chapter Materials

Jacqueline Lewis

In addition to the videos and reading links embedded into the chapter, students are required to complete the following:

Canadian Centre on Substance Use and Addiction (CCSA). (2019). *Edible cannabis: Always read the label*. (2019). https://www.ccsa.ca/sites/default/files/2019-10/CCSA-Edible-Cannabis-Read-Label-Infographic-2019-en.pdf

Centre for Addiction and Mental Health (CAMH). (2018). *Cannabis and your health*. https://www.camh.ca/-/media/files/pdfs—reports-and-books—research/canadas-lower-risk-guidelines-cannabis-poster.pdf

Drazen, J., Morrissey, S. & Camion, E. (February 14, 2019). The dangerous flavors of e-cigarettes. *New England Journal of Medicine*, *380*(7), 679-680. DOI: 10.1056/NEJMe1900484

Eastern Ontario Health Unit. (September 2017). *Fentanyl: Student fact sheet*. https://healthunit.org/wp-content/uploads/Fentanyl_Student_Factsheet.pdf

Lebel, C., McMorris, C. & Chaput, K. (September 1, 2020). *Marijuana & pregnancy: There's no evidence that exposure is safe. The Conversation*. https://theconversation.com/marijuana-and-pregnancy-theres-no-evidence-that-exposure-is-safe-144244

Public Health Agency of Canada. (2019). *Canada's lower-risk cannabis use guidelines*. Government of Canada. https://www.canada.ca/en/health-canada/services/drugs-medication/cannabis/resources/lower-risk-cannabis-use-guidelines.html

Roumeliotis, I. & Witmer, B. (January 8, 2022). *Alcohol should have cancer warning labels, says doctors and researchers pushing to raise awareness of risk*. CBC News. https://www.cbc.ca/news/health/alcohol-warning-labels-cancer-1.6304816

1.8 Chapter Assignment

Jacqueline Lewis

Assignment Formatting, Style, & Length Requirements

- Assignment formatting requirements: Arial 12-point font; 1-inch/2.54cm margins; single spaced; APA in-text citation style, reference section and cover page.
- Use proper paragraph style within the answer to each question.
- Clearly indicate which question is being answered using corresponding question numbers (do not write out the entire question). Follow-up questions must be answered as part of the numbered question. Avoid using automated numbering as it alters the left margin of the document, resulting in a margin larger than 1-inch/ 2.54cm.
- Assignment length: approximately 1000 words in length (give or take 100 words) (reference section and cover page not included in word count).
- Divide your time/space evenly across all questions.

- Proofread your submission to make sure it is clear, well written and intelligible.

Assignment Instructions

- After completing this chapter's materials (chapter content, including all embedded links to readings and videos, and the required chapter materials) answer ALL the questions below.
- In ALL your answers be sure to demonstrate knowledge of and engagement with the chapter materials. This is achieved through supporting points/arguments/positions via reference to the course material using in-text citations. Providing in-text citations to support your points/arguments/positions is essential and required. Be sure to use a diverse range of course materials as opposed to relying heavily on a few sources.
- Only use materials outside of those assigned when specifically instructed to do so.

Assignment Questions

1. Choose 2 psychoactive substances covered in the chapter materials. For each, identify: what drug classification it fits into; the possible beneficial and harmful effects tied to use; and what can be done to mitigate negative effects if choosing to use the substance.
2. Societies have a tendency to divide psychoactive substances and/or substance use into legal and illegal. What problems are associated with such a division? Use examples to help support your answer.
3. What is the most significant thing you learned from this week's course material that you did not already know? How has this knowledge impacted you? How can such knowledge help you move forward in this course and through society more generally?

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1.9 References & Media Attributions

Jacqueline Lewis

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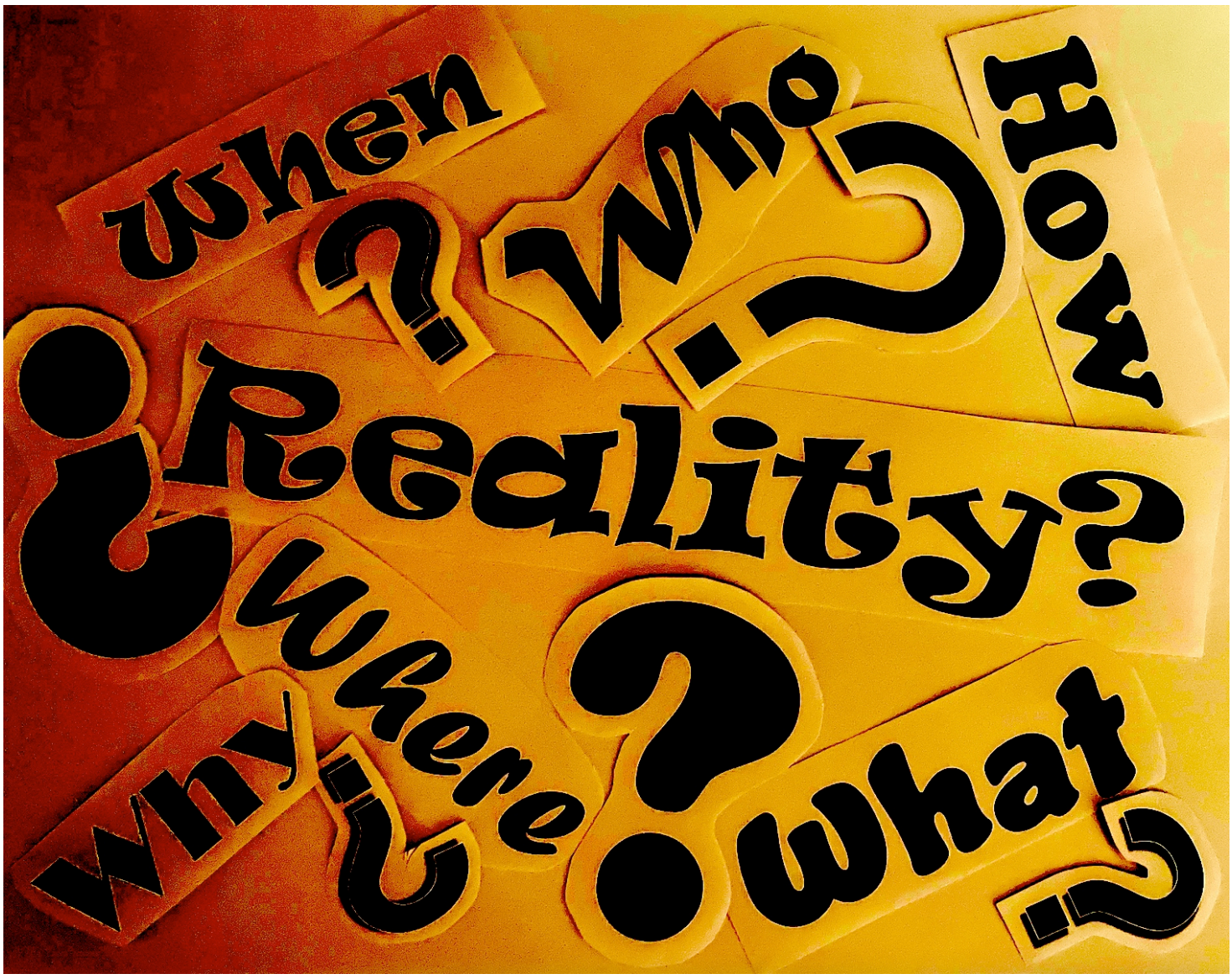
II

Chapter 2: The Social Construction of Drugs, Users & Policies



Jacqueline Lewis

2.0 Introduction

Chapter Introduction

How we come to view, understand, or make sense of social phenomena is a product of human interaction. Whether something is considered a social good, or a social issue or problem, is the result of how we as humans have come together to define and make sense of it. In other words, our perceptions or definitions of reality are social products or constructs. The constructs and definitions we use to understand and order our lives, are influenced by claims-making activities, and impacted by both the historical and cultural context in which we live. For example, have you ever stopped to consider how or why alcohol consumption is seen as a normative aspect of Canadian culture, but the use of other substances, such as cocaine or heroin, are not? Why is alcohol viewed as a necessary part of many social and celebratory activities (e.g., the popularized image of the "traditional wedding toast")? Has it always been this way? Whose reality do such definitions reflect, and whose reality is not represented? Why is this the case?

Another important question to ask is, who benefits from such perceptions of normality? On the one hand, are those persons and groups whose cultural values and beliefs are privileged through normalizing alcohol consumption. On the other hand, are those who profit from alcohol sales. On a daily-basis, the normativity of drinking is sold to us through direct-to-viewer alcohol advertisements, life-style branding, and product-placement, found in all forms of media. The idea being promoted and reinforced is that consuming alcohol is a normal and necessary part of fun, relaxation and socializing. Such promotional activities serve the interests of the alcohol industry, including the individuals, businesses, and corporations who manufacture and sell alcohol, and provide alcohol-related products and services.

Similar questions can and should be raised about all psychoactive substances. It is important to inquire as to why one form of substance use is considered normative, and another criminal or bad, and how/why such definitions change over time and/or context. This chapter uses a constructionist lens to explore varying definitions of substances and their use, both historically and cross-culturally. Part of this involves drawing attention to claims-makers, interest groups, and/or moral entrepreneurs, and their role in constructing how we view and respond to social phenomenon or social issues, such as drug use. As you work your way through future course materials, you will discover that the constructionist framework outlined in this chapter can facilitate the challenging of taken for granted ideas tied to drugs, their use, and the social polices we use to control them.

Chapter Objectives/Learning Outcomes

After completing the chapter materials, you should have an understanding of:

1. The importance of recognizing and problematizing existing societal attitudes and beliefs regarding drugs, the people who use them, and drug-related social control policies.
2. Social constructionist theory, its basic tenets, and concepts.
3. The social construction of drug-related issues/problems.
4. How myths about drugs are constructed and the purposes they can serve.

Questions to Think About When Completing Chapter Materials

1. How can using a constructionist lens aid in understanding how people who used drugs (PWUD) are viewed and treated in our society?
2. Think of a current media story about drugs, people who use drugs, and/or drug policy. In what way can constructionist theory help us to understand the slant of the story and how and why it is receiving media attention?
3. Identify two types of claims-makers in the chapter materials. Who is their intended audience? What types of claims are they making? Which cultural themes do they draw upon to win audience support? Who benefits from such claims? How do they benefit? Why these claims and this target, at this time?
4. Reflect on your beliefs about a currently illegal psychoactive substance and the people who use it. In what way do the chapter materials challenge and/or impact your beliefs? How can constructionism aid in your reflection process?

2.1 Demonizing Psychoactive Substances & their Use

If we look historically and cross-culturally, we find almost universal psychoactive substance use across human societies for a variety of purposes (e.g., healing, spiritual and mystical experiences, increasing self-knowledge and awareness, recreation) (Weil & Rosen, 2004). There is evidence of the use of psilocybin mushrooms (a hallucinogen) as far back as 9000 BCE in North Africa (Beck, 2021; Longrich, July 16, 2021; POPLAR, December 12, 2021), and the brewing and use of alcohol-based beverages in China dating back to 7000 BCE (Hect, J., December 6, 2004; Phillips, 2014; Wang, Jiang & Sun, 2021).

VIDEO: *The Complete History of Alcohol: A Video Timeline*

The following video provides a brief timeline of human use of alcohol.

One or more interactive elements has been excluded from this version of the text. You can view them online here: https://ecampusontario.pressbooks.pub/psychoactivesubstanceuseandsociety2nded/?p=58#oembed-1

While the use of some substances has been and is approved of and integrated into the life of most human groups, the opposite is also true for other substances (Weil & Rosen, 2004). The identification and targeting of certain forms of substance use as "bad", "evil", "sinful", or "immoral", is also something evident historically and cross culturally. Although there are many examples of the problematizing of substances and their use (some of which will be covered in future chapter materials), the two focused on in this chapter are coffee (caffeine) and tobacco (nicotine).

Click the link below to learn more about early human psychoactive substances use:

When Did Humans Start Experimenting With Alcohol and Drugs?

Between the 16th and 18th century, coffee was the subject of controversy and efforts to prohibit its use (Hay, May 22, 2018). In the 1500s, in the Ottoman Empire, coffee was viewed as a psychoactive substance, similar to opium and alcohol. Its use was labelled as immoral and the cause of social decay, resulting in coffee drinkers being subjected to harsh punishments (Majid, I., July 13, 2019). During this timeframe in Christian societies, coffee was labelled as "Satan's brew", due to beliefs that coffee drinking had its roots in non-Christian-based cultures. Attitudes began to shift, however, after coffee was blessed by the Pope (Chrystal, 2016; Mauro, September 26, 2018; Weber, April 19, 2018).

Click the link below to learn more about the changing perceptions of coffee consumption:

Coffee Was "Satan's Brew" Before Pope Clement VIII Baptized It

There was also a strong aversion towards tobacco in parts of Europe after its introduction in the early 16th century. The opposition to tobacco use was tied to its association with Indigenous spiritual rituals. In some countries, severe punishments were imposed on tobacco smokers, including torture and the death penalty (KCBC, January 19, 2005; Mancall, 2004; Weil & Rosen, 2004). For example, one Russia tsar banned "the importation of tobacco…[and] sellers could face death and confiscation of their estate,…buyers torture or public corporal punishment" (Sakharova, Antonov & Salagay, 2017, p. 1). In England, King James I referred to tobacco smoking as "a custom loathsome to the eye, hateful to the nose, harmful to the brain, [and] dangerous to the lungs" (King James 1, 1604), and imposed a 4000% sales tax in lieu of a prohibition. None of the imposed social controls in Europe were successful in curtailing the demand for tobacco (A counterblaste to tobacco, n.d.).

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2.2 Changing Definitions of Substance Use

As how we view social phenomena varies over time and across cultures, attitudes towards and control of the consumption of psychoactive substances are often subject to change. Continuing with the examples of coffee and tobacco products, we see how social perceptions of these substances have evolved over time. As noted in Chapter 1, today the most commonly consumed psychoactive substance is the nervous system stimulant caffeine. Coffee (a popular source of caffeine) is the second most traded commodity in the world (Chan, July 7, 2020). In other words, the ingestion of caffeine via drinking coffee is not only a socially acceptable activity in the 21st century, it is highly normalized. Tim Horton's boasts on their website that their coffee sales in Canada exceed more than two billion cups annually (Fresh Facts, n.d.).

Brown & Williamson cigarette advertisement (1957) glamourizing cigarette smoking.

Attitudes towards tobacco and its use have followed a somewhat different path than coffee, moving from being viewed with derision to social acceptance and back to derision. Although tobacco smoking became normalized, commodified, and even trendy after the introduction of commercial cigarette production (see cigarette advertisement above) and the popularization of cigarette smoking by women in public (see video and reading below) (Amos & Haglund, 2000; Mishra & Mishra, 2013), a return to negative views began in the 1950s, tied to increasing attention to the health concerns of smoking. This culminating with the release of the 1964 *US Surgeon General's Report*, that drew a causal link between tobacco consumption and many health conditions, including cancer.

VIDEO: *Woman Student — Camel 30-Day Test Commercial*

The following video illustrates some of the ways in which cigarette smoking was viewed and depicted in

television advertisements in the 1950s and 60s.

One or more interactive elements has been excluded from this version of the text. You can view them online here: https://ecampusontario.pressbooks.pub/psychoactivesubstanceuseandsociety2nded/?p=61#oembed-1

Click the link below to read a *BMJ* article about the changing views of women and smoking:

From Social Taboo to "Torch of Freedom": The Marketing of Cigarettes to Women

Despite the ebb and flow in Western societal attitudes towards tobacco use, if we look across cultures we find varying trends in use and perceptions of different forms of tobacco. For example, among some Indigenous peoples in Canada, natural tobacco (as opposed to commercial tobacco) is viewed as a sacred plant, as it has been for thousands of years (FHNA, n.d.; NCCAH, 2013). Today, it continues to be used for ceremonial, sacred and social purposes, including as part of purification and healing rituals (Cancer Care Ontario, n.d.; FHNA, n.d.; NCCAH, 2013). There is, however, a differentiation made between traditional and non-traditional use. The latter tied to commercial tobacco products (e.g., cigarettes, cigars, pipes, chewing tobacco) and their documented negative health impacts (FHNA, n.d.; NCCAH, 2013).

VIDEO: *Tobacco is Medicine*

The following video explores the role of tobacco and its importance in Indigenous cultures today.

One or more interactive elements has been excluded from this version of the text. You can view them online here: https://ecampusontario.pressbooks.pub/psychoactivesubstanceuseandsociety2nded/?p=61#oembed-2

2.3 Making Sense of Changing Definitions

How can we make sense of historical and cross-cultural variation in attitudes towards psychoactive substances and their use? How does a substance and its use elicit a hostile social response at one moment in time or in one culture and be seen as socially acceptable, normative or even socially desirable, at a different point in time or in a different culture? One way to address such questions is to explore these issues using a constructionist lens, as the constructionist framework can help answer the who, what, how, why and when questions pertaining to changing perceptions of social phenomena, including drug use.

Key General Questions to Ask Using a Constructionist Lens:

How do we as humans create meaning that then forms the basis of what we believe?

Why do some social phenomenon become the focus of public attention and not others?

Who is responsible for drawing public attention to social phenomenon and orienting how we view it?

What are the motives behind drawing attention to particular social phenomenon (e.g., wealth; prestige; social and/or political power; reinforcing a particular set of "morals")?

When does/did such meaning making activity occur — during which timeframe?

Where does/did such meaning making activity occur (i.e., cultural context, geographic location – world, country, province/state, region, community; among particular social or political groups, etc.)?

When we talk about psychoactive substances, we often classify drugs using a good-bad dichotomy (Loseke, 2003). Some types of substance use, by certain groups of people, is viewed as "good", "acceptable", "normal", while other forms of use by different groups is viewed as "bad", "sinful", "immoral", "deviant", or "criminal" (e.g., opioid use via prescription is viewed as an acceptable form of use; opioid use without a prescription is viewed as an unacceptable form of use).

The problem with such categorizations is that despite existing cultural definitions, substances and substance use are not inherently bad or good. Instead, how we view drugs and the policies used to control them are "products of human definition and interpretation and shaped by…cultural and historical context" (Kang, Lessard, Heston & Nordmarken, 2017, Unit 1, p.5). A constructionist lens is a useful tool to help us better understand how and why we view drugs the way we do, how and why perceptions of drugs and their use vary over time and across cultures, and how social processes and power relations influence our understandings of substances, their use, and what are viewed as appropriate means of social control.

2.4 Social Constructionist Theory

In order to apply a constructionist lens to help understand varying definitions of drugs and drug use, it is important to have a basic understanding of social constructionist theory. The idea of social constructionism first prominently appeared with the publication of the book *The Social Construction of Reality* by Berger and Luckmann (1966). Constructionists focus on the meanings that humans create or construct in an effort to understand our world (Berger & Luckmann, 1966). According to Maine (2000, p. 577), constructionism attempts "to show that no matter how sedimented social conditions may appear or actually be, those conditions nonetheless are produced, maintained and changed through interpretive processes."

VIDEO: *Social Constructionist Theory*

The following video provides a brief explanation of the basic tenets of constructionist theory.

One or more interactive elements has been excluded from this version of the text. You can view them online here: https://ecampusontario.pressbooks.pub/psychoactivesubstanceuseandsociety2nded/?p=66#oembed-1

Click the link below to learn about the processes involved in constructing reality:

Social Construction Simplified!

Flow chart of the processes involved in the social construction of reality.

VIDEO: *Social Constructionism: Claimsmakers & Audiences*

In the following video, Dr. Jacqueline Lewis explains the role of claims-makers and audiences in the constructionist process, using the social construction of drugs, people who use drugs (PWUD), and drug control policies as examples.

One or more interactive elements has been excluded from this version of the text. You can view them online here: https://ecampusontario.pressbooks.pub/psychoactivesubstanceuseandsociety2nded/?p=66

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2.5 Constructing Drugs & People Who Use Drugs

"Government officials, the media, and other authorities have found that drug addiction, abuse, and even use can be blamed by almost anyone for long-standing problems and the worsening of almost everything. Theft, robbery, rape, malingering, fraud, corruption, physical violence, shoplifting, juvenile delinquency, sloth, sloppiness, sexual promiscuity, low productivity, and all-around irresponsibility – nearly any social problem can be said to be made worse by drugs."

Harry G. Levine (2002, p. 170)

(Some older terms, now recognized as stigmatizing, are used in this quote)

Police making drug arrest.

Demonizing, or inaccurately problematizing various forms of substance use has created a cultural climate where both drugs and people who use drugs (PWUD) are easily constructed as folk devils, through various types of claims-making activities. According to Mosher & Atkin (2014), this climate serves the needs of a diverse array of claims-makers/interest groups, including politicians, criminal justice officials, and the media. Each has their own reasons/motives for vilifying drugs, including: drawing attention away from government policies or inactions that have led to, or exacerbated substance use; enhancing police and criminal justice system funding and budgets to "fight the drug war"; and increasing sales and profits of corporations (e.g., media, private prisons and security).

Constructionist theory facilitates our understanding of how and why particular drugs or forms of drug use suddenly become the focus of attention of claim-makers (e.g., politicians, media), and the social processes involved in altering public perceptions of substances and the people who use them. As we progress through the course, you will see that increasingly counter claims-making activities, by health care and community service workers, academics, advocates, and people with living and lived experience (PWLLE), are working to reconstruct, destigmatize and reorientate how we view substances and the people who use them.

Amanita Muscaria puzzle piece.

Click the links below to access the remaining required materials for this chapter and to learn about how drugs, PWUDs, and drug control policies have been constructed at various points in time in the 20th and 21st century:

Librarians and Other Subversives: Truth Can be a Casualty of Drug Wars, Too

The Social Impact of Drugs & the War on Drugs: The Social Construction of Drug Scares **(Read pages 58-63)**

Crack Then Meth Now: What the Press Didn't Learn From the Last Drug Panic?

Naloxone Urban Legends and the Opioid Crisis: What is the Role of Public Health?

2.6 Chapter Summary

Key Summary Points

1. How we view and respond to psychoactive substances and the people who use them, varies across time and culture.
2. A constructionist lens can be used to help understand changing definitions of drugs, and the impact of context (e.g., political, social, legal, cultural) on our attitudes and beliefs about drugs and the people who use them.
3. Constructionists point to the role human interaction and interpretation play in the way we view social phenomena and our social reality.
4. Claims-making and counter claims-making play a key role in defining and redefining social issues, such as substance use.

Additional Resources

Below are a list of supplementary resources for students interested in learning more about the chapter topics. These resources are NOT required course materials.

Additional Viewings

Čeika, Jonas. (June 13, 2018). *What does social construction really mean?* [Video]. YouTube. https://youtu.be/-UpSoosy9ws **(this video uses some out of date stigmatizing terms pertaining to substance use and substance use disorders)**

Dowl, D. (April 7, 2021). *Ken Gergen The social construction of reality* [Video]. Vimeo. https://vimeo.com/534071809

Providence. (December 19, 2014). *What does 'the social construction of reality' mean? By Dr. Dennis Hiebert* [Video]. YouTube. https://youtu.be/SqFhd-Igs6w

Rohall, D. (August 10, 2020). *SOC 360 Lecture 1 The social construction of reality* [Video]. YouTube. https://youtu.be/K1bVdql7Ooo

Sponsini, F. (April 17, 2014). *Ken Gergen talks about social constructionist ideas, theory and practice* [Video]. YouTube. https://youtu.be/-AsKFFX9Ib0

TEDx Talks. (May 10, 2017). *The social construction of facts: Surviving a post-truth world – Massimo Maoret* [Video]. YouTube. https://youtu.be/7tHbSasnvno

Additional Readings

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2.7 Chapter Assignment

Assignment Formatting, Style, & Length Requirements

- Assignment formatting requirements: Arial 12-point font; 1-inch/2.54cm margins; single spaced; APA in-text citation style, reference section and cover page.
- Use proper paragraph style within the answer to each question.
- Clearly indicate which question is being answered using corresponding question numbers (do not write out the entire question). Follow-up questions must be answered as part of the numbered question. Avoid using automated numbering as it alters the left margin of the document, resulting in a margin larger than 1-inch/ 2.54cm.
- Assignment length: approximately 1000 words in length (give or take 100 words) (reference section and cover page not included in word count).
- Divide your time/space evenly across the two main questions.
- Proofread your submission to make sure it is clear, well written and intelligible.

Assignment Instructions

- Complete this chapter's materials (chapter content, including all embedded links to readings and videos, and the required chapter materials).
- Read the media story *Is salvia the next marijuana?*
- Answer ALL the questions below.
- Answers to Question 2 must identify and discuss claims-maker(s), and claims-making activities (claims made, by whom, to whom, and possible explanations for those activities).
- In ALL your answers be sure to demonstrate knowledge of and engagement with the chapter materials. This is achieved through supporting points/arguments/positions via reference to the course material using in-text citations. Providing in-text citations to support your points/arguments/positions is essential and required. Be sure to use a diverse range of materials as opposed to relying heavily on a few sources. When relevant cite material from previous chapters. Any reference to or use of constructionist theory, including the use of theoretical concepts (e.g., claims, claims-makers, audience, typification, folk devil, etc.), must be properly sourced, as the theory and concepts are not common knowledge.
- Only use materials outside of those assigned when specifically instructed to do so. In this case, the Gresco (March 11, 2008) reading.

Assignment Questions

1. How can constructionist theory be used to help understand the slant of the coverage in the story by Jessica Gresco (March 11, 2008). *Is Salvia the Next Marijuana*? CTV News. https://www.ctvnews.ca/is-salvia-the-next-marijuana-1.281748
2. Who is/are the claims-maker(s)in the story?
    - What claims are they making? How is the "problem" being typified? What claims-making activities are they engaged in?
    - Who is the target audience? Why this audience?
    - What cultural themes is/are the claims-maker(s) drawing on to win over audience members? Why the use of these claims?
    - What explanation can you think of for this claims-making activity by this/these particular claims-maker(s) at the time the news story was written?

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III

Chapter 3: The Social Determinants of Health & Substance Use

Jacqueline Lewis, Jackie Durocher & Jillian Holland-Penney

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3.0 Introduction

Chapter Introduction

You may wonder why you are learning about the social determinants of health (SDoH) in a course about psychoactive substances and society. The reason is that SDoH impact various aspects of our daily lives, including how and why some people use psychoactive substances and/or develop problems associated with substance use. As you progress through the course material this semester, you will discover that using a health-oriented lens will aid you in developing a better understanding of, and critical engagement with, a variety of issues pertaining to drugs, drug use, and drug policy.

According to the World Health Organization (n.d., para. 1), "the social determinants of health…are the non-medical factors that influence health outcomes" (i.e., the conditions in which we live, grow, work and play, including social forces such as economic policies and political systems). These factors may lead to the implementation of social policies that harm our health (e.g., prohibitionist substance control policies). But they can also lead to the development of policies and programs that reduce health risks (e.g., access to reasonably priced healthy safe food and affordable housing), including reducing risks to people who use drugs/substances (PWUD/PWUS) (i.e., drug testing services, elimination of simple drug possession offences) and/or those experiencing substance use disorders (SUDs) (e.g., evidence-based drug education, safe consumption sites, safe drug supply). The purpose of this chapter is to facilitate an understand of the SDoH and how they can impact the health of individuals in both positive and negative ways, including the development of SUDs.

Chapter Objectives/Learning Outcomes

After completing the chapter materials, you should have an understanding of:

1. The social determinants of health (SDoH).
2. What is meant by upstream and downstream interventions.
3. How SDoH are tied to substance use and risks of developing SUDs.
4. The relationship between SDoH and socially and/or structurally vulnerable populations.
5. The meaning of primary and secondary prevention (including examples).
6. Canadian examples of SDoH and primary and secondary prevention efforts.
7. The next steps for helping people who use substances (PWUS) in Canada.

Questions to Think About When Completing Chapter Materials

1. How do structural and intermediary determinants relate to substance use disorders and people who use drugs in our society?
2. What are the benefits of upstream and downstream interventions? What is an example of each that may be used to address issues faced by people at risk of developing substance use disorders (SUDs)?
3. Reflect on social determinants of health that vary across populations. How does this change the way you think about health and well-being, as well as people who experience SUD?
4. What are some of the primary prevention models in your own community? How do they fit a social determinants of health framework?
5. How did the COVID-19 pandemic impact the social determinants of health? How might this act as a risk factor for substance use and SUDs?

3.1 Understanding Social Determinants of Health

Examples of Social Determinants of Health.

What are the Social Determinants of Health?

"The Social Determinants of Health (SDoH)are the complex, integrated and overlapping social structures, policies, and economic systems that affect health and quality of life outcomes" (PCDP, 2019, para. 1). They are apparent in the conditions (work and living) that impact our everyday lives (e.g., education, income, social status, social supports, social environments, and access to health/medical care), that vary across populations (CPHA, n.d.). SDoH can have both positive and negative impacts on health. For example, a person's socio-economic status (SES), and the SES of the area where they grow up and live, impacts current and future health status and health outcomes. Higher SES is associated with better health and positive life outcomes (CPHA, n.d).

VIDEO: *What Makes us Healthy? Understanding the Social Determinants of Health*

The following video provides an introduction to SDoH and the frameworks that are used to better understand how these determinants vary across populations.

One or more interactive elements has been excluded from this version of the text. You can view them online here: https://ecampusontario.pressbooks.pub/psychoactivesubstanceuseandsociety2nded/?p=82#oembed-1

Structural & Intermediary Determinants of Health

SDoH are classified as either structural or intermediary in nature, with structural determinants operating through intermediary social factors.

- **Structural Determinants** are the social and political context that shape and reinforce the class divisions within our society. These determinants use hierarchies, based on power and access to necessary resources, to define our individual socioeconomic status (Solar & Irwin, 2010).

- **Intermediary Determinants** are the more tangible things that impact our health status tied to our position in social hierarchies such as: housing, social environments, food, stress, workplaces, physical activity, and available social supports (Solar & Irwin, 2010).

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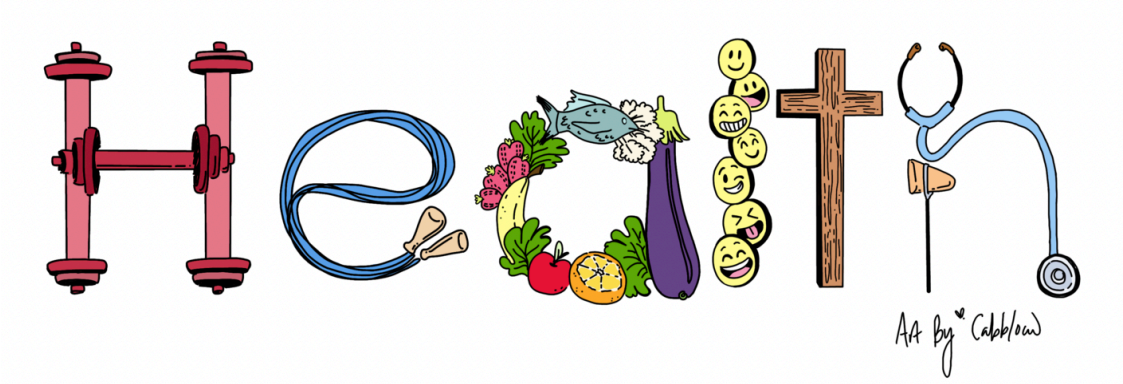
3.2 Upstream & Downstream Interventions

Upstream and Downstream are related concepts tied to different levels of intervention that can impact the SDoH. These intervention strategies are illustrated through the various ways that social structures and services support PWUS, and people experiencing SUDs.



Health Illustrated Text.

Upstream Interventions are macro-level intervention strategies tied to structural determinants of health that look at the root cause of inequality in our society (Bharmal et al., 2015). Upstream thinking seeks to even out economic and social structures and provide an equitable distribution of wealth, resources, and opportunities amongst all populations (NCCDH, 2014). This typically involves both national and transnational strategies that are designed to improve overall societal structures. Such strategies are directly related to health, as those with lesser access to resources tend to have poorer health outcomes (NCCDH, 2014).

Downstream Interventions are micro-level intervention strategies that focus on issues of equitable access to care resources and providing resources to those in need (NCCDH, 2014). For example, shelters, food banks, and soup kitchens are forms of downstream interventions that provide essential

services to people who are unhoused or are experiencing housing instability. Such strategies aim to change the effects of the causes identified by upstream interventions (NCCDH, 2014).

VIDEO: *Introduction to Upstreaming*

The following video provides a visualization of what it means to look upstream and identify intervention strategies that get to the root of inequalities in our society.

One or more interactive elements has been excluded from this version of the text. You can view them online here: https://ecampusontario.pressbooks.pub/psychoactivesubstanceuseandsociety2nded/?p=85#oembed-1

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3.3 Social Determinants of Health & Substance Use

Substance use is a social factor that influences individual health, functioning, and quality of life. It is also highly impacted by SDoH (Cantu et al., 2020). As noted in the Government of Canada report*Public Consolationon Strengthening Canada's Approach to Substance Use Issues* (2018, para. 9), "determinants of health are often at the root of problematic substance use."

VIDEO: *Social Determinants of Health & Substance Use*

The following video clip explains some of the social conditions that may increase the risks of substance use, and how upstream intervention supports PWUS.

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VIDEO: *Upstream Intervention & Substance Use*

The following video clip provides an example of how upstream thinking can facilitate an understanding of the social conditions that may lead to a person experiencing a SUD. Upstream interventions are an essential part of addressing such issues.

One or more interactive elements has been excluded from this version of the text. You can view them online here: https://ecampusontario.pressbooks.pub/psychoactivesubstanceuseandsociety2nded/?p=87

3.4 Disparities in Health

VIDEO: *Public Health Agency of Canada — Social Determinants of Health*

The following video provides a brief explanation of the relationship between disparities in health experienced by different populations in Canada and the SDoH.

One or more interactive elements has been excluded from this version of the text. You can view them online here: https://ecampusontario.pressbooks.pub/psychoactivesubstanceuseandsociety2nded/?p=89#oembed-1

A SDoH framework focuses our attention on health inequalities and the causes of those disparities. The aim is to better understand how marginalization (social and economic) impacts health and well-being (Allan & Smylie, 2015). Not all populations have the same access to social and economic resources. With regard to substance use issues, populations that are negatively impacted by resource allocation are at a greater risk for experiencing substance use problems and adverse outcomes. Indigenous people in Canada are one such population (Kim, 2019).

Research shows that Indigenous people, particularly youth, "carry a disproportionate burden of harms from problematic substance use in relation to the general population of Canada" (McKenzie et al., 2016, p. 378). For example, Indigenous youth who use drugs are thirteen times more likely to die prematurely in comparison to similar aged non-Indigenous youth (Jongbloed et al., 2017). These health outcomes and mortality rates are tied in part to Indigenous specific SDoH, such as experiences of historical trauma, racism, and discrimination (Government of Canada, 2018; Jongbloed et al., 2017). Researchers have concluded that health outcome differences between Indigenous and non-Indigenous peoples in Canada are a result of the "complex intersections of historical and present-day injustices, substance use and barriers to care" (Jongbloed et al., 2017, p. E1352).

The Government of Canada has acknowledged the egregious harms it has caused to Indigenous people and communities. In terms of substance use related harms, one of the main themes in the 2018 report "Public Consolation on Strengthening Canada's Approach to Substance Use Issues" is supporting Indigenous people (Government of Canada, 2018). Despite such acknowledgements, Indigenous communities continue to suffer from health inequities as evidenced by the rate of opioid-related poisonings (overdoses) during the COVID-19 pandemic. For example, in Ontario there has been a 132% increase in poisonings among Indigenous people, versus a 68% increase among non-Indigenous people (Chiefs of Ontario and Ontario Drug Policy Research Network, 2021).

3.5 Primary and Secondary Prevention

Community Icon

Primary Prevention

Primary Prevention seeks to prevent health problems before they occur. These prevention efforts look upstream to try to determine the root cause of the problem. Negative health outcomes can be prevented by screening and addressing risk factors and enhancing resistance to those risks (AFMC, 2022). We can prevent unhealthy substance use and substance use disorders, through addressing the community conditions that put people at risk (Saskatoon Health Region, n.d.). For example, in terms of the drug poisoning (overdose) epidemic, primary prevention efforts would focus on preventing poisonings (overdoses) by investigating the community conditions that lead to substance use in the first place (Saskatoon Health Region, n.d.).

VIDEO: *Primary Prevention*

The following video provides examples of primary prevention efforts.

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psychoactivesubstanceuseandsociety2nded/?p=94
Secondary Prevention

Secondary Preventionseeks to lessen the impact of health problems. Here the focus is on identifying issues and providing interventions and treatment as soon as possible, in order to reverse or slow negative health outcomes (Saskatoon Health Region, n.d.). For people experiencing SUDs, secondary prevention measures can include access to: non-judgemental information and treatment services; availability of clean/sterile equipment (e.g., syringes, pipes); a safe supply of drugs; the provision of naloxone to prevent drug poisoning (overdose) deaths, etc. These types of prevention measures are downstream oriented efforts that are more reactive in nature. They cannot get to the root of the issue/problem that lead to substance use issues in the first place, only proactive primary prevention efforts can achieve this goal.

Naloxone (Narcan) is used to reverse the effects of drug poisoning (overdose).

Sterile needle supplies.

Click the link below to learn more about substance use prevention and the methods that can be used to support people who use drugs:

Social Determinants of Substance Use & Overdose Prevention

3.6 Canadian Examples

VIDEO:*The Social Determinants of Health*

The following video features Canadian public health experts discussing the impact of the SDoH on a variety of populations.

One or more interactive elements has been excluded from this version of the text. You can view them online here: https://ecampusontario.pressbooks.pub/psychoactivesubstanceuseandsociety2nded/?p=96#oembed-1

It is important to understand social determinants of health within your own community when trying to consider the best methods of intervention. A key example of considering SDoH specific to circumstance, is how Canadian public health supported people experiencing alcohol use disorders (AUD) during the COVID-19 pandemic.

Click the link to learn more about public health and alcohol policy in Canada during the COVID-19 pandemic:

Maintaining a Public Health Approach to Alcohol Policy During COVID-19

VIDEO: *Putting People First*

There are many examples of cities throughout Canada that have supported PWUS and people experiencing SUDs. The following video describes efforts in Edmonton that put people first and provide support by encouraging equal access to resources.

One or more interactive elements has been excluded from this version of the text. You can view them online here: https://ecampusontario.pressbooks.pub/psychoactivesubstanceuseandsociety2nded/?p=96#oembed-2

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3.7 Next Steps for Canada

Canadian Parliament, Ottawa, ON.

In 2018, the Government of Canada held a 90-day public consultation to gather ideas from Canadians on future directions for drug control policies. In June of 2019, the results of the consultation were made public in a report entitled *What we heard: Strengthening Canada's approach to substance use*.

Common themes in the report *What we Heard: Strengthening Canada's Approach to Substance Use* (2019) include the need:

- To address the stigma and discrimination experienced by PWUS that act as barriers to care and treatment.
- For more research in order to better understand substance use issues (e.g., underlying and root causes).
- For improved access to high quality treatment (medication and non-medication assisted) and harm reduction programs in both urban and rural/remote areas across Canada.
- To tailor services "to meet the needs of individuals and groups" to ensure that services are culturally appropriate and designed with community input.
- To change the criminal justice system. For example, eliminate penalties tied to substance use and move to a health care focus for people experiencing SUD.
- To minimize harms tied to alcohol use issues (e.g., increase awareness, policy change, develop a national alcohol strategy).

(Canada, June 2019).

There is a lot that can be done to support people who use substances in our communities. Although there is a long way to go to help Canadians feel supported and to increase primary and secondary prevention efforts in our communities, it is important that we focus on SDoH when looking at ways to address substance use and substance use issues in Canada.

3.8 Chapter Summary

Key Summary Points

1. The social determinants of health are complex, integrated and overlapping social structures that impact the way people grow, learn, play, and access care.
2. There are two key categories of determinants: structural and intermediary.
3. Upstream and downstream intervention are models that work directly with the SDoH.
4. Primary prevention is an element of prevention that looks upstream to provide better access and social conditions for those who need it most.
5. Social conditions vary across populations, meaning some populations are more at-risk than others of developing SUDs.
6. Canada is beginning to consider changes to substance control policies, including implementing interventions that employ a SDoH framework.

Additional Resources

Below are a list of supplementary resources for students interested in learning more about the chapter topics. These resources are NOT required course materials. A list of required course materials, beyond those found throughout this chapter, are provided on the following page.

Additional Viewings

Durocher, J. (2022b). *Social Determinants of Health* [Video]. Yuja. https://uwindsor.yuja.com/V/Video?v=524814&node=2152290&a=197802225&autoplay=1 **(Click this link for the Word version of the *References and Media Attributions* for the video).**

Additional Readings

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The Association of Faculties of Medicine in Canada. (January 24, 2018). *AFMC primer on population health*. https://phprimer.afmc.ca/en/part-i/chapter-4/

3.9 Required Chapter Materials

In addition to the videos and reading links embedded into the chapter, students are required to complete the following:

Canada. (2013). *What makes Canadians healthy or unhealthy?* https://www.canada.ca/en/public-health/services/health-promotion/population-health/what-determines-health/what-makes-canadians-healthy-unhealthy.html#shr-pg0

Cantu, R., Fields-Johnson, D., & Savannah, S. (July 26, 2020). Applying a social determinants of health approach to the opioid epidemic. *Health Promotion Practice*. https://doi.org/10.1177/1524839920943207

McKenzie, H., Dell, C. & Fornssler, B. (September 2016). Understanding addictions among Indigenous people through social determinants of health frameworks and strength-based approaches: A review of the research literature from 2013-2016. *Current Addiction Reports*, *3*, 378-386. https://link.springer.com/article/10.1007/s40429-016-0116-9

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3.10 Chapter Assignment

Assignment Formatting, Style, & Length Requirements

- Assignment formatting requirements: Arial 12-point font; 1-inch/2.54cm margins; single spaced; APA in-text citation style, reference section and cover page.
- Use proper paragraph style within the answer to each question.
- Clearly indicate which question is being answered using corresponding question numbers (do not write out the entire question). Follow-up questions must be answered as part of the numbered question. Avoid using automated numbering as it alters the left margin of the document, resulting in a margin larger than 1-inch/ 2.54cm.
- Assignment length: approximately 1000 words in length (give or take 100 words) (reference section and cover page not included in word count).
- Divide your time/space evenly across all questions.
- Proofread your submission to make sure it is clear, well written and intelligible.

Assignment Instructions

- After completing this chapter's materials (chapter content, including all embedded links to readings and videos, and the required chapter materials) answer ALL the questions below.
- In your ALL answers be sure to demonstrate knowledge of and engagement with the chapter materials. This is achieved through supporting points/arguments/positions via reference to the course material using in-text citations. Providing in-text citations to support your points/ arguments/positions is essential and required. Be sure to: (1) use a diverse range of materials, as opposed to relying heavily on a few sources; AND (2) cite material from current AND previously covered chapter materials.
- Only use materials outside of those assigned when specifically instructed to do so.

Assignment Questions

1. Using the social determinants of health framework, how can "The Squeeze" (referred to in the UBC Medicine video in Chapter section 3.6 on Canadian Examples) help us to understand substance use and substance use problems, and how we need to change our focus to better address them? In your answer be sure to briefly explain the squeeze and how it is tied to the SDoH.
2. How can the concepts of "upstream" and "downstream" help us understand the overrepresentation of some groups of people among those with substance use problems. Use examples to illustrate and support your answer.
3. What is the most significant thing you learned from this week's course material on the social determinants of health that you did not already know? How has this knowledge impacted you? How can such knowledge be used to help people better understand substance use and substance

use problems?

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3.11 References & Media Attributions

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IV

Chapter 4: Early Canadian Drug Policy

Jacqueline Lewis & Jillian Holland-Penney

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4.0 Introduction

Chapter Introduction

In Canada prior to the early 1900s, there were no legal restrictions on the sale and consumption of psychoactive drugs, or moral stigma attached to substance use and addiction. Originally, "drug dependence" was not seen as immoral and/or regarded as a personal failing, crime, or an indication of a

psychological problem. In the late 1800s and early 1900s, however, there was a redefinition of the meaning of certain forms of drug consumption behaviour. This shift was in part due to: the influence of Protestant values and beliefs, that emphasized sobriety and moral purity; the medical communities increasing concern with non-regulated medicine(s); and colonial discourses that propagated the belief that substance use was "a contagion brought to the west by racialized outsiders, and thus, a threat to white middle-class morality" (CDPC, 2021). This chapter explores the history of the Temperance movement and alcohol prohibition in Canada, as well as early Canadian drug policies. It also identifies the role that some influential people in Canada played in the development of early prohibitionist/criminalizing drug laws and the definition of problematic substance use behaviour.

Chapter Objectives/Learning Outcomes

After completing the chapter materials, you should have an understanding of:

1. The history of Canadian attitudes towards drugs, the people who use them, and ultimately how we control drug use.
2. The history of Canadian attitudes towards alcohol, the people who use it, and how we control alcohol manufacture and use in Canada.
3. The role of moral reformers in changing attitudes and policies towards psychoactive substances and the people who them.

Questions to Think About When Completing Chapter Materials

1. Identify 2 key moral reformers who influenced prohibition in early Canada? What role did they play in the origins of Canadian drug laws?
2. What are the dominant themes used by moral reformers to gain support for alcohol and drug prohibitionist policies (i.e., what claims did moral reformers make about alcohol/drugs and substance/alcohol use)?
3. How has early Canadian drug prohibition shaped the ways in which Canadian's view drugs, drug use and people who use substances (PWUS) today?

4.1 History of Canadian Drug Policy & Prohibition

"Knowing about Canadian drug prohibition allows us to critically reflect on past practices, legal regulation, law enforcement, moral reformers and their agendas, new events and avenues to adopt."

Dr. Susan Boyd (CDPC, 2021, para. 2)

VIDEO: *Professor Susan Boyd: An Illustrated History of Canadian Drug Policy & Prohibition*

The following video provides a detailed history of Canadian drug and alcohol policy **(Watch to the 25-minute mark).**

One or more interactive elements has been excluded from this version of the text. You can view them online here: https://ecampusontario.pressbooks.pub/psychoactivesubstanceuseandsociety2nded/?p=113#oembed-1

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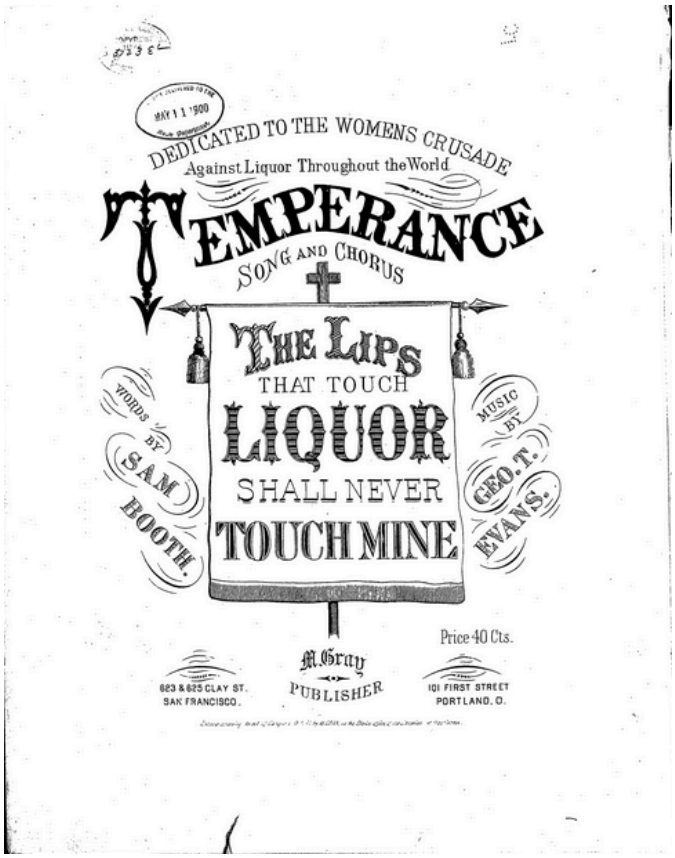
4.2 The Temperance Movement & Alcohol Prohibition in Canada



Temperance Song Sheet Music Cover.

Temperance Poster.

Temperance

The term temperance means restraint or "moderation in action, thought, or feeling" (Merriam-Webster, n.d.). In terms of the temperance movement, the meaning refers to moderation or abstinence from alcohol consumption.

The Canadian Temperance Movement

The temperance movement was comprised of a number of temperance societies and religious/church organizations. Together they were one of the most powerful political and social lobbing groups in Canadian history (Hallowell, 1972; Schweighofer, 1988). The first temperance societies appeared in Canada in Montreal and Nova Scotia during the early 1800s (Schweighofer, 1988). By the latter part of the 19th century and early 20th century, the movement reached its peak of influence.

Promoting the belief that alcohol was a corrupting force, responsible for many social ills (CDPC, 2021), the temperance movement argued that alcohol was a threat to "the individual and the nation, [resulting in]…financial ruin, immorality, sexual impropriety, physical degeneration, and social collapse" (Mallack, August 3, 2018). Although in its early days the movement advocated for moderation or total abstinence from alcohol consumption, "total abstinence only" principles eventually dominated its position by 1835 (Mallack, 2018a; Schweighofer, 1988; Spence, 1923).

Canadian Temperance Organizations

There were numerous temperance societies in Canada (McGregor & Zalken, 2019). Some of the more well-known organizations active in the 19th century include:

- The Dominion Prohibitory Council/The Dominion Alliance for the Total Suppression of Liquor Traffic.
- The International Order of Good Templars.
- The Royal Templars of Temperance.
- The Sons of Temperance.
- The Women's Christian Temperance Union (WCTU).

(Dupre & Vencatachellum, 2005; McGregor & Zalken, 2019; All about Canadian History, 2017b).

The Women's Christian Temperance Union (WCTU), whose first Canadian chapter was founded in 1875, played a dominant role in the push for alcohol prohibition in Canada (Ministry of Government and Consumer Services, n.d.; CBC Digital Archives, 1978; McGregor & Zalken, 2019).

VIDEO: *Dr. C. Heron: Prohibition and the Regulation of Liquor*

In the following video Dr. Craig Heron talks about prohibition and the regulation of liquor in Canada.

One or more interactive elements has been excluded from this version of the text. You can view them online here: https://ecampusontario.pressbooks.pub/psychoactivesubstanceuseandsociety2nded/?p=117#oembed-1

Canadian Alcohol Prohibition Policy

1. *The Dunkin Act* (1864)

Referred to as "the local option," this Act provided the option for the regional prohibition of alcohol in the Province of Canada (Quebec and Ontario post confederation) (Dupre & Vencatachellum, 2005; Spence, 1923). It allowed any county or municipality within the province to prohibit the retail sale of alcohol if supported by a majority vote (Canada Department of Trade and Commerce, 1939; Spence, 1923).

2. *The Scott Act/The Canadian Temperance Act* (1878)

This Act extended the "local option" process introduced in the *Dunkin Act* to the entire country (Canada Department of Trade and Commerce, 1939; Moffit, 1932; Spence, 1923).

Indigenous Peoples & Alcohol Prohibition

An amendment to the *Indian Act* (1884) made it a felony for Indigenous people to purchase, consume, or to enter a licensed drinking establishment. It also made it illegal to sell or supply alcohol to an Indigenous person (Indigenous Corporate Training, 2016; Hinge, 1985). It wasn't until 1985 that all discriminatory liquor polices both "on and off reserve were repealed… and band councils were… given

powers to control the sale and possession of liquor" (Indigenous Corporate Training, 2016, para. 18).

3. *Canadian Referendum on National Prohibition* (1898)

A national referendum was held on the implementation of a national prohibition policy. Although the referendum passed by a very slim majority (51%), the policy was never enacted (Boyce, 1923; Canada Department of Trade and Commerce, 1939; Dupre & Vencatachellum, 2005).

4. *The War Measures Act*(1915-18)

Prohibition was enacted in each province under this Act in 1914 (Dupre & Vencatachellum, 2005). It was promoted by the Dominion Alliance as a "patriotic measure" that would conserve needed resources (Hiebert, 1969). The form that prohibition took varied by province, with Quebec and the Yukon not participating (Canada Department of Trade and Commerce, 1939) and some provinces continuing to permit the manufacture and export of alcohol (beer and/or liquor) (Boyce, 1923). Although the federal prohibition ended shortly after WWI, some provinces continued their prohibition polices. In 1948, PEI became the last province to end alcohol prohibition (Prohibition in Canada, n.d.a).

Click the link below to learn more about temperance and alcohol prohibition in Canada:

Canadian Prohibition Timeline

Windsor & Detroit During Prohibition

Detroit police inspecting equipment found in a clandestine underground brewery.

Click the links below to learn about the role Windsor ON played in early alcohol prohibition:

Windsor Star Article "From the Vault: Prohibition"

VIDEO: *Crooked Cops & Blind Pigs: A History of Prohibition*

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4.3 Populations Targeted for Substance Use

Boarded-up Buildings in Chinatown after "Race Riots", Vancouver, BC (1907).

During the construction of the Canadian Pacific Railway (CPR) in the late 1800s, Chinese labourers were poorly compensated, faced dangerous working conditions and endured discriminatory and racist attitudes (British Columbia, n.d.). These culminated in the Vancouver Race Riots of 1907 (CISUR, 2015). Chinese Canadians were also the targets of various discriminatory Canadian policies, including early drug polices that focused on opium smoking and polices aimed at curtailing the Chinese population of Canada (i.e., *Chinese Immigration Act* of 1885, *Opium Act* of 1908, *Opium and Drug Act* of 1911, *Chinese Immigration Act*/*Chinese Exclusion Act* of 1923).

In the early 20th century, the consumption of opium was extremely common. Prevailing views of the dominant culture, however, were that the "respectable" way to consume opium was by drinking it (i.e., laudanum), the form of consumption used largely by the white middle-class (CISUR, 2015). In contrast, the "degrading" and "immoral" method of opium use was smoking it, which was the often preferred form of consumption among Chinese Canadians (Malleck, 1997). It was this method of use that resulted in harsher criminal punishments. As noted by the Canadian Drug Policy Coalition (2021, para. 27), "criminalized drugs have long been linked to marginalized and racialized groups, who have been depicted as outsiders to the nation threatening moral Canadians." In an attempt to control racialized communities and their use of drugs, prohibitionist drug policies were enacted throughout the 20th century (Canadian Drug Policy Coalition, n.d.).

Click the links below to learn more about the racist nature of early Canadian drug policies:

The Racist History Behind Canada's Marijuana Prohibition

The Influence of Opium and Cocaine Panic in Canadian Drug Policy

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4.4 Early Canadian Drug Policies

Canada's first federal narcotics law, *The Opium Act* (1908), prohibited the importation and use of opium for non-medical purposes (British Columbia, n.d.). The orientation of this policy and the redefining of the moral impact of opium on Canadian society, grew out of the efforts of a small group of politically/ socially influential moral reformers (CDPC, 2021). In 1911, *The Opium and Drug Act* was enacted, adding other drugs such as cocaine and morphine to the list of prohibited substances (CDPC, 2021). This Act also expanded police powers, which contributed to the targeting of Chinese men and an increase in drug-related convictions (CDPC, 2021). The *Opium and Narcotic Drug Act* was passed in 1920, and various amendments were made to the Act between 1920 and 1930 (Nolin and Kenny, 2002). Among these amendments were expanded police powers, including the ability to conduct drug searches without a warrant (Nolin and Kenny, 2002).

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4.5 Role of Moral Reformers in Early Canadian Drug Prohibition

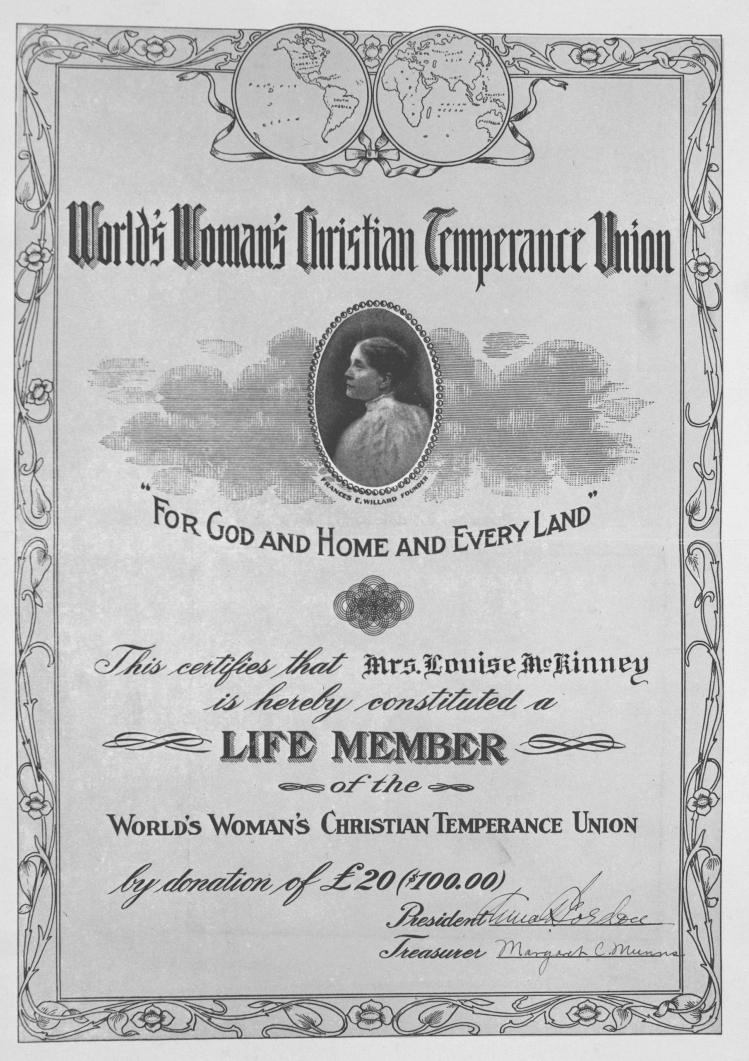
Click the link below to learn more about moral reformers and their role in early Canadian drug prohibition:

History of Drug Policy in Canada **(Read to "1960s – 1970s: The Counter-Culture Movement")**

Women's Christian Temperance Union (WCTU)

First Alberta Provincial WCTU Convention, Olds AB, 1913.

Members of the WCTU often held evangelical Protestant views and blamed alcohol for society's problems, believing that alcohol was the biggest cause of domestic violence, divorce, and violence towards children; ruining Canadians' physical health; and linked to crime, sexual immorality, and poverty (Sheehan, 2006).



World's Women's Christian Temperance Union Certificate Awarded to Louise McKinney.

Judge Emily Murphy

Portrait of Emily Murphy.

In the 1920s, Emily Murphy, the first female Canadian magistrate, published a series of McLean's Magazine articles and a book entitled *The Black Candle* (Murphy, 1922) in an attempt to arouse public interest in stricter drug laws. Her work was extremely racist, promoting cultural stereotypes of the "dope fiend" (Brandt, 1996), and linking drug use with sexual promiscuity and race-mixing (CDPC, 2021).

Click the link below to read a few pages from Judge Emily Murphy's book the Black Candle (1922) ⚠ (Book contains extremely racist, moralistic, and fearmongering language):

Emily Murphy's The Black Candle

William Lyon Mackenzie King

William Lyon Mackenzie King, 1942.

Referred to as the "father of prohibition," Mackenzie King wrote and submitted to parliament a report entitled *The Need for the Suppression of the Opium Traffic in Canada* in 1908. Although the report contained little in the way of evidence and was not debated in parliament, it formed the basis of the *Opium Act* (1908). King's concern with the moral impact of opium use set the tone for Canada's response to drug use for over a century (CDPC, 2021).

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4.6 Chapter Summary

Key Summary Points

1. The attitudes and beliefs that influenced the development of early Canadian drug policy continue to influence our views about drugs, drug use and people who use substances (PWUS) today.
2. The racist nature of early drug policies has shaped drug policy in Canada throughout the 20th and into the 21st century, with different racialized groups being constructed as PWUS and targeted through drug policy and enforcement.
3. Although perspectives surrounding drugs began changing in the mid-20th century, prohibitionist-style drug policies have persisted well into the 21st century. There has also been a great deal of resistance to progressive understandings of drugs, drug policy and people who use drugs.

Additional Resources

Below are a list of supplementary resources for students interested in learning more about the chapter topics. These resources are NOT required course materials.

Additional Viewings

York University – Faculty of Liberal Arts and Professional Studies. (November 23, 2010). *Prohibition in Canada: Prof. Marcel Martel*. https://www.youtube.com/watch?v=7dNw6o17UJI

Additional Readings

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4.7 Chapter Assignment

Assignment Formatting, Style, & Length Requirements

- Assignment formatting requirements: Arial 12-point font; 1-inch/2.54cm margins; single spaced; APA in-text citation style, reference section and cover page.
- Use proper paragraph style within the answer to each question.
- Clearly indicate which question is being answered using corresponding question numbers (do not write out the entire question). Follow-up questions must be answered as part of the numbered question. Avoid using automated numbering as it alters the left margin of the document, resulting in a margin larger than 1-inch/ 2.54cm.

- Assignment length: approximately 1000 words in length (give or take 100 words) (reference section and cover page not included in word count).
- Divide your time/space evenly across all questions.
- Proofread your submission to make sure it is clear, well written and intelligible.

Assignment Instructions

- After completing this chapter's materials (chapter content, including all embedded links to readings and videos, and the required chapter materials) answer ALL the questions below.
- In ALL your answers be sure to demonstrate knowledge of and engagement with the chapter materials. This is achieved through supporting points/arguments/positions via reference to the course material using in-text citations. Providing in-text citations to support your points/ arguments/positions is essential and required. Be sure to: (1) use a diverse range of materials, as opposed to relying heavily on a few sources; AND (2) cite material from current AND previously covered chapter materials.
- Only use materials outside of those assigned when specifically instructed to do so.

Assignment Questions

1. Identify 2 factors responsible for the demise of alcohol prohibition in Canada. Explain what role each factor played in its demise. Be sure to use examples from the course material to illustrate and support your answer.
2. Identify 2 factors that played a role in the origins of Canadian drug policy. Explain what role each factor played in the origins and continued use of prohibitionist policies to control psychoactive substances in Canada.
3. What is the most significant thing you learned from this week's course material that you did not already know? How has this knowledge impacted you? How can such knowledge be used to help challenge and possibly change Canadian attitudes toward drugs, people who use drugs, and the policies we use to control them?

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V

Chapter 5: Contemporary Canadian Drug Policies & Their Impact

Jacqueline Lewis & Jillian Holland-Penney

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5.0 Introduction

Chapter Introduction

This chapter explores contemporary Canadian laws and policies governing drug control, from the 1960s until today, as well as the implications of such policies. It also outlines the various commissions, committees and task forces that have been enacted to conduct research and make recommendations

regarding Canadian drug policy. As explored in the chapter on Early Canadian Drug Policies, morality and prohibition continue to impact constructions of psychoactive drugs, people who use substances (PWUS), and drug policy. The materials in this chapter, however, detail changing perspectives surrounding drugs that emerge from the growing reliance on research and scientific evidence, that began with the work of the Le Dain Commission in the late 1960s. The application of research and knowledge help us to restructure our understandings of psychoactive drugs, drug use, and PWUS, using an evidence-based model, as opposed to one based on morality. Increasingly, researchers, scholars and people working in public health recognize the need to: (1) develop public policy that is rooted in public health and harm reduction; and (2) treat PWUS and people who experience substance use disorders (SUDs) with compassion instead of stigma.

Chapter Objectives/Learning Outcomes

After completing the chapter materials, you should have an understanding of:

1. The history of Canadian attitudes towards drugs, the people who use them, and how we control drug use (1960s to present).
2. Canadian criminal laws and strategies pertaining to illegal substances, their use and trade (1960s to present).
3. Government commissions/committees/task forces struck between the 1960s to present to collect scientific data and make drug policy recommendations.
4. The impact of Canadian criminalization policy in practice.

Questions to Think About When Completing Chapter Materials

1. Numerous researchers have described the consequences associated with the *Safe Streets and Communities Act* (SSCA), alternately known as Bill C-10, passed by the Canadian Parliament on March 12, 2012. What does Bill C-10 consist of, and what are some examples of its consequences and harms?
2. Using the knowledge base in this chapter (and other chapters previously covered in the course), how would you explain the need for Canada to shift from a system of criminalization/ prohibitionist drug policy to one rooted in evidence and research?
3. What are the objectives of Bill C-22, An Act to amend the Criminal Code and the Controlled Drugs and Substances Act? If this Bill were enacted, in what ways could it help combat the costs and consequences produced from previous and current Canadian drug policy?
4. What are the 4 pillars of the Canadian Drug Strategy (2016)? What is the purpose of each? In what ways can they be modified to better address the existing critiques of contemporary drug policy in Canada?
5. Identify a contemporary example of the racist nature and/or impact of Canadian drug policy in action.

5.1 Canadian Drug Policy

Canadian Drug Legislation Post-1960

1961: *Narcotics Control Act (NCA)*
1987: *Federal/Canadian Drug Strategy (FDS/CDS)*
1996: *Controlled Drugs & Substances Act (CDSA)*
2007: *National Anti-Drug Strategy (NADS)*
2012: *Safe Streets and Communities Act (SSCA)*
2016: *Canadian Drugs & Substances Strategy (CDSS)*
2017: *Good Samaritan Drug Overdose Act*
2018: *Tobacco and Vaping Product Act (TVPA)*
2018: *Cannabis Act*

VIDEO: *Contemporary Canadian Drug Policies (1960s-Present)*

The following slideshow provides an overview of contemporary Canadian drug policies from the 1960s to early 2022.

One or more interactive elements has been excluded from this version of the text. You can view them online here: https://ecampusontario.pressbooks.pub/psychoactivesubstanceuseandsociety2nded/?p=141

Click the links below to learn more about Canadian drug law and policy:

Quick Facts: Canada's Drug Laws & Strategies

Cannabis in Canada: Get the Facts

Tobacco and Vaping Products Act

VIDEO: *Professor Susan Boyd: An Illustrated History of Canadian Drug Policy & Prohibition*

The following video provides a detailed history of Canadian drug and alcohol policy. **(Start watching at 25 minute mark).**

One or more interactive elements has been excluded from this version of the text. You can view them online here: https://ecampusontario.pressbooks.pub/psychoactivesubstanceuseandsociety2nded/?p=141#oembed-1

Canadian Drugs and Substances Strategy (CDSS)

Today, drug policies in Canada are informed by the *Canadian Drugs and Substances Strategy* (CDSS).

The goal of this Strategy is protecting the health and safety of all Canadians by minimizing harms from substance use for individuals, families, and communities (CDPC, 2020b; Health Canada, 2018). There are 4 pillars of the 2016 Drug Strategy, originally introduced through the *Federal Drug Strategy* (1987).

Pillars of the Canadian Drugs and Substances Strategy. © Heath Canada (2018). All rights reserved. Image used with permission.

Click the links below to learn more about the CDSS:

The New Canadian Drugs and Substances Strategy

Background Document: Public Consultation on Strengthening Canada's Approach to Substance Use Issues **(Read Pages 7-8)**

5.2 Drug Prohibition & the War on Drugs in

Canada

The *War on Drugs* in Canada

Stop the Drug War Collage.

Canadian drug policy was influenced by the war on drugs and drug criminalization policy more generally in the United States. Shortly after President Ronald Reagan declared a new war on drugs in the United States, Prime Minister Brian Mulroney attempted to do the same in Canada, stating in a press conference that "drug abuse has become an epidemic that undermines our economic as well as our social fabric" (Jensen & Gerber, 1993, p. 455). Canadian anti-drug policy, however, looked much different than the US war on drugs. This was in large part due to widespread skepticism about the claims made by Mulroney. According to Jensen & Gerber (1993, p. 461), "although a national policy was created, a drug problem was not constructed."

Racism Within Canadian Drug Criminalization

- Researchers have demonstrated how the war on drugs has led to the enforcement of drug laws that are heavily racialized. Much of this discussion, however, is centered on the United States where a substantial proportion of individuals arrested and prosecuted for drug possession are African American and Latino, despite similar rates of drug use across the social spectrum (Owusu-Bempah & Luscombe, 2021).
- More comprehensive criminal justice data collection is required to better inform future Canadian social policy. According to Owusu-Bempah and Luscombe (2021), due to a lack of access to racially disaggregated criminal justice data, little is known about how race influences drug law enforcement in Canada and what measures are needed to redress the harms caused by the war on drugs.
- Drug policies need to be evidence-based. There is a growing consensus that substance use is a health-based issue, more appropriately addressed by the health-care system and harm reduction measures (Zhang, 2021) (See Chapter on Harm Reduction). However, when making the shift

from a criminalization to health-care orientation, it is essential to conduct racial impact assessments to avoid the continuation of racial disparities in access to social institutions (Zhang, 2021), including treatment.

Click the link below to learn more about the racially biased legacy of drug policy in Canada:

Criminalization vs. Public Health: The Legacy of Canada's Racially Based Drug Laws

VIDEO: *Susan Boyd – Colonial History and Racial Stereotypes Are Deeply Entrenched in Canadian Drug Policy*

In the following video Dr. Susan Boyd describes how Canadian drug policy has historically constructed, upheld, and reinforced colonialism and racial stereotypes, as well as how the effects of these policy choices continue to be felt today.

One or more interactive elements has been excluded from this version of the text. You can view them online here: https://ecampusontario.pressbooks.pub/psychoactivesubstanceuseandsociety2nded/?p=144#oembed-1

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5.3 Canadian Commissions, Committees & Task Forces on Drugs

1. *The Le Dain Commission* (1969-1972)

The Government of Canada formed The Le Dain Commission (formally known as The Commission of Inquiry into the Non-Medical Use of Drugs) in 1969 to address a growing concern about the use of drugs and the appropriate societal responses to such usage (Riley, 1998). According to Riley (1998), the Commission analyzed the social (e.g., costs to law enforcement, courts, and correctional services) and individual costs and consequences (e.g., impact of a criminal record on the individual, including on employment; impact of broad search and seizure powers, etc.) of the current criminalization policy. It produced 4 reports, one of which focused solely on cannabis. The reports included a series of recommendations that were largely ignored by the Government (Owusu-Bempah & Luscombe, 2021).

Some Key Recommendations:

- Decriminalization of drugs – cannabis and harder drugs (Zhang, 2021; CBC, n.d.a).
- Eliminate cannabis possession as an offence (CBC, n.d.a).
- Trafficking of cannabis should not carry mandatory jail terms (Le Dain et al., 1972).
- Trafficking should not include the giving of cannabis by one user to another, that reasonably could be used by a person on a single occasion (Le Dain et al., 1972).
- Greater attention should be paid to harm reduction strategies (Zhang, 2021).

Click the links below to learn more about the Le Dain Commission Reports:

Le Dain Commission of Inquiry into the Non-Medical Use of Drugs tables fourth & final report

VIDEO: *Le Dain Tables Final Report Recommending Decriminalization of Marijuana*

2. *Senate Special Committee on Illegal Drugs* (2001)

The Senate Committee was tasked with examining Canada's approach to cannabis and the effectiveness of that approach (Nolin & Kenny, 2002a). They explored: policies used in other parts of the world; Canada's obligations tied to international drug treaties; and the social and health consequences of cannabis (Nolin & Kenny, 2002a). In their report the Committee argued that only behaviour causing demonstrable harm to others should be penalized (Nolin & Kenny, 2002b). Their primary conclusion was that cannabis (possession, production, and distribution) should be legalized and regulated by a government agency (Nolin & Kenny, 2002a).

3. *Parliamentary (House) Special Committee on Non-Medical Use of Drugs* (2001)

The mandate of the House Committee was two-fold: to study factors relating to the non-medical use of drugs in Canada and to make recommendations to reduce the dimensions of the problem involved in such use (Torsney, 2002). The recommendations contained in their report included: decriminalizing the possession of small quantities of cannabis, but maintaining all other drug prohibitions (e.g., those tied to possession, production, and trafficking); implementation of "safe-injections facilities" (now more commonly referred to as Safe Consumption Sites); and the establishment of special drug courts (Torsney, 2002).

4. *The Task Force on Marijuana Legalization & Regulation* (2016)

The Task Force was responsible for: seeking views of Canadians; engaging in discussions with Provinces, Territories, and experts; and drafting a report to advise the Federal Government on the design of a new legislative and regulatory framework for cannabis (Canada, 2016a). Some of the key recommendations in the report that were adopted by the government included: setting a national minimum age of 18 for cannabis purchase; applying comprehensive restrictions on advertising and promotion; requiring plain packaging with basic information and warning requirements; requiring opaque child proof resealable packaging; and prohibiting mixed substance products (Canada, 2016a).

5. *Health Canada Expert Task Force on Substance Use* (2021)

The final version of the *Recommendations on Alternatives to Criminal Penalties for Simple Possession of Controlled Substances*, was published by the Health Canada Expert Task Force on Substance Use in May 2021. The Task Force found that criminalization of simple possession causes harms to Canadians, leading to the conclusion that Canada needs to end criminal penalties and coercive measures related to simple possession and consumption. When making recommendations, the Task Force kept five core issues in mind: stigma; disproportionate harms to populations experiencing structural inequity; harms from the illegal drug market; the financial burden on the health care and criminal justice

systems; and unaddressed underlying conditions.

Some Key Recommendations for the Government of Canada include:

- Begin legislative change to bring certain Acts (i.e., *CDSA, TVPA, Cannabis Act*) under a single public health legal framework.
- Expunge all criminal records from previous offences related to simple possession.
- Make significant investments to provide a full spectrum of supports for people experiencing substance use disorders (SUDs) or who are in recovery.
- Implement a more comprehensive and responsive system to rapidly and effectively gather, use, and disseminate evidence about substance use, its effects, and the impacts of government policies on the health and well-being of Canadians.

The task force also "strongly urged Health Canada to respect the sovereign rights of the Indigenous Peoples of Canada and support their governments in providing appropriate prevention and treatment approaches" (Health Canada, 2021, p. 14).

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5.4 Costs & Consequences of Current Canadian Drug Policies

Outcomes of Canada's Current Approach to Substances Include:

1. The drug poisoning (overdose) crisis and an unregulated drug market.
2. Crime rates, drug-related crime, and organized crime.
3. Prison and incarceration.
4. Increased violence.
5. Stifling medical research.
6. Increasing the negative effects of drug use.

(CDPC, 2020a)

Click these links below to learn more about the outcomes of Canada's current approach to substances:

Outcomes of our Current Approach to Substances

Discussion Guide: Getting to Tomorrow – Ending the Overdose Crisis **(Read pages 17-22)**

VIDEO:*Outcomes of Our Current Drug Policies*

The following video provides an explanation of the costs and consequences associated with drug criminalization.

One or more interactive elements has been excluded from this version of the text. You can view them online here: https://ecampusontario.pressbooks.pub/psychoactivesubstanceuseandsociety2nded/?p=148#oembed-1

Additional Costs & Consequences of Existing Criminalization Policies

- Instead of improving the health and lives of Canadians, current policies have exacerbated the negative effects of substance use (CDPC, 2020b).
- The provisions of the SSCA are likely to affect many marginalized people, including people experiencing SUDs and structural vulnerability (Bennett & Bernstein, 2013).
- "Tough on crime" measures, including mandatory minimum sentences, are not an effective deterrent for people experiencing structural vulnerability and SUDs (Bennett & Bernstein, 2013).

Click the following link to learn more about the human and social costs of mandatory minimum sentences:

*Throwing Away the Keys: The Human and Social Costs of Mandatory Minimum Sentences***(Read the Executive Summary)**

5.5 Recent Canadian Drug Policy Bills

Recent Proposed Bills for Policy Change

- Bill C-236, *an Act to amend the Controlled Drugs and Substances Act* (evidence-based diversion measures) (2020), would amend the CDSA to "require peace officers to consider measures other than judicial proceedings to deal with individuals alleged to have been in possession of certain substances. It also sets out principles to be taken into account in the determination of the most appropriate measures to take" (Canada, 2021).
- Bill C-22, *an Act to amend the Criminal Code and the Controlled Drug and Substances* (2021), is an attempt to fulfill the Government of Canada's commitment to address systemic inequities, including the overrepresentation of Indigenous peoples, Black, and marginalized Canadians, in the criminal justice system (Canada, 2021).
- Bill C-5, *An Act to amend the Criminal Code and the Controlled Drugs and Substances Act* (2021), is an attempt to fulfill the Government of Canada's commitment to address systemic inequities, and systemic racism and discrimination in the Canadian criminal justice system (CJS). This Bill would amend the *Criminal Code* and the *Controlled Drugs and Substances Act* "to repeal certain mandatory minimum penalties, allow for a greater use of conditional sentences and establish diversion measures for simple drug possession offences" (Bill C-5, 2022).

Neither of the first two Bills moved forward beyond an initial reading in the House of Commons (February 7, 2022 for Bill C-236 and February 18, 2021 for Bill C-22). Although Bill C-5 received royal

accent on November 17, 2022, many critics express concern that its stated objectives will not be realized.

Click the link below to learn more about concerns tied to Bill C-5:

Bill C-5: Canada's Failure to Address the Mass Incarceration of Indigenous Peoples – Part 2

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5.6 Chapter Summary

1. Prohibition-style drug policy continues into the 21st century, with drug prohibition/ criminalization leading to negative social outcomes for people who use drugs and society more generally. Examples of negative social costs include the opioid poisoning crisis facing Canadian society today and the disproportionate impact of drug policies on marginalized and racialized communities in Canada.
2. There have been various committees, task forces, and commissions enacted over the years to study and provide recommendations pertaining to Canadian drug policy.
3. Canada continues to adopt drug strategies centered around criminalization and punishment (Zhang, 2021), despite the evidence-based critiques of this approach.

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5.7 Required Chapter Materials

In addition to the videos and reading links embedded into the chapter, students are required to complete the following:

Jensen, E. & Gerber, J. (1993). State efforts to construct a social problem: The 1986 war on drugs in Canada. *Canadian Journal of Sociology*, *18*(4), 453-462. https://www.proquest.com/docview/220530175?parentSessionId=8VxUA4amqSqcC8EW3pm3SmVlqlHjMTWbQXbWdNOsHrc%3D&sourcetype=Sch

Owusu-Bempah, A & Luscombe, A. (May 21, 2021). Race, cannabis & the Canadian war on drugs: An examination of cannabis arrest data by race in five cities. *International Journal of Drug Policy*, *91*. https://doi.org/10.1016/j.drugpo.2020.102937

Poulos, B. (November 25, 2019). Quebec is wrong to raise its legal cannabis age to 21. *The Conversation.* https://theconversation.com/quebec-is-wrong-to-raise-its-legal-cannabis-age-to-21-127429

Taha, S., Maloney-Hall, B. & Buxton, J. (August 19, 2019). Lessons learned from the opioid crisis across the pillars of the Canadian drugs and substances strategy. *Substance Treatment, Prevention & Policy*, *14*(32). https://doi.org/10.1186/s13011-019-0220-7

5.8 Chapter Assignment

Assignment Formatting, Style, & Length Requirements

- Assignment formatting requirements: Arial 12-point font; 1-inch/2.54cm margins; single spaced; APA in-text citation style, reference section and cover page.
- Use proper paragraph style within the answer to each question.
- Clearly indicate which question is being answered using corresponding question numbers (do not write out the entire question). Follow-up questions must be answered as part of the numbered question. Avoid using automated numbering as it alters the left margin of the document, resulting in a margin larger than 1-inch/ 2.54cm.
- Assignment length: approximately 1000 words in length (give or take 100 words) (reference section and cover page not included in word count).
- Question 1 should take up 2/3 of the time/space for the assignment.
- Proofread your submission to make sure it is clear, well written and intelligible.

Assignment Instructions

- After completing this chapter's materials (chapter content, including all embedded links to readings and videos, and the required chapter materials) answer ALL the questions below.
- In ALL your answers be sure to demonstrate knowledge of and engagement with the chapter materials. This is achieved through supporting points/arguments/positions via reference to the course material using in-text citations. Providing in-text citations to support your points/ arguments/positions is essential and required. Be sure to: (1) use a diverse range of materials, as opposed to relying heavily on a few sources; AND (2) cite material from current AND previously covered chapter materials.
- Only use materials outside of those assigned when specifically instructed to do so.

Assignment Questions

1. Identify 2 significant changes in Canadian drug policy since 1960 (only one has to be at the official federal level. The other could be provincial/regional in nature and/or associated with non-governmental organizations). For each, answer the following:
    - What was the change (including the focus of the change)? When did it occur? How broad was the policy (Canadian wide, a particular region, etc.)?
    - What makes it a significant Canadian policy change?
    - Why/how did the policy change come about?
    - How effective is/was this policy? What factors impact(ed) its effectiveness?

2. What is the most significant thing you learned from this week's course material that you did not already know? How has this knowledge impacted you? How can such knowledge be used to help challenge and possibly change Canadian attitudes toward drugs, the people that use drugs, and the policies we use to control them?

5.9 References & Media Attributions

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VI

Chapter 6: International Drug Policies

Jacqueline Lewis, Jillian Holland-Penney & Brandon Bernardon

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6.0 Introduction

Chapter Introduction

Beginning in the early 20thcentury, the United States began spearheading the implementation of international drug control policies that would guide Member States in the development of national

policies. The first of these international efforts resulted in a set of resolutions developed during the 1909Shanghai Convention. Numerous conventions followed, culminating in the three international drug conventions that are still in effect today. The primary focus of international drug control efforts, has been the elimination of the illegal manufacture, sale, trade, and use of psychoactive drugs, while making sure there is enough supply for medical and research purposes. This chapter explores drug control policy in an international context from the early 1900s to the present day. Knowledge of the history of international controls is important for understanding how and why drug prohibition/criminalization became the means to address the manufacture, trade and use of psychoactive drugs nationally and globally. It also helps us to understand why this form of drug policy is so sedimented and resistant to change, despite all the evidence that it is a failed policy (See Chapter on Drug Prohibition and the War on Drugs).

Chapter Objectives/Learning Outcomes

After completing the chapter materials, you should have an understanding of:

1. The history behind international drug control.
2. The three international drug control conventions: *the Single Convention on Narcotic Drugs* (1961); *the Convention on Psychotropic Substances* (1971); and *the Convention Against Illicit Traffic in Narcotic Drugs and Psychotropic Substances* (1988).
3. Critiques and challenges to the existing international drug control framework, including at UNGASS and via changes in legislation in some countries.
4. Recent changes relating to international policy, including the UN Common Position on Drug Policy (2018) and the International Guidelines on Human Rights and Drug Policy (2020).

Questions to Think About When Completing Chapter Materials

1. What are the three current international drug conventions? What is the purpose of each? How do they complement each other?
2. How has the UN worked to reinforce drug control regimes such as the U.S. war on drugs?
3. How have international drug control treaties contributed to the marginalization of minority populations across the globe?
4. Despite a loosening of international drug prohibition, there are still many states that support this type of policy. What factors can explain this position, despite the evidence that drug prohibition is a failed policy?

6.1 History of International Drug Controls

As described in previous chapters, prior to the early 20th century, it was common and even socially acceptable to use a variety of substances, both medically and non-medicinally/recreationally. This was the case in Canada, the U.S., and many nations around the world. Beginning in the 1800s, missionaries, church groups, and temperance societies in Canada, the U.S. and U.K. began organizing campaigns for the prohibition of alcohol and other psychoactive substances (Hallowell, 1972, Schweighofer, 1988) (See Chapter on Early Canadian Drug Policy), particularly among minority communities (Andersen,

2007; Belshaw, 2016), resulting in prohibitions on alcohol and other substances. The pressures exerted by religious groups and Temperance leagues helped persuade the United States to "initiate a worldwide anti-drug crusade" (Dion, 1999, para. 21).

The *Shanghai Opium Commission* (1909), a U.S. led initiative (UNODC, n.d.; Sinha, 2001), was the start of the development of international drug control efforts. Over the course of the next 40 years, numerous meetings of the international community were held, resulting in the formation of drug conventions/treaties aimed at strengthening, enhancing, and expanding upon an international drug control system (See Chronology: 100 Years of Drug Control below). Two key developments that occurred during this period of time were the formation of the League of Nations (1919), at the end of World War I, and its subsequent replacement by the United Nations (UN) (1945), formed at the end of World War II – both of which centralized the administration of drug control (Boister, 1996; Heilmann, 2011; Sinha, 2001).

In 1948 efforts began to consolidate the numerous existing drug treaties (Gregg, 1964; Heilmann, 2011; Sinha, 2001). This process took 13 years, resulting in the *Single Convention* (1961), one of three parts of the current international system of drug control. The international drug control efforts that followed include: *The Convention on Psychotropic Drugs* (1971); *The Single Protocol* (1972) (an amendment to the *Single Convention*, 1961), and *The Convention Against the Illicit Traffic in Narcotics Drugs and Psychoactive Substances* (1988) (UNODC, n.d.). Two constant themes run through the international drug control conventions, from 1909 to the present. The first is the differentiation between legitimate and illegitimate use of substances, with legitimate use being for scientific and/or medical purposes (Sinha, 2001). The second is the reinforcement and legitimation of prohibitionist/criminalization policies, both nationally and internationally, as the means by which to control the illegitimate manufacture, trade, and use of psychoactive substances.

UNITED NATIONS
Office on Drugs and Crime

Chronology: 100 years of drug control

1909 — The first international conference about drugs, the Opium Commission, meets in Shanghai.

1912 — The world's first international drug control treaty, the International Opium Convention, is passed in the Hague.

1914 — World War I leads to rapidly rising levels of drug use in several countries.

1919/20 — The International Opium Convention becomes part of the World War I peace treaties, spurring its ratification by many countries.

1920 — The League of Nations is established. The League becomes the custodian of the Opium Convention.

1925 — An upgraded International Opium Convention is passed, extending its scope to cannabis.

1931 — The Convention for Limiting the Manufacture and Regulating the Distribution of Narcotic Drugs aims to restrict the supply of narcotic drugs to amounts needed for medical and scientific purposes.

1936 — The Convention for the Suppression of the Illicit Traffic in Dangerous Drugs becomes the first international instrument to make certain drug offences international crimes.

International drug control transferred from the League of Nations to the newly created United Nations (UN). The UN

United Nations Office on Drugs and Crime Chronology: 100 Years of Drug Control. ©United Nations (n.d.). All rig reserved. Image used with permission.

6.2 The Three International Drug Conventions

The Im

Cont

The International Drug Control Conventions.

The Single Convention on Narcotic Drugs (1961)

By the 1960s, international treaties related to drug control were complex, contradictory, and difficult to enforce (Bewley-Taylor & Jelsma, 2011). As a result, the existing treaties were consolidated into one comprehensive document, The *Single Convention on Narcotic Drugs* (1961). This convention contained a scheduling (classification) system for different classes of drugs and their associated policies (Boister, 1996; Lines, 2010), with cannabis being placed alongside cocaine and opium in the highest and most restrictive schedule (Lande, 1962). It also expanded control measures to include the cultivation of plants that can be used for the production of narcotics and the abolition of traditional uses (e.g., religious and quasi medical uses) of opium within 15 years and coca and cannabis within 25 years of the convention coming into force (Armenta & Jelsma, 2015; Lande, 1962).

The Convention on Psychotropic Substances (1971)

A huge cultural shift occurred in the 1960s and with it increased experimentation with substance use (Wesson, 2011). Many of the psychoactive drugs (e.g., psychedelic drugs/hallucinogens, stimulants, sedatives) used at this time were synthetic in nature, a product of post-World War II pharmaceutical development, and were not included in the *Single Conventions* scheduling system (Armenta & Jelsma, 2015; Sinha, 2001; Wesson, 2011). Discussions over the need for an additional international control mechanism culminated in a meeting in Vienna Austria in 1971 and the signing of the *Convention on Psychotropic Substances*. Although designed using the *Single Convention* as a template, the psychoactive substances convention was heavily influenced by the pharmaceutical industry and as a result contained a much weaker set of controls (Armenta & Jelsma, 2015; Sinha, 2001). Two interesting aspects of the 1971 Convention were that it: (1) introduced drug education and prevention for the first time into international drug control, and (2) permitted alternatives to simply criminal punishment (e.g., treatment, rehabilitation, education, social integration) (United Nations, 1971).

The Convention Against Illicit Traffic in Narcotic Drugs and Psychotropic Substances (1988)

In 1988, the *Convention Against Illicit Traffic in Narcotic Drugs and Psychotropic Substances* was adopted to combat rising rates of drug use, as well as the global illegal drug market, which had expanded into a multi-billion-dollar industry (Armenta & Jelsma, 2015; Sproule & St-Denis, 1990; Transform Drug Policy Foundation, n.d.). It also worked to enhance enforcement against organized crime, specifically requiring countries to adopt criminal sanctions for activities relating to the manufacture, supply, sale and use of drugs (Sproule & St-Denis, 1990; Transform Drug Policy Foundation, n.d.). Through this convention, the prohibitionist nature of international drug control was strengthened, ultimately escalating the war on drugs that was already enfolding in the United States (See Chapter on Drug Prohibition/Criminalization and the War on Drugs) (Armenta & Jelsma, 2015; Sproule & St-Denis, 1990; Sinha, 2001; Stewart, 1990).

Click the following link to learn more about the 3 existing international drug control conventions:

The UN Drug Conventions: A Primer **(Read Pages 1-17)**

VIDEO: ***Professor Julia Buxton – How International Drug Laws Create a Global Health Crisis***

In this video Julia Buxton discusses the international drug control system, including the problems and harm resulting from its continuation.

One or more interactive elements has been excluded from this version of the text. You can view them online here: https://ecampusontario.pressbooks.pub/psychoactivesubstanceuseandsociety2nded/?p=167#oembed-1

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6.3 Recent Changes Relating to International Drug Policy

World Map made up of prescription pills.

UNGASS & Challenges to Prohibition at the International Level

The UN General Assembly Special Session on the World Drug Problem (2016) was a much anticipated and heralded opportunity for the international community to come together with civil society and engage in an open dialogue about drug policy (IDPC, 2016). Despite dissatisfaction with the outcome document reflecting the status quo (Bewley-Taylor & Jelsma, 2016; Ochoa & Nougier, 2017), and frustration with the closed nature of the meetings (i.e., the exclusion of non-governmental organizations from key deliberations, despite a General Assembly Resolution to the contrary) (Jelsma, 2019; Ochoa, 2016), UNGASS (2016) is seen as a pivotal moment in the international drug control debate (Collins, 2018; Ochoa & Nougier, 2017; IDPC, 2016) (Collins, 2018; Ochoa & Nougier, 2017). This moment ushered in "an era based on an evolving understanding of the UN drug control system" (Collins, 2018, p. 107).

Movement away from the harsh prohibitionist style international drug control, promoted over the past

century by the U.S., was signalled by both the lack of consensus at UNGASS 2016 on key issues (i.e., harm reduction, decriminalization and legalization, the death penalty) and the elevation of health and human rights as essential components of drug control (Ochoa & Nougier, 2017). Statements made by UN bodies, Member States, and civil society organizations calling out the lack of attention in the outcome document to a number of important issues (e.g., decriminalization and legalization, and harm reduction) further heralded a movement away from the status quo (Ochoa, 2016). It also pointed to a recognition of the need for flexibility in international drug control, that permits national and international innovations in drug policy (Chatwin, 2015) to better reflect the needs and rights of citizens.

Changes in national policies since UNGASS (2016) further indicate some successful loosening of the strict prohibitionist policies. The legalization of cannabis in Canada in 2018, despite warnings and risks of non-compliance with international law, illustrates how nation states can successfully side-step the international treaties (Habibi & Hoffman, 2018). The UN reclassification of cannabis in 2020 is another signal of change. In response to the World Health Organization's (WHO) recommendations, the *UN Commission for Narcotic Drugs* (CND) moved cannabis from Schedule IV (most dangerous drugs with no therapeutic value) to Schedule I (drugs with some safe and therapeutic value) of the *Single Convention* (1961) (WHO, 2020; UNDP, 2020). In addition, in reaction to the challenging of prohibitionist policies, the UN recently adjusted its stance on drug control to one that promotes human rights and health initiatives, focusing on reversing the harmful effect of prohibitionist control policies (UNDP, 2019).

Click the link below to learn more about the impact of the UNGASS (2016) outcome document as of 2021:

Taking Stock of Half a Decade of Drug Policy: An Evaluation of UNGASS Implementation **(Read pages 9-11)**

VIDEO: *CND 101: A Guide to the United Nations Commission on Narcotic Drugs*

In the following video, Marie Nougier talks about the Commission on Narcotic Drugs (CND), which is the central policy-making body of the UN drug control architecture. The video provides: some background on what the CND does and how it operates; a glimpse into the changing policies at the UN through the International Drug Policy Consortium; and how NGOs are helping to reconstruct legitimate use and prohibition.

One or more interactive elements has been excluded from this version of the text. You can view them online here: https://ecampusontario.pressbooks.pub/psychoactivesubstanceuseandsociety2nded/?p=170#oembed-1

The UN Common Position and the International Guidelines on Human Rights and Drug Policy

In 2019, the UN System Chief Executives Board for Coordination (CED), adopted the UN Common Position (2018). The Common Position is meant to provide a common basis for all UN agencies (UN,

2018), improving UN system coherence (Jelsma, 2019). It incorporates a number of elements from UNGASS (2016), as evidenced in its guiding set of shared principles, that provide support for Member States to develop "truly balanced, comprehensive, integrate, evidence-based, human rights-based, development-oriented and sustainable response to the world drug problem" (CEB, 2018, p. 12). In line with these principles, the Common Position endorses decriminalizing possession and use of drugs scheduled in the international drug conventions (HIV Legal Network, March 2021; UN, 2018).

Following the UN Common Position, in 2020 the International Guidelines on Human Rights and Drug Policy was introduced (November 2020). This policy "highlights the measures that States should undertake or refrain from undertaking in order to comply with their human rights obligations, while taking into account their concurrent obligations under the three international drug treaties" (i.e., *Single Convention on Narcotic Drugs* (1961); *Convention on Psychotropic Substances* (1971); *Convention against Illicit Traffic in Narcotic Drugs and Psychotropic Substances* (1988) (UNDP, 2020, para. 4). Rather than inventing new rights, these guidelines apply existing human rights law to international drug control, in order to ensure human rights protections (UNDP, 2020). The guidelines represent the latest evolution in international drug control.

Click the links below to learn more about new UN drug policy changes:

New UN Guidelines to Mainstream Human Rights in the Global Drugs Debate

Landmark International Guideline Launched on Human Rights and Drug Policy

VIDEO: *Following Up the UN Common Position on Drugs – CND 2020*

The following video outlines the features of the UN Common Position on Drug Policy, published in 2019.

One or more interactive elements has been excluded from this version of the text. You can view them online here: https://ecampusontario.pressbooks.pub/psychoactivesubstanceuseandsociety2nded/?p=170#oembed-2

6.4 Chapter Summary

Key Summary Points

1. The history of international drug control conventions has been a story of ever-increasing prohibition controls on the non-medicinal use of certain psychoactive drugs.
2. The *Single Convention* (1961) consolidates numerous previous drug treaties.
3. The three international drug control conventions currently in force are: the *Single Convention,* 1961; the *Convention on Psychotropic drugs*, 1971; and the *Convention Against the Illicit Traffic in Narcotics Drugs and Psychoactive Substances*, 1988.
4. Although some recent changes within the international community demonstrate support for the

implementation of alternative drug policy options and a loosing of the three international treaties, several powerful Member States continue to support the status quo.

Additional Resources

Below are a list of supplementary resources for students interested in learning more about the chapter topics. These resources are NOT required course materials. A list of required course materials, beyond those found throughout this chapter, are provided on the following page.

Additional Viewings

Green Leaves. (January 15, 2021). *Drug trafficking, politics and power Part 1* [Video]. YouTube. https://www.youtube.com/watch?v=tL6pJITOGwY

RC. (April 21, 2018). *Martin Jelsma: Opening statement, treaties, coca leaf & cannabis prohibitions & other points* [Video]. YouTube. https://youtu.be/khGZXmVFQbU

Additional Readings

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6.5 Required Chapter Materials

In addition to the videos and reading links embedded into the chapter, students are required to complete the following:

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International Drug Policy Consortium (IDPC). (October 10, 2023). *The 2024 Mid-term review: Paving*

the way towards transformative drug policies grounded in reality. https://idpc.net/publications/2023/10/the-2024-mid-term-review-paving-the-way-towards-transformative-drug-policies-grounded-in-reality

Volkow, N., Poznyak, V., Saxena, S., & Gerra, G. (May 12, 2017). Drug use disorders: Impact of public health rather than a criminal justice approach. *World Psychiatry, 16*(2), 213-214. https://doi.org/10.1002/wps.20428

6.6 Chapter Assignment

Assignment Formatting, Style, & Length Requirements

- Assignment formatting requirements: Arial 12-point font; 1-inch/2.54cm margins; single spaced; APA in-text citation style, reference section and cover page.
- Use proper paragraph style within the answer to each question.
- Clearly indicate which question is being answered using corresponding question numbers (do not write out the entire question). Follow-up questions must be answered as part of the numbered question. Avoid using automated numbering as it alters the left margin of the document, resulting in a margin larger than 1-inch/ 2.54cm.
- Assignment length: approximately 1000 words in length (give or take 100 words) (reference section and cover page not included in word count).
- Divide your time/space evenly across all questions.
- Proofread your submission to make sure it is clear, well written and intelligible.

Assignment Instructions

- After completing this chapter's materials (chapter content, including all embedded links to readings and videos, and the required chapter materials) answer ALL the questions below.
- In ALL your answers be sure to demonstrate knowledge of and engagement with the chapter materials. This is achieved through supporting points/arguments/positions via reference to the course material using in-text citations. Providing in-text citations to support your points/arguments/positions is essential and required. Be sure to: (1) use a diverse range of materials, as opposed to relying heavily on a few sources; AND (2) cite material from current AND previously covered chapter materials.
- Only use materials outside of those assigned when specifically instructed to do so.

Assignment Questions

1. What are the 3 international drug related Treaties/Conventions (post-1960)? What is the purpose of each individually? What is the purpose of the 3 collectively?
2. Identify 2 key challenges to the Conventions that result from the UNGASS on Drugs (2016) outcome document, the UN Common Position (2018) and/or the International Guidelines on Human Rights and Drug Policy (2020)? In what way do these challenges speak to the social determinants of health (be sure to cite material on the SDoH from previous weeks)?
3. What is the most significant thing you learned from this week's course material that you did not

already know? How has this knowledge impacted you and your understanding of Canadian drug policy (be sure to cite material on Canadian drug policy from previous weeks)?

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6.7 References & Media Attributions

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Chapter 7: Drug Prohibition & the War on Drugs – Costs & Consequences

Jacqueline Lewis & Jillian Holland-Penney

7.0 Introduction

Chapter Introduction

Prohibitionist-style drug policy is the dominant form of drug control policy within North America and globally. The best-known example of prohibitionist/criminalization policy is the War on Drugs. The aim of this policy is to eliminate or drastically reduce the illegal trade and use of psychoactive substances through police and military actions, criminal justice policies, and draconian sentencing, including mandatory minimum prison sentences. Despite increasing resource investment, the war has not achieved its goals. Rather than eliminating or reducing the trade in and use of psychoactive substances, paralleling the U.S. experience with alcohol prohibition in the early 1900s, the war on drugs has engendered an environment that fuels the growth of illegal markets, organized crime, violent injuries, and death of users, sellers, and police. The fifty-plus years of the war has also had lasting implications on perceptions and treatment of psychoactive substances, their trade, people who use substances (PWUS) and those individuals who develop substance use disorders (SUDs).

This chapter explores the failure of the war on drugs and how it has contributed to a growing array of social costs and consequences. Understanding the failed nature of the drug war and prohibitionist/ criminalization policies more generally, is essential for engaging in a discussion about progressive policy change. As you will learn in future chapters, there is growing support for the use of public health and harm reduction approaches, that treat substance use and SUDs as health rather than criminal justice issues. There is also an increasing recognition of the social benefits of progressive policy options, including decriminalization and legalization.

Chapter Objectives/Learning Outcomes

After completing the chapter materials, you should have an understanding of:

1. Drug prohibition, prohibitionist polices, and anti-drug messages – their functions and uses.
2. Factors that help explain the continuation of failed prohibitionist policies.
3. The costs and consequences of drug prohibition and the War on Drugs.
4. Why alternative policies need to be implemented.

Questions to Think About When Completing Chapter Materials

1. What are some of the costs and consequences of the war on drugs and drug prohibition/ criminalization more generally?
2. Given the evidence demonstrating the failure of drug prohibition policies, how can government inaction to move forward with evidence-based policy be explained?
3. Think of examples of anti-drug and drug prohibitionist rhetoric and propaganda that you have seen in your own life. What evidence-based arguments can be made to counter them?
4. Many people continue to believe that a tough-on-crime approach and prohibitionist policies are required to combat “the drug problem”. Using evidence from the course material from this and previous chapters, how would you explain that the opposite is in fact needed?

7.1 The War on Drugs

Ronald & Nancy Regan and Richard & Pat Nixon (and George Murphy) in California (Between 1965-1975).

Although the U.S. has been engaging in drug wars since the early 1900s, the term "War on Drugs" was introduced by President Nixon in 1971, heralding an escalation of repressive and militarized drug control (Fordham, 2021). In the 1980s, Nixon's policies were reinforced and expanded upon by President Reagan (History.com, 2019; DPA, 2016). During the Nixon and Regan eras, drugs were increasingly constructed as immoral and blamed for ongoing social problems. This served to divert attention from serious social issues including the elimination of social safety nets, the defunding of schools, and unemployment (DPA, 2016).

Today the war on drugs is a global campaign led by the U.S. The construction of drugs that helps fuel the war in the United States has impacted the framing of and meaning attributed to psychoactive substances, PWUS, and drug policy in Canada (Riley, 1998). As detailed in the Chapter on International Drug Control, international law also plays a pivotal role in building and maintaining a global prohibitionist regime (Santos, 2020). Drug criminalization was, and continues to be, one of the most widely accepted forms of social control. Despite all the problems associated with this form of policy, it is still viewed as a reputable, legitimate government approach by all types of government, ranging from democracies to fascist states (Levine, 2003).

Click the following links to learn more about the role of the U.S. in the global war on drugs, some of the vested interests behind the continued vilification of drugs and PWUS, and the maintenance of failed prohibitionist policies:

Vested Interest is the Driver of Prohibition

How the United States Fueled a Global Drug War, and Why it Must End

Prohibition is the Real "Gateway Drug"

VIDEO: *Ethan Nadelmann: Why We Need to End the War on Drugs*

In the following Ted Talk, Ethan Nadelmann, the founder of the Drug Policy Alliance (DPA), explains why prohibitionist drug policy does not work.

One or more interactive elements has been excluded from this version of the text. You can view them online here: https://ecampusontario.pressbooks.pub/psychoactivesubstanceuseandsociety2nded/?p=185#oembed-1

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7.2 Drug War Costs

Criminal Justice Costs

- 

Examples of psychoactive substances.

  Incarceration and mandatory minimum sentences, that are features of prohibitionist policies, are expensive for the state and personally costly for the individuals receiving them (Carter & MacPherson, 2013).

- Using criminal laws and the criminal justice system (police, courts, corrections) to "control a global commodities market is a recipe for disaster" (TED, 2014, 9:13).
- Time, energy, and money spent by law enforcement on drug prohibition takes resources away from other, more serious, and damaging offences (Learn Liberty, 2012).
- From 2014-2019, in Canada there were more than 540,000 arrests for drug offences, with 69%

of them being for simple possession (Ka Hon Chu, 2020; Submission to UN, 2020).
- The Canadian criminal justice system (CJS) costs (police, courts, corrections) tied to substance use laws was estimated to be more than $10 billion in 2020 (Canada, October 2023), up from $6.4 billion in 2017 (Ka Hon Chu, 2020). This is despite the 25% reduction in cannabis-related offences from 2019-2020 tied to the introduction of the *Cannabis Act* (2018) (Canada, October 2023).

Illegal Markets & Violence

The term "Illegal Markets" is used in place of the commonly used term "Black Markets." Click on this link to learn more about this type of language change and why it is important:

Say This Instead

- Drug prohibition policies, not psychoactive substances themselves, create a gateway into illegal markets (Fryklund, September 24, 2015).
- It might seem counter-intuitive that prohibition is not the most effective way to reduce the consumption of a good. However, research and economics (e.g., the law of supply and demand) help us to understand how prohibition generates illegal markets, which leads to other social problems (Learn Liberty, 2012).
- The legal system is not available within illegal markets, so individuals take matters into their own hands and violence becomes the primary mechanism to settle disputes (Learn Liberty, 2012).
- Homicide rates are higher with prohibitionist policies than without them (Learn Liberty, 2012).
- The intervention of government forces is one cause of the violent outcomes of the war on drugs (Santos, 2020).
- A consequence of drug prohibition is that it makes drugs more potent, dangerous, and addictive, demonstrating how prohibition is quite literally killing people through accidental drug poisoning (overdose) or toxic drug poisoning (overdose) (Burrus, 2019).

Click the link below to learn more about some of the hidden costs of prohibitionist policies:

The Hidden Costs of Drug Prohibition

VIDEO: *What You Should Know About Drug Prohibition*

In the following video Angela Dills, a professor at Providence College, explains the economics of drug prohibition and the problematic outcomes that drug prohibition has had on society.

One or more interactive elements has been excluded from this version of the text. You can view them online here: https://ecampusontario.pressbooks.pub/psychoactivesubstanceuseandsociety2nded/?p=188#oembed-1

7.3 Impacts on Marginalized Populations

San Francisco Police Department Stopping a Young Black Man.

One of the biggest consequences of the war on drugs is the overrepresentation of marginalized (i.e., people who are: young, socio-economically disadvantaged, experiencing housing insecurity, experiencing mental health issues, etc.) and racialized people in prison (DPA, 2016; Human Rights Watch, 2016). The war on drugs has made marginalized people more vulnerable to arrest, conviction, and imprisonment for substance use and low-level sales, even though prohibitionist policies are supposed to target high-level trade (CDPC, 2020; DPA, n.d.). For example, African Americans in the US have been consistently constructed as more likely to be involved in the trade/sale and use of drugs (DPA, 2016), rather than overrepresented in criminal justice system statistics (DPA, 2016; Rosenberg et al., 2018). Such inaccurate constructions lead to increased racial profiling by law enforcement, contributing to an enhanced likelihood of arrest and incarceration (DPA, 2016; Rosenberg et al., 2018).

Mode of substance consumption is also associated with differential targeting of marginalized populations tied to the war on drugs. Similar to the problematizing of smoking of opium in Canada in the early 1900s (in contrast with the consumption of laudanum or patent and proprietary opiate-based medicines – See Chapter on Early Canadian Drug Policy), we saw a distinction being made between crack and powder cocaine in the U.S. in the 1980s (DPA, 2016). As Ethan Nadelmann (TED, 2014) explains, part of the reason some drugs are legal, and others are not, or some forms of drugs are differentially regulated than other forms of the same drug (See Chapter 1 Section on Psychoactive Drug Classifications & Effects), has more to do with who is perceived to use them than the science tied to the actual drug and its harms and effects. With regard to crack cocaine, research has shown that beginning in the 1980s both racialized and/or socio-economically disadvantaged populations have been disproportionately targeted for their use of cheaper cocaine in crack form (Vagins & McCurdy, 2006; Palamar et al., 2015).

VIDEO: *What is the Drug War?*

In the following video Jay-Z talks about the war on drugs in the United States and how it has disproportionately impacted marginalized and racialized communities.

One or more interactive elements has been excluded from this version of the text. You can view them online here: https://ecampusontario.pressbooks.pub/psychoactivesubstanceuseandsociety2nded/?p=191#oembed-1

VIDEO: *Every 25 Seconds, Someone is Arrested for Drug Possession in the U.S.*

This video demonstrates the rate at which people are arrested for drug offences and the consequences of criminalizing drugs on marginalized populations in the U.S.

One or more interactive elements has been excluded from this version of the text. You can view them online here: https://ecampusontario.pressbooks.pub/psychoactivesubstanceuseandsociety2nded/?p=191#oembed-2

7.4 Moving Beyond Drug Criminalization

The war on drugs and prohibitionist/criminalization type drug policies more generally have failed to achieve their goals, paralleling past attempts at alcohol prohibition in North America. The critiques of the war point to the importance of basing policy on science/evidence, rather than ideology (CDPC, 2021). One option, covered in more detail in the Chapter on Alternative Drug Policies, is legally regulating and taxing most of the psychoactive substances that are now criminalized. This policy strategy would radically reduce the crime, violence, corruption, illegal markets, and problems of unregulated drugs, as well as improve public safety and better prioritize taxpayer resources (TED, 2014). Ensuring social justice, racial equity, reparations for communities harmed by the war on drugs, involving people with lived and living experience (PWLLE) in planning and policy discussions, and resisting corporate capture, are essential components of future drug policy reform (Fordham, 2021). The redesign of drug policy at all levels (local, provincial/state, federal, global), needs to be public health and harm reduction oriented, incorporating elements of legalization and/or decriminalization of drugs (See Chapter on Alternative Drug Policies).

VIDEO:*Envisage the World After the War on Drugs*

In the following video, members of the Global Commission on Drug Policy outline a pragmatic package to end global drug prohibition.

One or more interactive elements has been excluded from this version of the text. You can view them online here: https://ecampusontario.pressbooks.pub/psychoactivesubstanceuseandsociety2nded/?p=193#oembed-1

7.5 Chapter Summary

Key Summary Points

1. The prohibition of drugs, and more specifically the war on drugs, has not only failed to achieve its stated goals of reducing the use and trade of psychoactive substances, it has fueled poverty, undermined health, and failed socio-economically disadvantaged and marginalized communities throughout the world (Global Health Watch, 2017).
2. Prohibiting drugs through legislation and policy neither decreases supply of nor demand for psychoactive substances. Instead, criminalizing substances simply pushes the drug trade into underground illegal markets, that lack the regulation and control of legal markets. This contributes to reduced product safety, toxic poisoning (overdose) events and death, and a culture of violence used to maintain market control and settle disputes.
3. Other policy solutions rooted in science/evidence, such as those based on harm reduction and public health, can help alleviate the social costs associated with drug use.

Additional Resources

Below are a list of supplementary resources for students interested in learning more about the chapter topics. These resources are NOT required course materials. A list of required course materials, beyond those found throughout this chapter, are provided on the following page.

Additional Viewings

Kurzgesagt – In a Nutshell. (March 2016). *Why the war on drugs is a huge failure* [Video]. YouTube. https://www.youtube.com/watch?v=wJUXLqNHCaI&t=13s

7.6 Required Chapter Materials

In addition to the videos and reading links embedded into the chapter, students are required to complete the following:

Carter, C. & MacPherson, D. (2013). *Getting to tomorrow: A report on Canadian drug policy*. Canadian Drug Policy Alliance (DPA). https://tinyurl.com/y6b7fopo. **(Read pages 75-80).**

Daniels, C., Aluso, A., Burke-Shyune, N., Koram, K., Rajagopalan, S., Robinson, I., Shelly, S., Shirley-Beavan, S. & Trandon, T. (2021). Decolonizing drug policy. *Harm Reduction Journal*, *19*(120). https://doi.org/10.1186/s12954-021-00564-7

Global Health Watch. (December 18, 2017). *The war on drugs: From law enforcement to public health.* https://phmovement.org/wp-content/uploads/2018/07/C6.pdf

Harm Reduction International. (2022). *The death penalty for drug offences: Global overview 2022.* https://hri.global/flagship-research/death-penalty/the-death-penalty-for-drug-offences-global-overview-2022/#:~:text=In%20the%20course%20of%202022,an%20850%25%20increase%20from%202020. **(Read webpage contents NOT full report).**

Santos, A. (October 20, 2020). Drug policy reform in the Americas: A welcome challenge to international law. *American Journal of International Law*, *114*. https://doi.org/10.1017/aju.2020.59

7.7 Chapter Assignment

Assignment Formatting, Style, & Length Requirements

- Assignment formatting requirements: Arial 12-point font; 1-inch/2.54cm margins; single spaced; APA in-text citation style, reference section and cover page.
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- Only use materials outside of those assigned when specifically instructed to do so.

Assignment Questions

1. Much of this chapter's material (and course material to date) explains and demonstrates how prohibitionist drug policies fuel, as opposed to control, drug markets and how such policies exacerbate social harms to the user and society more generally. Using course material (from the current and previous weeks), explain the basis for this perspective on drug policy and how it can be used to advance the case for progressive policy change.
2. How do prohibitionist policies impact health of users and members of society more generally

(be sure to provide examples from the course material to illustrate and support your points/ arguments)? How do the SDoH help us to understand these policy impacts?

3. What is the most significant thing you learned from this week's course material that you did not already know? How has this knowledge impacted you and your understanding of existing drug control?

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7.8 References & Media Attributions

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Cover Photo: Pickering, V. (May 2017). *No more drug war* [Photograph]. Flickr. https://www.flickr.com/photos/vpickering/34571201971

VIII

Chapter 8: Alternative Drug Control Policies

Jacqueline Lewis, Jillian Holland-Penney & Brandon Bernardon

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8.0 Introduction

Chapter Introduction

As noted in previous chapters (See Chapters on Canadian Drug Policy, and Drug Prohibition & the War on Drugs), prohibitionist-based drug policy, such as criminalization policies tied to the war on drugs, are ineffective at deterring the trade or use of psychoactive substances. Instead, such policies have had

disastrous consequences, contributing to drug-related harms for PWUS and society more generally (IDCP, 2022, p. 5). As the voices of civil society calling for drug policy reform (e.g., public health workers, scientists, PWUS, and social advocacy groups) grow increasingly louder, the conversation around drug policy is gradually shifting away from criminalization towards health and human rights (e.g., UNGASS 2016; CEB, November 2022). Some countries are also enacting alternative drug control frameworks in the form of decriminalization or legalization. This chapter explores these policy alternatives and their potential benefits.

Chapter Objectives/Learning Outcomes

After completing the chapter materials, you should have an understanding of:

1. Drug decriminalization, its various forms and benefits.
2. Drug legalization, its various forms and benefits.
3. The key differences between decriminalization and legalization.
4. Examples of existing drug decriminalization and legalization.

Questions to Think About When Completing Chapter Materials

1. Given the demonstrated benefits of alternative drug control policies, why are countries not decriminalizing or legalizing more psychoactive substances?
2. What is the difference between de jure and de facto decriminalization?
3. Most efforts to reform drug policy have focused on cannabis. If we were to change the current Canadian laws governing opioids, what form should the new policy take (decriminalization or legalization) and why?
4. How do alternative drug control policies work in alleviating the harms tied to drug use, for both PWUS and society?

8.1 What is Decriminalization?

The gold standard of decriminalization "is removing all sanctions for the use of all controlled substances (those restricted by the international and national drug control regimes) and related activities and achieving improved outcomes for public health and human rights" (IDCP, 2022, p. 8).

DECRIMINA

Drug use

Possession

Cultivation

WHAT?

Removal of criminal penalties for selected activities related to **drug use**

Possession of paraphernalia

Purchase for personal use

Over 50 jurisdictions around the world have enacted some form of decriminalisation.

WHO

A growing nu
authorities enc
impleme
decriminali

Source: International Drug Policy Consortium (2016), *IDPC Drug Policy Gu*

IDPC (2022). All rights reserved. Image used with permission.

Falling short of the "gold standard" of decriminalization outlined by the International Drug Policy Consortium (IDPC) (2022), the concept of decriminalization has generally been used to refer to a range of policies that aim to reduce the negative impact of prohibitionist policies for PWUS (Greer et al., 2022; Jesseman & Payer, 2018). In practice, decriminalization policies involve the elimination or substantial reduction of penalties for possessing small amounts of an otherwise illegal/controlled substance (MacCoun & Reuter, 1999; Jesseman & Payer, 2018). Possession is usually the focus of decriminalization efforts, with manufacture and trade remaining illegal.

Among the wide range of decriminalization policies that exist, there are various outcomes that can result from being found in possession of a controlled substance. Whether or not there are penalties associated with simple possession (possession for personal use, with no intent to sell), depends on how the policy is formulated. Policies can range from full decriminalization (i.e., no penalties) to policies that include civil/non-criminal penalties (i.e., fines), or diversion (i.e., referral to education, social and/or health services) (Greer, et al., 2022; Jesseman & Payer, 2018; Stevens et al., 2019).

There are two forms of decriminalization policies, de facto and de jure. One involves changes to the legislation, while the other does not. Under a de facto decriminalization framework, an administrative decision has been made to not prosecute certain acts, usually simple possession of a controlled substance (IDPC, 2022; Jesseman & Payer, 2018; Stevens et al., 2019). Since there is no legislative change, possession technically remains illegal, but is assigned a low priority by police and the criminal justice system (CJS). The roots of the Dutch Coffeeshop model provide an example of a de facto form of decriminalization (Stevens et al., 2019).

In contrast, de jure decriminalization involves amendments to criminal legislation. In the case of substance use, criminal legislation is typically modified to permit simple possession (IDPC, 2022; Jesseman & Payer, 2018; Stevens et al., 2019), although decriminalization frameworks can include more than simple drug possession (for examples see the IDPC 2022 discussion of the gold standard of drug decriminalization; and the proposed changes to Canadian policy detailed in the CDPC report, 2022). The 2001 changes to Portuguese criminal law, making possession of up to a 10-day supply of any illegal substance an administration offence, is an example of de jure decriminalization (Jesseman & Payer, 2018).

Some benefits of adopting decriminalization polices include:

1. Respecting human rights by promoting social inclusion of PWUS (IDCP, 2022).
2. Reducing socio-economic costs of criminalization on the individual, including helping PWUS maintain jobs and housing (IDCP, 2022).
3. Reducing drug-related arrests and the associated CJS costs tied to police, courts, and corrections (Bonn, 2020).
4. Reducing social harm caused by drug criminalization/prohibition (IDPC, 2021).
5. Improving health outcomes for PWUS, through the availability of inclusive, non-judgmental, harm reduction, treatment and intervention, and general health services (IDPC, 2022).

Click the links below to learn more about drug decriminalization:

Decriminalizing People Who Use Drugs: A Primer for Municipal and Provincial Governments

(Download and read the document)

The Decriminalisation of People Who Use Drugs: An Essential Component of a Human Rights-Based Approach to Drug Policy **(Download and read Submission in English)**

VIDEO: *Calls to Decriminalize Drugs Grow Louder During Pandemic*

The following video illustrates the increasing support for decriminalization among Canadians during the Covid-19 pandemic.

One or more interactive elements has been excluded from this version of the text. You can view them online here: https://ecampusontario.pressbooks.pub/psychoactivesubstanceuseandsociety2nded/?p=208#oembed-1

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8.2 Examples of Decriminalization

Some version of drug decriminalization exists in over 30 countries around the world (IDPC, 2022). Although most of these efforts at decriminalization are a product of the twenty-first century, decriminalization is not a new policy. For example, in 1976, the Netherlands introduced a decriminalization framework that made possession and supply of soft drugs (e.g., cannabis) the lowest priority for police and prosecutors, and permitted the possession of single doses of harder drugs (Rosmarin & Eastwood, 2012). During the 1970s, 11 US states adopted cannabis decriminalization, making the possession of small amount of cannabis for personal use a non-criminal offence (Mooney-Scott, 2010). And, in 1987, South Australia (SA) decriminalized cannabis, "introducing an option to pay a fine instead of receiving a criminal charge" (ADF, October 13, 2023, para. 8). This section outlines some key aspects of more recent drug decriminalization efforts in Portugal, Oregon and the USA, and Canada.

Portugal

Government Buildings in Lisbon, Portugal.

In 2000, Portugal decriminalized the possession of all drugs for personal use (Greenwald, 2009). Since then, drug possession/use is no longer treated as a criminal offence (Transform Drug Policy Foundation, 2021). However, if the police find someone in possession of a drug, the substance is confiscated and the person is referred to a panel of experts, known as Commissions for the Dissuasion of Drug Addiction (CDT). CDTs have the power to impose fines and refer PWUS for treatment services (Transform Drug Policy Foundation, 2021; Greenwald, 2009). In addition to decriminalizing drug possession, Portugal also implemented and expanded programs aimed at helping people experiencing substance use disorders (SUDs) (Greenwald, 2009) and has moved to an evidence-based approached to drug education (Transform Drug Policy Foundation, 2021). Click the link below to learn more about how Portugal tackled its drug problem.

Outcomes of Drug Decriminalization in Portugal Include:

1. A reduction in drug-related deaths.
2. Low levels of drug use, consistently below the European average.
3. A substantial decline in the number of people in prison on drug-related offences.
4. Declining HIV diagnoses linked to drug use.
5. The expansion of treatment and harm reduction services.

(Greenwald, 2009; Transform Drug Policy Foundation, 2021).

VIDEO: How Portugal Successfully Tackled its Drug Crisis

This video explores the Portugal's unique approach to drug policy and to helping people experiencing substance use disorders (SUDs). **(Click "Watch on YouTube" below to access the video)**

One or more interactive elements has been excluded from this version of the text. You can view them online here: https://ecampusontario.pressbooks.pub/psychoactivesubstanceuseandsociety2nded/?p=213#oembed-1

Oregon & USA

Oregon State Capitol.

In November of 2020, Oregon passed Measure 110 and became the first state in the US to vote to decriminalize the possession of small amounts of illegal drugs (Transform Drug Policy Foundation, 2021; DPA, 2021; Lopez, 2020). Although the Measure was approved by 58% of voters in 2020 (Rush, September 1, 2024), Oregonian's quickly became disillusioned with the policy change and on Sunday September 1, 2024, drug decriminalization ended in the state. According to the Drug Policy Alliance (February 2024, p.1), the failure of the policy was the result of "an intense disinformation campaign by drug war defenders and by Oregon leaders who scapegoated Measure 110 [and PWUS] for every social issue in the state."

Oregon's House Bill 4002 reinstates the prohibition on possession of small amounts of illegal substances. The new Bill makes possession of illegal substances for personal use a criminal misdemeanor punishable with up to 6 months in jail. The House Bill also permits counties to opt into a "deflection program". Such programs allow counties to refer people to treatment programs instead of jail. As of September 1, 2024, 28 of the state's 36 counties have applied for grants to fund deflection programs (Rush, September 1, 2024). However, since counties are permitted to opt in or not, and those that opt in have "broad leeway" to "craft their own deflection systems" this will likely lead to disparities in how PWUS are treated across the state (VanderHart, August 22, 2024, para. 35-39).

Click the following links to learn more about what lead to the demise of Measure 110 in Oregon and House Bill 4002:

Oregon's Measure 110: What Really Happened.

Drug possession is a crime again in Oregon. Here's what you need to know.

Canada

Canadian parliament buildings.

Decriminalization is not strictly limited to the personal possession of illegal drugs, but also extends to legal exemptions from criminal charges in situations where a person may normally be charged. The *Canadian Good Samaritan Drug Overdose Act* (2017), for instance, provides protection to people who call 911 in the event of a drug poisoning (overdose), even if the person making the call has consumed and/or is in possession of an illegal substance (Moallef et al., 2021). Other examples of exemptions in Canada include supervised injection sites (SIS)/supervised consumption services (SCS) (See Chapter on

Harm Reduction), where drugs can be tested prior to use, clean/safe supplies/equipment are provided, and Narcan is readily available in the event of drug poisoning (overdose) (WHO, 2021).

Currently in Canada, in response to the opioid crisis and the rate of toxic drug poisoning (overdose) deaths, there is a push to decriminalize the possession of small amounts of all controlled substances. The recommendations of the Health Canada Expert Task Force on Substance Use (2021) support this position (see below). The Canadian Drug Policy Coalition's (CDPC) 2022 report, *Decriminalization Done Right* (see below), goes even further in their recommendations, calling for the full decriminalization of not only possession for personal use, but also sharing and/or selling in certain circumstances (i.e., for subsistence, to help with costs associated with personal use, and to ensure a safe supply) (CDPC, 2022).

An example of a stop-gap measure related to the Health Canada Expert Task Force recommendations, is the CDSA subsection 56(1) exemption granted to British Columbia in 2023 (from January 31, 2023 to January 31, 2026), to assist with efforts to respond to the drug poisoning (overdose) crisis in the province. Under the exemption adults found in possession of small amounts of certain illegal drugs for personal use are not subject to criminal charges (Canada, September 14, 2023, para. 2). The exemption was amended in May 2024 at the request of the Government of B.C. The provincial government requested that the exemption be modified to make it illegal to consume illegal substances in public spaces in the province (Health Canada, September 7, 2024). According to the amendment, Adults are still permitted to possess small amounts of illegal substances for personal use, but can only consume them "in private spaces and legal residences, overdose prevention centres, or other facilities operated by harm reduction organizations" (Singer, May 8, 2024, para. 4).

Click the following links to learn more about the B.C. Health Canada exemption:

No, Canada did not recriminalize drugs in British Columbia. CATO Institute.

Click the following links to learn more about recommendations for decriminalization in Canada:

Decriminalization Done Right: A Rights-Based Path for Decriminalization Policy **(Read Pages 2-4)**

Report #1: Recommendation on Alternative to Criminal Penalties for Simple Possession of Controlled Substances **(Read Executive Summary Pages ii-iii)**

VIDEO: *Canada's Police Chiefs Call for Decriminalization of Drug Possession for Personal Use*

In this video we hear from Canada's chiefs of police about their recommendation to end the prohibition of simple possession of illegal substances.

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8.3 What is Legalization?

How Do We End the Overdose Crisis?

Legalization refers to the removal of all criminal penalties for possession and personal use of a substance. Unlike decriminalization where there is no legal source of supply, under a legalization framework, the drug supply is moved from the illegal to legal market (Bogart, 2020; Toronto Public Health, 2018). Government regulations dictate how a substance can be legally produced, sold, taxed, and consumed, with a focus on ensuring product quality, and limiting both availability and product promotion (Bogart, 2020; Room, 2018). Legalization policies can take various forms, such as those regulating alcohol, tobacco, and pharmaceutical drugs. Under legalization frameworks, there are still activities that are classified as illegal, including selling to a minor or acting outside the legal framework. Recent examples of the enactment of legalization policies mostly pertain to cannabis, but there is a growing movement to legalize the use of psilocybin (magic mushrooms), at least as a medical therapy (see Chapter on the Cannabis & Emerging Psychedelic Industries).

Some benefits of adopting public-health oriented legalization polices include:

1. Respecting human rights by promoting social inclusion of PWUS (IDCP, 2022).
2. Reducing socio-economic costs of criminalization on the individual, including helping PWUS maintain jobs and housing (Hall, 2020; IDCP, 2022).
3. Improving health outcomes for PWUS through the availability of inclusive, non-judgmental, harm reduction, treatment and intervention, and general health services (Cussen & Block, 2003; IDPC, 2022).
4. Reducing individual and social harm caused by drug criminalization/prohibition and the

associated illegal market (Cussen & Block, 2003; IDPC, 2021).
5. Reducing crimes tied to an illegal drug market (e.g., theft, violence, organized crime) (Cussen & Block, 2003).
6. Reducing drug-related arrests and the associated CJS costs tied to police, courts, and corrections (Cussen & Block, 2003; Bonn, 2020).
7. Generating revenue from taxes (and CJS savings) that can be used for evidence-based drug education, substance treatment and intervention services, general health services and other social purposes (Cussen & Block, 2003; Hall, 2020).
8. Increasing the regulatory power of governments over substances, via controls that are not available with an illegal market/source of supply (Hall, 2020).
9. Ensuring product purity/quality (Hall, 2020).
10. Improving access and quality control for medicinal users (Hall, 2020).

VIDEO: *What are the Five Models of Regulation?*

This video provides an overview of a tiered structure that could be implemented to effectively control certain substances, while also legalizing the use of substances that are currently illegal to use in certain forms.

One or more interactive elements has been excluded from this version of the text. You can view them online here: https://ecampusontario.pressbooks.pub/psychoactivesubstanceuseandsociety2nded/?p=216#oembed-1

VIDEO: *The Reality of Legalizing Cocaine, Heroin, and Ecstasy: The War on Drugs*

The following video explores the failures of the US drug war and some of the complexities associated with legalizing drugs. **(Click "Watch on YouTube" below to access the video)**

One or more interactive elements has been excluded from this version of the text. You can view them online here: https://ecampusontario.pressbooks.pub/psychoactivesubstanceuseandsociety2nded/?p=216#oembed-2

8.4 Examples of Legalization

The Ontario, Canada seal for cannabis products.

- In 1996, California became the first US state to legalize medical cannabis (Reuters, 2022). By April 24, 2023, 38 states, three territories and the District of Columbia had followed suit (NCSL, June 22, 2023).
- In 2012, Washington and Colorado became the first two US states to legalize recreational cannabis (Coffman & Neroulias, 2012; Hansen et al., 2022). This number has steadily increased and as of November 8, 2023, 24 states, two territories and the District of Columbia regulate the production, sale, and recreational use of cannabis products (NCSL, June 22, 2023).
- In 2013, Uruguay became the first country in the world to fully legalize both cannabis possession and a cannabis supply chain (Queirolo, 2020). To access or grow cannabis, Uruguayans must register with the government. Cannabis supply can either come from licensed pharmacies or by growing it, individually or as part of a cannabis grower's club (Hall, 2020).
- In October 2018, Canada became the second nation in the world to legalize recreational cannabis via the *Cannabis Act.* The Act was amended one year later to allow for the production, sale and use of cannabis edibles (Canada, 2021; Canada, 2019). The Canadian policy is framed as a public-health oriented approach (i.e., advertising bans, plain packaging requirements, taxes tied to THC content) (Hall, 2020).
- In November 2020, Oregon passed Measure 109: Psilocybin Program Initiative. This initiative legalizes psilocybin for use in supervised and licensed therapy sessions to qualifying individuals over 21 (Roberts, 2020).

One Plant Cannabis Dispensary in Windsor, ON Canada.

Click the links below to learn more about the Cannabis Act (2018) and cannabis legalization in Canada:

Cannabis Legalization and Regulation

Final Regulations: Edible Cannabis, Cannabis Extracts, Cannabis Topicals

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8.5 Chapter Summary

Key Summary Points

1. Decriminalization refers to a range of policies that reduce the negative impact of prohibitionist policies. Criminal penalties tied to possession are replaced by civil penalties or diversion, and in some cases, no penalties at all. The two forms of decriminalization are de facto and de jure.
2. Decriminalization and legalization can be used to address the costs and consequences resulting from criminalization policies, including addressing public health issues.
3. Legalization refers to the removal of all criminal penalties for possession and personal use. A government regulatory framework is used to control production, sale, taxation, and consumption.

Additional Resources

Below are a list of supplementary resources for students interested in learning more about the chapter topics. These resources are NOT required course materials. A list of required course materials, beyond those found throughout this chapter, are provided on the following page.

Additional Readings

Drug Policy Alliance (DPA). (November 3, 2021). *Drug decriminalization in Oregon, one year later: Thousands of lives not ruined by possession arrests, $300 million+ in funding for services*. https://drugpolicy.org/press-release/2021/11/drug-decriminalization-oregon-one-year-later-thousands-lives-not-ruined

International Drug Policy Consortium (IDCP). (February 10, 2022). *Decriminalisation of people who use drugs: A guide for advocacy.* https://idpc.net/publications/2022/02/decriminalisation-of-people-who-use-drugs-a-guide-for-advocacy

Russoniello, K., Vakharia, S., Netherland, J., Naidoo, T., Wheelock, H., Hurst, T., & Rouhani, S. (2023). Decriminalization of drug possession in Oregon: Analysis and early lessons. *Drug Science, Policy and Law*, *9*, 1-16. https://journals.sagepub.com/doi/10.1177/20503245231167407

8.6 Required Chapter Materials

In addition to the videos and reading links embedded into the chapter, students are required to complete the following:

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Canadian Drug Policy Coalition (CDPC). (October 7, 2020). *Discussion guide: Getting to tomorrow – Ending the overdose crisis, beyond COVID-19*. https://gettingtotomorrow.ca/wp-content/uploads/2020/10/Discussion-Guide-EN.pdf **(Read pages 30-32).**

Ghosh, S. (February 17, 2021). *Changing how police departments respond to overdose calls could save lives*. CBC.ca. https://www.cbc.ca/news/opinion/opinion-police-response-to-overdose-calls-1.5893257

Jesseman, R. & Payer, D. (June 2018). *Decriminalization: Options & evidence*. Canadian Centre on Substance Use & Addiction. https://www.ccsa.ca/sites/default/files/2019-04/CCSA-Decriminalization-Controlled-Substances-Policy-Brief-2018-en.pdf **(Read pages 1-10).**

Lee, N. (November 2, 2023). *When Oregon decriminalised drugs, overdoes went up. Will that happen in the ACT?* The Conversation. https://theconversation.com/when-oregon-decriminalised-drugs-overdoses-went-up-will-that-happen-in-the-act-216736

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8.7 Chapter Assignment

Assignment Formatting, Style, & Length Requirements

- Assignment formatting requirements: Arial 12-point font; 1-inch/2.54cm margins; single spaced; APA in-text citation style, reference section and cover page.
- Use proper paragraph style within the answer to each question.
- Clearly indicate which question is being answered using corresponding question numbers (do not write out the entire question). Follow-up questions must be answered as part of the numbered question. Avoid using automated numbering as it alters the left margin of the document, resulting in a margin larger than 1-inch/ 2.54cm.
- Assignment length: approximately 1000 words in length (give or take 100 words) (reference section and cover page not included in word count). Divide your time/space evenly across all questions.
- Proofread your submission to make sure it is clear, well written and intelligible.

Assignment Instructions

- After completing this chapter's materials (chapter content, including all embedded links to readings and videos, and the required chapter materials) answer ALL the questions below.
- In ALL your answers be sure to demonstrate knowledge of and engagement with the chapter materials. This is achieved through supporting points/arguments/positions via reference to the course material using in-text citations. Providing in-text citations to support your points/arguments/positions is essential and required. Be sure to: (1) use a diverse range of materials, as opposed to relying heavily on a few sources; AND (2) cite material from current AND previously covered chapter materials.

- Only use materials outside of those assigned when specifically instructed to do so.

Assignment Questions

1. What do decriminalization and legalization mean in terms of drug policy (be sure to define the concepts)? Choose a psychoactive substance covered in Chapter 1 and compare/contrast what a decriminalized policy versus a legalized policy could look like.
2. What is potentially the quickest way to implement a decriminalization policy in Canada to address the current opioid crisis? How would this policy help address the health and human rights challenges, and harms caused by the current criminalization/prohibitionist policies? How would this change fit within Canada's obligations under the UN Drug Conventions?
3. What is the most significant thing you learned from this week's course material about drug policy alternatives that you did not already know? How has this knowledge impacted you and your understanding of existing drug control policy and the need for policy change?

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IX

Chapter 9: Stigma & People who Use Drugs

Jacqueline Lewis, Jackie Durocher & Jillian Holland-Penney

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9.0 Introduction

Chapter Introduction

One of the biggest challenges faced by people who use drugs (PWUS) and people experiencingsubstance use disorders (SUDs) is the stigma associated with psychoactive substances, particularly their use. Stigma involves the discrediting of an individual due to some perceived moral failing, disgrace, or defect in character. It negatively impacts how an individual is viewed and treated by others and how they may come to view themselves. In terms of health issues, stigma can also impact health and well-being and treatment outcomes. This chapter explores: the concept of stigma; the sources of drug-related stigma; the consequences of this stigma on individuals; and ways to move forward with positive social change, that best supports PWUS as part of the communities in which they live.

Chapter Objectives / Learning Outcomes

After completing the chapter materials, you should have an understanding of:

1. What is meant by stigma.
2. The three different types of stigma.
3. Examples of stigmatizing language and actions to avoid.
4. How policies can generate and reinforce stigma within society.
5. How stigma impacts PWUS.
6. The ways stigma acts as a barrier to creating social change.
7. Strategies to combat stigma.

Questions to Think About When Completing Chapter Materials

1. What are some examples of stigmatizing behaviour and language that you have witnessed or experienced in your own life? Based on what you have learned through this chapter's materials, how would you respond to and challenge such behaviour and use of language?
2. Of the early and contemporary policies covered earlier in the course, which have promoted structural stigma? How have they done this?
3. Consider what stigma is and reflect on how certain populations experience social stigma. How can we combat different forms of societal stigma?
4. Going forward, what strategy/strategies will you use to eliminate stigma and promote social change?
5. What are alternative drug policy options that can be implemented to combat stigma? How would implementing these policies address stigma?

9.1 What is Stigma?

According to Erving Goffman (1963, p. 3), stigma "refers to an attribute that is deeply discrediting," symptomatic of a moral failure, or a failure to live up to social norms. Such attributions can lead to marginalization and social exclusion (Lewis et al., 2013), and negatively impact identity, a sense of dignity (Villa, 2022), and one's health and well-being (Lewis et al., 2013). As the Health Canada (2019) publication *Why Words Matter* (see below) explains, stigma affects individuals or groups through prejudice, discrimination, judgement, or stereotypes. All of these are common experiences among PWUS. Experiencing stigma also makes it more challenging for impacted individuals to fully participate and engage in social and community life.

Click the link to learn more about how and why language can contribute to stigma:

Stigma: Why Words Matter

There are three main inter-related sources of drug-related stigma: prohibitionist style drug polices; attitudes and beliefs about psychoactive substances and the people who use them; as well as the use of

language/terminology pertaining to PWUS and those experiencing SUDs. How substances are regulated impacts the treatment and perceptions of PWUS. Prohibitionist style policies and the war on drugs (See Chapters on Canadian Drug Policy and War on Drugs) depict PWUS as problematic. They are blamed for many social issues/problems (e.g., crime, violence, poverty, urban decay, increasing police and medical care costs, etc.) as well as their own substance use issues (Dufton, 2012; Vincent, 2019).

Depicting PWUS as blameworthy not only deflects attention from the role of the state and its policies in the creation and maintenance of the social problems. It also creates a scapegoat for those problems (Friedman, 1998). Such scapegoating reinforces and perpetuates negative stereotypes of PWUS, that are reflected in language/ terminology. For example, the common application of negative labels, such as "addict", "junkie" or "abuser" to refer to PWUS and people experiencing SUDs, reproduces stereotypes and constructs substance use as the most important aspect of their identity (Jaffe, 2018).

VIDEO: *Words Matter*

The following video talks about the power of words and the importance of using respectful, medically accurate, person-first language.

One or more interactive elements has been excluded from this version of the text. You can view them online here: https://ecampusontario.pressbooks.pub/psychoactivesubstanceuseandsociety2nded/?p=234#oembed-1

9.2 Types of Stigma

Health Canada (2019) identifies three different types of stigma that pertain to substance use:

1. **Self-stigma** occurs when someone internalizes negative messages about PWUS and applies these messages to themselves.
2. **Social stigma** occurs when negative attitudes or behaviours about psychoactive substances and substance use are applied to PWUS and/or their friends and family.
3. **Structural stigma** is a by-product of policies, including those in health and social services, that increase stigma and barriers for people experiencing SUDs from getting help.

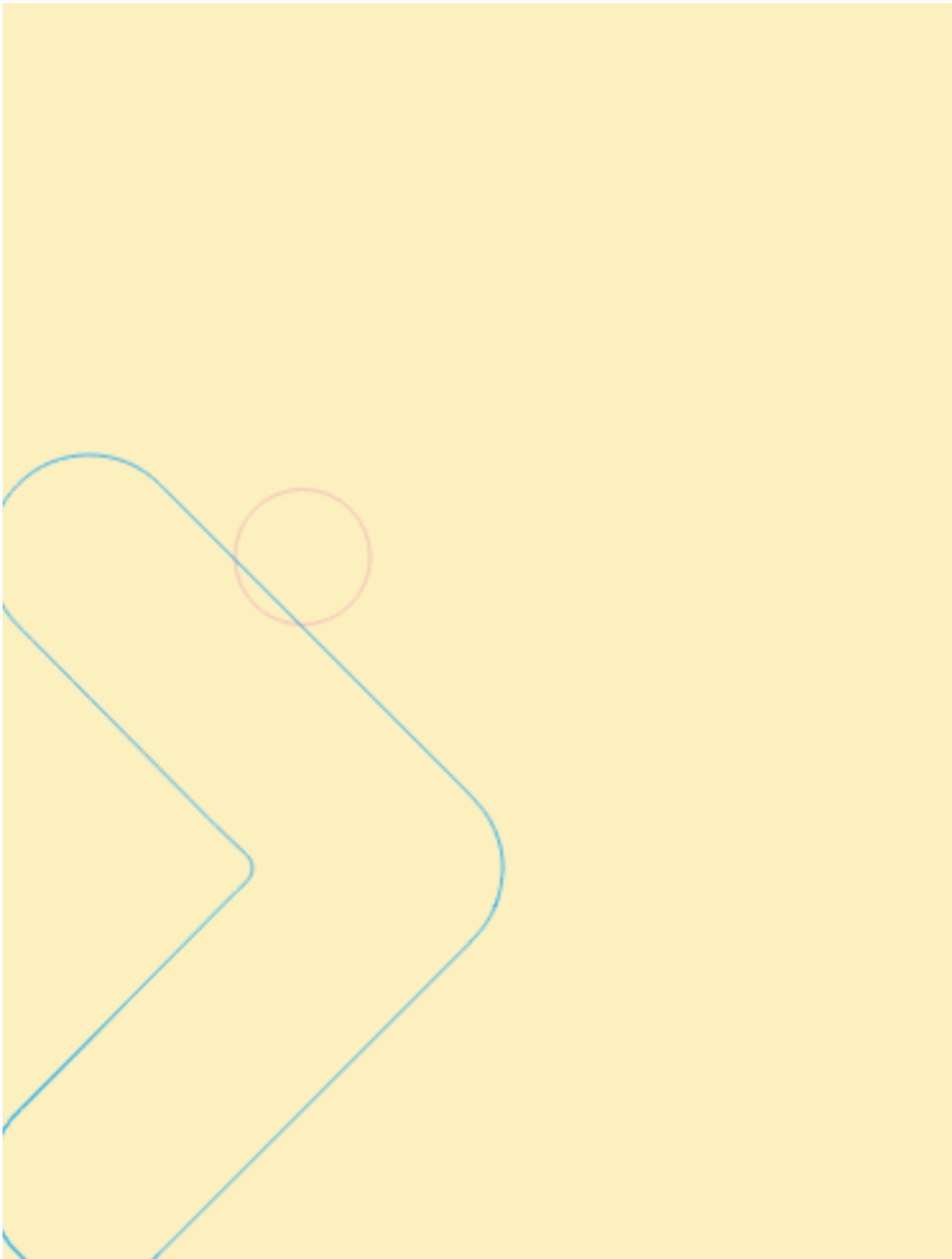
Self-stigma can take the form of low self-esteem and negative self-image tied to equating the person with their substance use (Committee on the Science of Changing Behavioural Health Social Norm et al., 2016). Social stigma may consist of prejudice, avoidance, rejection, and discrimination against people who have a socially undesirable trait or engage in culturally marginalized behaviours, such as substance use (Link & Phelan, 2001). And structural stigma (see following chapter sections for a more detailed discussion) can take the form of prohibitionist policies that criminalize and demonize substance use, perpetuating negative stereotypes of PWUS and the social stigma they experience (Committee on the Science of Changing Behavioural Health Social Norm et al., 2016).

9.3 Recognizing the Impacts of Stigma

Mental Health Word Collage.

Experiencing stigma can be incredibility detrimental. For PWUS, it can impact their health and well-being, as well as treatment and recovery efforts. Those experiencing stigma often feel alone and lack support, which can give rise to feelings of loneliness and isolation. Stigmatization also contributes to feelings of shame, low self-esteem, and a sense of social exclusion/not belonging, resulting in internalizing negative thoughts and beliefs about oneself (CCSA, 2019; Borenstein, 2020). A poor sense of self resulting from stigma can lead to difficulties in social situations, relationships, and at work, as well as to mental health issues (Borenstein, 2020). Internalized shame can also result in PWUS believing that they are uncared for/unloved and undeserving of help (CCSA, 2019). All of this contributes to a sense of hopelessness that makes it difficult for PWUS to access resources important for health, healing, and recovery (Borenstein, 2020).

Click the image below to access and complete the first of three interactive modules developed by the Canadian Centre on Substance Use & Addiction (CCSA). The module is designed to help improve your understanding of the consequences of stigma (Note: This module will resume where you left off. To re-start the module from the beginning, open a new Incognito Window (Chrome), Private Window (Safari, Firefox), or InPrivate (Edge)).



9.4 A Health Condition, not a Moral Failing

As noted in several chapters in this book, drug use has often been constructed as a moral failing that contributes to the stigmatization of PWUS and people experiencing SUDs. Such negative views of PWUS fail to take into account the science behind substance use and SUDs. Often ignored is the role played by the SDoH (See Chapter on SDoH) and substance use-related chemical changes (i.e., Dopamine) that occur in the brain (See Chapter on Understanding Substance Use Disorders & Addiction), on people experiencing SUDs (CCSA, 2019; Hardee, 2017). Instead, the individual is blamed for their "choices" and "lack of willpower."

VIDEO:*Shaming the Sick: Substance Use and Stigma*

The following video provides examples of stigmatizing language and explains the link between stigma and substance use.

One or more interactive elements has been excluded from this version of the text. You can view them online here: https://ecampusontario.pressbooks.pub/psychoactivesubstanceuseandsociety2nded/?p=243#oembed-1

Click the image below to access and complete the second of three interactive modules developed by CCSA that provides insight into substance use disorders (Note: This module will resume where you left off. To re-start the module from the beginning, open a new Incognito Window (Chrome), Private Window (Safari, Firefox), or InPrivate (Edge)).

Under

9.5 Implications of Stigmatizing Drug Policy

Public stigma persists in part because of structural stigma in the form of laws, regulations, and policies that endorse prejudice and discrimination against PWUS (Committee on the Science of Changing Behavioral Health Social Norm et al., 2016). Laws and policies resulting from the war on drugs, for instance, are one of the ways drug-related stigma is perpetuated in society (Transforming Drug Policy Foundation, 2015) (See Chapter on Drug Prohibition/Criminalization & the War on Drugs). The war on drugs has created harsh laws that criminalize psychoactive substances use, treating PWUS and people experiencing SUDs as deviant and criminal, while also reinforcing negative perceptions of people who use illegal substances (Transforming Drug Policy Foundation, 2015).

Prohibitionist policies also make it difficult for people experiencing SUDs to enter treatment and/or access medical assistance. Criminalization policies often prohibit or place restrictions on harm reduction interventions and other public health approaches to substance use treatment (See Chapter on Harm Reduction). An example of this is the *National Drug Strategy* (2007), that removed harm reduction as a pillar of the *Canadian Drugs and Substances Strategy* (Owusu-Bempah & Luscombe, 2021) (See Chapter on Contemporary Canadian Drug Policies).

On November 4th, 2015, Governor Charlie Baker announced a statewide campaign that had the goal of making Ma 2015). The campaign was designed to end stigma tied to SUDs (Baker, 2015; Massachusetts Government, n.d.).

VIDEO: *Health and Harm Reduction: Rethinking Conventional Drug Use and Policy*

The following video challenges us to rethink contemporary drug policies that stigmatize people who use drugs and offers solutions in line with a harm reduction model of intervention.

One or more interactive elements has been excluded from this version of the text. You can view them online here: https://ecampusontario.pressbooks.pub/

9.6 Person-First Language

Language Matters.

Language is a powerful social tool that shapes how we view the world. It also has a direct impact on those around us (Health Canada, 2018). Although the application of certain forms of language and labelling can lead to social and self-stigma, the opposite is also true – language can be used to combat stigma. Reframing the way we speak can have a profound impact on how people are viewed and treated. The use of person-first language is an important part of such a language shift. The term "people who use substances" (PWUS) is an example of person-first language. Such language works to combat stigma by putting the person before their substance use (Health Canada, 2019). Rather than prioritizing the use of substances, we prioritize the person. People who use substances are first and foremost people, who happen to use substances or who are experiencing a SUD. When we use this type of language, we reinforce and prioritize the PWUS as a person, rather than equating them and their identity with their substance use. This is the first step we can take to make a difference and support PWUS and those who experience SUDs.

Examples of person-first language include:

- People who use drugs (PWUD)
- People/person who uses substances (PWUS)
- Person experiencing a substance (drug/alcohol/opioid) use disorder (SUD)
- Person who occasionally uses substances/drugs
- Person with lived and living experience (PWLLE) of substance use
- Person who engages in heavy episodic alcohol consumption or substance use

(CCSA, 2019; Health Canada, 2018).

After learning how to speak compassionately about PWUS, the next step to helping eradicate substance use-related stigma is by sharing what we have learned with friends, family, and members of the community in which we live, work and play (Health Canada, 2019). In taking steps to help eliminate social biases and the use of stigmatizing language, we as a society can begin the process of reconstructing how PWUS are perceived, referred to and treated, thereby promoting positive change.

Click the links below to learn more about how we can combat stigma through language:

Changing How We Talk About Substance Use

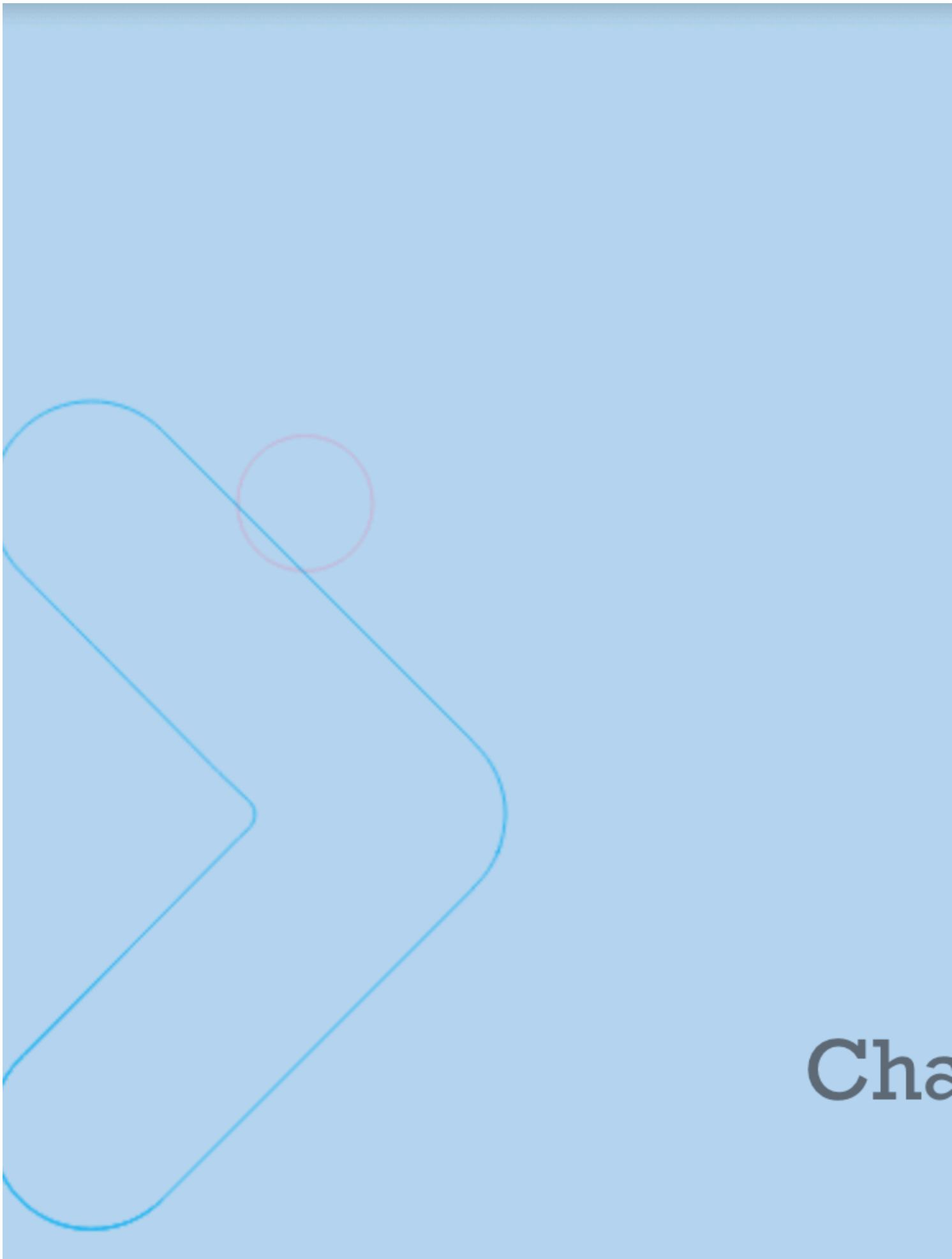
Never Call Someone an "Alcoholic" or "Addict"

VIDEO: *Changing the Stigmatizing Language of Addiction to Support Recovery*

The following video features PWLLE discussing the importance of changing the language surrounding substance use and PWUS.

One or more interactive elements has been excluded from this version of the text. You can view them online here: https://ecampusontario.pressbooks.pub/psychoactivesubstanceuseandsociety2nded/?p=250#oembed-1

Click the image below to access and complete the third of three interactive modules developed by CCSA. This module explores how you can play a role in ending stigma (Note: This module will resume where you left off. To re-start the module from the beginning, open a new Incognito Window (Chrome), Private Window (Safari, Firefox), or InPrivate (Edge)).


Cha

9.7 Involving People with Lived & Living Experience (PWLLE)

Nothing About Us Without Us Poster.

The continuous use of stigmatizing labels and stereotypes, as well as prohibitionist drug policy, has made it challenging to alter how PWUS are viewed and treated within society (CCSA, 2019). One step toward changing constructions and the treatment of PWUS is to recognize their expertise on the subject matter and involve/include them in (re)designing policies pertaining to psychoactive substances and their use. Such involvement includes the design, implementation and review of treatment and intervention programs that promote health, healing, and recovery (See Chapter on Harm Reduction). This contributes to a sense of inclusion for PWUS and provides first-hand lived and living experience to help address some of the real problems/challenges associated with drug policy and treatment (Open Society Foundation, 2008).

Click the following link to learn more about the importance of involving people with lived and living experience (PWLLE):

Nothing About Us Without Us: A Manifesto By People Who Use Illegal Drugs

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9.8 Chapter Summary

Key Summary Points

1. Stigma can lead to feelings of shame, contribute to a negative self-image, poor mental health, while impacting the health and treatment outcomes of PWUS.
2. There are three different forms of stigma: social, self, and structural, each of which impacts PWUS in different ways.
3. Stigma can make it difficult for PWUS to integrate into society and access resources for health, healing, and recovery.
4. Prohibitionist policies and the politics that the war on drugs have generated have reinforced and exacerbated the stigma faced by PWUS.
5. Education efforts that focus on explaining the implications of stigmatizing language and the importance of using person-first language, are critical to overcoming drug-related stigma.
6. Including the voices of PWLLE, and involving them as experts in the design, implementation and review of drug policy, treatment, and intervention programs, is essential to the process of de-stigmatizing substance use and promoting health, healing, and recovery for people experiencing SUDs.

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9.9 Required Chapter Materials

In addition to the videos and reading links embedded into the chapter, students are required to complete the following:

Canadian Centre on Substance Use & Addiction (CCSA). (2019). *Overcoming stigma through language: A primer*. https://www.ccsa.ca/sites/default/files/2019-09/CCSA-Language-and-Stigma-in-Substance-Use-Addiction-Guide-2019-en.pdf (**Read Pages 4-11).**

McGinty, E. & Barry, C. (April 2, 2020). Stigma reduction to combat the addiction crisis – Developing an evidence base. *New England Journal of Medicine*, *382*(14), 1291-1292. https://www.nejm.org/doi/pdf/10.1056/NEJMp2000227?articleTools=true

Transform Drug Policy Foundation. (June 1, 2015). *Count the costs: Promoting stigma & discrimination*. https://transformdrugs.org/assets/files/PDFs/count-the-costs-stigma.pdf

9.10 Chapter Assignment

Assignment Formatting, Style, & Length Requirements

- Assignment formatting requirements: Arial 12-point font; 1-inch/2.54cm margins; single spaced; APA in-text citation style, reference section and cover page.
- Use proper paragraph style within the answer to each question.
- Clearly indicate which question is being answered using corresponding question numbers (do not write out the entire question). Follow-up questions must be answered as part of the numbered question. Avoid using automated numbering as it alters the left margin of the document, resulting in a margin larger than 1-inch/ 2.54cm.
- Assignment length: approximately 1000 words in length (give or take 100 words) (reference section and cover page not included in word count). Divide your time/space evenly across all questions.
- Proofread your submission to make sure it is clear, well written and intelligible.

Assignment instructions

- After completing this chapter's materials (chapter content, including all embedded links to readings and videos, and the required chapter materials) answer ALL the questions below.
- In ALL your answers be sure to demonstrate knowledge of and engagement with the chapter materials. This is achieved through supporting points/arguments/positions via reference to the course material using in-text citations. Providing in-text citations to support your points/ arguments/positions is essential and required. Be sure to: (1) use a diverse range of materials, as opposed to relying heavily on a few sources; AND (2) cite material from current AND previously covered chapter materials.
- Only use materials outside of those assigned when specifically instructed to do so.

Assignment Questions

1. Based on the chapter materials, what is person first language? What is medically accurate language? How can the use of person first and medically accurate language help reduce the stigma faced by people experiencing substance use disorders (SUDs)? Be sure to provide examples to support your answer.
2. Based on the chapter materials, what factors can increase the risk of developing a substance use disorder? What factors can help reduce those risks? Why is this knowledge important for combatting the stigma tied to SUDs?
3. What is the most significant thing you learned from this week's course material with regard to stigma and people with SUDs that you did not already know? How has this knowledge impacted you and your understanding of substance use disorders and the need for societal change? What changes do you plan to make in the way you address these issues in your life, including with family and friends?

9.11 References & Media Attributions

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Cover Photo: Lewis, J. (January 7, 2023). *No stigma* [Image]. Canva.

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Chapter 10: Understanding Substance Use Disorders

Jacqueline Lewis, Jillian Holland-Penney & Brandon Bernardon

10.0 Introduction

Chapter Introduction

Negative perspectives of substance use disorders (SUDs) (addiction) and attitudes and treatment of people experiencing problematic substance use that are based on mis-perceptions, result in people who use substances (PWUS) being treated in negative ways: as outsiders, as blameworthy, as lesser, as non-deserving, as criminal, etc. Imagine a similar scenario, but substitute in a different medical condition. Think about judging and blaming, rather than treating them with compassion and understanding, a person who requires a daily medicinal substance to avoid physical and/or psychological pain/discomfort. Consider the implications on their health of not classifying their required health services as essential during a pandemic. Sadly, these are the everyday experiences of people experiencing SUDs. This chapter explores SUDs, from common mis-perceptions, to their complex nature and the variety and type of factors that put people at risk for developing a SUD. It ends with a discussion of the importance of a wellness and compassion-based approach to substance use.

Chapter Objectives/Learning Outcomes

After completing the chapter materials, you should have an understanding of:

1. Common misperceptions about substances and substance use.
2. The meaning of the term substance use disorder (SUD).
3. The risk factors associated with an increased susceptibility for substance use issues.
4. The impact of the COVID-19 pandemic on people experiencing a SUD.
5. The importance of taking a health-oriented approach to substance use and SUDs.

Questions to Think About When Completing Chapter Materials

1. What role do misperceptions of substances, PWUS, and people who develop SUDS play in:
    - The continuation of prohibitionist drug policies?
    - Attitudes towards and treatment of PWUS and people experiencing SUDs (including health-care personnel)?
    - The development of progressive social policies, and treatment and interventions for people experiencing substance use problems?
2. How does social isolation impact PWUS and people experiencing SUDs?
3. How does viewing substance use disorders as a medical issue, and not as an individual choice, work to alleviate stigma associated with PWUS and individuals experiencing SUDs?
4. What are the benefits of moving from punishment-oriented to health-oriented social policies to address substance use and problematic substance use?

10.1 Common Misperceptions about Substances & Substance Use

In order to understand substance use and substance use disorders (SUDs), it is important to recognize that there are many common misperceptions about substances and substance use, particularly problematic substance use. Common misperceptions include the following:

Misperception #1

"Some drugs are intrinsically dangerous and possess the power to control human behaviour" (Reist & Reimer, 2013, pg. 8).

This belief is based on flawed assumptions, with little supporting data (Reist & Reimer, 2013). Instead of placing the emphasis on the substance, we need to focus on the individual and the role social/ contextual factors play in substance use behaviour (CISUR, 2017; Reist & Reimer, 2013).

Misperception #2

Use of any substance with "addictive properties" will result in immediate addiction to the drug (CMHA, n.d.b; Alexander, n.d.).

The basis of this belief includes: a misunderstanding of substances; different attitudes and beliefs about the nature of legal and illegal substances (See Chapter on Introduction to Psychoactive Drugs); and a failure to consider the complex biopsychosocial factors that contribute to the development of problematic substance use and SUDs (CMHA, n.d.a.; Jemberie et al., 2020). While many psychoactive substances can be "addictive," problematic substance use is not caused by the simple consumption of a drug (CMHA, n.d.b).

Misperception #3

Illegal substances cause the most harm to individuals and society.

In reality, it is the legal substances, alcohol and tobacco (nicotine), that cause the most individual and social harm. The overuse of alcohol and tobacco cost the Canadian economy and public health more than all the other substances combined (CISUR, 2017) (see Chapter One).

In Canada in 2017, alcohol and tobacco contributed to:

- The majority of the costs to the Canadian economy and public health (63%).
- Over 66,000 preventable deaths.
- 89% of the 277,060 hospital admissions.
- 76% of the 751,356 years of life lost due to substance use.

(Stockwell & Young, 2020)

Misperception #4

People experiencing substance use issues and SUDs are to blame for their own substance using behaviour and any consequences that result from it.

No person chooses to develop a SUD (CMHA, n.d.a). Instead, there is a complex "combination of biological, psychological and social factors" that contribute to why a person may use substances and experience problematic substance use (CMHA, n.d.c). SUDs differ for each person and are connected to the places (physical and social) where they live, work and play (Ewald et al., 2019) (See Chapter on the Social Determinants of Health).

Misperceptions, such as the four outlined here, perpetuate the vilification of substances (particularly illegal substances), as well as the stigmatization and discrimination of people who use substances, particularly those who develop SUDs (See Chapter on Stigma). Such beliefs reinforce support for policies that continue to harm the health and well-being of PWUS (e.g., drug prohibition and the criminalization of PWUS; limited treatment options that are primarily abstinence-only in nature – See Chapters on the War on Drugs and Harm Reduction).

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10.2 What is the Meaning of Substance Use Disorder (SUD)?

Alcohol dependency is an example of a substance use disorder.

The term substance use disorder (SUD) refers to:

- Addiction, but is a less stigma-laden term.
- A complex health problem that is tied to problematic use of a substance, resulting in harmful consequences for the individual.
- A complex biological, psychological and social (biopsychosocial) disorder that has "multiple risk factors interacting at the individual and contextual levels" (Jemberie et al., 2020, p. 6), including: genetics/biology, brain function and barriers to accessing the SDoH (See Chapter on SDoH) (CMHA, n.d.a).
- A condition that can range from mild and temporary to severe and chronic (McLellan, 2017).

Click the links below to learn more about SUDs:

Substance Use & Addiction

Understanding substance use: A Health Promotion Perspective

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10.3 Risk Factors Associated with SUDs

VIDEO: *The Best Explanation of Addiction I've Ever Heard*

In the following video Dr. Gabe Maté explains the reality of SUDs, describing how SUDs almost always stems from trauma.

One or more interactive elements has been excluded from this version of the text. You can view them online here: https://ecampusontario.pressbooks.pub/psychoactivesubstanceuseandsociety2nded/?p=272#oembed-1

To move beyond traditional constructions that view problematic substance use and SUDs as an individual choice, it is necessary to consider the multiple risk factors that can influence a person's likelihood for developing a SUD (Stockwell & Young, 2020). Problematic substance use and SUDs are biopsychosocial in nature, with research identifying numerous complex and overlapping factors that can contribute to an increased susceptibility to problematic substance use behaviours (Jemberie et al., 2020). Risks for developing a SUD are believed to be additive. The more exposures one has, and the more diverse types of exposures, increases levels of risk (Ewald et al., 2019; McLellan, 2017).

Psychological Factors

- Over 50% of people who engage in problematic substance using behaviours are also experiencing a mental health issue (CMHA, n.d.c).
- Psychological states, such as stress, can impact an individual's behaviour consciously and unconsciously, potentially contributing to an increased likelihood of substance use and

problematic substance use (Goeders, 2003).
- In addition to the connection between trauma, stress, brain changes, and risk of SUDs in adulthood (Stockwell & Young, 2020; Ewald et al., 2019), one of the biggest contributing factors in life-long problematic substance using behaviour and SUDs is early childhood stressors and trauma that have a lasting impact on how the brain handles stress (Moustafa et al., 2018).

Childhood Trauma

- There is a strong association between childhood trauma and problematic substance use (Ewald, et al., 2019).
- Over 60% of individuals who experience substance use disorders were physically and/or sexually abused during their childhood (Moustafa et al., 2018).
- People who use opiates (e.g., heroin) experienced high rates of childhood trauma, such as receiving injuries due to physical punishment, penetrative sexual abuse, emotional abuse, and physical neglect (Moustafa et al., 2018).
- Studies have demonstrated how early life stressors, like the ones noted above, lead to permanent changes to the brain's stress circuitry (Moustafa et al., 2018), especially since the brain is still developing (Stockwell & Young, 2020).

Genetic/Biological Factors

- There is an inherited genetic component relating to SUD, with some people inheriting a vulnerability to the addictive properties of psychoactive substances (e.g., alcohol, nicotine, opiates, etc.) (CMHA, n.d.c).
- About half the risk for substance use disorder is determined by genetics, but a genetic predisposition does not always mean that a person will develop a substance use disorder (CISUR, 2017).

Psychosocial Environment

- The more an individual is exposed to stressors in their social and physical environments, the more likely they are to cope with that stress by using substances (Koob, 2008).
- Attitudes towards substance use to which people are regularly exposed (i.e., at home, with friends, at work, in the community) "can influence whether or not they will develop substance use problems" (CMHA, n.d.c, para. 11).

Examples of environments that can contribute to substance use and SUDs include:

- **Home:** Growing up in a family where there is a lot of conflict, stress and/or substance use, leads to a greater risk of developing SUDs, especially at a younger age.
- **School:** Peers play an influential roles in the lives of young people. It is through peers that young people are typically introduced to using psychoactive substances (e.g., alcohol, cannabis, nicotine, MDMA). If a young person's friends consume psychoactive substances, they are likely to follow suit.
- **Work:** There are certain forms of work or work environments that can contribute to substance use and SUDs including: high stress jobs, shift work, forms of frontline work that can expose

workers to traumatic events on a regular basis, etc.

(CISUR, 2017).

Individual Circumstances

- People often turn to drugs or alcohol because they believe it will help them cope with difficult feelings or circumstances (CISUR, 2017).
- People may depend on certain drugs to help them calm down when feeling stressed or make social situations easier. Relying on substances to help "get through" different life situations, however, can eventually lead to substance use problems (CISUR, 2017.).
- People experiencing structural vulnerability or disadvantages in their lives (e.g., tied to colonization, capitalism, housing insecurity, socio-economic disadvantage, etc.) can lead to an increased susceptibility to substance use and SUDs (See Chapter on the SDoH).

Click the link below to learn more about the causes of SUDs:

Factors that Impact Addiction & Problematic Substance Use

VIDEO: *Decolonizing Substance Use & Addiction*

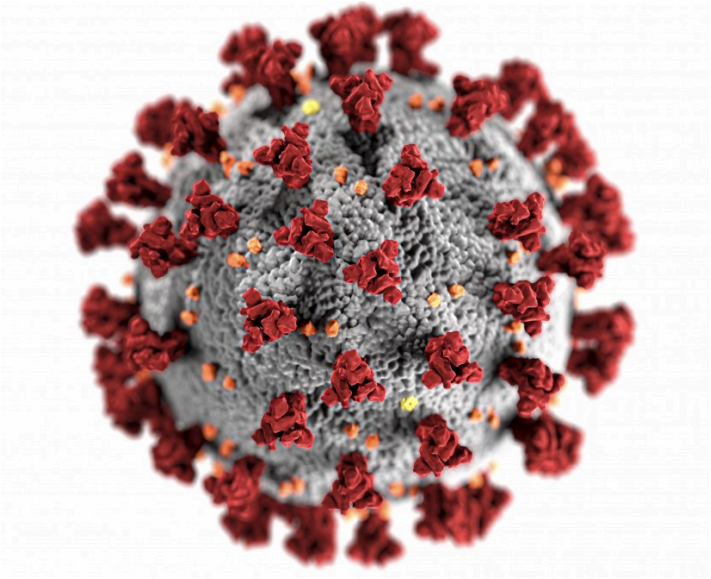
In the following TED Talk, Len Pierre Pierre discusses substance use and SUDs through an Indigenous lens.

One or more interactive elements has been excluded from this version of the text. You can view them online here: https://ecampusontario.pressbooks.pub/psychoactivesubstanceuseandsociety2nded/?p=272#oembed-2

Although certain risk factors increase an individual's susceptibility to problematic substance use, not everyone who has existing risk factors will develop a SUD (CISUR, 2017). Understanding the risk factors for the development of substance use problems, is crucial for moving beyond existing drug-related stigma and working towards the implementation of effective policies, treatments and intervention programs (CISUR, 2017). Ultimately, the acknowledgement of SUDs as a biopsychosocial condition, as well as its de-stigmatization among policy makers and practitioners, are essential components for comprehensive and multifaceted strategies that will protect and address the needs of people experiencing SUDs (Jemberie et al., 2020).

10.4 Impact of COVID-19 Pandemic on People Experiencing SUDs

"Addiction is a disease of isolation, so it stands to reason that social distancing…is counter to most efforts to engage in a recovery community" (Grinspoon, 2020, para.5).



SARS-CoV-2 the virus that causes COVID-19.

Prior to the start of the COVID-19 pandemic, public health officials, front line service providers, grassroots organizing and advocacy groups, including PWLLE, were raising the alarm about a worsening opioid poisoning (overdose) crisis. The pandemic exacerbated this crisis. People experiencing SUDs are more vulnerable to both contracting COVID-19 and experiencing more severe illness (See Chapter on SDoH) (Grinspoon, 2020; Smith, 2021). In addition, the recommended COVID-related public health measures exacerbated the crisis by: increasing isolation and psychological trauma; worsening mental health issues; reducing access to social supports and SUD treatment services; and impacting the ability of PWUS to follow harm reduction guidelines (Grinspoon, 2020; Jemberie et al., 2020; Smith, 2021).

COVID-19/pandemic related risks expanded on & exacerbated drug poisoning risk factors that existed prior to the pandemic including:

- Isolation.
- Stigma & discrimination.
- Lack of access to a safe supply of drugs.
- Lack of access to a safe supply of equipment (e.g., clean needles).
- Lack of access to safe consumption sites and other social services.
- Lack of access to Naloxone.

(Jemberie et al., 2020; Grinspoon, 2020; Smith, 2021).

Women experiencing the harmful effects of isolation.

Click the following links to learn more about the impact that the COVID-19 Pandemic had on PWUS:

A Tale of Two Epidemics – When COVID-19 & Opioid Addiction Collide

Canada's Hidden Crisis: How COVID-19 Overshadowed the Worst Year on Record for Overdose Deaths

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10.5 An Approach Emphasizing Wellness & Compassionate

The material in this chapter builds upon the critique from earlier course material, of how we as a society deal with substance use and people experiencing substance use issues. It points to the importance of taking an expanded, comprehensive view of substance use and SUDs, one that is more health-oriented. This is a more humane and compassionate approach that echoes the tenants of the SDoH (See Chapter on SDoH). By focusing on the person, rather than the substance, and taking into consideration the context, the reasons people begin to use and continue to use substances (CISUR, 2017), and the need for multi-sectorial strategies, we can better help address the needs of people experiencing SUDs, especially during public health crises such as the COVID-19 pandemic (Jemberie et al., 2020; Reist & Reimer, 2013).

As part of a more humane and compassionate approach to substance use and SUDs, it is important to emphasize wellness, as opposed to illness. This means supporting people who use substances to do so

more safely. It means focusing on "supporting health and well-being for everyone" (Reist & Reimer, 2013, pg. 7). It means helping people who use substances to understand the factors that impact their health, and to achieve the goals they set for themselves, rather than goals others may want to set for them. This can mean, for example, choosing a path that does not involve, or at least does not begin with, abstinence (See Chapter on Harm Reduction) (Reist & Reimer, 2013).

Changing the way society frames and/or approaches these issues (e.g., viewing SUDs as health as opposed to criminal justice issues), and how we view and respond to people experiencing SUDs (e.g., viewing people who use substances as people first), allows us to adopt an expanded view of substance use and SUDs. For example, with such changes we can orient our focus to both "upstream" and "downstream" interventions (See Chapter on SDoH), adopting "social protective policies," and shifting to integrated care systems (Jemberie et al., 2020, pg. 714). This fits with the recommendation of the Canadian Mental Health Association, namely that we put an emphasis on "protective factors" – aspects of a person's life that make them less likely to develop substance use issues (e.g., having positive role models and personal goals; being self-motivated and involved in meaningful activities; and having reliable connections to a supportive community) (CMHA, n.d.a).

VIDEO: *Everything you Think you Know About Addiction is Wrong*

In the following TED Talk, Johann Hari talks about how in order to overcome the harms associated with SUDs we need to provide PWUS with support and love. **(Warning: some stigmatizing language and concepts are used in this video, including the term "addict")**

One or more interactive elements has been excluded from this version of the text. You can view them online here: https://ecampusontario.pressbooks.pub/psychoactivesubstanceuseandsociety2nded/?p=278#oembed-1

10.6 Chapter Summary

Key Summary Points

1. There are many misperceptions about substances, substance use, and SUDs that negatively impact how we view and respond to substance use and people experiencing SUDs.
2. SUDs are complex health problems associated with a number of interacting biological, psychological, and social risk factors. These factors interact to increase susceptibility to substance use problems.
3. The COVID-19 pandemic, and its impact on social services, had a disproportionately negative impact on PWUS and people experiencing SUDs, including increased rates of drug poisoning (overdose) and fatalities.
4. The future direction of efforts to prevent substance use issues, while providing outreach and services for PWUS and those experiencing SUDs, needs to be based on wellness and compassion. With an upstream and downstream focus on health, we can address protective factors in the prevention of SUDs. We can also offer services that are compassionate and respectful of the needs of people experiencing SUDs, where they are right now.

Additional Resources

Below are a list of supplementary resources for students interested in learning more about the chapter topics. These resources are NOT required course materials. A list of required course materials, beyond those found throughout this chapter, are provided on the following page.

Additional Viewings

DW News. (February 26, 2021). *High on lockdown: Substance abuse during the pandemic | COVID-19 Special* [Video]. YouTube. https://youtu.be/kyYy6jrxUXw.

Additional Readings

Alberta Health Services. (August 2019). *Abstinence & harm reduction*. https://www.albertahealthservices.ca/assets/info/hrs/if-hrs-abstinence-and-harm-reduction.pdf

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10.7 Required Chapter Materials

In addition to the videos and reading links embedded into the chapter, students are required to complete the following:

Moustafa, A., Parkes, D., Fitzgerald, L., Underhill, D., Garami, J., Levy-Gigi, E., Stramecki, F., Valikhani, A., Frydecka, D. & Misiak, B. (August 28, 2018). The relationship between childhood trauma, early-life stress, and alcohol and drug use, abuse, and addiction: An integrated review. *Current Psychology, 40*, 579-584. https://doi.org/10.1007/s12144-018-9973-9

Stockwell, T. & Young, M. (July 7, 2020). *Substance use in Canada costs almost 46 billion a year according to latest data*. Canadian Centre on Substance Use & Addiction. https://www.ccsa.ca/substance-use-canada-costs-almost-46-billion-year-according-latest-data

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10.8 Chapter Assignment

Assignment Formatting, Style, & Length Requirements

- Assignment formatting requirements: Arial 12-point font; 1-inch/2.54cm margins; single spaced; APA in-text citation style, reference section and cover page.
- Use proper paragraph style within the answer to each question.
- Clearly indicate which question is being answered using corresponding question numbers (do not write out the entire question). Follow-up questions must be answered as part of the numbered question. Avoid using automated numbering as it alters the left margin of the document, resulting in a margin larger than 1-inch/ 2.54cm.
- Assignment length: approximately 1000 words in length (give or take 100 words) (reference

section and cover page not included in word count). Divide your time/space evenly across all questions.
- Proofread your submission to make sure it is clear, well written and intelligible.

Assignment Instructions

- After completing this chapter's materials (chapter content, including all embedded links to readings and videos, and the required chapter materials) answer ALL the questions below.
- In ALL your answers be sure to demonstrate knowledge of and engagement with the chapter materials. This is achieved through supporting points/arguments/positions via reference to the course material using in-text citations. Providing in-text citations to support your points/arguments/positions is essential and required. Be sure to: (1) use a diverse range of materials, as opposed to relying heavily on a few sources; AND (2) cite material from current AND previously covered chapter materials.
- Only use materials outside of those assigned when specifically instructed to do so.

Assignment Questions

1. Identify two of the main problems with the way we view and treat people experiencing substance use disorders (SUDs)? What are the consequences of these problems (on individuals experiencing SUDs, their communities, society more generally)? How have these problems contributed to the current drug poisoning (overdose) crisis in Canada?
2. How can an understanding of population health and/or social determinants of health, covered in earlier chapters, help us understand why people use substances and/or develop SUDs and how we can best provide them with support and treatment? Be sure to provide examples to illustrate the points in your answer.
3. What is the most significant thing you learned from this week's course material with regard to SUDs that you did not already know? How has this knowledge impacted you and your understanding of SUDs and the need for societal change? What changes do you plan to make in the way you address these issues in your life, including with family and friends?

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Chapter 11: Harm Reduction & Treatment

Jacqueline Lewis & Jillian Holland-Penney

11.0 Introduction

Chapter Introduction

As you have learned throughout this eBook, drug prohibition policies originating in the 20th century continue to negatively impact the health and well-being of people who use substances (PWUS) and people experiencing substance use disorders (SUDs). Rather than stopping or curtailing substance use, these costly policies have exacerbated harm to PWUS, their families and communities. A harm reductionist orientation to substance use, particularly around injection drug use, began to emerge in different parts of the world in the mid-1980s as a less costly and less harmful way to address the harms tied to substance use. Harm reduction (HR) initiatives have been the subject of extensive research and have grown and spread since that time. This chapter explores the principles and practices of harm reduction as they apply to substance use, substance use control polices, strategies and practices.

Chapter Objectives/Learning Outcomes

After completing the chapter materials, you should have an understanding of:

1. The meaning and basis of HR.
2. The science behind HR.
3. The variety of HR programs and initiatives that exist.
4. The rationale for expanding HR programs and for HR-oriented policy change.
5. The importance of including people with lived and living experience (PWLLE) in the design, implementation and evaluation of substance-related policies and programs.
6. The impact of HR interventions (upstream & downstream) on the social determinants of health (SDoH) of PWUS and people experiencing SUDs.

Questions to Think About When Completing Chapter Materials

1. What did you know about harm reduction (HR) and HR approaches/programs prior to taking this course? What did you think of HR prior to completing this week's material and the course more generally? In what ways has your opinion/perspective changed? Explain the change and why you think it occurred.
2. What are the benefits and barriers to HR approaches and policies?
3. In what way is the implementation of HR services/policies/approaches a matter of human rights?
4. Why do you think governments have been reluctant to implement HR initiatives and policies, despite the research and evidence that demonstrate their effectiveness?
5. What research and evidence would you use to argue in favour of HR policy and program implementation/expansion?

11.1 What is Harm Reduction?

There is no single, commonly agreed upon definition of HR. In fact, HR can be understood in a variety of ways:

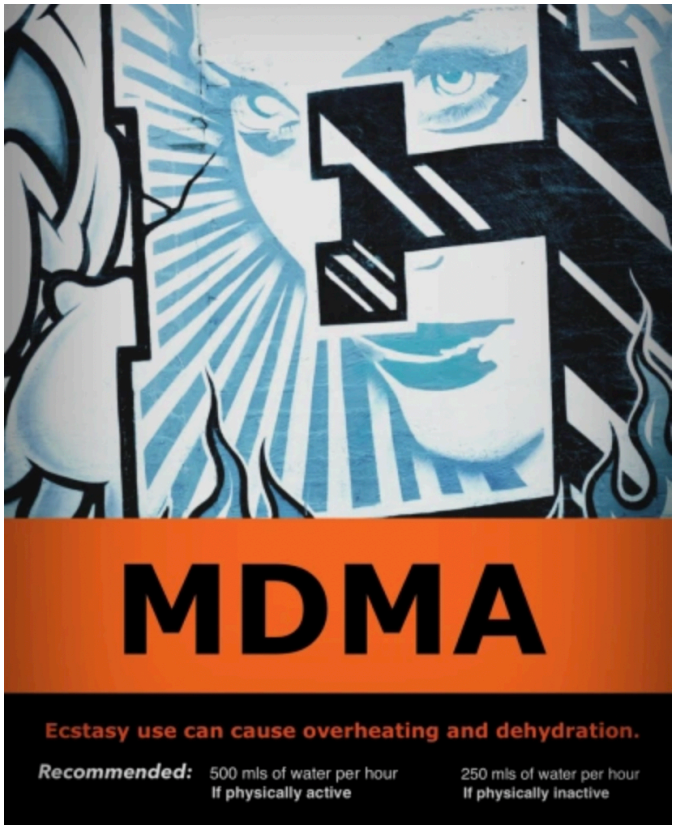
- As an orientation to substance-use, PWUS, and treatments for SUDs.
- As the basis or goals of policies, strategies, and programs tied to substance use.
- As a philosophy of how to deal with substance use and PWUS (both substances defined as legal and illegal).
- As a political, activist and/or social justice movement built on a belief in the human rights of PWUS and the importance of treating all people with dignity and respect.

Or HR can be understood as any combination of these.

HR can be viewed as an evidenced-based, client centered, pragmatic public health orientation to substance use, substance use services, and control policies. The aim of HR is to reduce substance use-related harms, to the individual, the community and society more generally, and improve overall health and well-being (e.g., physical, social, emotional, spiritual). HR is a pragmatic approach, accepting both substance use as part of society, and a continuation or maintenance of substance use as a trade-off for a reduction in substance-use related harm (CMHA, n.d.; Understanding Harm Reduction, 2020; TEDx Talks, 2019; National Harm Reduction Coalition, 2020).

Although definitions of HR vary, Harm Reduction International (n.d.), a non-governmental organization that aims to reduce the negative impacts of substance use and substance-control policies, offers a good definition that encapsulates many of the elements of HR noted above:

- Harm reduction refers to policies, programmes and practices that aim to minimize negative health, social and legal impacts associated with drug use, drug policies and drug laws.
- Harm reduction is grounded in justice and human rights. It focuses on positive change and on working with people without judgement, coercion, discrimination, or requiring that they stop using drugs as a precondition of support.
- Harm reduction encompasses a range of health and social services and practices that apply to legal and illegal substances and their use.



Examples of HR public service ads

Click the link below to learn about harm reduction:

Principles of Harm Reduction

VIDEO: *The Harm Reduction Model of Drug Addiction Treatment*

In the following TED talk, Dr. Mark Tyndall, an epidemiologist, physician, and public health expert, discusses the problems of drug criminalization and how HR strategies, like supervised injection sites (SIF)/supervised consumption services (SCS), are helping to address the drug poisoning (overdose) crisis.

One or more interactive elements has been excluded from this version of the text. You can view them online here: https://ecampusontario.pressbooks.pub/psychoactivesubstanceuseandsociety2nded/?p=294#oembed-1

11.2 Harm Reduction Myths and Facts

There are many myths, misconceptions, and misunderstandings concerning harm reduction approaches to substance use, substance use services, and control polices. The following resources identify some of these myths and provide evidence to counter them and enhance our understanding of HR.

Click the links below to learn more about HR myths & facts:

Dispelling Myths & Fears Around Harm Reduction

Prison-based Needle and Syringe Programs: Myths and Facts

VIDEO: *The Umbrella Project Module 3 — Myth vs. Fact*

The following video explores the various myths related to HR strategies.

One or more interactive elements has been excluded from this version of the text. You can view them online here: https://ecampusontario.pressbooks.pub/psychoactivesubstanceuseandsociety2nded/?p=296#oembed-1

11.3 Emergence of Harm Reduction

Early HR initiatives began to emerge in the mid-1980s in a number of countries around the world, including The Netherlands, Western European nations, The UK, Australia, and Canada. Following the lead of the first Dutch HR programs, these efforts were aimed at responding to and curtailing the rising rates of Hepatitis B and then HIV, among people who inject drugs (PWID), which were viewed as greater social threats than substance use. Program features included: the social marketing of safer substance use; outreach and peer advocacy; improving access to treatment and services; and the extension of voluntary counselling and testing. Below are a few key early HR program examples.

The Netherlands

In the late 1970s, in response to the country's heroin crisis, harm reduction initiatives began in The Netherlands. The programs were developed to provide a range of services including methadone, needle/syringe exchange, and social-medical care (van den Berg et al., 2007). The Dutch needle/syringe programs were the first in the world (van Saten et al., 2021). These early HR efforts impacted the transmission of Hepatitis B and C and HIV among people who inject drugs (PWID), and limited the nations transmission rates (van den Berg et al., 2007; van Saten et al., 2021).

The United Kingdom

In the mid-1980s, the Mersey Harm Reduction program was implemented in Liverpool and the surrounding areas of Merseyside and Cheshire in the UK. There were three features of the program: needle/syringe exchange; methadone prescribing (for a small number of program participants heroin was prescribed); and community outreach designed to increase the number of PWID accessing the program's services. Service uptake was rapid and included many people with no previous contact with services providers. Similar to the early Dutch HR programs, the Mersey program had a significant impact on the spread of HIV among PWIDs in the Mersey region (Ashton & Seymour, 2010; O'Hare, 2007).

Canada

Early Canadian HR efforts began in the late 1980s with informal, grassroots, and peer-driven syringe distribution initiatives. In 1989, as a result of a joint agreement between Health Canada and five provinces, eight formal syringe distribution programs were implemented. In 2003, *Insite*, the first North American supervised injection facility (SIF)/supervised consumption services (SCS), opened its doors in Vancouver. To date, although there have been many drug poisoning (overdose) events, no one has ever died at the facility (Hyshka et al., 2017).

Insite Supervised Consumption/Injection Site in Vancouver, BC.

11.4 Key Issues in Harm Reduction

Structural Vulnerability

- Many people with SUDs (and alcohol use disorder [AUD]) also experience structural vulnerability or disadvantage (i.e., tied to colonization, capitalism, housing instability, socio-economic disadvantage, etc.). HR initiatives can be framed to address both SUDs and the factors underlying structural vulnerability (Ivsins et al., 2019).
- PWID are vulnerable to SDoH inequities (e.g., housing instability, food insecurity, lack of social support, and poor access to health care). HR services help people experiencing SUDs to re-establish connections with health-care and social services, and make new connections with services that offer shelter to people who are unhoused or experiencing housing instability (Kermin et al., 2020).

People who are unhoused or experiencing housing instability are an example of a population experiencing structural vulnerability.

Alcohol & Harm Reduction

- North American alcohol policy focuses predominately on moderation of use or abstinence to prevent and reduce alcohol related harms.
- Harms associated with high risk drinking among people experiencing an alcohol use disorder (AUD) and structural vulnerabilities (i.e., tied to colonization, capitalism, housing instability, socio-economic disadvantage, etc.) are inadequately addressed by conventional policies and programs (Ivsins et al., 2019).
- Managed Alcohol Programs (MAPs) aim to reduce alcohol-related harms for people experiencing structural inequalities and severe alcohol-related problems (Canadian Observatory on Homelessness, 2016; Ivsins et al., 2019).

Supervised Consumption Services (SCS)/Supervised Injection Sites (SIS)

Supervised Consumption Site.

- Provide a safe, clean space for people to consume their own substances, preventing accidental poisonings (overdose) and reducing the spread of infectious diseases (e.g., Hepatitis and HIV) (Health Canada, 2023).
- Provide opportunities to re-establish connections to and access important health and social services (Health Canada, 2023; Kerman, 2020).
- Provide potential downstream interventions to address some of the SDoH inequities experienced by PWUS and people experiencing SUDs (Kermin et al., 2020).

Indigenous Peoples & Harm Reduction

- Indigenous people are five times more likely to experience a substance-related poisoning (overdose) than non-Indigenous people. These poisoning levels are a reflection of the continuing colonial trauma experienced by members of Indigenous communities (Johnson, 2021).
- Reconciliation in Canada requires substance policy that: (a) addresses the systems creating trauma; (b) accounts for the legacy of colonization; and (c) dismantles the structural forms of racism shaping Canadian drug policies (Lavalley et al., 2018).
- The Indigenization of harm reduction and treatment tied to SUDs, must integrate Indigenous values that are aligned with harm reduction principles (Lavalley et al., 2018) and include more traditional ways of healing into treatment (e.g., conversing with elders, smudging, sweat lodges, drum circles, etc.) (Johnson, 2021).

Click the links below to learn more about Indigenous HR principles & practices:

First Nation in BC and the Toxic Drug Crisis

Indigenous Harm Reduction Principles and Practices: Fact Sheet

Indigenous Harm Reduction = Reducing Harms of Colonialism **(Read Page 4)**

Involvement of People with Lived & Living Experience (PWLLE)

It is important:

- To recognize the people who actually do harm reduction are people who use substances and people experiencing SUDs.
- That people with lived and living experiences be involved in policy decisions and programming that impacts their lives.
- That PWUS and HR services users be meaningfully involved in the design, implementation, review, evaluation and governance of HR programmes.(CDPC, 2020; Csete & Elliott, 2021; Harm Reduction International, n.d.; Kermin et al., 2020).

Click the following link to learn more about involving people with lived & living experience:

Lived and Living

Drug Poisoning (Overdose) Crisis

HR initiatives play a vital role in public health responses to the drug poisoning crisis (CDPC, 2020).

Click the link below to learn more about opioid and stimulant related harms:

Opioid- and Stimulant-Related Harms in Canada

Changing the Way We Speak

Lexiconic or vernacular changes, such as poisoned, accidental poisoning, opioid poisoning, toxic drug poisonings, drug poisoning crisis, toxic drug supply crisis, drug poisoning calls, provide more medically accurate and less stigmatizing alternatives to terms/phrases such as overdose(d), overdose crisis, overdose calls (Csete & Elliot, 2021; CDPC, 2020; The Chief Staff, 2021).

Click the link to learn more about lexiconic or vernacular changes:

Stop Calling It an 'Overdose" Crisis

Safe Supply Approach

- The disappearance of a reliable supply of heroin and major cutbacks in opioid prescriptions, has left many thousands of Canadians in a position where they must choose between purchasing unpredictable substances via illegal/unregulated sources or abstaining from use. The latter is not an option for many people experiencing a SUD (Tyndall, 2020). This problem was exacerbated during the COVID-19 pandemic (Smith, 2021).
- Safe supply involves people who at risk of poisoning (overdose), using existing pharmaceutical-grade medications as an alternative to highly toxic street drugs. It can also establish pathways to care and treatment for people experiencing an SUD (Health Canada, 2019).

- Research demonstrates that injectable hydromorphone and diacetylmorphine (prescription heroin) are successful in helping to stabilize and support the health of some patients experiencing an opioid use disorder (OUD), including an increased retention in treatment programs (Health Canada, 2019). Canada is the first country to approve injectable hydromorphone as a treatment for severe OUD (Health Canada, 2019).

VIDEO: *Free Heroin: The B.C. Clinic Providing an Alternative to Dangerous Street Drugs*

In the following video, Kieran Collins, a Vancouver man experiencing an OUD, talks about securing a spot in Vancouver's Crosstown Clinic's program that supplies clean injectable heroin to people with OUDs, and how it saved his life. **(Click "Watch on YouTube" below to access the video).**

One or more interactive elements has been excluded from this version of the text. You can view them online here: https://ecampusontario.pressbooks.pub/psychoactivesubstanceuseandsociety2nded/?p=306#oembed-1

11.5 Some Recent Canadian Policy Changes

- The COVID-19 pandemic impacted the drug supply in Canada and increased risks to people experiencing SUDs. In response, Health Canada temporarily loosened the prescribing and dispensing rules for a number of substances that people experiencing SUDs require, in an effort to lessen reliance on illegal/unregulated sources. The temporary revised rules allowed prescribers to provide a person experiencing a SUD, who was at risk of both COVID-19 and suffering withdrawal systems, a prescription for up to a 23-day supply of pharmaceutical opioids, stimulants, and benzodiazepines (Canada, October 21, 2022; CDPC, 2020).
- On May 31, 2022, the Canadian Federal government announced that it was granting the province of British Columbia's request for a subsection 56(1) exemption under the CDSA. The goal of the exemption being "to support the public health response to the drug [poisoning] (overdose) crisis in BC" (Canada, September 14, 2023, para. 4). Under the granted exemption, from January 31, 2023 to January 31, 2026, any adult 18 years of age or older in BC "will not be subject to criminal charges for the possession of a cumulative total of up to 2.5 grams of certain illegal drugs for personal use" (Canada, September 14, 2023, para. 2).
- In November 2022, Bill C-5 An Act to amend the *Criminal Code* and the *Controlled Drugs & Substances Act* received royal assent. This enactment repeals "certain mandatory minimum penalties [and] allow[s] for a greater use of conditional sentences and establish diversion measures for simple drug possession offences" (*Bill C-5*, 2022).

Click the link below to learn more about recent Canadian policy changes:

Federal Actions on Opioids to Date

Federal Actions on the Overdoes Crisis

11.6 Harm Reduction Examples

VIDEO:*The Harm Reduction Vending Machine*

In the following video Brad Pommen, Founder and owner of Smart1 Technologies, discusses the invention of the harm reduction vending machine.

One or more interactive elements has been excluded from this version of the text. You can view them online here: https://ecampusontario.pressbooks.pub/psychoactivesubstanceuseandsociety2nded/?p=310#oembed-1

Examples of HR Efforts to Prevent Substance Use-Related Harms:

- Impaired driving prevention programs.
- Encouraging drinking water while consuming alcohol.
- Using the nicotine patch or vaping instead of smoking tobacco.
- Outreach and support programs.
- Providing information and resources on safer substance use practices (legal and illegal).
- Using substances in safe environments with trusted others.
- Needle/syringe supplying and recovery programs.
- Access to clean substance use equipment.
- Opioid substitution therapies such as methadone or Suboxone.
- Safe legal drug supply (e.g., opioids)/prescription maintenance programs.
- Available Naloxone kits to reverse opioid poisonings (overdoses).
- SCS/SIS and drug poisoning (overdose) prevention services.
- Drug checking services.
- Mental wellness and healing support programs and centres.
- Peer support programs run by and/or that involve PWLLE tied to substance use and SUDs.
- Good Samaritan laws (e.g., the 2017 *The Good Samaritan Drug Overdose Act* in Canada – See Chapter on Contemporary Canadian Drug Policies).
- Decriminalizing substances and substance use.

(CAMH, 2019; Canada, 2021a; Understanding Harm Reduction, 2020; Jesseman & Payer, 2018).

VIDEO: *Vending Machine Dispenses Heroin Substitute for At-Risk Users*

The following video explores "MySafe," a vending machine that dispenses hydromorphone to patients whose biometrics have been programmed into the scanner, as part of a unique Vancouver-based program aimed at preventing drug poisonings (overdoses).

One or more interactive elements has been excluded from this version of the text. You can view them online here: https://ecampusontario.pressbooks.pub/psychoactivesubstanceuseandsociety2nded/?p=310#oembed-2

11.7 Harm Reduction Benefits

Some Benefits of Harm Reduction Programs Include:

- Increased referrals and improved access to support programs.
- Reduced substance use in public spaces.
- Reduced stigma and increased access to health and social services.
- Reduced sharing of substance use equipment.
- Reduced blood borne illnesses, such as HIV and Hepatitis C.
- Reduced toxic poisoning-related (overdose) deaths, and other early deaths among PWUS and people experiencing SUDs.
- Increased knowledge around safer substance use.
- Increased knowledge around safer sex, sexual health and increase condom use.
- Improved health of PWUS and people experiencing SUDs.
- Reduced health care system costs.
- Reduced criminal justice system costs.

(CAMH, 2019; Understanding Harm Reduction, 2020).

Safe Injection Kit.

11.8 Chapter Summary

Key Summary Points

1. HR is an evidenced-based, client centered, pragmatic, public health orientation to substance use, substance-use services, and control policies.
2. HR services are essential in preventing many of the harms linked with substance use. They serve to lessen the likelihood of long-term health complications of substance use, reduce the likelihood of toxic drug poisoning events and deaths, and improve overall health and well-being.
3. HR works to address the stigma associated with substance use and SUDs. Through reducing stigma and providing needed support and resources, HR initiatives help PWUS and people experiencing SUDs to access needed health and social services.
4. Involving people with lived and living experience (PWLLE) is essential in the design, implementation and evaluation of HR polices and programs.

Additional Resources

Below are a list of supplementary resources for students interested in learning more about the chapter topics. These resources are NOT required course materials. A list of required course materials, beyond those found throughout this chapter, are provided on the following page.

Additional Viewings

CBC. (2008). *Staying Alive* [Video]. The Fifth Estate. https://www.cbc.ca/player/play/1367469592

Additional Readings

COM-CAP & Public Health Ontario. (September 2023). *Substance use services with, and for, Indigenous Communities*. https://www.publichealthontario.ca/-/media/Documents/S/2023/substance-use-services-indigenous-communities.pdf?rev=c50da5f26fea491caf6bfc937a0d9060&sc_lang=en

Interagency Coalition on AIDS. (March 19, 2021). *Indigenous harm reduction = Reducing the harms of colonialism.* https://caan.ca/tools-and-resources/resource/indigenous-harm-reduction-reducing-the-harms-of-colonialism/

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Harm Reduction International. (n.d.). https://www.hri.global/

National Harm Reduction Coalition. (n.d.). https://harmreduction.org/

Ontario Harm Reduction Network. (n.d.). https://ohrn.org/

11.9 Required Chapter Materials

In addition to the videos and reading links embedded into the chapter, students are required to complete the following:

Canadian Drug Policy Coalition (CDPC). (October 7, 2020). *Discussion guide: Getting to tomorrow – Ending the overdose crisis, beyond COVID-19*. https://gettingtotomorrow.ca/wp-content/uploads/2020/10/Discussion-Guide-EN.pdf **(Read pages: 26-29. Start at "Some Positive Developments").**

CBC News. (March 25, 2021). *Harm reduction dispensing machine now operating in Sackville*. https://www.cbc.ca/news/canada/new-brunswick/harm-reduction-vending-machine-sackville-1.5963339

Csete, J. & Elliott, R. (May 21, 2021). Consumer protection in drug policy: The human rights case for safe supply as an element of harm reduction. *International Journal of Drug Policy*, *91*. https://doi.org/10.1016/j.drugpo.2020.102976

Ghartey,K. & Upshur, R. (June 27, 2023). *Let evidence, not opinion, guide harm reduction policy and practice in Canada's drug poisoning crisis*. The Conversation. https://theconversation.com/let-evidence-not-opinion-guide-harm-reduction-policy-and-practice-in-canadas-drug-poisoning-crisis-207679

Health Canada. (May 15, 2019). *Government of Canada approves new treatment options for opioid use disorder and supports research treatment & harm reduction projects in Ontario*. https://www.canada.ca/en/health-canada/news/2019/05/government-of-canada-approves-new-treatment-options-for-opioid-use-disorder-and-supports-research-treatment-and-harm-reduction-projects-in-ontario.html

Health Canada. (February 28, 2023). *Supervised consumption explained: Types of sites and services.* https://www.canada.ca/en/health-canada/services/substance-use/supervised-consumption-sites/explained.html

Ivsins, A., Pauly, B., Brown, M., Evans, J., Gray, E., Schiff, R., Krysowaty, B., Vallance, K. & Stockwell, T. (April 9, 2019). On the outside looking in: Finding a place for managed alcohol programs in the harm reduction movement. *International Journal of Drug Policy*, *67*, 58-62. https://doi.org/10.1016/j.drugpo.2019.02.004

Johnson, M. (May 2, 2021). *Meet the people putting Indigenous culture at the heart of addictions treatment.* CBC News. https://www.cbc.ca/news/canada/british-columbia/reconnecting-saves-lives-1.6010361

Kermin, N., Manoni-Millar, S., Cormier, L. Cahill, T. & Sylvestre, J. (May 31, 2020). It's not just injecting drugs – Supervised consumption sites & the social determinants of health. *Drug & Alcohol Dependence*, *213*. https://doi.org/10.1016/j.drugalcdep.2020.108078

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11.10 Chapter Assignment

Assignment Formatting, Style, & Length Requirements

- Assignment formatting requirements: Arial 12-point font; 1-inch/2.54cm margins; single spaced; APA in-text citation style, reference section and cover page.
- Use proper paragraph style within the answer to each question.
- Clearly indicate which question is being answered using corresponding question numbers (do not write out the entire question). Follow-up questions must be answered as part of the numbered question. Avoid using automated numbering as it alters the left margin of the document, resulting in a margin larger than 1-inch/ 2.54cm.
- Assignment length: approximately 1000 words in length (give or take 100 words) (reference section and cover page not included in word count). Divide your time/space evenly across all questions.
- Proofread your submission to make sure it is clear, well written and intelligible.

Assignment Instructions

- After completing this chapter's materials (chapter content, including all embedded links to readings and videos, and the required chapter materials) answer ALL the questions below.
- In ALL your answers be sure to demonstrate knowledge of and engagement with the chapter materials. This is achieved through supporting points/arguments/positions via reference to the

course material using in-text citations. Providing in-text citations to support your points/ arguments/positions is essential and required. Be sure to: (1) use a diverse range of materials, as opposed to relying heavily on a few sources; AND (2) cite material from current AND previously covered chapter materials.
- Only use materials outside of those assigned when specifically instructed to do so.

Assignment Questions

1. Identify a downstream harm reduction (HR) program/intervention in the chapter materials. What are the goals of the program/intervention? How do these goals fit with the harm reductionist framework/what makes this a HR program/intervention? How can the program/intervention impact the social determinants of health (SDoH) for the population(s) it serves? Be sure to make use of/cite the SDoH Chapter materials when answering this question.
2. Many HR programs related to substance use focus on downstream interventions. Identify an upstream HR program/intervention or policy change that could be introduced or ramped up to reduce the downstream impact (the example chosen could be from the course materials, other sources, or something you have thought up). How could this program/intervention or policy change impact substance use and the SDoH of populations at risk of developing SUDs? Be sure to make use of/cite of the SDoH chapter materials when answering this question.
3. What is the most significant thing you learned from this week's assigned material on harm reduction? How has this knowledge impacted you and your understanding of substance-related policies, programmes and/or treatments and the need for social change?

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XII

Chapter 12: The Cannabis & Emerging Psychedelic Industries

Jacqueline Lewis & Jillian Holland-Penney

12.0 Introduction

Chapter Introduction

Despite more than a century of draconian policies aimed at psychoactive substances and the people who use them, starting in the late 20th century we have seen a gradual shift toward more progressive drug policies, attitudes toward substance use, and treatment of people who use substances (PWUS) in various parts of the world. As noted in previous chapters (See Chapters on International Drug Policy, Alternative Drug Control Policies, and Harm Reduction), such changes are tied to evolving conversations around drug policy and substance use, with a growing focus on health, harm reduction and human rights.

With regard to cannabis policy, although in 1996 California was the first state in the U.S. to legalize the use of cannabis for medical purposes, in 2001 Canada became the first country to implement a national-level medical cannabis policy. The introduction of full legal recreational cannabis followed in 2018, with the enactment of the Canadian *Cannabis Act* (Uruguay was the first nation to legalize recreation cannabis in 2013). As part of the legalization of cannabis for medical and/or recreational purposes, we witnessed the birth of the legal cannabis industry. Following on the heels of the legal cannabis industry, are more recent efforts to legitimize the medical use of psychedelic substances and develop a medicinal psychedelic industry (e.g., research, production and supply, administration and treatment, etc.).

This chapter explores the origins, growth, and challenges faced by the legal medicinal and recreational cannabis industry, with Canada as the primary focus. Specific attention is paid to the history of Canadian legal medical cannabis policy; the origins, growth and expansion of the legal cannabis industry in Canada; the challenges faced by the industry; government response to industry challenges; and needed change to the legislative framework. The chapter concludes with an examination of the emerging psychedelics as medicine movement, including pioneering research, legislation, and commerce.

Chapter Objectives/Learning Outcomes

After completing the chapter materials, you should have an understanding of:

1. Contemporary Canadian medical cannabis policies and key court decisions.
2. The emergence of the Canadian cannabis industry.
3. Challenges faced by/in the cannabis industry.
4. Challenges to the cannabis legalization framework/the *Cannabis Act* (2018).
5. The emergence of psychedelics for medical purposes and the psychedelic industry.
6. The push for changes in laws regulating psychedelics.
7. Challenges faced by psychedelic science and the psychedelic industry more generally.

Questions to Think About When Completing Chapter Materials

1. What lessons can be learned from the study of cannabis legalization?
2. What other currently illegal drugs covered earlier in this course would benefit from the move to a legalization framework? What form could these policies take?
3. How can the implementation of legalization policies be made easier?
4. What challenges and barriers is the legal psychedelic industry likely to face? How can these be addressed?
5. What are the challenges and barriers to complete legalization of all currently illegal psychoactive substances? How can these be addressed?

12.1 History of Canadian Medical Cannabis Policy

Beginning in 2000, medical cannabis policy in Canada has been the subject of a number of court cases and Charter challenges that have influenced and impacted Canadian cannabis policy more generally and the origin and evolution of the cannabis industry. In 2013, under the MMPR, a legal commercial cannabis industry to supply cannabis for medical purposes began to take shape. Various policy changes since that time have paved the way for the development of both the legal medicinal and recreation cannabis industry that we see in Canada today. The infographic below provides information on the history of Canadian medical cannabis policies and key court challenges. At the bottom of this page are several additional required readings that provide further important information on this topic.

Canadian Medical Cannabis Policies & Key Court Decision

Historical Timeline

2000 - R. *v.* Parker

- Regulated medical cannabis industry began with this Ontario Court of Appeal decision.
- Case was an s.7 *Charter* challenge: "Right to life, liberty & security of the person."
- Ontario Court of Appeal decision: CDSA blanket prohibition against possession and production of cannabis was unconstitutional.
- Decision spearheaded the development of the first of 4 regulatory schemes to govern the production, sale and use of medical cannabis in Canada (MMAR).

2001 - MMAR

Marihuana Medical Access Regulatio

- First Canadian medical cannabis legislation.
- Non-commercial industry, small "garden" style product sites.
- Required physician's approval.
- Required applying to Health Canada for an Authorizati to Process medical cannabis (an ATP).

MMAR Supply Options for Patients

- Purchase from Health Canada (only one strain available
- Personally produce pursuant to a Personal-Use Produc License (PUPL).
- Designate a third party to produce on one's behalf purs to a Designated-Person Production License (DPPL).

2014 - 2016 Court Cases

Allard *v.* Canada (March 21, 2014)

- The Federal Court granted an interlocutory injunction allowing the plaintiffs to continue to produce medical cannabis for personal consumption, until the constitution matter could be adjudicated at trial.
- Decision impacted the continuation of the MMPR, as it allowed any individual with a PUPL or DPPL, issued prior March 21, 2014, to continue to produce medical cannabi

R. *v.* Smith (June 11, 2015)

- Prohibition on non-dried forms of cannabis limit liberty ar security of the person, is arbitrary, and therefore not in accordance with the principles of fundamental justice as s.7 of *The Charter* (Supreme Court of Canada).
- Decision results in expansion to MMPR to include other forms of cannabis (e.g., oils, tinctures, food, tea, etc.).

Allard *v.* Canada (February 24, 2016)

- Federal Court struck down ban on home growing introduced under MMPR and ruled that:
  - MMPR regulations were "over-board & arbitrary".
  - Requiring individuals to acquire their cannabis only through licensed producers violated s.7 Charter right
- Extended ongoing injunction for Canadians licensed to produce under the MMAR (approximately 28,000 people)
- Declared MMPR invalid, but suspended decision for six months to provide the government time to enact a new o parallel cannabis regime. The new regime was the ACMP

2016 - ACMPR

Access to Cannabis for Medical Purposes

- Similar to MMPR: Sets out framework for commercial production and distribution by licensed producers.
- Similar to MMAR: Sets out provisions for patients to produce limited amounts of cannabis for their own medical use or to designate someone else to produce cannabis for them.

Canadian medical cannabis court decisions & legislation: Historical Timeline. Canadian medical cannabis court de & legislation: Historical timeline. Creative Commons: Attribution-NonCommercial-NoDerivatives 4.0 International BY-NC-ND 4.0).

Access the Word file containing text for the Canadian Medical Cannabis Policies & Key Court Decisions Historical Timeline infographic

Click the links below to learn more about the history of Canadian medical cannabis policies and related court decisions:

Federal court finds that Marihuana for Medical Purposes Regulations are unconstitutional

Reflections of Stevenson Whelton partner on his role in cannabis legalization – R. v. Parker

Update: R v. Smith – Supreme Court sensibly strikes down arbitrary restrictions in Canada's regulations on medical cannabis

12.2 Cannabis Industry Growth & Regulations

Cannabis growing facility

On April 1, 2014 the MMPR (2013) came into force, providing the framework for the start of the commercial cannabis industry in Canada (Canada, December 15, 2012). Under the MMPR, companies interested in becoming licensed medical cannabis producers (LPs) were required to submit applications to Health Canada for review and assessment. Health Canada's forecasted predictions for profitability in the industry sector (over a billion dollars in sales by 2024), led to a green rush, with large numbers of entrepreneurs vying for a share of the market (Anexco Resources Ltd., May 21, 2014; Tranchemontagne, n.d.).

Despite the volume of interest expressed in obtaining commercial licences, and the outlay of money required for the application process (i.e., hundreds of thousands of dollars or more) (dicentra, September 2, 2014), the rigorous, lengthy, and expensive nature of Health Canada's LP application process (Jones, June 4, 2014) resulted in a high volume of unsuccessful and incomplete applications, and ultimately only a small number of LPs. For example, by June 2014 only 13 LPs were listed on the Health Canada website (Alves & Lickver, June 3, 2014). By the end of 2014, of the 1,300 LP applications received by Health Canada, only 19 full licences had been granted, with 6 additional cultivation-only licences (Visual Capitalist, Spring 2015). According to Laleh Bighash (AAPS, January 16, 2015, para. 6), of the applications to Health Canada between the implementation of the MMPR through to March 2015, "252 were refused, 224 [were] in process, 40 [were] withdrawn, 935 [were] rejected, [and] 643 [were] deemed incomplete."

Click the link below to learn more about the challenges faced by LPs, and in particular an unsuccessful application for a Windsor-area company:

CEN Biotech to fight medical marijuana licence rejection in court

The federal cannabis licence application process evolved with the introduction of the *Access to Cannabis for Medical Purposes Regulations* (ACMPR) and subsequently the *Cannabis Act* (2018). Under the ACMPR, Health Canada announced in May 2017 its plan to streamline the application process in order to both increase the number of LPs and volume of cannabis production (Health Canada, May 26, 2017). As a result of this Heath Canada decision, the number of LPs grew from 44 to 89 between May 2017 and February 2018. With the introduction of the *Cannabis Act* (2018) and the legalization of the recreational use of cannabis in Canada, federal cannabis regulations expanded to include licence categories specific to: processing cannabis; selling cannabis; selling cannabis for medical purposes; testing cannabis (analytical testing licence); researching cannabis; producing drugs containing cannabis; selling, distributing or receiving drugs containing cannabis; and growing industrial hemp (Health Canada, January 9, 2023). Each type of licence has its own unique application and application process, such as the application for Cultivation and Sale for Medical Purposes Licence. As of August 2023 the number of federal cannabis licences was 957 (Health Canada, August 30, 2023).

Health Canada
Santé Canada

Applica
und

This form should be completed and subm
and Cannabis Branch (CSCB); the addre
incomplete application form may be retur

This application is valid for **one** site only;
submitted for each site.

While this application is filed under the C
relevant Acts or Regulations in the opera

Cannabis Licensing Application, Canada

Click the following link to learn more about the distribution of retails stores across Canada:

Canadian recreational cannabis stores, by province and territory

In conjunction with the *Cannabis Act*, the provinces and territories have their own cannabis legislation responsible for governing the retail market within their borders. For example, in Ontario under the provincial *Cannabis Licence Act* (2018), the Alcohol and Gaming Commission of Ontario (AGCO) is responsible for reviewing retail licence applications and the licensing of retail stores, operators and managers (AGCO, n.d.a; n.d.c). It is also responsible for regulating, monitoring, inspection and enforcement of licensed retail sites (AGCO, n.d.c). The licensing of retail stores in Ontario began slowly via a lottery system, with only 25 Retail Store Authorizations (RSAs) available to applicants as of January 2019. An additional 42 RSAs were included in a second lottery in August 2019, and an open application system was implemented in January 2020 (Maurer, n.d). Although only 18 stores opened in Ontario within the first 6 months of cannabis legalization (compared to 86 in Alberta and 25 in Newfoundland and Labrador) (Myran, Brown & Tanusepurtro, 2019), that number has increase exponentially to 1742 in August 2023, accounting for 46% of all cannabis retail outlets in Canada (MJBizDaily, August 2023). Click here to view the AGCO map of cannabis retail stores in Ontario.

Click the link below to learn more about the AGCO detailed application process:

Cannabis retailer licensing journey map

Cannabis Industry Regulations Division of Responsibilities

Oversight of the legal cannabis regulations in Canada are the shared responsibility of the federal, provincial and territorial governments (Canada, July 7, 2021).

"The Federal government's responsibilities are to set:

- Strict requirements for producers who grow and manufacture cannabis.
- Industry-wide rules and standards, including:
  - Types of cannabis products available for sale.
  - Packaging and labelling requirements for products.
  - Standardized serving sizes and potency.
  - Prohibitions on the use of certain ingredients.
  - Good production practices.
  - Tracking requirements of cannabis from seed to sale to keep it out of the illegal market.
  - Restrictions on promotional activities.

Provinces and territories are responsible for developing, implementing, maintaining and enforcing systems to oversee the distribution and sale of cannabis. They are also able to add their own safety measures, such as:

- Increasing the minimum age in their province or territory (but not lowering it).
- Lowering the personal possession limit in their jurisdiction.

- Creating additional rules for growing cannabis at home, such as lowering the number of plants per residence.
- Restricting where adults can consume cannabis, such as in public or in vehicles."

Canada (July 7, 2021, para. 9-10)

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12.3 Cannabis Industry Challenges

Stock chart showing the price of a stock over a specific period of time.

The legal Canadian cannabis industry has made a significant contribution to the Canadian economy. Since its inception in 2018, the industry "contributed $43.5 billion to Canada's GDP…and $13.3 billion to Ontario's GDP… [and] sustained 98,000 jobs annually" across the country (Deloitte, 2022, p.3). Given its early start in the industry, Canada is positioned to become a leader in the world cannabis market as the number of countries around the world enacting and/or considering enacting medical and/or recreational cannabis legalization continue to grow (Canadian Cannabis Exchange, October 25, 2022). Despite the industries economic impact and future market opportunities, in both Canada and other nations, the legal cannabis industry has been plagued by difficulties since its inception. Several of the most common issues are addressed below, including: access to banking industry services and the impact of the illegal cannabis market and other industry stressors.

Access to Banking Industry Services

International drug prohibition (see Chapter on International Drug Policies) and banking regulations have negatively impacted the financial resources available to the cannabis industry since its start. Just after Uruguay became the first country in the world to legalize cannabis, US banks put the Uruguayan banking industry on notice that they would cease involvement with Uruguayan banks offering services to cannabis industry businesses (Londoño, August 25, 2017). This problem persists into 2023, with Uruguayan banks reluctant to provide financial services to the industry, due to foreign banking and international money laundering regulations (Maas, May 4, 2022).

Canadian & U.S. currency.

Despite the number of U.S. states that have legalized medical and/or recreational cannabis between 1996 and 2023, the cannabis industry in the U.S continues to struggle due to the Federal prohibition on cannabis. Those who can obtain licences experience difficulty finding banks that will offer them services (e.g., bank accounts, loans, mortgages, etc.), cutting businesses off from important financial sector assets necessary for raising capital. Cash-only businesses also complicate financial transactions (e.g., paying employees, vendors, and taxes) (Mallison, Hannah, & Cunningham, 2020) and make potential business investment risky, due to difficulties obtaining insurance, including bankrupt insurance (Kavousi et al., 2022).

Needed US legislative change, however, may be on the horizon. An article in Reuters in January 2023 reported on the expected re-introduction of several important pieces of legislation for the cannabis industry in the 2023 legislative session, including: *The Secure and Fair Enforcement* (SAFE) *Banking Act*, that will "provide protections to financial institutions and…other professional service[s providers] doing business with state-legal cannabis businesses"; and the *States Reform Act* (SRA), that would both Federally decriminalize cannabis and defer "to state powers over prohibition and commercial regulation" (Malyshev & Ganley, January 19, 2023, para. 10-11). In September 2023, the former of these two pieces of legislation was introduced to the US Senate, under a slightly revised name (i.e., *The Secure and Fair Enforcement Regulation [SAFER] Banking Act)* and was subsequently amended during a Senate Banking Committee hearing (Herrington, October 2, 2023; Kumar & Bose, September 27, 2023).

The Canadian cannabis industry has faced similar problems with the banking industry. Although credit cards can be used by consumers to purchase cannabis products, some companies in Canada struggle to access and/or maintain banking services. In an effort to address these issues, in February 2023 the legal cannabis industry brought a class action suit against major Canadian banks (RBC, BMO, TD, CIBC, National Bank, and Desgardins Federation) alleging "that the named banks have engaged in financial discrimination against actors" in the legal industry (Groupe SGF, February 10, 2023, para. 1). The listed services denied the industry detailed in the suit include: opening bank accounts (and sudden closure of existing accounts) and access to financial tools (e.g., mortgages, lines of credit).

VIDEO: ***The cannabis industry has a banking problem. But that could change.***

This video from the Wall Street Journal explores the challenges the legal cannabis industry in various U.S. states continues to face, due to their lack of access to banking industry resources.

One or more interactive elements has been excluded from this version of the text. You can view them online here: https://ecampusontario.pressbooks.pub/psychoactivesubstanceuseandsociety2nded/?p=454#oembed-1

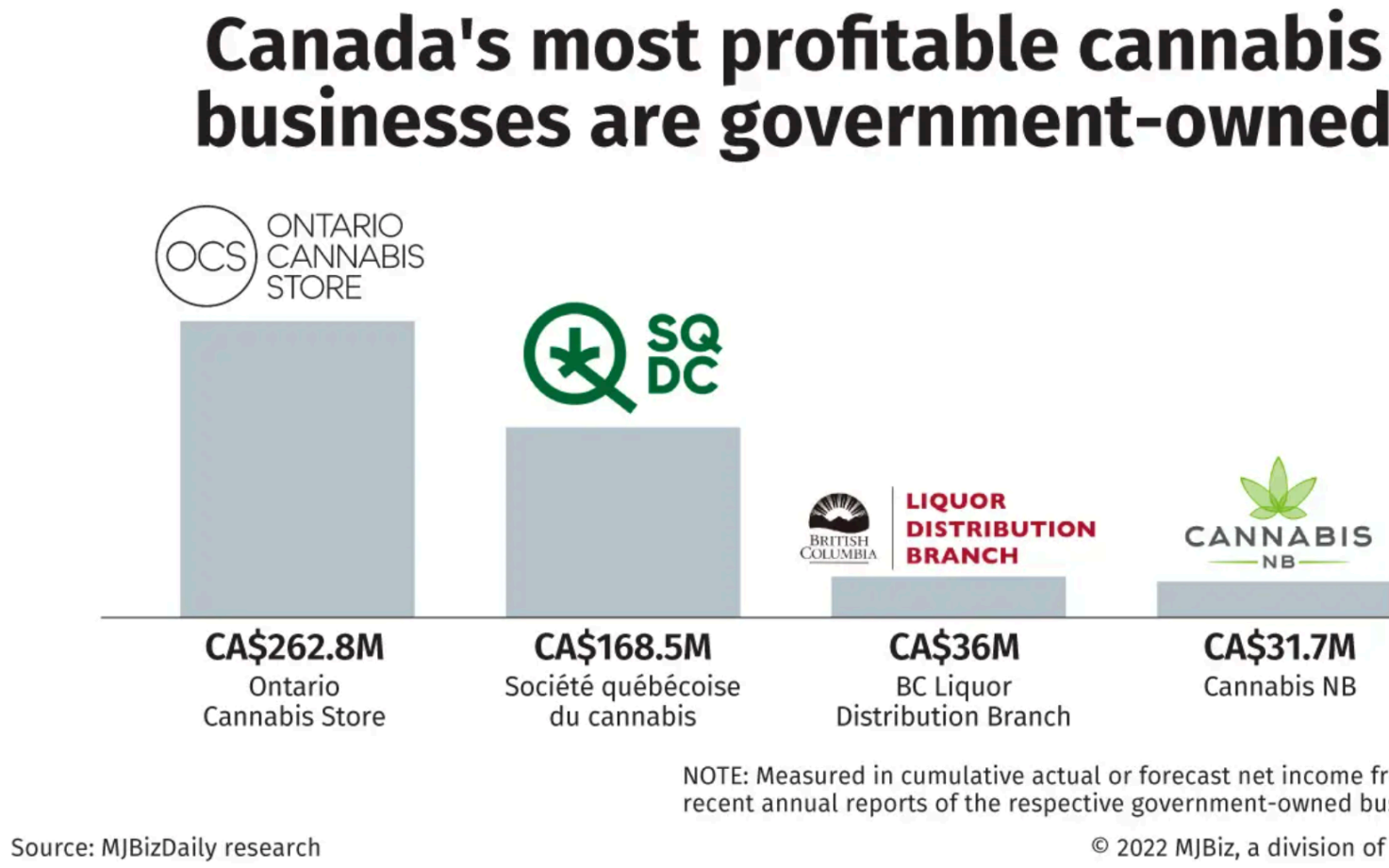
The Illegal Market and Other Industry Stressors

Although it was anticipated that the legal cannabis market, with regulated supply, quality control, and accurate product labelling, would displace the illegal market, the illegal market still persists in jurisdictions where legal cannabis production, sale, and use are permitted. The continuation of the illegal cannabis market impacts legal cannabis businesses' profitability and sustainability (Deschamps, February 9, 2023). Several factors that contribute to the perpetuation of a dual market are: cost, availability, convenience of accessibility (Childs & Stevens, 2021; Goodman, Wadsworth & Hammond, 2022) and potency (Mahamad et al., 2020). In Canada, for example, at the start of legalization in 2018, legal cannabis retail prices were often much higher than those in the illegal market (Childs & Stevens, 2021), up to 55% more (Public Safety Canada, June 15, 2020). There were also issues with supply and availability, particularly of preferred products (i.e., edibles, extracts, and topicals were not legal until October 2019, with availability slowly rolling out in 2020 – see Chapter on Alternative Drug Control Policies) (Watts, Newell & Putyra, December 13, 2019).

Higher prices in the Canadian legal market are attributed to high taxes, the regulatory and licensing fees (El-Cheikh, Bontes & O'Riordan, July 20, 2022; EY, 2022), and the capital expenditures and start-up costs of new businesses and a new industry (Deloitte, 2022; Ekidna, May 23, 2022). Taxes account for a large portion of every cannabis sale. For example, according to an Ernst & Young (2022) industry report, in Ontario taxes and provincial mark-ups make up over 45% of the price of legal cannabis products. Legal retailers and producers are therefore only able to capture a very limited amount of what illegal businesses can for cannabis sales (e.g., in Ontario 26% of cannabis prices charged to customers go to retailers) (EY, 2022).

In Canada, the most profitable cannabis businesses are government owned (see bar graph below for details). For example, the Ontario Cannabis Store (OCS) (Ontario's government owned online store and sole wholesale supplier to all legal cannabis retailers in the province) earn $234 million dollars in 2022 with a total of "$459 million of accumulated profits sitting in the bank" (Armstrong, November 29, 2023, para. 1). Although price reductions, improved product availability, and an increase in retail establishments since 2019 has helped to reduce illegal market demand by consumers (CCSA, June

2022), dropping product prices in the legal market (41% drop in wholesale prices in 2022) without a corresponding drop in taxes, combined with a highly competitive cannabis market, are particularly challenging for this nascent industry working toward profitability (EY, 2022).



Bar graph of most profitable government-owned cannabis businesses. ©MJBizDaily (2022). All rights reserved. Ima permission.

The number of cannabis licences at the Federal level (Health Canada, December 21, 2022) and increases in retail stores, in those provinces and territories with a private retail system (Alberta, British Columbia, Manitoba, Newfoundland & Labrador, Nunavut, Ontario, Saskatchewan, Yukon), particularly Ontario (MJBizDaily, August 2023), has resulted in an over-surplus of cannabis and greater competition for a market share (Paglinawan, August 17, 2022). The outcome being licensees struggling for survival, with businesses laying off their work force, closing facilities, and some going out of business (Blunt, January 10, 2023; Yun, February 10, 2023). For example, according to the Cannabis Council of Canada (C3), in the first 6 weeks of 2023, over 1000 jobs in the industry were lost (Lamers, February 16, 2023). Even large businesses have been impacted, as evidenced by Canopy Growth's February 2023 announcement of layoffs and plant consolidation plans (Deschamps, February 9, 2023). This has led C3 to lobby the government to consider changes in the current policy, advocating for reduced regulatory demands, fees, and rates of taxation (Eñano, December 1, 2022; EY, 2022; Lamers, February 16, 2023).

VIDEO: Canada's cannabis industry asking government for help.

This CTV Your Morning segment from February 17, 2023, discusses the challenges faced by Canadian cannabis industry and the changes the industry is seeking.

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12.4 Government Response to Cannabis Industry & Regulations

Provincial & Territorial Responses

Beginning in fall 2022, two provinces have announced incremental modifications to their cannabis regulations in response to industry concerns and an attempt to support the cannabis marketplace. For example, an October 4, 2022 Government of British Columbia news release introduced a new cannabis retail licence, the Producer Retail Store (PRS) licence. The availability of the new PRS came into effect on November 30, 2022 and allows "eligible federally licensed cannabis producers to sell non-medical cannabis products from stores located at their cultivation site" (B.C. Gov News, October 4, 2022, para. 1). In early 2023 in Ontario, the Ontario Cannabis Store (OCS) (February 16, 2023, para. 1) announced changes to its pricing structure. On September 11, 2023, the OCS transitioned to a fixed mark-up pricing model (OCS, June 2023), designed to improve profitability in the cannabis market and help the legal cannabis sector to complete with the illegal market (Leroux, August 8, 2023). Other provincial and territorial level changes are likely, following the completion of the federal legislative review of the *Cannabis Act* (2018) (see below).

Click the link below to read more about the OCS pricing structure changes:

Changes to the OCS pricing structure

Map of Canada

Federal Response

The Cannabis Act (2018) Objectives

Section 7: The purpose of this Act is to protect public health and public safety and, in particular, to

(a) protect the health of young persons by restricting their access to cannabis;

(b) protect young persons and others from inducements to use cannabis;

(c) provide for the licit production of cannabis to reduce illicit activities in relation to cannabis;

(d) deter illicit activities in relation to cannabis through appropriate sanctions and enforcement measures;

(e) reduce the burden on the criminal justice system in relation to cannabis;

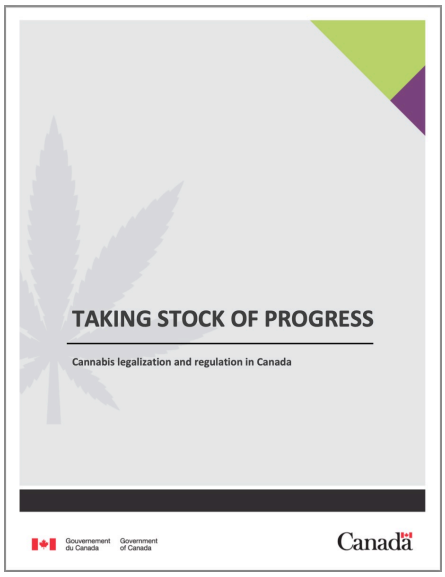
(f) provide access to a quality-controlled supply of cannabis; and

(g) enhance public awareness of the health risks associated with cannabis use.

The Cannabis Act (S. 2018, c16)

During the development of the *Cannabis Act* (2018), "it was widely recognized that effective implementation of the new legislative framework would require ongoing monitoring to assess early impacts, and flexibility to adapt and respond to emerging policy needs" (Health Canada, October 20, 2022a, p. 2). Towards this end, on September 22, 2022, the Federal Minster of Health, the Minister of Health & Addictions, and the Associate Minister of Health announced the start of the required legislative review of the *Act* . The purpose of the review, conducted by an independent Expert Panel, is to evaluate how the *Act* is meeting its stated objectives (see blue box above). The Expert Panel's focus also includes:

- "Economic, social, and environmental impacts of the Act.
- Progress towards providing adults with access to strictly regulated, lower-risk, legal cannabis products.
- Progress made in deterring criminal activity and displacing the illicit cannabis market.
- Impact of legalization and regulation on access to cannabis for medical purposes.
- Impacts on Indigenous Peoples, racialized communities, and women, who might be at greater risk of harm or face greater barriers to participation in the legal industry based on identity or socio-economic factors" (Health Canada, October 10, 2023, p. 3).



Cover from the Taking Stock of Progress Report

The goal of the review is to develop a report for Parliament that will assist with legislative revisions and reforms meant to improve the function of the *Act*. As part of the review process, on October 20, 2022, the federal government released a document entitled "Taking stock of progress: Cannabis legalization and regulation in Canada." The document outlines the key features of the *Cannabis Act* framework, provides information and evidence tied to the *Act*'s implementation, and "asks a series of key questions to solicit feedback from the public, partners, and stakeholders" (Health Canada, October 20, 2022a, p. 3).

Cannabis industry stakeholder input submitted to Health Canada reflects concerns for industry profits and sustainability, some of which are detailed on the previous page. Common themes in the industry input documents received by the government (see below C3, November 22, 2022; Olijnyk, October 22,

2022) include:

- Revising and reducing industry fees, taxes, and product mark-ups.
- Cracking down on the illegal market to level the playing field.
- Increasing allowable THC levels in cannabis edibles.
- Reducing restrictions on packaging and advertising.
- Removing taxes on medical cannabis products.

However, given the evidence-informed public health and public safety objectives of the *Cannabis Act* (2018) (see blue box above), it is likely that the Federal government will make smaller/incremental changes to the *Cannabis Act*, that may not be as responsive as hoped by the industry stakeholders (Raycraft, December 20, 2022).

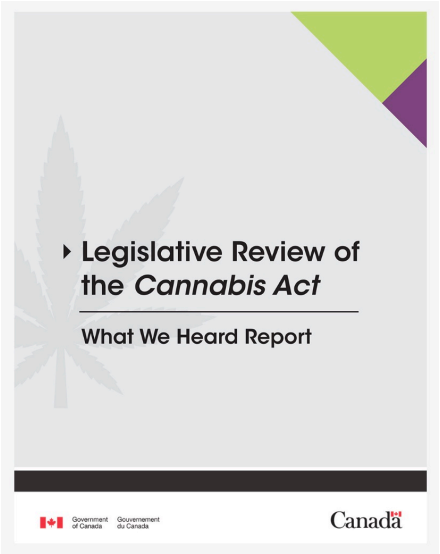
Click the link below to read C3's input into the *Cannabis Act* legislative review, which echos the input of other industry stakeholders in Canada:

Cannabis Industry Submission to Cannabis Act Review Calls for Immediate Financial Relief and for Governments to Bring Down the Walls of Stigmatization

Other stake-holders, particularly those in the public health sector, voice concerns about any lessening of the public health and safety and harm reduction measures of the legislation. Particular concerns are tied to harmful consumption patterns, made more likely with lower prices, increased ease of access, higher THC-level products, less restrictive labelling and packaging requirements, and products that may be appealing to children (CAMH/UVic, November 21, 2022). Evidence-based reports submitted to Health Canada, as part of the legislative review, by the CCSA (November 2022), CAMH/University of Victoria (November 21, 2022), and numerous academic researchers put public health first, reiterating the importance of adhering to the health and safety orientation of the stated purposes of the *Cannabis Act* (2018). While there is support for cannabis legalization in the Canadian public-health sector (Bogart, October 25, 2022), the general view is that "addressing the impacts of legalization on the health of Canadians must take precedence over the financial concerns of the cannabis industry" (Myran and Finkelstein, October 13, 2022, para. 3).

Click the link below to read the input of the Canadian Mental Health Association (CMHA) of Ontario into the *Cannabis Act* legislative review, which echos the input of other public-health organizations in Canada:

Legislative Review of the Cannabis Act



Cover from the Legislative Review of the Cannabis Act: What we Heard Report

On October 10, 2023, a preliminary report from the Expert Panel's legislative review of the *Cannabis Act* was released, with its final report and recommendations for the Canadian government expected in March 2024. The report summarizes what the Panel heard in their meetings with and via written submissions from the public and various stakeholders, including those in both the cannabis industry and public health. A number of issues and challenges are documented in the report, including those tied to achieving equity, diversity and inclusion (EDI) in the Canadian cannabis industry.

Click the link below to read the 8-page Executive Review in the Expert Panel's *Report*:

Legislative Review of the Cannabis Act: What we Heart Report

EDI Issues in the Cannabis Industry

Psychedelic cannabis leaf

Since its inception, the cannabis industry in Canada has been critiqued for its lack of representation and exclusion of certain populations (e.g., women, members of racialized communities). This is attributed to challenges experienced in applying for and obtaining government approved cannabis production and

manufacturing licences and, with legalization of recreational cannabis, the ability to receive licences to open retail establishments. For example, in terms of Federal Licences issued by Health Canada, in 2020, two years after the enactment of the *Cannabis Act*, "racialized men and women were significantly underrepresented among cannabis company executives and directors, 72% of whom were Caucasian men" (Deloitte, 2022, p. 8). Despite making up 50.9% of the Canadian population (Statistics Canada, 2022), women held only 14% of these positions (12% caucasian women, 2% racialized women) (Maghsoudi et al, 2020; Maghsoudi et al., 2023).

With regard to Indigenous representation in the industry, the Expert Panel's report (Health Canada, October 2023) notes that although Indigenous people make up 5% of the population residing in Canada, they hold only 2% of executive level positions in the cannabis industry. As of early 2023, "Indigenous-owed or -affiliated companies authorized to cultivate or process cannabis", made up only 6% of the 913 Health Canada granted licence holders (Health Canada, October 20, 2023, p. 38), and of the 3300 existing provincial and territorial retail establishments, less than 1% were operating in Indigenous communities (Health Canada, October 10, 2023; Lamers, February 24, 2023). Some of these disparities could be at least partially addressed through modifications to the *Cannabis Act,* that would grant authority to Indigenous governments to "issue licences for cannabis-related activities" on Indigenous land (e.g., cultivation, processing, distribution, and sale) (Health Canada, October 10, 2023).

Click the links below to learn more about EDI issues in the cannabis industry:

Underrepresented Communities Face 5 Major Systemic Barriers to get a Pot License: Health Canada

Indigenous Cannabis Entrepreneurs Underrepresented in Canada, Data Suggests

How Diverse is Canada's Legal Cannabis Industry? Examining Race and Gender of its Executives and Directors

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12.5 Psychedelics, Medicine & Research

From Cannabis to Psychedelics

The term psychedelic was coined in 1957 by Dr. Humphrey Osmond, a psychiatrist, to mean "mind manifesting", due to the ability of this class of substances to stimulate "changes in thought, perception, mood" (Osmond, 1957, p. 418).

The introduction of legal cannabis policies, combined with other experiments in drug policy (e.g., Portugal's full decriminalization of drugs in 2001), the implementation of harm reduction measures (e.g., safe consumption sites, drug testing facilities, safe supply, etc.), and an increase in scientific research about psychoactive substances and their effects, have helped open the discussion about other progressive policy changes. One class of drugs receiving much attention are psychedelics (e.g., Psilocybin, Ketamine, MDMA, LSD, Ayahuasca) for medical purposes. Recent reviews of research on medical use of psychedelics from the middle of the 20th century, combined with a rapid growth in research on psychedelics, has fueled the latest push for policy reform and the legalization of certain psychedelic drugs for a variety of mental health conditions. Along side efforts to medicalize

psychedelics, a legal psychedelic industry has begun to take shape.

VIDEO: *How psychedelics work, explained in under 6 minutes – Matthew Johnson*.

In the following video Johns Hopkins professor, Dr. Matthew Johnson, provides a quick explanation of the science of psychedelics substances.

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Psychedelics as Medicine

First Wave: Traditional Medicines

Rock painting of Selva Pascuala, near Villar del Humo.

The use of psychedelics for spiritual, mystic, health and healing purposes (e.g., mescaline, psilocybin, peyote, ayahuasca) by Indigenous communities long predates western-centric medicine and medical practices, and written historical accounts (Samorini, 2001; Strauss et al., 2022). This first wave of psychedelics as medicine is evidenced in fossils and rock art discovered by anthropologists around the world (Samorini, 1992, 2001), including the use of psilocybin mushrooms as far back as 9000 BCE in North Africa (Beck, 2021; Longrich, July 16, 2021; POPLAR, December 12, 2021) (see image above). Although there is much diversity in the specific rituals, practices, and beliefs across Indigenous groups, some similarities include psychedelics being viewed as sacred, "often administered through the guidance of a knowledgeable spiritual leader;… and carefully passed down across generations" (George et al., 2020, p. 5). Despite being one among an abundance of plant-based medicines integrated into modern Indigenous cultural and spiritual practices, such traditional knowledge and expertise, and the first wave more generally, is often overlooked in discussions of psychedelic medicine today (George et al., 2020; Sessa, 2006).

Second Wave: Western-Centric Medicine, 1940-60s

The event that precipitated the western-centric medical exploration of psychedelic substances, and the second wave of psychedelic medicine, occurred in the 1940s, when Dr. Albert Hoffman accidentally discovered the hallucinogenic properties of LSD (Lysergic Diethylamide). This discovery heralded the start of research into LSD-assisted psychotherapy. By the 1950s, Britain had a rich history in the area of psychedelic assisted mental health research and treatment (Sessa, 2006, p. 6) and studies in the area were taking place in other parts of the world (Costandi, September 2, 2014). From the 1950s-1965 the body of western-centric research grew, with studies finding that psychedelics could be used to treat a number of mental health and substance use issues. During this period of time, over 40,000 patients received LSD as part of their psychotherapeutic treatment. The studies of those treatments formed the basis for several dozen books and more than 1,000 published research reports (Costandi, September 2, 2014), some of which appeared in the newly founded Journal of Psychedelic Drugs (now known as the Journal of Psychoactive Drugs) (Smith, 2019).

Among the sources of promising research findings of the times, were Canadian studies at the University Hospital of Saskatchewan in early 1950s. These studies found LSD therapy to be an effective treatment for people experiencing alcohol use disorder (AUD), with some participants significantly reducing their consumption of alcohol, finding stable employment, and increasing their engagement with family and peers (MacDonald, June 12, 2007). Unfortunately, two issues emerged in the mid-1960s impacting psychedelic research: (1) a number of the studies of this time were critiqued for their lack of control groups and potential research bias (Costandi, September 2, 2014); and (2) in the 1960s LSD became embroiled in the politics of the counter-cultural movement, with its use demonized and blamed as the cause of social change occurring around the globe. By the end of the 1960s, LSD was criminalized in most countries and medical research in the area became extremely unpopular and difficult to conduct (Doblin et al., 2019; Sessa, 2006).

Click the link below to learn more about early Canadian research on psychiatric use of psychedelics:

Peaking on the prairies **(Warning: some stigmatizing terms are used, including the term "alcoholic", "mental hospital", "mental disorder", etc.)**

Third Wave: Western-Centric Medicine, Late 1990s+

Psilocybin for use in clinical trials.

Following a similar western-centre approach to medicine as the second wave, the third wave of psychedelic medicine (also referred to as the "psychedelic renaissance") began in the 1990s, with a rapid growth in research studies and publications (Dobin et al., 2019) applying contemporary research methods to the study of psychedelics. The research "came from two parallel directions. One was the development of neuroimaging and psychopharmacological studies… and the… [other] from some small exploratory clinical studies" (Nutt, 2019, p. 141.). In the second decade of the 21st century, psychedelic medicine is showing much promise for treating a variety of mental health conditions, becoming a separate field in the literature (Hadar et al., 2023).

Clinical trials have been exploring the efficacy of various psychedelic substances (e.g., psilocybin, MDMA, ketamine) to treat conditions such as: PTSD; SUD, including OUD and AUD; depression; social anxiety; eating disorders and body dysmorphic disorders; grief; death distress and anxiety, etc., with promising results (Rush et al., 2022a). For example, in a 2022 publication in the Journal of Psychopharmacology, the researchers report evidence that suggests "that psilocybin-assisted treatment for MDD produces large and stable antidepressant effects throughout at least 12 months after treatment" (Gukasyan et al., 2022, p. 157). A 2016 study of psilocybin treatment among patients with a life threatening cancer diagnosis found that "under psychological supportive conditions…, a single dose of psilocybin produced substantial and enduring decreases in depressed mood and anxiety, along with increases in quality of life and decreases in death anxiety in patients" (Griffiths et al, 2016, p. 1195).

Click the link below to learn more about the state of knowledge based on medical psychedelic research from Homewood Research Institute & Queen's University:

Psychedelic Medicine: A Rapid Review of Therapeutic Applications and Implications for Future Research: Executive Summary

12.6 Evolving Psychedelics as Medicine Policies

Accompanying a trip with psychedelics, Imperial Center for Psychedelic Research.

As of July 1, 2023 there are now four countries that permit to varying degrees the use of psychedelic-assisted therapies to treat various mental health conditions, Israel, the U.S., Canada, and Australia (MAPS, February 3, 2023; Australian Government, July 3, 2023). In 2019, the Israeli Ministry of Health approved the compassionate use for MDMA-assisted psychotherapy for PTSD (MAPS, February 4, 2019), with the U.S. Food and Drug Administration (DEA) doing the same later that year (MAPS, January 17, 2020). In January 2022, Health Canada announced a Special Access Programme (SAP), that allows doctors to submit requests on behalf of their patients for access to drugs for psychedelic-assisted therapy (Gilman, January 4, 2022). The rules and regulations of that program, however, can make it difficult for patients to meet the bar required for access (see video below). On July 1, 2023, Australia became the first country to to "classify psychedelics as medicines at a national level" (Nunn, June 30, 2023, para. 3), permitting authorized psychiatrists to prescribe psychedelics (e.g., MDMA, psilocybin) as part of psychedelic assisted psychotherapy, for the treatment of certain mental health conditions (Australian Government, July 3, 2023).

VIDEO: ***Terminal Cancer Patient Denied Compound in Magic Mushrooms After Rule Change.***

This CBC News report shares the story of Janis Hughes, a Canadian woman with stage 4 breast cancer, and her struggle to obtain approval from Health Canada for psilocybin to help treat her anxiety around

her diagnosis and impending death.

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In December 2022, Quebec became the first Canadian province or territory to cover doctor's services to administer psilocybin-based psychotherapy under its provincial health care plan (the Régie de l'assurance maladie du Québec — RAMQ) (Dunne, December 15, 2022). As of January 16, 2023, the province of Alberta enacted regulations that allow registered and licensed psychiatrists in the province to offer therapeutic administration of hallucinogenic substances, in a therapeutically supportive environment (Dyck, January 15, 2023). There are concerns though that the regulatory requirements of the new provincial policy will make it more difficult to offer and access such services (Kaufmann, January 9, 2023). The Alberta system parallels the new nation-wide Australian policy that came into force July 1, 2023. The Australian legislation permits authorized psychiatrists to prescribe psilocybin to patients for treatment-resistant depression and MDMA for PTSD (Alcohol and Drug Foundation, March 7, 2023; Carpenter, February 6, 2022).

At the state level in the U.S., on January 1, 2023, Oregon became the first in the U.S. to legalize the opening of licensed psilocybin service centres, that provide a supervised setting in which adults at least 21 years of age can consume psilocybin (Oregon Health Authority, n.d.). Under the new legislation, the Oregon Health Authority can "license and regulate the manufacturing, transportation, delivery, sale, and purchase of psilocybin products and the provision of psilocybin services" (Oregon Health Authority, n.d., para. 1). In the November 2022 U.S. election, Colorado voters supported a ballot measure that will permit the state to follow the example of Oregon, legalizing and regulating psilocybin and psilocybin services. As with Oregon, it will take several years to put the regulatory system into place, but as of January 4, 2023, psilocybin was decriminalized in Colorado, making it no longer illegal to possess for personal use or to use natural substances (e.g., psilocybin, DMT, ibogaine and mescaline), or grow psychedelic mushrooms in private residences (Gillette, March 13 2023). Legislation similar to Oregon and Colorado has been introduced in other states (eg., California, Connecticut, New Jersey) (Ducharme, February 8, 2023).

Click the links below to learn more about access to psychedelic medicine in Canada, Australia and Oregon:

Psychedelics on cannabis fast track to legalization

Magic mushrooms as medicine

Adults can now use magic mushrooms with supervision in Oregon

12.7 Psychedelic Industry Growth & Challenges

Emerging Psychedelic Industry

Stock chart showing the price of a stock over a specific period of time.

Along side the growing body of third wave research, as governmental policies evolve away from the prohibitionist orientation of the last century, the psychedelic industry has started to take form. Speculation of a potentially large market and growing demand for treatment products, has entrepreneurs and investors vying to become part of the potential future psychedelic industry (Brown, July 25, 2022). Investment continues into the dozens of publicly listed companies, many of which are relatively new startups (Jacobs, October 25, 2022). Despite steep stock price dips in 2022 (e.g., two of the largest publicly traded companies, Atai and Compass, fell 66%) (Filament Health, February 16, 2023), market projections like those by InsightAce Analytic are driving investments, with predictions of market growth increase from $3.94 billion in 2022 to $13.29 billion by 2031 (Insight Ace Analytic, June 27, 2023).

In this uncertain market with high pressure for returns, there are a variety of challenges that companies in this industry may face including: changing regulations and compliance rules; difficulties with trying to develop and patent products based on natural substances; the stigma associated with psychedelics (Bock, September 22, 2022); and pressure to produce large profits for investors (Phelps et al., 2022). As noted by Filament Health (February 16, 2023), in order for market projections to be realized, such as those of InsightAce Analytic (June 27, 2023) (and regulatory hurdles passed), a continuation of scientifically sound quality research is needed, as is the development of treatments that exceed the effectiveness of those currently used for identified mental health conditions. Developed treatments also need to be less-expensive/more cost-effective. In light of these pressures, Phelps et al. (2022) warn that the many companies funding their own research need to ensure that bias is not introduced into the studies.

Click the following links to learn more about the emerging psychedelic industry:

Investing in psychedelic stocks

The psychedelic industry's next hurdle is to go mainstream

EDI Issues in Psychedelic Research & Treatment

One significant problem with the existing body of medical psychedelic literature is the lack of diversity of research participants and researchers. Under-representation among research participants is problematic from a scientific perspective because it can lead to limited generalizability of research findings (Thistle, February 3, 2022; George et al., 2020). Exclusion and underrepresentation in research means a lack of knowledge of the effectiveness of psychedelic-assisted treatments for mental health issues experienced in Indigenous and racialized communities (Thrul & Garcia-Romeu, 2021) and unequal access to psychedelic-assisted treatments (George et al., 2020). In terms of researchers, practitioners, and the science of psychedelics, the absence and/or extreme underrepresentation of the psychedelic knowledge base of Indigenous and racialized peoples is a form of cultural appropriation, failing to recognize traditional healing methodology and expertise and "the value of a cross-cultural approach to understanding" for mental health care (George et al., 2020, p.5). According to Rush et al. (2022a, p. 9), those engaged in psychedelic research "need to acknowledge the risks to Indigenous people associated with appropriation of these medicines and to treat their origins with respect."

Click the links below to learn more about EDI issues in psychedelic medicine research:

How does Race and Ethnicity Influence Psychedelic Mental Health Outcomes? Psychedelic Spotlight

Whitewashing Psychedelics: Racial Equity in the Emerging Field of Psychedelic-Assisted Mental Health Research and Treatment

12.8 Chapter Summary

Key Summary Points

1. There have been various Canadian cannabis policies (e.g., *MMAR*, *MMPR*, *ACMPR*) and key court decisions (e.g., *R. v. Parker*, *Allard v. Canada*, *R.v. Smith*, *Allard v. Canada*) that led up to the eventual enactment of the *Cannabis Act* (2018) and legal recreational cannabis in Canada.
2. The Canadian cannabis industry began with the medicinal cannabis industry, under the *MMPR*. Obtaining a licence under the *MMPR* was a time-consuming and expensive process. Improvements have been made in the application process under the *ACMPR* and the *Cannabis Act*, resulting in an extremely competitive industry today. The same has occurred in the provinces and territories who permit private retail sales outlets.
3. The legal cannabis industry has and continues to face a variety of challenges including: access to banking industry services, the impact of the illegal cannabis market, and other industry stressors.
4. In fall 2022, a legislative review of the *Cannabis Act* (2018) began. The goal being to develop a report for Parliament that will assist with legislative revisions and reforms meant to improve the function of the *Act*.
5. Despite the traditional use of psychedelics throughout history and in Indigenous cultures, and the benefits found through Western-centric research, many ideas and policies surrounding psychedelics are rooted in stigma and misinformation. This is gradually changing in the 21st century, with evolving and innovative policy changes in countries like Australia, Israel, Canada, and the U.S. (particularly in Oregon and Colorado), contributing to an emerging psychedelic industry.
6. Both the cannabis and emerging psychedelic industries face challenges tied to equity, diversity and inclusion that must be addressed moving forward.

Additional Resources

Below are a list of supplementary resources for students interested in learning more about the chapter topics. These resources are NOT required course materials. A list of required course materials, beyond those found throughout this chapter, are provided on the following page.

Additional Viewings

Global News. (November 17, 2020). *Canada's cannabis industry has a diversity problem* [Video]. YouTube. https://youtu.be/CEx8gi9z6kQ

Additional Readings

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12.9 Chapter Assignment

Assignment Formatting, Style, & Length Requirements

- Assignment formatting requirements: Arial 12-point font; 1-inch/2.54cm margins; single spaced; APA in-text citation style, reference section and cover page.
- Use proper paragraph style within the answer to each question.
- Clearly indicate which question is being answered using corresponding question numbers (do not write out the entire question). Follow-up questions must be answered as part of the numbered question. Avoid using automated numbering as it alters the left margin of the document, resulting in a margin larger than 1-inch/ 2.54cm.
- Assignment length: approximately 1000 words in length (give or take 100 words) (reference section and cover page not included in word count).
- Divide your time/space evenly across all questions.
- Proofread your submission to make sure it is clear, well written and intelligible.

Assignment Instructions

- After completing this chapter's materials (chapter content, including all embedded links to readings and videos, and the required chapter materials) answer ALL the questions below.
- In ALL your answers be sure to demonstrate knowledge of and engagement with the chapter materials. This is achieved through supporting points/arguments/positions via reference to the course material using in-text citations. Providing in-text citations to support your points/arguments/positions is essential and required. Be sure to: (1) use a diverse range of materials, as opposed to relying heavily on a few sources; AND (2) cite material from current AND previously covered chapter materials.
- Only use materials outside of those assigned when specifically instructed to do so.

Assignment Questions

1. With the issues faced by the current legal cannabis industry and the emerging psychedelic industry in mind, identify one similarity and one difference in terms of the issues faced by the two industries. Explain both and discuss what factors can account for the similarity and difference you identify?
2. Using the current week's materials **AND** the materials assigned up to this point in the semester, explain how we have arrived at a point in time where we are loosening our prohibitionist stance

toward substances, substance use, and people who use substances. Be sure to identify and discuss important policy and attitudinal changes that have made such movement in the direction of progressive policy change possible.

3. What is the most significant thing you **learned in this course**? How has this knowledge impacted you and your understanding of substance-related policies, programmes and/or treatments and the need for social change? If you could change one thing in terms of substance-related policies, programmes and/or interventions, what would it be? Why? What would need to happen in order for this change to occur?

12.10 References & Media Attributions

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APPENDIX A – Chapter Reviews

University of Windsor students and recent graduates reviewed and provided feedback on the chapters in this eCampus Pressbook. The following are the brief overall feedback summaries provided for each chapter.

Chapter 1 Review

"Chapter 1 is a comprehensive and well-organized introduction into psychoactive substances that provides students with a sound foundation for the rest of the book" (Alyssa Woodbridge).

Chapter 2 Review

"The chapter requires the learner to be present, as we navigate between past, present, and futures entanglements of the changing definitions of drugs and the impact this has on the people who use them. One of the most interesting features of this chapter is how the author opens up new ways to think about something while enclosing action and potentialities for the learner to discover" (Bridget Nicholls).

Chapter 3 Review

"Overall, this chapter provides an in-depth description of certain social factors that may impact one's health/wellbeing, possibly leading to substance use disorders (SUDs). While this chapter goes over important prevention methods, it also elaborates on groups which may be disproportionately targeted by these social harms. All in all, the importance of this chapter lies in its relevance to Canadian society and its recommendations to expand Canadian policy through 'upstream' methods" (Olivia Mirisola).

Chapter 4 Review

“This chapter provides an insightful and engaging look at the history of Canadian drug policies, and the societal changes that contributed to their formation. Throughout the chapter, students are able to hear from both voices that were directly affected by the formation of these policies, and experts on the history of Canadian drug policy. By the end of the chapter, students are given the opportunity to critically reflect on the impact-fulness of the material” (Chantelle Dagley).

Chapter 5 Review

“Chapter 4: Contemporary Canadian Drug Policies & Their Impact educates readers on the Canadian Drug Policy and the impact that drug prohibition and the war on drugs had on society. The chapter takes readers on a journey through the process it took to get to the Canadian Drug Policy we have today. Through engaging videos and easy-to-read articles, the readers are able to understand the negative effects resulting from drug prohibition, and allows them to better understand the effects of drug policies that are not usually talked or thought about in today’s society” (Yara El-Houssami).

Chapter 6 Review

“Chapter 5 is an informative chapter that allows students to broaden their perspective and knowledge of drugs and drug policy” (Alyssa Woodbridge).

Chapter 7 Review

“All in all, this chapter lays the groundwork for prohibitionist drug policy and the effects it has on society in regard to substance use and substance use disorders. It discusses the current war on drugs and elaborately details how harshly penalizing drugs and drug usage only fuels this crisis, triggering negative outcomes” (Olivia Mirisola).

Chapter 8 Review

“Critically engages students in discussions surrounding both decriminalization and legalization of substances. By comparing alternate models of decriminalization, students are able to address social and economic impacts of decriminalization” (Holly Deckert).

Chapter 9 Review

“An engaging chapter that enables students to reflect on the times when they themselves contributed to stigma and learn how to adapt a more inclusive and judgment-free mindset” (Alyssa Woodbridge).

Chapter 10 Review

“This chapter provides students with factual information that gives them the tools they need to distinguish fact from fiction regarding people who develop SUDs” (Alyssa Woodbridge).

Chapter 11 Review

"An engaging chapter that allows students to understand and critically reflect on the benefits of harm reduction strategies" (Chantelle Dagley).

Chapter 12 Review

"This chapter offers its readers not only an engaging examination of the legal pathways, but an insightful window into the challenges and tensions over acceptance and illegality. The author takes the reader on a journey through seeing cannabis and psychedelics challenged and encourages her readers to reconsider their understanding of these drugs, as well as the business, political, and medical practices surrounding them" (Bridget Nicholls).

2

APPENDIX B – Materials Used With Permission

Subchapters	References & Attributions
1.3	CSUCH Scientific Working Group. (2020). Canadian substance use costs and harms 2015–2017. (Prepared by the Canadian Institute for Substance Use Research and the Canadian Centre on Substance Use and Addiction.) Ottawa, ON: Canadian Centre on Substance Use and Addiction. https://csuch.ca/publications/CSUCH-Canadian-Substance-Use-Costs-Harms-Ontario-Infographic-2021-en.pdf Canadian substance use costs and harms 2015–2017. © Canadian Institute for Substance Use and Addiction (2020). All rights reserved. Image used with permission.
5.1	Health Canada. (2018a). Pillars of the Canadian drugs and substances strategy. https://www.canada.ca/en/health-canada/services/publications/healthy-living/pillars-canadian-drugs-substances-strategy.html Pillars of the Canadian drugs and substances strategy. © Health Canada (2018). All rights reserved. Image used with permission.
6.1	United Nations Office of Drugs & Crime (UNODC). (n.d.). Chronology: 100 years of drug control. [Photograph]. https://www.unodc.org/documents/wdr/WDR_2008/timeline_E_PRINT.pdf United Nations Office on Drugs and Crime Chronology: 100 Years of Drug Control. ©United Nations (n.d.). All rights reserved. Image used with permission.

7.1

International Drug Policy Consortium (IDPC). (February 10, 2022). Decriminalisation of people who use drugs: A guide for advocacy. http://fileserver.idpc.net/library/IDPC-Decrim-Guide-EN.pdf

Decriminalisation of people who use drugs: A guide for advocacy. ©IDPC (2022). All rights reserved. Image used with permission.

9.3

Canadian Centre on Substance Use & Addiction (CCSA). (2021).The Pain of Stigma: Recognizing Stigma and its Impacts. [Online Module] https://www.ccsa.ca/module/stigma-learning-module-en/#/

The Pain of Stigma: Recognizing Stigma and its Impacts. ©CCSA (2021). All rights reserved. Online module used with permission.

9.4

Canadian Centre on Substance Use & Addiction (CCSA) and Community Addictions Peer Support Association (CAPSA) (2021). Insights on Substance Use: Understanding the Science on Substance Use Disorder. [Online Module]. https://ccsa.ca/module/stigma-learning-module-2-en/#/

Insights on Substance Use: Understanding the Science on Substance Use Disorder. ©CCSA and CAPSA (2021). All rights reserved. Module used with permission.

9.6

Canadian Centre on Substance Use & Addiction (CCSA) and Community Addictions Peer Support Association (CAPSA) (2021). Insights on Substance Use: Understanding the Science on Substance Use Disorder. [Online Module]. https://ccsa.ca/module/stigma-learning-module-3-en/#/

Stigma ends with me: Changing the Conversation about Substance Use. ©CCSA and CAPSA (2021). All rights reserved. Module used with permission.

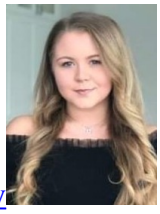
12.3

MJBizDaily. (2022). *Canada's most profitable businesses are government-owned*. https://mjbizdaily.com/wp-content/uploads/2022/09/canada-profit.webp

Canada's most profitable businesses are government-owned. ©MJBizDaily (2022). All rights reserved. Image used with permission.

About the Authors

Jacqueline Lewis, PhD (She/Her) is an Associate Professor in the Department of Sociology & Criminology at the University of Windsor. She received her doctorate in sociology from the University of Toronto in 1994. Over the course of her career, her teaching and research has focused on: the impact of public policy on the health and well-being; identity and stigma management; drugs, drug use and drug policy; illness, death and dying; sex work, sexual labour and sex work policy; and research ethics.



Jillian Holland-Penney completed her MA in criminology from the University of Windsor in December 2021. During 2021-22 she worked as the project manager for two eCampusOntario course development projects. For 6 years, while completing her BA and MA, she was a fastpitch athlete and an Academic All-Canadian. In 2022 she was awarded both the MVP trophy and the University of Windsor Lancers Captain's Trophy.