EXPLORING THE HELP-SEEKING / HELPING DYNAMIC IN ILLEGAL DRUG USE

by

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A thesis submitted in conformity with the requirements for the degree of Doctor of Philosophy
Graduate Department of Adult Education and Counselling Psychology
Ontario Institute for Studies in Education
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ABSTRACT

Heuristic qualitative research techniques (Moustakas, 1990) were used to explore the dynamic of the help-seeking / helping relationship in illegal drug use from the perspective of the professional. Six professionals, expert in helping people living with an addiction, shared their opinions and insights, analyzed problems, explained the rewards, and made recommendations for improvement, based on their own practices within the health care and social services systems. These professionals identify stigma as a major barrier to the provision of quality care in addictions, and analysis shows that a cultural predilection for scapegoating underlies the application of stigma. The many layered social purposes served by the designation of certain substances as illegal and the utility of scapegoating to hegemonic, vested interests is surveyed. This thesis reviews the true social costs of addictions, the entrenched and enmeshed nature of the alternate economy, and the many above ground institutions and professions sustained by the use of drugs designated as illegal. Prohibition and imprisonment as a response to illegal drug use is exposed as costly, inhumane, dangerous, and overwhelmingly counterproductive in terms of limiting harm from illegal drug use. A recent example of drug prohibition propaganda is deconstructed. Consideration is given to the role of the Drug War as a vehicle to accelerate social creep toward a fragmented self-disciplining surveillance society of consumer-producers in the service of economic elites. Classism is brought forward from a fractured social ground characterized by many splits: sexism, racism, age-ism, able-ism, size-ism, locationism, linguism, and others, to better track the nature of the social control that illegal drugs offer to economic elites. The
moral loading that surrounds illegal drug use is deconstructed and the influence of religion is presented for discussion. The primitive roots of human understanding that endorse the ritual *Drug War* and its supporting mythology, leading to the demonization of illegal drugs and the people who use them, are uncovered. Direction is taken from Benner and Wrubel's *Primacy of Caring* (1989) and other leaders in the professions as a means to move practitioners away from their roles as agents of social control into a paradigm of social change.
DEDICATION

This thesis is dedicated to the memory of Giovanni (Johnnie) Belanco, my adopted son of the spirit. He died too soon, of overdose under suspicious circumstances in 2007, just after his 32nd birthday, in Yorkville, Toronto.

After a drug-using career spanning 17 years, Gio had turned his life around. He left *The City*, completed his schooling, worked out religiously, and made amends where he could. He planned to study business while working as a hairdresser, in hopes of opening an image center where people could rebuild their lives, starting with their appearance and going on through counseling to redefine their lives.

In the past, Gio had organized a cocaine deal for the woman in whose home he died. She failed to pay her debt, and he was on the hook. Gio had received threats from a wannabee Hells Angel, who was owed the money. These amounts of money are hard to come by without involvement in illegal dealings. Gio stood between the woman and the wannabee. Gio visited her to enquire about an apartment, but succumbed to overdose instead. The firefighters who responded to the 911 call said that, had they been called even 5 minutes sooner, Gio might have lived. The woman, an illegal immigrant from Columbia, in Canada for the last 15 years, during which time she was never known to have had any job except dealing, was missing, together with her drugs and Gio's stake, money intended to cover first and last month's rent. Strangely, the Toronto police found nothing of concern in Gio's death. The woman is rumored to be an informant for the same police, and there is suspicion about the police themselves.

Gio's death represents all I have stood against, for all my many years of work in the field of addictions, and all the dysfunction brought by the prohibition of certain drugs. The pain evoked by Gio's passing is especially keen given the lethal head-on collision between the focus of my professional life, dealing with addiction, and the traumatic surfacing of the consequences of the illegal drug trade in my personal life. It is hard to lose a child, especially one of promise, when he finally abandons despair, decides to listen, turns his wayward self around, settles down, and works on making this worn world a little better.

Despite all his years of using and the hard life which accompanies it, Gio at his worst was brighter than most of us at our best. He greeted the world with enthusiasm and was accepting of all kinds of people. People had to really work hard to earn his disregard, and I have yet to meet the person who, despite any bad behavior, wore a hole in the respect that Gio held out to all he encountered.

Each period and comma on these pages represents a teardrop shed in the pain brought by Gio's untimely death. Yet, with the turn of each page, a keen ear might also hear his generous belly laugh roaring through the house. Readers are forewarned to brace themselves for fear of Gio's bear hug springing on them at the end of each chapter.
ACKNOWLEDGMENTS

The preparation of this thesis has taken far longer than I would have thought possible. Accordingly, I have two full Committees to thank for their help! The first Chair of my Doctoral Committee was Dr. Barbara Burnaby, who nurtured me along through the initial research stages of interviewing, transcription, grounded analysis, and family crises. The current Committee, which has seen this thesis through to the end, is chaired by Dr. J. Gary Knowles. I especially credit Dr. Knowles’ pragmatism, gentle prodding questions, and unfailing good cheer with helping me bring it on home.

As I reflect on the winding path to completion of this piece of work, I recall a key piece of advice from Dr. Don Sabo, given me at the time I completed my Master’s thesis. He cautioned me about my research agenda: “Carol, your research agenda is like a great big pie: You have to tackle it one piece at a time!” (I have been, Don.) I would also like to acknowledge with gratitude that Dr. Betty Lou Lynn, who I met in research class at OISE, is still by my side with her sustained and ongoing support. I also wish to thank Mr. Walter Cavalleri, MSW, social worker par excellence, with whom I worked in Parkdale for many years, for his steadfast belief in me and in our patients.

I wish to thank my colleagues, expert in the care of people living with an addiction, for speaking openly from the heart with me about their concerns and for trusting me to do justice to their truth-telling. Addictions work, done right, is possibly the most demanding area of professional practice: It not only complicates every illness, it moreover challenges our most profound understandings of humanity and forces us to be clear about what we think we’re doing professionally and about what we think is our purpose here in this world.

I credit my patients and colleagues who use, or who spend time with those who use, for their patience. My interest in exploring what goes on in the help-seeking / helping dynamic when illegal drug use is part of the picture came out of the experiences they shared with me. I came to see that, all around the globe, people who use an illegal drug feel that they are not treated as well as others who have problems with their health. As a person who educates professionals, I felt I needed to know more about what was going on.

I am proud of my family, who tolerated my academic habit for years and years: books and papers sprinkled all over the house, milk crates full of books stacked to the rafters, money gone forever into the yawning maw of the photocopier, weekends absorbed in study, and continual discussion of social inequities. This thesis is a testament to their love, tolerance, and ability to see beyond: thanks!

Finally, I wish to acknowledge the Ontario Institute for Studies in Education, the Social Science and Humanities Research Council, and the Canadian Nurses’ Foundation for their financial support. Without their support, this thesis would still only be a dream: Many thanks!
PROLOGUE
Baird Really Sticking it to the Poor

Of all the cynical acts of the government, probably none matches the show put on this week by cabinet minister John Baird when he announced a plan to make social assistance recipients undergo drug testing or lose benefits. There he stood in front of a Queens’ Park news conference, . . . , tossing [syringes] around the room, doing his utmost . . . to incite fear and loathing of the poor, doubling the stigma the most vulnerable in society bear by suggesting that to be in need is almost by definition to be a drug abuser. Baird said that syringes are, for many people, “the instruments of despair.” He said he didn’t want the poor “shooting their welfare checks up their arms”, or using “their welfare check to feed their drug habit instead of feeding their children. . . .”

The government’s almost naked malevolence, its breathtaking hypocrisy, its astonishing ignorance of—or indifference to—the complex nature of addiction, which neuroscientists are just beginning to understand, is sickening. First, as with most diseases, addiction is scrupulously democratic. It is spread across all socioeconomic groups. There is no evidence it is more pervasive among social assistance recipients than any other class. Addiction has nothing to do with intelligence, success, social standing, or willpower. . . . Anyone who has attended a 12-step meeting in this city knows he or she is as apt to encounter Queen’s Counsels [elite lawyers] and Bay St. [stock market] players, award-winning actors, athletes, authors, a sizable contingent of media personnel, and, I dare say, the occasional politico, as they are someone who spent the previous night on a park bench. . . . In fact, if anything, research tends to show higher incidence of substance abuse among those in high-pressure jobs. . . . Cops are particularly susceptible. Doctors too, especially since they have easy access to supply. It’s funny, since the former carry guns and the latter wield scalpels, either of which might be injurious, and both are on the public payroll, that Baird isn’t proposing to take his urine jars to police stations or hospitals. . . . No, Baird was obviously out to stigmatize the poor.

The major problem is alcohol; always has been, probably always will be. Alcohol is subject to vastly more abuse and is the cause of vastly more personal and property damage than all illicit drugs combined. . . . Baird’s “instruments of despair” should have probably been a shot glass or draft glass. But that would have made it too mainstream, too middle-class. That would have made it far less easy for Baird to demonize social-assistance recipients, to define them as law-breakers, as something alien and anti-social, as something other than us. . . .

Hypocritical . . . would not be too strong a word. . . . Neither would despicable. . . . Or calculated. Or callous. . . . But when it comes to the government and its unspeakable treatment of the poor and vulnerable, words usually fail us.

(Jim Coyle. [2000, November 18]. The Toronto Star. Saturday, p. A7. about the Mike Harris Conservative Government of Ontario)
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Katrina

Benign looking, even beautiful from a safe distance, hurricanes bring confusion, alarm, chaos, harm, and death in real life, in the same way that destructive interacting social forces whirl around the illegalization of certain drugs.

Acrylic on felt (Polych, 2009)
CHAPTER I
WHY CARE ABOUT A JUNKIE?
This is Care. . .

Anna, a 27-year-old Canadian-born mother of two, was treated in the Emergency Department of a major Toronto hospital for a near-lethal overdose of heroin. Once recovered, Anna was caught red-handed by the nurse, loading syringes into her purse: Security ejected Anna from the Emergency Department (ER) for stealing and she was barred from ever returning. Two weeks later, Anna again overdosed and, blue-lipped, was rushed in a taxi by her friend, Ruby, to the same near-by Emergency Department. Security recognized Anna before Ruby even had a chance to ask for help with carrying Anna. Both women were immediately and forcefully thrown out.

Without medical intervention, Anna died in Ruby’s arms 5 minutes later on the lawn in front of the hospital. How did Anna come to such an untimely death? Where did things go wrong? The manner of Anna’s death did not make the news: Why not? As I struggled through my dismay and asked myself these questions, I was keenly aware that behavior takes place in context, and I asked myself how Anna’s drug use and death made sense given the circumstances.

This thesis, presented in ten chapters, will profile some of the findings of this heuristic study (Moustakas, 1990), integrated with interview material and relevant literature, that helped me better understand what had happened to Anna. I interviewed six professionals at length; they are widely acknowledged experts who are respected generally for their contributions to the field of addictions: Aldo, Doug, Harry, John, Max, and Neal. Material from their interviews is interspersed with information gleaned from the literature and with my analysis of the situation surrounding illegal drug use. The interviews highlight particular aspects of the analysis, itself driven in large part by clues provided by the participants in their interviews, and bring depth to the study of the dynamic of help-seeking / helping in illegal drug use.

As I prepared for the interviews, I was aware that it was important to consider how each professional represents himself if I was to successfully
interpret the report I would receive from the professional of his approach to people who seek help with addictions. By necessity, the participant has the central place in his account of his career and experience. Each interview can be thought of as an interpretive performance, which weaves from montage to montage across timelines to form a coherent and powerful narrative mosaic. It was my hope that I would come to better understand the patterns evident in the treatment of addictions and the complexity of what help means in addictions, based on the situations detailed in each story. The narratives shared by the participants were vivid and instructive, and illustrated the shifting intersects of possibility, intentionality, and mastery in the practice of their professions. As I listened to the chronicle of events that served as way markers on the journeys of these professionals, undertaken to close the gap between what we have and what we need in addictions, I noticed that an ironic chuckle was never far away.

From the introduction of Chapter 1 right through to the conclusions drawn in Chapter 10, this thesis draws on direct quotations (often set off in a block) that highlight the actual observations, insights, and analyses of Aldo, Doug, Harry, John, Max, and Neal. This thesis aims to: a) underscore the importance of a more careful consideration of illegal drug use; b) to clarify some of the hardships, costs, and benefits of illegal drug use in North American-EuroWestern society; c) to stimulate more thoughtful understandings of how illegal drug use fits in Canadian culture; and d) to outline more productive approaches to living with the use of drugs that are now deemed illegal.

This research digs deep into the dynamic of illegal drug use. I will first review the background to illegal drug use in Canada and North America, followed by an examination of the cultural roots of addiction, then I will present material to further illuminate the social context of illegal drug use. The path leading to my concern about what happens to people who use an illegal drug is outlined. I next summarize the views of the participants, related in detail throughout the text of the thesis, and attempt a thumbnail sketch of each professional interviewed. I will go on to consider pharmaculture and the mythology surrounding illegal drug use within the North American-EuroWestern context, and will follow that with an
exploration of the role of deviance in maintaining the social control of behavior in industrial society. Next, I hope to acquaint the reader with causal network analysis as one avenue to better understand the complexity of the social dysfunction involved in illegal drug use. I will then review the basis of professional behavior, and introduce material from Benner and Wrubel's Theory of the Primacy of Caring (1989) as a possible source of guidance toward the legitimation of a healthier, authentic, professional style and practice. Finally, I offer a synthesis of some of the conclusions that I drew in the course of analyzing the data, reviewing the literature, and my reflections on the evolving social context of illegal drug use. I close this thesis with a summary of concerns, cautions, and recommendations for change and indicate some priorities for further study. Appendix A features more detail about the heuristic research approach (Moustakas, 1990) from which this thesis developed.

The tone of this heuristic thesis necessarily reflects my populist (Goodwyn, 1978) philosophy and worldview. My position as a professional working in the field will indelibly color my exploration and interpretation of the dynamic of help-seeking / helping in addictions; however, I have tried to root that account in the perspective of a person whose feet are firmly planted on the street. News items, lively and evocative vernacular, word pictures, poetry, metaphor, and paintings have been used to support a fuller appreciation of the embedded complex understandings of helping and addiction.

**State of Usage: Canadian Scene**

The use of substances, legal and illegal, to affect mood is extremely common in Canada. Canadians may believe they are world champions in beer drinking, but, in point of fact, they place only 12th worldwide in per capita consumption (NationMaster, 2010). Somewhat jarring to the comfortable self image, it is for illegal drug use that Canada takes the bronze, placing 3rd in cocaine use (CBC News, 2007; World Drug Report, 2006) and 8th worldwide in per person consumption of marijuana (NationMaster, 2010). Researchers who surveyed Vancouver club-goers for the use of 15 common drugs were
disconcerted when the first 20 partiers identified an additional 30 drugs recently taken for recreational effect (Stockwell, 2007).

Max, one of the participants interviewed in this research, reflects on the implications of such widespread everyday use:

People have a multiplicity of ways of getting high. It seems to be pretty well buried in human behavior. There are very few purists who use opiates and nothing else; they can be numbered on one hand. Most people have poly-substance problems. And not just that they use, but they have problems with those substances, such as we see with cocaine.

Cannabis use is very common among younger people, calling into question many common stereotypes about illegal drug use. About 44.5 percent of all Canadians surveyed voluntarily admit to using cannabis, although, 52 percent of people educated at the post-secondary level say they use marijuana (Canadian Centre on Substance Abuse, 2005, p. 73). In Ontario in 2005, only 10 percent of people over 45 years of age admitted to the use of cannabis; whereas, 38 percent of those aged 18 to 29 years reported that they took marijuana, although only 20 percent in the same age group would admit to smoking tobacco (Centre for Addiction and Mental Health, 2008). Ontarians further detail their use of substances on survey in 2004: 10 percent say they use hallucinogens, 9 percent take cocaine, and 5.5 percent turn to speed (amphetamine) with a further 4 percent using ecstasy. All together, over half of all twenty-somethings admitted to illegal drug use, while the general rate of use of illegal drugs by those Canadians aged 15 to 55 years hovered between 40 and 50 percent (Tjepkema, 2004, p. 11).

Doug, another expert participating in this research, points out a glaring contradiction in the understandings of the authorities and a gaping hole in the provision for health care in Ontario:

The government said it was going to force all the people on welfare to undergo urine and maybe blood testing to see if they’re using drugs. Then it would force cocaine and crack addicts into treatment: Where were they going to send them? And what were they going to do about marijuana use? They’d have to treat half the population! How can they force someone into treatment if they [government] don’t recognize it as a disability in the first place. . . ? Talk about bizarre contradictions. [chuckles]
These figures, based on voluntary uncorroborated self-report in response to surveys about illegal drug use, are vastly different than findings that do not rely on an admission of wrongdoing. Joyce Bernstein (cited in Wysong, 1997), epidemiologist for the City of Toronto Department of Public Health, found in 1997 that up to 14 percent of patients seeking help in the Emergency Departments of downtown Toronto hospitals had chronic cocaine problems. Hair analysis of babies born in 1991 in downtown Toronto showed that 12.5 percent of all newborns had prenatal cocaine exposure as a result of use by their mothers (Forman et al., 1994), a rate almost eight times higher than the 3.5 percent of Canadians (including males) who 2 years earlier voluntarily reported cocaine use. In 2004, 15 years after that survey, the rate of voluntary admission by Canadians to cocaine use had climbed to 10.6 percent, a threefold increase (Canadian Centre on Substance Abuse, 2005, p. 90). One can only wonder what the true incidence actually is.

Max distinguishes between the very common use of substances and the use of drugs in manner that could be understood as addictive:

Addiction is not substance use. It might spring up from substance use, but not always; and not for everyone does substance use lead to an addicted state, i.e., loss of control–compulsive use in spite of adverse consequences. . . . There are neurobiological aspects to addiction, as opposed to substance use. . . . Addiction, in contrast to substance use, is a chronic, relapsing condition . . . embedded in an environmental-social-political context. . . . [Relapse] is not failure. . . . They’re [users] engaged in a struggle. . . . They’re learning and re-learning how to live in the world without using a substance. . . . It’s [treatment] not just a happy, one-way street.

The Canadian Addiction Survey of 2004 (Canadian Centre on Substance Abuse, 2004) reported that roughly 4 million Canadians admit to having used an injectable recreational drug at some time. Health Canada has documented 125,000 regular injectors of cocaine, heroin, or steroids, and is particularly concerned that those using cocaine may inject as often as 20 times daily (Health Canada, 2001). While 1.1 percent of all Canadians admitted to injecting, mature people aged 45 to 54 years inject twice as often as younger people, at 2.3 percent (Health Canada, 2007, p. 60). Although heroin use has been reported
by about 1 percent of Ontarians, medical prescription has actually become the most common route to obtain opiates, usually in pill form, except in the port cities of Vancouver and Montreal (Fischer, Rehm, Patra, & Cruz et al., 2006).

Aldo, who also took part in an interview for this research, discusses his observations and understanding about how physiology makes addiction so preemptive and stubborn:

People who are addicted can tell you in great detail about their first use of that chemical. They have tremendous recall of this profound experience: they’re telling you the day of the week, the people who were with them, the colour of the wallpaper, the music that was playing on the jukebox.

When the drug is taken, there’s an excessive sense of reward, a memory of that reward, coupled with a compulsion or a hunger or a drive or a need to re-experience that reward. Somebody whose brain chemistry is waiting for opiates and who gets demerol for a broken leg never forgets it. The whole sense of reward-benefit is very different. The filter for the drug is broken, and we now know that’s tied in with brain chemistry. Somebody who doesn’t have that brain chemistry feels vaguely ill, maybe some nausea, out of sorts, says, “Geez, I don’t want that again.”

The tragedy of being addictive, is that you don’t know it until the chemical has been administered. If one has a family history of addiction, one is at greater risk of becoming addicted. The genetic vulnerability is clearly worked out now. The science is irrefutable.

It is not clear whether the previously mentioned figures from the Canadian Addiction Survey indicate an actual tripling of usage or a tripling of admission to use over the last 10 years (Canadian Centre on Substance Abuse, 2005, p. 93). Further questions arise about how accurately such survey data reflect the actual rate of use anyway, given the findings of Forman’s (1994) and Bernstein’s (1997) research. Still, even the figures from survey data reveal how widespread is the use of illegalized drugs, giving the lie to common beliefs about the exceptionality of illegal drug use. Despite the ubiquity of illegal drug use, Canadians absolutely deny any increase in harm from illegal drug use to their own physical health, home life, work life, social life, or finances. Still, many people do decide that their substance use is problematic and initiate treatment; about 80,000 Ontarians entered detox or substance abuse programs in 2005 (Ministry of Health and Long Term Care, 2007, April)—many, many more do not.
Aldo has found that, to change, people must be brought to the point that they realize how drug use is harmful to them and to see that, notwithstanding the risks accompanying treatment, change does indeed bring opportunity:

It’s a tremendous upheaval. . . . All that ambivalence: that awful, difficult place between admitting and accepting. “Do I, or don’t I [go into treatment]. . . ?” The message in the treatment of addiction is, “You’re responsible for you. How can I help you be responsible? I can’t do it for you.” It’s totally empowering. . . . I recognize that, to the outside, there’s a perception of rigidity, inflexibility, confrontation, anger, beat-your-head-up. It’s not the case. It’s the very opposite. I can’t imagine anything being more empowering. “You are responsible for you. You are accountable for your behavior. How can I support that. . . ?” Peers make a huge difference. It’s the peers that give the feedback (and that’s terribly important), rather then the staff saying, “Thou shalt . . .”

Interestingly, despite the still significant social harm visited upon Canadians by the response to the widespread use of illegal drugs, the bottom-line mortality figures do not support the sanctions brought in against them. The two substances most lethal to Canadians are, in fact, alcohol and tobacco, which, not coincidentally, are not illegal. Cook and Reuter (2007), economists, point out the cultivation of an indolent attitude among the general public by those who profit from the legal alcohol trade. Other professionals are even more concerned about the inordinate toxic influence of business on the good judgment of those who make decisions about health policy (Gual, 2007). Acknowledging alcohol and tobacco as the deadly drugs that they are would imply that drug use is not a deadly plague, but is a normal, pervasive part of life, and that drug users are neither evil fiends nor degenerate criminals (Kleiman, 2007), but neighbors and family. Drug users then must needs be treated seriously and their health problems addressed responsibly. Based on identification of the commonalities of addictions, many researchers call for a unified approach to the problematic use of alcohol, tobacco, drugs designated as illegal, legal drugs used in ways not originally intended, and all other substances, to better reflect the safety of use and to accommodate the burgeoning recognition of a variety of vehicles of addiction.

Harry, another professional working in addictions and participant in this research, has already adopted this understanding in his practice. “All addiction
is the same, whether it is to one drug or another. . . . I try to focus on that. . . . I think that the underlying problems are all the same, whether it’s alcohol or drug addiction.”

**Death-Dealing Substances**

Tobacco, the most lethal (legal) substance, resulted in the need for health care stretching over 2.25 million hospital days, more than 10 percent of the total capacity in the health care system; tobacco-related death followed for over 37,000 Canadians in 2002 (Rehm et al., 2006). The death count is very similar to that which would ensue if 9-11, the destruction of the US World Trade Center in New York on September 11, 2001, were duplicated in a cycle sweeping from the east to west of Canada. Each month, 3,000 Canadians die an untimely death, as surely as if disaster steamrolled, year in and year out, coast to coast, over each one of the 12 Canadian provincial and territorial capital cities. Sounds appalling? It is. But it’s perfectly legal, and evidently is entirely acceptable.

The next most deadly substance for Canadians is alcohol. It has both widespread and profound social effects, with one third of Ontarians classified as problem drinkers, and the use of 14 percent of those moreover assessed as hazardous (Canadian Centre on Substance Abuse, 2004). Liver disease and accidents account for most of the illness due to alcohol, putting Canadians in the hospital for over 1.5 million hospital days each year, and legally and predictably claiming about 8,000 Canadian lives annually.

Aldo says that we need to design new tools to quickly identify those who might benefit from treatment for addictions before harm comes to the person living with the condition or others:

One in five visits to a family doctor’s office is made by an active, drinking alcoholic. . . . Family doctors are very busy; they don’t have time to sit down and take a 30-minute detailed psycho-social-spiritual history—not on a fee-for-service system with 30, 40, or 50 people going through their offices daily. . . . They need history-taking tools or decision trees that let them, within 30 seconds, weed out those folks. It’s good to use such tools: they’re tested, and result in change in behavior when they use them. Such tools should also be used with every patient going into the hospital, because of the co-morbidity of addictions and other disorders.
Prescription drug use results in many more deaths than illegal drug use, but such deaths evoke very little attention. Roughly 24,000 deaths and 6,000 cases of permanent disability took place in Canadian hospitals in 2000 alone, primarily as a result of adverse reactions to medications\(^2\), according to workers at the Canadian Patient Safety Institute (Baker et al., 2004). The second leading cause of death related to medication use is simple error. (At this point, the only prescription drug death data available is that reflecting hospital treatment. One can only speculate about deaths among people who were treated in the community by drugs prescribed by their family doctors, as there is absolutely no systematic data available.)

There are a number of drugs that could potentially be prescribed to treat addiction. *Buprenorphine*, an opiate replacement mixed with an antagonist is now available in Canada, although *levo-\(\alpha\)-acetyl-methadol (LAAM)* is no longer offered for fear of heart trouble. *Methadone* is still the main drug approved for use in Canada to treat opiate addiction, but many opiate users do not find relief from methadone and its use has been tainted by negativity. Further, doctors who wish to treat their patients with methadone face additional training to prescribe it, even though their training already prepares them to prescribe any other opiate for any other condition. One site in Canada is now offering very limited access to heroin prescription on trial.

Doug is very clear that there is a place for court challenge to open a way to improve health care for those with an addiction who wish to be prescribed an effective legal substitute.

It can’t be shown that methadone is more dangerous than other drugs that are being prescribed for which no rules exist. . . . It might be a good thing if some legal challenge ended up in court, where the other side would be forced to defend their arguments in a context of the usual standards of practice. . . . I’d relish the challenge, to get before a court with a reasonable judge where arguments could be laid out and the other side couldn’t interrupt you and couldn’t give irrational arguments. Addictions treatment would be tested from a position of reason and analysis, and we would see what arguments held. I feel very confident that the merit of the argument for normalizing methadone is far stronger than any argument that would call for restricting it. . . .
But there's no one to hold the authorities accountable for their behavior. . . . There is no political will for a class action suit, and there is no class of people. You need political will and determination, and there's not a group of junkie-activists formed, organized, and able to take this on.

Paradoxically, the lethal cull among Canadians resulting from tobacco, alcohol, and prescription drug use make the macabre consequences of illegal drug use pale in comparison. Illegal drug use resulted in about one-tenth of the days in hospital due to alcohol and tobacco, and the deaths of 1,700 Canadians in 2002 (Canadian Centre on Substance Abuse, 2004). These figures are presented for comparison in Table 1.

Table 1:

<table>
<thead>
<tr>
<th>Cause</th>
<th>Death</th>
<th>Disability</th>
<th>Hospital Days</th>
<th>Year</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>tobacco</td>
<td>37,000</td>
<td></td>
<td>2,250,000</td>
<td>2002</td>
<td></td>
</tr>
<tr>
<td>adverse Rx, drug reaction</td>
<td>24,000</td>
<td>6,000</td>
<td></td>
<td>2000</td>
<td>permanent disability</td>
</tr>
<tr>
<td>alcohol</td>
<td>8,000</td>
<td></td>
<td>1,500,000</td>
<td>2002</td>
<td></td>
</tr>
<tr>
<td>suicide*</td>
<td>3,650</td>
<td></td>
<td></td>
<td>2007</td>
<td>300 via drug use</td>
</tr>
<tr>
<td>car crashes³</td>
<td>3,000</td>
<td></td>
<td></td>
<td>2005</td>
<td>for comparison</td>
</tr>
<tr>
<td>illegal drugs</td>
<td>1,700</td>
<td></td>
<td>350,000</td>
<td>2002</td>
<td>300 due to suicide</td>
</tr>
</tbody>
</table>

See Endnote #3 re: car culture (Transport Canada, 2006)  * (Kutchet & Szumilas, 2008)

Harry Simpson (2006), Director of Substance Abuse Services for Detroit's Community Health Awareness Group, which runs a needle exchange and other harm reduction initiatives, is aghast at the incoherent responses to a surge in untimely deaths related to illegal drug use. In a cameo tragedy, 125 people died in Detroit of overdose over the fall and winter of 2005-2006, a result of the substitution of fentanyl, a far more powerful opiate, for heroin. He reports that public health authorities all but ignored this outbreak. This indifference stands in bleak contrast to the hyperkinetic response in 2003 to the potential spread of
Severe Acute Respiratory Syndrome (SARS) corona virus, which resulted in widespread community education and rapid mobilization of health personnel. His analysis of the unconscionable paralysis of Public Health points straight at the stigma cast onto drug users, who are often seen as worthless throwaways in the prevailing drug prohibition paradigm.

Poem 1: Keen

Well now, I miss you
Just as this blue night settles in.
I've got the cat right here on my lap,
But never a drop of comfort.

Moon's up, I see you,
Lop-sided grin, shine down on me.
I'm slipping right along that star path,
Going so nowhere so fast.

Cold fog, I felt you
Far away, turn and cross the field.
I always thought you'd be right next me,
On the phone, in touch, at hand.

Black night, I need you.
Maybe you forgot to come home.
I'm tired of holding tight, waiting right
Here where you left me, alone.

'Splain how I lost you,
Between your heartbeat and my breath.
I'm looking for the one right answer.
Was she so much more than me?

And now I ask you,
So Smooth, where've you gone and got to?
Plans, deals, fast moves, rushing right on past.
What's her name? You say, “Cocaine.”

Carol Polych (2007)
Health Costs of Illegal Drug Use

The antithetically termed health care presently offered to people who use an illegal drug is overwhelmingly confined to downstream after-the-fact, disease-related treatment. Illegal drug use constitutes about 20% of the total cost of all substance use in Canada. About 20 percent of the total social cost of illegal drug use is attributable to health care. It is estimated that current health care costs related to illegal drug use across Canada as of 2002 were $1.1 billion (Rehm et al., 2006, p.1, 4). Pittance goes to prevention and research, at $16.5 million.

Hospitalizations related to drug abuse [sic] constitute a tiny proportion of all hospitalizations in Canada, 0.2 percent; still, this rate represents about 350,000 days in hospital (Rehm et al., 2006, p. 4), a rate about seven times greater than that of otherwise comparable people who do not use any illegal drug (Laine et al., 2001). Of admissions to hospitals in 1995 due to illegal drug use, 30 percent were due to drug-induced psychosis, 15 percent were related to cocaine, and 15 percent were in the aftermath of assault (Single, Rehm, Robson, & Van Truong, 2000). Pneumonia causes about 20 percent of admissions, and cellulitis and abscesses result in about another 15 percent (Palepu et al., 2001). Figure 1, following, illustrates the causes of hospitalization among people who use an illegal drug.
Figure 1: Illegal Drug Related Hospitalization by Cause: 0.2 Percent of Total

The use of an illegal drug was to blame for about 1 percent of all deaths of Canadians, resulting in a total of about 1,700 lost lives (CBC News, 2006). About 1,000 people succumbed to fatal overdose (OD), 300 completed drug-linked suicide, 150 were killed by terminal Hepatitis C infection (HCV), and almost 100 Canadians died of complications from Human Immunodeficiency Virus (HIV) contracted through illegal drug use. The main causes of death of people whose loss of life was related to illegal drug use is charted in Figure 2 below.
Max acknowledges the difficulty of developing a coherent and successful response to illegal drug use, and foregrounds the importance of matching a number of substitution therapies and treatments to the needs of the individual at least according to their metabolism and symptom profiles:

Patients’ needs have to be assessed on an individual basis and a treatment plan figured out. Some medications are going to work better for different people at different points in treatment. . . . It’d be good to have an array of medications, so treatments can be matched to patients’ needs. . . . We have yet to develop the perfect drug, and it ultimately may be determined by a person’s metabolism. . . . Some people find that methadone doesn’t get at the itch. There is a 24-hour up and down cycling on methadone, and for some, that peaking up and down is unacceptable. *LAAM* (levo-α-acetyl-methadol) taken twice a week is longer acting. . . . resulting in an almost steady state in the bloodstream; there’s no ups, no downs, no nothing. It’s just there. Some patients report that they feel more normal taking medication less frequently and have higher energy levels. Supplies of LAAM would run about $2,000 per patient, about double the $1,000 yearly cost of methadone, because LAAM came in from the United States. Similarly, the manufacturer of
buprenorphine, another type of opiate substitute, is in New York. We need to have a consistent supply of opiate substitutes, whether methadone, LAAM, or buprenorphine. If you run out of stock, it interrupts treatment.

“Just Say, ‘No’”

Behind bars.

In Canada, being caught with illegal drugs often results in incarceration, a solution which some might think would prohibit further use during the time while the person who violated the law served their penance. In truth, even inside supposedly secure correctional facilities, illegal drug use is prevalent (Pearshouse, cited in Gillis, 2007). Australian studies show that 75 percent of prisoners treated with methadone report sharing needles while inside (Dolan et al., 2005). In Canada, 15 percent of prisoners serving time for drug use admit to injecting while inside, 60 percent of the time, unfortunately, with a used syringe. In British Columbia (BC), incarceration has been shown to confer more than a 2.5-fold greater risk of catching HIV infection (Werb et al., 2008). And death from overdose has been documented at a rate 20 times more often among those behind bars in provincial custody and 50 times more often among inmates of federal penal institutions than among people living in the community (Fruehwald & Frottier, 2002).

Max is concerned about the entertainment of any ideas about using coercive strategies to address illegal drug use. He finds the specter of institutional internment particularly problematic:

We don’t have effective treatment that works in spite of people’s unwillingness or not wanting it. . . . Maybe one day we will have a neurochemical cure when we can change somebody’s behavior in spite of their wishes, but I see that fraught with difficulty. It’s going to be a dangerous tool. It’s going to ride in with all kinds of other problems. . . . When the administration of mind-altering substances is left to the state and you start talking about being able to affect thought, there are some real scary elements. . . . We need to be alert to the possibility that, in the wrong hands, substances or chemicals could be used to influence populations. . . . Psychiatric hospitals have been political prisons in our lifetime. . . . That’s the risky part of it. But there’s nothing that we do to improve human life that doesn’t present us with some problems further on. . . . It would be ill advised not to try to understand what danger is suggested.
Canada’s past Public Safety Minister in the current Conservative Federal regime, Stockwell Day, recently exercised of the power of his office by shutting down programs for safer tattooing behind bars, claiming that he didn't want to “waste taxpayers’ money.” The Chief Public Health Officer of Canada, Dr. David Butler-Jones, says the safer tattooing program would have recovered the full $100,000 annual cost of its implementation by preventing only 4 new hepatitis infections yearly. He points out that the program was not given enough time to demonstrate its worth (cited in Kondro, 2007, January), and he is concerned about the staggering potential consequences of its closure.

Day, an active fundamentalist-Christian (Hedges, 2006) extreme right-winger (Hoover, 2000), also shut down needle exchange behind bars. This intemperate action flew in the face of evidence from the Public Health Agency of Canada that needle exchange behind bars clearly decreases infection rates while causing no new security problems (Elliott, 2007). The lifetime cost of treatment for one Canadian who contracts HIV in Corrections (or elsewhere) is estimated to be over $250,000 (Werb et al., 2008). Werb et al. further point out that genetic typing of HIV now enables identification of the exact source of infection. Elliot speculates that both Day and Corrections Canada may come to a better understanding of the situation following legal action.

While Day’s behavior lends itself to open speculation about his motives, Doug has heard it all before, and voices his annoyance about the confusion generated by treatment approaches that are believed to be exclusionary:

The viewpoint of the people that would say that they are part of the so-called abstention camp derives, not from life experience, but from moral and philosophic grounds. . . . I’m weary of the term, harm reduction. *Harm reduction versus abstinence* represents a false divide between people and their views. . . . The term, harm reduction, raises tensions when you have these allegedly opposing viewpoints. . . . Even some very strict people say that they believe in harm reduction, but they’re the very ones who still breathalyse people; they won’t allow coke [cocaine], and so on.

**Needle exchange.**

Day’s misguided actions were abetted by those of Stephen Harper, another admitted religious fundamentalist, Bilderberg acolyte, and neocon.
Prime Minister in Canada’s Conservative Federal government. He appeared to be following Nancy Reagan’s simple-minded advice of 1983 to “Just say, ‘No’,” counsel displaying all of the sensitivity of Marie Antoinette’s social analysis, and doubly ironic given the addiction shared by the two Queens to ostentatious ornamentation and dress. Harper stated that, based on his understanding of the scientific data, Insite, the only safer injecting site operating in Canada, located in Vancouver, British Columbia (BC), must shut down. Even though research unequivocally documents the effectiveness of the safer injecting site (Canadian HIV/AIDS Legal Network, 2007, p. 12), Harper says he believes the evidence is heavily flawed. Small and Drucker (2007), internationally recognized experts on the HIV epidemic in North America, accuse authorities, bent on shutting down the safer injecting site, of having blood on their hands. Provincial authorities successfully challenged Harper’s dictate but face further appeals by the federal government still bent on shutting down Insite (Tibbetts, 2010).

Harry, another participant in this research, comments about the self-sabotaging efforts of some people living with an addiction. His insight mirrors the counter-productive behaviors of some authorities who, unfortunately, ignoring well-founded advice, make major decisions that affect many others:

I find a lot of people cut corners. . . . If you’re going to do your income tax and you have a question . . . you’re going to go and see an accountant. . . . So now you have an addictions problem and things have deteriorated to this extent, why do you think you can do it without going to an addictions worker [chuckles] and doing what that person tells you. . . . I’m not saying that the addictions worker is the end all and be all, but you go to somebody who knows more than you, and you put your trust in them. . . . The ones that think they know, the individuals who are going to do it their way, those are the ones that come back. . . . They don’t know what they need; they only know what they want.

Harper’s analysis is contrary to entrenched global public health principles and diametrically opposite to the recommendations of the Legal Affairs Section of the United Nations (UN) International Drug Control Programme (Canadian HIV/AIDS Legal Network, 2007, p. 9). It is, though, clearly attuned to the long-standing backward measures of the International Narcotics Control Board. In an astonishingly egregious manner, the Secretary of this Board, Kole Kouame, saw
fit in 2006 to scold Stephen Lewis, then the UN Secretary-General’s Special Envoy for HIV/AIDS in Africa, for supporting “opium dens,” after Lewis publicly commended Insite for its work (Canadian HIV/AIDS Legal Network, p. 13). This censure is entirely consistent with the position of the Board, which has been sitting in Vienna glowering at Canada for opening Insite in 2003, and which has pressured Canada ever since with unrelenting badgering and unjustified bullying (Small & Drucker, 2007).

Doug has weighed the analyses of the authorities, and finds that many decisions about illegal drug use are ill-informed:

The vast majority of debates are based on pure philosophical and ideological grounds that have nothing to do with evidence, have nothing to do with the dangers of drugs. . . . Decisions are made based on moral judgements, views of what addicts are like, and a philosophic opposition to the use of drugs . . . as intoxicants. The authorities have no good answers . . . . But they’re not bad; they just trundle on [chuckles].

The current Canadian government’s ham-handed approach to eliminating illegal drug use seems, in an echo of the past, to depend upon eliminating illegal drug users. In the late 1990’s British Columbia was disgraced internationally when HIV and Hepatitis was left to explode in Vancouver among injecting drug users, a direct result of undue restriction on needle exchange in a population in which cocaine use by injection was known to be very common (O’Shaughnessy, 2001; Small & Drucker, 2007). In British Columbia, 16 percent of the population admitted to cocaine use while only 2 percent reportedly used heroin (Canadian Centre on Substance Abuse, 2005, p. 73). Politicians, anxious to placate an outrageous, self-declared “moral” faction, disregarded their public health experts and imposed restrictions on the numbers of needles allotted each person who attended at the lone downtown Vancouver needle exchange.

Aldo, when speaking of the history of workers in addictions, might as well have spoken of political decision making in addictions:

You cannot use your own experience of personal illness alone in a therapeutic sense: You need to be trained as well. It’s a bit like someone saying, “I’m diabetic, so I’m going to treat diabetes, because I know what it’s like.” You may well have empathy; you may well have insight; you may well be able to develop a therapeutic bond more quickly than
someone who’s not diabetic: But you still have to go off and take the training.

Those in charge of making decisions about needle exchange may have been unaware of the different injection needs associated with cocaine and drugs used more commonly elsewhere. Cocaine is often injected at social gatherings, in a pattern of multiple frequent injections, sometimes not even 15 minutes apart, in bouts that can take place over a number of days. Because heroin takes 6-8 hours to metabolize and so is injected less often, typically no more than three times daily, injection is more likely to be planned and carried out in more controlled, private settings and requires fewer fresh needles than cocaine.

Objectors to needle exchange in BC pointed to the fact that those attending needle exchanges had higher rates of HIV infection than those who did not, and insinuated that exchange itself somehow spread HIV. Caught unawares by this “yellow-fingers-cause-lung-cancer” type of accusation, the scientific community was flummoxed and did not respond effectively until 2007 (Grebely et al., 2007). At that time, painstaking irrefutable research documented that, just so Virginia, the exchanges were indeed selectively and effectively reaching those HIV-infected users, who responsibly wished to eliminate any chance of spreading HIV by accessing fresh needles for each use.

Max sees a key role on a continuum of constructive intervention for trusted exchange staff to facilitate entry into treatment:

Treatment works when people want treatment. When people clearly don’t want treatment at a particular point in time, harm-reduction makes sense. When people don’t want to reduce the use of their substance, we need harm-reduction to give information about the substance and less injurious ways of using it. . . . There’s a need for attitudinal change to help staff recognize harm-reduction as a prelude to treatment and people’s readiness and willingness to enter treatment. . . . That’s [wanting treatment] a plastic, variable thing, which can be influenced through relationships with others.

The legacy of the failure to initiate appropriate needle exchange in Vancouver in a timely manner and the niggardly limits placed thereafter on needle provision to cocaine injectors has resulted in international infamy. It also bequeathed a scandalous prevalence rate of Hepatitis C, presently just below 70
percent, and an estimated HIV rate of 30 percent among people who live in the Downtown East Side of Vancouver (Leidl, 2007), an area home to many who are known to use an illegal drug.

The Canadian Drug War

Illegal drug use continues, in spite of the incarceration of legions of illicit drug users, prisoners in a draconian war against drugs. About 93 percent of the money spent each year on Canada’s Drug Strategy goes to enforcement intended to reduce the supply side of illegal drug use, despite documentation that drug seizures have no effect on street availability, price to the user, or overdose (Wood et al., 2003).

Max confirms the hypocrisy of enforcement strategies, acknowledging the immunity conferred by class and power, and noting the negative moral judgment cast onto those who are convicted:

Everybody uses drugs. It is not so much the use of an illegal drug that brings difficulty, but more so being caught or the fear of being caught. The thing is, only those who get caught with it, or are in some way caught into using it, or have to use it; those are the ones who are weak morally—the dependency of it. Who hasn’t smoked marijuana? Who hasn’t done this? Who hasn’t done that? In fact, for different sectors at different times, it’s considered almost a badge of courage. Okay, Bill Clinton [American ex-president] didn’t inhale, but Al Gore [usurped American president] did [loud, jovial voice, laughing]: He admits.

It has been said that, when the US catches a cold, Canada sneezes. Line Beauschesne (2002), professor of Criminology at the University of Ottawa, advised the Senate Special Committee on the Non-Medical Use of Drugs that Canada has the second highest rate of drug user imprisonment in the world, after only the land of stars and bars (Hedges, 2006, p. 18). As of 2002, Canadian drug laws had criminalized an astonishing 1.5 million Canadians for simply using marijuana, with 30,000 more charged each year with possession (John Howard Society, 2002). Roughly 150,000 Canadians yearly are under the supervision of the criminal justice system (Prison Justice, 2007). In Ontario, police were busy laying drug charges in 22,500 incidents in 2003, which resulted in a conviction rate of about 40 percent for trafficking and about 30 percent for possession (Canadian Centre on Substance Abuse, Ontario Enforcement
Report, 2006). And the Conservative Federal Harper government is set to expand prison capacity by a further 5,775 beds (Piché, 2010).

People who use an illegal drug may be caught up in the *carceral circle* (Foucault, 1997, p. 35), eddying dizzyingly through the criminal justice system, to be spit back into the population at large, only to be trapped again in the institutions intended to process them. Locally, the Waterloo Region Community Safety and Crime Prevention Council (cited in Contenta & Rankin, 2008, p. A7) confirms that, in their area, over half of all crimes committed are linked to substance abuse. Data from the Canadian federal prison system supports the Council’s observations. They report that about 50 percent of prisoners were under the influence of a substance at the time they were caught in the criminal act that resulted in their sentence, that roughly 80 percent of inmates arrive with a serious substance abuse problem, and that 90 percent of offenders have been previously convicted (Correctional Service Canada, 2007). (Missed opportunity here?)

Max outlines some of the bottlenecks which result in difficulty accessing the community based substitution treatment for addictions that could potentially subvert the circuit:

[Agency] Boards are often made up of ex-patients or ex-consumers, who may never have seen good methadone treatment, and their experience may have been that it is not helpful. . . . Some agencies recognize the value of substitution therapy and the utility of methadone, but it may have required change at the Board level and changes to staffing. . . . Others haven’t been able to get the funding needed to expand services or to add the additional counsellors and case managers [needed to offer substitution therapy].

**Justice Costs - Overt and Covert**

The economics of imprisonment do constitute good business, *collars for dollars*, (Reiman, 2004) an especially glaring economic fact in consideration of the US prison-industrial complex. During the lull between wars, precipitated by the collapse of Eastern European communist regimes, the decrease in US military spending, estimated at -$256 billion in 1998, was offset nicely by escalating spending on the control of street crime, which increased that year to $210 billion (Evans, 2005, p. 217). (Since, spending on US prisons has
continued to hover at about $214 billion as of 2006 (Bureau of Justice, 2010), while US military spending has climbed to an estimated $1 trillion for 2008 (Johnson, 2008).) Moreover, monies from the sale of property seized by American authorities from those said to be involved in the illegal drug trade further augmented the budget of many a state.

The direct cost of incarceration in the Canadian federal corrections system is currently reckoned as being about $250 per prisoner per day ($93,000 / yr), while the cost of incarceration in provincial facilities is estimated to be about $160 daily ($58,500 / yr) (Contenta, Powell, Rankin, & Winsa, 2008, p. ID6), the lesser amount a partial reflection of the paucity of programming for those serving 2-years-less-a-day or under. Together with policing, court costs, and the total costs of supervising offenders in settings other than prison, the yearly expense of the criminal justice system is estimated to hover between $10 billion (Prison Justice, 2007) to $13 billion (Contenta, Powell, et al., 2008, p. ID4).

Policing illegal drug use cost Canadians about $2.3 billion in 2002, more than double the amount spent on related health care. Sick time and time lost at work together with other costs related to illegal drug use were calculated to cost society an additional $4.7 billion. In comparison, funding for prevention was limited to a pitiful $16 million. In all, illegal drug use accounted for about $8.2 billion in direct costs in 2002 (Rehm et al., 2006). The Province of Ontario alone lost almost $3 billion to illegal drug use that year. Figure 3, following, summarizes some of the financial impact of illegal drug use on Canada in 2002. Notably, these figures do not begin to capture the human costs of the heartache associated with illegal drug use and the social responses to it.
The father of modern policing, Sir Robert Peel, advised that the quality of policing should be judged by the absence of crime, not simply by the visible evidence of police action (Puder, 1998). Disturbingly, despite all the effort, evidence shows that police cracking down on illegal drugs does nothing to reduce drug use at all and does not even affect price or availability. One gram of cocaine cost $600 in 1981 (about 10 days’ pay), but only $135 in 2006 (about ½ day’s pay), while purity increased from 60 percent in 2003 to 70 percent in 2006 (O'Shaughnessy, 2007); in 2008, cocaine sold in Canada was even cheaper: One gram of 99 percent-pure cocaine only cost the end user $70 (UN Office of Drugs and Crime [UNODC], 2009, p. 261) although it could be had in some locations for as low as $40 per gram (Royal Canadian Mounted Police [RCMP], 2010, p. 37). In 2009, the price of the longer lasting stimulant, methamphetamine (crystal), was $50 - $80 per gram (RCMP, p. 18), while the common party drug, 3-4methylene-dioxy-methamphetamine (ecstasy), sold for...
per gram (UNODC, p. 270), but was available by the tablet for $10-25 each (RCMP, p. 18). A gram of opium cost $30 - $150 (RCMP, p. 37); and refined heroin sold for $180 - $1,200 per gram (RCMP, p. 37). A gram of 23 percent-THC marijuana brought $10-$15 (UNODC, p. 264). As the War on Drugs wore on, despite escalating enforcement activity, the end user price for illegal drugs has steadily dropped over the last 10 years while purity and strength have only increased.

Harry reflects on what this means to the person who buys illegal drugs from the street:

A heroin user, starting off, could get by with not even $40 or $50 a day maybe; though things are changing quite rapidly on the street. Now it’s crack cocaine, which, depending on the individual, $50 can go in 20 minutes or a half hour.

The main effect of cracking down seems simply to be the employment of police in driving illegal users deeper underground or into new areas, thereby making outreach and access to service more difficult (Wood, et al., 2004). Spin-off work is also generated for the courts and corrections as a result of this type of focused policing that targets end users. Unfortunately, treatment capacity seems to be choked and capped, so that such intensive policing efforts lead only from the courts to prison with effectively no new treatment entrants.

As a culture, Canadians face not only the loss to the justice system of parents, siblings, and neighbors imprisoned, sometimes for decades, on drug charges, but also fruitless financial stress on the entire society. The billions, set aside to prohibit, police, and punish illegal drug use and related activities, are diverted from public monies that could support healthy families and a vibrant society in which drug use is unlikely. The relationship between social spending and rate of imprisonment is reciprocal, with Canada, ranking 5th from the bottom in welfare spending, while imprisoning its citizens twice as often as high-support countries such as Sweden or Finland (Downes & Hansen, 2006). Social initiatives which suffer underfunding as a consequence of high rates of imprisonment, to name only a few that would benefit young people include: child care, pre-school programs, special-needs education, language integration
classes, enrichment classes, outdoor education, school lunches, community centers, pools and playgrounds, after-school activities, living stipends for homemakers, university tuition, apprenticeship incentives, fitness activities, team sports, development of the arts, and so on and on.

The Waterloo Region Community Safety and Crime Prevention Council (cited in Contenta & Rankin, 2008, p. A7) complains that waiting lists for treatment are ridiculously long. Of every 10 identified drug users, 3 sought treatment for addiction in 2005, but were not able to find it (Fischer, Cruz, & Rehm, 2006). The past Chief of Ontario’s Office of Child and Family Service Advocacy bitterly observes that help is not available even for teens diagnosed with a mental health disorder, such as an addiction. He concludes that, since there is nowhere to send them for help, they collect in the youth justice system by default (Finlay, cited in Contenta & Rankin, 2008, p. A7).

Doug agrees there is a crisis due to a lack of timely appropriate treatment, and recommends adding an emergency-type service and Intensive Care Unit (ICU) model to the repertoire of treatment:

- It is important to have treatment available on demand. If someone needs or wants to be treated for crack cocaine, they need it within the next hour, not a few days or even a week later, never mind months later.

The lack of effective treatment of substance use ripples out to affect, not just the individual user, but his or her partners, parents, siblings, workplace, the rest of the community, and our entire society as well (Williams, 2006). Children, unparented, may be warehoused. The Centre of Excellence for Child Welfare confirms that, in cases in which child neglect is substantiated, 45 percent of the children come from families in which a parent struggles with the use of drugs or alcohol (Mayer, Lavergne, & Baraldi, 2004).

Dr. David Butler-Jones (cited in Contenta & Rankin, 2008), Canada’s Chief Public Health Officer, estimates that every dollar spent in a person’s early years saves $9 in future spending in the health, welfare, and justice systems (p. A6). *(Stitch-in-time saves nine.)*

Max is disgusted with the current approach to treatment for illegal drug use and finds incarceration especially problematic and ineffective:
In another 50 years, people will look back at our efforts in mental health and addiction treatment and say, “Woooo-oh! Dark ages! Barbaric...” We’ve got a long way to go... Our efforts to do something about illegal drug use are, at best, confused and ill advised in many ways. Increasingly, we can demonstrate that jail is an expensive, ineffective response. It’s a costly, ineffective way of responding to addiction.

**Corrections as a Magnifier**

Corrections is actually aware of the poor health of the inmates for whom it assumes responsibility, yet *health care* in Corrections exists largely only as an oxymoron with a necrotic bouquet. There is a crying need for appropriate intervention to creatively deal with the syndemic (Freundenberg, Fahs, Galea, & Greenberg, 2006) of Human Immunodeficiency Virus / Hepatitis B Virus / Hepatitis C Virus / Tuberculosis (HIV / HBV / HCV / TB), but despite tacit recognition of illegal drug use in prison, Corrections only stonewalls. An example is the previously mentioned inexplicable closure by the federal government of successful needle exchange behind bars (Kondro, 2007), in contempt of clear direction from health authorities (Canadian HIV/AIDS Legal Network, 2007, p. 14) and in the face of unequivocal evidence supporting its value and safety (DeBeck, Wood, Kerr, & Montaner 2007). These closures took place even while the prevalence of hepatitis C among the 13,250 prisoners held by the federal system was documented at 25 percent, a stark contrast to the less than 1 percent hepatitis C infection rate found among Canadians living in the community in 2004. As well, HIV infection has been documented to run almost 10 times higher, at 1.5 percent, among men behind bars, in comparison to the rate of 0.2 percent experienced by Canadians who were not incarcerated (Correctional Service of Canada, 2007).

Among inmates with a history of injection drug use, the picture is even grimmer. The hepatitis C prevalence rate has been documented at an alarming 73 percent, and the HIV rate at 3.8 percent for men and 12.9 percent for women. A report prepared by Corrections in 2004 for the Public Health Agency of Canada indicated that roughly 11 percent of inmates admit to injecting drugs while incarcerated and that, of these, roughly 30 percent acknowledge having shared used needles—a recipe for disaster (Kondro, 2007). Anecdotal evidence,
however, places the benchmark closer to one third of those who are incarcerated using illegal injection drugs while inside. This figure is supported by data from Vancouver, which shows that, among people who identify injection drug use as the means by which they contracted HIV, 20 percent reported that they caught the virus while they were in prison (Kerr, 2007). The role of Corrections as a magnifier and transmitter of disease seems to be a function that Corrections Canada is less than keen to acknowledge. Table 2 summarizes these figures.

**Table 2:**

<table>
<thead>
<tr>
<th>Infection</th>
<th>Unincarcerated</th>
<th>Federal Inmate</th>
<th>Hx IDU Inmate</th>
<th>Year</th>
</tr>
</thead>
<tbody>
<tr>
<td>HIV</td>
<td>0.2%</td>
<td>M F</td>
<td>M F</td>
<td>4%</td>
</tr>
<tr>
<td></td>
<td></td>
<td>1.5% 4%</td>
<td>4% 13%</td>
<td>2004</td>
</tr>
<tr>
<td>Hepatitis B</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hepatitis C</td>
<td>0.8%</td>
<td>M F</td>
<td>M 73%</td>
<td>2004</td>
</tr>
<tr>
<td></td>
<td></td>
<td>*25% 37%</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Risk Factors</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Prison Injectors</td>
<td></td>
<td>(30% by anecdote)</td>
<td>11%</td>
<td>2004</td>
</tr>
<tr>
<td>also Share Needles</td>
<td></td>
<td>(admitted on survey)</td>
<td>30%</td>
<td>2004</td>
</tr>
<tr>
<td>Tattooing</td>
<td></td>
<td></td>
<td>45%</td>
<td>2007</td>
</tr>
<tr>
<td>Body Piercing</td>
<td></td>
<td>(Kondro, 2007)</td>
<td>17%</td>
<td>2007</td>
</tr>
<tr>
<td>Repeat Sentence</td>
<td></td>
<td></td>
<td>90%</td>
<td>2007</td>
</tr>
<tr>
<td><strong>HIV Source of New Infection by Risk</strong></td>
<td></td>
<td>Corrections</td>
<td>Location</td>
<td>Year</td>
</tr>
<tr>
<td>Injection Drug Users</td>
<td></td>
<td>20% Vancouver</td>
<td>2007</td>
<td>2007</td>
</tr>
<tr>
<td><strong>HIV and Hepatitis Infection Rates among Vancouver Downtown East Siders</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>HIV</td>
<td>30%</td>
<td></td>
<td>BC</td>
<td>2007</td>
</tr>
<tr>
<td>Hepatitis</td>
<td>70%</td>
<td></td>
<td>BC</td>
<td>2007</td>
</tr>
</tbody>
</table>

*Figures rounded off for ease of comparison*
Imprisonment takes an already vulnerable population and places their every movement under the authority of the state for the duration of the sentence, during which time Corrections assumes the responsibility to provide for the ordinary care of the inmate, all within the purview of security. Together with the acknowledged mandate to protect the public from individuals who might pose a danger, Corrections has also been charged by the courts with the responsibility to ensure that those under its supervision receive the same level of health care as that provided its other citizens who live in the community. However, the current practices of Corrections Canada place its charges squarely in harm's way, rendering them exquisitely susceptible to yet another potentially terminal, not-quite-forgotten infection, tuberculosis (TB).

X-rays may detect tuberculosis, classically located in the lung, once cavities have been eroded or calcified nodules have formed to contain the infection. It can also be diagnosed at an earlier stage by a reactive TB skin test which looks back over 6 months or longer, to see two things simultaneously: if the person was exposed to TB, and, if so, that the person’s immune system is strong enough to react to an infection. Neither test says anything about very recently acquired infection, nor can the skin test distinguish between those who do not have a TB infection and those whose immune system is simply too weak to react to the test. Undetected or left untreated, one person with active TB may infect 10 to 15 other people each year.

About 1,600 Canadians deal with a new case of TB each year, at a cost to the health care system of about $20,000 per person (BC Lung Association, 2007). At this point, the majority of Canadians have only had to cope with ordinary TB, 65 percent of which occurs in foreign-born Canadians. About 1 percent of people newly diagnosed with TB, however, have the more complicated multi-drug resistant (MDR-TB) type (Public Health Agency of Canada, 2008). Of still more concern is the deadliest strain, extremely drug-resistant TB (XDR-TB), which has been identified in some Canadians returning home from abroad. Internationally, about 30,000 people have been infected by XDR-TB, and over half have died. For those who already are coping with an
immune system weakened by HIV infection, XDR-TB is even more lethal (BC Lung Association).

Should a person with an unknown case of XDR-TB be imprisoned, the consequences could be truly tragic, as TB is very efficiently transmitted within the crowded confines of prison walls (McLauchlin et al., 2003). Further, prisons are not hermetically sealed, and transmission of XDR-TB can be reasonably expected to bridge into the entire outside community via Corrections workers and their families as well as through the release of inmates and from visitors leaving the facility. Despite Canada's experience in 2003 with SARS outbreaks, few structural changes have been made to prevent epidemics caused by airborne infection. Setting aside sensible approaches to wrongdoing, many precautions, such as placing ultraviolet lights inside existing ventilation ducts to sterilize the flow of air and bringing in fresh air from outside without recirculating stale air, are cheap and easy in comparison to the nightmare threat of XDR-TB.

Most epidemiologic research tracks the fate of people grouped by the presence of one condition isolated from all other considerations. In a setting, such as Corrections, that targets people who embody multiple vulnerabilities, subjecting them to extreme stress and undernutrition and sequestering them in facilities that are often overcrowded and antiquated, estimates of the overlaps of risk from HIV and TB are guesswork. Even identifying co-infection is problematic due to the bare-bones approach to health behind bars; nevertheless, Table 3 presents what data are currently available.

Table 3:

<table>
<thead>
<tr>
<th>Tuberculosis in Canada 2006-2007 (overlaps not documented)</th>
<th>Cases/Yr</th>
<th>Foreign-born</th>
<th>HIV</th>
<th>IDU</th>
<th>SA incl alcohol</th>
<th>Prison</th>
</tr>
</thead>
<tbody>
<tr>
<td>New Cases Yr</td>
<td>1,600</td>
<td>63%</td>
<td>*est 15%</td>
<td>*est 10%</td>
<td>*est 18.7%</td>
<td>*est 12%</td>
</tr>
<tr>
<td>AB resistant TB</td>
<td>¥ 8.8%</td>
<td>§1%</td>
<td>§.01%</td>
<td>§.01%</td>
<td>§.01%</td>
<td>§.01%</td>
</tr>
<tr>
<td>MDR-TB</td>
<td>§1%</td>
<td>§.01%</td>
<td>§.01%</td>
<td>§.01%</td>
<td>§.01%</td>
<td>§.01%</td>
</tr>
<tr>
<td>XDR-TB</td>
<td>§.01%</td>
<td>§.01%</td>
<td>§.01%</td>
<td>§.01%</td>
<td>§.01%</td>
<td>§.01%</td>
</tr>
</tbody>
</table>

*(PHAC, 2008) *(Phyphers, 2007) *(Oeltman et al., 2009) *(Sterling et al., 2006) AB - antibiotic
The Ethics of Illegalization

Incarceration may begin as an inappropriate social reaction to an unacknowledged health problem for which illegal drug use is but a marker; it then improperly superimposes involuntary exposure to the risk of life threatening infections, particularly Hepatitis, HIV, and TB; and finally it slaps inmates with the indelible deviant label that marks them for what's left of their life. The army of police, law, and corrections officials dedicated to drug prohibition monitor every movement of Canadians more and more closely. Those not caught up personally in illegal drug use still face suffocation from unparalleled restriction on their freedom and violation of their civil liberties (Oscapella, 2007), exacerbated by imposition of the more recent 9-11 security measures. More police arresting more endusers on the street only swells the rising tide of people who use while imprisoned. Almost without fail, it is the individual user who is caught and punished, while wholesalers located on the upward end of the food chain pass largely unremarked, the proceeds of their investment being seamlessly integrated into the larger, visible economy.

The clarion call for treating addictions as a health issue, not a criminal offense, originating from première health workers such as Kate Hankins (2000), now Chief Scientific Advisor to UNAIDS, is echoed by workers in law enforcement (Cole, 2007), the traditional bastion of conservativism, and is chorused by economists working even in right-wing agencies such as the Fraser Institute (Easton, 2004). Given the acuity of insight from multiple sources into the escalating (but self-defeating) efforts that characterize prohibition and interdiction as a means to control illegal drug use, it does seem marvelous that government, torpid as it may be, has not implemented the proposed solutions.

Max too endorses a more supportive, long-term, health-based approach to addictions, which may include medication:

We’re still stuck in, “This is a struggle of will and moral behavior” [intoned in a serious, funereal voice]. . . . “Dependency is the marker of moral inadequacy,” but that is the part that we don’t understand. What is going on in the brain. . . ? We don’t have a correlate to what’s happening in somebody’s brain. . . . This [addiction] isn’t just some strange little matter of self-indulgence. I think that there are people who will need
supplementary chemicals for the rest of their lives, just like somebody who is depressed or someone who is psychotic.

An example of leadership in the area of medical ethics as it relates to prisons has emerged, not from the *Land of the Brave and the Free*, but from apartheid South Africa. Professor Kalk and Dr. Veriava (1991) of Johannesburg, fearing that the health of their patients, hospitalized under the supervision of Corrections, would be put in jeopardy should they return to prison, resolutely refused to release their recovered patients into the hands of armed officials, and took the matter right to the World Court. They call on doctors to resist the development of a security mentality and insist that physicians are obligated to take to the courts if the health of their patients is threatened by the conditions of imprisonment. This position has been supported by rhetoric from the American Medical Association (AMA), which makes it clear that physicians practicing in the US are ethically obliged to seek legal changes to conditions that are contrary to the best interests of the patient (Coulehan, 2005).

There is a noticeable slip ‘twixt theory and practice at this time. Most members of Canada’s medical community have been complicit in allowing Canadian judicial authorities to crack the whip whilst a troupe of policy makers capers ecstatically behind the marching band bruiting the punitive American approach to illegal drug prohibition. Rather than taking its cue from the British mother country’s more inclusive, down-to-earth, health-related approach to addictions, Canada has unfortunately fallen in with a pernicious addiction to scapegoating.

Neal, a participant in the research for this thesis, says that more time has to be spent on developing a truly humane philosophy in the helping professions and educating students for ethical practice, whether it is in the field of psychology, community work, nursing, medicine, or another:

The issue of power needs to be addressed; it impacts all these professions. . . . If you’re really patient centered, you have to accept the fact that your patient is who he or she is, and that the patient uses drugs, and that you can’t boss them around. . . . If you try to control, you’re not respectful. . . . The *patient-centered approach* usually is given lip service only. In teaching, it’s spoken about but it is not exemplified, because teaching is not student centered. You have a disparity there: you have a
top-down system saying, “We want to be equals; but we can’t do it because we’re not allowed to, because we’re top-down.” Until the schools adopt a different style of teaching . . . exemplifying what equality means, to the extent that it’s possible in a teaching context . . . there’s not going to be much change.

Let’s Be Practical Here. . .

While effective action seems to have eluded the authorities, bloggers on Vive le Canada, an Alberta-based, self-defined education website for democracy, social justice, and environmental issues, have identified a solution which seems reasonably likely to undermine the profits which drive organized crime. They advocate for legalization of marijuana use, prostitution, and gambling, activities, they say, that people are going to take part in anyway. Vive points out that such activities may then be taxed judiciously (Siamdave, 2007).

Doug finds even well intentioned attempts to control drug use through interdiction frankly inappropriate:

I accept that people use intoxicants. And provided that the use of substances doesn’t interfere with or harm others and doesn’t harm the individual, then I don’t have a problem with it. Now, many of them do harm individuals, like crack cocaine or excessive alcohol, but I don’t think that the response to it should be legal and punitive or that it should be through the judicial and corrections systems.

The populist analysis of conservative bloggers is not an isolated partisan view. Edward Ellison (1998), the former head of Scotland Yard’s Anti-Drugs Squad, says that policing will never take the criminal out of the supply chain. He calls for legalization of all drugs, a fiat he says would track straight from quality standards for production, to control of distribution of the drug, to education for the user, leading to plummeting prices, which would undercut the criminal basis of drug use and result in much less violence and crime. Jack Cole (2007) of Law Enforcement Against Prohibition (LEAP) agrees with this analysis, and points as proof to the falling numbers of new illegal drug users in the Netherlands where drug laws are conspicuously non-punitive (p. 9). The Minister of Health for the Netherlands reports that Holland has succeeded in making drug use boring, accounting for the drop in illegal drug use in that country (Gray, 2008). Portugal too, which in 2001 decriminalized the personal use of a number of drugs
declared to be illegal in many other countries, has not seen any particular increase in the incidence of use of illegal drugs, but rather has noted success in redirecting many more people who live with addictions into treatment (Greenwald, 2009).

Max is comfortable with such a practical harm reduction approach to illegal drug use, and urges sober realism in consideration of the approach to illegal drug use:

You’re never safe. I think the notion that life is safe is problematic. You’re not safe driving a car. There’s no safe sex; there’s safer sex. There’s no safe drug use; there’s safer drug use. . . . Harm reduction; Harm reduction might even include selling substances in a controlled way so that people have access to better quality material. That’s what a heroin trial is: You give pharmaceutical-grade heroin that isn’t mixed with other junk, in a safer context where you provide information, and users can take it moderately and safely. Using moves towards a safer point.

Aldo notes that conviction of a drug-related crime typically does not lead to anywhere even close to treatment. He does see a potential place for coercion, but only as a route to bring people into treatment. In Aldo’s experience, coerced treatment, properly carried out in a skillful way, is as effective as that given people who enter treatment through other avenues:

Some coercion is very strict and severe and some of it’s very mild, but it’s coercion nonetheless. . . . “Does coercion work?” The answer’s, “Yes.” But it only works when the professional has the ability to motivate people to change. . . . “Why are you here?” “I’m here because the judge said I have to be here, or I’m not going to get my driver’s license back”; that’s very common. . . . If the treatment’s appropriate and done professionally, the outcome is just the same as if they’re not coerced.

Doug finds that treatment is ideally characterized by counseling. Counseling allows the person living with an addiction to deal with the full range of trauma that they may have experienced. Such trauma, often profound, may be replicated when it is left unaddressed by a disinterested, dismissive social response:

All sorts of issues can come up [in treatment]: physical abuse, sexual abuse as a child, families that have been broken down, people getting their lives back together. Some of it’s just that patients like reporting something—it’s their way of being rooted and grounded—not that there’s any power or reward, but people will say, “No drugs this week.” “No
drugs.” The actual process of reporting helps some people to stay off drugs.

**Criminal-Nation**

Even as they crouch wounded, unpalatable and unwanted, beside the morass of dysfunction that characterizes the health care system, people who use an illegal drug may be gobbled up into the justice system where they are marooned in custody as punishment in a move said to be meant to control their use. Canadians witness marionette politicians, heads wagging in time to the martial air struck up by martinet drug warriors in the US, shuffle-hop away from the interfering din raised by annoying public health experts, who insist on talking sense while the marching band is trying to play. In an unwitting imitation of the ill-informed, unilingual tourist abroad, who wishes to get through to the lack-wit locals who do not understand good English, politicians turn up the volume of interdiction higher and higher.

Dramatic television programs produced in the US often feature violence and tragedy forged by the criminalization of certain drugs, linked by the well-worn fetters of poverty and race to overflowing prisons and HIV. The US incarcerates its own citizens about 7 times more than any other industrialized country in the world, with 1 of every 32 Americans living under the supervision of Corrections. Largely as a result of the record of imprisonment which 1 in every 3 Black American men can expect, 13 percent of Black Americans are denied voting rights (an estimated 6 million voters [Treadwell, 2007]). Such manipulation of voting is a key aspect of present-day *de facto* American *apartheid* (Mauer, 2006; Mauer & King, 2007) and was one of the deciding factors ushering in the Bush presidential *putsch*.

In a barefaced act of structural *hegemony* (Gramsci, cited in Mastroianni, 2002), public monies are misdirected into unproductive, downstream, reactive punishment of Canadians who use an illegal drug. Such actions are often undertaken in the name of *public safety*, an admittedly high-priority public good. Ironically, the diversion of funds into the machinery of prohibition supports those repressive elements within society which quietly constitute both old and new established hegemonic interests and whose activities are arguably far more
dangerous than those of the illegal drug users and low-level dealers upon whom the searchlight of police attention most piercingly falls. Income garnered from the underground economy is channeled into diverse legal businesses through laundering, resulting in the entrenchment of newly legitimate interests, which now wield considerable political clout derived from their financial standing. Once-shady money, washed clean in the light of the above ground economy, is then further protected by the same tax laws that favor the extremely wealthy.

The analysis outlined above is clearly understood by many who are involved personally with illegal drugs. One blogger shares his grim analysis of the Drug War:

Understand that the war on drugs is meant to be continuous; no one seriously believes that prohibition will eliminate illegal drug use. It is simply meant to keep funneling money into police and jails and the like, and keep profits high for the real drug dealers, who, with all their money, wield great power across the world. . . . More so, it is a method of control and domination that the elite ruling class uses to confuse, screw, and keep down the average working class man who smokes a joint (Groat, 2007).

---


The Fat Cats in the Canadian economy, some fresh from doing dirt in offshore sandboxes or in underground economies, daintily sit around the solid oak Bilderberg table, claws discretely out of sight, lapping up the cream served up by the public service milkmaids in Parliament, while they plan their next meal. At their feet under the table, enjoying the warmth of their privileged position guarding the Fat Cats, yellow-bellied watchdogs grovel, licking each other and stroking their weapons. An excited yelp occasionally signals fantasies of pursuit, replete with flashing lights, blazing tasers, and satisfying shootouts should any of their charges, the common herd of Canadians trudging steadfastly along their set
path, make a break for it. The smooth-coated medical weasels responsible for keeping the feast running flawlessly and clearing the table (in return for which they get first lick at the leftovers on the plates) can’t quite hide their sidelong, envious glances at the Fat Cats. In counterpoint to this agreeable domestic tableau, the alert listener may pick out the coyote howl of the off-the-books economy, lurking outside just barely out of sight: feral, ever ready, ever hungry—gleefully making the most of the compost, a still-rich buffet of leavings.

Most Canadians slog along their accustomed paths everyday into their usual stanchions. Even if they notice the few sad cases twitching feebly in the ditches, hamstrung and felled by the wildcat organized crime gangs lying in wait at the side of the road, most Canadians mind their own business. The overwhelming majority, thinking they’re best off not to know too much, keep their heads down, keep their eyes on what’s in front of them, remember the promise of a pension once they’re put out to pasture, bite their tongues, ruminate, and say nothing. Occasionally, a wild conspiracy theory surfaces, causing a nostril to quiver delicately and the eyebrows to lift disparagingly, but most just laugh off any suggestion that something’s up over at the slaughterhouse. In their time off, most Canadians lock into the latest high-definition confection dreamed up and beamed down to them by the media vultures, now grown so grossly obese on the largesse garnered through promoting the interests exuded by the Fat Cats, that they are scarcely able to flap a lazy wing while circling overhead. Secure each in his or her own little stall, ordinary Canadians, try as they might to content themselves with their homogenized, pre-masticated, pre-digested daily fare, still cannot help but notice the unseemly snuffling and belching of the elected piggies coming from their luxury pens as they root through the aromatically attractive slops lining their political troughs. Canadians pop a mountain of pills to help them batten down the resentment that threatens to bubble up their gorges.

Does anyone wonder that sensible Canadians snatch the chance to nibble on a serendipitous, clandestine daisy, even if illegally obtained? It’s said that those who have a little daisy on board are full of energy and develop a high-flying sense of false confidence, believing that they, too, are intelligent and worthwhile.
They then find it hard to settle down like the rest of the team to a career in the yoke, working from sunrise to sunset, and being milked dry every day, in return for a minute's peace simply to chew on one's cud. And clover—it's hard to separate myth from reality! They say that the first time is forever: One taste, and you're hooked. You will do anything to get back into it, and you can never roll enough in it. Some believe that even fresh, green grass is just a gateway, leading one astray to further fields. Most Canadians, however, confine their escapes to the local watering hole, and acting out a bizarre, morbid attraction, indulge their dirty little habits behind the smokehouse. Still, congruent with quintessential Canadian custom, most conform, concede, and comply, and do so courteously, contenting themselves with the pharmaceutical mood-modifiers, slipped them by the weasels, for which they pay through the nose.

A rotting miasma roils up from the scrap heap out back, where the self-esteem flayed off ordinary low-income Canadians is tossed to fester, flows down the road, and squats over the market square where it congeals. Even the well-shod traders in designer outfits, come downtown just long enough to do their business, make passing comment on the brown, low-hanging, acrid smog that scalds the town before making good their escape to their estates in the 'burbs.

Behind the scenes in the summer-kitchen, anomie is rendered into despair in the pressure cooker formed from the hard, cold facts presented by remorseless market forces, while cupidity, fanned by advertising and the media, fires aspiration to the white-hot heat of avarice. The mass may now and again blow off steam in screaming resistance, but the suffering goes unnoticed except perhaps by the corpulent cook's helper, who sanctimoniously intones his mantra, "Just deserts. Just deserts." He presides over the extraction in his gray, grease-encrusted, pocked apron, upon which a faded and tarnished gold cross can now be made out only with difficulty. The cook herself, queen of the kitchen, breezing in just long enough for a photo-op granted to quiet the clucking of the trailing paparazzi, straightens the bouffant hat crowning her pate. She wipes her brow with an old dollar bill, turns the screw a little tighter, cranks the pressure up, and
gives her helper a cautionary shake of the ladle. Muttering to himself in an ancient, arcane language, he flashes an oily grin and crosses himself for luck.

Only in Canada, you say? Well, in the US, the Fat Cats have corralled the market on milk, skimmed off all the cream, and sold it back to the cows at a killing. They've now ridden off in a posse across the globe, trampling over any fences, to brand all the cows for themselves, shooting any strangers who cross their sights (Chomsky, 2003a).

Alternate economy.
The alternate economy thrives on the designation of certain drugs as illegal in the same way that American alcohol prohibition fostered the entrenchment of profitable and durable underground distribution systems (Lunde, 2004, p. 119). *Fifth Estate*, a public affairs TV program, estimates that the underground commerce in Canada generates about $20 billion yearly (McKeown, 2006). The illegal economy thereby generated spins out into problematic effects on culture, ranging from neighborhood deterioration to political corruption (Cook & Reuter, 2007).

Illegal drugs are known to fuel organized crime in Canada. The Criminal Intelligence Service of Canada (CSIS) reports that 80 percent of identified Canadian crime groups are involved in the illicit drug market, and that together drug selling and related sex trade and theft occupy about 300 street gangs that employ roughly 11,000 people (Public Safety Canada, 2006, pp. 14, 17). Internationally, the illegal drug trade was believed to have been in the order of $325 billion in 2003, (Pollard, 2005). Narcotics are further said to represent 70 percent of these financial resources (Glenny, 2008, p. 223). The bustling trade in illegal drugs is only one arm of organized crime: additional entrepreneurial activities include credit card theft, vehicle theft, insurance fraud, mortgage fraud, internet fraud, software replication, counterfeiting, stock market manipulation, loan-sharking, illegal gambling, extortion, violence, and the smuggling of weapons and people. The International Monetary Fund (IMF) has identified
Canada as the *laundry* for an estimated $22 to $55 billion of these proceeds each year (Criminal Intelligence Service Canada, 2007).

The tracks of drug profits lead straight to the doors of big business, particularly multinationals, now infiltrated by organized crime. Many governments do not raise a finger against multinationals, since they are held to be "creating wealth," albeit by stealing and robbing at both ends, from producers and consumers alike, enslaving all (Deak, 2007). Some aware Canadians do correctly identify the embedded and networked nature of contemporary economic systems featuring the military-industrial-big oil-pharma-real estate-government complexes, but they may not recognize the extent to which organized crime is enmeshed in these “legitimate” enterprises to the point where it is hard to tease out.

Monies devoted to the common good are collected solely from taxation levied on the visible economy and are distributed within the country in a more or less equitable manner. The Government of Canada is responsible for administering common services meant to support a decent-enough quality of life for all Canadians. Social goals made possible through taxation might include environmental stewardship, democratic rights, self-realization, community and social solidarity, personal security, and even the address of drug use (Brooks & Hwong, 2006, p. 21). These social initiatives receive no tax support from the off-the-books economy because there is no official account of cash surfacing from underground sources, so naturally there can be no tax.

Canadians who shop for illegal drugs in the underground economy are moreover left with that much less to spend in legitimate venues, cutting the visible profits of local shopkeepers and tradespeople, a portion of which finds its way back into the common pocket through taxes. The same tax laws that favor the wealthy protect money laundered through investment and other means when it surfaces in the visible economy. To further aggravate the drain on tax monies that should by rights go to benefit all Canadians, profligate expansion of prisons and policing that focuses on simple low-level “criminals,” who are only the most visible participants in the alternate economy, evaporates more funds out of our
national joint account. The consequence of the disjointed, heavy-handed, low-level social response to addictions has been to distract many Canadians from the political address of larger pressing social issues.

Increasingly unrestricted trade across borders after the dismantling of the global Bretton Woods economic agreements had the effect in North American-EuroWestern countries of intensifying the gap between poor and rich (Chomsky, 2000, pp. 208-213). With increasingly easy relocation by business across borders, union gains in the areas of wages and job security were rolled back and social benefits were cut. Many low income earners lost jobs and suffered acute financial crises. Agribusiness displaced many small farmers; newly superfluous, they tended to migrate to inner cities to join a low-paid workforce that was already restive and therefore dangerous to entrenched interests. Examples of such unrest include the Watts riots of 1965 and 1992 in Los Angeles and the secession movement in Quebec. As if in answer, the War on Drugs was declared by the US. Further to the social value of disciplining an unruly citizenry, people learned an object lesson about how those deemed superfluous can expect to be treated (Chomsky, 1998, p. 125).

At the same time, with the lifting of international trade restrictions in the 1970s, the US flooded other countries with essential products priced to undercut local sources. Many cash strapped countries ceded to economic pressure to convert local family farms to agribusiness producing commercial crops for reciprocal export, leaving their rural populations struggling for subsistence. Hungry farmers and workers in many countries became desperate, began to organize, and explored communal solutions, often prompting repression by US-backed Government forces. Small farmers, forced into marketable monoculture, found that, to survive, it only made sense to plant crops that bring the best return internationally: such crops included *herb*, *coca*, and *poppy* (Chomsky, 2001).

**Economics of illegal drugs.**

Even the Fraser Institute, a right-wing think tank devoted to supporting business, cannily sees the wisdom of government regulation of the marijuana trade. It quietly admits that members see a decided benefit in removing such
monies from the coffers of organized crime and in restoring enforcement to its more legitimate activities. They estimate substantial taxation income. They projected, at $7 tax from a retail price of $10 per marijuana cigarette, tax income of over $2 billion in 2004 from domestic consumption alone, with additional tax income from the export market (Easton, 2004, p 27).

Casting a pall over the interest in legalization is the prospect that the very refreshing *carnaval* spirit of enterprise and the affirming survival strategies currently seen in the operation of independent family grow-ops, will probably be replaced by factory farming handled by multi-national corporations, likely resulting only in further shredding of local economies and ecologies while the ability of families to make a decent living is again jeopardized. Sadly, the legalization and privatisation of the production of marijuana is likely to simply free up *Big Brother* (Orwell, 1949) to better enforce the interests of *Big Business*.

Estimates of the cost of illegal drug use in Canada have ranged from a rough estimate of $3.6 billion, $2 billion of which is due to law enforcement alone (Gnam, 2006), to a more nuanced estimate of over $8 billion (Johnson & Lipski, 2006, p. 9; Rehm, et al., 2006, p. 1). While these costs are sobering, the expense of illegal drug use is completely eclipsed by the costs of legal drug use. Disturbingly, in a stunning display of obtuseness, the budget for addictions treatment is miniscule in comparison to that allotted for policing of illegal drug use and associated Corrections costs.

Social and economic costs for all substance use in Canada were estimated to be $40 billion in 2002 (Thomas & Davis, 2007). The cost of alcohol abuse [*sic*] is estimated at $14.6 billion (Johnson & Lipski, 2006, p. 9) by the Ontario Federation of Community Mental Health and Addiction Programs, while tobacco use is estimated to cost Canadians about $17 billion (Rehm, et al). Johnson and Lipski also assess a cost for mental illness separately from addiction at about an additional $14 billion annually in Canada (p. 9). Figure 4, following, graphically illustrates the costs of illegal drug use as compared to the costs of other substance use, separate from the costs of mental illness.
Many people believe that it is the wealthy elite in society who have the power and who exercise it to benefit themselves. This may be the case, but such control is contested at every turn. Police crowing over marijuana seizures at show-and-tell press conferences (Cole, 2007) are not quite able to drown out breezy internet commentary about how much the brisk marijuana trade contributes to the informal economy of some provinces.\(^{11}\) The Organized Crime Agency of BC (2001, p. 23) estimated the BC crop value at $6 billion, and others note that it contributes 6% of BC’s GDP (Glenny, 2008, 2^{nd} picture series), and employs 100,000 workers (Glenny, p. 214). In Canada, clandestine marijuana production is believed to have contributed $7.5 billion to the economy in 2006.
These amounts compare to the export value in 2003 of wood at $5.6 billion, mining at $3.7 billion, and manufacturing at $3.4 billion (Botchford, 2003), while revenue from cattle came in at $5.6 billion, and that from wheat at $1.7 billion according to the CBC (2007, July 6).

Remarkably, the impressive income from marijuana has been raised in the face of squads of police beating the bushes in hopes of eradicating such crops, without the benefit of state subsidies that are often associated with other products, and without widespread environmental degradation. The costs and contributions to Canada of the various industries, substances, and activities are charted in Table 4 for comparison.

### Table 4:

<table>
<thead>
<tr>
<th>Consideration</th>
<th>$ Costs</th>
<th>Law+Order Costs</th>
<th>$ Contributions</th>
<th>Year</th>
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</tr>
<tr>
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<td>17,000,000,000</td>
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<td></td>
<td>2006</td>
</tr>
<tr>
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<td></td>
<td></td>
<td>2006</td>
</tr>
<tr>
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<td>411,000,000</td>
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<td>2004</td>
</tr>
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<td>2007</td>
</tr>
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<td>underground economy</td>
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<td>20,000,000,000</td>
<td>2006</td>
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<td></td>
<td></td>
<td>1,700,000,000</td>
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</table>

Questions

My review of the background to the illegal drug trade in Canada had brought me a little closer to understanding why Anna’s death was not news. Anna seems to have been just another dusty, footworn casualty on the losing side in the War on Drugs being waged in Canada. Without treatment options at hand, Anna simply carried on as best she knew how with her addiction to heroin. She was no more than a small broken cog in a tiny piece of the faulty industrial machinery of illegal drug use, the loss of which caused not so much as a hiccup in the conduct of business as usual. Human rights? Negligible. Purpose in life? Negotiable. Beloved by whom? No one important. Acceptable? Never.

My review of the background to illegal drug use left me with more questions than answers. Foremost in my mind was the puzzle presented by a culture in which such a toxic response to the use of a drug designated as illegal makes sense. What kind of culture would make such products illegal, criminalize the people who take them to ease their lot, then claim that imprisonment is the most fitting response? And why?

The next chapter reviews the North American-EuroWestern cultural basis of addiction. It examines certain present day economic arrangements for their contribution to the dynamic of addiction and the social functions served by poverty. The role of governments in promoting illegal drug use is discussed and remark made of the role of illegal drug use in maintaining social order. An example of government propaganda is presented and analyzed, and the purposes served by such discourse are discussed.
Recuerdos

As the enquiring eye looks deeply inside the dynamics surrounding illegal drug use, the multiple recursive nested echoes of the core cultural addiction to consumerism reflects the greed and fear that feeds off the isolation engendered by the pernicious individualism that has come to infest Canadian culture.

Colored pencil on paper (Polych, 2009)
CHAPTER II
YOU CAN NEVER BE TOO RICH (OR TOO THIN) Wallis Simpson

Canada’s Cultural Addiction

Substance use does not take place in isolation, but within society and in context. Anna was a creature of her culture. Since the late 1960’s, North American society as a whole has been characterized as a consumer culture of individualism, with each person out for themselves (May, 1991, p. 115). At this time, under the aegis of the International Monetary Fund (IMF) and the World Trade Organization (WTO), North American-EuroWestern culture is geared to global transnational exploitation by a wealthy elite devoted to the pursuit and accumulation of personal excess and is marked by a short-term contest for status based on the conspicuous display of disposable trappings (McQuaig, 2001, p. 95). Ordinary people jostle for a share of the spoils, elbowing aside loyalties and disregarding long-term consequences in the sweaty rush to partake.

John, one of the professionals interviewed in the course of research for this thesis, outlines the philosophy, countercurrent to the mainstream, that guides his work. In contrast to many, John draws rewards for his work from a different source:

Simple is better, slower is better. . . . Know your limits and what you’re capable of. . . . Maybe I can make things a little bit better. . . . If I touch a life, that person will go on and say, “I am who I am because of that contact. . . .” I don’t fit in to the schematic; I don’t want to fit in to the schematic. . . . What do I get out of it? I get a paltry paycheck; I pay my taxes; I go home with headaches some days—but I’ve done something.

At this time, the major cultural addiction in Canada, fulfilling all of the diagnostic earmarks of an addiction, is to money. It is money that structures the entire day for many: thinking about it, getting it, and using it. People will go to the ends of the earth for it, run themselves into the ground for it, and will do anything to get it: scheme, lie, cheat, steal, betray any trust, even work a lifetime for it. People can never have enough: they will kill to get it and die to keep it. Peculiarly, those in most deeply are touted on Forbes List, not denounced as robbers or gangsters on the Most Wanted List, and almost never do penance for
their wrongs.

In the past, education has been one route to relative enrichment for those overlooked by Fate at birth. Many Canadians, angling for a way out of the McJobs (Etzioni, 1986) of their youth, complete their education and crash head-on into car culture (Graves-Brown, 1997). Bought and paid for over time, they join the rat race, scrambling for success and power, multi-tasking and leveraging their way into positions of comparative affluence where private property comes readily to hand. Cultural values indispensable to attaining such material wealth and status include shrewdness, dupery, and toughness (Goff & Reasons, 1978, pp. 180-189).

Aldo subscribes to a different philosophy that guides his work:

I try to live more in a place of gratitude, as opposed to, “I’m here to achieve something . . . .” I don’t have a sense that I am here with a purpose; I don’t think that way. I don’t think of myself that way.

Many Canadians would give anything to buy into this sweet (transnational) dream. Still many more harbor never a hope of enjoying the spoils, only marveling as they look on from outside, noses pressed to the window. After all, not everyone can be a member of the elite. (Privilege, comfortably ensconced in the saddle of Private Property and straddling the back of Deprivation, rides, carefully shepherded by the Police Posse through the pockmarked landscape of Poverty.) This, then, is the cultural context within which substance use takes place (Alexander, 2001).

John targets consumerism as being fundamental in bringing addictions about:

Drug addiction cannot be severed from the rest of society. It’s a social issue brought on by the way we live. . . . Society itself is crumbling from what we believe. The things that we once held as sacred are no longer sacred: religion, the golden years as we age—all of that’s crumbling before the dollar. If we could turn people around and say, “Look, the dollar doesn’t matter. You can live poor and proud,” then what would end up happening is a whole new generation that would believe that this is not the way to live, like this, and buy out of it. . . . If everyone stopped using crack, the entire industry would fold.

North American-EuroWestern culture currently is defined by materialistic consumption headlined by a developmental journey focused on independent
achievement, reflecting the cultural values of autonomy, competence, control, and profit. Advertising accentuates widespread dissatisfaction with what Canadians have (Giroux, 1981, p. 41), escalates anxiety about who they appear to be, and drains away, leaving only a residuum of confusion about purpose, in the wake of planned obsolescence. The market solution to such discontent is the increasing acquisition of more and more *stuff*, which holds out the two-fold promise of the prefabricated identity borne on the labels displayed on the outside and the jealousy of an admiring, aspiring audience.

Harry finds that he has to actively administer an antitoxin to self-absorption as part of his treatment approach in addictions:

I’ve been working in addictions now for years; I love it. I use spirituality with my patients. Spirituality and drugs are like oil and vinegar: they don’t mix; they separate. . . . The goal is to help people see what we as humans have to do to become the people that we were meant to be. . . : to be honest, to be responsible, to share. . . . The goal is to help people see out of themselves, that there is more than just themselves.

Paradoxically however, the spin-offs of consumerism lead straight downhill from admiration, past envy, through resentment, gathering antagonism from the have-nots, circle back into gated exclusionism guarded by security, only to sputter into the dead end of isolation. The capitalist social system perpetrates *cultural fraud* (Eckersley, 2005) as a side effect of its emphasis on wealth for the few at the expense of well-being for the many.

John believes that the dynamic that drives addiction is a toxic brew of selfishness spiked with consumerism:

It’s a social issue, brought on by the way we live. It’s not an individual failing, not a moral failure. There’s an awful lot of, “It’s my right. . . .” Well, your rights are dictated by the limitations of society. So if you take, take, take, and you dry the well out, no one else can drink; so take a little, take what you need. That way, there’s always something for someone else. When we’re selfish and trying to gather stuff in the *you-are-what-you-own* mentality, that’s when we’ll fail: We’ll fail the world.

**Just Deserts**

The image of human potential that underlies the North American-EuroWestern belief systems that support capitalist consumer culture regards the worth of people as matching their ability to take part in the monetized economy,
by producing and consuming. Such a vision depends upon the understanding that individuals are self-determined, autonomous, and can rely upon a fair chance in life, a fact guaranteed by the justice-based ethics that order a just world featuring different entitlements according to worthiness.

Such North American-EuroWestern analyses are based upon the philosophy of deservingness, or *just deserts*. According to such understandings, people come into life equipped with a reflex set of rights and obligations, which they are expected to take advantage of and follow through on in a fair and trustworthy manner. This view presumes a just world in which specific expectations will be met and certain assumptions that will be borne out according to the person’s place in it. Human potential is thereby said to be self-determined, and the person’s life course mirrors his or her just deserts. To the individual goes the credit for success or the blame for failure. In such a belief system, what happens to a person can be seen to be a reflection of that just world, and such a belief system will further determine what can be done by others to a person. It is according to individual ability and merit that a person reaps the fruits of his or her labors: success, affluence, ease, and popularity; or failure, poverty, misery, and isolation.

John recognizes the toxic effects of isolation emanating from the dissolution of community as key to generating addictions. “What has happened to our society?”! Broader picture: We are not our brothers’ keepers anymore. Broader picture: Everyone’s an individual. If tragedy strikes across the road, “Oh my God, I don’t want to get involved.”

**The Drug War**

It is largely to the hindmost of the shambling mass of Canadians, who are less financially endowed and who occupy positions outside the mainstream decision-making structures, that the stick of judicial punishment is selectively applied (Reiman, 1979/1989, p. 159). Huge numbers of illegal drug users have been taken prisoner in the so-called *War on Drugs* in a hegemonic strategy designed to serve as a caution to other potentially disorderly members of the less-privileged strata of Canadian society. Imprisonment furnishes an object
lesson in the value of conforming to the dominant norms of consumer culture that generally circumscribe life in industrialized countries: deference to authority, participation in the economic cycle of wage-based production, and needs- and leisure-based consumption of the commodities on offer in the marketplace (Gans, 1971).

Chomsky (2009) believes that the Drug War is an outgrowth of coordinated state planning in the interest of multi-national corporations oriented towards resource extraction, macroproduction, and agri-business. It further serves as a cover abroad for counter-insurgency (pro-capitalist) efforts, while domestically it offers a means of controlling the dangerous classes: those who don’t have a place in the current industrial system and so are superfluous. The War on Drugs frightens many dissatisfied folk into compliance and effectively gets rid of the volatile useless (Chomsky, 2002). In a North American echo of the poor/work houses of Dickens’ day, the potentially dangerous classes, securely penned behind bars, might even be of use as chattel property effectively forming an unpaid labor force (Chomsky, 1998). Finally, the War on Drugs underwrites commercial enterprises in surveillance and security, the fastest-growing white-collar job sector.

Doug’s call for research that clarifies what success in treatment might actually mean elaborates the theme of conformity, connection, and compliance that underlines the goals of treatment.

Successful treatment programs are those that offer comprehensive counselling . . . provided by addictions nurses and counsellors. . . . Counselling is critical. Everybody acknowledges that there’s a difference in the success rates; counselling means the difference between 55 percent and 85 percent [success rate]: that leaves a huge number who are going to fail. . . . Success may mean that the patient’s not using opiates, but it depends: it really does depend, and it’s consistent. There are other measures like: Are they employed? Are they back with their family? Have they stopped doing crime?

**Canadian Class**

At the carrot end, goals for the entire society are set before Canadians in a two-handed approach featuring pervasive communications paired with persuasive advertising. Such tactics promote immediate gratification, lure
consumers to purchase the goods on market, valorize a focus on the individual, and normalize the private exploitation of common resources (Chomsky, 1996. p. 118). And life can be good for those on top: Worldwide, the top 1 percent monopolize the same income as that shared by the 3 billion people around the globe who make up the bottom 57 percent (Chomsky, 2000, pp. 208-213). In Canada, the income of the top 1 percent approaches 15 percent of the total income earned by all Canadians. Together, the richest 10 percent of Canadian families control almost 60 percent of the total wealth (financial assets less debts), while in contrast, the bottom half of the Canadian population must make do with about 5 percent of the wealth (Scott, 2005, p. 16).

In this age of information and technology, those less educated, less skilled, and less capable Canadians are less and less in demand—social junk (Spitzer, 2007). Canada is now a low-wage country, according to the Canadian Labour Congress (Scott, 2005, p. 11), second only to the US in the race for the bottom line among industrialized countries (Barlow, 2005, p. 129). A huge proportion of Canadian workers are low paid, earning less than $10 hourly: about one quarter of all full-timers, one in three women (Scott, p. 12), and 45 percent of workers aged 14-24 years (Institute of Wellbeing, 2009). Only about 10 percent of low-wage workers receive benefits. Of those who do hold down a full-time, low-paid job, work is precarious at best. About 15 percent of workers can find only temporary work, and in all, almost 40 percent of Canadians work in contingent situations. Almost 20 percent of working Canadians are part-timers, but one third of these would like full-time work (Scott, p. 13). According to the Organization for Economic and Cooperative Development (OECD), 12 percent of Canadians live in outright poverty (OECD, 2008). Figure 5, following, displays the glaring maldistribution of income within Canadian society:
Figure 5:

Percent of Canadian Population by Proportion of Total Wealth

Class is the basis of one of the most pernicious biases operating within North American society. Because Canada is billed as a classless society, even acknowledgment of the existence of class as a social phenomenon is compromised. Like steps on a poorly-lit stairway running down into the basement, class, together with consumerism, capitalism, racism, sexism, ageism, able-ism, size-ism, locationism, linguism, and so on, is pitching Canada break-neck back into the plutocracy of the 1920s (McQuaig, 2004) in a spasm borne of suicidal greed (Mengell, 2008). The elite justify their position by capitalizing on the belief that the authority to dominate is thrown up out of the failure of the subjugated to do so, and that the dominant simply help those who are less capable. In return for such civic-minded assistance, naturally, the elite are entitled to the privileges they claim as their due. In a society structured to differentially reward individual actions and to penalize group solidarity (Chomsky, 1994), people of all classes, taken as individuals, generally find it impossible to resist grasping any opportunity put in front of them, even if they know the gain will last only for the short run. In this way, individuals are co-opted and class
interests are kept split one from another, and thereby under control. Divide and conquer.

While those of the working poor and even those doing slightly better have little real prospect of ever achieving affluence, widespread internalization of the general ideal of success, measured out in dollars, still propels ambition. Those few rags-to-riches Canadians who transcend poverty to rise into the elite may then be held up as an object lesson of merit and will (à la Horatio Alger), “proof” that it is only a lack of proper application that holds the ungifted dullard and untalented slacker back (McQuaig, 2001, p. 113; Killian, 2008). Actually, it is the classist hegemonic policies now in place that favor the economic elite at the expense of the rest of the population, resulting in grievous underfunding of the so-called underclass (Scott, 2005, p. 16), amputation of opportunity for the lower classes, and loss of dignity for all.

Aldo takes objection to the habit many Canadians have been trained into, to look for a magic bullet from outside to fix what ails them. He believes that satisfaction resides within:

The message we’ve got in society is that, “The bluebird of happiness is out there; I just have to find it.” The reality is that the bluebird of happiness is in here [points to heart]; we just have to find it. . . . The solution to most human difficulties lies within us.

Despite the wholly inadequate living circumstances visited upon many Canadians, the eruption of open, barefaced class conflict is not common at this time. Class-based control is however clearly manifest in the social pressures which ghettoize people deemed social junk, those who have fallen or jumped through the cracks of our social system and are now dependent on others to meet their needs. Crowding close behind the distaste of nice folk and elbowing its way forward is the foreboding that such social junk might turn rebellious. In the end, it is the legal system, backed up by strong-arm tactics ending in incarceration, that holds back such social junk from transmuting into social dynamite (Spitzer, 2007).

In such a quiet, well-ordered, “classless” culture as Canada is said to be, where people find it hard even to recognize the class boundaries which set out...
their life chances, the next step, the support of population-wide, class-based, 
*trickle-up* policies that favor those most disadvantaged, to thereby indirectly benefit all Canadians, is well beyond the grasp of most. The harm associated with class often goes unrecognized. How does one tally up missed opportunity or take stock of lost potential?

**Social Control**

Like the relationship between a restive horse and the rider on its back, the population submits to the direction and exploitation of the elite even though it is within the body of the population that power actually resides. Rulers reign only insofar as they control general opinion, command agreement, and are ruthless enough to pull on the bit, apply the spurs, or take up the lash on occasion (Chomsky, 1994).

And it is Canada that has set North American-EuroWestern society a dangerous example of military repression as a response to the expression of dissident opinion. Pierre Trudeau, velvet glove-iron fist Prime Minister of Canada for 15 years, elected on a platform of restoring a just society among other paradoxes, imposed martial law in Quebec in 1970 in response to a secession movement that escalated into violence directed at two pro-business government officials. Trudeau suspended civil liberties and called in the army for 6 months, invoking the *War Measures Act* (CBC, 1970) to contain the threat posed by the separatist *Front de Libération du Québec* (*FLQ*). About 500 or so Québécois, many of whom were intellectuals, were summarily apprehended; but once the dust from the treads of the tanks had settled, only 9 people were ultimately judged guilty of anything (Blake, 2001). Quebec has yet to secede.

In the present situation, where we see a few large multi-national corporations dominating the current version of monopoly capitalism, nationality is irrelevant, communities are optional, jobs are mobile, people are disposable, and values are contingent (Barlow & Campbell, 1991, pp. 14, 112). Bamboozled Canadians watched, unspeaking, as the social safety net was shredded in the 1980’s, unions were muzzled in the 1990’s, students were hamstrung by debt in the 2000’s, and jobs fled south over the decade leading to 2010. Big Business
has given away the country to international absentee landlords, gutted the unions, and downsized and outsourced neighbors, all with the whole-hearted approval of its batboy, the government elected by ordinary Canadians. Canadians have exercised their choice at the polls, occasionally changing the party in power, but anxious-to-please, business-minded Conservative and Liberal Governments currently are said to be distinguishable only by the slight variation in the width of the red pinstripe in their navy suits.

Religion, Marx says (cited in Sobsey, 2007), is the sigh of the oppressed . . . and . . . the opium of the people. Marx believed that religion is a signal of distress, given out simultaneously both as a protest against pain and a groan of agony, the expression of which, at the same time, diminishes that pain. Marx is alarmed by the social conditions that underlie and necessitate a phenomenon such as religion, which serves to blunt the jagged edges of the fault lines of class. Marx desperately begged people to refuse to settle for the pie-in-the-sky\textsuperscript{13}, ephemeral comforts of the next world as promised by religion, so that they might take concrete steps in the here and now to better their lives. He called on ordinary people to upend the exploitative economic social structures that result in near destitution for so many.

As society becomes more competitive, work more dehumanizing, and ordinary people more isolated from one another, they experience alienation from their roots and grow more desperate. With the fracturing of family life, people may grasp at religious fundamentalism in their search to hold on to something of constancy and surety in hopes it may give meaning to their lives. John, in contrast, uses religion as a therapeutic tool to help the unique individual reconnect with the common ground of humanity:

I don’t say, “Well, I’m going to give you religion now. . . .” I say, “If you really want to know about you, forget about yourself. Thank the bus driver who got you from A to Z safely.” And I’ve got more people doing that [chuckles]. \textit{Junkies:} Junkies saying thank you when they get off the bus. Somebody else, human, has done something for them. Say thanks. Be courteous. . . . If I want to know myself, I forget about me.

The powerful too find fundamentalist religion useful to salve the occasional twinge of conscience. Taking center stage, apologists trot out the
paradox of grace, which holds that people, even the best of us, try as we might to do good, still do harm; profiteers are thereby absolved a priori of responsibility for the deprivation and misery of those they exploit (Chomsky, 1994).

Fundamental religionists of the ultra-right can be expected to try to exercise leadership to get society back on track and running their way. At this time the religious right has made considerable inroads into influencing how Canada is run, successfully fielding acceptable federal candidates in mufti, who persistently promote the virtues of proper place, prayerful patriarchy, and private property, enacting ever more reinforcing legislation to buttress their power base. As can be seen by the election of a Conservative Federal Government in Canada, political power is indeed within the grasp of the ultra-right, provided that they do not spook the bulk of the population by wild waving of the red flag of fundamentalism.

**Uses of Poverty**

In a competition based society, there inevitably are winners, adept at competing or otherwise advantaged, and necessarily, as in any competition, there will be also-rans and losers—many, many losers. With the replacement of a marginal subsistence economy by waged work, one expects that such work will maintain not just the worker but also those who do not undertake paid labor, at least at the level of survival. Canadian society, structured to differentially reward people according to their ability to compete and contribute in the work-a-day world, makes some provision for the absence in the workforce of the young, the elderly, the sick, and those in special circumstances, like students and parents. But at what level and at what cost? And what about the disaffected, the discouraged, the untalented, the incapable, those living with invisible wounds, and the misfits?

Harry believes that addiction may be a response to distress in life, and he makes a clear distinction between addiction and the more common problematic use of a substance:

There are some people who think it’s [addiction] a disease, but I believe people may have a stress in their life; they lose a loved one, say a spouse or someone that they were very much dependent on, a parent, so they
might have a period [of use] in their life. Then they abstain for a while and get some quality in their life. But every once in a while, they’ll use a drug. That would be your problematic user: problem drinker, problem druggler... There’s a big difference between an idle user, a problematic user, and a drug addict [sic].

Gans (1971) has succinctly clarified the usefulness of poverty to North American-EuroWestern society. Poverty calls into existence the respectable occupations, such as law, public health, social work, and so on, all devoted to disciplining and helping the poor. The poor classes provide a substrate for such professionals to rise into the middle classes as well as an outlet for sporadic charity efforts on the part of the wealthy, seeking to assuage a little guilt and gain a little tax relief.

The poor ensure a low-wage labor pool that is unable to be unwilling to perform dirty work at low pay (Gans, 1971), thereby subsidizing a variety of economic initiatives which benefit the affluent and guarantee the status of those who are not poor. The poor are easily identified and punished as deviants, so upholding the legitimacy of conventional norms. Defenders of the norms of honest hard work, thrift, and the ideal of monogamy are quick to spot those poor folk who they can identify as dishonest, lazy, promiscuous spendthrifts. Accordingly, with such obvious individual moral deficits driving the containment of the poor in the lower strata, the pressure for systemic social action evaporates, and more equitable economic redistribution can be successfully presented as an unfair, low-down, dirty-socialist plot intended to increase big government and benefit only the unworthy.

With the casting of poor people as deviant, their social practices are understood to be abnormal and, as such, they are exposed to scrutiny, offering an opportunity for cultural voyeurs to experience a delicious vicarious thrill without incurring any risk. In a mix of disapproval, fear, and anger, stereotypes link ideas of poverty, characterized by defiance and violence, together with the images of the undeserving poor and the potentially dangerous underclass (Myrdal, cited in Gans, 1995). Poor people are portrayed as artifacts of culture, depicted in many a contemporary movie, cautionary tales about life on the mean streets. Simultaneously, people living in poverty enrich and provide society with
cultural heroes, art, and music ranging from the blues, country, rock, folk, and rap music.

Neal is well aware of the paralyzing power of stereotyping and stigma to stay effective action. He has borne witness to the degree of personal harm that its victims find preferable to the lash of scorn:

People [who use an illegal drug] often will not go through the door of a doctor’s office or a hospital because of the hostility that they’ve met and because of the bad experiences that they’ve had. . . . People may be embarrassed about going into places for service because they’re not feeling welcomed, or they’re feeling different—or they’re feeling the same—and therefore are full of chagrin. Services need to be moved out of offices and reach out on the street, either with mobile sites or on foot.

The simple maneuver of conflating illegal drug use with poverty enables the authorities to tread with assurance in familiar social territory. The undeservingness of the poor was entrenched in the Poor Laws of 1830's Britain, when the well-heeled intelligentsia determined that character flaws such as feeblemindedness, laziness, and debauchery were genetically inherited. (It is of interest that people do not typically complain about the undeserving middle class or the dissipated idle and morally deficient upper crust.) More lately, since the 1950’s or so, society has evolved to the point where the problems of people who are poor are often attributed to an ingrained culture that, over the generations, perpetrates a welfare mentality (Gans, 2007).

The poor are often believed to boldly flout social norms, beginning with a flagrant disregard for the virtue of hard work. The hackneyed picture of the poor person leading a supposedly worry-free life of effortless ease and comfort especially escalates the disquiet and insecurity of those working poor clinging to the ladder up just one rung higher as they survey their own precarious economic position while juggling sometimes two or three low paying jobs.

Class-based competition is pervasive and ferocious, and may most easily be recognized at the margins, where resistance meets control. We are witness in Canada to the paradox embodied in the police-ization of the military (Brandl, 2003), who now focus on keeping the peace abroad, and the alarming militarization of the police, armed to the teeth against citizens of their own
country (Balko, 2007). As Canadian farmers and hunters line up to register their rifles and shotguns, they must simply take note of the open proliferation of illegal handguns and automatic assault weapons, now felt to be essential in the gun play on the streets that has become part and parcel of survival in the increasingly high-stakes trade in illegal drugs.

**Governance and Illegal Drugs**

The very designation of illegal drugs as illicit can be tracked back to restrictions placed on opium at the beginning of the 1900’s, the result in Canada of parochial protectionist efforts by dominant social groups on the west coast, who intended to restrict economic competition by upstart immigrants from Asia (Morone, 1997). Prohibited from engaging in unseemly pogroms, established upstanding, enterprising Canadians saw a route to control those more capable immigrants simply by regulating their substances of choice and then selectively enforcing the associated laws. Not only would this get rid of the business competition but potential young firebrands could also be effectively extinguished. *(Win-Win.)* Drug laws continue to be a key means of cautioning the anxious class (Reich, cited in Gans, 1995, p. 52) and controlling the underclass, which the overclass can never quite fully depend upon to conform to the organization of society which most benefits that same elite (van Krieken, 1991).

Many reasonable people find the collusion of government with organized crime hard to believe, and wish to discount the evidence as incredible. It is the more astute serious thinkers, familiar with but not enmeshed in the systems that benefit from illegal drug use, who sound a sober note of caution. James Gray (2008), Superior Court Judge in California, admonishes those who would be dismissive that they should assess information branded by the authorities as conspiracy theory very carefully indeed.

Historically, government has had a huge stake in the drug trade. It was alcohol exchanged for furs that opened up His Majesty’s dominions in Canada, and cultivation of the tobacco habit among Europeans that finally established the American colonies. Although Britain may have lost the battle over tea fought by American colonists united against heavy taxes, it won the *Opium Wars,*
undertaken to open the Chinese market to opium grown in another colony, India, as a means to offset the monies drained from the British economy by the tea trade with China. In a paradigm of successful marketing, up to 16 percent of the population of some Asian areas were believed to use opium before American-led drug-limiting attempts were initiated in 1907 after it took possession of the Philippines, won in the Spanish-American war fought with Mexico over territory now part of the US (UN, 2009).

After the revolution that established the communist government in Russia at the time of World War I, workers movements, punctuated by the outbreak of World War II, swept around the globe. The return of well-armed servicemen, with their hard-won, world-wise egalitarian insights, preceded the outbreak of the Red Scare, mobilized in the US by McCarthy and his cronies in the 1950’s. McCarthyism was designed to root out possible socialist subversives who were deemed a potential threat to the American (capitalist) way.

The Central Intelligence Agency (CIA) of the US, formed after the Second World War, took proactive steps abroad to safeguard American (capitalist) interests, often involving deals with the devil. To break the strike of unionizing dockworkers in Marseille, the CIA called again upon the Corsican Mafia, that, as the only organized body still standing, had helped the Allies stabilize war-torn Italy (Glenny, 2008, p. 302). In exchange, the authorities looked the other way while the Mafia established the French Connection for heroin coming into Europe from the Golden Triangle. Since, Americans (led by pro-capitalist elements) have taken advantage of the flourishing drug trade as a source of financing for covert operations intended to obstruct the galloping menace of socialism. Such interventions abroad dress up quite nicely as anti-drugs assistance extended to factions that, not coincidentally, are dedicated to the rights of (capitalist) business to exploit opportunities to make a profit or that support a positive trade balance (good business), even when so doing may compromise the ability of the host country to provide the necessities of life for its own citizens.

In the 1970’s, the CIA financed the involvement of mercenaries in the fight to restrict the influence of Red China-backed North Vietnam through airlifts of
heroin. It was Air America planes that flew the harvest from newly planted cash crops of opium poppy out of the Golden Triangle area of Laos, Burma, and Thailand. In the 1980’s, exposure of the Noriega-North-CIA-cocaine fiasco shone a bright light on the murk surrounding perfidious government practices and profoundly disconcerted those who were paying attention. In the Noriega-North arms-from-drugs scam, the CIA of Reagan’s Government provided the Nicaraguan (pro-capitalist) Contras with arms to combat the (socialistic) Sandanistas. According to Robert Bonner (1993), head of the CIA at the time, munitions for the (pro-capitalist) Contras were paid for by the proceeds of covert US military-run cocaine sales into Los Angeles and by profits from surreptitious sales of arms to Iran.

Afghan poppy cultivation and opium production was initially encouraged by the CIA as a means to fund tribal warfare against the Russians. The weapons sold by the US to Iran (and the training to use them) were intended to support the Iranian and Afghan resistance against the Soviet Russians, who the Americans felt were poised to intrude through the Balkans on the oilfields of the Middle East. The trade route through the Balkans has since proved ample to move the bumper crops of opium (8,200 Metric Tons in 2008) produced yearly in Afghanistan since the 2000’s (UN, 2009, p. 40), under the oversight of the North American-EuroWestern armies of occupation. The overt imperialism, expressed in the jingoistic policies of George Bush’s US, kindled alarm among many Afghans and fired much of the fierce religious fundamentalist jihadism later aimed at Americans and those believed to be their allies. Poor Americans, who overwhelmingly make up the bulk of front line US armed forces, are now paying the price in blood of the cynicism sown each year in the poppy fields that sustain the Afghan economy with sales of $1 billion US at the farm gate (UN, 2009, p. 1).
**Poem 2: Artificial Flowers**

Come sit close here in my meadow
wind rich waves riffle your brown hair.
Take a fresh little sandwich
all the crust completely cut off,
And I will bring you artificial flowers
artificial flowers for you to hold.

We’ll talk of high wide and far
all the doings of the day.
Sit down stretch out blanket-near
and lean back pillow-next to me.
I will put my head down close
and whisper all you want to hear
About artificial flowers
artificial flowers fall from your arms.

And in this sunny season
when the butterfly is wild,
The fox himself will teach us
all those bunny-best behaviors,
While we sit with our pens up
close-lipped all set up to sketch out
all those artificial flowers
artificial flowers you know so well.

At last the day comes to a close
and you will wave good-bye and go,
Taking all we’ve learned so far
about the way all things fit or die.
And we’ve come to understand it all too well
all about the way the world runs down.
And you won’t forget your flowers
artificial flowers weigh on your mind.

Carol Polych (2006)
Uses of Illegal Drugs

Continuing widespread illegal drug use has its less obvious functions in society, just as does poverty (Gans, 1971). It is these deep functions that make it unlikely that the powers-that-be will spontaneously deal compassionately with people involved in the use of an illegal drug, even if humane treatment is proven to be the only approach that makes sense. Social Darwinism confirms that society functions as it does for good reason: somebody stands to benefit.

Illegal drug users as a group sustain a great many legitimate professions including criminology, social work, mental health, treatment, detox, corrections, law, and public health. As the individual user is exposed and subjected to sanctions, conventional norms are defined and upheld for all to see. Illegal drug users are painted as moral deviants engaged in debauchery, serving thereby as a reference point for the rest of the ostensibly non-using society. In this way, the nice law-abiding folk in society have someone to look down on, thereby enabling them to relish a small sense of security about status and social location. (Uptown folk who occasionally sally downtown to dabble in illegal drugs can be said to be “acting decadent.” Even though some of their behaviors mirror those of down-and-dirty illegal drug users, dabblers take part without ever actually seriously considering themselves to be morally deficient.)

Finally, if in fact it actually is believed that it is the moral failure of individuals that causes illegal drug use, there is less pressure on decision makers to alleviate the conditions that underlie and drive drug use. With the root of the problem nestled firmly within the individual, those better off in society need not feel guilty for lining their pockets as they exploit or simply neglect the more vulnerable in society. If illegal drug users ever got the idea that they have rights, they would fight against abuses of those rights, and society would be compelled to scrounge up new scapegoats. What else could we do?

Gans (1971) believes that change comes only when those affected gain enough power to overcome the efforts of those more privileged to maintain established economic, social, and political arrangements. Power is claimed, not given.
Illegal drugs and work.

The use of illegal drugs can be a way in which the individual, alert to opportunities to offset the numbing alienation engendered by the dehumanizing roles and fractured families that support wage-labor (Marx, cited in Himelfarb & Richardson, 1984, p. 212), can creatively experience a bit of novelty and transgress a little social norm while they’re about it. O’Malley and Mugford (1991) point out that, if the Protestant work ethic is one face of the coin of modern producer-consumer culture, then the flip side is that of Romantic self-discovery. It is the self-realization experienced by many who use an illegal drug that so troubles the peace of the authorities. They fear that workers who refuse to defer gratification may give up on forward-looking aspirations, attenuate their acquisitiveness, impair their sense of calculative prudence, and deaden their spirit of enterprise and industry, thereby jeopardizing their participation in the workforce and the marketplace.

Society relies on the majority of the public to engage in wage-labor which features personal discipline, deferred gratification, and the exercise of self-control. Yet, paradoxically, with the click of the clock at week’s end, the same workers are expected to throw themselves into a consuming frenzy, enjoying instant gratification selected from a variety of hedonistic leisure pursuits as glamorized by advertising. Drug use actually serves the same function as the ubiquitous cocktail hour, popping workers out of the routine dictated by the roles within which they function during the day into the nightlife party atmosphere reigning in clubs. Aldo recognizes the quick appeal of drug use:

You know that your drug will always change the way you feel very quickly and you know that it’s always there. That’s opposed to a healthy way of making yourself feel better about yourself and your place in the world. But, take a walk... You’ve had a hit of heroin and a toke; that’s what you’ve done in terms of brain chemistry. You’ve made endorphins, and you’ve tickled some pleasure centers.

The robust North American-EuroWestern underground economy exudes omni-present visible cues, such as gangsta-chic and other forms of counterculture conspicuous consumption. Shift and 9-to-5 workers struggling to hold their own in the daily rat race may experience a gnawing resentment over the
apparent unearned affluence of those in the off-the-books economy, raising the
general level of dissatisfaction with the common lot. High rollers in the shadow
economy get to spend freely and enjoy all the privileges of membership in the
upper echelons, without worry about paying taxes earmarked to fund social
programs. The higher ranks of the underground economy join other card-
carrying members of the business class, and together with their toadies in the
mainstream, entertain themselves by idly poking more holes in the moth-eaten
social safety net left to Ontarians by the Conservative Government’s lethal slash-
and-burn policies of the early 1990’s. In this way and others, substance use and
the overheated spin-offs of social dysfunction flowing out of drug prohibition
threaten to engulf the entire social system in suffering. Those not drowned
outright in the hosing may suffocate in the tsunami of malaise set to follow.

Staff of the Drug Abuse Survey Project in the US succinctly outlined the
goals of treatment: “Society wants the addict [sic] to stop using . . . and
committing crime and instead to find a job, stabilize his personal life, generally
improve his character, and become a useful and productive citizen” (DeLong,
1972). Overlooking the insult to the value of people who are otherwise not able
to participate in the market economy, DeLong’s terse summation is easier said
than done. At no point in the trajectory of substance use are substantial effective
provisions made for help of any kind (Amaro, 1999). DeLong shares his opinion
that, “Since no one knows why people become narcotics addicts [sic], no one
knows either how to make them stop or what will happen to them if they do stop.”
Some believe that addiction may serve an adaptive function for those with
psychic problems. DeLong pithily pictures the addict [sic] population as painted
by the US National Institute for Mental Health: 25 percent suffer from depression
and chronic anxiety, 25 percent are hedonists, and the half remaining are
psychopaths looking for immediate gratification.

Harry’s experience is in sharp contrast with DeLong’s (1972) theories
about people living with an addiction:

I know a guy, very strong willed . . . family, children, very important job:
he was a heroin addict for 25 years. Shot three times a day, same hole
every time. Even his wife didn’t know . . . . He was able to pass. He was
able to succeed. And a lot of people can do that; just live a normal life. Heroin: if you can afford it, you can live a normal life—you actually use the drug to be normal. . . . He wasn’t interested in doing anything about it. But it takes its toll. Eventually something’s going to fall by the wayside; eventually he lost it. . . . Your guard is going to be down, and people are going to know that you’re using. The wife found out, and he decided that he should get some help, and he went into recovery.

**Economics as anodyne.**

North American-EuroWestern culture is now and has been one where politics is the handmaiden of profit, governance is by propaganda (Lessing, 1986, p.41), ideology is advertising, the military imposes stability where peace is forgotten, trust in technology drives ritual sacrifice by automobile, worker units are infinitely disposable and replaceable, and the most common addiction is to money. And money, like opium, comforts and kills pain; however, neither fix the existential distress identified so clearly by Marx (cited in Easton, 1983, p. 128) or Durkheim (1893/1951, p. 255) after him. Doug’s opinion parallels that of Marx, but he sees no reason that people should not safely access their narcotic of choice:

A drug may give some very temporary respite to the existential pain of life. There is a psychic numbing, even if it’s only for a few minutes. Drugs can leave you free in a fashion, from feeling what some people feel we shouldn’t be feeling. (I don’t like to make that judgment.) Narcotics are different from cocaine and crack cocaine, which are really nasty drugs that can be quite harmful. With a narcotic there can initially be nausea, some people can get itching, and there’s the well-known side effect of constipation. If they take too much, there can be nodding and sedation.

On the narcotic side, what’s the big deal if someone who has chronic pain takes opioids for the rest of their life? Or, if they’re already addicted but they’re functional and they just need a safe supply to remain productive, what’s the big deal about letting them have it? No one’s yet presented to me a strong enough argument as to why they shouldn’t be able to get safe unconditional access to narcotics.

Cultivation by the individual of a sense of purpose requires awareness, and therefore precludes dependency on any painkiller of any sort. If Canadians give up the illusion that the promised pay off is so close at hand for each and every one of us deserving folk that we only need reach out and grasp it, Canadians will also simultaneously have to renounce buy-in to the current economic system of competitive wage-based employment designed to primarily
benefit corporations and their shareholders. They will have to get rid of the middle-class mind-set, often-misplaced, that they may somehow be able to benefit, even if someone else (preferably an unidentified stranger) goes in want.

Harry targets the sense of isolation that arises from selfishness and competitiveness as a feeling fundamental to sustaining an addiction:

It’s all feelings; the underlying stuff is insecurity and loneliness. . . . Drug use is a very, very selfish thing. When people say, “I have to do it [quit] for me now,” I understand what they’re saying. But I think, “It’s about time you stayed clean and sober for everyone else in your life, for the people that need you.” I believe selfishness is the opposite of love and loving. Love and hate: I don’t believe they’re opposites—I believe love and selfishness are opposites. . . . Community and communication are the opposite of isolation. Isolation is a very dark, dingy place.

Propaganda

Tony Clement, while in office as Federal Minister of Health for Canada, sent out a series of flyers, which exemplify the type of propaganda that drives the stigmatization of illegal drug use and elicits buy-in from unsuspecting Canadians. Lessing (1986) identifies three main techniques in propaganda: a) reduction of complex social issues to a simple slogan, b) creation of tension followed by presentation of a means of release, and c) repetition. Clement’s flyers ostensibly seek an opinion from constituents, but admirably serve to illustrate how this intransigent reactionary conservative government controls the dialogue about wrongdoing with regard to illegal drugs.

Drug crime.

The first of these black and white flyers released in February of 2008 shows a split frame, with the left panel featuring a pair of hands gripping the bars of a cell, and the right, an empty swing. The bars and floor show dark spattered areas. The caption reads: “Drug dealers belong here [behind bars], not here [in the playground]: Drug dealers should be doing time, not doing deals.” This slogan is followed by three bullet points which highlight: a) mandatory minimum sentences, b) harsher penalties for dealers who target kids, and c) more money for police and border guards. Directly under the bullet points the reader is asked a question and is presented with two boxes in which to mark a forced choice answer: “Do you support the Conservative Government's fight against illegal
drugs in Canada? Yes or No.” Plate 1 follows; it consists of two pages that replicate the two-sided flyer sent by Clement.

Plate 1: Drug Dealers Belong Here: Not Here
Flyer sent in 2008 by Tony Clement, then Minister of Health in the Conservative Government of Canada, to his constituents, in hopes of eliciting support for the illegal drug arm of its so-called *get tough on crime* policies.
Tony Clement stokes the fear of the reader as he goes on to explain that illegal drugs destroy those who use them and unravel the fabric of our communities. He points out that drugs make our neighborhoods less safe and feed both petty and organized crime. Then in a release of tension, he mollifies that fear by giving the reader to understand that, somehow, he alone knows how to separate out the nasty dealers and conniving producers (in need of incarceration) from the presumably pitiable users, and offers his solution to the drug problem: mandatory minimum sentences. The Minister of Health makes no mention of the dearth of effective addictions treatment through his Ministry for either users or dealers.

**ADHD, drugs, and Corrections.**

While the Minister of Health has clued into a venue, the schoolyard, that is important for the understanding of the use of substances, he seems confused about what to make of it. Clement seems unaware that few drug dealers, if any, can afford to sell an illegal drug for the amount of the allowance earned by most of the patrons who do their swinging in the playground. Canadian playgrounds are hotbeds of drug use, but Tony Clement seems completely accepting of the widespread provision of prescription mood- and mind-altering stimulants to the one in ten school kids diagnosed with Attention Deficit Hyperactivity Disorder (ADHD) (Canadian Paediatric Society, 2008). Kids do deserve bonus marks for entrepreneurial initiative though. The Learning Disabilities Association of BC (no date) informs the reader that, while 5.3 percent of students in Grades 7 to 12 did indeed properly use the stimulant, *Ritalin*, to treat the ADHD with which they had been diagnosed, another 8.5 percent admit that they take Ritalin just for fun. Clement similarly seems unaware of studies which document that one in every five students on Ritalin actually pass it along to others, while a business-minded 7.3 percent are said to make money from trafficking the drug.

About 60 percent of those diagnosed as kids with ADHD are known to continue to be symptomatic through their teen years (Ingram, Hechtman, & Morgenstern, 1999), resulting in 4 to 5 percent of the total adult population carrying an active diagnosis of ADHD (Weisler, 2006). Coincidentally, the
Learning Disabilities (LD) Association of Windsor-Essex County (no date) further points out that, while learning disabilities affect 10 percent of all Canadians, about one third of whom have a diagnosis of ADHD, this number rose to 75 percent among inmates, now adult, who had a learning disability in school. British assessments of adult prisoners confirm that 65 percent have a reading age below 8 years (Ramsbotham, 2003). Of adults diagnosed with ADHD, half have been identified as meeting the criteria for a substance problem, while by the same token, between 15 to 25 percent of adults diagnosed with a substance use disorder meet the criteria for preexisting ADHD (Wilens, 1987). It was the efforts of the preceding Conservative Government which 20 or so years ago slashed special education from classrooms in Ontario. Coincidence? Maybe: Maybe not.

Incarceration.

A companion in the series of flyers sent out in February 2008 by the Minister of Health shows a bearded young man, in real life likely one of Clement's staff, with a cigarette in his hand, clad in an undershirt that reveals an underdeveloped frame, slouched in a tawdry, outdated easy chair. He is evidently drinking a bottle of beer while apparently watching TV. The expression on his face is abstracted, sober, and possibly sad. The slogan reads: “Jail? Why should convicted thieves, arsonists, and vandals serve their sentences watching TV, playing video games, and surfing websites on the internet? They shouldn't.” Tony Clement explains that, due to a weak justice system that did not jail him, the young man is condemned, not to the penance accompanying the degradation ceremony of imprisonment, but to serve his time supposedly in comfort while “loafing about” in his own living room. Plate 2 replicates in two pages the double-sided flyer mailed by Clement.
Plate 2: Jail?
Why should convicted thieves, arsonists and vandals serve their sentences watching TV, playing video games, and surfing “websites” on the internet?

They shouldn’t.


For too long, previous Liberal governments turned a blind eye as serious criminals were sentenced to serve their time in the comfort of their own homes. Canadians will not stand for that. The Conservative Government demands a tougher justice system. Vendors, thieves and arsonists should go to jail and not be left to loaf about their own living rooms.

I think thieves and vandals should serve their sentences in jail.

☐ Agree  ☐ Disagree


TONY CLEMENT, MP
PARRY SOUND—MUSKOKA

1-866-975-8669 Clement.T@parl.gc.ca www.tonyclement.ca

Flyer sent in 2008 by Tony Clement, then Minister of Health in the Conservative regime, to his constituents, in hopes of eliciting support for the 5,000-bed prison expansion planned by the Federal Government of Canada.
The dangerous classes.

This flyer represents part two of the neo-con dialogue emphasizing enforcement efforts to control the drug-crime nexus. If the previous flyer focused on stoking fear in the reader, the sub-text of this flyer skillfully arouses anger: it assaults the reader's sense of fairness that a young, healthy male is blithely violating accepted norms by “loafing” instead of working like good folk do. By implication, the young man, presented as a convicted criminal, is a cheater who makes monkeys of honest working stiffs as he flouts the unstated social rules about work while supposedly enjoying his leisure. The details of the picture carry the earmarks of the lower class, conflated here with the dangerous class, all part of the “rotting mass of social scum exuded by the lowest layers of society” (Marx & Engels, 1977, p. 92). Clement’s flyer implies that, for such young men, it is second nature to engage in thievery, arson, and vandalism. So does disinformation lead to imagined knowledge and vilification foster negative moral judgment, resulting in the discriminatory labeling of an entire class.

In this depiction, the young man is portrayed as flaunting his leisure by unfairly enjoying unearned pleasures, in contrast to the difficult conditions of life experienced every day by hard-working, law-abiding people. As a scofflaw, the young man can be seen to represent a public enemy. Extreme measures now seem not only reasonable but also necessary to either bring him into line or else teach him a lesson and make him pay, as is only fair. This young man and his ilk, deviants, othered and identified as hostiles living comfortably like cancers nourished within the social body (McCaffrey, 1997), can now serve as ideal scapegoats. Such felons are living symbols that embody the ills of the Canadian social system and simultaneously, targeted by archaic punishment rituals, expiate such sins for all, through proper incarceration beyond the pale. Mr. Clement has skillfully lifted his readers away from any reference to fact and wafted them directly into the moral dimension of symbolism.

Propaganda and disinformation.

Mr. Clement avoids presenting objective data in this flyer, an attempt, he says, to elicit opinion, instead painting a picture of bias for his constituents that
invites the demonization of those labeled as criminals. Strangely, the Minister of Health raises no awareness on the part of his reader about the links between health, poverty, limited education, blocked opportunity, illegal drug use, and crime. Neither does he bring forward for discussion the problematic effectiveness of imprisonment as a response to any crime whatsoever (Ramsbotham, 2003). Nor does he alert his constituents to the noxious impact of incarceration on the ex-inmate’s life chances following a jail term. In this flyer, Tony Clement targets those who engage in minor property crime: vandals, thieves, and arsonists as most in need of jailing. Abracadabra! The greatest problems in society are a result of just such low-level street crime. Hocus-pocus! White-collar crime perpetrated by those who inhabit the upper echelons is not even worth mention. Suite crime (Goff & Reasons, 1974, pp. 180-189) has become inconsequential and invisible. Alakazam!

Tony Clement’s flyers do not bring up the widening gap between the have-yachts and have-nots in Canada nor do they mention the impact of burgeoning corporate crime. The reader can only wonder if Clement is unaware of the decades long, much speculated about decrease in the violent crime rate that took place independent of policing efforts and prior to the expansion of the police force over the last decades. Despite the escalation of hyperbolic media reports, crime in Canada has dropped more than 25 percent over the last 15 years alone (Falconer, 2008). The Minister of Health does not highlight the niggardly funding by his portfolio for the treatment of addictions or the reallocation of scanty treatment monies from that thin purse into policing. Minister Clement does not acknowledge the savings to Corrections gained when the responsibility for monitoring the behavior of convicted criminals is tossed back, unremunerated, onto already hard-pressed families. The Minister of Health fails to inform his reader that, due to the market inflation which accompanies the designation of almost any product as illegal, many users must undertake a certain amount of wheeling, dealing, stealing, or peeling as a means to meet expenses (Health Canada, 2008). Accordingly, it is usually impossible for anyone to distinguish between user and dealer, but Mr. Clement gives his
reader to understand that somehow he can. Strangely, Mr. Clement’s flyers make no mention at all of the abysmal failure of the *War on Drugs* in the US (Economist, 2009) together with the tremendous social sacrifice that accompanies it.

**Labeling.**

Clement’s use of the labels: “thieves, arsonists, vandals,” and “drug dealers” deflects the reader’s attention away from the unacceptable social behavior and throws the emphasis onto the reprehensible personal qualities of the guilty miscreants. Clement’s language conflates the person with the crime, and the direct connection of the crime with the collective crisis-of-the-moment seems so self-evident at the level of *myth* that the victimizing process is scarcely noticed. By this means, the fault can be located squarely within the individual anti-social recalcitrant. Readers are left with the sense that such criminals are an entirely different breed and a kind of people much worse than they. Clement has *de facto* sidestepped any consideration of the social and economic conditions under which such crimes might make sense.

As he rouses the fear and ire of the reader, while inviting widespread public condemnation of the *desperados* here depicted, Tony Clement simultaneously offers the *good* folk of the community an opportunity to come together in solidarity and a venue for positive civic action. The reader is urged to strike back by simply marking their choice—agree or disagree—with harsher conditions of incarceration. Given this hair-raising presentation, one would feel an ungrateful fool to do other than agree. Clement’s flyers do not leave space for comment, but force the reader to choose a simple “Yes” or “No” to the agenda he has set out. Clement does not mention the widespread recognition in the US that their *tough on crime* experiment has proven a colossal failure, and that a number of states are beating a retreat from *three-strikes* (Falconer, 2008, p. AA6). Mr. Clement’s flyers conspicuously fail to present for his reader’s consideration any responses other than abstinence, interdiction, criminalization, and punishment for illegal drug use, although maintenance, substitution,
medication, vaccination, legalization, and regulation are control options which all have merit as well.

In his flyers about illegal drug use and crime, the Minister of Health has very effectively taken control of the discussion about acceptable ways for good folk to count as solid citizens, generate an income, use their leisure time, and pursue the pleasures of life. He has marked out the area open for discussion, framed the nature of responses as an expression of morality, and set out the appropriate social response to violations of norms. Mr. Clement has neatly blocked the entry of other analyses into the discourse set by his Ministry (Tooley, 1994).

Mr. Clement’s flyers give the impression that he wishes to eliminate the enjoyment of daily life on the part of criminals. Although the history of prisons is replete with ingenious mechanisms designed to punish and torture inmates (Foucault, 1979, p. 113), in point of fact, present-day Canadian law is clear that the only penalty that the law may impose is on the liberty of the person (Elliott, 2008). Criminalization is no longer grounds to otherwise punish offenders. Once the freedom of movement of the inmate is secured, Corrections has no license under the law to impair the efforts of people behind bars to eke out some enjoyment in life. Further, unnoted by Minister Clement, the position of the courts on health care is exquisitely clear: imprisoned Canadians are entitled to the same level of health care as that available in the community at large (Ford & Wobeser, 2000). Recognition of this right, problematic still, begs the question as to how treatment for those “dealers” of illegal drugs, caught at the school yard and destined for the prison yard, will play out when treatment is so generally inadequate.

Unfortunately, the plan developed by the Minister of Health to deal with illegal drug use focuses on law enforcement at the expense of health. He does not call to increase funding for amelioration of the social and economic conditions that underlie illegal drug use and the property crime or sex trade that often funds it, but rather plans to increase policing monies, a downstream strategy which has been shown to have absolutely no effect on either the price or
the supply of illegal drugs. It may be of interest that the professional preparation of this Federal Minister of Health is not, in fact, in health, but rather is in law.

Questions

As I came to better understand the cultural utility of illegal drugs as an hegemonic means to maintain social order and support the economy, I did come to better contextualize the responses that Anna experienced. I had witnessed the stigma applied to Anna and other people known to use an illegal drug. I now began to wonder if Anna’s health care providers might have tailored their reactions to Anna’s presentation for help to reflect a larger social response said to be meant to deter or punish a person who has flagrantly engaged in an activity that has been criminalized.

I was moved to ask further questions about why a health care system, designed to offer comprehensive health care in an accessible manner to all Canadians, would leave suffering individuals to medicate their own conditions and to carry an addiction as best they could. I wondered about the way in which Canadian society follows through with the shared responsibility to provide its members with the social substrate needed for health. I asked myself what beliefs might underpin the way in which Canadian society attempts to create the conditions for well-being and how it responds to illness? What drives addiction anyway?

The next chapter examines the transition of health from an attribute to a social good to a commodity and maps out who benefits from the institutionalization and monetization of care. The commercial bias of government together with the defunding of health care as a prelude to privatization is exposed. The social regulation of behavior within the North American Euro-Western context is analyzed and the social context of illegal drug use is further developed. Evidence of the ubiquity of addictions and theories about the individual basis of addiction are reviewed and the cyclic nature of current responses to illegal drug use is discussed.
Here Be Monsters

The presentation of some may be regarded as strange, disturbing, alien, repulsive, morally offensive, and even threatening at first glance. Yet often, calm consideration and closer understanding reveals unexpected sense and beauty.

Marker pen on foam (Polych, 2009)
CHAPTER III
HEALTH AND ILLEGAL DRUG USE
Downstream-Upstream Paradox

By law, Canadians, including Anna, are assured of equitable access to what health care is available, generally downstream interventionist measures, as provided through public monies. Ironically though, upstream access to the necessities of life is currently so problematic, particularly for Canadians bringing home low incomes, that protective factors as basic even as a healthy diet and safe, stable shelter may be out of reach (Tsering, 2007, p.8). Those who live in isolated rural and northern communities face prices for staples such as fruit or milk that may place them well out of reach of the average family.

Fallout from classist policy enacted in Canada has often resulted in penny-wise, pound-foolish distribution of public monies earmarked for the public good (Rachlis & Kushner, 1994. pp. 11, 80, 227). About 40 percent of the Ontario health care budget is dedicated to hospitals, and a further 25 percent goes straight into the pockets of physicians (Ministry of Health and Long Term Care, 2007). Adding mortal insult to an injurious dead-end health care system and coincident with the shredding of the social safety net in Ontario starting with the Harris Conservatives, government spending in Canada was cut overall by 10 percent of the Gross National Product (GNP) in the decade from 1992 to 2002 (Scott, 2005, p. 23). This move, sure to please business, has caused misery for those less well-off.

The area of addictions has never been well funded, and it fared no better once restraints were applied. Aldo describes the low status of addictions at the time he started working in the area:

Addictions was located off site and below ground—below everything else—that’s as low as you can get. That’s where we came in the hierarchy. . . . I met with senior administrators, “Where do you think drug and alcohol [treatment] is going?” “Absolutely nowhere.”

Congruent with supporting disease care provided by the same elite clinicians whose golf clubs jostle those of the politicians enacting legislation and the accountants drafting up the budget, the cost-cutting scalpel has bypassed
dramatic down-stream medical intervention. At the same time, preventive care and home care have been largely cut out and proactive provisions, such as pharmacare and dentacare, are not even mirages on the horizon. Publicly funded acute care is often now all that is available to working-poor Canadians, who pray for a miracle while hoping against hope to stave off the worst at the end. In Canada, patients diagnosed with hepatitis, HIV, and other illnesses related to illegal drug use flail out for access to end-stage heroic life-saving pharmaceutical and medical treatments, for many the only recourse. With almost no funding from the public purse directed to public health and prevention, and with the financial means for healthy living left to trickle down (or not) through the market to the lower classes and to people who are economically exploited, the conditions which breed both social illness and physical disease are set in place. Confused and ill-prepared at best and exclusively self-interested at worst, health authorities observe, close-lipped, as needless infection runs rampant among people using an illegal drug and overdose strikes repeatedly, seemingly out of the blue (Elliot, 2007).

Max points out some of the grievous funding gaps within the health care system that reflect the disregard of the effects of complex social problems and the mental health issues that follow:

We have a fee-for-service system for physicians; but when it comes to the counselling and ancillary services that research has demonstrated are essential to good outcomes [in addictions], that’s where the shortage of funding has been most problematic. There hasn’t been a freeing up of those dollars.

The response to health care needs in Canada actually seems to resemble the structure of a tattered suspension bridge. The first anchor point, well established but undermined, hollowed out, and constantly threatened, is that of fully funded, acute heroic health care, offered in a last ditch effort to individuals as available. This type of care often comes in only downstream at a point when the health of the patient has already been needlessly damaged, disease is evident, and intervention may well be too late. An example may be seen in the expansion of dialysis services, even while obesity is fed by an unfettered fast food industry that entices diabetes to run amok. The second insecure point of
anchor is that *mélange* of preventive measures generally brought in amid flurries of lobbyists and special interest groups; an example may be seen in tobacco regulation. Always at issue in developing preventive legislation are the tensions among the health of the public, public order, the exercise of so-called lifestyle *choice* by citizens, media influence, the interest of business (profit), and reelection pressures. The rest of the mess in health care dangles over an abyss, disrepair and distress disregarded, haphazardly supported in times of illness according to income.

**Population Health as Good Business**

The overwhelming majority of Canadians can be identified as suffering from a variety of health deficits or, given their way of living, exposure to high levels of needless risk. Paradoxically, for their own good, the social milieu may be regulated to contain or reduce risk, to the point that, in some respects, it takes on the worst characteristics of a *nanny state* (Illich, 1976, p. 86) with few of the benefits. Health, understood as an attribute endowed by nature and possessed to some degree by all as a birthright to be cultivated, has taken flight, becoming nothing more than an ever-receding goal on the horizon, to which access is restricted only to those entitled to it by virtue of social position or social justice. The jaundiced, panoptic gaze of preventive medicine regards people as patients even though they are not sick. It subverts personal responsibility, which is brought under the purview of professional agencies, at the same time that it is blind to the truncation of self-reliance that accompanies consumer culture. An example may be seen in current legislation enacted in Ontario that penalizes drivers who smoke while a young person is also in their car.

The expense of such health initiatives is distributed throughout Canadian society as part of the cost of capitalized wage labor, in recognition that a certain level of maintenance keeps the worker cog well oiled and humming along. But even as the regulation of certain behaviors of individuals comes under the supervision of the state, the inaction of the Canadian Government with respect to regulating the health-related impact of business is remarkable. Examples would include the pollution of Ontario waterways by cocktails of industrial exudates.
including manure from factory farming, toxic mercury from pulp and paper, carcinogenic dioxin from manufacturing, and the miasma arising from mining effluvia. The businesses that produce these and other contaminants are, strangely, exempted from liability.

**Why People Use**

In a humdrum life of producing and consuming, the use of illegal drugs can bring an enticing variety of agreeable moods and delightful states not otherwise immediately available from surrounding reality. The person who uses an illegal drug may subscribe to images which may include those associated with affluence, serious art, culture, music, peace, protest, and so on. People typically hope for something good when they take an illicit drug: ease of suffering, relaxation, peace, a sense of alertness and confidence, a feeling of potential energy, radically transformed perception, or even ecstatic happiness. For many, the *cachet* of taking an illegal substance centers around a sense of kicking over the traces, of running against the current, or of living life dangerously. Less welcome states may however intrude on illegal drug use: inebriation, agitation, hallucination, drowsiness, black outs, complete anesthesia, addiction, or death. It is these more problematic effects of illegal drug use that are typically addressed in most professional drug literature and which are often sensationalized by the media.

Doug emphasizes the physical basis of addictions but quickly confirms that the dynamic encompasses far more than a simple physical process:

For sure, there are changes in the brain once someone is addicted; there’s no doubt about that. There is some evidence of a physiological proclivity to addiction; some people are physiologically inclined to become dependent, and maybe psychologically once they’ve started—I don’t know who. The ones who persist on it no matter what, are really physically and psychologically dependent. But why do people even test out the drugs in the first place?

Aldo has noted the complexity of the dynamic of addiction, which may be triggered following a negative reaction to adversity:

There’s a combination in any addictive behavior, of genetics and environment. . . . Both play a part. . . . If you get a message in your life that you are worthless, “We will love you if you’re perfect,” that makes you
feel less good about yourself, you’re certainly at greater risk of using substances abusively and therefore addictively. Eighty percent of women in treatment have a history of sexual abuse, and 35 percent of the men. Physical abuse is even greater, particularly in the men. Emotional abuse, you could argue, would be 100 percent in both. . . . Does that mean that’s why they’re addicted? . . . That’s too simplistic. . . . But where you get the message that, “I’m worthless. But when I take this chemical, I like me better, so I’ll keep taking it”: the sense of reward again.

Harry has found that people reach for a drug as self-medication for intolerable emotional pain:

It is self-medicating. It’s [drug use] not a cure, like penicillin or an antibiotic. It’s more like a painkiller. . . . But it’s [addiction] a lot more in depth. . . . They [users] understand that life is a lot easier if they use a drug. It’s their best thinking. It’s what they understand. It’s what they know. . . . Fear also keeps them using. They’re afraid of pain—emotional pain: the lack of love, the lack of trust, and the lack of faith. . . . It [addiction] might relieve some pain in the short-term, but eventually, it’s going to take its toll.

**Addiction and Health System**

To date, government responses to illegal drug use revolve around pandering to moral-punitive factions, featuring so-called *law and order* approaches which diverge wildly from the pragmatics called for by health authorities and even the more thoughtful elements within Corrections. Noxious responses from the Canadian social system can be excavated to display the sedimented layers (Smith, 1998) of the hegemonic representation of illegal drug use that underlie the ostensibly *tough on crime* analysis.

From the time of first contact with the health system, people who use an illegal drug are likely to encounter workers who fail even to recognize addictions as a factor affecting health, never mind a discrete serious health problem. When an addiction is noted, the systemic response within health care is typically wholly ineffectual. If the system is engaged, workers may attempt to split hairs and deal with a mental health component that they somehow feel they can distinguish from an addiction. Conversely, with no account paid to the social situations underlying usage and no mind paid to the emotional reasons for the individual’s behavior, illegal drug users may be taken for cure into the treatment system for 3 weeks, then discharged “home” with little or no assistance. The result is that
illegal drug users are often isolated, humiliated, and ground into abjection (Stevens, 2000) within an unyielding and unresponsive system.

Aldo is frustrated by the ineffective, partial, or absent responses that typify addictions treatment in health care:

Some clinicians make moral judgements, where those clinicians have not realized that addiction is an illness. The attitude of pessimism, the attitude of morality, the attitude of, “It’s just a bad behavior”; and so it’s discounted. They don’t identify addiction as an illness because they never learned about it in school. Professionals have blinkers; they don’t think of addiction. . . . “What’s my role?” “You don’t have one.” Those words aren’t said, but that’s the message. . . . It’s just not that important.

What is important is this other thing: get that mood stabilized, or work out the trauma issues, or “You had a bad experience; here’s a chemical.”

Those who use an illegal drug do not constitute a homogenous population, but form only a certain segment within a broader drug-using distribution. Five broad patterns of drug use, often complicated by concurrent mental health problems, have been distinguished in the US, as reported in Table 5 below:

**Table 5:**

<table>
<thead>
<tr>
<th>Type of Drug Use</th>
<th>Associated Diagnosis</th>
</tr>
</thead>
<tbody>
<tr>
<td>A no drug of any kind</td>
<td></td>
</tr>
<tr>
<td>B By Rx only: sedatives, tranquillizers, opiates</td>
<td>anxiety</td>
</tr>
<tr>
<td>C cannabis only</td>
<td></td>
</tr>
<tr>
<td>D club drugs, stimulants, hallucinogens</td>
<td>all Dx more common, incl antisocial personality</td>
</tr>
<tr>
<td>E Polysubstances (alcohol, nicotine, caffeine, etc)</td>
<td>depression</td>
</tr>
</tbody>
</table>

Rx prescription; Dx diagnoses (from Agrawal, Lynskey, Madden, Bucholz & Heath, 2007)

The near ubiquitous use of alcohol is presumably captured within the last category. Tobacco use is so accepted that it often is not even considered a drug and caffeine-containing beverages, sugar, and salt are widely regarded as foodstuffs. Researchers now call for an understanding of the non-medical use of
drugs as attempts at self treatment for pain, anxiety, or other undiagnosed health conditions left unaddressed by an oblivious and inadequate health care system (Fischer & Rehm, 2007).

Max confirms that some people understand substance use as self-medication or treatment for pain, but cautions that recognition does not absolve the clinician of responsibility:

Because someone arrives at your door with a solution that they’ve implemented, that doesn’t mean it’s the best solution. It means that’s the solution that they, within their experience, have arrived at. It may be the only one that they’re willing to entertain, and that may determine the course of their life. Someone may arrive at your door and say, “I’ve learned how to deal with stress by smoking 4 packs of cigarettes a day.” Yeah, cigarettes are a way of dealing with stress . . . but there are a variety of ways. . . . Substances impair people’s ability to live in the world and to realize themselves as human beings.

DeLong (1972), whose opinions about the unwholesome personalities of people who use illegal drugs now sound so inept (p. 65), had a point—sort of. *Post-Traumatic Stress Disorder (PTSD)* is known to result in characteristic patterns of behavior which are often self-destructive and which may include the use of substances to excess. Gabor Maté (cited in Melnyk, 2008), an activist physician working with sex-trade workers and other residents of the Downtown East Side of Vancouver, has observed over his years in practice that every single addict [sic] he has cared for was a victim of neglect, abandonment, or abuse. He believes that emotional pain is related to chronic long-term deficiencies of neurotransmitters in the individual, and concludes that the result is use of illegal drugs in bid to generate *endorphins* and *dopamine*.

John too has recognized that people who live with an addiction have experienced serious trauma that has gone unaddressed:

Most of the patients are emotionally arrested at about 12 or 13 years of age. Something has happened: There’s some sort of trauma, be it psychic, spiritual, social, whatever. Then they developed a coping mechanism that included drugs. I am paternalistic. . . . They’re children needing guidance.

Maté’s (2008) insights are supported by data dating back 10 years from the US Bureau of Justice (1999) that tallies information mainly about prisoners of
the American *War on Drugs.* They noted that 6 to 14 percent of male offenders and between 23 to 37 percent of female offenders admitted they had experienced *Childhood Sexual Abuse (CSA),* a frequent forerunner of PTSD, and that these numbers rose to 44 percent of men and 87 percent of women who had grown up in foster care or institutions. Of those inmates who admitted to being subjected to abuse, 76 percent of men and 80 percent of women reported that they regularly used illegal drugs. Further, particularly for women prisoners, ongoing abuse, which can be expected to compound PTSD, followed them throughout their lives, with half confirming physical or sexual abuse just before their imprisonment.

Harry has noticed the same age of onset of illegal drug use as John has, and blames a poor quality of home life for addiction:

Ninety percent, if not all, of the people I treat started using drugs when they were early adolescents: 13 to 15. Why? There’s a reason. Everyone experiments at that time. They want a taste of it. How many high school students will drink to the point of intoxication or smoke marijuana or take something to the point of intoxication? Most, the overwhelming majority. . . . But why do they end up addicted? . . . Depending upon how much quality this person has in their life (and that doesn’t mean which walk of life they come from) . . . there’s a wrong direction, and addiction starts.

From the other direction, the view of the relationship between illegal drug use and PTSD is no cheerier. Up to half of those seeking help for substance abuse have been diagnosed with PTSD, and among those who depended upon a drug rather than alcohol, the incidence of PTSD was doubled (Driessen & Heinz, 2008). People seeking treatment have further been assessed as bearing a disproportionate burden of other mental health problems. Those diagnosed with a mental illness include 35 percent who tested positive for major depression, 14 percent who struggle with social phobia, 12 percent who were found to have bulimia, 6 percent who were diagnosed as obsessive-compulsive, 5 percent who suffer from generalized anxiety, and 4 percent who live with agoraphobia (Castel, Rush, Kennedy, Fulton, & Toneatto, 2007).

Aldo also has made the link between mental health, coping, and addictions, and agrees that it is in the early teen years when addictions set in:
Emotional arrest as a teen underlies addiction. What does a 5-year old do when he or she gets hurt? Goes and tells somebody and gets support. Where did we lose that behavior? When does it go? 13, 14, 15? I don’t know; but it goes. And we get the message that we’ve got to find someone out there to fix it [our pain] . . . . The treatment of addiction, to be simplistic, is helping isolated human beings to re-peopolize their lives with healthy people.

Poem 3: Mystery

Mystery, look at me.
Silent, giving nothing away
Veiled, you crowd into the shadows.
Inarticulate enigma.

Mystery, speak to me.
Replay, squeeze play, foul play, pay day
Date, name, and place in history
Imprint engraved on your dark face.

Mystery, come to me.
Point your finger, whisper the way
Story a myth, make me a map
Constrain, control, choice, circumhap.

Mystery, you know me.
You've been seen before this sad day
You'll be seen once more before long
You’re well known to every child born

And still you remain: aloof, alone.

Carol Polych (2007)

Health as a Common Good

Some people claim that the health care system in Canada is the crowning element of the social safety net that once defined the nation. The Canadian health care system was crafted to cover five basic conditions: reasonable access (accessibility) from province to province and abroad (portability) for all Canadians (universality) to all medically needed services (comprehensiveness), which would be publicly administered (not for profit) (Begin, 1987, p. 25).
Social safety net.

The Canadian social safety net grew out of the desperate conditions of life in the Dirty 30’s and from the battle, fought by our great-great-, great-, and grand-parents from the turn of the century onward, against exploitationist industry and a plush, elitist government, to establish generally fit conditions of life for ordinary people. Tommy Douglas and the Cooperative Commonwealth Federation (CCF), later renamed the New Democratic Party (NDP), with a power base seated in western Canada, were able to take a lead from the Wobblies, International Workers of the World (IWW), to drive the government to install the earliest version of Canada’s social seat belt (Guest, 1991, p.142; Naylor, 1986, p. 143). The end goal perhaps may have been to eventually ensure that all Canadians could live out the Four Freedoms articulated by Roosevelt in his State of the Union address of January 6, 1941: to freedom of speech and religion and from want and fear (Miller Center, 2010) in hopes of leaving each person free to realize their potential and flourish within society (Ignatieff, 1984, p. 15).

Interestingly, the NDP was defeated in Saskatchewan in 1962 following a doctor-led backlash against the introduction of medicare. Nevertheless, medicare ultimately did go through (over the doctors’ dead bodies).

Since then, the wheels have come off. A number of primary stabilizing Canadian institutions oriented around social solidarity: religion, tradition, nationalism, and even the family have been victims of a hit-and-run politics. Fuelled by rampant, abrasive consumerism and steered by reactionary elements, right-leaning, self-centered politicians, hiding out in the Trojan Horse they call Common Sense, connive to assure the economic advantage of the elite through sheer flimflam. Such politics, festooned with rhetoric about putting the common good on a solid economic footing, might best be understood as the camel’s nose of deceptively low-key, literate yet dangerous, religious fanaticism in the service of an economics of exclusion and exploitation. Such analyses call into question the right of those less fortunate to a claim even to the basics in life, and cast doubt on the morality of Canadian society (Ignatieff, 1984, p. 13).
John is just not philosophically able to practice in the kind of tough, rule-based approach to addictions within which he was expected to work, when his patients were not able to secure even the bare necessities in life:

I may be a dinosaur, but I don’t really believe in the empowerment model. Empowerment comes from being allowed to do certain things in life. If you do not believe that you are allowed, you will not take the chance. . . . Empowerment! [snorts] My belief is that, while every rule is made for a purpose, every rule is also made to be bent—not broken—bent. You don’t break them; you bend them to what you need at the time. . . . What we’ve done is, we’ve gotten stuck in what we’ve been told we have to do. We have to turn that around, and say, “No. You don’t always have to do that thing. You can change it.” All things are possible. All things can happen. I really despise programs that say, “These are The Rules.” Guess what: Bend them. Bend them. Detox is shelter. Sure, it’s detox, but it’s also shelter. Use it as shelter while you’re waiting for your bed [in treatment].

Health spending.

Originally, the Canadian Federal Government was closely involved in overseeing the provincial administration of monies earmarked for health, but recently it has been moving away from funding involvement and responsibility, to the general detriment of health care, allowing the system to deteriorate and thereby indirectly paving the way for privatization (Public Health Agency of Canada [PHAC], 2004, p. 3). One third of all health care spending by Canadians is now private (Barlow, 2005, p. 134). Even something as basic to life and health as water is no longer safeguarded as a common good.

Walkerton, a small rural town north of London, Ontario, was, in the year 2000, the site of a predictable tragedy that saw 7 people die and hundreds fall ill from drinking water contaminated by a killer strain of E Coli, leached from factory-farm manure into a community well allowed to deteriorate (Johnson, 2004). These deaths were just part of the price of doing business for the Conservative Government of the day, which had cut infrastructure funding and public health jobs to cede an emaciated version of water testing to for-profit labs while fostering toxic agri-business policies (Rachlis, 2004, p. 178). Dr. Murray McQuigge is the Medical Officer of Health for Grey County where Walkerton is located. In a pastel-pale flashback to London, England of the 1850’s where
Dr. Snow took decisive action to interrupt the spread of cholera by stealing the pump handle off the Broad Street well, McQuigge delicately suggested that the government really ought to weigh and rebalance its support for business against its obligation to defend the health of the public.

Max is distressed by the consequences of incoherent, inadequate, and irresponsible policy decisions that have resulted in profound structural deficits in the health system:

Therapeutic relationships in drug use do not take place in isolation; they are not independent. The structure is critical. If you look at the structure, it’s totally messed up in terms of delivering adequate services and having treatment services available for the whole time. We don’t have the agencies or the structural relationships between agencies such as public health and addictions treatment to allow professionals to work into that.

**Decline in spending on public health.**

Government spending on public health programs, such as those which ensure the basics like clean water, has declined dramatically—anywhere from 20 to 80 percent (Byers, 2003). Federal funding for public health activities across Canada came in at about 2 percent, or $2 to 3 billion, of a total health budget of $112 billion in 2003 (Public Health Agency of Canada (PHAC), 2004, p. 4). In 2008, the Government of the Province of Ontario spent about $40.4 billion for all health care expenses, just about 43 percent of the total $96 billion in the provincial coffers (Steed, 2008), an amount expected to increase by 6 percent yearly (Canadian Union of Public Employees, 2004). Hospitals soak up about 45 percent of the Ontario health care budget (Steed, 2008), while public health protection and prevention is funded provincially to just over 1 percent or about $469 million for 2007/08. In Ontario during 2003 and 2004, public spending meant to fund mental health and addictions care stalled at 4.3 percent, well below the 5 percent identified by the Europeans and the World Health Organization (WHO) as the bare minimum needed to provide basic mental health services (Jacobs, et al., 2008). Within that amount, community-based mental health in Ontario was allotted about $583 million for 2007-08 (Ministry of Finance, 2004) and addictions treatment in Ontario was funded in 2003-2004 at an even lower level of $130 million. These figures for Canada and the Province
of Ontario are presented for ease of review in Figure 6.

Figure 6:

...
There's rivalry. Why? They [funders] breed it. Lack of funding breeds empire building. This is the way the system is built. Power tripping again: Who's in best? Who doesn't want to admit failure? Everyone's kissing up to get more money. My agency's better than across-the-way, or across-the-way's better than us; and, "Go close them down and give us the money."

Why? What are we doing? Fighting over how many junkies we can get? To what end? "Because our stats look better than your stats." "Great, have our stats. I really don't give a hoot." Why should we have to play that game? We don't need to play that game. What they're forgetting is that the patient suffers. I waste more time filling out paperwork than I should have to, to defend what we do, when I could be giving service. Leave me alone. Let me do my job. Be creative. Trust the people who run the program.

So, if we put aside our differences, realize that the marionette strings are being pulled by the government and that the government guidelines are actually bunk, we can go beyond them. We take control and deal with it. We'd be better off. Who said we can't do this? "It's not done. It's not professional." That's the other time to do our job.

**Why IDU’s Stop Using**

Despite the increasing costs of the *Drug War*, people who use an injection drug report that it is not any legal consequence which brings them to the point where they wish to stop the use of substances, but stressful major life events and changes in their personal circumstances. Drug users identify specific precipitants to treatment that include: becoming a parent, trouble coping with bereavement or illness in the family, experiencing poor mental health, or traumatic physical sequelae of drug use. Policing, imprisonment, and other interdiction efforts, which are touted as supposed deterrents, were not once mentioned (Neale, Sheard & Tompkins, 2007).

Harry's experience bears out the findings of the research, that most people who use an illegal drug find it helpful in many ways, making it hard to change:

When it comes to asking them [people who use], "Why do you want to stop using drugs and alcohol?" they want to stop the lifestyle; they want to stop how it affects them— but not the drug. Why would someone want to stop? Most drug addicts know what they want; they don't know what they need. That's why recovery is so hard. Harm reduction, if that's what the person is only capable of at that time in their life, well definitely try that. But, I think they're cutting
corners; I believe they’re ripping themselves off of a better life: more peace. . . . The ultimate goal is to look for peace.

**Principles of Public Health**

Public health, as an organized effort is based on several principles. It does acknowledge that the responsibility to protect the collective health of the whole population rests with the state, with particular attention to the socio-economic determinants that underlie health and disease. The emphasis of public health is on prevention, using a multi-disciplinary approach to develop interventions in partnership with the populations served (Arah, Westert, Delnoij, & Klazinga, 2005).

Because robust public health provisions target many of the non-medical determinants of health or the risk factors for disease, it can avert or minimize the need for expensive remedial or endpoints treatment. Most gains in longevity and improvements in health have not come about through the current narrow focus on downstream technical physical care, but actually have been due to better living conditions and safer practices of work (Arah & Westert, 2005). Analysis of health within North American-EuroWestern cultures along class lines shows grievous health inequities, primarily attributed to the unfair social distribution of property, wealth, and power (Khalema, 2005). Indeed, social justice constitutes the very cornerstone of public health (Krieger, 2003).

Doug is concerned about the risk of aggravating discrimination against people who use an illegal drug by high profile advocacy for fair treatment of addictions:

The health care system is inadequate. . . . There’s a danger in public debate in case the point is raised, “Why do we treat these people in the first place. . . ?” It’s a perfect argument that the government uses. “It’s more important that we fund cancer treatment than treatment for junkies who brought this disease upon themselves. . . .” Everybody has pain; it’s a kind of a bizarre discussion about who has more pain. I don’t have a meter to measure pain or who’s most deserving. The government is going to set priorities, and no one’s going to argue with them.

**Health and Social Class**

Although risky behaviors such as the consumption of tobacco, alcohol, drugs, and junk food are currently often regarded as lifestyle choices, these
social behaviors may be better thought of as the proximal manifestations of more contextual factors. Contextual determinants of health include the national, cultural, institutional, economic, political, and legal factors which impact health through immediate, proximate, and underlying micro and macro factors (Arah, Westert, Delnoij, & Klazinga, 2005). Contextual social factors interact via a number of mechanisms in distinctive ways to variously affect particular segments of populations, with deleterious effects often at different levels in a specific distribution, characteristics which can lead to the identification of certain trends.

The social value of particular classes is reflected in the social choices which drive these multi-factorial intersectoral dynamics and, likewise, determines the macro characteristics of the health system. The response to heart conditions may serve as an example of the preferential funding of a downstream physician-determined technologic health care industry devoted to intercession meant to prolong the lives of particular individuals at the end point, rather than funding widespread nurturing and supportive measures to encourage healthy living and prevent illness among the citizenry as a whole. Canadians bear witness to the failure to provide for mental health generally and to the dearth of constructive action on chronic illnesses, including addictions (Kirby, 2006, pp. 205, 225).


Max’s attitude about the choices open to those living with an addiction reflects a highly pragmatic survival rationalization, given the pinchbelly funding of social supports and the effective lack of treatment for addictions and the issues that underlie addictions:

You have to be prepared to accept that somebody will decide that, “Hey, substance use is a rational choice; it is the way that I am choosing to deal with life, and I’m going to continue to do that.” That’s fine with me. . . . People may just as well decide to kill themselves, “Hey, and so what. . . ?” It’s not a decision that I want them to make, but it’s also a decision that I’m prepared to accept that they will make. . . . Somebody else can’t decide that because they’re a substance user or an addict [sic] or they use compulsively, that they can’t make any kind of rational decision about their life: I don’t think so. After assessing all of it, do I understand what the level of emotional pain is? What will ease it?
Health and context in IDU.

A range of contextual factors (Arah, Westert, Delnoij, & Klazinga, 2005) influence the health of the individual illegal drug user as well as that of the rest of the population; some examples follow. In the economic environment key factors include: income distribution, wealth (assets less debt), opportunity for good jobs, access to and adequacy of social assistance, access to the alternate economy, and the pressure from the elite to maintain compliance among those who are chronically jobless versus full employment. Demographic factors of importance include: the proportion of the total adult population that carries HIV, HBV, and HCV; the numbers and distribution of injectors; and the proportion of the illegal drug using population that is imprisoned. One critical factor in the physical environment is that of the availability of certain drugs given the geographic location of the user.

Harry identifies the social environment as crucial to the development of coping skills that may include the use of an illegal drug:

If somebody lives in the norm in society, they’re going to have opportunity to see what’s right and wrong. If somebody doesn’t know or doesn’t learn . . . there’s quite a good chance that he or she is not going to [act right]. . . . Their understanding is that life is a lot easier if they use a drug. . . . Then there are those few that, even though they understand what they should do, they don’t do it. Still, I believe that people can learn a better way because they’ve seen a hard life; anyone can learn at any age.

Factors in the social environment which affect illegal drug use include the quality of policing, the degree of ostracism of illegal drug users, presence of effective outreach initiatives and drug education, the quality and availability of needle exchange, and the accessibility and appropriateness of treatment. Legal provisions are major factors to consider in illegal drug use, specifically, the choice to criminalize people who use certain drugs designated as illicit, tolerance for abuse against those more vulnerable members of society, human rights legislation and disparity of treatment of physical and mental health problems (including addictions), and the climate for class action law suits. Factors from the cultural milieu with a major impact on illegal drug use include the dependence on scapegoating of a marginalized contingent of people who are
socially excluded within the context of widespread exploitation, insecurity, fundamentalism, and intolerance, with all of the accompanying overblown, rococo moral rhetoric.

Doug is aware that he walks a thin line as he tries to balance the expectations held by society of him as a professional with his need to maintain his own personal integrity:

I don’t agree with society’s response to drugs: I make that pretty clear. I am straightforward and make it very clear what we are prepared to do or what we can’t do. . . . I just engage the person on a very frank level. . . . I say to them, “No matter what you do, you will be able to get your health care here; but unfortunately we have to live within the rules.”

The national setting further contextualizes illegal drug use in Canada. Canadians have made social choices that have excluded addictions from the field of mental health and have then largely ignored even mental health. Further decisions at the national level have led to the defunding of the health portfolio followed by downloading it to the provinces as part of a well-orchestrated staged privatization initiative. And, lastly, the international scene exerts a major influence on understandings of illegal drug use in Canada, which has thus far, followed the US lead in its dependence on the metaphor of war. Canada has also literally marched off to bloody war, tucked up behind the US war machine, under the cover of “freedom”, code for the covert justification and entrenchment of North American-EuroWestern transnational interests intent upon the exploitation of global resources through manipulation of multi-national trade (Barlow, 2005, p. 263). (If you can’t beat ‘em, join ‘em.)

**IDU and Morality**

Gil Puder (2001) notes, from a law enforcement perspective, how impoverished was the social climate that resulted in the original enactment of alcohol prohibition in the 1920’s. Economic realities were harsh, privation was common, and fear, marked by intolerant racist and religious fundamentalist belief systems, predisposed people to disparage the morality of others as a means to maintain a good self-concept, in lieu of improving the quality of their own characters. The present course of the Canadian Government’s democidal (Rummel, 2001) response to illegal drug use follows this well-trodden, alcohol-
sodden path, leading blithely past Health Canada’s exquisitely clear stance that illegal drug use is first and foremost a health and social issue (Health Canada, 2001), to ever more punitive responses. Kate Hankins (2000), a talented physician and one of Canada’s foremost HIV researchers, states that current punitive drug policy is based on a mistaken understanding of illegal drug use as a moral issue, instead of the health problem it is.

Should illegal drug use be acknowledged as an aspect of poor health, it would follow that investment in effective legal and public health policy to mitigate the consequences of use is reasonable. People would demand political intervention designed to address the emotional, social, and economic conditions that underlie illegal drug use. Such steps are clearly not palatable to the present Canadian Government and are definitely not compatible with the agenda of the elites entrenched behind it.

John categorically denies the moral theory of addictions even while acknowledging the influence of religion in shaping people’s judgements:

I hear about people being prone to addiction, a weakness said to be bred genetically. But take the most religious person in the world and give them a set of circumstances that they can’t cope with and, if their God will not help them, they’ll go for something, whether it be externally directed anger, alcohol, or drugs. . . .

Addiction isn’t a moral weakness at all. . . . It’s medication. . . . It’s a coping mechanism to cope with what you can’t cope with at this time. . . . It’s medication to ease some of those fears. It’s a coping mechanism. . . . It’s a positive action to deal with a situation at that moment. . . . When your whole life centres on the here and now, and you don’t see the future and you don’t see the past, that’s when you lose. . . . That’s an addict. It’s, “How do I get another hit today?” They’re today-centered.

Addiction as Illness

The US Supreme Court has recognized for 50 years that narcotic addiction is an illness that may be innocently or involuntarily contracted. It ruled that the criminalization and imprisonment of a person thus afflicted . . . constitutes a cruel and unusual punishment in violation of the Fourteenth Amendment. If similar punishment were meted out for other illnesses, say for the “crime” of being found to have the common cold, even one day in prison
would be universally condemned (Robinson v California, 1962), yet, bizarrely, the illness of addiction to an illegal drug is often treated by imprisonment.

Doug deals up front with the stigma and differential treatment that often accompanies illegal drug use, and sets out for patients the boundaries within which he practices:

I let them know that I don’t think that they’re any worse of a person for using an illegal drug, and find out whether they want to do anything about it. . . . Do they need assistance? If they want to quit, then I make it quite clear that I’m prepared to assist them in any way possible. I’m not going to reject them, or judge them, or think that they’re bad or anything like that. . . . I let them know my own personal views on drug use, and they are not necessarily in accordance with what government regulatory bodies think. Drug use is not a legal problem; if they want to view it as a problem, it’s a health problem.

Questions

North Americans have officially recognized addictions as a health issue since the Temperance movement in the US devolved into a stain on the pavement to be washed into the gutter together with the detritus left by the failure of alcohol prohibition in 1933. The overt moralism of temperance was replaced in 1935 by the still popular non-denominational evangelical Oxford Group-inspired Alcoholics Anonymous, with its 12-steps that highlight the acknowledgement of God (or a greater power) as in charge of the individual’s disease and life, examination of character flaws, confession, amends, and help of others. Presently, health care and social service workers openly endorse the doctrine of equal access to impartial service for all who need it: How then can we understand the countless reports by many people who use an illegal drug of prejudicial treatment by these same workers? This question led to many others.

My head was spinning with speculation. What sense does Anna’s treatment make? How could Anna be denied the life-saving help of the professionals working just a few steps away? How can we understand the responses of professionals when people who use an illegal drug look for help? How do professionals understand our present treatment of illegal drug use? What sense do professionals make of illegal drug use, addictions, and overdose? How do they explain their actions and inactions, their attention and
inattention? Under what circumstances and within which belief systems does Anna’s death make sense? What happened to the social contract that assures people of an answer when they are in trouble and they call out for help from their neighbors? How can we explain why the health needs of people who use an illegal drug are minimized and their actions are recast as manifestations of criminality? Why do people who use an illegal drug feel diminished as human beings by their contact with professionals when they seek help? And why does it matter to me? Who am I to take issue?

The next chapter tracks the personal development and professional experiences that led me to question the way in which society responds to illegal drug use and how I came to talk with colleagues about illegal drug use. It was sensitivity to marginalization, resulting from adversity experienced in my early years together with survival of a life threatening illness, that brought me to the point where I felt I had to try harder to understand what approaches would actually be of help to people who use an illegal drug.
Belonging

With birth, we are each cast into life, into a family, into a society—or not—without any say in the matter: Spiritual beings embarked upon a human experience. Who we become depends upon our circumstance and what we make of it.

Oil pastels on paper (Polych, 2009)
CHAPTER IV
WHO AM I ...

Pursuing Research

Researchers do not spring, previously unformed, from a program of education, ready to undertake the generation of new knowledge. Rather, researchers' interests develop from their observations, life experience, and understandings. To become aware of who one is as a person and as a researcher requires a careful examination of the way in which one is embedded in context and the pathways taken through life. From there, the play of values, beliefs, and attitudes can be tracked through the researcher's career, and areas of investigation which the researcher can productively pursue may be identified.

As a person, my life was full of contradictions. Told daily by an accomplished mother who taught school for a living, that I would be one of the leaders of our society, I had trouble getting enough even to eat. While my mother dreamt of the achievements awaiting my attention, I watched her life disintegrate under the burden of untreated schizophrenia, augmented by the alternating effect of the doctor's weight-loss and sleeping pills: amphetamines and barbiturates. The echo of her encouragement seemed chilly and tinny, while I hid up a tree for the night from my stepfather for fear of a beating, shivering and with an empty belly. The world would shrink into a tiny spark; I guarded that bit of warmth in the hope contained within immediate existence. I had no confidence in tomorrow, and the past was better forgotten; only the moment was real.

I would gather crumbs as I could, and I enjoyed them to the full. No present at Christmas: my friend would never miss just one little dolly; I would give myself a (borrowed) present. No lunch: a banana would be just wonderful. No winter jacket: a sweater under my raincoat, and I'd be just fine as long as I kept on the run. Moving every year to a new town, leaving friends behind: Perry Mason, Hoss, and the Flying Doctor were well known to me, as were Cherry Ames, Nancy Drew, and Frank and Joe Hardy. But nothing could fill the empty space reserved for my mother—including mother herself.
Given life, I arrived inexplicably, unexpectedly, and prematurely in the world, bringing a hospital bill ten times more dear than my sister’s. My mother told me how she again gave me life as she carried me, newborn, into her mother’s house, taking the blows meant for me, dealt by her estranged husband waiting there. It was Grandmother, the *Cat Lady* of Wiarton, who raised me in my earliest years. Over time, the town crept up around the big, drafty, old farmhouse where Grandmother lived with her broke-back Clydesdale, Chester, and her contingent of cats. Every day, we would walk uptown past the bakeshop to *Howell’s Fish Market*, where we collected scrap fish heads and tails, and took them home wrapped in newspaper to feed our flock of felines. It was on these trips that Grandmother schooled me: “It’s not ‘you and me’ go for a walk; it’s ‘you and I’.” It was a special treat when we’d stop in at the *Midget Market* and Grandmother, a natural-born teacher, would buy a succulent cherry tart, impart her counsel, “Do unto others as you would have them do unto you,” then plug in that cherry tart. I was a quick learner.

These were my sunshine days of belonging, which still generate wave after wave of happy memories. I recall spying out from the coolness found in my best hiding spot, under the *spiraea* tree. I would sleep like a princess whenever and wherever I pleased on the summer-scented grass growing tall in the sun-filled hay field. I would plaster on Grandmother’s flannel-covered back in the big bed, my feet on an oven-warmed flatiron. Bowls of brown-sugar oatmeal floating in milk would wait for me at breakfast every day. I would go to work in the upstairs closet every morning where I would play pretend with the typewriter. Cups of sweet *milque-tea* with the ladies on Tuesday afternoons would be mine, a reward for quilting five stitches to the inch. And the feel of a thick, soap-smelling facecloth still brings back memories of my weekly bath in the washtub set on the kitchen floor, where Grandmother would wash my hair with rainwater warmed in the boiler on the woodstove.

At three years of age, my mother swept me off in the 1953 Pontiac belonging to her new boyfriend to live with her and my sister in Clifford, in a tiny, rickety, white, clapboard house trimmed in delphinium blue. It was my
responsibility to go first thing each morning into the back shed to bring in the wood and arrange it in the stove. I would jitter, frozen, from bare foot to bare foot on the cold floor in front of the woodstove, waiting for my big sister to light the fire. When Grandmother finally came to help my mother, I was thrilled to present her with a surprise, craftily gathered and secretly stashed—a fortune in brilliant diamonds! These I had carefully prized from the broken windshields of the wrecks reposing next door at Demerling's Garage where we would play each day.

Grandmother had taught me my numbers and how to print while we still lived in the farmhouse, where it was my job to review the newspaper every day for her, clipping and pasting interesting articles into a giant yellowed musty book. Just the same, after a spirited discussion between the town policeman and myself about the benefits and risks of playing trucks on the line painted down the middle of the main road through town, I was bound for school with my mother and my sister. Shortly after I started school at four years of age, my mother, the Principal, secretly married my stepfather, the Janitor, a man twice her age, pitching me into an acute state of puzzlement about my own father. This confusion was not cleared up for years to come, and was not sped up by the smacks to the ears should I voice my interest.

Both Sides Now

I had learned at all costs to hide my body from my mother’s flaying ice-blue eyes after her last attempt at bathing me when I was three resulted in a vicious scald; consequently, I was not only ragged, but also extremely dirty. When it was time for the required school physical, embarrassed by my filthy undershirt, I fought like a tiger with the doctor and his nurse: I was not examined. Health class taught me the valuable and enduring lesson of tooth brushing, and, with the presentation of a complimentary toothbrush, I was in business. I did learn a lot in class, but school still was always a mystery to me. I felt apart from the other kids, and not just because of the second-hand dresses down at the hem or the holes in my panties. Periodically, when the Grade Sixers needed a lesson, I was pulled from my Grade Two class by my mother, stood up
at the front of the class, and told to read from the board or work out a problem. I soon found out that this teaching technique was an attempt to motivate learning through humiliation. I learned a lot about dissembling.

When I was seven years old, Grandmother took cancer and died, leaving me with my sister in the hands of my mother and stepfather. Had there been any other place to go, I would have gone. Ever since I was small, I had lived under constant threat: If I was bad, I would be sent to 999 Queen [infamous psychiatric hospital in Toronto]. Further, I was informed that, if I tried to run away, the Truant Officer would catch me and bring me right back; and if he couldn't find me, the Children's Aid Society would. No escape. I resigned myself to living at home as best I could. Clearly, the safety and care that I could see characterized family life for my contemporaries was beyond my reach.

Life with my family was punctuated by two summers of extra misery when I was farmed out, once at 8 years of age and elsewhere again at 14. I was dropped off at a farm like an unwanted kitten, without any discussion or preparation, where I was expected to earn my keep through my labor, and labor I did. It was my responsibility to feed the hens, collect and wash the eggs, clean the coop, and put the chickens in at night. It was up to me to hoe, plant, weed, and water the vegetable garden, and then prepare the vegetables for the table or to go into canning that same day. I was needed to help cook the breakfast, lunch, and dinner, and wash up the dishes. I was the one who did the laundry, hung out the drying, and ironed and mended the clothes. At the end of the day, I would help with the milking, clean the milk cans, make sure the milk-cooler temperature stayed steady, and keep the milk house clean. I learned to drive the tractor (with blocks on the pedals) during haying, with a sure demotion to loading the bales should I make the load jerk. And most loathed job, I had to attend to the personal grooming needs of the lady of the house, plucking out her stray eyebrow hairs.

Friday night, though, was special: All the kids roundabout would load on the tractor, kick it into road gear, and get on down the road 10 miles or so to the square dance. We'd arrive covered in dust, but the boys still brushed up fine in
their red shirts and freshly creased blue jeans. We girls would be pressed and ruffled and curled, ready to dip and dive through the ocean waves. Then, all hanging off the tractor, we'd dust back again under the harvest moon, singing at the top of our lungs and laughing like fools for the simple joy of being alive.

As summer's end came, my mother dropped by, wordless, and grudgingly picked me up. I found I was actually relieved for a day or so to be back to the norm.

Movin' on

When I entered Grade Five at 9 years of age, I joined my older sister in preparing the lesson plans for my mother's classes. We made teaching notes on the required material, set the exams, and marked the tests. Despite our best efforts and my mother's struggles to hang on to a job, the local School Board each year propelled us on to a new town. Typically, they would detect my mother's illness by winter, write her up a glowing letter of reference, and turn us over in the spring. I truly grew up in Smalltown, Ontario.

I had read my way through the public school library by the age of 9, and so turned for entertainment to the Encyclopaedia Britannica, to be followed at 10 by Victor Hugo, Dickens, Dostoevsky, and other authors imported from high school by my big sister. I took up babysitting, and was able to save enough money to buy some smart school clothes while broadening my literary horizons with bodice-rippers such as A Stone for Danny Fisher and other blue classics.

That January, the oil furnace in our rental house exploded, burning up my savings, my hard-earned and treasured wardrobe, my geraniums, and my dearly beloved kitty. Unfortunately, my stepfather, who spent his days drinking at the local hotel, was out. An unknown, absent physician graciously opened his winterized cottage to us until summer. Here in this oasis of culture, I was able to make friends with his collection of classical music, early science fiction, and timeless Chinese decor. I marveled at the lack of chaos, leisure, and peace that clearly underlay such refined interests, and at the fact that these fineries obviously were excess to the owner's essentials.
That next summer in Wasaga Beach, at 11 years of age, I took up formal paid employment, cooking and cleaning at the beachside *Holiday Knoll Lodge*. I quickly learned to side-step Uncle Sammy, a wealthy American visitor who relished watching kids make out under the influence of alcohol. The next summer brought me a clerical career in Fine China at *Osborne’s Department Store* where I earned 50¢ per hour. The biggest benefit of this job was unlimited access to all the paperbacks in the book section, provided they were returned still looking new. It also saw the initiation of my short-lived career in crime, when I learned to dip into the till under the tutelage of the other clerks who thereby supplemented their admittedly meager income. Fueled by this success, I struck out in the fall into shoplifting in Barrie, in an attempt to obtain those indispensable adolescent trappings that I otherwise had no hope of ever enjoying. I cut this career short in the spring, as I did not care for the anxiety or deception that accompanies crime, nor did I find the self-image appealing: So ended my life on the wrong side of the law.

I was 12 years old when I watched my sister, an intellectually brilliant, musically-talented, natural artist, now matured into a beauty of 16, walk out the door into her own life. My big sister, who always had fed me as best she could and who protected me from the worst of my stepfather’s rages and drunken beatings, was cut out of the family. Even while I admired her and envied her escape, I faltered under the burden of parenting my mother, avoiding my stepfather, and keeping the house running. Any semblance of normalcy was impossible. I was profoundly embarrassed by my family.

Four long years later at 16, the earliest I could be sure I wouldn’t be dragged back, I followed my sister’s lead and got out. I worked evening shift in a nursing home where I lived in residence while I completed high school in Gravenhurst. I enrolled in nursing at university in Toronto, and financed my studies with double shifts on the weekends and full-time work in the summers. Clutching my shiny new degree in Nursing, like a ticket to my new life, I headed north to Hudson’s Bay. I lived and worked with the Cree people of Fort Hope and Sandy Lake, learning some of the language, taking part in hunter-trapper
culture, and absorbing some of the teachings. It was only when I left the North that I learned from an adult cousin the secret of my childhood and why I had been so little welcome: My father was an Ojibway, and I had been the black (red?) sheep of the family, an unhappy accident of my mother’s lapse in judgment. Finally, life was beginning to make a little sense.

Keepin’ on.

While up north, I married the love of my life and shortly after learned a great deal about spousal abuse. I lost my children to my husband who abducted them, and reconnected with my sister. As soon as I located the children, I went to battle for them, only to see the court award custody to their father, a police officer, who then, together with the woman of the house, turned in earnest to abusing them. It would be years before they returned to me; my youngest has yet to come.

I survived the theft of my children by focusing on the present as a way to hang on to my marbles. I was particular to keep out of the bottle, off the pills, and away from the needle. I occupied my mind with academic study, honing my understanding, and worked every chance I had. Not surprisingly perhaps, cancer surfaced at this time: treated, I survived. Having stroked the face of my Creator and in agreement that we will meet again later, I do now feel that, in many ways, I can do exactly whatever I want because every moment of time I have been given ever since is an unexpected gift, not to be squandered or made light of. The leisure I once felt I had, to defer my opportunity to make a difference, is gone: My time is now.

My education continued over the years. I learned a lot about poverty, hunger, and homelessness; broken families; mental illness; alcoholism and addiction; emotional, physical, and sexual abuse; the theft of children and parental alienation syndrome; legal and cultural abuse; and homelessness. In my work, I bore witness to the struggles of others. I saw the dislocation experienced by Native people, outsiders in their own land from the north to the south of Turtle Island, and the loneliness of recently immigrated displaced people, far from their own. I came to know people living with HIV, people bereft
by HIV, and people given HIV. I walked beside people living on the street or close to it. I cared for people who were stigmatized, criminalized, and psychiatrized. I took meals with people living in poverty. I came to know how much it means to have a scrap: of food, of kindness, of hope. I came to know how it is to live on the edge—the very edge—alone and unremarked, small in the unremitting cold of this merciless white world swept by lonely, jagged winds.

Poem 3: I Am

I am an invisible little gray thing,  
Shot through with sun and shadow and zing,  
Pushed and shoved in order to live  
But never changed.

Carol Polych (1970)

Why Anna's Death Matters...

One place where I worked was in the Emergency Department (ER) of a community hospital in a cash-poor, immigrant-rich neighborhood, caring for patients cheek-to-cheek with physicians earning ten times my salary while doing essentially the same work. It was outrage on my part, over the mistreatment by his own peers of a medical colleague, Randy, who contracted HIV, that prompted me to seek work in public health to educate professionals about HIV. It was irritation on my part, with the appalling lack of provision for people who live in poverty, which activated my 10-year involvement with Street Patrol, initiated through Anishnawbe Health Toronto, a downtown Community Health Centre (CHC) that provided care for urban Aboriginal people. I recall the treatment accorded those patients who came to ER with a mental health problem or an overdose. It was my sense of repugnance with the condescending approach to addictions on the part of my colleagues that led me to start a weekly group at Parkdale CHC for people who inject heroin. Even if I could do nothing at that time for my own children, still I could do something for other mothers' children.
During my dark times, my vision could not stretch one day beyond tomorrow. My past was locked away, secured in compartmentalized containers, so that my life was never older than 5 years at any given time. My grip on my place in life continues to be tentative. Even now, I still act as if: as if I have weight in the world, as if plans could be seen through, as if I have expectations. And this is the basis under which I have undertaken this study.

Anna's death mattered to me—as did her life. It was her execution by exclusion and other related incidents that piqued my interest in how helping professionals viewed the relationship between themselves and a patient who was believed to use an illegal drug. As a teacher of Nursing, I had struggled to cultivate critical analysis and a well-informed caring orientation among my students, and I was greatly troubled by the gap between professional learning and rhetoric, and what I often saw of professional practice. Further, the reality was that it was not only illegal drug users who were left out in the cold while I stood by with my hands in my pockets and watched.

**Drawin’ the Line**

As the 1980’s came to a close, I witnessed death from HIV striking all around me, leaving nothing but the burned out bodies of many fine young men scattered like the charred residuum of a hail of lightening bolts aimed by an angry, insane, and virulent god. The gay community exploded with HIV, a fastidious but lethal disease at the center of a conflagration where sexuality, morality, marginalization, and mortality fed off each other, leaving suffering and havoc in the backdraft. Together with many others, I raised my voice in an unholy howl: “Robbed! We've been robbed! This is not how life is meant to end.” Out of this ash heap of death, like a phoenix, broke *gay pride*. But not so for illegal drug users (IDU's). HIV seemed to especially stalk them in the shadows through which they must shiver and slink in pursuit of their lives.

Sickness, however, was not confined to the suffering wrought by the HIV virus. I watched Randy, a respected physician with whom I had worked, sick as a dog with AIDS, hang his head before his colleagues when he had the gall to come to his own for help. His colleagues gossiped and squawked louder than a
flock of chickens pecking the weak one to death. I stood by as nurses debated why they should bother to resuscitate a patient overdosed on an illegal drug, who, they were offended to say, had brought destruction on himself. Shocked, I listened to moral explanations of HIV—that it was God’s way of cleaning out the drug users, the gays (Pieters, 1994), and the Blacks (Bogart & Thorburn, 2005)—leaving “us” a better world. I heard, with unbelieving ears, about the government plot to infect unwanted Africans (useless eaters?) with HIV, under the guise of free oral polio vaccine (Hooper, 1999). I counseled HIV-infected men who, in anger and pain, wished only to spend what was left of the rest of their lives sharing with others the same taste of death that sauced their lives. I walked by their sides as sorrowing pregnant women made their pilgrimages each week to the doctor, desperately hoping to save at least the lives of their unborn babies, if not their own.

The larger picture of HIV infection was no easier to bear. Although HIV first broke out in young men who had sex with men, epidemiologic research makes it clear that, more recently, it is injection drug users, at 14 percent of new HIV infections, and their partners, at 21 percent of new infections, and families who are now bearing the brunt of HIV infection (Smith, 2007). In the early days, the diagnosis of HIV and Acquired Immune Deficiency Syndrome (AIDS), often made simultaneously, carried a life expectancy of about six months; now, thanks to anti-viral cocktails, the lifespan of an infected person has been greatly lengthened. However, access to the cocktail, itself no panacea, depends upon successful entry into a functional medical system that is responsive, and adherence to an appropriate pharmaceutical regime which itself may be contingent on the means to pay for the drugs.

It was not just the aching, raw need displayed by illegal injection drug users for those who would see, but also my own personal observations about the comparative social value of people in our culture that drove my commitment to working with people who use an illegal drug. From my experience as a child, I learned how important it is to be able to perform worthwhile work in exchange for the necessities of life. I learned how people who have nothing to offer are
viewed as worthless, and I realized how alone and empty-handed in this world of private property they are. I learned how people who are deemed unworthy are not seen and are not heard. I observed those with plenty turn their backs and walk away, when so little would have made all the difference. I learned the price of refusal by the privileged, paid by those who have nothing. I learned the value of a buck.

When I heard my colleagues describe drug users as human garbage and listened as they passed judgment on people infected with HIV or those struggling with an addiction, “They deserve to die,” I felt a shock of recognition followed by a tidal wave of outrage. These people were my own—outcast and with nothing, denied anything, unseen, voiceless, and unheard. There were no devils, no monsters, no degenerates, and no criminals standing here before me; just some other woman's children on the same journey as I, all of us looking for some acceptance in life and maybe a little peace.

I could not help but notice that, within the population of people diagnosed with HIV, all of whom had to struggle ferociously for appropriate care, those known to have contracted this infection from injection drug use faced an all but impossible uphill battle to get treatment for the infection or even simply to remit their addiction. This seemed a grossly unfair situation in health care. While I did not know much about injection drug use, there were certain things of which I was sure. I knew that learning is there for any who will reach for it. I knew that expertise is there for any who will work at it. I knew that today's state-of-the-art is tomorrow's arcane ritual. And I knew that I could never agree with the received wisdom about addictions as encapsulated in the phrase, no pain-no gain. I knew I had to take a fresh look at addiction.

**Whose Team am I On?**

We know that, in life, when caring fails, what we next hope for is fairness. I would prefer to be treated with care, but at the very least, I hope for justice. On the way to ensuring fairness in my work with other people, the minimax principle has been helpful. I have chosen to orient my work so that elitism and exclusionism are minimized, and quality and participation are maximized. But
over and above fairness, for me, the romantic, humanistic ideal of bettering the human condition is still alive.

I take the stance that all people, by rights, have weight in the world. While it is true that in many ways, we are all stereotactically enmeshed in the grip of the same networks that have created, envelop, and sustain us, movement is still possible, particularly with the strength of a reference group. Heavily marginalized people may find such movement most easy, since there is less holding them in position and they may experience immediate benefit from change. They have the least to lose. Powerless: I don't think so!

Still, I was just a professional, albeit in possession of the initials behind my name, which would reserve a small seat at the bottom of the big table where big-K knowledge was being dished out up top by the Big Boys. I was no expert in illegal injection drug use. I had to rely on those who were expert—the users—for that knowledge. As a professional who is aware that it is dismembered fairness that provokes pain and disappointed hope that underlies anger, I saw it as my place to reach out to the illegal injection drug users who I could contact, listen to their stories, validate the unfairness in treatment that they experienced every day, and spark their anger. Once there was a flicker of anger, if I could fan it, feed it, and foster it, there was a chance to help them focus it, and thereby fire their determination for change. Together, we could piece out what needed to happen to improve the situation, and begin there.

It is the opinion of Herbert Gans (1995), sociologist extraordinaire, that the survivors of poverty, like combatants who live through a war, will ever after carry the effects (p. 5): So do I. It is my populist values (Laclau, no date) that ground my research. What I could bring to the creation of new knowledge was some technical expertise, access to those who had the skills needed, an insider’s view on positioning, and the ability to make the most of well-meant critique and to deal with ill-intentioned criticism from other professionals. What I could commit to was to guarantee that the voices of the people directly involved would be heard, that the faces of the people would be seen in our projects, and that the understandings we developed together would be tri-lingual: street argot,
professional jargon, and everyday English, as appropriate and advantageous to our shared enterprise.

Using Participatory Action Research (PAR) techniques, I initiated a group for people who injected heroin, the Finally Understanding Narcotics (FUN) Group (that in 2010 is still running). Together we undertook a series of projects. We completed concept mapping of the meaning to users of health in illegal drug use. From this base, the FUN Group submitted a successful proposal that, following on the heels of some community organizing, opened up methadone for administration in local community settings. We surveyed drug users and others about their knowledge, attitudes, and beliefs about illegal drug use. The FUN Group (1994) filmed Fit: From Expert to Novice, a 45-minute harm-reduction video on safer injection of illegal drugs, and produced Pointers, a pocketsize series of safer using pamphlets. And FUN secured monies to conduct qualitative research into the user's perspective on the provision of health and social services to illegal drug users.

It's a Big Job, but . . .

It became apparent in the course of my ongoing work with marginalized populations that addictions presented an additional degree of complexity. Addictions complicated life for Anishnawbe people living in Northern Ontario and in urban settings. Addictions often figured in the lives of teens who had attempted suicide, homicide, or other violence. Addictions were well known to many patients diagnosed with mental illness who sought help in the Emergency Department. Addictions loomed large in the lives of many infected by HIV. Addictions often featured in the lives of people dealing with gender issues. Addictions might masquerade as purpose in the lives of people who made their living in the underground economy through wheeling, stealing, peeling, or dealing. Addictions often resulted in time served in Corrections. Addictions brought comfort to people living on or near the street. Addictions cohabited with homelessness. And addictions often converged with poverty. It became abundantly clear to me that the medical system did not do an especially good job
for those people bearing multiple burdens over and above a discrete, identifiable, and curable disease for which they might seek help.

Max finds that addictions layers additional levels of complexity onto the everyday problems of life with which everyone must deal, and that people working in addictions face some of the most demanding work in health care, which calls for the highest level of professional training:

When you're dealing with a whole array of life problems into which addictions are inextricably woven, you have more of a challenge. . . . If somebody comes in and they have a variety of problems: they have legal problems, they have medical problems, they have housing problems, addictions makes it more complicated and difficult to respond. . . . For many people, poverty is a concurrent issue in relation to the kinds of treatment that they have access to or get. . . . There are fewer services for users with higher needs, and those services aren't resourced to respond to the degree of need. . . .

The care-provider's frustration in the face of a long-standing, chronic relapsing condition can be extremely high. . . . You will be seeing people over and over. Treatment may have its cycles of up and down. It might range from active to barely place-holding contact in some kind of an inactive relationship, there to be reactivated in case crisis reemerges. . . . This means that training for professionals has to increase the awareness of self and of social structures. . . .

Addictions workers need to be more senior, multi-skilled people with university preparation, because the patients tend to have longer-standing histories, with complicated interactions and problems. . . . A professional who has limited life experience, or whose experience hasn't been informed by either formal education or some other mode of training that helps them to distance themselves, may have trouble realizing where their issues leave off and the person's begin; this lack can lead to problems.

Wrapped in the daily routine, there always are those professionals whose work stands out for one reason or another. There are always those bright lights who seem better able to understand; those are the professionals who have a reputation as being particularly helpful. Others are recognized as the go-to people, leaders in their fields. Then there are those who are spoken of in whispers accompanied by dark looks. My work brought me into contact with all of these and more.
Questions

My personal and professional commitment to my patients is to do my best to help them more fully become themselves as they were meant to be, to fulfill their *causa formalis* as a means to express the larger *causa finalis* (Benner & Wrubel, 1998, p. 31; Illich, 2005). My purpose as a teacher is to assist learners as they develop themselves and nurture them as they turn to help their patients engage in the same enterprise. I realized that I simply did not know enough about *helping* in illegal drug use to tailor my teaching to prepare students to embody the attitudes which are truly helpful to patients and which persist in practice.

Anna’s death had confronted me with a mystery. I still could not account for how the caring professionals waiting inside the Emergency Department, poised to help those who are hurt or injured, justified Anna’s treatment and made sense of the manner of her death. Although the dynamic of help-seeking / helping has been explored from the point of view of people who use, the outlook of the professional will necessarily be different, and might shed some light on what happened to Anna and others who use an illegal drug. Accordingly, I undertook this heuristic study to explore professionals’ perspectives on the help-seeking / helping dynamic in illegal drug use, and to answer two questions: a) How do professionals explain their actions and inactions in helping people who use an illegal drug? and b) How do professionals make sense of illegal drug use?

In the next chapter, I will introduce the experts who took part in this research and summarize their thoughts about addictions, professionalism, and helping in illegal drug use. As I listened to these dedicated, experienced professionals share their ideas, I heard both echoes of my own thoughts and divergent opinions. Familiar or foreign, I could not fail but to be impressed by the acuity of their analyses and the depth of their commitment to their work.
Fathereing

Homely, inept, ludicrous in fact, yet beautiful in their own way fathers may also nurture, protect, and guide their little ones as best they know how. Could any of us do better? And still help the little ones become who they were meant to be?

Watercolor on manila (Polych, 2010)
CHAPTER V:
WHO DOES THAT? *(WORKS WITH USERS)*

The Participants

Each participant came to the decision to engage with the treatment of addictions through deep concern about the health of people living with an addiction, the meaning they attach to their professions, and how they are in the world. The capacity of participants to problematize current approaches to addictions is based upon their ability to identify with the lived experience of others and the clarity of vision to see how help might better be carried out. Their ability to bring about change derives from their professional skill, contextual expertise, and is framed by their situated freedom. Their motivation derives from their moral engagement with others and their sense of responsibility (Benner & Wrubel, 1989).

**Aldo**

Aldo is a dapper, dignified, quiet-spoken, but fiery-eyed man, whose voice is still tinged with the intonation and cadence of his home country. Aldo openly discusses his personal struggle with addictions, and uses it as an object lesson in teaching. Aldo’s focus and intensity brings a whole world of meaning to the current buzzword, *mindfulness*. He is as devoted to his family as he is to his work, and his attention to detail is legendary within his workplace.

Aldo says that, to a person who doesn’t understand addiction, drugs are the problem—to an addict, drugs are the solution. He relates his own addiction to an unhealthy family dynamic which emphasized perfection and which was amplified by competition in his professional life. Moreover, Aldo has noticed that many people who use do come from homes in which love depends upon perfection. In Aldo’s personal experience, it was the fact that he didn’t like himself that was the basis of his addiction. “I, Self, and Me (ISM) kept showing up.” Aldo does blame those around him, though, for blocking the consequences that might have brought his addiction to a stop. Addiction came to be who he was. Aldo reached the point that he either had to change, or suicide was inevitable. He knew that there was no magic bullet or any chemical that could
ever ease such torment. Aldo made the choice to treat his ISM, and *repeopled* his life with those who are healthy.

After coming through his own crisis, Aldo’s disquiet over the poverty of addictions treatment saw him change the direction of his career. He left a high-status position to start over at the beginning in addictions, a low-status field. Aldo admits that he is frustrated by the low status of addictions work, which results in poor funding and often a complete oversight of addiction in general clinical practice.

Aldo finds that the perceptions of people who use are very keen, and attributes this to *stimulus augmentation* by the addicted person. Aldo emphasizes the depth of the shame he felt, being a professional living with an addiction. Aldo reflects on how his profession brought him a sense of control in his life through the exercise of power over others. He now takes pride in reaching out to other professionals, and points out that about 8 percent of health care professionals do have difficulty with alcohol or drugs, just like everyone else. Aldo is pleased that his work has led to greater access to treatment and an improvement in the approach to addictions treatment.

It is Aldo’s opinion that people who use certain drugs to excess may have a genetic vulnerability, almost as if the filter in the brain meant to keep that drug out is broken. Still, it is his sense of spirituality informed by gratitude that forms the basis of his work, and he finds his work highly satisfying. He has noticed that, when he engages the person’s spirituality, the therapeutic relationship rockets into a new dimension. He says that he relies on motivational counseling to engage the person looking for help, meeting them where they are on a spectrum of understanding. Aldo explains that the approach to treatment needs to be individualized, and that success depends upon each person’s ability to assume responsibility and accountability for their own behavior. Aldo tracks healing by progress toward certain agreed-upon criteria. Aldo believes that, even though coercion may work for a while, depending upon that person’s readiness to change, it is really for someone else that people finally get better.
Aldo has noticed that students often become cynical and feel depressed when they realize that the altruism with which they enter their professions will likely not survive their training. He has also identified some of the attitudes among those in practice which lead to trouble: moralism, pessimism, unhealthy approval-seeking from patients, or avoidance of people living with addiction. Aldo speculates that such attitudes may arise possibly as a result of discomfort due to the professional’s own vulnerability to addiction. He believes that the training of professionals needs to incorporate an addictions component into every element and phase of training as a matter of course.

Aldo is aware of the negative stereotype of addicts as useless, helpless, hopeless people, who never get better. Aldo notes that many people living with an addiction have been physically, sexually, or emotionally abused, and remarks on the extensive comorbidity of addictions with many other conditions.

**Doug**

Doug is a wiry man with a lined face and independent-minded hair. He has a rapid-fire but exquisitely precise way of speaking, which can leave the listener reeling. Doug’s verbal pyrotechnics issue from a manner that is the last word in low-pitched, low-key, and laid-back. It is entirely possible that the unsuspicious and well-fed among us, failing to listen with care to each word and comforted by Doug’s reassuringly cluttered office, his unassuming posture, his downplayed non-verbals, and his bland clothing, which would pass in any setting from the board room to the curbside, might be lulled into assuming that he was discussing nothing more interesting or contentious than the weather—nothing of the sort.

Doug believes that moral judgments go on all the time with addicts. Doug is clear with his patients that he does not think less of them because they use, and makes sure that they know that he will not reject them as patients if they continue to use. Doug simply asks his patients, without any moral judgment, if they want to do anything about their drug use and helps them accordingly. He says he is going to look after his patients, no matter what they do. He points out that, if the patient is capable of stopping only one drug, the opportunity to stop
that drug is forfeit if the professional improperly imposes a standard of abstinence from all drugs on the patient. Doug says that measures of success need to capture more than simple abstinence: function, productivity, and stability. Is the person back with the family? Has he or she stopped doing crime? Is he or she employed? Doug likes patients to set down their objectives. Sometimes, the objective is to cure a specific, limited problem, such as an infection, not to stop using their drug.

Doug is familiar with the negative stereotypes about the moral weakness of users. He is disgusted by the contradictions of blaming. Poor people, who are more visible since they live close to the street, are condemned; but at the same time, he points out that it’s considered perfectly fine for the Ontario cabinet to drink themselves silly with Scotch all night long at resorts up in Northern Ontario.

Doug accepts that people use intoxicants and, unless it harms others or the person themselves, he doesn’t have a problem with drugs. The welfare system doesn’t recognize addiction as a legitimate health problem, but at the same time, government officials talk about forcing recipients into treatment. How can they do that, he asks, if they don’t recognize addiction as a bona fide disability resulting from a health problem? Even when the drug used is harmful, Doug doesn’t believe in punishment delivered through the judicio-correctional system.

Doug can’t see why people who have a dependency should not have unconditional safe access to a safe supply of narcotic so that at least they can remain productive. Doug uses the story of William Halstead, a physician credited with founding surgery in North America, who used morphine for most of his adult life, to teach the lesson that a clean, steady supply of drug can allow a person to function as a normal, productive, totally responsible citizen. Doug deals daily with philosophic opposition by professionals to the use of drugs. He cautions that there is a danger, given limited resources, in letting the debate about the treatment of addictions get too public, for fear people might ask, “Why do we treat these people in the first place?”
Doug marvels that some people hold that addicts [*sic*] are weak and actually deserve any sickness that follows because they are believed to have brought it on themselves. Doug has found that, once a person is pigeonholed as an addict, there are huge barriers to treatment of any other condition. Doug notices that most users distrust professionals, especially physicians, and most physicians don’t want to deal with addicts. Doug says that doctors view addicts as unlikable liars who are deceptive and can’t be trusted, “They’re manipulative and dishonest,” even though these behaviors are just survival skills. “Who cares about junkies?” “Most people’d rather see them dead anyway.” “It’s their own fault.” “Pull up your socks and quit.” Doug is embarrassed by this attitude.

**Harry**

Harry carries himself with all the grace and poise of a model while he carries on with his work as though it is second nature to him. That impression is called into question as his clear blue eyes take the measure of the person he is about to speak with. When he does speak, after folding himself comfortably in an armchair, his voice is deliberate, and his words are carefully chosen with lots of space and time left between for reflection. As our conversation progresses, Harry impresses me as being an experienced and trustworthy guide though hazardous territory fraught with unknown danger, even though some of that unpredictable terrain appeared at first glance to be simply the common features of a familiar urban social landscape.

Harry freely discusses his personal experience with addiction. As Harry came to understand how important it was to him to be able to give back, he dramatically changed his line of work, opting to help other people desperate to stop using, just as he received help at his time of need. Harry believes that he was meant to work in addictions, as he has for many years, interrupted only by occasional bouts of excessive use. Harry believes that he is his brother’s keeper.

Harry characterizes his work as spiritually based. Harry has noticed that many people who use mix up life and living with survival, and believes that users have to learn to live instead of die. Harry believes that drug use keeps a person
from becoming all that they can be. Harry is convinced that drug use is selfish and isolating; he does not believe in using socially. He says that he takes a tough love approach to addictions, which does include confronting people who use about their selfishness.

Harry finds that, although people may wish to stop the disruption in their lives caused by the lifestyle forced upon users, many people do not want to actually stop using, even when their lives are in disarray. He worries about the people who try to cut corners and quit their substances all on their own instead of seeking the help of experts in addiction.

Harry doesn’t see any essential difference between someone drinking alcohol, abusing prescription drugs, or using hard drugs like heroin or crack. He says that the underlying problems are all the same. In Harry’s opinion, many people who use fear life, and use an illegal drug to medicate emotional pain, with a goal of achieving peace. Harry points out that it is the best thinking of the user that has brought them to this point. He is also concerned that detox and treatment staff are not as well prepared to care for drug users as for alcohol users. He feels that such acute services make no provision for the persisting psychological vulnerability experienced by drug users. Further, he is troubled by the lack of recognition that, even when a person stops using, they might still be involved in illegal activity because that’s what they know. He asks, “How do you one re-habilitate someone who’s never been habilitated?”

John

John is a fast-talking, slow-walking man, cleaving to his values in a heavily contested world. He bears witness to the splintering apart of humankind, difference by difference: gender splits; class distinctions; the divides of geography; the gap between families of choice and of birth; occupational snobbery; shady street versus sweet suite deals; private property, marketing, and free choice; and institutional treatment at the expense of community-based help. All these fractures undermine our shared world and bound the common good. Fences stake out and lines edge John’s world: the boundaries of professionals, the mandates of agencies, admission criteria, funding pots, and
even the labels on clothing. While it is peace in this world that John craves, the predilection of people to just go along unquestioningly with things gets John’s blood on the boil.

John believes that drugs and alcohol are medications for a larger symptomatology, rather than a diagnosis. Drug addiction, John says, is not a moral failure and is not a weakness, but rather is a positive effort to cope with a difficult situation in the moment. He has noticed that people living with an addiction have undergone a psychic, spiritual, or social trauma that has caused emotional arrest at about 12 or 13 years of age. But when it becomes destructive, that’s when the patient’s got to correct it.

John says that he is happy doing exactly what he does; his work is meaningful and gratifying. John explains what he does with his patients: They walk along together, a journey during which they share a few laughs and a few tears. Then, he says, when they’re done, they walk away, hopefully, better off. He characterizes his goal in counseling as trying simply to understand the human condition. John says that God is his anchor, and that there are three essential ingredients for treatment: engagement, caring, and love. He believes he has a message to get across: Be the best you can be. Simple is better. Know your limits and what you’re capable of.

John has come to the opinion, like Harry, that illegal drug use is definitely a selfish act. He marvels at how many people feel entitled, but cautions that rights actually are dictated by the limitations of society. John laments that we no longer are our brothers’ keepers. He recognizes that each person experiences conflict about their illegal drug use. There’s the selfish act, the effort to keep up appearances, but there’s also a part of the user that is in rebellion against those stereotypes. John tries to develop that contrary spirit, “Why do you have to be on drugs? All you’re doing is perpetuating what they believe you to be: Change it. Do something different. Be what you want to be.”

John is exasperated with a government that splits funding for addictions and mental health, conditions that he says are intrinsically intertwined. Typically, addictions sends patients somewhere else to psychiatry, fragmenting service.
He says that professionals need to be jacks-of-all-trades more and provide full psychosocial interventions as needed.

John also bristles at arbitrary requirements for reporting that are tied to funding. “Patients come in. That’s an outcome measure.” The authorities say, “Not good enough. It has to fit in this format.” He is flabbergasted by inter-agency rivalry. “What are we doing?” “Fighting over how many junkies we can get?” John is appalled at the result. Funders favor programs such as two-week cocaine programs and home detox that just won’t work, since there’s not enough support. In John’s opinion, many small, staffed but homey detox houses, alliances with local health clinics, and roving doctors would be more useful.

Max

As Max welcomes me into his workplace, I can’t help but notice that Max appears to embody the Type-A personality, with its emphasis on multi-tasking, time-maximizing strategies, competitive jockeying, aggressive undertones, unrelenting alertness, and control issues. Max’s presentation supports this impression, with his military-cut hair and precise dry cleaner creases in crisp counterpoint to his light but manly, woodsy fragrance. Max talks fast, triggers quickly, keeps a repertoire of authoritative turns of phrase close to hand, and responds to queries instantly with a withering, rapid-fire barrage aimed at demolishing doubt. It is only in discussion that the paradox of Max becomes evident, as Max explains how he uses his hard-nosed approach in his work at a cutting edge addictions program even while he emphasizes how important it is for staff to meet the expectation of personal spiritual discovery.

Max also left a job where he was required to adhere rigidly to policy that took no account of the analysis of front-line workers. Max found his ability to make a meaningful difference in the lives of patients was severely restricted by the truncation of his professional scope. Max now has a role in a facility where he is free to move from direct patient contact to policy matters and back. He also is able to influence the tone of the workplace and the approach that others take with their patients. Control in the workplace is still an issue for Max, but now he’s in charge.
Max believes that the tendency to get high is buried in human nature and that people find many ways to get high. Max notes that there are degrees of habituation. Resources, including relationships, help to bound a habit. He distinguishes between substance use and addiction. Max notes that addiction is a chronic, relapsing condition that is embedded in a socio-political environment within which people struggle to learn and re-learn how to live in the world without substances. Max finds that addiction is still often seen as a struggle of will and morals, and reports that many view those who get caught in addiction as morally weak.

Max believes that the struggle against stigma and prejudice depends upon increasing the general understanding of addictions. He encounters many people who are skeptical about substitution therapies such as methadone, “Bad drug.” “Now you’re giving an addict drugs: How does this make sense?” Max himself finds substitution medication problematic—but because there is such limited choice. He reports that methadone doesn’t get at the itch, so some people combine methadone with antipsychotics or valium-type medications, which can lead to overdose. Max is in support of new treatments, but cautions that drugs actually should not be tested out on people who are actively using, as they are a particularly vulnerable population.

Max is irritated that government treats addictions as a low priority for funding. Max’s experience has taught him that, if he wants to get on with change, not to engage directly in battle, but use a guerrilla approach. Max regards jail is a stupid, expensive, ineffective response to drug use, and believes this approach reflects the undue influence of the US. Further, Max has noticed the conspicuous absence of the police in collaborative public health efforts to reduce drug-related harm.

Neal

Neal, a fit and attractive, naturally debonair, mature gentleman accessorized with an academic aura, seems to be part chameleon, so seamlessly and appropriately does he fit into his surroundings. He has been seen occasionally conducting street outreach although camouflaged by everyday
clothes and an ordinary manner, but is harder to spot behind the scenes where he now more often works, consulting in the addictions and education fields. The care with which Neal picks his words, to precisely frame the concepts that he wishes to discuss betrays his first love, creating meaning from language. This talent has brought self-talk, the language of oppression, and respectful communication to the awareness of many people who have been street-involved as well as to professionals. Ultimately, Neal’s well-honed professional skills and redoubtable social skills, including his gift of the gab, have helped many others to create meaning from life.

Neal is aware that drugs don’t always dominate the picture of the patient. “What’s problematic?” But despite the identification of addictions as a major health problem by an overwhelming majority of the clientele of the agency where Neal worked, he was expected to focus on problems other than addictions. Neal felt forced to leave his long-term job after other staff claimed discomfort with the sometimes-battered people coming to him for help in their struggle with a life that included an addiction. Unable to reconcile agency policy with his professional ethics, Neal took paid work in a completely different area of his profession. He does, however, continue to make a difference in the field of addictions though work on a volunteer, casual, networking, and consulting basis.

Neal is dismayed that some professionals are in sentient denial, a dynamic sometimes indulged in by the whole staff of an agency: It’s not, “Oh, I never noticed”; it’s “I don’t want to see it: We don’t have any drug users here.” The most difficult thing to address, Neal says, is the attitudes and values of workers: It calls for reframing, and that’s tricky. You have to help them see how their attitudes and values can help them do the work that must be done. Neal has noticed that many professionals pass terrible judgment on patients who have not met their criteria to enter treatment: “Stop using, then come and see me. You haven’t hit bottom.” Neal believes that those who still work in the older model come initially from a good place of caring, of wanting the patient to be healthy, “like me”. He is distressed by the misuse of power.
Neal believes that there has to be reflexivity between the patient and the worker. “I can’t work with you unless you do it my way.” It’s a therapeutic disaster if the professional doesn’t understand the needs and the style of the person they’re working with and adjust to it. He has found that when people seek help with their addiction and run into these workers, they can feel insulted, demeaned, degraded, and infantilized, and they walk out. It’s unpleasant to be served by someone who’s holding their nose and looking the other way when they hand you something, even if it’s clean syringes that you are desperately in need of. Many people who use won’t go through the office door because of the hostility they’ve met and the bad experiences they’ve had.

Neal was trained to refuse services to people when they were high, but he says that it works to provide care when the patient asks for it, and that more and more people feel comfortable doing this. Harm reduction is out there.

Neal has noticed that community placements are not properly vetted. “What are they learning?” He worries that the philosophy and ethical grounding may not be in place before students go in, and that their eyes may not be opened enough to think critically. Neal is also concerned about how to foster a patient-centered approach on the part of professionals, an idea that he says gets lip service only because students do not experience student-centered teaching. “We want to be equals, but we can’t do that, because we’re top-down.”

Questions

As I listened to the observations shared by the participants, I was overwhelmed by the struggle for integrity on the part of these workers who merely wished to treat Canadians who live with an addiction decently. Why was such hardship necessary? I heard mention of the malign influence of mythology in maintaining misconceptions about illegal drug use. How were these things related? The very capable professionals I spoke with had, without exception, improved conditions for those who are often scorned in Canadian culture, but it had taken years of hard work and substantial risk. Was criminalization simply the ancient dynamic of scapegoating risen again? How does a deviant come to
be so labeled? Was stigma to blame? And what was this about demonization—in this day and age—of illegal drugs? Where did Anna fit in any of this?

Chapter VI reviews the social basis for the determination of deviance and the role it plays in maintaining the dignity of normal individuals, social norms, cultural beliefs, and moral understandings. Stigmatization, scapegoating, and demonization, social processes prominent in illegal drug use, are explored. The crafting of the ideology that justifies the Drug War and the discourse that explains and creates it is discussed, as well as how drug-related ideology sustains North American Euro-Western hegemony. The role of metaphor, myth, ritual, and rite in pharmaculture is explored and the institutionalization of sin is reviewed.
The Ties that Bind

Individuals often band together to better the conditions of life. To belong, each must add something to the life of the whole. Those who do not conform may be suspect, and may find their activities abruptly curtailed and their lives in-valid. Flight may be the only escape from the often fierce consequences of exposure.

Acrylic on paper (Polych, 2010)
CHAPTER VI: 
DEVIANCE

Socialization

Socialization is the preferred means to prepare people to participate in established ways of life and to follow agreed upon means to make social changes. Different social groups will, no doubt, have their own ideas about the goals of socialization, who gets to decide on priorities, how to slot people into different channels leading through life, who gets what rewards, and which social agencies are responsible for what aspects of socialization and how their different agents integrate their activities (Gil, 1990).

Society turns to coercion as a last resort, to control those who are not able to internalize social standards or who refuse to conform for politico-ideological reasons. Disagreement is common over what situations merit coercion and what measures are appropriate (Gil, 1990, p. 32). Social control is modified by chance or coincident events, is conditioned by the attributes of the target and initiating groups, and manifests according to the individual predilection of the local agent. Underlying any reasonable consideration of the control of behavior is the appreciation that behavior is always congruent with the symbolic universe of the individual and the larger society, is relative to specific understandings, and expresses certain values.

It is at the margins of social control and resistance that power is displayed in its nakedness. Such power derives initially from social policy that is always in the interest of particular parties. Clarity about the values, needs, and interests of those who judge behaviors and therefore set social values is particularly pressing. *Cui bono?* In any instance of conflict, true resolution calls for involvement of the people who are said to have the problem to clarify the values that are acted out in the problematic behavior.

Aldo highlights the profound difference in point of view between some people who use an illegal drug and those who look on: “To the person who doesn’t understand addiction, the drugs are the problem— to the addict, the drugs are the solution.”
Social Institutions

Social institutions solidify out of multiple decisions based on specific understandings forged in unique social contexts and resulting in certain practices that come to be regarded as natural and obvious. We make the path by walking it. As like-minded people interact with each other, events are interpreted, understandings are reinforced, meanings are negotiated, common sense develops, knowledge is accepted, norms are hammered out, roles are developed, and people are grouped. Over time, particular social rules, purposes, patterns, sanctions, theories, and metaphors are adopted or worked out. Society crystallizes out of such habitual, bred-in-the-bone understandings. Social norms, supported by cultural mythology and religion, are internalized during upbringing, are legitimized by education, and are maintained by socialization. In turn, society defines our social identity, bonds us in prescribed ways, imposes meaning, structures our beliefs, presents possibilities, fires our aspirations, casts our dreams, and bounds our expectations. Personhood is culturally constructed.

Max clarifies why politics, one of our key social institutions, is useful, and discusses how he has managed to use politics to accomplish what he thought necessary:

We need politics, or we’d just pick up a rock and bash each other’s brains out. . . . There’s only so many ways you can cut the same blooming pie. Who’s to say heroin users are more needy than mothers of young children who have cocaine problems. . . ? It’s better sometimes not to engage directly in battle. Sometimes, guerrilla forces are able to make massive changes behind the scenes. . . . Establish a network and get on with business, instead of doing the high profile thing. Sometimes, it’s better to just do it.

According to Gil (1990), social institutions are based on the clustering of social policies that arise to provide for both basic survival needs and perceived human needs. These policies then in turn determine the structures, dynamics, and values of people’s ways of life. Social policies shape the way in which individuals, groups, and classes live. They determine our circumstances, the nature of the human relations we experience, the power we may exercise, and the quality of our lives. Social policies deal with human capital and resources; address the organization of work; regulate the production of the means of
subsistence and distribution of profit from commodities; administer social
benefits and exact responsibilities; guarantee civil and political rights; provide for
governance and legitimation; and ensure reproduction, socialization, and social
control.

Max pithily expresses his opinion of the current social context of addiction
and available treatments: “There’s a battle to be won—and it’s a political battle—to
increase the understanding around addiction, the efficacy of treatment, and
substitutes. Addictions is a real backwater area and substitution therapy is even
more backwater.”

**Culture**

The term *culture* is a misnomer in that society is actually composed of
many competing cultures that reflect different values, meanings, and practices,
mediated by the inequitable distribution of class, wealth, control, and power
(Giroux, 1981, p. 148). Different cultures embody diverse sets of interests that
define and qualify how people reflect on the world. Culture-bound experiences
condition the knowledge, expectations, biases, and beliefs that define a
particular world-view. This way of thinking then confers meaning on the
experiences of the individual, sets out the proper way to relate to others, and
problematises certain aspects of life: its issues, tensions, and struggles (Giroux,
pp. 8-15). Such understandings, whether centering on progress, technology and
its place, political economy, interpretative consensus, or the replication of power,
bury many problems and hide many conflicts

People are categorized as to social group membership by three
dimensions: a) *intension* or qualification for group membership based on certain
traits, b) *extension* or display of the characteristics which identify members, and
c) *permeability* or firmness of group limits. Two key questions are: a) What
properties must an individual possess to be considered and treated as a member
of this particular society? and b) To what beliefs must he or she be seen to
conform to maintain membership? People are individually assessed consistent
with their ability to add something to the community and by the likelihood that
she or he may need to draw upon the resources of the group. The placement of
individuals with respect to a group according to these dimensions triggers the decision to include, ignore, reject, or discriminate against them. Valuation on a moral plane, of the person as good or bad, follows immediately together with their inclusion or rejection (Zukier, 1996).

**Outsiders.**

Moral understandings or ideas about right and wrong are based upon a particular conception of the potential of people and of human nature. Moral understandings speak to ideas about what society in general expects of a person and what can be done with those whose performance does not measure up. The dominant group regards the behavior of *primary deviants* who do not conform as a willful rejection of mainstream values and reacts as if its morals were being challenged (Zukier, 1996). Non-conforming behavior positions the deviant as morally depraved, and moreover, in the case of illegal drug use, as threatening and sinister, since drug use, even while said to destroy a person’s life, is often not easily recognizable. The process of expulsion and exclusion from the *in-group* results in *secondary deviance*, as the outsider is condemned, like it or not, to membership in an oppositional and possibly antagonistic *out-group*, where they must learn the skills to survive.

Doug’s experience confirms the robust operation in health care of moral judgment that highlights the neediness of the patient rather than taking account of any possible contribution to the community or potential:

*Doctors view addicts as nothing but hassles and problems, and filling out forms, and too complicated to deal with, and dealing with jails and courts and lawyers, and that they’re liars and can’t be trusted, and are going to hit them up for drugs, as well as security concerns. They see it as one big hassle. And some people just don’t like addicts: They view them as unlikable, deceptive liars. . . . I heard a well-known addiction doctor in town say, “Addicts are, for the most part, manipulative liars who can’t be trusted. . . .” My view is that those are just survival skills; those are good things, not bad things.*

Outsiders may very well be cast as degenerate inhumans, objects no longer even fit for comparison. The degenerate is barred from everyday life in the community. Prison offers society the opportunity to eliminate both the deviant and the threat he or she poses. The criminal is thrown into prison to *rot,*
out of sight, out of mind, forgotten by all, leaving no trace but an echo as she or he falls headfirst into the abyss yawning just inside the prison gate, whereupon he or she disintegrates day by day into abject bodily ruin, to be halted only by annihilation—not quite. But at least the moral sting of dissent is removed for the moment together with the carrier.

**Labeling.**

Labeling is a means to quickly communicate information to others about an exceptional or undesirable person. It encodes information about group membership and what behavior might be expected and called for. Labels are applied by those in the mainstream to those who are judged to not belong. Labeling carries with it the potential for stigmatization in which the person is regarded as inferior or tainted, as a consequence of being found to embody difference (Goffman, 1963). The deviant is blamed for having acquired the devalued attribute, becomes the object of animosity, and is shamed for displaying deficits. The very humanity of the person targeted by labeling may be overtaken and obliterated as stigma takes hold. The labeled person may no longer be considered quite human. Dehumanization enables the majority to justify limiting the human rights of the labeled person and for curtailing their access to common resources. Society feels it is absolved of the responsibility to deal constructively with the problems facing the individual once the person has been so judged, labeled, and placed in a deviant group.

Doug is distressed by the way many colleagues blame illegal drug users for willfully bringing on the difficulty that leads them to seek help:

Who cares about junkies? Most people’d rather see them dead anyway. “Pull up your socks and quit.” “It's your own fault. . . .” “They're weak people. . . .” People view dependency as a failing, a moral weakness. Some of this view is based on religion: They made their own independent choices to make themselves addicts, to make themselves sick and they should bear the consequences. . . . They brought it upon themselves. They deserve it.

Stigmatization depends upon robust social stereotypes that incorporate generalizations summed up in labels that are so accepted that they are truisms beyond question. The person who is so labeled may accede to the label, take on
the traits which support it, and assent to the limits which it entails, resulting in a redefinition of self based on the identified deficits, a downward shift in self-esteem, and the development of learned helplessness.

Stigma is contagious; those who associate with or help the stigmatized person may also be contaminated by the negative aspects of stereotyping (Goffman, 1963). Helping professionals may experience discomfort in their work with stigmatized people, as they may carry the same social prejudices as untrained people; they may ask themselves, “Who does that (works with illegal drug users)? And why?” They may also struggle with unrecognized countertransference involving disappointment due to past experiences while working with others who were labeled as deviant. Professionals may also carry a fear of personal vulnerability to the condition so clearly manifest in the person before them.

Doug cautions that the stereotypes that accompany the labeling of a person as an addict often act as a master role, blocking out all other considerations. “Once you’ve been pigeonholed as an addict, the hassles to get treated for other conditions are huge. The view of the health professionals will generally be unfavorable.”

**Stigma**

The exercise of stigma often follows the application of a label. *Stigma* is a term that refers to any attribute, trait, or disorder that marks a person as different from normal people, and which elicits negative sanction by the community. Stigmatizing diseases, such as leprosy, syphilis, tuberculosis, cancer, and HIV are distinguished by their intrusive, insidious, implacable erosion of the body to the point of dissolution. Application of a stigmatizing label to those who live with an invisible condition, such as illegal drug use, can be equally destructive to self-esteem, identity, security, and life chances of the people so marked (Scrambler, 1998). It is the opinion of the UN Office of Drugs and Crime (2000, p. 216) that illegal drug users are indeed morally stigmatized.

Stigma exists when cultural elements of labeling, stereotyping, separation, status loss, and discrimination (Link & Phelan, 2001) come together in a power
situation which allows them, resulting in needless adversity. Stigma carries negative health consequences in and of itself: a) it generates psychological stress, b) it can result in avoidance by the individual of situations (like health care) where the stigma might be noticed, c) it may result in service provision at a lower level, and d) it causes the well-being of the entire population to suffer. Despite these negative sequelae of stigma, communities continue to exclude on the basis of assessed social worth (Reidpath, Chan, Gifford, & Allotey, 2005).

Harry has noticed, even among people who live with an addiction, that there is a hierarchy of acceptability. Some are stigmatized by the method they use to take their drug or by the drug itself:

It’s based on self-control. . . . Within the same drug, whether they’re shooting, smoking, or snorting, whether they’re using powder or crack [cocaine] or heroin, there’s a hierarchy. . . . “Oh, I would never use a needle.” And the heroin addict that uses a needle would think that it’s a waste to snort it. Or the alcoholic judges the drug addict, “I’m drinking and I’ve got a problem, but it’s legal. . . . I never touch drugs.”

Stigma is believed to fulfill a social purpose. Stigma marks a person as unworthy of social investment. Stigma excludes those thought to be untrustworthy to reciprocate the care of the family, the kindness of friends, and the benefits of the community. Violation of the moral obligation to reciprocate constitutes a net drain on the community, with some people subject to more blame than others: cheaters are most reviled; those without the means to reciprocate are generally not as poorly thought of; while transients or outsiders come in for the least sanction. People often defame stigmatized individuals following their reduction in social value, citing moral failings such as laziness, stupidity, or a lack of talent to explain the social exclusion to which they are subjected (Reidpath, et al., 2005). Circular arguments raised in the 1850’s against the education of women at the university level exemplify this dynamic: “There are no women studying at university.” “Why not?” “Because they’re too stupid.” “How do we know this?” “Because there are no women studying at university.” “Why not?” And around we go again. . .

Historically, stigmas, aligned along the moral faultline between vice and virtue, have been deeply set by gender, race, class, and religion. More recently
further distinction is drawn on the basis of age, ethnicity, gender, sexuality, ability, size, language, location, origin, and other supposed markers of social worth. Those not of the mainstream “founding” cultures that invaded Canada—strangers in the village—arouse special concern. It is felt that they may disrupt our hierarchies, subvert our principles, corrupt our society, and lead us to ruin (Morone, 1997). Depending on the bias associated with the characteristic, such people, while not generally cast off straight into jail as are illegal drug users, may very well be shouldered aside as of less worth, be sidelined through systemic discrimination, or be assailed by bigotry.

Moral judgment shapes the definition of rights, distribution of prestige, and entitlement to social benefits. People are sorted into categories which result in the de facto forfeiture of many citizenship rights: criminals are regarded as predatory; children are said to be incapable of exercising rights such as informed consent or undertaking responsibilities; women, elders, the disabled, and others must make do with less; and the poor are deemed undeserving (Morone, 1997). Whole populations are stereotyped and marked as threats to the community through cultural images, such as those attached to people categorized as criminals, addicts, and loafers, propagated by media, keen to sell advertising, and other social institutions such as the church, anxious to restrict entry to the Just Reward only to the deserving.

Neal objects to arbitrary and ill-informed decisions to declare particular substances illegal and briddles at the results:

There are cultures overseas where chewing khat [a stimulant herb] has been a part of the culture for hundreds of years. In North America, it’s now illegal; people are being arrested for doing something culturally appropriate and are being put in jail: Being in jail is not part of that culture. Maybe some men in khat-houses mess up their families—some do; some don’t. There are many people who’ll say that khat is not a problem. There are many cultures that hold that grass is not a problem. People in bars break up families; then we go to the suffragettes again.

Who defines the problem? Do we have a right to be in control? Are we health fascists? . . . That’s unethical. It demonizes the drug; it demonizes people. I think we’ve succeeded very well in demonizing cocaine and particularly heroin to the point where our demonizing and illegalising has made them very damaging.
Scapegoating.

Ivan Illich (1976) was one of the first to describe the pernicious political transmission of iatrogenic disease. Political decisions resulting from muzzy thinking about illegal drug use have brought about a range of deadly effects which shuttle users, willy-nilly, along a path that often leads from overdose and infection through gunplay and the sex trade to family dissolution and impoverishment. Unaddressed, distress spins out and precipitates into society to puddle in a *nidus* from which radiates insidious anxiety, pervasive insecurity, and widespread dissatisfaction. The dialogue on illegal drugs exemplifies the way in which the social agents of mainstream capitalism perpetrate *cultural fraud*. Social problems are loaded onto the shoulders of vulnerable individuals who are then blamed for being vice-ridden. Fear of the immoral and dangerous other (Morone, 1997) spreads and, in a spinal cord reflex, justifies a deepening of the punitive posture toward petty crime and illegal drug use, as can be seen in Canada.

Labeling is the first step in the stigmatization process that leads to scapegoating. Ryan (1971) has identified a number of maneuvers which support the process of scapegoating, in which the victims are blamed by the mainstream for their misfortune as a means to ease its conscience, even while it enjoys a degree of privilege at the expense of those less privileged. These steps are: a) generate awareness of a social problem, b) professionals study those who have the problem to identify how they are different, c) professionals present the differences as the cause of the social problem, and d) professionals design a program to address the differences (Ryan, p. 8).

Girard (1982) believes that scapegoating is a dynamic that takes place under the covers and that it is the unacknowledged parent of *myth*. Scapegoating is a function of cutthroat rivalry within society for resources that may be legitimately or artificially scarce. Periodically, social conflict is diverted into a 2-step collective fiction designed to allow people to blow off steam rather harmlessly. The persecutors perpetrate a story about the harm to society done by the activities of an identifiable and comparatively powerless group of people.
The scandalized *lumpenproletariat* then buys in to this diversion *en masse*. In the process of first articulating the transgression of social values by the culprit and then organizing to punish or purge the common enemy, society is for a while united and distracted from the daily grind. Familiar targets include the evil enemy poisoning the wells, the crazed terrorist undermining security, the bloated speculator destroying the economy, the sly agent of sedition corrupting the body politic, the insolent single welfare mother, or the dissipated lout contaminating our moral fabric.

Girard (1982) outlines four characteristics of the scapegoating dynamic: a) a social or cultural crisis of *indifferentiation*, b) a transgression that can be made out to be the cause of the crisis, c) a culprit associated with the problem who is accused because he or she is vulnerable, and d) coercion or violence dressed up as rightful action. The trigger often is an increase in economic pressure. In indifferentiation, lines that previously have been clear become smudged, and social anxiety ratchets up as people see that anything goes and chaos is felt to skulk just out of sight in the shadows. Indifferentiation encourages people to cross the line. Those who do not fit in or who do not stay in their place violate established norms, inducing nervousness and apprehension (Gordon, cited in Eyles, 2001, p. 172). It is a matter of behavior being out of place, rather like *dirt*, which simply is matter out of place. Disquiet feeds offense, which transmutes into anger. With public exposure, boundaries are clarified as the offending scapegoat is identified and restored when he or she is expelled. As the crisis abates, catharsis clears the air like a good rain, uncertainty is washed away into the gutter, and a sense of order is refreshed. Paradoxically, it is just as social conditions become more tolerant and egalitarian, and indifferentiation therefore more common, that one expects the intensity of scapegoating to increase. Such a dynamic may be seen in the *hippie* movements of the 1960’s and the ensuing conservative backlash that has brought neocon politics to the fore.

Scapegoating has been a defining element in North American-EuroWestern cultures whose main religion, Christianity, is based in large part on
the story of Christ, one of the more famous scapegoats in history. The main text, the *Bible*, actually is replete with sacrificial victims including Cain, Joseph, and the prophets (Kerney, 1995). In Canada, in these days of multi-culturalism, when the ability of the population to reproduce itself has fallen below replacement levels and when society depends upon immigration to staff undesirable jobs, it is not politic to scapegoat based on race, country of origin, or language, and discrimination on these grounds and others is, in fact, prohibited by law. Since the outsider of old is no longer separated from us by origin, place, time, or distance, but now lives among us and demands recognition as a fully-entitled citizen, society turns to inventing *outsiders* who then embody the fears and incarnate the fracture lines of society (Zukier, 1996).

**Poem 5: Scape Free**

Awake, alert, aware  
I see your eyes half-closed  
As you look up at me.  
You count on me to go  
And take away your pain.  
Say what would that leave me  
On that long and lonely way.

Your eye slides up to mine  
Trouble, trick, trash, betray.  
Say where do I go now  
And who do I be next?  
What do I take with me  
When I go away?  
Why can’t you just see me?

It's true I've lived with you.  
Say you forget my name.  
My heart cries out to you  
I cling in fervent hope  
A scrap will come my way.  
I see my time is done  
No more friend, but enemy.
Never a place for me.  
Always the dark journey.  
Never a rest once there.  
My blood boils, my bones ache.  
By my hand you'll know me.  
By my path you'll mourn me.  
I beg you, don't turn away.

Carol Polych (2007)

**IDU and the Social Contract**

A number of chronic relapsing conditions or illnesses that are not easily understood, including illegal drug use and even the diagnosis of addiction, violate the largely unspoken terms of the social contract and may provoke hostility from mainstream health care providers. *Unpopular patients*, such as those who use an illegal drug or who do not otherwise conform to the conventional sick role, evoke anxiety in the clinician who may have to confront primitive social concepts of disease—illness as the wage of sin—that emanate from the province of religion and which come bursting through the scientific veneer.

Some of the fetishism that surrounds the illegal drug itself (Tooley, 1994, p 41) can be disturbing. Clinicians may find a number of phenomena that are part and parcel of illegal drug use troubling, particularly when a foreign body such as a needle is introduced into the body. Professionals may be dismayed by breaches of taboo on the part of patients who may attempt to mislead them in an effort to obtain drugs. Patients may disappoint the helper when they fail to respond positively to the treatment on offer. Professionals may be hard pressed to offer an alternate explanation for the weakness of will which has been attributed to those harboring an addiction. Workers may question their core social values as they bear witness to the loss of soul said to parallel the degrading income-generating activities engaged in by some users. And clinicians may be led to an analysis, arising from awareness of the harm surrounding illegal drug use, that invokes the manifestation of *evil*. Patients who use an illegal drug may be deemed *antisocial* and as such, overriding any health
concern, may be shunned by medicine as *untreatable*. In a blurring of the line between therapy and social control, the offenders may be shunted into the prison system in a last ditch effort to contain the unruly behavior.

Max has found the pressures of working with people who use an illegal drug daunting:

> How do you sustain and keep a positive attitude and positive regard for folks when you struggle with them for the fifteenth time over housing conditions? You don’t live and work in a war zone for very long without *vicarious trauma*. . . . Inability to de-stress is an ingredient in distancing patients: Boundaries. We have been designed as physical animals; dealing with mental or emotional stress is not something that has been part of our evolutionary development.

**Ideology**

It is discourse that organizes and constructs truth and knowledge at any given time and place (Status of Women Canada, 2002). *Discourse* refers to anything written, said, or communicated. It is through the analysis of discourse and examination of the accompanying institutional practices, which are based on a particular underlying ideology, that the cultural understanding of addiction can be developed (Fillingham, 1993, p. 100) and the ideology that drives it articulated, in hopes that a better reasoned approach to addictions may be developed. Sontag (2003) quotes others, “Nobody can think and hit someone at the same time” (p. 118).

Neal gives an example of clear communication of ideology by social control agents and resistance to that ideology, even when it may cost the patient a great deal:

> I would not want to be told, “Stop [using], and then come and talk to me. . . .” The patients flee [chuckles]; or they put up with it for a bit, then flee; or they put up with it because they need something that the professional can give them, whether it’s a prescription, or a letter for their probation officer, or whatever. It’s a bit of bargaining here. In many cases though, it’s not an honest relationship. . . . Patients are insulted and they’re infantilised, and they’re demeaned and degraded by the approach, “You’re not good, unless you do what I want you to do”; it’s terrible. So they leave. . . . They don’t want to be bossed: Don’t boss them.

Habermas (cited in Held, 1980, p.345) recognizes that language, a medium for social power and an instrument of domination, is often used to
legitimate relations of organized force even while it pointedly does not articulate
the power base from which it emanates and which it supports. Presaging Giroux
(1981), Habermas points out that all smoothly functioning communication, such
as that employed by Mr. Clement in his flyers, depends upon the consensus of
all parties about validity claims. The truth underlying contested claims can only
be redeemed when there is mutual understanding between participants,
recognition of the right of each party to participate in dialogue as an equal and
autonomous partner, an equal chance to speak and to be heard, and agreement
based on the better argument. When these conditions are violated, the reader
knows that communication is distorted, and that it is intended to promote the
interests of one party at the expense of another. Such communication renders
suspect any claims made without consensus, and the legitimacy of all social
action arising from any such analysis is in doubt. Mr. Clement’s flyers are a
textbook example of the way in which the elite uses language as a means to
further domination.

Ideology may be understood at a beginning level as a set of systematic
distortions, false beliefs, illusions, mystifications, or, plainly, lies. The term,
ideology refers to the tacit norms, assumptions, and beliefs that influence
perception, understanding of experience, and practice, as well as the formation
of values, meaning, and identity. More precisely, it can be thought of as a value-
laden set of beliefs and social practices that contain and hold in tension
oppositional assumptions about the varying elements of social reality: society,
economics, politics, authority, human nature, and so on. Ideology results in the
analysis of problems from its own perspective, whether that be conservative,
liberal, socialist, anarchist, religious, or another. Ideology frames the experience
of people and imposes the structure that attends the dominant worldview on
people’s attempts to make sense of life. It channels the desires, hopes, and
needs of those under its spell. Ideologies become hegemonic when they are
institutionalized by the dominant society. They are stripped of any real
independent power and are used simply to legitimize the social practices of that
dominant culture and to support the existing institutional arrangements that
benefit dominant sectors.

**Hegemony**

*Hegemony* (Gramsci, cited in Mastroianni, 2002) is an ideology that limits
discourse in a society by fronting dominant cultural understandings as rational,
natural, permanent, and universal. Hegemony seldom requires the actual use of
force, although the expansion and militarization of the police force in Canada
does send a clear message. The Government of Canada takes a dip in the
direction of governance by public consent through elections that are managed so
as to offer a pale illusion of choice to citizens. This tactic has become so
threadbare that the federal election of 2008 saw the poorest voter turnout, at 60
percent, in the history of Canada. The purported assent expressed by the
electorate supposedly validates the dominant values and beliefs that sustain the
political economy of private enterprise. These elitist values are then recast as
public goods and, as such, are enacted in routine social practices. Such values
then go on to be reproduced by the ostensibly non-partisan social agencies that
provide moral and intellectual leadership to Canadians. Schools, mass media,
family, religion, and so on all take part in socializing Canadians to accept norms
favorable to the dominant classes and enact the means that favor control by the
elite over the common resources of civil society.

The orchestrated quality of governance was clearly exemplified in 1990 at
the time of the election of the leftish Ontario New Democratic Party (Ehring &
Roberts, 1993, p. 303). At this time, the unpalatable left-leaning concerns,
subversive analyses, and critical elements of the NDP were simply subsumed,
diluted, and leaked by the apparatus of the state until the elected government
was helplessly beached, thereby enabling the economic elite to cling on to
control until they were able to shake off this upstart party. Since, in a rather
pointed elision of interests, the erstwhile leader of the NDP, Bob Rae, has slid
across the aisle and now holds power in the Liberal (small business) camp.

It is through the shaping of hegemonic taken-for-granted views that the
dominant class attempts to influence the dispositions, interests, and needs of
subordinate groups, even as it contains radically different analyses by controlling and limiting oppositional discourse and practice. Oppositional discourse is sidelined or squashed outright by the same hegemonic interests which set the political agenda, define the issues and terms of debate, and exclude antagonistic ideas (Giroux, 1981, p. 23). Clement's flyers beautifully exemplify such tactics.

The Drug War.

Gil Puder (1998), a front-line police officer from Vancouver, now deceased, believed that the aphorism, “The first casualty of war is truth,” applies to the Drug War. It was the media that loaded the cannons that fired the first shots in Nixon’s War on Drugs. Myth disguised as science provided justification for callous treatment of drug users by spinning problems as manifestations of atomistic individual failings, rather than as the predictable consequences of social decisions (Gifford & Humphreys, 2007). Sensationalist media coverage of the American “crack epidemic”, often featuring Black or Brown urban minorities, riveted attention on the relationship between drug use, violence, and the hardships springing from the poverty which had taken up residence in many American inner cities (Freundenberg, et al., 2006).

To redeem the possibility of truth, apply justice more reasonably, and open up more actual freedom of choice, the discourse on illegal drugs must be reopened and restructured. The claims about the use of illegalized drugs and behaviors said to be criminal must be reviewed, explanations must be revisited, the very nature of compromised “knowledge” about illegal drug use must be questioned, and the conceptual frameworks opened up and moved a little closer to reality (Habermas, cited in Held, p. 345). Three steps are crucial in such a course. The first step is the scientific testing of addictions theories that are clear about exactly whose interests are being served by the analysis, with careful planning to offset distortion. Next, illegal drug users and others who have been criminalized must be supported as they illuminate their place in society and articulate their interests. Lastly, appropriate approaches and tactical strategies must be put into place so that all citizens, including people who use an illegal
drug, may fully take part in an authentic political process, (Habermas, cited in Held, p. 348).

**Metaphor, Myth, Ritual**

Metaphors act within a culture to reduce complex phenomena to the simple. *Metaphors* function as symbols that stand for things toward which certain hegemonic culture-specific feelings are prescribed. Metaphors help people transfer their understandings from a known situation into unfamiliar circumstances. Widespread or fearsome illnesses that are not well understood may be explained through extension of an established metaphor. Metaphors act as a handle upon which can be hung a number of stereotypes and stigmas (Weimer, 2003, p. 17). Social ills may be metaphorically embodied by particular illnesses, and come to be viewed as morally contagious (Sontag, 1977, p. 6). An example may be seen in description that wrongly likens addiction to a *plague*, implying that addictions are sweeping radical and deadly abnormalities that can suddenly strike the unsuspecting in an otherwise normal society.

Neal is keenly aware of the pernicious effect of the mythology that is rife in the area of addiction:

> It's [addiction] not a black or white thing. . . . I've seen people that've controlled any number of drugs. It's disturbing that this mythology is there, that this sort of thinking is there. . . . Addiction needs to be un-demonized and looked at realistically; all drugs need to be. . . . Some drugs are worse than others, and alcohol is probably one of the worst. . . . Temperance was a very rigid religion within which alcohol was seen as the demon drug. It really is a matter of moderating what you do, not letting it get out of hand.

A *ritual* has been defined as any well-established form of behavior that leads those who participate in it to a certain belief. Ritual enactment encompasses rites or procedures whose imagined purpose allows the participants to see beyond what they are actually doing (Illich, 2005, p. 140). Rituals have the power to generate a deep adherence to convictions, even those that may be highly contradictory to common sense. It is participation in the behavior of the rites that constitute the ritual that evokes belief in the myth being enacted. Ritual is mythopoetic. A ritual that has come to be taken for granted and which has come to be generally believed in, may become ingrained and
taken as a matter of faith—a *myth*. Objects used in performance of the rites may become fetishized, embodying the symbolic weight of the ritual, and regarded themselves with devotion. Doug acknowledges the power of fetish in one type of ritual in illegal drug use: “The needle is strongly connected to the heroin. The needle is part of the whole ritual.”

Myth and ritual are reflexive. Myth brings meaning to ritual; enactment of the ritual enables myth to spring to life. When in the thrall of myth, people wholeheartedly subscribe to ritual because they believe in the rightness of the goal, the necessity of achieving it, and know no other means to reach it. The precise actions prescribed by the myth take on the solidity of ritual through practice, and function to bring about something of the kind of life that the myth embodies. Ritual does more though than simply embody myth; it actively generates faith in it. It is through participation in collective myths that people develop a worldview where life is predictable, a sense of belonging to a culture where they will be understood, a society where they are protected, and a community where they can experience closeness to others (May, 1991, p. 53). For example, North American-EuroWestern cultures subscribe to the rags-to-riches myth that individuals determine the course of their own lives, triumphing against all odds, or if not, have only themselves to blame for failure or mediocrity (Gifford & Humphreys, 2007).
Poem 6: *Homo ritualis*

Velvet *Telos* walks beside me
Hard traveled far to bring me word
Whispers dark purpose in my hear
The why of who I am
And what I may become.

Fireside *Ethnos* calm waits our meal
This claim runs through right back to birth
We share a song of home and hearth
Of who I am to you
To whom do I belong.

Dappled *Logos* sits rapt in thought
Head down, lists each detail in turn
Mapping out such busy plans
The how of who I am
Steps toward my being.

Sunlit *Ethos* custom folkways
Strong sultry spirit of the land
Hums routine as is old habit
The way of who I am
Cautions I must behave.

Gentle *Cearu’s* lavender tear
Sorrows at my pain, takes my part
Celebrates and still holds me dear
Concern for who I am
Shows me I am beloved.

Rainbow *Mythos* shimmers above
Faded echo of a story
Dares me rise proud to say out loud
For what it is I stand
In what do I believe.

Mother Ethnos, Father Telos,
Brother Logos, Sister Cearu,
Grandma Ethos, Grandpa Mythos
Hold me close, encircle me,
Time gone by and yet to be.

Carol Polych (2007)
A myth is a story powerful enough to account for and conceal its own paradoxes. Even when the effects of ritual are clearly deleterious, faith in the myth may persist. The medicine man performing a rain dance does not stop his dance because rain does not come, but dances all the harder, discounting the hardship his ritual brings him because he is certain that his efforts will improve the future (Illich, 2005, p. 140). Those enmeshed in the institutions that support the ritual are not able to do else but believe in the necessity and the goodness of what they are supposed to believe in (Illich, 1976, p. 116). Somehow, the adherence to the belief is stronger than most people's ability to question those beliefs. Systems incorporate their users.

Drug interdiction rituals, which disregard any common sense analysis of the history of alcohol or drug prohibition, ignore the consequent embeddedness of organized crime. The Drug War is simply intensified in the face of continuing drug use despite the spiraling costs and increasing social harms. Discounting any contrary evidence, believers escalate the rites of punishment for illegal drug use in North American-EuroWestern culture, unshaken in their conviction that somehow, someday, prohibition and interdiction will stop drug use. The persistent enactment of rituals such as those seen in the War on Drugs emanates from powerful mythologies about addictions that are reflected in the fetishization of illegal drug use.

No matter what the current ideology, Harry believes in a practical approach to helping people who live with an addiction. He sees a place in his practice for interim harm reduction just as he supports abstinence as a goal:

I believe in hard drugs and soft drugs. The hard drugs, in my opinion would be heroin, cocaine, amphetamines; and softer drugs would be marijuana, mushrooms, LSD, and alcohol. I believe that there are different degrees of euphoria, and the person can smoke marijuana and not go on to a harder drug. The reason for that is because they’re satisfied with that. . . .

I believe in harm reduction, depending on how far down [into drug use] the person went. . . . I believe that a hard drug user needs to stay totally off drugs. If somebody has abused cocaine or heroin, I don’t think that person can use mind-altering substances and still avoid thinking about the euphoria they once experienced. They may think they can pick up a gram of cocaine on a Friday night, and say, “Okay, I’m just going to
have that much.” But, when they finish that amount, how much energy is used to limit further use, where they could put that energy into a different, more positive direction and concentrate on getting some quality in their lives.

Within every culture, a certain range of drugs is available to the potential user. The user selects certain drugs from the array at hand, and makes decisions about how she or he will use them. The effect of a drug and its desirability depend in many ways upon the milieu in which they are taken. More experienced users will often advise the novice about the best process to obtain and take the drug. Repeated use establishes preferences, and the user learns the most satisfactory means by which to take the drug. In this way, the patterns of drug taking are set within the culture. Patterns of drug use may develop into ritualistic behaviors that then in turn define the subculture surrounding drug taking (Illich, 1976, p. 71).

Max differentiates between habituation and the more compulsive behaviors that define addiction:

I think there’s a continuum going on in addiction. . . . Dependencies may be under some degree of control, and the patient may be able to change back into a habit with great exercise of control. Say you get up and smoke a joint pretty much every day, but not on a constant basis. You only smoke one. It’s only in the morning; it’s only at night. And that’s it. And you do that for years and years. It can be thought of as a habit and a dependency. It’s contained in some way. . . . Those people have internal or external resources that help them bound it. . . . You contain it in some way with other things in your life, or other people contain it for you. You construct it mentally as your reward at the end of the day. . . .

There are some people who can bound their usage. . . . There are some chemicals for which it’s inherently harder to do that. I don’t see too many people that can bound their use with only one shot of heroin at the end of the day, because of the nature of heroin, of that chemical action in the body. And the knowledge that, “Oh, I’m feeling so lousy, man [without it],” and all it takes is just one shot, and, “I’m back.” [Snaps fingers, excited voice] “I’m back in the saddle and ready to go.” It’s a fundamentally difficult chemical. I see a lot of people aspiring to that [bounding their use] with opiates, but not too god-damn many really get there. . . . [William] Halstead is a famous surgeon who did it. . . . If they can figure out how to do it, more power to them. Why not? Most people; you say, “How much do you use?” “How much can I get?”
Pharmaculture

According to the present classification scheme, ritalin is nothing short of a miracle for exuberant children confined to the classroom; but adult speed freaks, many of whom also struggle with unrecognized Attention Deficit Disorder (ADD), are demonized. A post-war army of suburban housewives in the 1960’s whizzed through their vacuuming and bubbled over at their 11:00 a.m. kaffee-klatches until they tired of staying awake all night and threw out their diet pills. Their grandchildren however, the teens of today’s Midwest, are irrevocably enmeshed in the toils of a cousin of the monster named Methamphetamine and, fershor, court certain brain damage that, while unknown, is believed to be permanent, donchano. Heroin, marketed by the same Bayer company that popularized aspirin in 1899, was purified from naturally derived opium and injected with the new-fangled hypodermic syringe. It was lauded as one of the most effective nostrums in an era without antibiotics, a blessing from the angels for women living at the turn of the 19th century when infectious illnesses killed one third of the population, syphilis ran rampant, and Pelvic Inflammatory Disease (PID) was ubiquitous among women. Once declared illegal, heroin transmogrified overnight into the biggest, awfulest boogey-man to spring upon the hapless victim who, Pandora-like, was fool enough to open the medicine cabinet.

Doug reacts negatively to arbitrary distinctions drawn between legal and illegal substances and specific drugs:

All the mystique about methadone! Strict regulatory controls, with methadone being the least problem of all the narcotics prescribed by doctors. . . . Never mind all the other misprescribed substances, like antibiotics and non-steroidal anti-inflammatories, which kill several hundred Canadians each year: no controls, no audits, no standards, no nothing. But for methadone, the most commonly available drug to treat heroin addiction, major rules and obstacles. . . . The standards that are enforced with methadone don't apply to any other area of medicine.

If one uses the same community standard that is applied to other drugs . . . and it can't be looked at in isolation from other drugs and other standards . . . there's nothing extraordinary about methadone that calls for these regulations other than the mystique, the objection of using an addictive drug to treat another addiction. . . . It's based purely on philosophical and ideological grounds that have nothing to do with
evidence, nothing to do with the dangers of drugs. . . . I find the contradictions incredible!

At this point, there are in all societies those who influence the opinions of others and who have the power to make key decisions on behalf of all. In the area of illegal drug use, it is legal and law enforcement authorities who make the decisions, with some input from medicine, about which drug use will be designated as illegal and under what circumstances. Even the designation of a substance as a drug is fraught with cultural-affective content. Given that a substance as ubiquitous as water can be and is used to the point of intoxication, substances as harmful as tobacco and alcohol are unproblematically available, and that mood-altering substances are sold to a huge segment of the Canadian population by a pharmaceutical industry enjoying killer profits, it is clear that any designation of illegality is indeed arbitrary. Declaring the use of a certain drug as illegal is a manifestation of raw power, albeit often cloaked in a more palatable but fraudulent shroud of paternalistic concern. In contemporary global society, moreover specific government bodies (perhaps most infamously, the Central Intelligence Agency [CIA] of the US) have been found to be themselves covertly involved in promoting illegal drug use and profiting from the illegal drug trade, all the while overtly condemning it. Political decisions to designate the use of a substance as illegal reflect judgments about the risk to society posed by those who use a certain substance in a particular way and who do not conform to cultural expectations of producing and consuming in ways which accord with the interests of mainstream capitalism.

Drug Abuse

Different substances have been regarded with trepidation depending on social fashion, cultural familiarity, the way the drug is used, who is believed to use it, whose interests are at stake, and what the drug represents. A frightened physician, using terminology befitting the impact of the Black Death, shared his alarm:

The abuse . . . has taken on the characteristics of a plague—it is not only confined to men, but has even spread to women and children. . . . This abuse . . . takes the form of an imperious and irresistible craving. . . . The situation is becoming very dangerous.
The horrified doctor hoped to alert his colleagues and the citizenry of 1930’s Tunisia, which was gripped by a galloping addiction to tea (Economist, 2002). His warning might equally well have described the streets of New York where terrified folk confronted the crack cocaine outbreak of the 1980’s, or from the suburbs of the American mid-West 20 years later where agitated parents witnessed their teens use of crystal meth. Consonant with the perceived level of threat, response by the authorities to the use of a drug can also be extreme. Daryl Gates, ex-Chief of the Los Angeles Police Department, testifying in 1990 before the Senate Committee on the Judiciary, which was evaluating the National Drug Strategy, railed, “Casual drug users . . . ought to be taken out and shot . . . ! We’re in a war, and drug use is treason.” (Daily Digest, 1990; Eigen, 2008).

Such passionate opinions about an inert substance develop when the substance is fetishized as a moral agent carrying moral force in and of itself. Moral loading surfaces prominently in the application of the term abuse, which describes a moral judgment made about substance use behaviors (DeGrandpre, 2006). Such moralism has its roots in shared cultural myths about collective values, personal identity, and timeless meanings about what it is to be human. Drug use in North American-EuroWestern cultures is conditioned by a cultic faith in pharmacology, propelling mythology to the forefront of drug taking, but then abandoning myth in the wake. A cult incorporates all the power of a myth but operates without the social limits of responsibility seen in myth (May, 1991, p. 24). The mythology surrounding illegal drugs calls for and justifies the ritual scapegoating of users while the cultic aspect of the myth cancels social obligations to care for the more vulnerable.

Drugs come in for special social consideration because of their power to act directly on the thoughts and actions of the willing or unwilling, believing or unbelieving user. In the past, only magic had such power; in the present, only science. Together, interventionist medical science and pharmacology have been cast as the panacea that can bring people relief from the effects of distress related to life in a society that is evolving even as it disintegrates. Despite
evidence about the equivocal effectiveness of antidepressants (Mulder, 2008), the pharmaceutical solution to such dis-ease has been the provision of antidepressants to 1 of every 14 Americans (about 7 percent) (Schlosser, 2003, p. 220). As of 1997, 15 percent of men and 24 percent of women in North America were identified as affected by depression (Mulder, 2008), a condition that is expected to increase each year, leaving plenty of room to expand profits.

**Drugs as signifier.**

Prior to the industrialization of health, effective medications from the apothecary, taken by Europeans in herbal form, included opium, quinine, digitalis, reserpine, and ipecac as well as a host of other whole-plant remedies. Pharmaculture started with the replacement of herbals by purified and concentrated extracts patented and produced by pharmaceutical companies who pocketed obscene profits. Present-day drug culture began with a vengeance when the Bayer company brought aspirin to market. Systematization of the production of purified pharmaceuticals was paralleled by systematization in the medical profession with its discrediting of non-allopathic providers such as midwives, herbalists, naturopaths, osteopaths, homeopaths, and chiropractors.¹⁰

Today, drugs are omnipresent in Canadian culture. Even though indigenous populations and healers have used comparable drugs for centuries, certain drugs have been designated as illegal by Canadian authorities. At this time, the use of an illicit drug constitutes more than a simple violation of law. It is a flash point by which to judge others in the society, an orienting point in a changing culture that informs the distinction between worthwhile and worthless. Once the authorities have exposed a person as a user of an illegal drug, the individual is divested of personhood and the status of a signifier–criminal–is applied. The person who has been found to be using a drug designated as illegal comes to stand for a particular reprehensible type of person and their previous social identity is eradicated.

**Regulation of Pleasure**

In Canadian post-protestant culture, moralism has crossed paths with marketing, leaving *the powers* heavily preoccupied with the regulation of
pleasure, principally expressed in the control of sexuality, whether pornography, promiscuity, prostitution, divorce, abortion, or alternate sexualities. Drug prohibition is yet one more venue for the regulation of ill-gotten pleasure in which solidarity between medicine and law can be displayed. Illegal drugs offer their takers a private means to access states of pleasure guarded from the panoptic gaze of a highly routinized dead-end nanny state set within a surveillance society.

In Harry's opinion, the rush of cocaine is even more attractive than sexual activity:

The rush of cocaine is more powerful than a simple orgasm. You have a higher feeling. The euphoria of addictions is stronger. . . . There still is the myth that cocaine is a sexual drug . . . but it’s not. It’s not. It’s not for an addict. . . . Even using with somebody else, it’s still lonely. It comes to the point where you don’t want anyone else there. “If I have a partner around, I have to share it.” It ends up being lonely. You’re still alone because it just satisfies your needs. Cocaine is a very isolating drug.

Doug waxes rhapsodic in recollecting the pleasures of narcotic use:

I . . . was given an injection of morphine intravenously. . . . It was like pure nectar. . . . I still remember the feeling. I'll never forget the feeling. I felt nothing. I didn’t care about anything in the world. You really are totally numbed out of any angst of any kind. I didn’t care about anything. It was absolutely fantastic. Sweet nectar of narcotics!

Demonization of IDU

The drug war is primarily a means to make an example of those who are easily victimized, because they often are the people who are most obvious and chaotic in their use and so may be already marginalized. Comparison of arrest figures to those drawn from prevalence of use data tell us that, while drug prohibition is of concern to those who use an illegal drug, it certainly does not diminish usage, and in fact, paradoxically may increase it. The current response to illegal drug use echoes innumerable other attempts to control the behavior of the unruly classes. In her study of the 18th Century gin craze of Britain, Warner (2002, pp. 213-217) sets out a number of conditions for the demonization of drugs. The drug must be new or rediscovered, be affordable and available, be perceived as stronger and “worse” than other substances, appeal to a marginal group, typically be used under unsavory conditions, and be certified as
dangerous by experts. Demonization must present a human face that encourages pity for users and censure of sellers and that calls for extreme measures to deal with victims and villains, including the use of undercover informants. Lastly, complex social problems can be (handily) oversimplified and the authorities can blame the problems on the substance and the people who use it (Warner, pp. 217-219).

Warner (2002) cautions that, while legislation cannot prohibit debauchery, there are a number of means by which the law can encourage it. As a consequence of the attention focused on the drug by the authorities, the substance takes on greater importance than it would otherwise merit. The illegal drug and its use is fetishized. Members of the counterculture may gleefully increase their usage, in sheer defiance of the harsh or unfair penalties imposed by the authorities on users.

Max reflects on the use of substances within society and social responses to the use of unapproved substances:

I don’t think you can go though life without some habitual comforts, but a cup of coffee is not a cup of LSD. . . . There are clear qualitative differences. There are degrees of habituation. There are things that any group of people determines is acceptable behavior and things that they will exclude. Societies will, for varying reasons, label some of them worse than others. . . .

Some forms of substance use seem to get excluded from any group. . . . You will be banned or pushed out of the group. There aren’t ways of doing that anymore, so we disenfranchise people in some way. We push them into jails—not necessarily a smart move, often quite a stupid move—a poor response, an ill-informed response.

**History of illegalization.**

The Executive Director of Law Enforcement Against Prohibition (LEAP), Jack Cole, a retired Detective Lieutenant of the New Jersey State Police, provides some history on drug prohibition in the US. Post-alcohol interdiction efforts in the late 1930’s after the Depression focused on reduction of the marijuana trade chiefly out of Mexico, resulting in escalation of cost to the end user. In response, post World War II, heroin and cocaine, substances that bring an even greater profit and are easier to smuggle, were brought in from abroad. The switch to heroin or cocaine by the end user only made sense, as it was quite
affordable in comparison to the consequently inflated cost of marijuana (Cole, 2007). Since, the repertoire of drugs available to alter mood and mind has continued to expand, as has the roster of drugs declared illegal.

The quality of double-speak (Orwell, 1949) is rife in the area of addictions and illegal drug use. Even the very term, addiction, conveys confusion and is fraught with negative connotation. Coming from the Latin addicere, bound to or enslaved (Potenza, 2006), addiction implies a malignant state in which the individual's behavior is beyond his or her own control. This nomenclature is associated with a particular picture of the illegal drug user: an hopeless habitué abandoned to a bad habit, a roué wantonly ignoring other life considerations, a helpless victim in thrall to an irresistible external force, an unfortunate deviled by a weak will, a fraudster blithely betraying any loyalty, a malefactor glibly undertaking any nefarious scheme or shady activity to procure the object of interest, or a criminal callously disregarding any injury to others while in pursuit of the drug. This picture blurs over the face of a celebrated, dedicated top-flight surgeon like William Halstead, whose daily routine included attention to his drugs of choice, morphine or cocaine.

Doug was pleased to be able to assist a colleague who came to him on the quiet for help with his use of massive amounts of prescription drugs taken intravenously. At the same time, he is upset by and impatient with the stigma associated with drug use cast onto less advantaged people:

The hypocrisy is in the number of professionals who are addicted. . . . The condemnation goes on the people who are poor or on the streets . . . as if there's something more morally acceptable associated with wealth. . . . The contradictions and hypocrisy are amazing.

Like the war on terror, the term War on Drugs, popularized by ex-US president Richard Nixon, is recognized by many as neocon code for American global domination. The various wars being conducted by the US elide into one global war of domination in aid of the high life for the elite and the good life for the petit bourgeoisie at the expense of the low life: mainly expendable poor, often racialized, inner-city populations and people from the majority world. The War on Drugs elides the trade in drugs (Falconer, 2008, p. AA6) with arms and oil
and profits (Chomsky, 1998).

**IDU and social norms.**

Even though the Minister of Health informs his constituents that the use of illegal drugs destroys the person, in point of fact, it is the very lack of destruction or other external distinguishing markers of illegal drug use that complicates and frustrates the pursuit and criminalization of illegal drug users. (*The Barenaked Ladies* come to mind.) One source of the anxiety that unsettles those who lead North American-EuroWestern society arises from the erstwhile normalcy of those who come to be labeled as criminal users of an illegal drug. The average member of society cannot help but feel nervous, never knowing who might be exposed tomorrow as a person who has used an illegal drug or who might next be shown, in actuality, to be a felon who has infiltrated the social body and who, undetected, is undermining it through illegal drug use. Ironically, survey data tells us that the proportion of society that might be so branded is so huge that it constitutes the majority in many instances.

The illegal drug user, in transgressing social norms undetected and with impunity, exposes the contingent nature of the underlying values, undermines respect for moral conventions, and thereby subverts the collective consciousness of the culture. The resultant potential moral breakdown, so feared by the authorities, surfaces in social anxiety that may be most evident in the behavior of those in the front lines of law enforcement. Frantic to achieve clarity in their worldview and meaning in their work, many involved in interdiction efforts resort to an analysis that casts citizens as binary opposites: innocent victims or conscienceless pushers. Such black-or-white thinking is betrayed by some of the pejorative terms in liberal use by law enforcement personnel to refer to identified illegal drug users: “scum”, “shit”, and so on, and in the descriptive terms for the materials associated with illegal drug use; for example, used needles are called “dirty.” Society does not deal kindly with dirt: material out of place, disorder, or people who do not nicely fit in (Tilbury, 2006).

The US as a state was founded by contentious folk unwilling to abide by the standards of their mother society. It has a proud history of bloodshed,
predating even its inception as an independent state and refreshed continuously
in a never-ending series of wars. Over and above the perks that come with
domination, conflict can be a means to articulate identity through differentiation
from outsiders, hostile interlopers who are further damned as immoral wretches
(Morone, 1997). The first step in legitimizing hostilities is to identify an outsider
as a serious threat to domestic values such as territory or way of life. President
Nixon, who opened the current *War on Drugs*, characterized heroin as a foreign
import, a poison in the American life-stream, and described addiction as a cancer
which comes quietly into homes and destroys children (Nixon 1971, cited in
Wooley & Peters, 2008).

**Absolutism.**

Nixon's use of the metaphor of addiction as cancer harked back to well-
established conventions marking cancer as no mere lethal disease, but an
invasion by the *other*, a scourge within, a pathology of the will, a demonic enemy
carrying corruption and shame (Sontag, 1977, pp. 57, 61). Those US citizens
who used an illegal drug were thereby marked out as the carriers of a
mysterious, insidious, internal disease evoking the deepest dread of an
inescapable fate, a sure slide into weakness, dysfunction, decay, pollution,
anomie, and death. Secondary signification may even more closely describe the
problem for *Homo economicus*, as the behavior of cancer can also be
understood as the redirection of purposive sustaining and creative energy, into
non-productive, self-centered pursuits that lead nowhere but to oblivion. Those
who have it are marked by a lack of interest in consuming-producing even while
they are themselves consumed. They focus inward, minimizing their expenditure
of energy, and curtail productive activities such as work (Sontag, p. 62), only to
produce tumor. The battle against such cancer calls for extreme and brutal
measures to save the life of the patient from the invading malignancy: slash,
burn, and poison—shoot, taser, and jail.

In contrast, Doug advocates taking the same approach to interventions
designed to minimize the harm from illegal drug use as is taken with any other
condition in which the treatment is tailored to the goals of the patient. He draws
a comparison with the treatment of a smoker who drinks and who develops high cholesterol:

He's at risk for a heart attack. He's not going to stop smoking. “I'm not changing my diet. . . .” He's going to continue to eat red meat every day. What are you going to do? Say, “Sorry, you can't have the cholesterol-lowering drug because you're not following the other recommendations”? The objective is to lower his cholesterol through the means which will work best for him now, and that excludes most of the traditional things.

The absolutist tendency to insist on abstinence from mood or mind-altering substances speaks to the need to define values and control the unpredictable. In a culture of individualism, where success depends on meeting life head on, and the position of the person reflects their just deserts, there is no place to blame society or fate for difficulty in life, for trouble coping, for failing to thrive, or for succumbing to the comforts offered by illegal drugs. To those who regard complex explanations with suspicion, the appeal of slogans, such as “Just say, ‘No’,” lies in its simplicity. Abstinence as a theory has other rewards as well: Those of *us* who have seen the light can take pleasure from the aesthetic of self-discipline; pleasure in the recognition of austerity; comfort from the fact that we, ourselves, in contrast, are moving closer to perfection; even as we feel gratification when we succeed in converting, reforming, and redeeming the “other” (Warner & Riviere, 2007).

Doug says he just can't subscribe to absolutist philosophies in the care of a patient struggling with an addiction.

How I would describe a reasonable approach to addiction? . . . If they're not doing heroin, they're better off than if they are doing heroin. It's better that the person with an abscess gets an antibiotic than not get the antibiotic. If that's all that can be done, that little thing's better than nothing. . . . I don't buy it that, “You have to quit all drugs. . . .” If . . . they're only capable of stopping one drug, then you forfeit the opportunity to stop the one drug.

It is the meaning applied to a drug by the authoritarian state which casts it into classification as an illegal black-market drug capable of enslaving the unwary, an ethical pharmaceutical medicine developed to save us from the troubles of the day, or an ambiguous social drug such as alcohol or tobacco properly enjoyed for pleasure and relaxation. It is this classification system that
supports the moral certitude of drug warriors and underpins the conviction of Daryl Gates and others like him who are dedicated, they say, to the elimination of demon drugs. The unsaid part of what they say, however, seems to be that the eradication of illegal drugs is paramount, even at the cost of extermination of the *dope fiends* who take them.

**Social cleaning rituals.**

In a culture in which the long-standing religious lock onto the infinite has become badly corroded, leaving a residual unease speckled through with uncertainty, the importance of abiding by the law and adhering to the norms of work and social living is confirmed by the public sacrifice of certain individuals who are designated as deviant and punished by incarceration. Deviants are identified, singled out, and expelled from society in tormented convulsions brought on by abortive attempts on the part of authorities to set out ultimate standards of behavior. Social cleaning rituals that purge those who pose a moral threat are an important venue for the government to symbolically display its power to maintain a secure social order. Such signification services hegemony by culling the misfits from the herd.

When the response of the larger culture to certain activities is punitive or brutal, one can predict that people so mistreated will band together, and that an equally robust parallel subculture designed to transmit its own values will develop, together with the practical everyday skills required to evade detection and ways of understanding needed to survive the mainstream. It is the viciousness of the rejection by the law-abiding community that determines the extent to which people who use an illegal drug are driven underground into a shadow life of deception and the likelihood that they end up impoverished in a ghetto of isolation.

In an age when even enjoyment has been taken away, packaged, and marketed back as a commodity for consumption to those who have means, for some, taking a drug—any drug—may be the only route to access a little pleasure in life or assert a modicum of control without the interference or oversight of
others. Life may be more worthwhile when lived out in the necessary privacy of the shadow cast over illegal drug use by the underground economy.

Poem 7: Smug

For all their warm houses with convenient doors
And factory-new racing machines,
I've got something they'll never have;
Frosty crunch of blue snow and the first morning sun,
Winter-cold legs, red running nose,
And the strength I need to go on.

I look ahead with fresh eyes, no call to look back;
Nothing there but despair, lost chance.
Around every corner, fate waits frozen in place,
Drifts piled high, no choice but go on.
I look at these others, secure in their houses;
And what know they of life lived raw?

Carol Polych (1969)

Sin.

The use of certain drugs has been demonized by North American-EuroWestern cultures, cultures overwhelmingly characterized even to this point by a tradition based on the Christian ethos. Demons in Christian understandings are, at bottom, fallen angels, upstart emissaries of the Creator. Such angels were among the host of intermediaries whose purpose was to act in the material world to see to the implementation of an omnipotent but ethereal God's will. The initial biblical role of the Devil, the Accuser, who was to become the chief demon, was to function as an angelic crown prosecutor, testing humans and calling them to account for their behaviors. As Azazel, this entity receives scapegoats offered up by sinners in exchange for absolution. It was this same free-thinking fire spirit, known as Lucifer (bringer of light), while embodied as a serpent—the living symbol of wisdom—who shared the secret of knowledge with the first people, bringing them into the awareness of consciousness, although they were thrown out before they could learn the secret of immortality. The Old Tempter was
known to counsel people to renounce their duty in life, understood as the grateful living out of the conditions of their life according to a distant God’s will, even while suffering any noxious circumstances, in favor of exercising their earthly power to act in their own immediate best interest. This spirit, also called Satan, the Adversary, challenged even the Creator and was cast down for its trouble to rule over Anger in the otherworld.

Jesus, held to be the mortal incarnation, the embodied son, chip off the Old Block, avatar of an incomprehensible, omniscient, all-powerful, but insubstantial God, is said to have established his freedom from corporeal limits and transcended the particularity of time and matter through the very renunciation of the exercise of self-serving power. Jesus cleaved to his purpose on earth and set an example, while bearing the condition of his humanity and publicly suffering like a man the terms of the mortal penitence imposed on him by the authorities after his conviction in law as a criminal judged to be too dangerous to the Roman hegemony to live.

Aldo finds that ordinary people can also transcend difficulty in life and make progress in their development as humans, provided he can trigger their spiritual engagement:

When you speak to people about their spiritual beliefs, the therapeutic relationship rockets to a different dimension. . . . Spirituality’s an aspect of being human. I believe that every human being has a human spirit, in whatever frame of reference the individual has: I think that it’s important that it be acknowledged . . . and what behaviors that individual follows to try to let that aspect of his or her humanity grow.

If one’s innate purpose, as a creature with a part to play in the workings of the larger whole, is endowed together with one’s humanity, and given that all life is believed to be contingent on the pleasure of an all powerful Creator, sin can be understood as the betrayal of that God-given purpose to the pursuit of selfish comforts brought by power. Traditionally, people are cautioned to be wary of the dangers that accompany excess: pride, anger, envy, lust, gluttony, greed, and sloth. Material excess can come to define the meaning of the good life and the pursuit and acquisition can confer a sense of meaning and control, in lieu of faith
in an original purpose that resides over and above the individual and the society into which we are thrown at birth (Illich, 2005, p. 102).

John feels it is important that his patients engage with finding their purpose and fulfill their potential in life:

See this tree? What is its purpose?" He says, “To give shade.” I say, “No.” He says, “To grow.” I say, “No.” He’ll say, ”I don’t know.” I say, “It is; therefore, it is.” Nothing else; simple as that. . . . What is its purpose in life? To be, and that’s it; simple as that. So, “What is your purpose in life, translated from this?” “It’s to be.” “To be what?” “To be the best you can be—not to be what society tells you to be; not to be what the treatment facility says you have to be—it’s to be the best you can be.”

Historically, when an individual transgressed a social norm, he or she sinned against a person, and, when she or he faced that wronged person, the guilty party hoped for a chance to make amends for the injury and maybe gain forgiveness. With the criminalization of sin, the malefactor was shunted into the justice system and onto the mercy of a dozen uninvolved peers. The institutionalization of crime has flung individuals from the sphere of particularity, fit, place, contingency, conscience, understanding, remorse, amends, ultimate good, and grace, into the realm of generality, fairness, law, control, guilt, penalty, value, and judgment. Paralleling the systematization of health care, this institutionalization in law has been the harbinger of a move from being known as a person to being known as a type, from human being to human doing, from existence to instrumentality.

John believes that helping his patients recognize the facticity of their existence and place in the world brings them closer to understanding the inherent purpose that emanates from their essential humanity:

You get people to look at the intricacy of what they’re missing everyday in their life. There they are walking by the flowers, “Oh, flowers, okay.” “No. Look at them. Stare at them. Search them out. They are part of you, and you are part of them and the whole thing; and you have to take care of everything.” But nobody wants to look at that when we’re looking at drugs and alcohol. “By being stoned, you’re not taking the time to see the absolute beauty of the world. Everything’s a crisis. Hold back. Take the time. . . . What do you see? Peace, tranquility, part of the beauty and the joy that belongs to you. . . .” Nothing else in the world matters; the world disappears now here in nature. To what end? Why is it here, and what is the purpose? It’s here for you to enjoy and to respect and to help
Questions

Faced with such sobering results from my enquiry into the cultural roots of stigma in illegal drug use, I felt discouraged about the possibility of improving the situation for people who are affected by illegal drug use. I wondered if anything at all could be done to change such cut-throat social habits. I tended to believe at this point that it was stigma that resulted in the treatment given Anna—or not given her—that resulted in her death. I felt it was important to better understand how deviance is manufactured and maintained to better determine how to offset it. My ruminations about illegal drug use had taken a decidedly gloomy cast, punctuated by flashes of red tooth and well-manicured, dripping claw and shot through from above by flashes of the wake of the God-whose-name-we-dare-not-speak. I wondered how to best honor the sacrifices made by the professionals I had interviewed and the embodied sacrifices made of the thousands and thousands of people whose death or harm came to them from their use of a drug deemed illegal in this society. I also felt confused about where I might find guidance in structuring student experiences to help them learn how to actually be of help, in turn, to those who use an illegal drug.

Chapter VII begins with a discussion of how deviance is controlled through the agency of medicine and the law and the uses of labeling in upholding the social norm. The benefits and costs of the sick role are explored and treatment is exposed as a means to enlist the person living with an addiction in assuming their “proper” role in the production-consumption economy. The relationship of the industrialization, commoditization, and dehumanization of health care to crime, moral failure, and sin is further explored, as is the impact of anomie.
Breaking a phenomenon down into its component parts may be one means of enhancing one’s understanding, but unfortunately, vivisection fails to capture the essential dynamic quality of the phenomenon, the context within which it makes sense, and the interactions that characterize it. Models have no life of their own.

Pencil on graph paper (Polych, 2010)
CHAPTER VII
ADDITIONS AS DEFICIT

Deviance

As Anna’s friends grieved her passing, Ruby recalled one of Anna’s forays into treatment. The intake worker had voiced her opinion that, with Anna’s intelligence, she had the potential to finally make something of herself, maybe even as a social worker someday. Anna, never at a loss for long, reportedly swept the social worker with an appraising glance and leaned forward to return the compliment, “Your body’s not that bad; you’ve got some potential: Drop 40 pounds, work a bit on your strut, and, with the right clothes and some coaching, you might be able to get out on the corner and make some real money one day”!

Definition of Crime

Civil society is a complex construct of multiple rational and non-rational contested public spheres that are nested within and contained by one another, just as communities are set within national frameworks and associations within shared interests. Within society, sub-cultures develop based on subscription to common narratives that are often defined by interest, opportunity, location, and goals, and which are further conditioned by class, age, gender, ethnicity, and so on. Civil society is intensely occupied in repeatedly and painstakingly dividing the world into two parts: insiders and outsiders (Jacobs, 1996), us and them. It draws increasingly fine lines between citizen and enemy, in Canada separating respectable democratic taxpayers and hard workers from undesirable predators and unworthy slackers. It is at the interface of context and code, in the interaction between event and narrative that the interpretation of an action as a crime occurs.

A crime may be thought of as an act that offends the transcendent authority of society, antagonizing the powerful common, well-defined sentiments of society (Durkheim, cited in Zeitlin, 1981, p. 296). The discovery of crime brings together those of upright conscience and concentrates their anger in an expression that is felt to be widespread, but which can be traced to no one in particular (Durkheim, p. 297). Consensus within the society is created by social
institutions such as those that drive the designation of a behavior as criminal and the ensuing charges, arrests, convictions, and punishments. Punishment of crime is a venue in which the community affirms the validity of its rules, the vitality of its values, and safeguards its cohesion (see Clement’s flyers).

Max’s explanation for the attempts to control individuals who do not conform is highly rational, but it does not touch the underlying abuses resulting from systemic econo-structural faults, leaving them in a lightless vacuum:

When somebody is addicted; i.e., they’ve lost control, it’s particularly problematic. . . . When their use is compulsive and they’ve really lost control over it, people will do things to themselves and to others that they would not normally do. . . . You’ve got 10 people acting one way, and one person acting outside of the norm; who’s going to change? All ten to fit the one? They’re not going to change. . . . Treatment often then comes into play. The problem is that treatment doesn’t necessarily seem to be effective.

Common sense tells Canadians that any society to this point, to be stable, does need to set norms, distinguish deviance, classify it as to type, and make an effort to control those whose behavior does not conform (Illich, 1976, p.124) in hopes of containing those who cause injury or damage, with a stated goal of limiting the impact and preventing the spread of such deviance. Each culture defines deviancy for itself and creates its own particular response to atypical behaviors. People who behave oddly are perceived as potentially threatening until their startling behaviors are slotted into a recognized pigeonhole based on the formal identification of characteristic traits. Assigning a name and a role to the deviant enables society to efficiently manage misfits who are disturbing and to tame loose cannons that otherwise might be disruptive. Once the authorities name the spirit that underlies deviance, and have successfully labeled the person as either inappropriate or unacceptable, diseased or criminal, the abnormal behavior becomes more understandable and therefore less feared, more predictable, and more manageable. Once the troublesome behavior is interpreted within a customary framework and the meaning of it is communicated through language, social control of the deviant is within the grasp of the authorities.
Max is well aware of the pernicious influence of stigma and how received wisdom distorts social responses:

They [addictions] absolutely exist; there’s a desire, a need. The *War on Drugs* proves it. . . . There’s scepticism about providing substitution therapy. . . . The stigma of addiction creates distance, and the history of heroin as “that really bad drug” compromises acceptance. “You’re doing what? You’re giving a drug addict drugs? Oh I see; So now we’re going to let speeders speed on the highway. How does this make sense?”

Labeling serves as a type of shorthand that enables rapid communication with others to explain unsettling exceptional conduct. Such labels inform others about possible unruly behaviors and describe the prescribed way to relate to the person to limit the disruption. The mandate of the agent charged with intervening may derive from medical, religious, juridical, or military authority. Authority places the deviant within a particular framework of understanding and social custom, turning him or her from a subversive threat into a familiar character, someone who has a place, slotting him or her into position within the very social system which they threaten to disrupt. It is of note, however, that such trepidation typically targets isolated individuals and focuses attention on the unwelcome behavior of the poor. Even while manufactured carcinogens, exploitative corporations, industrial pollutants, contaminated water, and unsafe workplaces cause misery and claim the lives of many more Canadians than will ever be harmed by armed robbery or any other crime ascribed to poor people, the rich go free and *fêté* (Reiman, 2004). Interestingly, although poor people are arrested more often, in a survey across class strata, it was those of the middle-class who admitted to perpetrating 87 percent of the reported armed robberies (Reiman, p. 110).

**Social Norms**

The sense that our shared cultural and moral standards as Canadians is under siege is exacerbated by superficial and undiscerning media reportage of low level street violence that takes no account of context, together with a failure to problematize the consequences of systemic inequity. From a policy perspective, it is considerably easier to just follow along with scapegoating poor people (Newman, 1973) than it is to educate people about the less lurid but more
realistic long-term politico-social threats to their well-being. It is more complicated to explain the ins and outs of redistributive income-sharing schemes than it is to blame drug-marinated welfare cheats for the economic problems facing Canadians. Further, warehousing troublemakers is more likely to meet the approval of the elite than is reforming labor, corporate, tax, and international law to bring in fair taxation for business, good jobs to Canadians in low-income brackets, and reasonable means of subsistence for those who are not paid workers. Further, calling managers to account, criminalizing stockholders, and imprisoning heads of companies seldom, if ever, takes place in North American-EuroWestern society.

Max is aware of the uphill battle facing those who wish to persuade others of the legitimacy of an unpopular approach to the difficulties experienced by disempowered people. Max will fight for what he believes in, but his forte does seem to be that of behind-the-scenes tactics, where he takes a hard line, more so than in undertaking head-on conflict:

There is a role for heroin prescribing in a whole treatment system. We have a hard time selling methadone; I'm not so politically naïve to think that we'll go out there and sell heroin without a full understanding of it. . . . It is how we do things in life: real world political discussions. . . . Other people pay taxes for this: We have to respect them enough to explain the need for this. . . . Everybody claims the righteous moral high ground–on both sides. . . . There's no shortage of people who feel holier than thou. The harm-reduction side is not immune from that sensibility, and certainly the abstinence-oriented, anti-drug-using side is not immune from it. We're people. . . . We need politics to avoid having to take up spears. We have to be able to convince each other. . . . We're human beings. It's a political battle.

Driven by sensationalistic media coverage of violence against individuals, the level of fear of ordinary Canadians for their personal safety has escalated, despite the (largely unreported) global fall in violent crime taking place independently of policing efforts. Unaware that the likelihood of violence has actually fallen and worried about the possibility of the intrusion of disorderly behavior into their quiet spheres, many Canadians uncritically endorse calls such as that of Health Minister Tony Clement for harsher judicial penalties. Alfred Blumstein, criminologist at Carnegie Mellon University tartly observes: People
do not wish to be confused by the facts, but base their decisions on ideology (cited in Reiman, 2004, p. 28), such as that accompanying the systemic distortion which leads to *tough on crime* provisions.

Harry’s pragmatic advice about the address of the use of drugs is grounded in his experience and deviates significantly from the ideas of the Minister of Health. “Scare tactics don’t work; if they did, people wouldn’t smoke. Smoking is hard to give up, even though everyone knows how bad it is for you. . . . Education for users about the effects of drugs would be helpful.”

In a healthy community, the person offering help does so as a result of a spectrum of emotions which motivates them to take action to benefit the person cared for. In due time, he or she can look forward to reciprocity of caring from within the community, resulting in benefit to all parties (Shogan, 1988, p. 58). The ability of people to discern suffering and the need for care arises from internalized values that are based on what they pay attention to and what comes to count as important (Shogan, p. 81). In Canada, it is largely left up to the media to decide what is newsworthy and report on it, granting to the media the opportunity to *spin* the issues they select, tempering the understandings and response of the public. Innumerable cop shows currently foster unfavorable beliefs on the part of the general public about the motivations of illegal drug users, engender negative emotions, and compromise sympathy for people who use. Such negative representations lead directly to the extirpation of conscientious care for people caught up in illegal drug use (Shogan, p. 38). Discrimination blinds and narrows the onlooker’s range of perception, allowing moral failure to crowd close up behind (Shogan, p. 68).

John is willing to take whatever approach works to help his patients with their use of drugs so long as it is respectful of both parties:

It’s a matter of being able to talk one to one, as human being to human being. . . . Don’t treat me with deference like I’m a God, because I’m not. All I am is one human being who’s gone through something and is sharing it with someone else. Maybe my way works for you and maybe it doesn’t. Try it. If it doesn’t work, come back and tell me. We’ll change it, because I’m not stuck in a particular model.
Social intimidation rituals.

People identified as deviant may be thrust into an escalating series of crude but effective intimidation rituals designed to safeguard the status quo by promoting conformity and ending with removing the incorrigible. O'Day (1974) has identified two stages in such social intimidation rituals. The first, indirect intimidation, has two phases: a) nullification followed, if need be, by b) isolation. The second stage is direct intimidation, also characterized by two phases: a) defamation and b) expulsion. The failure of society to effectively provide for addictions as a mental health issue or even to take account of the ubiquitous impact of addictions on the physical health of sick people represents an enormous blind spot. Denial (nullification) does not make illegal drug use go away, but it does result in singling out of the individual user (isolation) who may be derogated as failing in some way, whereupon the person may be hospitalized or sent away for treatment for 3 or 4 weeks, exemplifying stage one. If the person continues to use the illegal drug, they may face legal charges in stage two that often result in branding as a criminal (defamation) and in removal from the home environment, through outright imprisonment or via neighborhood-avoidance requirements set by Probation (expulsion).

Max has witnessed the extreme response to illegal drug use and addictions, and is distressed by its origin and the suffering it brings:

I think that there are some kinds of behaviors and diseases that are acceptable; we have these notions around what acceptable diseases are and what are not. I think that [opinion] emerges from a lot of other prejudices and beliefs. . . . In relationship to drug use and the understanding of it, it’s thought of as a moral weakness; and it doesn’t get responded to in that [neutral] way, and people do suffer stigma and prejudice.

Organizational Society

Organizational society developed hand in hand with the entrenchment of the industrial revolution, nest mate of the capitalist economies of EuroWestern nations. Industry, drawing on the appropriation of natural resources, called for trained and compliant but low-wage and self-sustaining mobile labor pools overseen by centralized authorities, supported largely within nominally
democratic governments that promoted the myths of equal opportunity, self-
direction, and differential individual reward according to merit. Country folk
uprooted and displaced abroad or to urban centers by the privatization of
common property, industrial monoculture, and chattel labor had no grounds to
staunch the exploitation of the land. In North America, the dream evolved. The
image of the wrench wielded by the blue-collar worker and the ballpoint pen of
his white-collar manager took shape out of the clouds of dust shaken off the blue
denim of the iconic small farmer with his plough and the cowboy hat worn by the
rugged frontiersman following along the trails of painted savages. Dignified
white-coated professionals followed, trailing trains of carefully made-up
deferrantial pink-collar workers and striding with assurance, arm-in-arm together
with the black-robed, mortar-boarded professors who grant them legitimacy, into
the concrete castles built by their brother engineers. Scientific rationality
supported such institutions and helped to systematize a worldview that lauded
the ideals of free will, choice, human action, self-development, control, breeding
for the best, and survival of the fittest, strung together like beads on the Great
Chain of Being, all set within a well-ordered arena of monetized work that
featured predictability, efficiency, and productivity in the service of progress and
profit. Everyday life became problematic not so much for its unhappiness and

John suffers too, caught in the inner workings of reporting intricacies
overseen by authorities divorced from the field but attuned to the bottom line:

One of the agencies got something from the government that said, “We
need outcome measures or we’ll cut your finding off.” The director said,
“If patients come in, that’s an outcome measure.” “Not good enough. It
has to fit in this format.” It doesn’t. Anyone who’s dealt with severely
psychiatrically-involved people knows it doesn’t. If they come in and eat
and don’t throw the food against the wall, there’s an outcome measure.
We’ve trained them to do that. Funders need to stop restricting us by
ridiculous outcome measures. They don’t need to be so black and white.
Who suffers? Patients suffer.

Mad-bad dichotomy.

Contemporary medicine, hand-in-glove with the law and accessorized by
religion, stakes out the bounds of the social body. In the field of illegal drug use
at present, medicine faces challenges from the law, which as a complementary aspect of the hegemonic social system developed to deal with deviant behavior, vies for the authority to judge the fitness of a deviant. Penrose (1939), a eugenicist and psychiatrist, in an echo of observations made in the infamous *Malleus Maleficorum* of the 15th century, articulated the inverse reciprocal balloon-type relationship between prisons and psychiatric hospitals, an association that still holds true. As the psychiatric hospital population wanes, the number of criminalized inmates waxes: As the number of people hospitalized for psychiatric reasons rises, the population of prisoners falls. The proportion of people classed as deviant stays about the same, even while changing governments enact more or less humane legislation. Penrose’s observation is especially acute at this time, when, circumventing treatment, prison is the preferred destination for the disposal of many people diagnosed with a mental disorder (Gunn, 2000) or addiction. About 50 percent of people seeking treatment for an addiction were found to have a mental health problem; about 20 percent of those seeking help from mental health services also live with an addiction (Canadian Centre on Substance Abuse, 2009). Many psychiatrists feel justified in turning away people who they label *untreatable*, often those who are hard to like or who are burdened with very complex conditions. By default, then the criminal justice system is called in to contain the misfit. Gunn notes that current punitive responses to health problems reflect the political climate and play into negative stereotypes, while also playing out fear of the imagined dangerousness of people diagnosed with an unaddressed mental health problem, itself often complicated by the use of illegal substances.

Aldo has recognized that psychiatry has a lot to learn from addictions about helping very troubled patients control their disturbing behavior:

The addiction model is something that’s effective for patients that really don’t do well elsewhere. . . . *Personality Disorders* do wonderfully in addictions treatment: You never hear of cutting [slitting wrists] or heads through windows. . . . Patients don’t act out in addictions treatment because the structure is so tight and there’s so much accountability.

The medicalization of deviance brings a specific set of considerations to the fore. Once medicine has diagnosed the sufferer with a disease, the social
state of illness enters. Many workers note the gap between the diagnosable symptoms that constitute disease and the patient's experience of an illness that troubles them. When the deviant is diagnosed with a disease, he or she is eligible to take up the *sick role* (Parsons, cited in People, 2007) that, in an industrial milieu, legitimizes his or her exceptional behavior and confers a hiatus in the expectation of conformity to other ordinary roles. Together with the official designation as sick, the person is guaranteed certain privileges. He or she is absolved by the physician from moral blame for the sickness, has a right to be taken care of, and while sick, is exempted from usual social obligations such as work (People).

**Medicine men.**

Medicine men of old, engaged in healing, were expert in the art of distinguishing evil spirits from good. Currently, in North American-EuroWestern society, the medicine man still commands the skill of discerning bad from good, even though he has been relocated to a hospital and has altered his regalia. His costume is now a spanking white lab coat accessorized by a plain paper mask. His healing totem has shrunk to a stark black stethoscope that grants him the power to hear what others cannot. His medicine pouch has grown into an entire arsenal. The time-honored moral enterprise of separating *Good from Evil* indelibly colors the work of physicians as the timeless vices: sloth, gluttony, intemperance, and fornication are recast as medical risk factors: sedentary lifestyle, obesity, addictions, and risky sex (Gunderman, 2000).

Physicians further make it their business to detect the unsuspected presence of disease, distinguish sickness from health, and declare the legitimacy or factitiousness of illness. Despite the apparent certainty of physicians, misdiagnoses and misunderstandings litter the annals of medicine. Until the turn of the 19th century, physicians ascribed hysteria to an unsettled uterus wandering about the body, and only slowly came to realize that women were simply really, really fed up. Pellagra gave rise in the US to the myth of the lazy, corn-fed Southerner before it was identified in the late 1930’s as a vitamin B deficiency state but not before entire hospitals full of people were warehoused with the
4-D’s: diarrhea, dermatitis, dementia, and death. Sufferers with Lyme Disease were written off as delusional in the 1970’s until clinicians realized this type of arthritic joint pain was caused by *borreliosis*, a tick-borne spirochetal infection. In the 2000’s, doctors discounted illnesses that they did not yet understand, such as the Gulf War Syndrome, Chronic Fatigue Syndrome, and Fibromyalgia, often accusing patients of malingering. Similarly, addiction may be cast as a glitch in the person’s hierarchy of values or a mistake in the priority of the beliefs that are supposed to fit people to deal appropriately with the present day North American-EuroWestern econo-social environment. As such, it may not be unconditionally accepted as a disease (Campbell, 2007).

Doug tracks much of the suffering due to addictions to the inability of society to develop an appropriate frame of reference to understand addictions, and therefore to its failure to respond responsibly to addictions:

Underneath all of this [blaming], lies philosophy, ideology, beliefs about addiction, and moral judgment at least on the part of health professionals, governments, and society. They’re [users] weak people . . . . But it’s okay for elected government officials to drink themselves silly with scotch all night long at resorts in northern Ontario: That’s perfectly fine [chuckles].

Medicine men of olden days identified demons, but never claimed the power to invent new ones. As medicine was professionalized, physicians “discovered” new scientific categories of disease that were developed and defined to describe unproductive behaviors. These new diagnoses then were available to accommodate those displaying problematic behaviors, who became newly diagnosed as *sick*. People found to be symptomatic were accordingly inducted into the newly vacant sick roles to which they were assigned. In 1989, psychiatrists producing the *Diagnostic and Statistical Manual of Mental Disorders (DSMIII-R)* handbook introduced one such previously unnoticed disease, *Self-Defeating Personality*, as a new, potentially remunerative clinical entity calling for medical treatment. This diagnosis was subsequently dropped only due to the strong public outcry, fed by the fear that such a label would simply add to the burden of women by pathologizing motherhood and unpaid work within the home.
Social Control

Those individuals not able to keep pace with the socio-industrial change sweeping them out of the 19th century presented with problems: nerves, neurasthenia, neuroses, depression, dissipation, alcoholism, and addiction. Religion initially responded to these expressions of distress, fielding a social gospel and diagnosing the problem as poverty, unemployment, and rootlessness. Since the treatment required social change that elites found unacceptable, religion was soon elbowed out of the picture (Abbott, 1989, p. 293). Given that the conditions of work were not going to change, individual workers and their families must. As the 20th century rolled along, psychiatrists and psychologists rushed in, Johnny-on-the-spot, to help (control) the disaffected. Medicine, with its focus on the diseased individual took on the adjustment of the individual to the realities of the daily grind, organizational routine, supervisory discipline, and the compromises workers must make with their integrity (Abbott, p. 148).

Aldo has witnessed patients who have paradoxically drawn on spiritual strength for healing when science could offer no more, forcing him to acknowledge the limits of any scientific explanation for the power of religion:

Religion and science are separated in our culture, but in other cultures, they are very closely intertwined. I have seen people that were hopeless and helpless get better, and they didn’t get better because of the science; they get better for someone else, for something else. . . . People say, “I can’t do this myself; I need another power”: Change happens. . . .

Students are asked. . . , “What’s your evidence for human spirituality? What’s the evidence that prayer works? What’s the evidence that God exists?” These are questions that men and women have been asking since time began; they’re still important questions in terms of the healing of the human being.

The sick role.

Medicine initiates the deviant into the social presentation of sickness and coaches him or her in how to appropriately inhabit the sick role. It is the opinion of Talcott Parsons (1951, cited in Rosenfeld, 2006) that success in inhabiting the sick role is based on the display or enactment of understandings common in North American-EuroWestern society. Patients are expected to regard their
illness as undesirable, search out professional help to combat disease, and make an effort to get over their condition. Once the deviant assumes the role of a patient, she or he de facto agrees to submit to the health authorities and follow orders intended to bring about a cure. She or he implicitly agrees to give up his or her own analysis of the problem and abandon his or her own attempts to solve it. The physician’s prescription is based on more than medical expertise, bearing also the full weight of moral authority. Following the doctor’s orders is not just good sense; it is the right thing to do to effect a cure. And a successful cure for the deviance can be seen in the patient’s newfound ability to be seen to conform to social expectations.

Max finds that people who live with an addiction can present with extreme difficulty that surfaces over and over again:

It’s a struggle. People have difficulties and try to sort them out. It’s a struggle back and forth. I consider it the highest compliment, to struggle with people—I don’t mean struggle against them—to agree to struggle with someone through the problems that they’re having. . . . Who doesn’t have problems in life? . . . You don’t have all the answers, and they don’t have all the answers. Together, as human beings, you struggle to overcome some of the difficulties of living.

Medicalization of human responses to social problems such as inequitable income distribution and unequal life chances has resulted in the exemption of a few sick individuals from soul-deadening participation in consumer-producer culture. In a dysfunctional social system such as that established in Canada, in which many workers find their aspirations disappointed, patients are anxious to gain the benefits of medical dispensation, as they are sensitive to the negative loading of labels, that might otherwise be attached to them for not taking part in the workforce by the criminal justice, labor, or political systems. In exchange for the income support that frees them from daily drudgery, those who come forward for diagnosis must then demonstrate that they are following the doctor’s orders. On balance, it may still be considerably less onerous to take a pill for every ill from the doctor than it is to take part in the social struggle for control over the tools and rewards of production.
Max works with the patient’s goals, and provides for patients to come back under his care if things don’t work out as the patient hopes:

Patients have their own ideas. . . . We . . . try to work with them, “Okay, if that's your goal—to taper off—here are ways of doing that.” We make it so that, if they do taper off and subsequently get back into difficulty with using, they’re not going to be too proud to go back to methadone. We have an open door policy.

Aggravating the reduction in hospital beds in progress since the 1990’s and the increasing difficulty in securing health services, the Emergency Department has retreated from the almshouse role so important to dependent poor populations, increasingly becoming no more than a gateway limiting access by marginalized people to the universal health care that, in theory, is available. Unfortunately, it is well known that health care providers embody the same prejudices as the rest of society, and actively discriminate based on income, ethnicity, race, age, gender, size, class, social standing, living arrangements, family disengagement, and involvement with the authorities, against people they judge to be the undeserving sick, often denying them access to care (Lincoln, 2006).

In his work, Max has had to make a special effort to address the aftermath of the prejudicial treatment sustained by many illegal drug users:

Some people don’t want treatment because they feel they are not worthy of treatment. Their prior experiences and their life experience has been to be demeaned, shamed, blamed. . . . In a caring, therapeutic relationship, they may be able to see a different side of themselves. . . . Then the worker can pose the possibility that they [the patient] may actually want treatment. It’s a delicate thing. . . . Are you influencing them in spite of themselves, or are you trying to overcome some of the prior injurious experiences?

**Medicine and the status quo.**

Such a patchy emergency bandaid approach by physicians to the hemorrhage caused by deadly social ills is congruent with the role cast for doctors as managers and brokers of social control. Many physicians abdicate the responsibility of accurately diagnosing the human face of alienation that often peeks though a curtain of depression or lurks under physical illness. In this, many physicians are complicit with maintaining the smooth function of present-
day dehumanizing social systems that depend on the construction of scarcity no matter what the human cost. In this manner, the purview of physicians has begun to leak into economics, flow into law, and leach into religion. The doctor certifies disease, excuses the sick individual from normal duties, and oversees the patient’s claim for insurance or other income security, thereby becoming a de facto warden of the patient. The physician then assumes the robes of the priest, propagating the storyline that the patient is an innocent victim of biological mechanisms, rather than a disrespected, disempowered, discouraged, disheartened, disillusioned, or dispirited citizen (Illich, 1976, p. 129) suffering from anomie and caught in the meatgrinder that is North American-EuroWestern consumer culture. It is the minor anesthesia wrought by the small comforts on offer by the physician that stands between the patient and effective address of the underlying social illness. It is the medicalization of patients’ complaints that enables them to do nothing effective to bring about change, so setting at naught any political alliances which might otherwise generate a real solution to suffering (Illich, p. 128).

Doug finds the control inherent in the role of the physician irritating and contrary to professional ideals and the best interest of the patient:

The line between policing and doctoring sometimes is indistinguishable. It’s all about control. Every principle in health care upholds the rejection of paternalism: informed consent, patients making their own decisions. None of that is upheld in addiction treatment. It’s a doctor who has to decide on behalf of the patient all the time. Other reasonable clinicians who understand this stuff can’t believe the control and how crazy it is.

Medical diagnosis is not without cost. It intensifies stress, defines incapacity, and imposes inactivity. It foregrounds the possibility of non-recovery, focuses apprehension on uncertainty, and thrusts well-being into dependency on future medical findings. It makes the person into an invalid. Taken together, these side effects of diagnosis all lead to a loss of autonomy, self-definition, and
self-efficacy. As much as a diagnosis serves to protect patients, it also isolates them. When the physician diagnoses a condition, the patient enters into a social state arising out of the doctor’s presumably authoritative evaluation (Illich, 1976, p. 97). Once recovered, most sickness leaves the patient’s reputation intact, with no lingering taint of disorderly conduct or other deviance; however, the case may be different in some conditions such as addictions.

Harry worries about the concept of cure in the treatment of addiction to the use of an illegal drug:

Even when somebody abstains from drugs, they still might be involved in illegal activity . . . because that’s what they know. They still have to live, and how do they do that? How do they survive living the same lifestyle, without the negativity that surrounds the use of drugs? . . . How do you re-habilitate someone who’s never been habilitated?

In certain conditions, particularly those identified as psychological in origin, the impact of the illness may irreversibly degrade the identity of the patient, resulting in their being defamed and branded forever with a permanent stigma. The patient may become an outsider, cast out of the mainstream (as his or her illness may be regarded as possibly contagious). People may be labeled by their illness (schizophrenic), by its cure (insulin-dependent diabetic), or as one beyond repair (terminal palliative). People may be labeled by their attempt to secure what is regarded as inappropriate help from the health care system (goldbricker) or medical treatment (drug-seeker). Such labeling depends upon assessment of the known facts, rating of the validity of the illness, and a review that invokes the professional’s core values (Clarkson, 2002, p. 9). Even in the best-case scenario, although the medical label does offer some protection from punishment on the one hand; on the other, it demands judgment from others, inflicts the rigors of treatment which may be interminable and even deadly, invites the imposition of instruction, and marks him or her out for potential discrimination. All these interventions are intended for the (professionally-presumed) benefit of the patient.

Max distinguishes between dependency that is contained, and addiction, which describes compulsive or destructive use of a substance that may bring the behavior of the user to the attention of the authorities:
There are some people who are able to manage their dependency, but they’re rare. Most people don’t. A lot of people talk about it. A lot of people aspire to it. There are day-traders [investing in the stock market] who make a huge whack of money, and there are a lot of people aspiring to that and losing their shirts. We tend to focus on the few who are successful and forget the rest. . . . The same thing happens in drug use. “Oh, we’ll be able to manage this [light, sing-song voice], and we’ll keep that under control,” but I’ve got to tell you that there are very, very, very few people who are able to do that. . . . Dependency is a pretty rare phenomenon. For most people, it [dependency] falls into compulsive use in spite of adverse consequences.

The objectives of treating addictions are seldom confined to simply eliminating the illicit use of illegal drugs. As a rule, it is the clinician who decides what change is needed, while patients are expected to admit their inability to control their own behavior, acquiesce to a treatment regime, and accept whatever grim reality is considered appropriate. In treatment, an attempt generally is made by the professional to engage the identified addict in a conventional, work-a-day life, which in actuality will often consign the reformed addict to a life of low pay, anemic prestige, limited access to the goods of an affluent society, and never-ending insecurity. Other attitudes and behaviors which the clinician finds to be pathological, on the basis of his own opinion and society’s prejudices, will also be targeted for change, including values relating to work, income generation, family responsibilities, friendships, and use of leisure time. Should such patients benefit from their treatment and meet the expectation of conformity, the contribution they subsequently make is often little valued or respected (Newman, 1973).

Aldo discusses how important it is for treatment to take account of the goals of the patient and for care to be provided in such a way that respect for the patient is clear:

It’s a matter of readiness to change. If there’s somebody who’s not ready to change . . . and a professional who can’t establish empathy, then the patient’s memory of that relationship’s going to be negative: It’s going to be blaming. It’s going to be, “I didn’t like so-and-so. He was no good for me, so I stayed drunk.” There’s going to be blaming; that’s the memory of that encounter.
Social Use of Stigma

Medicine and Normalcy

Each culture has its own unique perception of disease, and thus its own particular understandings of illness, characterized by distinctive hygienic masks and specific prescribed healing rituals. At this time, society looks to science and medicine for “rational” accounts of the causes of phenomena that affect people’s health (Frost, Bradley, Levitas, Smith, & Garcia, 2007). It is to physicians, represented as objective and supposedly morally-neutral medical experts, clad in a spotless patina of truth and speaking in the name of Health, that society turns for final judgment about normalcy and the legitimacy of disease. (The irony of disease practitioners commenting on health is completely lost in the fever for the final say.) Just as they claim the right to cure by dosing patients with potentially poisonous remedies and radiation or by wielding the knife upon which hangs the patient’s life, physicians enthusiastically declaim: assessing, diagnosing, labeling, and treating aberrant behaviors which are considered to be atypical, confusing, disturbing, subversive, or potentially threatening.

Doug’s analysis gives the lie to much of the pathologizing that goes on in addictions:

Part of my duty is to teach people about what drugs do, without making any moral judgment about whether they should be using it or not. I tell them the story of William Halstead, who was considered the father of North American surgery... He was a morphine or opium addict for 30 years. I tell this story to give the lesson that, for narcotics at least, if one has a clean, steady supply, he or she can be a normal, productive, responsible, totally functioning citizen.

Doctors and Illegal Drug Use

The only area of human life where medicine has been unsuccessful in laying down the law is in the regulation of illegal drug use, which sees the legal system refusing to cede any turf to medicine. Historically in the US, the law, in service to business interests, contested head to head with medicine over the use of opiates, stimulants, hallucinogens, and marijuana. Physicians fought the law, and the law won (Curtis, 1965). In the 1920’s, 35,000 American physicians were indicted and many served time (Libby, 2004) for supposedly violating a narrow
legalistic interpretation of an obscure clause of the Harrison Narcotics Act of 1917, a piece of US legislation slipped through channels under the skirts of the tax department. It stated that narcotics may only be prescribed in the course of professional practice, which the law, overstepping itself, unilaterally decided did not include managing addictions, while clearly, in the opinion of physicians, it did. It was as a direct result of the enforcement of this law that the underground trade in opiates and other illegalized drugs blasted loose.

Doug bitterly resents and takes exception to the policing duties expected of physicians:

I hate urine samples [drug tests]; they're just forms of control. . . . Our patients all tell us when they use drugs. . . . If the professional is straightforward, very clear what she or he is prepared to do or can't do, and just engages the person on a very frank level. They tell us, and we don't punish them. . . . Doctors are not the police to give people drug tests.

Desperate users, confronted by the locked doors of their persecuted doctors, resorted to the burgeoning black market for their drug supply, leading the government in turn to escalate interdiction. The shadow economy, only too pleased to meet this new need, surged, fertilized by sky-high profits. Although this ill-considered decision was overturned shortly after, in Linder v. the United States (1925), the prosecution of so many physicians left the profession leery of prescribing any narcotic whatsoever. As a result, undermedication has been the tragic lot for many suffering patients living out their last days. Further, physicians, even to the present-day, break out in a severe allergic reaction to any sniff of government interference with professional practice.
Poem 8: Help Me Please...

I know you know (nothing)
I know you have your standards
I know you know how things really are
I know you know where you stand.

Please look down on me and smile
Please don't walk away from me (worm)
Please reach out and take me in
Please let me have what I need.

You have everything
You have an education, you have a job
You have an income, a car, a home (stars)
You have a wife, a family, hope.

I don't mean to be rude
I don't mean to smell, or curse, or despair
I don't mean to yell or strike out
I don't mean you harm (die).

Please, oh how I wish to please (good girl)
Please see the clean middle-class in me
Please see the top of the class of Grade 2 in me
Please see the influential person I can be.

Pleas in the night, in the cold
Pleas for my friend, my love, my heart (frozen ice)
Pleas for my child, more to me than life
Pleas for my useless, worthless, worn-out self.

Please see me for who I am, who I can be
Please grant me a place on this earth
Please allow me the dignity with which we are born (dust)
Please treat me as you would want to be.

I know you're important, respected
I know you're tired and you work hard
I know you pay taxes and shower and go to church and consume
I know you're better than me (eat dirt).

You have the power here (privilege)
You have the knowledge I need (blind)
You have the skill to fix me up (neglect)
You have the strength to say no (criminal).

Please remember we share the same air (sad)
Please remember your job depends upon me (mad)
Please remember I know your daughter, your husband (bad)
Please remember you need me (help me: help you).

Help me. Please...

Carol Polych (1993)
Doug has had experience with the oversight of practice by poorly prepared government monitors who still endeavour to control narcotic prescription:

The authorities wanted to talk to us about morphine and percocets. “That’s fine; but we’d like to have the patients there.” Our principle is that, if patients are being talked about, they ought to be there...whether it’s case management meetings, team meetings, whatever. They should be there. That’s about the last thing they [the authorities] expected. “We don’t think it’d be appropriate.” “Appropriate! [outraged tone] We’ve got nothing to hide...” “We just don’t think it’d be quite proper.” So we worked out an arrangement. “We just want you to hear the story of one of the patients...” This woman was the type of person that grabs your heart as she speaks. She was quite disabled at that time and she later died. These auditors... were completely dead silent, just crushed. They felt awkward being there for this purpose...

We had another outside clinician, reputable, confirming that this is the right thing to do. That’s always a smart thing to do when you are using these drugs. Keep photocopies of every prescription. Part of the game is being defensive and anticipating things, so we copied prescriptions, stuck them in the patient’s record. So we had all that... We never heard from them again...

They were good people. I don’t think they were trying to intimidate. They were good people—they were just doing their job. I do my job; they’ve got to do their jobs. They are accountable to their supervisors and to people higher up.

Religion and Health Care

Currently, religion, the crown of society, has a bi-cornuate form honoring a pantheon over which rules the great god, Mammon. Perched insouciantly on one horn is the physician, the new medicine man serving the new God of Science. Here, spirit is mediated by neurotransmitters, soul has been exorcised by mind, and heaven has translocated into space. Drugs, ever of use in ritual, have not been demythologized, but remythologized (DeGrandpre, 2007). Religion is traced out in the mapping of the genome that brings the power to give life. It is reflected in plans to pave over even the surface of Mars, planet devoted to the God of War. Religious fundamentalism hawks its wares from its vantage point atop the other horn, taking its lesson from the good servant who, given the master’s money in trust, doubled it (Bible, Matt 25: 14-30). The fundamentalist, chatting incessantly to her or his kindly handyman and devoted best friend, God,
seeks blow-by-blow inside advice on the minutiae of the day. From the promise of transcendence through physical suffering (Sontag, 2003, p. 99) to the pledge of reward in the next world, in inverse proportion to earthly deprivation, religion, one way or another, is first and foremost society’s original painkiller, our most effective tranquilizer, much as Marx explained.

John encourages his patients to claim their place now in this earthly universe of God’s and to lean on their God:

“I’m so ashamed.” We took a towel and put it on the floor. “Wash,” because you wash before prayer. “Pray. Then come back.” He came in, “I feel so clean. Now I can talk.” He still comes. He’s still being seen. He’s still clean. He came and he prayed here: Prayed. Any place is a place of prayer.

Pray: you need to pray. . . . Have a God, whether the God be an oak tree or whatever, because that will give you the 12-steps. That will give you the Higher Power. . . . That’s what you need to anchor onto. That’s your God. That’s for you to hold onto so you can stay clean and sober. . . . If you really want to know what you’re made of, forget about yourself. Look at everything around you, because you are part of all of this. An eagle in flight soaring to the heavens; that’s my God, and that will carry me though.

The side effects of industrial health care exert a powerful noxious iatrogenic effect on North American-EuroWestern culture. Rather than supplicate to the priest or royal as in the past, it is now to the physician, positioned as the final authority in matters of life and death, that the patient applies for salvation (or at least, for salvage). Medicine claims the patient even when the diagnosis is uncertain, therapy is experimental, the etiology unknown, the prognosis unfavorable, and the outcome unhappy (Illich, 1976). The more attention is devoted to the technical component of treatment, the greater the symbolic weight of the professional, and the more expansive the social influence of medicine. One of the prominent features of medicine is that of healing through ceremonies: magic. Health professionals have hijacked the hope of the sick person, dangling the possibility of a magic bullet (Ehrlich, cited in Brandt 1910/1987) to cure the human condition (Malraux, 1933/1970), and interposing policy and procedure where mythic ritual once held sway. The attempt to work a medical miracle is an heroic hedge against failure, since miracles may only be
hoped for and cannot, by definition, be expected. No matter which way it works out, live or die, the miracle worker is covered in glory.

Harry’s own experience of cure was diametrically opposite to the socio-technological solutions common in health care:

Treatment was not exactly what I needed; love was what I needed, and to be my brother’s keeper. . . . It’s selfish isn’t it, if we don’t care about other people. . . . Aren’t we a community? Aren’t we our brothers’ keepers? Karma. . . . I’m supposed to be here [working in addictions]. I don’t know why, I just have this feeling.

Decontextualization of Illness

In the past, the recognition of failure on the part of another carried with it, appended as a codicil, a responsibility to help. Now Canadians can turn away from the one in need in good conscience. Society relegates the failing person to the care of a professional paid to attend, a tidy means to dispense with the responsibility to care. Once a professional is called in, the person’s condition is diagnosed, he or she is categorized and labeled, and is slotted into a clinical pathway where plans to provide for them are drawn up based on the needs likely to arise given their condition. Providers rely for guidance and justification on the four threadbare, frayed, faded, and overstretched principles of North American-EuroWestern ethics: autonomy, beneficence, non-maleficence, and justice (Kuczewski, 2007), which largely ignore the person’s ties to family, position in the community, and responsibilities within society. Health becomes simply another commodity up for sale rather than an experience, illness is decontextualized as disease, and death presents itself as an enemy to be defeated. Unfortunately, the humanity that surfaces in caring relationships is often shucked off too, together with the responsibility.

Max has serious concerns about the appropriateness of the consumer / client model of health care and the disengaged professional style that leaves the responsibility for treatment vested in the patient:

If you just offer treatment in an information mode and say, “Okay, we’ve got this treatment here, and we’ve got this other treatment. Which would you like [loudly and brusquely]?” It’s totally onto you as a consumer. It presupposes that you’re totally informed and are totally capable of making that informed decision. However, that’s not the case when somebody’s
neural processing function is impaired by the use of chemicals. How are they going to make a decision? They might also be impaired by prior experiences, the subtlety, extent, duration of which we don’t know. . . . Resilience and the ability to manage stress seemingly is laid down in the very early years in what may be an unchangeable way. . . . Abuse below the age of 2 years causes damage that we’re only beginning to understand; stress produced at those times affects the ability to process information later on. . . . The folks that we see here often have been subjected to those kinds of things in ways that we can’t completely uncover. We are far from absolutely sure of the effect of that history on their ability to process information about choices when they are presented with a straight informational model.

The expectation that Canadians sequester in institutions those among us who break out in illness results in demoralization of the family and the entire community in turn. Relying entirely and unquestioningly on medical technology to save the failing person bereaves ordinary people of even the vocabulary to describe what they have lost. Caught up in the felt necessity for income generation, the larger community is stripped of the ability to care and left inarticulate, unable even to explain why it matters that we personally care in place for those less able among us. Service provision displaces charity, probability eclipses faith, risk management settles in the lees of hope, preservation of life supersedes redemption, and every death must be scientifically accounted for irrespective of purpose. The health care industry admits no vestige of tolerance, acceptance, or inclusion (Illich, 1976, p. 37), ceding all to the ideals of fair treatment, efficiency, and standardization.

Max recognizes the limits imposed on professionals by the industrial model of health care:

There are limits to how much we can all give to other people. . . . In our society, we have translated caring work into a monetary relationship: a transaction, not necessarily between patient and professional, but between the patient, the state, and the paid professional. . . . Well, “There are limits to pay. You don’t buy all of my time; you don’t buy my life. This is not the priesthood [aggressively]. . . .” Because we’re not priests, we’re not going to give the people coming here unconditional regard; we give them conditional regard, and that’s in a good-case scenario. Sometimes, it’s just, “Here are the conditions: You pick. Get out of here.”

Once inside the institution, the person who is anxious is medicated, the person who flails out is contained, the person who cries out is isolated, and his or
her pain is anesthetized in an effort to moderate disruption. Unfortunately and coincidentally with such treatment of the human condition, the connection of the individual to the human race then too is amputated, and the meaning of the ensuing pain is cored out and incinerated, leaving nothing but a residue of suffering. Contact restricted to polite visiting under observation during certain hours, those continuing on their daily rounds outside in the community fall short of the experience of essential proximate human mutuality, as the person in need is abandoned to professionals and patient profiles. Institutionalized, invalids are split from their contexts, shorn of their unique identities, stripped of their essential dignity, and their capacity is starved out, while those most dear to them, who have abdicated the responsibility to care, careen unwittingly into sin (Illich, 2005, p. 56).

Aldo recognizes the poverty of the type of care that can be typically offered within an institution:

Demoralization: to be alienated, to be bewildered, to be despairing. . . . That’s the place patients are when they walk in here. . . . I look at that, and I say, “How can an hour a week help this human being?” It can’t: It has to be much more profound, much more meaningful, much more consistent, much more rewarding than an hour of a therapeutic interaction with a professional when you’re truly demoralized as a human, as a human soul, as a human spirit.

**Dehumanization within health care**

Although the widespread transition of caring in Canada away from communities into health care institutions overwhelmingly staffed by women, has limited the exploitation of women in some ways to some degree, it has done so only imperfectly and at a rapacious price. Set within a faulty institutional structure, dedicated more to the financial expectations and convenience of high-level professionals than to the needs of the people who depend for care upon the system, role-defined relationships, nominally designed to benefit the patient through the provision of activities said to be caring, are generally motivated by limited self-interest. Accordingly, such transactions often lack the compassion that is called forth in more diffuse and complex caring relationships.
Max has sympathy for workers struggling along in stressful jobs on the front lines, but feels that consideration for the worker has to be balanced with the needs of patients:

Low staff turnover is positively correlated with improved outcomes. . . . There’s a lot of changeover of staff that isn’t illness related. . . . There’s a balance between supporting the worker and making that person available to the patients. You can’t have a worker on leave for half the year and still expect a close and supportive therapeutic relationship: It takes time. . . . Teamwork, in which there’s some basic awareness of what the patient’s issues are and some kind of a relationship helps, but intimate relationships aren’t infinitely substitutable. Another professional might be able to help with a crisis, but they’re not going to be able to help with the subtleties of an issue that you’ve been working on over a period of time. . . . The worker’s not there when the patients need them. . . . It’s a balance between staff receiving the support they need and staff providing services to patients. The two elements need to be attended to.

Professionals occupying a role take part in dehumanizing their patients and are themselves dehumanized by their work, as the meaning of their action is uncoupled from personal meaning and motivation. Their identity is separate from the social relations with which they are involved while in their role, because those actions are not socially integrated (Habermas, 1987, p. 321, 386). There is no call to negotiate personal understandings or even to seek agreement on a daily course of action, because the conduct of workers is so closely prescribed by the official regulations of both the organization and profession.
Poem 9: Intra(veno)us

Main line, heart line, life line, IV line
Here I lie tangled in plastic spaghetti
So carefully tended by my caretaker.
My head is down and my soul heavy.
Grey miasma rocks me like a tide.
A cold despair rises up like bile.
I drift, and still I’m anchored to reality
But on my cheek the breath of my unmaker.
Though called to go, I’m not yet ready
Tied to life only by IV line.

Tied down in body, but not in mind
Do you see this tattered husk, now so empty,
Full of memories: love, sorrow, and anger,
Fear, grief, regret, missed apology.
Never go back; all things have their time.

Little nurse, where do you find that smile?
Do you have hope I’ll find comfort, rest, ease, peace?
The surprise of life being over
At the end. Grant us all dignity,
Forgiveness, and someone to be kind.

Doctor, look deep into my dark eyes;
Your own bright eyes look back secretly.
I know your turn is coming too, if later.
You and I are both securely tied
IV line, life line, heart line, main line.

Carol Polych (2000)

Max has given careful thought to the risks of suicide or other harm to patients, given the limits to caring structured into the industrial system of health care that professionals work within:

When I’m at the end of the road, when I decide my life is not worth living for whatever reason, I want the option to be able to take my life away. It is a glorious freedom in some ways; I’d go the glorious distance because I think it might be stepping across a barrier. You make that decision.

In our society, a whole set of religious beliefs mitigate or try to prevent that; they say, “You shouldn’t do that. You shouldn’t do that”: It’s a bad thing to kill yourself. You can probably trace the history back to something of the work ethic. However, right now it is a traditional set of beliefs that people don’t even question; they don’t even think it
through. . . . Because somebody decides that they’re going to take their life, that’s not necessarily a bad decision. I would argue that it is my duty to preserve the possibility of that decision [to die]. I’d like to inform it as much as I can and I’d like to influence it as much as I can, but I will be damned if I will take it away from them. . . .

I am not their life. We can go as far as we possibly can; we should push ourselves to try and understand what that distance is. But that doesn’t mean that I am going to . . . take care of a patient 24 or 36 hours a day. No, that is not what I am going to do. I’m sorry; I’ve already established that there are limits to my unconditional caring. People set different limits, and they have a right to. You’re buying people’s time and their energy; you’re not buying their life.

Anomie and Purpose

Without faith in a purpose loftier than that of consumption and production alone, the individual may well experience *anomie* (Durkheim, 1893/1951, p. 255; May, 1991, p. 21). A person-with-no-name may be unsure of his or her place, uncertain about where she or he belongs, unclear about what he or she stands for, and confused about who matters. Anomie is a condition in which she or he feels lost without a purpose, helpless, disconnected beyond reach, cast adrift out of the mainstream of humanity on an undifferentiated sea of uselessness, swamped by loneliness, and in danger of drowning in despair. It is in the company of others to whom one is close, as the everyday small routine caring rituals are enacted, that one’s sense of larger purpose takes root, and there, stepping back, one may recognize the power of such rituals to fuel belief in a higher purpose and in a predictable universe. Acting *as if* makes it so—to a point.

Aldo tartly observes: “Psychiatry says that you think yourself into healthy acting: Addictions says you act yourself into healthy thinking. . . . Even though psychiatrists ignore addictions when they’re dealing with psychiatry, an addictions worker can’t ignore psychiatry when they’re dealing with addictions.”

Questions

At this point, I still was puzzled by what factors had resulted in the development of a health care system so emaciated and pernicious that Anna’s death was no more than business as usual. It did seem to me that major change in the way professionals understand health and addiction is needed. It was also clear that crafting any such approach will require a careful reexamination of the
systems within which health care is delivered. And I wondered what a better
direction might be so that more effective ways to address addictions become
commonplace.

Chapter VIII outlines some potential answers to the questions I had been
asking about how Anna’s death made sense. Causal network analysis is
introduced as a potential way to more fully understand the complexity of
addictions. This perspective brings a robust four-fold focus that expands the
analysis from the concentration on agent and host alone to include that of vector
and environment. The role of metaphor in structuring professional responses to
illness is reviewed as well as the place of schooling in perpetuating an unhealthy
dynamic. The dissatisfaction experienced by many clinicians is explored and
potential guidance to enhance professional practice is gleaned from Benner and
Archaeology

The fossilized imprint of expectation, habit, and custom often defines the appreciation of a phenomenon. Even when the phenomenon of interest is clearly deficient, even if it is no more than a shell of the ideal, within that reality, even when premised on deficit, beauty and something of value may still reside.

Acrylic on paper (Polych, 2010)
CHAPTER VIII
IN MY OPINION: ANSWERS
Addictions as a Deficit

Illegal drug use has been variously thought of as a risky behavior, a bad habit, a maladaptive coping mechanism, an expression of an immature personality, a failing in mental health, a toxic state, a disease, or a criminal offense (Hughes, 1989). The numerous labels applied to those who use an illegal drug reflect the disparate frameworks from which professionals work. It is the understanding of the many professionals who deal with illegal drug use that determines their approach. Nevertheless, generally, all such analyses cluster around the presumed deficits of the person and obscure personal strengths (Kramer & Buck, 1997). All such analyses have in common the effect of diminishing the humanity of the labeled person through distancing techniques that are incorporated into the regulation of communication by professionals working towards the goal of social control. Such analyses further have the effect of absolving the professional from censure.

Neal has worked with patients who were expected by the professionals from whom they sought help to meet certain standards as a precondition to be eligible for help:

I don’t find the philosophy of the professionals practicing that old-school fundamentalist style to be really so different from my own. . . . Most of them come, at least initially, from a place of caring, of wanting the world to be better, of wanting the patient to be healthy, or wanting the patient to be “like me.” This is not necessarily bad; but it probably is if you want your patient to emulate you or to be like you. . . . When a patient says, “I can’t work this way,” and leaves; the professional says, “Well, you haven’t hit bottom.” To me, that’s a terrible judgment. . . . There’s this whole thing of power. . . . That concept really says, “I can’t work with you unless you do it my way, unless you do it on my terms.” I think they’re coming from a good place, but it’s misguided. . . . It’s a mistake; they’re [patients] to be like themselves, but healthier.

Blame the Sick

Health care in Canada is set within a culture that features subscription to an ideology of free choice in which people are theoretically the authors of their own intentions and purportedly determine the course of their own lives. Even
public health, with its population-based analysis, often casts the responsibility for
disease onto individual sufferers who supposedly have failed in their duty to take
reasonable steps to safeguard their health. Such blame takes no account of
circumstance or social and contextual factors, while it valorizes self-efficacy, free
will, discipline, self-control, prudence, and adherence to a healthy lifestyle as
essential to maintain good health (Lawton, Ahman, Peel & Hallowell, 2007).

Diseases, such as addiction is said to be, are understood by many
professionals though metaphors (Sontag, 1990), particularly those that refer to
computer symbology, drawing on the output of biotransmitters and the input to
bioreceptors within the individual. Biomilitary images are also common, bringing
weakness, strategy, and blame to the forefront. Popular discussion about illness
often relies on analogies to malevolent and aggressive terrorism or deception by
a fifth column lying in wait for an opportunity to strike. Sometimes, comparison is
drawn between disease and the burgeoning blight of contagion or the havoc
wrought by overwhelming and unpredictable storms (Hanne & Hawken, 2007).

Doug explains his understanding of the negative view of illegal drug users
held by many professionals who may fear for their own safety:

There’s a general distrust on the part of professionals, especially
physicians; and most don’t want to deal with addicts. They don’t trust
them and feel that addicts try to take them for drugs. Locally, many of the
AIDS physicians want nothing to do with addicts who are HIV-infected
because of security worries. There are far more risky occupations [than in
health care]: One hundred and ten farmers die each year in Canada.
One has to view it that way: What are the standards that are
acceptable...? That doesn’t mean though that they should be reckless.

Implicit in such a picture are meshed assumptions, about the value of life
and the social value of the individual that revolve around work, industry, and
diligence, Calvinist behavioral orientations instrumental in demonstrating
worthiness. Income occupies a key place in the consideration of social value,
reflecting, as it does, the financial disparities that support North American-
EuroWestern consumer culture.

Aldo too is aware of the negative opinions of illegal drug users held by
many professionals, particularly physicians, and the poor treatment that ensues:
Addicts are what’re called *stimulus augmenters*. . . . They enlarge, blow up, and feel more, in terms of stimuli. So, you read body language . . . very vigilantly, very vigilantly. When people say, “I felt demeaned by the doctor,” right on; absolutely. Not every doctor, but in normal interaction with physicians, addicts have not been well dealt with. . . . The current attitude among mainline (mainline!) mainstream physicians . . . is, “Addicts are useless, helpless, hopeless people who never get better anyway; they just cause a lot of demands, a lot of problems.”

**Caring and Professional Behavior**

Noddings (1986) sets out three components to caring: the apprehension and sense of immediacy of another’s reality, a commitment to action on the behalf of the other, and reaching out and following through according to ability (p. 16): feeling, thought, and action. Since a person cannot be everywhere and personally see to everyone and everything, it is essential that the person who cares about others contributes to a caring community set within a moral environment which features the good treatment of others. It is also critical that such caring people take an active part in moving the social system toward greater fairness, and that they, themselves, develop the ability to manage social change just as well as skills they use to help individuals (Shogan, 1988, pp. 20, 33, 76). Such movement in the area of illegal drug use may be managed through reframing drug use as a transnational industrial epidemic\(^{15}\). At this time, global address of illegal drug use is almost entirely focused on prohibition targeting the visible *agent* believed to be to blame for producing a drug or selling it, with secondary attention devoted to reducing the exposure of the individual *host*, followed by faint tertiary interventions said to ameliorate the susceptibility of the individual host, and no attention whatsoever paid to the social context underpinning the use of illegal drugs.

Neal urges front-line agencies to become more aware of unmet needs related to addictions within the communities they supposedly serve, and to step up responsibly:

You have to know what you mean by community. You really have to want to be open to the range of people who are out there in the community, be welcoming to them, be interested in them, be curious, and be respectful. . . . The manager of one street-focused agency . . . told
me. . . , “We don’t have any patients here who use drugs.” I thought, “Wow! Who is your community?” “The needle exchange around the corner has people coming in to pick up needles.” “That’s run by public health; it’s quite separate.” “Who is your public. . . ?” I think that agency is in denial, but sentiently in denial; they know they’re denying. This is not, “Oh, I never noticed”; it’s, “I don’t want to see”: There’s a difference, and I think it’s deliberate. . . . I sure would like to see that agency opened up . . . but if you bring in one staff, that person is going to be a token and probably have no end of trouble, unless that person is a strong personality and has a little bit of support.

Causal Network Analysis

Causal network analysis foregrounds the equal importance of vector and environment in the phenomenon of illness, redirecting attention away from a narrow focus on just the agent and the host. The vectors produced by poorly-crafted laws which designate certain drugs as illegal, prohibition, and the entrenchment of exploitation by big business on the one hand and the off-the-books economy on the other drive illegal drug use as surely as any individual host vulnerability. Environmental realities, such as life in a selfish and impoverished yet relatively affluent culture, which engineers scarcity of even the necessities of life and then ignores the subsequent distress, impact with the same weight as any characteristics of the stereotypical plush drug runners trolling on the corners or the hackneyed vision of emaciated buyers creeping around dark back alleys. Causal network analysis forces attention back upstream toward the root cause of the damage and outward toward the social context that supports it (Jahiel & Babor, 2007), giving professionals additional ways to understand illegal drug use and opens up a range of other options and legitimates alternative approaches to help people who use an illegal drug.

John’s analysis of addictions takes account of the hijacking of purpose into the economics of mass production and consumerism, which leaves many people feeling desperate:

“Why are you using. . . ?” “Don’t like myself. . . . Can’t get ahead. Want everything that life has to offer, but don’t have the money to do it with. . . .” Society has told you that you are what you own. . . . Cut out of the system a little. Say, “No. I don’t need this.” You don’t need the big apartments; you don’t need this; you don’t need that. All you need is a roof over your
head, food in your belly, someone who loves you. That’s all you need in life; everything else is extra.

**Domination and the Professions**

Professional schools represent themselves as imparting objective knowledge intended to benefit patients, but more correctly, they can be understood to teach such that graduates will flawlessly continue to support the interests of the dominant professional group. Domination and power represent a silent *leitmotif* in school life, expressed in the replication of class, gender, age, race, and other cultural biases, generally unacknowledged (Giroux, 1983). When they enter into professional practice, graduates are likely to replicate in turn the oppression they have experienced in school.

Aldo reflects on the impact of the unhealthy dynamics that are perpetuated in professional schooling:

If you take the alcohol out of alcohol-ism, you’re left with the -ism—I-S-M—which stands for “I, Self, and Me”. The problem with me, in my life, was I kept turning up; I couldn’t stand me: So I needed to change me. And the only way I’d learned was to use chemicals. . . . Now, I’ve learned other ways that people who come from healthy backgrounds, healthy environments, learn intuitively. . . . It wasn’t modelled to me at home. It certainly wasn’t modelled to me in my education; the more professionals I was around, the less healthy behavior I was seeing. . . . My career was like a drug. I was in control. I was part of the hierarchy: I knew my place; people knew who I was, and exactly what I could do and what I couldn’t do. I had all kinds of power. I was in charge. When there wasn’t chaos, I could create it.

Kalish and Kalish (1987) review some of the cultural assumptions held about health care in North America. Physicians, overwhelmingly men, are still seen as the leaders in the provision of scientific bio-psycho-social health services ostensibly designed to benefit the recipients, while other workers, primarily women, are relegated to devalued technical or helping roles. Even when health care is provided as a joint effort, as a rule it is the physician who captains the multidisciplinary team. Progress in health care, directed by biomedical research and carried forward by technological advances, is believed to reflect the drive of these physicians to better society. Health care is portrayed as improving every day, as illustrated by increasing longevity—if not enhanced
quality of life—and further progress is expected to yield only better health care (Kalish & Kalish, 1987, p. 182).

John’s approach is based on a philosophy of respect and shared learning that is profoundly at odds with common elitist approaches:

I support a cognitive-behavioral model. . . . It’s not a woman’s model, it’s not a men’s model—it’s a human model. We are all equal in the eyes of God. Whatever the belief system is, let’s try to play it out equal. Because you’re Black or you’re Asian or whatever else, you’re no different. Culturally, you have different things going for you. I can embrace some of your culture, and you embrace some of my culture. . . . You’re no better than me: I’m no better than you.

Professional Identity

Formal education is identified as the primary force in professional socialization and the development of a professional identity. Socialization into a professional identity is an interactive process in which the professional selects a role and, within those limits, decides how they will undertake their work. Identity, an integrated concept of self, draws upon the views of society, together with the person’s understandings of those views, and develops through conflict and the clarifying responses of one’s reference group. The work setting modifies the self-perception of the professional, together with role set relations with colleagues, the chosen reference group, and the resolution of role expectations with role realities. The occupational image of the professional is also based on perceived job worth, perceived competency, and job satisfaction. The identity of professionals who work in the field of addictions and illegal drug use is further complicated by contamination related to the nature and extent of their work with deviant or taboo behavior, association with pariahs, and deemphasis of the scientific canon of health care (Galatzer-Levy & Galatzer-Levy, 2007).

John ruminates about who he is as a professional, and ends by making his decision to base his identity mainly on competency as measured by patient feedback:

Do I want to be a pen to paper pusher? Do I want to sit back and fill out forms and checklists, and CAGE’s and DAST’s [pen and paper screening tests for alcohol and drug use]? Do I want to do all that stuff? No. I want to sit and say, “Why do you do what you do?” Try to understand the human condition a bit more. Have a few laughs along the way, have a
few tears along the way. Walk the journey, and when they’re done, they walk away. Hopefully they’re better off, and that’s it. If I touch a life, I’ve done something.

Many elite professionals are gifted with a strong sense of entitlement, ignoring the reality that entry into their professions is at the pleasure of society itself, a body from whom, upon graduation, new professionals often race pell-mell to distance themselves, following the example of their betters (Abbott, 1989, p. 118). Such professionals seem to disregard the fact that it is society as a whole that endorses the selection of the individuals who enter into training in a profession. It is society that grants students the leisure to study with the best in the field, and gives them access to the accumulated wisdom of the culture as concentrated in their teachers. It is society that decides who to entrust with the work that will mobilize help for the most vulnerable among us in their time of need. It is society that cedes to professionals the respect accorded those with insider knowledge of important and difficult work. And it is society that imparts the privileges that reflect such status. In return, any member of the society, liked or disliked, strong or weak, old or young, user or non-user, who then needs the benefit of that knowledge should, by rights, have equal access to such professionals. Everyone should receive comparable service from providers, if only in recognition of the heavy price paid by the community to support these same professionals during their training and in return for the disproportionate recompense accorded the graduate professional practitioner.

Doug thinks about the extreme reaction he has seen in response to people who try to have input into their own addictions treatment:

There is absolute outrage from a few doctors: The notion of the patient having any say in their course of treatment is anathema to them. “The doctor should be deciding! You can’t trust these people anyway—manipulative, dishonest.” Most people I know don’t even want to be on methadone after a while. Most patients who are stabilized don’t escalate. . . . They get tired of it.

Some professionals, caught up in the opportunity to generate a high income, especially when that income is tied to fee-for-service (piece-work), cherry-pick through patients who now must often make application for services.
wish to be held back by looking after difficult, complicated, unpleasant, or otherwise challenging patients. Many health care providers have seemingly forgotten that the privilege they enjoy has its roots in the deprivation and difficulty they scorn.

John acknowledges that he may be seen as a rebel by some of his professional colleagues, but feels that he is better able than some of those same colleagues to actually help people who use an illegal drug with their problems:

Let me start right off and say that my way of doing things is probably different from most [laughs]. . . . I may be a rebel, and I may be outspoken, and I may not be shut down completely on problems in the treatment of people who use illegal drugs. . . . I don’t know what you’d call me; I could be what you might call a parent of drug treatment. . . . I’m not like some who make their living in drug treatment; I’m not like those people. What I am, is somebody who’s got a way of talking to people. I talk to them, and they listen.

**Professional ethics.**

In tandem with government defunding of health-related social activities, development and testing of pharmaceuticals has devolved onto for-profit drug manufacturers. Up to 35 percent of pharmaceutical revenue is devoted to marketing, which includes gifts given to physicians in the hope that they will then prescribe the drugs on offer (Cohen-Kohler & Esmail, 2007). No matter what the gift: samples, lunches, sports tickets, ski suits, television sets, study cruises, or trips to tropical resorts, it is accompanied by the tacit expectation of reciprocal considerate behavior. Concomitant with the restricted role of government in monitoring drugs and with the skyrocketing growth in the drugs industry, has come corruption of the credibility of medical science as seen in fabricated, falsified, and deceptive research results. The corrosion of confidence in medicine as a healing enterprise (Egnew, 2005) over the first decade of the new millennium has resulted in an effort to develop new codes of ethics for health care providers and more grounded approaches to training.

John walks the talk. He has undertaken a searching inventory of his own ethics, and refuses career advancement if the price is that of compromised patient care:
I’m happy where I am. I don’t want to be a big shot. As a professional, I don’t fit in to the schematic with all my foibles. I don’t want to fit in to the schematic. I’m still here [in the field of addictions]; but I’m on the outside, criticizing the inside: That’s the worst position they could be in—they [the authorities] may try to co-opt outspoken people, but front-line people may not be interested. People on the street know where they get good treatment. . . . Let me deal with people. Take the people away from me, and I’ll wither. I’m doing what I want to do.

I don’t want to go any further. I don’t need it. Some people need it: Some people don’t. I’m mature. I’m happy. . . . I don’t want to climb; some people just have that ambition—I don’t fault them for it. Conscience-wise, they aren’t in my spiritual realm. They don’t live with what I live with; therefore, they do not feel the same way that I feel. That’s okay. . . . That’s the way they’ve got to play out their lives; I’ve got to play mine out differently. Mine means standing on a line and saying, “I’m not walking past that line,” and if someone else tells me, “You have to,” I say, “No, I don’t. Push me, and I’ll fight back; leave me alone, and I’ll be fine.” That’s the way I do it, and I’m very at peace with it.

**Professional training.**

Public scrutiny and censure of the increasing intrusion by business into medicine, together with jostling from other health professions, has resulted in the reassessment by medicine of its fiduciary responsibilities for the care of patients and the health of the public. Increasing cynicism and hostility on the part of the public has forced some leaders in medicine to take another look at the monetary-consumer ethic that has come to the fore in medicine. Since the mid-90’s, the concept of *professionalism*, itself, has come under scrutiny (Rees & Knight, 2007), with a resulting redefinition that focuses on responding to the health needs of society, sustaining the interests and welfare of patients, quality in practice, and credibility in knowledge development.

Neal emphasizes how important it is that students are engaged in articulating their own philosophy of helping and that they are taught to conduct critical and ethical analyses in the field and within the workplace:

The area of addiction is rife with mythology. They [students] are sent to agencies that are not properly vetted; the school doesn’t have a real knowledge of how the [agency] people are working. No one is checking on these things. . . . Someone who is in the know has to be able to decide when to say, “No,” to certain physicians, and “No,” to certain agencies. For example, if they send a student to a private methadone clinic, what are they learning? Have they been prepared? Are their eyes
sufficiently opened before they go in there, to think critically? Do they have the value piece in place? The philosophical piece? Do they have the ethical grounding? It is critical: critical.

Important elements of professionalism that have been identified include: service, duty, altruism, excellence, respect, honor, integrity, accountability, (Tsai, Lin, Harasym, & Violato, 2007), and empathy (Newton, Barber, Clardy, Cleveland, & Sullivan, 2008). Teachers recognize the need to move toward professional standards themselves, submitting a set of responsibilities for education that includes cultural proficiency in clinical care, a respectful and sensitive focus on patient needs that transcends the self interest of the professional, support of colleagues, and commitment to the broader social goals of the profession (Walsh, 2007).

Poem 10: Professional
Put your hand here in mine.
I'll take you safely there
To where you've never been,
I can show you how
To have a better life.

Stand tall, raise up your head.
Eyes gaze right into mine.
I've made the trip before
I'm the one who knows.
Just come along with me.

Are you looking behind?
Why do you ask of me
Am I sure, do I know
The right way to be?
You know you can trust me.

I learned all about this
I went to school, took notes.
I'm certified.
I know what's needed in life.
I understand
How best to think things through.
Come do as I say.
(I need you too.)

Carol Polych (2007)
Aldo identifies the time-sensitive nature of training in addictions. He stresses the need for techniques to cultivate self-awareness on the part of students, sensitize students to cultural and social variation, and ensure students display respect for individuals who cope differently with adversity. He also feels that students need training in maintaining their own value set despite indifferent or hostile conditions of work.

By the time they get into 3rd year, students are getting into the work experience: They are there when the drunks come in. They are there when the drug-seeking behavior is taking place, and a negative stereotype is entrenched. Then they’re placed with a clinician with that negative stereotype, and it’s reinforced, reinforced, reinforced. The clinician might react unconsciously from his or her own vulnerability, see him or her self in addicts and shy away from them. . . . The clinician brings their bias in and that impacts on the student profoundly, so the student goes along. . . .

Training [in addictions] in 2nd year results in knowledge that is acute, interviewing skills that are far better, and an attitude that is much more positive. . . . It’s the next generation of professionals that will benefit from changes. . . . With those already practicing, we have to be a broken record.

Teachers also call upon graduates for simple kindness, compassion, honesty, morality, right action, and intellectual rigor, even in the face of competing demands in their work (Huddle, 2005). Students identify accountability to and respect for patients as key characteristics of professional conduct, together with integrity and prudence. In recognition of the limits to practice imposed by inadequate social systems (Jones, Avant, Davis, Saultz, & Lyons, 2004), some professions have also forwarded social justice as a critical area of work (Kuczewski, 2007), and call on practitioners to design suitable systems.

Harry has made a conscious decision to practice in the way that he has assessed as best for the patient, even if it runs counter current:

I like the rational-emotive approach. . . . What I do, I do from my heart. I believe in more of a *tough-love*, direct approach; and in this day and age, *tough-love* is not in vogue. . . . Sometimes, it takes me into tough spots. . . . If you want to help somebody to see how addictions affect not only them but others—how they’re selfish—you have to challenge, not bad thinking, but *poor-me*. I try to give what I see an individual needs, as
opposed to what he may want. They might not like to hear something, but maybe they need to, and they may need help to see that difference.

**Discrimination in health care.**

Gostin and Webber (1998) sounded the alarm about the pernicious discrimination in health care against those infected by HIV. Even though the courts have ruled that health care professionals have a legal duty to treat people infected by HIV (Gostin & Webber), professionals are still members of society, and so subscribe to the same stereotypes and enact class-based bias just as anyone else does. Patients who live chaotic lives or who are otherwise distasteful to professionals, such as those who are seen to be poor, who are believed to carry contagious infections, or who have been branded as drug-seeking or users of illegal drugs, may be deterred from seeking health care or social services by subtle techniques of discrimination. Such barriers may include rigid appointment times; copayments and penalties; long waiting lists for acceptance into a practice; class-drenched and unfriendly waiting rooms; inappropriate comportment, dress, or diction of staff; and punctilious, disrespectful, or abusive communication from health care workers toward difficult patients.

Neal identifies stigma within the health care setting as a major barrier to people seeking care related to an addiction:

It’s hard [for a patient] to get past the barriers to getting help. Agencies aren’t permeable. Clinics in hospitals need to be more friendly. Staff have to listen to the patient and provide services in a more respectful manner. . . . It’s unpleasant to be served by someone who’s holding their nose and looking the other way when they hand you something, even if it’s a package of clean fits [syringes] that you desperately need: It’s demeaning. . . .

Whether they use drugs or not, full medical and health service has to be given to people. . . . Legislation might help. . . . There’s a need there for education, but there’s also a part for management. . . . If staff and agencies had to do it, they’d do it, even with some reluctance. . . . The most difficult thing you do is to address people’s attitudes and values, because, the chances are, you’re not going to change them. . . . You’ve got to work to help staff see the way that their present attitudes and values (as different though they are from mine) can help them do the work that must be done. . . . That’s a tricky thing, because it means a lot of work on reframing.
Anomie of Professionals

Health care professionals are, by and large, trained in specific curative approaches, said to be based on dispassionate scientific observation and objective data collection, enabling them to provide services in an impartial and non-judgmental manner. However, paralleling the isolation of suffering patients in bureaucratized, corporatized, and desensitized institutions, health care providers, too, have suffered depersonalization and moral erosion. With the impoverishment and hollowing out of interpersonal relationships that attends confinement to closely circumscribed or simple technical roles, clinicians often merely preside over pain from which meaning has been eviscerated (Kuczewski, 2007).

Aldo is concerned about graduates of professional schools who end up cynical and depressed as they confront the realities of professional limits:

They feel that their altruistic ideas at the front door will never be met at the back door. . . . Healthy graduates know their own limits, recognize that they’re agents of change, and don’t take too much responsibility: a) for people getting sick, or b) for getting them better. . . . Professionals who are healthy really don’t care if an addict uses or not: They can be empathetic and will look at choices. Those who are sick will look to the patients for validation and thanks. They may violate boundaries or over-invest, get caught up in enabling and writing prescriptions, wanting people to be happy all the time, and wanting people to like them all the time. They may’ve come from homes where the message was, “We’ll love you if you’re perfect”; but you can never be perfect: we’re human beings. . . . If you’re looking to your patients for your validation as a human being, look out! You’re in big trouble because, eventually, they’re going to let you down. They’re going to let you down because they’re human.

Health care workers may experience distress rooted in feelings of helplessness, anxiety, depression, a sense of personal failure, inadequacy, frustration, anger, guilt (Jackson et al., 2005), shame (Huddle, 2005), vulnerability, and loneliness, particularly in the care of those with an unresponsive or chronic deteriorating terminal illness. Health care workers often do not recognize such emotions. When such uncomfortable feelings surface, clinicians often suppress or ignore them, or acknowledge discomfort just long enough to rationalize (Coulehan, 2005) and dismiss it, thereby making it even harder to cope with the stress of demanding work.
Aldo points out that the work of professionals is stressful in many ways, and they themselves may also turn to an illegal drug for relief:

Drug use can be understood as normal in many ways. The medical professions tend to be the same as the general public in terms of drugs and alcohol difficulty. . . . Eight percent [of doctors] admit a past or current difficulty with alcohol or drugs. Eight percent: It’s a lot, but no greater than the general public. The use by medical people of licit versus illicit drugs is far higher because they have access to the candy store. Very few MDs use street drugs. They don’t need to buy junk on the street. They can get champagne in the form of demerol, morphine, or fentanyl. They can get it very easily, as opposed to having to buy street junk.

Professional Advocacy

Professional colleges, responsible for regulating the professions, now voice the expectation that practitioners undertake systemic advocacy on the behalf of patients as an ordinary standard of practice. Yet the role of social advocate is in no way compatible with the old style of practice where the professional behaves as an agent of social control. Advocating for measures that result in less harm to patients who remain immersed in marginalized subcultures may, in turn, expose the professional to risk. It is unlikely that the powers-that-be will welcome the exposure by professionals of the origins of health problems that are entrenched in the very structure and substance of society. Conscientious professionals actually may be regarded themselves as harmful or even dangerous by others who are invested in maintaining the social system from which they benefit and which enables the elite to dominate social decisions and control rewards and wealth: Those in control know which way the wind blows.

Doug’s work has been shaped in part by the impact of stigma, that excludes those who live with an addiction from the fora in which decisions that will affect their lives are made. It is Doug’s opinion that those affected by the problem being discussed have a right to be present, and practice shows that better quality decisions are made when all parties affected are included in the process. Doug has noticed that in professional circles, he’s in a real minority:
Someone like me has to play it a bit on the inside. There’s no other choice actually; there is no outside political force. At least with HIV/AIDS, refugees, or police brutality, there are outside political forces that pressure the state or regulatory agencies; that doesn’t exist for addicts. So there’s no choice but to go into this crazy, time-consuming process to try and be at least a voice for addicts who aren’t there [in decision-making fora], because they [the authorities] don’t have addicts there. They should be there, but they’re not there. (That is classic professional paternalism to tell you the truth, but there’s no other way around it. Who can go and organize addicts?). . . . I try to come to some accommodation with the authorities, but part of playing inside the system is the risk of compromising too much.

Caring and Professionalism

Caring is crucial to establishing a therapeutic relationship. Benner and Wrubel (1989) report that patients feel dehumanized, devalued, angry, and fearful when health care is hurried and distant, or when staff are seen as being there only to get a job done (p. 5). The importance of establishing an effective caring relationship is particularly evident when one considers that many people who use an illegal drug are beset by multiple problems. Many struggle with poor physical health, social difficulty, trauma, and personality problems. German researchers found that 55 percent of opiate users seeking help in Hamburg in 1998 had a diagnosable mental disorder (Krausz, Degkwitz, Kuhne, & Verthein, 1998). Even though the burden of need has been identified as weighing particularly heavily upon illegal drug users, many report that they sense that their health care and social service workers do not care about them.

John pleads for health care and social service workers to move beyond simple perfunctory professionalism to make real human connections in responsible and meaningful ways with patients:

Don’t be dead from the heart up. We breed it [engagement] out of them [students]. We do it with physicians, we do it with lawyers, we do it with social workers; we breed it out of them. In my own profession, it was, "Don't become emotionally involved. Don’t engage. Set limitations, boundaries: boundaries all over the place. Three feet of personal space. . . ." “No, no!” If somebody’s dying for affection, dying for that hug that will make their day and make it safe, give it to them.
Kinds of Caring

In reflecting on what theory bases might provide guidance in my search to understand help-seeking / helping in illegal drug use, I turned to The Theory of the Primacy of Caring as developed by Benner and Wrubel (1989). They developed a robust model of the primacy of caring as it applies to the nursing profession that calls for culturally-competent particularized approaches to care for individuals or communities set within a well-developed understanding of how common conditions affect people. One of the key precepts of this model is that of “meeting patients where they are,” such that outreach to a suffering person, just as they are, by the professional is legitimated and promoted as a normal part of ordinary care. Validation of the person’s experience by the professional together with respect for the goals of the patient and appreciation of the person’s concerns are fundamental to helping the person being cared for to actualize.

Benner and Wrubel (1989) identify five kinds of caring: a) being with the person in an engaged manner; b) doing for the person by providing assistance, support, and comfort, c) knowing the uniqueness to the patient of loss, challenge, satisfaction, or triumph; d) enabling healing, and e) maintaining the belief that a person can actualize (p. 5). Benner and Wrubel support the view that caring is a cultural strength, a complement to the ethic of responsibility. Responsibility is based upon a sense of membership in a common humanity that necessarily competes and shares, consumes and produces, loves and loses, and suffers and glories. It is this sense of membership that fosters in people a sense of meaning, concern, purpose, commitment, and aspiration that leads to the exercise of skill. In direct contrast to the North American-EuroWestern cultural myth that presents autonomy as the hallmark of maturity and health, Benner and Wrubel regard caring and interdependence as the goal of human development (p. 368). They analyze the ethics of justice and rights as necessary—but not sufficient—to human well-being, noting that a more robust ethic of relatedness, care, and responsibility, which leads to trust and a focus on possibility, is needed for the evolution of a healthy society.
John bases his work on an ethic of relatedness and sharing, and is irritated by clinical efforts to label the dynamics that underlie feelings and so contain and nullify them:

Some professionals are dead from the heart up. They die from the heart up; little by little, it’s bred out of them. Professionally, we distance. Transference: I love it. I love transference. What is *transference*? It is interaction between two human beings. If I talk to you, I have transference: It’s a *fait accompli*. . . . Let it go. Let it go. Don’t talk about transference and counter-transference. Your patient tells you something and cries and you become emotional: There’s counter-transference. It’s okay to be emotional. It’s okay to laugh. It’s okay to cry. It’s okay to be angry at what happened to your patient. It’s okay for your patient to be angry about what happened to you. That’s okay. That’s the bonding process. When you bond, the trust builds. When the trust builds, you let more out.

**Harm Reduction**

While government rhetoric fronts the ever-so-fine moral goal of abstinence from illegal drugs for Canadians, cooler heads in practice acknowledge harm reduction as a workable approach here and now to the safer use of illegal drugs, which in time may lead toward abstinence. An outreach worker remarked, “It is hard to encourage abstinence when the patient has died of overdose or infection in the meantime.” In the harm reduction framework, the professional is positioned as an *ally* of the patient, and together they strategize to practically reduce the harm to the person who is using. As the alliance matures, a common pattern of social problems that affects many others may become evident over and above any individual pathology (Waitzkin, 1998), leading to the social advocacy role recommended for professionals by their Colleges.

Doug has drawn his own conclusions about the effectiveness of different ways of caring for people who use an illegal drug:

The 12-step abstinence program should be available for those who are addicted and want to be rid of all drugs. . . . But people should not be compelled to take part in it . . . and it should not be held up as somehow more acceptable or necessarily better than other approaches. . . . If people want to stop all drugs, that’s a legitimate objective, and a health care professional should help them. If they don’t want to stop all drugs, if they want to stop only part, that’s also a legitimate objective and they also should be assisted with that, not punished for it. . . . Abstinence is not the only measure of success. . . .
Care and Possibility

*Reality*, for Benner and Wrubel (1989), is a source of possibility, and not just a reflection of deficits in relation to pre-specified ideals. The possibility stance allows the helper to see clearly the field of actual potential and constraint inherent in the specific situation, rather than focusing on pre-conceived standards and ideals (Benner & Wrubel, p. 395). There are three key questions to guide the work of the professional who wishes to help the person who is using an illegal drug (Benner & Wrubel, p. 397): What can be done now, in the meantime, before the ideal is realized? Is the end in sight the most worthy? And, is there another way to achieve the same end? Caring professionals know the trajectory and range of possibilities within a condition, and attempt to understand the illness experience from the perspective of the patient. Benner and Wrubel consider professional caring work, well done, as a metaphor for intimacy (p. 393). Caring professionals are there to hear the secrets born of vulnerability. Professional care at its best is not competitive, manipulative, or efficiency-based, but reflects loving concern.

Neal reflects on the meaning of behavior that some would call manipulative and, like Tyl Ulenspiegel (de Coster, 1918), holds up a mirror to professionals:

Professionals manipulate: Users manipulate—they have to survive. They’re dealing with a professional who manipulates, and there’s a belief that, “You fight fire with fire.” Someone’s manipulating you: You manipulate back. . . . The patient’s trying to survive under awful conditions. The professional is working, getting paid to do a job. Manipulating for the professional is a way of maintaining power, of keeping their position of privilege; They’re surviving too. In a way, they’re not all that different, except professionals are getting paid to survive. The other people [users] aren’t. For the person on the street, survival is life and death: For the person who’s a professional, it may be a matter of prestige. A minor loss for a person on the street is major: For a professional, a minor loss may not be that major; a professional can get another job.

Care and concern.

Benner and Wrubel (1989) maintain that caring is a primary human orientation. It enables a differentiated world of meaningful distinctions where
some things matter more than others, and it maps out possibilities as people review their choices and decide how acceptable they are (p. 1). When people care about someone or something, they are rendered vulnerable, creating a personal concern that may call for action. The specific relational qualities of caring enable the professional to enter into a situation through concern and then to recognize which aspects are relevant in the context of the person they are caring for.

Harry points out that people make the best choices, as they understand them, from the options they see open to them, given their abilities and opportunities:

> It is their best thinking that’s got them there, not their worst thinking. . . . It gets to the point in someone’s life when the addiction is no longer helpful. They’re not living—just the opposite—they don’t face life. . . . Addiction stops living. . . . I’ve said, “This is the worst place you could possibly be, but it’s also the best place for you right now. You have come to the point where you had to come for help. You have come to the point where your life has become unmanageable, and you’re busy dying; you need to start living. . . .” An alcoholic or drug addict doesn’t understand that. They’ve survived, but that person really doesn’t know how to live. . . . They get them mixed up: survival and living. Addiction’s not incurable. It’s just a matter of learning to live, instead of dying!

Concern on the part of the professional arises out of her or his own personal history, professional experience, and the situation (Benner & Wrubel, 1989, p. 92). From concern, the professional develops a sense of involvement with the patient in the situation. The professional is able to build a bridge to the person’s lived experience through their presence with the other: being both physically present and available to understand, being aware of the other’s unique personhood, and acknowledging a shared humanity (p. 13). As the person receiving care assesses the concern and ability of the professional, the conditions for trust may be set, which can allow the person to take advantage of the help offered and to feel respected and cared for.

Harry doesn’t pull any punches in his analysis of addictions, even when his analysis is not welcomed. Harry enters into the world of the patient to target the selfishness and the fear that he believes is the main driver of illegal drug use:
I believe it’s all fear. I believe everybody that is admitting to using, is a coward. (That’s a hard word.) “Who’re you calling coward!” “You’re selfish.” The guard goes up, “Selfish? When I have some rock [cocaine], I share it with people.” “Why?” “Why?” “Why?” Quite often at first, they won’t look at it. “Because you want something; you want something from that person. Try going over to that guy’s place and do something for him, but don’t say anything to anybody. I won’t say anything.” They want something from it: “You’re a good guy,” or a pat on the back. . . . They’re self-centered. . . .

The street is the buddy system. You need that guy out there to survive, but it’s not a matter of being a real friend. A real friend’s not going to do a crime that’s going to get you in trouble. A real friend will support you. A real friend is not going to contribute to you falling—falling—falling and making your life worse.

**Difficulty working with IDUs.**

Some health care workers may be aesthetically disturbed by the hardship attending illegal drug use. The physical reality of injection of illegal drugs brings with it a special risk from infection, not just by HIV, but also from pneumonia; liver failure following hepatitis; heart disease as a result of bacterial endocarditis; and abscess which can evolve into cellulitis and end in amputation or go on to septicemia and death. The social consequences of illegal drug use carry other harms: stigmatization, social isolation, criminalization, demonization, violence, poverty, and family breakup. Many people who use an illegal drug have trouble maintaining conventional jobs, and may even face the loss of their relationships and homes. Substantial additional risk adheres to income-generating activities in the alternate economy that offers opportunity for dealing, sex-trade work, fraud, or stealing, lucrative *hustles* to which many people who use resort. In 2005, 40 percent of opiate users reported income derived from illegal activities (Fischer, Cruz, et al., 2006). Drug-related crime underlies the overwhelming majority of charges that result in incarceration, to the point that Canada is among world leaders in imprisoning its own citizens (Hartney, 2006).

Max realizes that professionals working with people who use an illegal drug must find a way to manage the pain they may feel as they witness the impact of destructive behaviors on the patient and those close to him or her. They also must make their peace with their own limitations that become clear as *relapsing* patients come in and go out of care:
You have to factor in the stress of longer-term addictions work. . . . How do you sustain a positive attitude? There have to be rewards for staff. Just bearing witness isn’t like seeing growth and change. Those who work in a war zone have to deal with *vicarious trauma*. . . . The care provider bears a weight. What are the limits to what human beings can sustain: physical, mental, or emotional stress? How do they vary among individuals? Training needs to focus on the awareness of self. Distancing and boundaries are important: There are limits to unconditional caring. “I’m concerned about you as a human being and I have warm feelings for you, but I won’t interrupt my whole life to provide for you. You don’t buy all of my time. You buy my time and energy, not my life.”

In our society, it’s a bad thing to kill yourself. If somebody decides that they’re going to take their life, that’s not always a bad decision. Do I understand someone else’s emotional pain. . . ?

How the care provider is supported is going to affect the treatment outcome as well. But there aren’t infinite resources to do that. Addiction treatment doesn’t get the same kind of reward as high-tech workers coming out of college: base salary and all the perks. Addiction treatment is a low priority issue in government. . . . In the best of all possible worlds, I’d make sure that everybody had the opportunity for two weeks for self-care at least once a year to go and recreate.

**Concern and Care.**

Caring grows out of concern; concern emerges from caring. Concern underlies the reason for taking action. *Concern* is the ability to have people, events, and things matter in a constitutive and motivating way, wherein the world is apprehended directly in terms of its meaning for the self. Concern attunes the professional to salient cues and objective signs (Benner & Wrubel, 1989, pp. 86-88). Concern is linked to knowledge through expertise which is not only specific and habitual, but which also is contextual and relational (p. 95). Concern embeds the professional in the situation, so that she or he perseveres, persists, and remains available, regardless of the inconvenience or upset that may result.

Aldo acknowledges the right of patients to set their own goals, but further displays concern, based on his understanding of the challenges the patient may face, and takes steps, as an expert, to safeguard the patient:

The professional helps the patient identify their preferred choice; but at the same time, the professional doesn’t have to agree with that choice. . . . I present a menu of choices to the patient. . . . Choices may be: a) harm reduction or modified use or b) do nothing. . . . In other words, “I’m using six pokes of heroin a day; I’m sticking myself six times daily.” “What about methadone. . . ?” That’s harm reduction, not
treatment. “You and I stay connected and down the road, if it’s not successful, we can look at some other choices.”

While the ability to interpret concerns (Benner & Wrubel, 1989, p. 88) enables the professional to help patients, understanding complements concern, in that it builds a bridge to the lived experience of the patient. It determines how problems are defined and the meaning of tragedy and success to the person. Benner and Wrubel believe that understanding moves back the walls of isolation and suffering, making self-understanding and common ground with others possible. Understanding is based upon a deep appreciation of a condition and a personal coming to terms with its implications, such that the professional can convey acceptance to the patient and help them come to terms in turn with their reality. Understanding is linked to meaning and results in motivation, goal setting, and achievement.

**Professionalism**

Professionalism is an attitudinal construct of the kind that is believed to underlie behavior. An attitude is a positive or negative evaluative reaction toward something or someone, which may be inferred from the expression of the person’s affect, feelings, thoughts, beliefs, intentions, or behavior. People form intentions as a result of their understanding of the consequences of the behavior under consideration, appraisal of their capacity, beliefs about the expectations of others, and assessment of a range of situational features that may help, channel, control, or hinder the behavior. Other factors that affect intention include environmental conditions and constraints as well as the skills, abilities, and vulnerabilities of the individual being helped and those of the professional.

Harry muses about the impact of personal experience with addictions on the professional philosophy of workers. “A lot of addictions workers come from that life themselves, and they have come to believe that abstinence is the way to go.”

Detailed descriptions of behavior include the target, timing, context, and details of the action and, since the explanation of behavior is a social act, behavior may be best accounted for through story (Rees & Knight, 2007). Malle’s (2003) folk-conceptual theory outlines three levels to stories meant to
explain behavior: conceptual, psychological, and linguistic. While an explanation of unintentional behavior simply revolves around the cause, a full-bodied conceptual explanation of intentional behavior will account for the reasons as well as the causal history and the background to those reasons, together with the related beliefs, values, and desires, and factors that enable or limit the behavior. Stories, such as those related by the participants in this thesis, reveal the psychological processes of the teller, reflecting the knowledge available to him, his projections or rationalizations, and impression management goals based on his assessment of the social desirability of the behavior in the eyes of the audience. Finally, the linguistic forms used to articulate the explanation of behavior serve as markers of the mental processes (thinking, feeling, values, and preferences) that convey information about the responsibility and involvement of the teller in the behavior.

Doug uses rich detail to quickly outline a poignant story of one patient he cared for whose treatment illustrates the ethical analysis that underpins his approach:

Her arms were swollen to twice their size–festeri ng wounds from above her elbows to right down: They were hideous; it was very difficult to look at her arms. She muscled: boom, boom, boom; just stuck them [needles] right in. The only thing she wanted was to save her arms. . . . “Okay, that’s the objective of methadone. It’s all you want; it’s good enough.” She stopped using needles; her arms went down to normal size. . . . She still does cocaine, very small amounts; functions as best as she can. The objective was not to stop cocaine. The objective was to stop putting needles into her arm to prevent infection in her arms, which could lead to a fatal infection of her heart: which she did. She achieved the objective of treatment; the objective did not include stopping cocaine.

Well-Being

Benner and Wrubel's (1989) Theory of the Primacy of Caring focuses on well-being: the exercise and experience of situated possibility, which reflects the lived experience of health. Well-being is defined as congruence between one's possibilities, one's actual practices, and lived meaning. Well-being is based upon caring and feeling cared for. Well-being is contextual and relational, fully embodied, and conjoint with trust in the power and capability of the body and the world. The manifestation of the health of the individual depends partly upon her
or his sense of identity and the salience of particular changes which may constitute triumph, thriving, satisfaction, loss, or suffering to the person. The restoration of health is based upon the interrelationship of five factors: a) the situation; b) formal beliefs, deliberate choice, and planning; c) the role of meanings and concerns; d) embodied intelligence; and e) emotions (Benner & Wrubel, p. 165). Well-being takes account of illness, but does not confine itself to the limitations, deficits, or suffering wrought by sickness.

John touches upon these five factors as he tells the story of Marie, a woman who he helped through treatment to get her kids back. She recovered her health, leaving her use of illegal drugs behind her as a result of appropriate treatment tailored to her specific needs and delivered in a caring manner. His account is rich with detail and captures the desperation faced by many who use an illegal drug when they consider stopping and the gratification experienced by a helping professional who sees another do well:

We just talked about life. . . . “How do I get off the streets if I’m addicted to coke; and how do I get off my coke addiction if I don’t have housing, and I need to cover that [cocaine use] up; and I really hate hooking, so I use coke before I hook. . . ?”

It’s a matter of playing the game out; of talking with people and making some alliances. . . . The public assistance lady yells at you, don’t lower yourself to her level. Say, “Thank you very much,” and write it down on a piece of paper. You unnerve them 100 percent by writing it down in front of them. . . . Learn how to play the system; use it—it doesn’t care about you—learn how to play it. . . .

You don’t need to be on drugs: Why do you have to be on drugs? All you’re doing is perpetuating what they believe you to be. Change it; do something different. Be what you want to be. . . . In court . . . the judge looked at her and said, “You’ve changed. Something’s happened.” He cut her a bit of slack. . . .

Now, Marie and her husband own a house, she got the children back, and she’s not used ever again. She donates money every year to help others in similar situations.

Questions

As a result of this enquiry, I had a better sense of some of the factors that interacted to bring about Anna’s death. I still had questions about the proximate details of Anna’s death. Anna was an experienced user: How did she end up overdosed—twice in 2 weeks? Did she have to go to a new source? Was her
heroin mixed with a stronger opiate, such as fentanyl, instead of cut with sugar? Was she in despair? What actually had happened? I also had questions about the patterns revealed by Anna’s death. How can such deaths be prevented? How can professionals better help people who use an illegal drug? And how can the culture as a whole relate more productively to people who use an illegal drug?

Through this heuristic exploration, I had come to better grasp how professionals understand help-seeking and helping in illegal drug use. I also had expanded my appreciation of the social, economic, and cultural roots of addiction. I had learned about the enactment of the term, *democide*. I had heard about the difficulties of dealing with addiction from the perspective of the professional and learned more about the hardships visited upon the individual user who is maintaining an addiction. Many of the findings were disturbing to me. I was particularly troubled by the classed, nested, enmeshed, and reinforced qualities of the ruts cut by the dysfunctional dynamics surrounding illegal drug use.

Now I had to ask myself what my colleagues and I could do about it. Even as I questioned how such sedimented social dynamics might ever change, I was comforted by the examples set by the participants who had spoken with me and heartened by the direction provided by Benner and Wrubel (1989).

The next chapter presents a summary of my conclusions about how we can collectively better understand the genesis of addictions and more effectively help people deal with the use of illegal drugs. The practical social changes and longer term reorientation that I recommend were drawn in large part from the insights I gained as a result of this heuristic exploration of help-seeking/helping from the perspective of professionals. Interestingly, these recommendations echo quite a number of those made by many other serious thinkers, even though their vantage point on the culture may have been different.
Picture 9:  I Spy

I Spy
Once a person’s eyes have been opened, how can one not see? Once a thing has been seen, how can it be unseen? And if the vision is too sharp, the pain of seeing too great, how can one close one’s eyes? And what does another see?
Watercolor pencil on paper (Polych, 2010)
CHAPTER IX
SO WHAT’S YOUR POINT?

Anna’s Death

Once I had completed this heuristic exploration of help-seeking / helping in illegal drug use from the perspective of the professional, I did, in fact, have a better grasp of how Anna had come to die in such an untimely way and untoward manner. I had learned that the workers in the Emergency Department likely embodied the usual social prejudices, regarding illegal drug users as untrustworthy hassles not worth the effort. They may actually have taken further offence at Anna’s apparent violation of the tenets of the sick role, which holds that the sick person is to listen to professionals and show how she is improving. Working in an industrial institutional organization, they no doubt felt they had provided the level of care that fulfilled the expectations of their roles as professionals when they resuscitated Anna previously, and that they were justified in banning Anna because she broke the rules by taking syringes. They may even have felt that banning Anna was ultimately in her best interest. (No pain; No gain.) No doubt their feelings were also hurt that Anna would, seemingly wilfully, set their effort to save her life at naught by this clear demonstration that she simply planned to repeat the same action that had resulted in her overdose.

Anna had tried methadone, but had been kicked out of the program some years earlier for using cocaine. And it wasn’t like she could have gone right into treatment, even if she wanted to. Chances are treatment was simply not available. If available, treatment may have required thousands of dollars in private payment, placing it beyond her reach. Even when her admission date to a public facility rolled around, treatment might very well not have been appropriate, somehow chunking out the privation that colored Anna’s life and dissecting off the mental health component, ignoring the PTSD and depression from which she suffered, legacy of the sexual abuse beginning in childhood and of the violence that had followed Anna throughout her life. Or treatment may have been dogmatic and shaming, the last thing Anna needed more of. Anna,
no doubt, also was wary of the disrespect she likely anticipated and the probable discounting of her considerable accomplishments. Anna would have had to consider who to entrust with the care of her children while she was away and, being Anna, how she could pay back such a guardian angel. Further limiting the avenues whereby Anna might potentially have sought help, is the short length of most programs, typically only 3 weeks, a duration and intensity of treatment that seems laughably inadequate for Anna’s needs, although some treatment programs do offer follow up of groups of patients weekly over 1 year.

The likelihood of Anna extricating herself from The Life was slim, given the multiple hardships she had experienced. Should she manage to “clean up” (!?!) any financial support she could expect would be heavily conditional and starkly inadequate for decency; whereas any “legitimate” work she might pull in would no doubt be off-shift on the minimum wage—hardly better. And how would she manage at the end of the month when the bills all come due? Had the police caught Anna, she likely would have been imprisoned and removed from her family, neighbourhood, and social circle. At least in street life, Anna had a place; people knew her as a bit of an artist, a woman of her word, a loving mother, and a trustworthy person to go to in times of need.

I was forced to the conclusion that Anna had served society by embodying the role of deviant. Her behavior, together with that of her reference group, marked the edge of the acceptable in consumer culture, beyond which dwell only monsters. The professionals waiting in the Emergency Department to care for the wounded clearly did not intend to intervene in Anna’s approaching death, as she had violated the expectations they hold of patients and, even more offensively, had not properly benefited from previous contact. The society in which Anna lived did not see fit to provide appropriate, accessible, affordable, timely treatment or safe, effective medications in a manner that would meet Anna’s needs. And the culture accepted, normalized, and depended on a variety of violences visited upon Anna over her lifespan, just as it does with other Canadian women and citizens who take a drug labelled as illegal. Anna’s culture was fully prepared to let her live in want, die in need, blame her for all of it, then
breathe a sigh of relief as, with her death, it was relieved of the problem.

**Toxic Responses to Addiction**

My exploration had left me with a nauseated chill as I went about my daily work within the health care system, doing my little bit to try and help others. Despite having worked for many years with marginalized folk and regardless of my difficult upbringing and chaotic life as an adult, I had not previously methodically assessed the iatrogenic impact of the noxious social system within which I live and work. I was profoundly moved anew by the way in which ordinary people still managed to create meaning while residing in the interstices in which they find themselves and then moreover, craft beauty, and further, break out in song about it. Curiously, I found solace and hope, not in the tawdry maliciousness of religion, but in the wisdom and lament shared with others in the plaint that colors the *blues*, as have many before me.

I was angered, too, by my own and others complicity in such a malignant social system and disturbed by the complacency of those professionals around me. I remembered Gramsci’s (1937/1971) call to professionals to commit class suicide (p. 77-80) to bring about a society that better serves the needs of the most vulnerable members. I wondered if class suicide is even possible. I reflected on the admonishments from the Colleges that govern the work of professionals, charging their practitioners with the responsibility to advocate for systemic change. I was aware of the usual violent purgative reaction to any whiff of nonconformity with the party lines of the institutions within which clinical work takes place, recently borne out in the highly questionable if not downright reprehensible treatment accorded even high profile workers like David Healey (Coyne, 2005) and Nancy Olivieri (Shuchman, 2005).

I had time to consider the impact of ameliorating efforts on the part of many who mean well in their efforts to offset the harm of various social processes, ranging from environmental degradation, to hunger, to homelessness, to police misconduct, to illegal drug use, to imprisonment. I mulled over the merits of differential rewards according to contribution, skill, efficiency, or station—just deserts. I thought about my work in Toronto to
establish more appropriate services for marginalized folk: food and blankets from Street Patrol, community-based methadone provision, Native traditional healing ceremonies, a hostel welcoming to transgendered people, and care for prisoners living with HIV/AIDS. I mused over the theory that, if there were no food banks, effective income supports would have to be brought in; if there were no anti-prison movement, prisons would be widely condemned as outdated and abolished as outlandish institutions; if there were no kindness, violence would expire. (There are no cats in America, Fievel [Nibbelink & Wells, 1991].) Maybe, but I couldn’t buy it.

I was intrigued, however, by the examples set by countries that have legalized drugs now designated as illicit in Canada, and the benefits that legalization has brought. If there were no illegal drugs, users would not be criminalized. Such drugs could be handled with due care like other substances that people take, and further, it might be possible to mitigate some of the more harmful effects of particular behaviors associated with the use of illegal drugs. Of course people who use a substance no longer tied to illegality may want to be treated with respect, have a steady job, and go home to a nice house like the rest of “us.” But how could we then maintain the necessary scarcity to support the elite? What would happen to profits in corporate Canada if there were full employment and workers believed they deserved fair pay? (Oooh! Sounds like trouble!)

I did come to believe that responsible civic engagement with issues that touch on the humanity and potential of people is crucially important. I looked to the success of the Green Party in establishing itself in Canada and many other countries and even the popularity of the Marijuana Party in BC as hopeful signs. Once considered deviant, these politically active groups have made considerable impact on the conduct of business as usual. I noticed a refreshing atmosphere of resistance in the on-line plebiscite to rename the former Federal Public Safety Minister, Stockwell Day, Doris. I admired the spirit behind the quintessential Canadian custom of pie-ing badly behaved politicians, a roster that includes at least 3 Premiers and 1 Prime Minister (The Canadian Press, 2010). I was
pleased by the vigor of responsible resistance that saw young Ontarians organize effectively on line to counter moves by government to further limit their driving privileges. I was happy to see an upgust of civic cooperation that stopped a huge subdivision, slated for construction on the moraine that naturally filters water for the Toronto area, in its tracks.

Martin (no date), one of the founders of the Carbon Defence League, explains that a critical deviant is a person who recognizes the discrepancy between their own values and those evidenced in the mainstream, and who then allies with others to set standards and laws that more closely reflect their beliefs. Of course, even in such a group, there will also be those who find they are not well served politically, financially, or culturally by any such group, resulting in disappointment, mistrust, anger, and splitting off in turn. Smaller groups can be expected to splinter away, reforming into micro-networks with yet different social norms. Martin suggests that society may best function—more inclusively and respectfully—as a pile of splinters, rather than as an undifferentiated, homogenized, cohesive whole.

What this meant for me was that, to succeed in humanizing the approach to addictions within North American-EuroWestern cultures, it is necessary to forge respectful alliances between professionals dedicated to helping and those who have direct experience with illegal drug use and who are affected most by it. A strength-based, inclusive approach likely is the most effective. It is also important to expect and constructively accommodate splintering, such that various parties may readily strike off in pursuit of specific outcomes targeted to address the unique problems that certain people find particularly pressing. Further, it is important to keep channels of communication and cooperation open, with clear pathways to facilitate the coming and going from networks that coalesce around different interests, abilities, and approaches.

The Canary in the Coal Mine

Bearing in mind that addictions may be, as one of the participants asserts, a symptom of a larger problem, in the same way that high blood sugar indicates diabetes, what might that larger problem be? To really grasp the extent of the
problem, I needed to consider it piece by piece. The participants had pointed to a number of potential problems. Consumer culture itself is toxic. Canadians are not our sisters’ and brothers’ keepers. Government is not for the people, but is intended to benefit the plutocracy. *Gangstas rule* down at Bay and King or College and University, same as at Parliament and Dundas or Hastings and Main. The wrong social institutions are funded. Health care, as provided, is entirely too after-the-fact treatment of established disease. Professionals are malignantly elitist. Mental health and addictions are all but dismissed. PTSD (Post Traumatic Stress Disorder), CSA (Childhood Sexual Abuse), LD (Learning Disorders), ADD (Attention Deficit Disorder), TB, HIV, and HBV / HCV are given hardly more thought than the alphabet in our soup. Big problems, structural problems: Symptoms of *industrial disease* indeed!

And what about addictions as a mental health issue? Given the dearth of constructive attention currently paid to mental health and emotional dis-ease together with the generative pressure of the toxic social dynamic set in motion by unbridled, conscienceless, capitalistic exploitation, it does not seem to have been especially productive to cast addictions as a mental health deficit. Reframing addiction as a coping response to stress or as a marker of a more pervasive problem may enable a more carefully thought through address, featuring radical— to the root—supportive and nurturing social structures (Alexander, B. K., 2001). Reassessment of social priorities, such that the most vulnerable are positioned to thrive, is essential; as a spin-off, all other sectors will coincidently benefit through the *trickle up-rise up* effect, bringing a re-imagining of the *bottom line*.

Canadians will benefit from the expansion of well-run initiatives designed to limit the harm from using drugs generally and particularly those now designated as illegal; such interventions presently include appropriate needle exchange and safer using facilities such as Insite. Vigorous management of addictive habits and constructive address of the conditions that underlie addiction may start with short-range supportive efforts like outreach that, together with affordable access to safe, criminal-free drugs and provision of a
variety of effective substitution medications, may lead to reasonable testing, evaluation, and pricing of prescription drugs, and end with problematizing and reorienting of pharmaculture. People who currently use the services now available are well positioned to identify other helpful strategies, and further guidance may be drawn from those who do not typically access services, but who continue to use a drug now considered to be illegal in Canada.

**Echoes of elitism.**

Given the common observation that illegal drug use surfaces in the early teen years, and given the frequent report from people who turn to illegal drugs that they have experienced childhood sexual and other abuses, adequate social safeguards are imperative to actually prevent violence and deal effectively with abuse in its multiple layers and manifold presentations. Reversal of cultural norms, that feature individualism, greed, scarcity, and fear and so furnish a matrix that fosters anxiety and nourishes violence, will entail a major reorientation within society away from the consumption of material goods toward more genuinely durable social goods. Media representations set a tone of brutality, portraying thrillers that depend upon violence often targeting vulnerable people including those involved with illegal drugs; more responsible, insightful, balanced, and nuanced stories that portray characters in social and historical context and represent reality from multiple viewpoints would be helpful and considerably more interesting.

Classist abuse of the less powerful is a motif that is replicated in the Canadian workplace, where front line workers often earn not much more than $10 hourly even though the bosses who depend on their work may bring in $600 or more for that same hour. Elitism splatters up from the puddles into the faces of people waiting at the bus stop to go to work as their more privileged neighbors drive to the coffee shops in their Hummers. Exploitation is taught in schools that begin with separating students into *special* and *gifted* classes to better prepare them for their place in fast food and industry or business and the professions respectively. Exclusionism is perpetrated through differential access, often income based, to non-curricular activities, such as sports, camp, hobbies, music,
or travel, that confer richer understandings and cement class-based alliances.

Social tolerance, collusion, perpetration, and valorization of violence is grossly inappropriate whether by commission or omission, irrespective of its economic, physical, sexual, emotional, intellectual, cultural, or spiritual basis, and regardless of its direction at individuals, groups, classes, or other nations. There simply is no ethical place for the abuse of anyone in a cooperative and respectful society. The admonition to treat others as ends in themselves, not as means to an end, still holds: Grandmother was on to something good

The urgent need for social change highlighted by the ubiquity and pervasiveness of addictions calls for redress beginning with the basic structural faults in Canadian society that enable the excessive and expanding divide between the poor and the rich. Flattening the monetary inequities among the professions would be helpful to rebalance the downstream weighting toward disease care and redirect the attention paid to social dysfunction upstream toward the conditions that foster well-being and maintain health. Downsizing and demobilization of the armed forces together with a reduction in the numbers of police, corrections, and justice workers in the field of social control will free up remarkable numbers of talented people for retraining and repositioning in more constructive, socially helpful, yet adequately remunerated roles. The monies that have funded such repressive and retrogressive institutions will then be freed up to support values clarification, negotiation of restitution, and conflict resolution as more mature approaches to cooperatively living out different values within the community.

Education tailored to address learning disabilities and a range of abilities is essential. Opening up of opportunity of education, by expanding cooperative work-school programs, taking education to the work site, granting of the means of subsistence while students are in school, and dispensing altogether with fees for tuition paid by the individual, would go a great way to improving the class-based monopoly in many professions and simultaneously reorient many who might otherwise turn to the alternate economy.
Requiring a mix in all schools of classes, incomes, genders, abilities, and heritages may help to realign exclusionary and exploitative values. Core curricula that broaden the educational focus from the intellectual and written skill sets alone, to include physical development, deconstructive and constructive communication, cultural awareness, and the practice of civics, would be helpful in raising and sustaining social competency. Academic material may be offered openly to all on line and through other venues such as study circles and communities of interest to include those who live close to the land or in isolated areas. Redirection of sectarian influences over education, by limiting exposure to content together with curricular requirements that detail the functional basis of religion, survey the breadth of different cultural beliefs around the world, and explore the historical depth of religious-type mythologies, will help fundamentalists and others to better respect differing world-views.

Fair taxation of production, based on real long term and ecological costs, is needed. Incentives to support healthier and simpler lives of conservation and cooperation together with implementation of “clean and green” natural technologies will slowly head cultural relationships of excess and exclusion toward greater inclusion. Legislation linking the siting of industry to tenure and profit sharing back into host communities will help build community stabilization. Capping of profiteering by taxing back will help the principals in business understand their social responsibilities a little better. Industry standards need to encompass flatter income provisions, such that workers have the ability to maintain decent living conditions within sustainable communities set in healthy environments. Responsible redirection of exploitative finances will go a long way to improving international relations between the North American-EuroWestern minority “North” world and the majority “South” world.

They Tried That Once

None of the social changes discussed here are news. All have been proposed before and many have even been tried. Because they have not already come about or have been applied in ways that were flawed does not mean that they are not worthwhile aims. Just as a tree root finds its way through
the cracks to break down even concrete, there are myriad routes to diminishing and restructuring plutocracy. The power structure of society is characterized by multiple pressure points that are sensitive at particular times. It is through the work of diverse civic action groups that concentrate on building the social conscience of each citizen, raising awareness about particular concerns, and fostering respectful inclusion, that social change will come about. The job of the teacher in this effort is crucial. And everyone has something to teach, if others will only learn.

This thesis has touched on religiosity and the influence it exerts on the structures within which people live, together with the ways in which cultural understandings that include social mores, based in part on religion, shape the very meaning of life. Ethical scholarship demands that the social dynamics surrounding the phenomenon of interest be scrutinized carefully even if the exploration is awkward, the conclusions unwelcome, and the scholar made unpopular; such social substructures include moral underpinnings, religious beliefs, and spiritual influences. It is only through articulating such quiet, dark, deep-running factors that better quality, more inclusive social decisions can be made in the light of day. It is only through such well-considered awareness that individuals can undertake actions that may, in fact, be truly helpful to others. The dynamics illuminated in this thesis are troubling, and the presentation was designed to be provocative and stimulating to conscious thought. While the material presented here is certainly not the last word, it may open up for discussion some of the undercover dynamics that drive key social relationships. And that’s got to be good, right?

Some portions of the material under consideration in this thesis were revisited from different perspectives. Such reconsideration illustrates the interlocked, enmeshed, and nested quality of major social dynamics in general. In particular, such recursivity in examination is essential to understand the complexity of the dynamics surrounding the use of illegal drugs. The social response to illegal drug use taps into a self-reinforcing power source with many deep and intersecting channels, while the drugs designated as illegal take on
alchemical significance as touchstones set in a palisade protecting a well-ordered civilization and the people who use them unwillingly serve a variety of unwholesome social functions. Inevitably perhaps, the recursive pattern that characterizes illegal drug use is also evident in this thesis.

My work, together with that of many others who insist on treating the people under their care as complex human beings who matter, is important. It seems that, if ever I hope to see 100 percent change, I had best keep on doing my 1 percent whenever I can, and encourage 99 others to do the same: The maxim has meat. Yes, Anna’s death was preventable and it depended upon welcoming her into her place in the fold just exactly as she was.

Questions

I undertook the research that supports this thesis to answer two questions. How do professionals explain the actions and inactions of professionals that are meant to help people who use an illegal drug? This answer depended upon the explanations related to a more basic question: How do professionals make sense of illegal drug use? Answers to both questions are embedded in the body of this thesis and are as complex as the phenomenon of addictions itself.

The final chapter reviews the social implications that follow from this research and identifies areas for potential development in research, education, and practice. The heuristic methodology that guided the development of the understandings presented in this research is reviewed in Appendix A, and is presented together with a number of models that deal with issues fundamental to the nature of the truths revealed in this research (Appendix C).
Miles to Go
The butterfly is known to embody change within its very being. Change itself may be thought of as opportunity at the heart of danger. The monarch, frail as it seems, is tough enough to migrate from hemisphere to hemisphere, arriving in a cloud of beauty. Is it the flap of the butterfly’s wing that causes the hurricane? Watercolor pencil on paper (Polych, 2010)
CHAPTER X:

THE WAY AHEAD

The research outlined in this thesis was undertaken in search of answers to the questions about how professionals understand illegal drug use and how they explain what goes on in the help-seeking / helping relationship. Part of the framing of the answer involved looking at how North American-EuroWestern culture makes sense of illegal drug use, because professionals live and work in context.

The first step in identifying how addiction complicates life in North American-EuroWestern societies is the exposure of the ubiquity of difficulty in coping with a selfish and dislocating society that manifests in industrial disease, such as now surfaces in addictions and other health problems (Alexander, 2001). Such coping difficulty takes place across all ages and life stages in all health care fields, and results in multiple comorbid conditions. Treatment plans for any condition need to take account of the deep structure of addictions and interventions must be tailored to the circumstances of the individual. Careful tracking for effectiveness of approach over the short and long run will be needed to fine tune particular strategies. Further, any thoughtful approach to addictions demands a parallel track to assess erstwhile laudable addictive cultural processes, such as that to money and stuff, together with the implementation of specific social interventions tailored to the peculiarities of the society.

Social Implications

The drop in drug use experienced in Holland and Portugal, countries that have decriminalized drugs considered illegal by many other countries, may give Canadian legislators a positive direction. Offsetting the potential benefit from decriminalisation of over half the population and the ensuing possibility of better treatment of people who use an illegal drug are the likely losses to powerful vested interests, ranging from the underground economy to the state to private enterprise. Reaction to such losses may vary from the social propensity to designate other scapegoats, who may then serve as examples to the potentially unruly majority, to inappropriate placation of security companies and arms
manufacturers through to the declaration of a new war on a different unfortunate “enemy”. Decriminalisation is typically followed by a surge in demand for treatment and addictions facilities. Organizing to meet such needs would no doubt employ equal numbers of workers, albeit workers whose nature and way of relating to others is different than that of the Law and Order Cartels, whose occupation now is military combat or the civil pursuit and incarceration of “criminals” in the so-called War on Drugs.

The fears of people such as Tony Clement, past Minister of Health for Canada, that decriminalisation of drugs now declared illegal in Canada would lead to the ensnarement of youngsters in addictions and a tidal wave of drug use, has simply not been borne out by the experience of other countries. Government oversight of the production of such drugs instead would lend itself to regulation of use and care in distribution, while removing the criminal element altogether from the arena of drug use. In the long run, a more inclusive approach to the needs of people who now turn for comfort to drugs designated as illegal is likely to lead to a more humane society generally. Exit from the parallel toxic ruts cut by the scapegoating-laissez faire dynamic that shapes the shame-blame circuit, will enable the responsible social address of complex health issues that surface as anxiety-depression-anomie-addictions.

Explicit inquiry into the purposes served by the categorization of certain drugs as illegal is needed to expose the purposes and mechanics of demonization and how that dynamic feeds social control and economic stratification. Even from a simple economic perspective, Canadian society, which now is largely characterized by an exploitative consumerist orientation, may best be invigorated by containment of the dyadic extremes of elitism-poverty, together with moderation of other social factors that feed addictions. Overhaul of archaic and classist legislation that promotes a plutocracy remarkable for its exploitation by private interests of ordinary Canadians and the natural resources of Canada is crucial. Investigation of the best means to reorient society toward more durable goals and redistribute access to common
resources is urgently needed. Answers to the question, “Cui bono?” have never been more pressing or closely guarded and hard to track.

**Implications for Research**

Further research may extend the findings of this heuristic study of the perspective of professionals on the help-seeking / helping dynamic in illegal drug use. At the heart of further research is the question about what help means in the context of illegal drug use. The techniques of Participatory Action Research (PAR) lend themselves beautifully to both quantitative and qualitative research approaches and naturally guide researchers to seek inclusive input on important issues from all parties including those who take the brunt of the negative impact of illegal drug use and so can offer a particularly acute understanding of the dynamics that surround illegal drugs.

Further research might start from the views expressed by the experts interviewed for this research and go on to clarify, expand, and test out the limits of their insights. The researcher might then ask for clarification about what kind of short-and long-term responses from professionals are most helpful to people who use an illegal drug and at what point those responses are most likely to improve the situation. Finally, tracking outcomes against the approaches taken by professionals would generate the data needed to identify the most practical interventions in specific circumstances for those with particular needs.

The next question might be how best to prepare clinicians for their professional roles with respect to addictions. Further steps in the research agenda would include exploring how well beginning practitioners are able to put their learning into practice and identifying supports and barriers to quality practice. Research into how different attitudes held by the beginning clinician tie in to various practices and the corresponding outcomes would be helpful. Further productive investigation may lead to articulation of the means by which certain attitudes are shaped in training, with an eye to inculcating those most productive. Tracking attitudinal shifts within the student body and graduates of professional schools will lend itself to comparisons with changes in the quality of feedback from patients. Follow up might include research to determine for how
long the attitudes held in training last, how and why they change, and what effect those changes bring to practice. Such investigation implies testing out what “best practice” means in specific situations, and research into how positive outcomes are defined and distinguished by different parties.

Building on some of the remarks of the experts interviewed for this research, questions follow about the benefits to the individual of using an illegal drug. Needs-gap analysis might then direct providers to interventions targeted more precisely to meet the needs exposed by the use of an illegal drug. Potential areas of need might include interventions to address PTSD, further development of non-industrial teaching models beginning with the lower grades, educational initiatives to systematically address learning disabilities and different abilities, innovative approaches to ADD, and implementation of a range of effective protective practices. Needs-gap analysis may also bring forward the need for larger social changes in the realms of personal relationships, cultural norms around the expression of aggression, and structural financial discrimination. Research is needed to map out the sources of initiative, achievement, competition, indifference, exclusion, and violence as set in comparison to sources of cooperation, satisfaction, collaboration, responsiveness, solidarity, and confidence.

Comprehensive tracking of the overt and covert, immediate and long-term, individual and social costs of illegal drug use and its sequelae may be instrumental in freeing up the monies needed to fund the detailed research discussed above. Research is needed to look at the larger impact of consumer culture on health. Exploration of the effect on addictions of community fragmentation and dissolution, so key to present-day employment in Canada, is needed. As well, as identifying practical, more generally sustaining economic arrangements that support healthy communities is important. Research into the positive factors that support hope and happiness within a community may also have a place in developing understandings about the use of drugs labelled as illicit. Research into social decision making by plebiscite or through means other
than electoral parties may be needed to identify how to enact legislative change that otherwise may be beyond entrenched and hegemonic political cadres.

**Implications for Education**

Systemic change has been marked as a priority by professional colleges that set out skills in advocacy as a basic expectation of all professionals, yet progress is scant and halting. While there has been recognition that whistleblowers need protection within the workplace, whistleblowers are still generally ostracized and ejected from the workplace while constructive uptake of whistleblower concerns stutters and dies. Investigation is needed to determine effective supports for those who call a halt to questionable practices and who engage in systemic change. Testing is also needed to identify effective strategies designed to reward advocacy work, particularly when it runs counter to vested interests. It is also important to map out the essentials for advocacy skills development during training, with a focus on communication within small groups, development of skills in managing social change, and practice in negotiating political systems. Continuing education provisions are also needed to help practicing professionals continue to develop their advocacy abilities.

Practitioners in the helping professions would benefit from the development and normalization of skills in *deep power analysis* including the tracking of multifactorial reward pathways, dissection of overlapping approval structures, and familiarity with the complex intermeshing networks that harbor and protect vested interests. Simultaneously training professionals to analyse the ethical application of power and effective use of power would result in clearer-headed decision making. Such training may immunize students against cooptation into an oppressive power structure that supports the maintenance of an elite at the expense of common folk. Skill in community development, group facilitation, public speaking, and presentation are abilities key to redistributing power in a healthier manner and ultimately to build more productive ways to respond to illness, pain, and dis-ease.
Alliances

Supportive granting for excellence in community organizing and monies to support advanced professionals who practice from a populist base is not likely to come from conventional sources of funding, so alternatives must be developed, and may include government agencies, unions, community coalitions, and interest groups. Determining the criteria for excellence of populist practice by professionals and then profiling exemplary cases is important to establishing the usefulness and validity of populist practice. Although much health care and social service work is done in private, it is important to open public dialogue and improve understanding about the implicit, often covert, trade offs, compromises, and jerry-rigged or second-rate substitutions made by professionals in the course of their work. Bilingual ability—ordinary language as well as professional argot—on the part of professionals is needed to ensure public feedback that will help professionals stay focused on the enterprise at hand.

Application of affirmative recruitment guidelines of the type developed to address racial splits and gender divides may productively be applied to other schisms along the lines of class and income, as well as fuzzier cultural fault lines related to language, origin, location, ability, size, and so on. Teaching strategies that cultivate a spirit of solidarity with the population base, rather than a sense of alignment with the elite, need to be designed to facilitate the shift in the role of professionals from agents of social control to agents of social change. Realignment of professionals can be more solidly inculcated by structuring both the formal program of instruction and actively influencing the informal curriculum. Students coming from a populist background will require adequate financial supports to enable them to complete their professional studies, the provision of which will entail changes to present provision of general education as well as financing for university, apprenticeships, and advanced, specialized studies.

Providing instruction in common across the paradigms and professions to the maximum extent possible will help to offset entrenched elitism through contact with the diverse philosophies of health and values of various disciplines. Inclusion of non-allopathic paradigms of health, including those that rely on mind-
body-spirit links, whole plant remedies, and natural technologies will support and expand approaches to well-being and healing options. Devalorizing downstream, end-point intercession within the professional educational system is important to shift health and social practice onto a more sustainable and healthy basis. This initiative may include reeducating professionals about the type and place of the end-stage interventions on offer and the intent and manner of the involvement by professionals in the experience and management of illness. The current cultural fear of the hereafter calls for reframing just as does the apparition of the isolated individual struggling alone in a hostile environment cry out for address. Reworking and conscious selection of the metaphors that inform illness and frame death within North American-EuroWestern culture is a worthwhile but complex long-term need amenable to a variety of approaches, beginning with education. Media reeducation is of pressing importance together with incentives to help media recast the representation of professionalism as end-state heroism, in favor of more thoughtful full-bodied analyses of social and health issues.

Secure adequate public financing of high-quality education is essential to develop healthy professionals whose stock in trade is health based. Simply redirecting the $500,000,000 yearly set aside to operate the new prisons slated to open in Canada to house 5,000 inmates at a cost of roughly $100,000 each per year, would fund 20 small universities that could each enrol 5,000 students who need pay no yearly tuition. To enable universities to regain direction of their own research and develop in-depth knowledge according to public priorities, they must be able to pool donations that are now directed by private, for-profit interests hoping to benefit themselves. Monies gained by private companies that market products related to university research may be redirected back into the university system to help fund ongoing study generally. Simultaneous taxation of business at a level that takes account of the real impact of the production, displacement, and use of consumer goods on social and natural environments would provide a funding base for advanced universal education that would enable development of abilities across income levels.
Determining Quality

Restructuring the economic incentives that attract trainees into the various areas of specialization to favor those that emphasize upstream preventive approaches would also help professionals identify and self select into areas of genuine need by ability and preference. Restricting financial influence on schooling from interested third parties and replacing these monies by pooled donations and more targeted taxation on corporate profits would also help professionals focus more clearly on the actual needs of the population, rather than those of pharmaceutical companies or business interests or on income generation upon graduation.

The usefulness of more populist and upstream approaches to health care may be tracked through ongoing assessment of population health baselines that mark changes in the development of preventable illness. Markers that may be helpful to gauge the effective helpfulness of interventions may include tracking: specific illnesses such as hepatitis and HIV; nutritional status; devolution diseases such as diabetes, hypertension, asthma, and dementia; vaccine uptake; anxiety, depression, and anomie; income spread; sentinel conditions such as CSA, addictions, and homelessness; marker behaviors such as pharmaceutical use; and marker states such as community stability, property ownership, water quality, wildlife diversity; and rural residence. Researchers will also need to develop robust new approaches to tracking health as more than the absence of disease and construct new indices for conditions such as happiness, creativity, and thriving.

Implications for Practice

Large social decisions are still made in Canada by governments brought into power through the multi-party election process, rather than through the coalition concept inherent in proportional representation. In the past, governments have acted as agents for business, particularly big business, fostering a climate for corporate profit and consistently reducing the taxes paid by corporations, at the expense of ordinary Canadians. The present noxious cycles of consumption would respond nicely to revision of the currently prevalent
trickle-down social philosophy that holds that quality of life depends upon production for profit, wherein jobs are exuded simply as a byproduct, meant to enable the worker in turn to buy, courtesy of marketing magic, the goods on sale. Extracting taxes in a manner that benefits the poorer segments of Canadian society from the upper echelons would enable a higher standard of healthy living generally for individuals and their communities. Strategies might include taxation such that exorbitant income from profiteering becomes unattractive, together with pricing that better reflects the real costs of products. In such a case, police would require redirection and retraining to focus on the more covert and damaging suite crime rather than on more obvious and alluring street crime, as is now the case.

Forming effective coalitions with other professionals, community allies, interested parties, and people who use an illegal drug is crucial to orchestrating change that is designed to take serious account of complicated social issues such as addictions. Informed professionals are well advised to enlist and support champions such as those progressive police at LEAP, enlightened public health officials, concerned health personnel, and articulate, high-functioning users of illegal drugs. With support, members of the social justice movements within theology may be able to provide a correction to the pernicious influence of religious fundamentalists. Such a coalition will be needed to sustain the point position, field robust debate, and deal with the hostility to be expected from entrenched interests as all drugs come under legal regulation, careful distribution, and responsible consumption.

Vested Interests

Unmasking the enmeshed multiple layers of vested interests in maintaining the illegality of illicit drugs and tracking profits from the illegal drug trade is part and parcel of restructuring the social response of Canadians to addictions. Articulating the enmeshed quality of business, capital, and government and the functions served by cultural scapegoating can only help Canadians make better quality decisions about what is important to them in society. Critical education is important in high school and earlier, that covers
hegemony, the operation of markets and economies, and tracking skills to detect the influence of *de facto* coordinating networks ranging from the Bilderbergers to the steam room at the yacht club. Deconstruction skills as applied to a variety of fields ranging from history to marketing, would help Canadians track the undercurrents that affect their lives and help them to decode the spin placed on artificially engineered scarcities within a commoditized monopoly marketplace. Evidently, students also need instruction in how to detect and challenge outright propaganda, disinformation campaigns, and distraction ploys produced by government and others. Teens can be introduced to the political process, alternatives to the multi-party election system, and their engagement facilitated so that they gain skill in using electronic communication to direct their political representatives in parliament and become accustomed to holding them accountable.

Professional education that blends the training of all health professionals will encourage respect for and recognition of the breadth and depth of expertise of all levels and types of providers. Opening up of access by patients to the full range of understandings of health will undermine the monopolization of resources currently seen in the heroic, allopathic, end-stage, disease-focused model of high-tech health care provided by experts. Compensation of practitioners within a practise area, tied to gains by patients in health matched to age, may enable rebalancing within the health care system, as proactive, upstream, cooperative, supportive, and nurturing interventions become more financially attractive.

**Social Inclusion**

Future research may productively map out the barriers to the systemic change identified as necessary by the experts who participated in this research. Public education is needed to increase the level of awareness of ways in which we all enact stigma against others and to develop the language to discuss instances in which we ourselves are targets of stigma. Venues to address stigma are also needed. The education system of Canada has recently endured serious slashing to elements of education designed to support civil society while
the components necessary to ensure competitive, capable, compliant, uncritical, uncomplaining, and unattached workers have been enhanced. Improving the social literacy level generally though formal schooling in social studies, healthy relationships, communication, healthy living, and fitness would benefit the ability of Canadians to behave inclusively and respectfully toward each other. Ethics education that crosses genders, world cultures, religions, and histories would familiarize Canadians with understandings other than the emaciated, parochial analysis currently promoted within the North American-EuroWestern hegemony. Education that develops the ability in children and teens to deconstruct communications produced by organs of the state and other interests may enable them to make more conscious decisions about priorities in life. Familiarizing students with deviance and conflict theory, with particular attention to punishment rituals, restitution models, and inclusion techniques would be especially useful. It would be helpful to include in pre-teen education some elements of psychology that foreground the centrality of reference groups and habit in determining behavior together with skills to decode advertising, as well as practice in making good-quality decisions and engaging in constructive dissent.

**Leadership**

Interest groups within professional organizations will be of help in promoting healthy systemic change that undermines the oppressive power structures that prohibit the inclusion in decision making of people who use an illegal drug and others who do not engage in waged labor or who have been seen as less worthy. Within professional groups, some important transitional steps to deal more constructively with illegal drug use may be identified, starting with identifying the range of approaches within present practice, developing criteria by which techniques may be rated, and moving on to expansion of the available repertoire of interventions. Based on an assessment of effectiveness, practitioners may then engage in a staged process of change from within and, with a coalition, from outside. Setting the changes in place will depend upon the development of reinforcers for behaviors that meet the targets. Punitive action,
however, is by nature retrogressive, and as such has little or no place in such a forward-looking endeavour. Leadership might best be provided by a balanced coalition of patients and providers with weighting toward the public and populist health and social services workers rather than institutionalized, elite, downstream, disease practitioners. Pathways to facilitate cooperation across typically siloed professions and agencies need to be mainstreamed to deal effectively with multi-faceted complex social phenomena such as addictions.

Traditional Aboriginal approaches to community life may also provide some insights into healthier ways to reorient Canadian society. Such approaches may include a focus on what a person can contribute or give back, rather than on what they can bilk others out of or get away with. In this strength-based approach, problematic behaviours are reviewed within the community to determine how to best resolve conflict so that no harm comes to anyone and so that all retain the respect that comes with being part of the community. A Council of Elders and peers together with those having conflict or difficulty develop a plan and assist one another to follow through. Such restorative strategies of preservation may offer guidance to the larger Canadian society and merit careful study.

**Access to the Basics**

Ultimately, it will be necessary to guarantee the provision of the necessities of life for all Canadians as a means to ensure a reasonable chance at good health in all its fullness. With one in three children and, typically, their mothers, living in poverty in Toronto (Toronto Community Foundation, 2009) and with food banks in common use, professionals may need to advocate for open access to the basics for all. Safe drinking water and careful water management is essential to quality of life for Canadians. Healthy food may be made widely available cheaply through schools, work places, or community centres. Wartime measures such as food stamps, although not without problems of their own, may have some potential to ensure access to basic healthy nourishment. Reassessment of the value of life close to the land such as family or communal
farms and support for approaches other than factory farming to growing food may be helpful.

Expansion of basic decent, energy-wise housing, set within organic communities, is crucial. Additional support may be needed to promote healthy living within families and communities and to provide a nurturing upbringing for children. Safety alone demands the legalization and regulation of all currently illegal substances, presented jointly with easily available addictions and other health and social care.

Access to basic protective clothing suitable for Canada's inclement weather is essential, as is access to timely, clean public transportation in a country as large as Canada. With such a huge and cold country, development and open access to renewable, cheap energy sources is important to live well; but protection and stewardship for Canada's non-renewable resources is also of top priority.

In the past, some have thought of Canadians as hewers of wood, miners of ore, fishers of cod, and mothers of Québècoise songbirds, tatterdemalion camp followers of a dejected army of hard workers marching on its belly, plundering an inexhaustible larder of natural resources with wild desperation and selling them off to the highest bidder. There is no war—really. And the march toward progress, accompanied by its fanfare of advertising, for the sake of change, in the name of profit, may carry a price too high. The cod on the east are gone, the salmon on the west, the pine beetle is thriving, the polar bears are drowning, and the ducks have tar coats. And it turns out that progress was code for entropy: devolution in the march to dissolution. Big problems, structural problems. Industrial dis-ease indeed! But the lark still bravely singing flies (McCrae, 1915/1981): There is a need to reimagine the role of Canadians in the world and at home.

Electronic plebiscite offers the opportunity to sidestep much of the politicking about these sometimes-inflammatory issues and forward such initiatives. Trialing a variety of approaches in a number of different communities would offer the opportunity to identify the pros and cons attending each approach
and make informed decisions about how to best manage the details of provision, as well as to track ensuing problems. (No system is without its problems.)

Social changes of the type described above are likely to attract vigorous criticism on the grounds that they are overly controlling. Of course, that criticism is likely to originate with those who currently profit from the present order of business, who exert control covertly behind the scenes.

Conclusion

This research targeted answers to the question, “How do professionals explain the actions (and inactions) of professionals that are meant to help people who use an illegal drug?” This answer depends upon the explanations related to a more basic question, “How do professionals make sense of illegal drug use?” This thesis featured integration of the findings, interview material, and the contribution of relevant literature presented in ten Chapters.

Chapter I introduced Anna’s story together with the background to illegal drug use in Canada and North America. Chapter II reviewed the cultural basis for addiction. Chapter III developed the social context of illegal drug use. Chapter IV gave personal information about the researcher’s interest in the field of addictions treatment. Chapter V presented thumbnail sketches of the participants and a synopsis of some of their views. Chapter VI served to review pharmaculture and the myths surrounding illegal drug use in the North American-EuroWestern context. Chapter VII focused on deviance and the social control of behavior in industrial society. Chapter VIII presented causal network analysis as one means of puzzling through the social dysfunctions surrounding illegal drug use and professional behavior. It also introduced material from Benner and Wrubel's (1989) Theory of the Primacy of Caring as a means to reestablishing professionalism on a healthier basis. Chapter IX offered a venue for musings about where Anna’s death fits within the larger social structure, and led to discussion about some potential practical changes to better the situation. Chapter X concluded the thesis with a summary of specific recommendations for change and for further study. Appendix A covers detail about the actual heuristic methodology used to explore how experts account for the nature of professional
help in illegal drug use. Appendix C graphically represents some of the theory base that helped me understand the dynamic of help-seeking / helping in the context of illegal drug use as developed in this thesis. Models of addictions based on this research and of scapegoating as it is currently practiced in Canada is also included.
EPILOGUE

It might have gone down as the death of a "quasi-transient" woman with a history of abusing drugs. That's how the May 9, 2007 death of Edith Isabel Rodriguez was initially reported to the Los Angeles County coroner's office. . . . Rodriguez, a California native, was poor and uninsured. She reportedly had a history of narcotics use and lived with various relatives. . . . She died of a perforated bowel, which probably developed in the last 24 hours of her life. . . .

emergency room workers, including contract physicians, evaluated Rodriguez over the three days before she died but each time found nothing seriously wrong.

But five weeks later, her demise has become a cause célèbre, a symbol of bureaucratic indifference. . . . Despite a long history of problems at Martin Luther King Junior-Harbor Hospital, two things set the Rodriguez case apart: the existence of a security videotape showing the woman writhing for 45 minutes on the floor of the emergency room lobby and . . . two 911 calls in which witnesses unsuccessfully pleaded with sheriff's dispatchers for help. . . . "Here's a person crying for help. Will no one help?" said Arthur Caplan, a bioethicist at the University of Pennsylvania. . . . "What kind of a society are we, when we can't even render aid to someone who's in their own blood and vomit on the floor and you're mopping around them? It's a kind of morality tale of a society gone cold. . . ."

The case . . . has crystallized people's fears that even in their most desperate moments, the emergency system won't take them seriously. . . . Many people like her die, their cases forgotten by everyone but friends and family. "They don't die on camera," said Dr. Felix Nuñez, medical director of the South Central Family Health Center in Los Angeles. "It's usually poor people dying on skid row, and they're just carted away. We don't hear and see anything about them."

The county Sheriff's Department, health officials, and the Board of Supervisors all are feverishly trying to determine who was to blame and how to prevent a recurrence. . . . Dr. Robert Splawn, senior medical director of the County Department of Health Services . . . named earlier this week as interim medical director of King-Harbor . . . suggested that Rodriguez was high on cocaine or methamphetamine at the time of her death. . . .

Results of toxicology testing by the coroner showed that Rodriguez did not have cocaine in her system. She did test positive for methamphetamine, but the level was not "life-threatening."

Pure and Simple

A simple pond flower growing by itself in pure water—Hardly. This water lily, complex in itself, sustains an interdependent web of tiny others all engaged in a struggle for the final bite, while predators patiently lurk. All while detoxifying the sludge exuded by humans. And still it manages to look good.

Acrylic on paper (Polych, 2010)
NOTES

1. Anna's Death

I became aware of Anna’s death in 1995, when Ruby told me at one of our Finally Understanding Narcotics (FUN) Group meetings about her recent experience at the hospital. Ruby was a stalwart of this weekly group that I founded and co-facilitated for 10 years at Parkdale Community Health Centre in Toronto. The purpose of this group was to share information about health and wellness in the context of illegal injection drug use. Anna attended occasionally, off and on over a year or so.

To really know Anna was to have listened to her sardonically hilarious recitation of daily events in her life, illuminated by the weird glow of humor shed by her delicious and acute sense of the absurd. Anna, a whipcord thin woman whose spare-fingered grip was like steel, would throw her head back and laugh like a horse when something struck her funny bone. Her grin, ear-to-ear, would flash her many teeth, strong, broad, and white, albeit gapped, framed by neon-red lipstick and set in a rather weathered countenance that some unkind folk even might call leathery. Anna supported her heroin habit by stealing powdered baby formula from the drugstore to resell and by sex work, neither of which was her preferred vocation. The loss of Anna’s life, while it resulted in a net gain for the Fashion District (since she was no slave to fashion), could have been measured by mega-Watts of brilliance suddenly dimmed across the city’s skyscape.

At a time when it was estimated that there were 18,000 active heroin users in Toronto alone but only 125 methadone treatment slots in Ontario, the FUN Group originated a ground-breaking proposal to move methadone maintenance into the community, with the result that now, 15 years later, there are over 5,000 methadone treatment slots in the province. The Group also filmed and produced a safer using video, Fit, shown internationally (The FUN Group, 1994); a series of pocket cards about safer using, Tips; and numerous research projects devoted to improving life for those using an illegal injection drug. The Group also provided speakers for professional education venues, fielded members to serve on the Boards of different community agencies, and supported a number of initiatives related to improving life for those who used an illegal injection drug, such as a community-based inquiry into police brutality against Torontonians who live close to the street. Co-incidentally, at a time when HIV infection was sweeping the city, the incidence of ongoing injection drug use among members fell dramatically over the lifetime of the Group, with some going on to methadone, some switching to less harmful ways of using their drug, and some discontinuing use altogether: tragically, some also died.
2. Adverse Drug Reactions

Dr. Joel Lexchin (2006) is an Associate Professor in the School of Health Policy and Management at York University and in the Department of Family and Community Medicine at the University of Toronto. He reported in an affidavit to the Ontario Superior Court of Justice on 30 June 2006 that, while over 10,000 adverse drug reactions were documented each year in Canada, he believed this figure may have underestimated the actual incidence by up to 98 percent (p. 12). From these figures, the reader can calculate that Canadians likely experience at least a half million adverse prescription drug reactions yearly; of course, not all are fatal. Lexchin is concerned that marketing incentives, totaling $1.4 billion in Canada in 2004 (p. 20) and directed mainly at doctors, drive inappropriate prescription of drugs. Despite marketing claims, based on French data, only about 3 percent of new drugs actually offer enough improvement over what is already available to merit a change in prescribing (p. 18). Further, following government cutbacks to regulatory agencies, data gathered by pharmaceutical companies about the usefulness of their medication goes largely unexamined by disinterested bodies and is generally unchallenged (pp. 8, 17, 48, 54).

Other physicians (Null, Dean, Feldman, Rasio, & Smith, 2004, pp. 1-34), whose allopathic practice is included as a part of their more holistic approach to health care as distinguished by them from disease care (p. 15), estimate the burden of morbidity and mortality from medicine to be much higher. Their data, based on US figures, may be divided by a factor of 10 to gain a rough idea of Canadian equivalents. Accordingly, of a potential 300 million total prescriptions written yearly (p. 23) in Canada, about 2 million would have been for unnecessary antibiotics alone, intended by the doctor to treat viral infections that actually do not respond at all to antibiotics as bacteria would (p. 2). Null et al. estimate an error rate of 20 percent in medicine. They cite Lazarou, who discovered that almost 5 percent of all hospital admissions were due solely to a serious adverse drug reaction (p. 19). Each year, we can expect about 220,000 adverse reactions to prescription drugs to take place in Canadian hospitals, which carry an iatrogenic fatality rate of 14 percent (p. 7). These figures generally support the direct estimate by Baker et al. (2004) of 24,000 deaths in Canadian hospitals annually due to adverse prescription drug reactions. Null et al. go on to cite studies that show that between 4 and 18 percent of consecutive outpatients suffer an iatrogenic event (p. 21), and report survey findings in which 25 percent of Canadians admit to having experienced a medical or drug error in the past 2 years.

Null et al. (2004, p. 1-34) also share Lexchin's (2006) concern about the inability of regulation to check exaggerated or false marketing claims by pharmaceutical companies (p 5). Further, Null et al. indict the American Medical Association for its delay, going back to 1964, in acknowledging the health risks of our other most lethal legal drug, tobacco, a silence that, they imply, was bought by donations from tobacco companies in the order of $2 million yearly over 9 years (p. 19).
Cassels (August, 2007), a Canadian drug policy researcher located at the School of Health Information Sciences in the University of Victoria echoes the concerns of Lexchin (2006) and Null et al. (2004, p. 1-34) about government reliance on the pharmaceutical industry to be truthful. Many deaths from prescription drugs, over and above those due to error, result from the toxic nature of the drug itself, prescribed to treat a particular condition.

Cassels (August, 2007) reports that inadequate testing of Vioxx, marketed to treat arthritis, left about 60,000 Americans dead of heart attack and stroke, slightly more than the number killed during the Vietnam war. Cassels lists a number of legal killer prescription drugs which had to be taken off drugstore shelves including: Tambocor meant to treat irregular heart beat, pulled due to higher levels of cardiac death; Baycol, with which doctors hoped to lower cholesterol, discontinued due to muscle damage and kidney failure; Rezulin intended to treat diabetes, withdrawn due to risk of liver failure; and Prepulsid used to improve digestion, discontinued due to increased incidence of fatal irregular heart beat. He also discusses the problematic acceptance of Herceptin which targets breast cancer, but which also causes cardiac toxicity; calcium-channel blockers meant to lower high blood pressure, which result in higher rates of heart failure; and ACE inhibitors, similarly meant to lower high blood pressure, which increase the risk of stroke (Cassels).

3. Car Culture

Car culture refers to the current arrangements of manufacturing priorities, distribution of goods, city planning, shopping patterns, employment, and social interaction (Wikipedia, 18 October 2007) now prevalent in North American-EuroWestern culture. The auto industry has described itself as the engine that drives the economy, but it runs on other industries: oil, steel, rubber, and road construction, and is held together by social technologies such as assembly line work and marketing. The auto industry in turn carries many other industries ranging from tourism to insurance to retail mall and suburb development. The face of global culture, as we have come to know it, is marked by a tire tread right up the middle.

Cars enable working-class people to get to work (so they can pay for a car), and in a Catch-22, simultaneously block access to work for those who cannot afford to pay for a car. Auto concerns, flexing “job-creation” muscle, have managed to bring in legislation that favors cars over people. The auto industry racket receives direct pay-offs from Canadians in the form of tax breaks and bailouts, as well as indirect financial subsidy in the form of infrastructure such as publicly-funded multi-lane highways rather than functional public transit. Lower-level individual crime opportunities opened up by car culture range from bank robberies to car jacking.

Car culture, like that early vehicle of death, the Trojan Horse, may have looked good at first glance, but it has brought death and disability ever since. In Canada, motor vehicle crashes injured 210,000 people in 2005 and caused
3,000 deaths, almost twice that due to illegal drugs (Transport Canada, 2006). Car culture generates intolerable noise, depletes non-renewable resources, and produces deadly air pollution from carbon monoxide. Car culture has resulted in environmental degradation ranging from surface run-off diversion and salinization, to the defacement of open-pit gravel quarries, to the havoc caused by exploitation of the Tar Sands. Cars have irreversibly damaged the bio-habitat of all species including people.

While car culture has opened otherwise remote areas to development, it is always at a cost, and that expense is never simply the immediate dollar outlay. Blowback from car culture has included infectious diseases such as HIV, trucked along continental trade routes through the African savanna and straight to the front door of Canada. Health problems spewed out in the exhaust of car culture include but are not limited to smog-related asthma and lung disease and the growing levels of indolence among obese suburbanites who must drive their sport-utility vehicles (SUVs) to the corner coffee shop. Other less obvious effects include worsening levels of anxiety related to growing helplessness in the face of the juggernaut, and the exacerbation of Alienation, which rides in the passenger seat, while Loneliness together with its inseparable companion, Suspicion, occupy the back seats. All of these factors have increased the focus on self alone, which, when blocked, boils over into road-rage.

Some of the social problems imported with car culture include the loss of leisure time to rush hour commutes and twice-daily gridlock; the loss of the sense of journey, place, and immediacy; and the loss of a sense of belonging to and being known in a community. Confusion about individual values may be addressed through attention to advertising intended to promote car sales and uptake of the machismo message that saturates such marketing. Key attributes highlighted by car culture include the concepts of status display, useful life, planned obsolescence, disposability, and mobility. On the positive side, car culture has brought us some breath-taking movie chases (Paul Newman) and some heart-breaking travellin' songs (Bobby McGee).

4. The Bilderberg Group

The Bilderberg Group was initiated in 1954 by Prince Bernhard of the Netherlands and l'eminence grise, Joseph Retinger, brilliant scholar, Polish freedom fighter, favored of the Pope, union darling, and friend to business. The aim of the Bilderberg Group was to counter the post-war anti-Americanism (socialism) rampant in Europe and the global upsurgence of populism, exemplified by the apparent success of the Soviet Union. The intent of the Bilderberg Group initially was to coordinate economic “recovery” in Europe, restore long-term planning for global business, and set strategic international policy (Bilderberg Meetings, 2010).

The Bilderberg Group, known for its success at hiding in plain sight (Reynolds, 2006), is the subject of worldwide speculation. It is now said that its intent is to domesticate and homogenize the world primarily for the benefit of the
elite. One hundred plus attendees are invited to attend Group meetings by the Chair, selected from those who hold powerful positions in finance or capitalist ventures or who occupy key government positions—the ruling class—and their media helpers. Proceedings are not discussed openly nor are they publicized.

The Bilderberg Group grew out of Milner's Kindergarten of 1910 splitting later into the UK Royal Institute of International Affairs, known as Chatham House; the US Council on Foreign Relations (CFR); and the Trilateral Commission, founded by one of the Rockefellers, which includes the Japanese (Reynolds, 2006, p. 280), all decision-making groups that operate without the benefit of NATO regulations. These civil groups are buttressed by executive meetings like the G8: the US, Canada, Japan, Germany, Britain, France, Italy, and Russia. International economic institutions such as the International Monetary Fund (IMF) and the World Bank oversee the global flow of capital. They are supported by trading arrangements similar to the North American Free Trade Agreement (NAFTA) and the General Agreement on Tariffs and Trade (GATT) (Chomsky, 1994).

German-born Prince Bernhard, educated in law and major stockholder in Royal Dutch Petroleum (Shell Oil) was an honorary member of Hitler’s SS and worked at one point for IG Farben. (The same IG Farben that profited from the labor of those interred at the Auschwitz Death Camp in Nazi Germany.) In later years, he was a member of the Board of KLM Royal Dutch Airlines, which has now been exposed for having organized easy-entry flights after the end of World War II from Germany into Switzerland, from whence many Nazis made their way to shelter in Argentina (BBC, 2007), a country headed by Juan and Evita Peron, who were friends with Prince Bernhard.

Stephen Harper, head of the currently ruling Conservative party in Canada, attended the 2003 meeting of the Bilderberg Group in Vienna, before election to the position of Prime Minister, and a member of his coterie has attended each meeting since. The 2006 meeting was held, amid secrecy as usual, in Ottawa at the Brook Street Resort, which was summarily cleared of guests before the meeting and closely guarded throughout (CTV, 2006). The Group met recently (June 3rd-6th, 2010) at the Dolce Hotel in Sitges, Spain (Smith, 2010).

5. Neocon

The term, neocon is held to refer to disaffected liberals (Democrats) who cannot fully embrace conservative (Republican) big business ideals. Neocon thinking erupted out of the backlash against the counter-culture peace and other populist movements of the 1960s. Neocons fear social chaos if human nature (which they know to be selfish) is not kept under strong control, and represent themselves as standing up for moral values and traditional norms. In an apocalyptic paradigm, neocons fuse quasi-Christian “moral” traditionalism with economic libertarianism, set against the creeping moral decline which they believe is sapping individual initiative. Neocons see secular humanist
conspiracies all around them, which they believe come from socialist and communist thinking, a product of Satan and his allies (Berlet, 1998).

Neocons view democracy and, more particularly, free enterprise, capitalism, and unrestricted trade, globalization, as providing the remedy for economic polarization and impoverishment in society (Clarkson, 2002, p. 6-8). Neocon housing policy for the most disadvantaged Canadians, for example, involves opening the door to US corporations to build prisons (Clarkson, p. 117). Neocons support tax cuts as a means to stimulate the economy. They are more than willing to initiate preemptive war in the fight for “democracy” and feel it is legitimate for the government to enforce morality (Naim, 2005, p. 271). Neocon advisors supported the militant efforts of the US to circumscribe Communist influences and neocon politicians were behind covert operations, including the Iran-Contra debacle. With the dissolution of the Red Menace embodied by the United Soviet Socialist Republic, their attention has turned to “policing human rights” in selected areas of the world, typically those with economic value to the US.

Neocon ideology currently is expressed by uneasiness about Communist China and post-Soviet Russia, alarm about the Middle East, and hostility toward poor countries whose populations are predominantly of the Muslim faith. It also legitimizes the demonization of certain North American groups by the far right, who tend to endorse the analysis of religious fundamentalists who believe the Antichrist has manifested. Neocons subscribe to the belief that the social order is under threat from a number of sources that may take the form of international “terrorists”, “sinful” abortion providers, “anti-family” feminists, gay “special rights” enraged activists, rock musicians, “pagan” environmentalists, liberal secular humanists and their big government allies, and globalists plotting the New World Order leading to one world government. These demonized groups are kept in check by the vigilance and dedication of quasi-Christian-based groups such as the Patriot movement, which are kept informed by organs such as the John Birch Society. Groups of such guardians include: survivalists, libertarians and neoNazis, White Supremacists, antiSemites, gun rights proponents, anti-tax organizations, anticommunists, and antiabortion organizations (Berlet, 1998).

Musicians (social analysts) from rock to heavy metal have made their concerns about the impact of neocon behavior clear. Two samples follow:
You call yourself a Christian.
I think that you're a hypocrite.
Your say you are a patriot.
I think that you're a crock of shit.

And listen, I love gasoline,
I drink it every day,
But it's getting very pricey,
And who is going to pay?

How come you're so wrong
My sweet neo con?... Yeah

‘Cause democracy’s our style,
It’s liberty for all,
‘Cause democracy’s our style;
Unless you are against us,
Then it’s prison without trial.

But one thing that is certain,
Life is good at Halliburton*.
You’re really so astute,
You should invest at Brown & Root**

Yeah

How come your’re so wrong
My sweet neo con?
If you turn out right,
I’ll eat my hat tonight.

Yeah, yeah, yeah, yeah...

It’s getting very scary,
Yes, I’m frightened out of my wits.
There’s bombers in my bedroom,
Yeah, and it’s giving me the shits.

We must have loads more bases
To protect us from our foes.
Who needs these foolish friendships?
We’re going it alone.

How come you’re so wrong
My sweet neo con?
Where’s the money gone?
In the Pentagon.

Mick Jagger and Keith Richards
(2005, September 5)

The war on terror
No truth, all lies
Awaken the masses
Open your eyes
Yeah!!
Kill, rape, torture, pillage,
as time marches on
A vicious agenda de force

Neocon

Prize in sight, so we fight
And we pray that the kids are all right
that we sent off to die.
Letters sent from the base
tell the tale that we face every day,
But we tend to deny that the cause
is unjust,
So we must pray to god
so the wrath is his will, so we kill.
Branded weak are the sheep
with no minds of their own
So they do what they’re told,
and they will.

Thou shalt not fight for you!!

US über alles except for itself,
A country divided by fascists and wealth
Begging for mercy, the truth never told
Families are broken, bodies are cold.
Deaf, blind, all sides
getting took for a ride
Being fed steady diets of gray
Death starved, so we dine up
with a chill up the spine
as we drink it and wish it away.

Such a price to endure,
All the theater of death has to give
in the place where we live.
Play god for the term, play it well
Never learn, never will we forget or forgive.

Thou shalt not kill for you!!
Bring it on!
Thou shalt not die for you!!
Bring it on
Neocon

Pro-Pain (2005, August 28)
Dick Cheney, while serving as Secretary of Defense for George HW Bush, organized a scheme to privatize logistical support for the armed forces: meals, laundry, cleaning, and so on (McQuaig, 2005, p. 108). Halliburton won those contracts and profited enormously. Halliburton subsequently hired Cheney as CEO, paying him $35 million from 1995-2000 and millions more in stocks. Cheney then, in 2000, heading up the selection committee to chose a Vice-President for George W Bush, selected himself. G-Dubya, with his roots in oil, received more money from big oil prior to his election than any other US federal candidate had over the previous decade (McQuaig, p. 84). Condoleeza Rice, appointed Secretary of State in the same administration, was also very comfortable with oil, being a Board member of Chevron during the 90's.

While the US, home to 5 percent of the world’s population, uses 25 percent of the world’s oil and so generates ¼ of global warming emissions, it has only 3 percent of reserves (McQuaig, 2005, pp. 12, 40). Tongue-in-cheek, irritated protesters mockingly demand, “How did our oil get under their sand (Cantarow, 2003)?” Saudi Arabia sits on 25 percent of the easily extracted oil deposits in the world (McQuaig, p. 77) and Iraq is home to 10 percent (McQuaig, p. 62). Projections estimate oil extraction from Iraq at $30-70 million yearly (McQuaig, p. 77), although Bush and his neocon backers claimed that they invaded Iraq only in the name of “democracy.” The US also refused to sign on in 1997 to the Kyoto Accord to reduce greenhouse gasses produced by burning fossil fuels, warning Canada that agreement would dry up investment in Alberta’s oil patch and force half a million Canadians out of jobs (McQuaig, p. 160). (No pressure.)

* Halliburton – an incestuous Houston-based oil well conglomerate that provides military, security, and reconstruction services to the US government under contract.

** Kellogg, Brown & Root – now known as KBR, an engineering subsidiary of Halliburton, provided military personnel and services to the US army during the Vietnam War. Since, KBR was awarded billions for the Restore Iraqi Oil (RIO) contract after previously being paid to write the specifications for the bid (McQuaig, 2005, p. 94-95, 105-110).

6. Downtown East Side Vancouver

The Downtown East Side (DTES) is the oldest section of Vancouver, Canada. The neighborhoods of Victory Square, Gastown, Thornton Park, Oppenheimer, Industrial, Strathcona, and the Hastings Corridor are home to about 18,000 people, about ⅓ of whom live in social housing (DTES Directions, 2009). Vancouver’s Skid Road is located here, a term harking back to the days when unemployed fishermen, miners, and loggers would drink, gamble, and fight while they sheltered in the area, waiting, sometimes for days, for work skidding logs. Since then negative connotations have come to characterize Skid Road, known as a gutter harboring poverty, drug addiction, prostitution, and violent crime.
The DTES is a vibrant *mélange* of affluence and poverty, which sees a mix of races, from strapping urban Natives to diminutive Canadians of Chinese or Japanese ancestry, rubbing shoulders with a blend of runaways, transients, pan-handlers, sex trade workers, petty criminals, people using drugs, people living with mental health problems, and those who work with them. The result is a potent recipe for the community activism for which the DTES is also known. The heart of the district is the intersection of Hastings and Main, often portrayed as a dangerous location, hazardous home to the desperate and despondent, where a person can buy any kind of drug or other pleasure on the *al fresco* market. Dozens of young women working the sex trade, driven from other areas of town by police action into the *low track* in the DTES, have been preyed upon and many have been killed; almost 50 are believed to have died at the hand of Robert Pickton alone.

The DTES is known for its many single room occupancy (SRO) hotels, the only affordable, convenient, practical accommodation for many on social assistance, housing threatened by gentrification and speculation tied to the winter Olympics of 2010. The DTES is also known as the locale with the highest rate of HIV infection in the western world (Wikipedia, 4 November 2007), with 40 percent of injection drug users testing positive (Livingston, 2007), a consequence of the poorly thought through needle exchange policies of the 90’s.

7. Sex Kills

I pulled up behind a Cadillac;
We were waiting for the light;
And I took a look at his license plate-
It said, just ice.
Is justice *just ice*?
Governed by greed and lust?
Just the strong doing what they can
And the weak suffering what they must?
And the gas leaks
And the oil spills
And sex sells everything
And sex kills ...
Sex kills ...

Doctors’ pills give you brand new ills
And the bills bury you like an avalanche
And lawyers haven’t been this popular
Since Robespierre slaughtered half of France!
And Indian chiefs with their old beliefs know
The balance is undone-crazy ions-
You can feel it out in traffic;
Everyone hates everyone!
And the gas leaks
And the oil spills
And sex sells everything
And sex kills ...
Sex kills ...

All these jack-offs at the office
The rapist in the pool
Oh and the tragedies in the nurseries-
Little kids packin' guns to school
The ulcerated ozone
These tumors of the skin-
This hostile sun beating down on
This massive mess we're in!
And the gas leaks
And the oil spills
And sex sells everything
And sex kills ...
Sex kills ...
Sex kills ...
Sex kills ...

Joni Mitchell, *Turbulent Indigo*, Track 2

8. The Anti-Terrorism Act and the Economy

Among the most heartbreaking calls for government to do something are those from bewildered grieving Canadian families, who have lost members to the violence resulting when those who live in deprivation act out their despair of ever seeing their plight set right (Mandel, 2004, p. 43). Inevitably, families personalize such tragedy and look right to Canadian security officials to hedge them safely in, rather than calling out their leaders to account for the national and global policies which ensure economic exploitation of people around the globe to the point of outright death from starvation and the guarantee of life-sapping poverty for many Canadians (Guillemin, 2006). In Ontario, welfare payments, after the rent on one-room accommodation is paid, typically leave single recipients a total of about $30 weekly to provide for food, clothing, personal hygiene, transportation, and any other needs. Such scant support leaves social assistance recipients cold, standing there, hands empty, in the midst of privilege, with little to lose.

Canada has now been robbed of many fine young people, dead in battle, casualties in the war in the Middle East initiated by the US. (Further, the rule of thumb warns Canadians to expect two wounded for every death [Mandel, 2004, p. 60].) The primary allegation in circulation is that the war was a simple guise for a grab at the easily extracted oil that underlies the region (Chomsky, 2003, p. 86; Moore, 2003, p. 87; Mandel, 2004, p. 27). Potential transportation routes to move this second-largest deposit of oil range through mountainous Afghanistan north to the US's inveterate foe, Communist Russia, or east to it's implacable
rival, Red China, or hopefully, south for ocean shipment home through the Indian Ocean to the US from Pakistan’s coast on the Gulf of Arabia or through the Mediterranean. Of note in the strikes against the US economy that supposedly precipitated the US-named War against Terror, is that the first site, the World Trade Center is very visibly the epitome of commerce in the US. The second site, the Pentagon, while less recognized as an institution of business by Americans, evidently was deemed so by al-Qaeda.

The American economy, chronically dependent economically on the stimulation of war, has had the Pentagon rooting around for another victim ever since the Red Scare wore off. It is clear that, without the shot across the bow fired by al-Qaeda (The Base), the American Government, warless now that the Russians are no longer coming, would have had great difficulty indeed in justifying austerity for common folk paired with policies tailored to pad the accounts of the elite. Examples of generosity of the public toward business include the granting of patents to private manufacturers for materials developed through the university system and the presentation of market-ready research in high-tech electronic, pharmacological, and biologic areas for final development by private interests (Chomsky, 1994).

It is true that the income of Americans has grown on average by 26 percent from 1980, but the distribution of gain is anything but equal. For the bottom 99 percent of taxpayers, growth has topped out at 8 percent, while for the top 1 percent, growth in real income has averaged about 175 percent, and for the elite 0.01 percent, times have been even better, with growth of income over 400 percent (Gibbs, 2007). Should governments, including Canada’s, become confused and implement populist policies supportive to the lower classes, they will find they are hostage through debt held by multinational interests and by instantaneous redirection of the flow of international investment (Chomsky, 1994). The larger issue is how to deal with bullies and hostage-takers...

Globally, as shoestring countries are forced by instability to buy into the International Monetary Fund (IMF) plan of open trade and cash crop export-based agriculture, structural poverty for the many simply increases (Schrecker, 2008). Rural farmers find they are not able to afford to provide for their own families, and may be forced off the land into risky, abysmally low-paid, environmentally toxic production for export, exemplified by the maquiladoros of Mexico. Even when caught as they are between the threat of the US Drug Enforcement Agency (DEA) and it’s proxies with their chemical warfare, government forces, and the menace of the paramilitaries representing different armed cartels, cultivation of crops that furnish drugs now deemed illegal still makes good sense to farmers who would otherwise eke out a living in poverty—maybe. Global cocaine production for 2008 is believed to have run at about 865 metric Tons, down from 1024 Tons in 2007 largely from Columbia, Peru, and Bolivia, 80 percent of which goes straight into North America-EuroWestern countries where 10.7 million users pay $275/Gm (Schrecker, p. 103) for a total of about US$ 70 billion (UN Office of Drugs and Crime, 2010). Americans use about half of the cocaine yield, paying US$35 billion in 2008 for 175 Tons
In Afghanistan, farmers face a similar squeeze play. Afghanistan produced 95 percent of the world’s opium even under the oversight of the Americans, at 6,900 Tons in 2009, which goes on to conversion into 380 Tons of heroin (Schrecker, p. 109), of which only a delicate 22 Tons are sold in North America (Schrecker, p. 111). The stockpile in Afghanistan of opium awaiting processing, at 12,000 Tons (p. 109), may have had an effect on the 1000 Ton reduction of the crop since last year [UN Office of Drugs and Crime, 2010]). Afghan farmers in the poppy fields and local traders will bring home about US$2.3 billion of the $55 billion in retail end sales of heroin. The main export route follows the silk and oil roads leading through Pakistan and Iran into west into Turkey, or north into Tajikistan and Kazakhstan, handled at these points mainly by Pashtuns, Kurds, and Persians often in exchange for weapons. Two thirds of Afghan opium farmers also grow cannabis despite its thirst for water, bringing farmers another $67 million for its yearly production of 3,000 Tons, making Afghanistan the world leader in marijuana production as well (Norton, 2010). In the midst of this spiral into absurdity, at the eye of the storm, the elites continue to do well.

Maureen Basnicki, flight attendant and wife of one of the 24 Canadians killed in the attack on the World Trade Center twin towers in New York on September 11th of 2001, directed a blind-eyed, impassioned appeal to the Canadian Parliament to extend the Anti-terrorism Act, which came up in 2007 for its scheduled review (Canadian Press Ottawa (2007)). The provisions of this Act empower the authorities to “preventatively” arrest people who they believe might be involved in terrorist activities and hold them for 72 hours without charge. Although that doesn't sound so bad, Sub-sections 6 and 7, which authorize detention for "any other just cause," evoke serious concerns about the potential for abuse. Stephane Dion, then leader of the Federal opposition Liberal Party, has pointed out that such security certificates have not been helpful, do nothing to fight terrorism, and simply open the door to violation of civil liberties (Feraday, 2007).

Ms. Basnicki said nothing about Canadian collusion with US global economic policies that force many into desperation; Ms. Basnicki may be unaware that the US is known internationally for its support of brutal regimes as it attempts to control energy, resources, and trade abroad (Chomsky, 2003). Nor did she mention the domestic policies that result in widespread dependence on food banks among the families of the very armed services personnel who she expects to protect her.

9. Money Laundering

Money laundering refers to the means by which organized crime returns the money they receive for illegal goods or services into the visible economy via businesses which are characterized by large cash flows, such as laundries, taxi services, restaurants, charities, or even private banks, so that the authorities do
not take alarm at large cash deposits. Laundering illegally-gained income enables the upper echelon in the underground economy to relax and enjoy the proceeds without fear of being accused of a crime or otherwise attracting police attention, since their often lavish lifestyle will appear to be funded by legitimate, hard-earned income. Since the entrenchment of the e-conomy, money is often additionally laundered through shell companies, overseas or offshore tax havens, and wire transfers (Lunde, p. 44).

One of the first money laundering operations was initiated in Prohibition Era Chicago by Al Capone's outfit, after he bought up a number of genuine laundry businesses, so that income from bootlegging and “protection” money could be banked after being blended with the proceeds of ordinary services (Lunde, 2004, p. 40). By 1931, Capone was cleaning about $50 million yearly.

It is estimated that 5 to 10 percent of the world Gross Domestic Product (GDP), $2 to 4 trillion (Naim, 2005, p.137), is laundered around the globe. Organized crime has as many additional income sources as it has inroads into legitimate businesses. Over and above the illegal drug trade, pornography, prostitution, people smuggling, slaving, trade in human organs, fake pharmaceuticals, and weapons all represent opportunity for organized crime. Cyber crime alone brings in an estimated $40 billion yearly (Lunde, p. 49) and profits from illegal gambling in the US are estimated at $100 billion yearly. A modest estimate of monies generated by organized crime and related businesses internationally is just over $1 trillion annually, just a little less than Canada's yearly GDP of $1.4 trillion (Bank Introductions Canada, 2007). Globally, the shadow economy is said to account for 15 to 20 percent of GDP (Glenny, 2008, p. xv).


The links between big business and the military have long been locked in place but often not recognized. A brief stroll along one path of collusion, touching lightly on some points of interest, shows us that the Rockefellers have come a long way from Grandpa's day, when he made his living selling snake oil. (Some products, such as Nujol [new oil] hair pomade, were available until recently.) There is more than a little irony here, as it was Rockefeller Foundation funding that led to the national assessment of American medical schools and the entrenchment of allopathy resulting from the Flexner Report of 1910. This Report and the legislation that followed it effectively disenfranchised homeopathic, naturopathic, osteopathic, chiropractic, and any other approach to healing and criminalized any practitioners, such as midwives and herbalists, not credentialed as allopathic physicians graduated by certified schools.

The impetus for the Rockefeller fortunes came, however, not from snake oil, but from crude oil. Sonny's bloody-minded focus on controlling American oil, starting with Standard Oil, which later morphed into Esso and Exxon, joined by Mobil, generated huge profits. It was the efforts of the Rockefellers to avoid
paying US taxes which led them to invest their money abroad, a practice which introduced the world to the conscienceless multi-nationals we see today.

The Rockefellers became major stakeholders in IG Farben, the infamous pharmaceutical company in Germany that collaborated with the Nazi regime, producing Zyclon B together with many other lucrative products (Hasslberger, 2003). Under Rockefeller guidance, the IG Farben conglomerate knew a good thing, and it bought up a large share of stock in the Ford Motor Company. After World War II, IG Farben split into pharmaceutical / chemical companies AGFA, BASF, Bayer, and Sanofi-Aventis, continuing to do well given the trade provisions and patent protections courteously put into place by accommodating government officials who knew how to please. Charitable donation, as a vehicle for tax deductions, also gained considerable mileage from the Rockefeller aversion to taxation.

Another notable connection in the military-industrial-big oil-pharma-real estate-government complex is that which led to the prohibition of marijuana. The ruthless military chemical giant DuPont, financed by Andrew Mellon's bank in its takeover in the 1920s of General Motors, had just patented the process to make nylon, was researching production of latex paint, and had just sold Randolph Hearst the sulfur-based chemical process they had developed to treat wood pulp to make paper. Mellon, the Treasury Secretary in Hoover's Government, was a heavy investor in DuPont's paper treatment process. Hearst had lost huge tracts of timberland during the Spanish-American war at the turn of the century and was grudgeful toward marijuana-marinated Mexicans. Not to be bigoted in his vendetta, mobilized through yellow journalism, Hearst gave equal time to cocaine-crazed soul and Satanic-jazz loving Negroes and popularized the yellow peril represented by opium-smoking Chinese immigrants, all of whom were, no doubt, after Whitey's woman (Herer, 1997).

Harry Anslinger, nephew by marriage of Andrew Mellon, was put out of his job as Assistant Commissioner of Alcohol Prohibition when prohibition was repealed, and was duly appointed to head up the Bureau of Narcotics in 1931. Anslinger was not given much of a budget, but was able to take advantage of the prurient nature of Hearst's yellow journalism to swing and build public opinion by demonizing cocaine and marijuana and its users. The infamous film, Reefer Madness (1936) was funded by the proceeds from sales of newly legal alcohol. Anslinger had before him the example of the success of legislation that, through taxation, restricted ownership of the machine guns that had proliferated during Prohibition. Anslinger was able in 1937 to stampede the passage of the Marijuana Tax Act past the few attending members of the Southern-dominated Ways and Means Committee, sweltering through the August meeting, thereby avoiding the open debate that would have awaited such legislation had it followed the proper channels through Congress. Those present were largely unaware that the substance they banned over that 30 minutes, presented to them by its Sonoran slang name, marijuana, was even the same substance as the well-known farm cash crop, hemp. Anslinger presented marijuana as a demon drug, in proof of which he read aloud, as evidence, excerpts from
Hearst's lurid articles. The Committee agreed to require tax-paid stamps be displayed upon the sale of marijuana; since no stamps were ever printed and none were ever available, any sale of marijuana was, *de facto*, illegal.

This back-scratching orchestration was a bold-faced means to outlaw hemp cultivation, poised, with the invention of the Decorticator, to branch into products such as paper, fabrics, biodegradable plastics, and paint of superior quality, potentially jeopardizing profits for the principals, DuPont and Hearst, as well as investors including Uncle Andy. This legislation ushered in the era of synthetics, pesticides, and rampant environmental degradation, and coincidentally, did its share to put the “closed for business” stamp on the family farm, by outlawing a very viable, hardy, and versatile crop.

11. Copperhead Road

Well my name's John Lee Pettimore,
Same as my daddy and his daddy before.
You hardly ever saw Gran'daddy down here.
He only came to town about twice a year.
He'd buy a hundred pounds of yeast and some copper line.
Everybody knew that he made moonshine.
Now the revenue man wanted Granddaddy bad.
He headed up the holler with everything he had.
It's before my time but I've been told,
He never came back from Copperhead Road.

Now Daddy ran the whiskey in a big-block Dodge.
Bought it at an auction at the Mason's Lodge.
Johnson County Sheriff painted on the side,
Just shot a coat of primer, then he looked inside.
Well him and my uncle tore that engine down.
I still remember that rumblin' sound.
Well the sheriff came around in the middle of the night
Heard Mama cryin', knew something wasn't right.
He was headed down to Knoxville with the weekly load.
You could smell the whiskey burnin' down Copperhead Road.

I volunteered for the Army on my birthday.
They draft the white trash first, 'round here anyway.
I done two tours of duty in Vietnam,
And I came home with a brand new plan.
I take the seed from Columbia and Mexico.
I plant it up the holler down Copperhead Road.
Well the DEA's* got a chopper in the air.
I wake up screaming like I'm back over there.
I learned a thing or two from ol' Charlie, don't you know.
You better stay away from Copperhead Road.
Copperhead Road.
Copperhead Road.
Copperhead Road.

Steve Earle (Track 1 from *Copperhead Road*)

* DEA - Drug Enforcement Agency of the US

12. **Tommy Douglas**

Tommy Douglas was the head of Saskatchewan’s Social Democratic government for almost 20 years at the end of World War II. Douglas had profound religious roots, being a Baptist minister (somewhat like Stockwell Day, who, at one time, assisted a Pentecostal pastor (Hoy, 2000, p. 38). Unlike Day, the well-educated Douglas had a concurrent focus on social justice, partly gained from awareness stemming from a bout of osteomyelitis that almost cost him a leg and from exposure to brutal union-police conflict (Stewart, 2003). Douglas and the CCF were key in constructing Canada’s social safety net. Douglas was ultimately voted “The Greatest Canadian” in 2004.

Like his Teacher, Douglas often used story to get his message across. One of Douglas’ parables [amended] (Wikipedia, 25 August, 2007) went a bit like this:

The mice of Mouse-Lanada were caught on the horns of a dilemma. They had to choose a government from one of two major parties of Cats. The mice at first voted in the Fat Cats, a hard-line, right wing party representing big business interests, who promised to look after mice by looking after the bottom line at any cost. Then the mice found out how hard life was, living under the iron-blue claw of the Fat Cats. Come the next election, the mice overwhelmingly voted in the Cheshire Cats, the more liberal, closer-to-center right-wingers representing small business, who promised to look out, with a smile, for the little mouse. Then the mice found out that the Cheshire Cats just lied right through those red teeth of theirs, and life wasn’t much different under the self-satisfied grin of the Cheshire Cats.

As the desperately unhappy mice debated the best approach to their dilemma, one mouse reared up on his hind legs and declared that the dilemma facing them was not a real dilemma at all, but a made-up, false dilemma. The choice before them was really no choice at all. Instead of trying to pick the Cats who would best represent the interests of Mice, the mice should be choosing among Mice to run their country—not Fat Cats, Cheshire Cats, Green Cats, Worker Cats, Family Cats, City Cats, Country Cats, or any other kind of Cat—but Mice! Mice would run for office, Mice would vote, Mice would form a
government, Mice would wield power, and Mice would benefit Mice. Cats could
go prowl or howl as they chose.

When they heard this, the Cats were afraid that they might be caught with
a paw in the kibble jar and that they might lose their place at the trough. They
knew they were living off the fat of the Lanada, skimming off the cream, and that
the gap between cat and mouse grew wider and wider every year, with mice
licking up crumbs, living paw to mouth, while Cats lived high on the hog.

There was a great upmeowr in the press and allegations flew. Right-
thinking cats were appalled when they read that the mouse who had spoken
could, in fact, be a catnip addict. TV labeled him a Commousenist. Caught by
the Securi-Cats like a rat in a trap, the mouse was hauled up post haste before a
court of Scaredy Cats, where he was branded a terrierist, convicted of rattling the
status quo, and caged in a secret prison for an indefinite time under the Anti-
Terrorism Act, as a threat to national security.

Then the CCF won the election in Sassy-Cat-Chew-On, and the Cats
found something out: Even if you call names, cast aspersions, run down and
ridicule, claw up the character, kick up an upmeowr, or trap a trouble-maker,
thought still scampers free. And those ideas lead straight to power.

13. The Wobblies

The Wobblies, a moniker adopted by the Industrial Workers of the World
(IWW), was an organization established first in the US in 1906. It had a strong
presence on the west coast of Canada, where miners and loggers actively
promoted membership. Wobbly membership was open to any working person,
including women (who were prohibited at the time from holding property or
voting) and non-whites, who were generally treated as personae non gratae.
The Wobblies undertook the responsibility for greeting immigrants upon arrival,
and had a powerful Asian presence in the IWW as a result of this and other
promotion. It was the Wobbly voice raised in solo protest at rhetoric directed at
Hearst’s Yellow Peril. It was a Wobbly-led general strike in 1906 in British
Columbia (BC) that forced government to bring the 8-hour workday into Canada.
Wobblies, predictably, often met with slaughter, orchestrated in the interests of
business. In light of the power of the opposition, the movement came to be seen
as tainted, although it still has a minor presence in North America and abroad
(International Workers of the World, 2010).

Wobbly understandings shared many points in common with the socialist
zeitgeist sweeping the globe at the turn of the century. Wobblies exposed the
exploitation of workers by business and moreover targeted religion as an agent
abetting their oppression. Songs were used to effectively educate, convey
Wobbly philosophy, and build solidarity. Coopting the call and response
technique of gospel, Wobbly Joe Hill coined a phrase, *pie in the sky*, to caution workers against waiting to set their tables with the promises of evangelists.

**There’ll Be Pie in the Sky When You Die (That’s a Lie)**

sung to the tune of *In the Sweet Bye and Bye* (hymn)

Long-haired preachers come out every night,
Try to tell you what’s wrong and what’s right;
But when asked how ’bout something to eat
They will answer in voices so sweet.

Chorus: You will eat [You will eat], bye and bye [bye and bye]
In that glorious land above the sky [way up high];
Work and pray [work and pray], live on hay [live on hay],
You’ll get pie in the sky when you die [That’s a lie!]

And the *Starvation Army*, they play,
And they sing and they clap and they pray,
’Till they get all your coin on the drum,
Then they tell you when you’re on the *bum*.

*Holy Rollers* and *Jumpers* come out
And they holler, they jump and they shout
Give your money to Jesus, they say,
He will cure all diseases today.

If you fight hard for children and wife—
Try to get something good in this life—
You’re a sinner and bad man, they tell,
When you die, you will sure go to hell.

Workingmen of all countries, unite.
Side by side, we for freedom will fight.
When the world and its wealth we have gained,
To the *graiters* we will sing this refrain.

You will eat, bye and bye,
When you’ve learned how to cook and to fry;
Chop some wood, ‘twill do you good.
Then you’ll eat in the sweet bye and bye.

You will eat (You will eat), bye and bye (bye and bye),
When you’ve learned how to cook and to fry (how to fry);
Chop some wood [Chop some wood], ‘twill do you good (do you good).
Then you’ll eat in the sweet bye and bye. (That’s a lie!)

Joe Hill (1911)
Starvation Army: A play on words that highlights the inadequate attention to the necessities of life by religious groups. The Salvation Army in particular, is a quasi-military religious sect that prides itself on instrumental help offered as a means to gain salvation of the soul.

Holy Rollers: Refers to practitioners of evangelical religions, such as the Pentecostal Christian, that emphasize conversion of sinners by the intrusive promotion of their beliefs at the doorstep and in public fora. The custom of falling to the floor and rolling about while possessed by religious fervor during group worship and speaking in incoherent tongues led to the reappropriated descriptor, Holy Roller.

Jumpers: The Jumper religion formed from a branch of the Molokan religion founded in Russia in the 1700's, when they split from the Orthodox Christian church. Western Canadians became the puzzled neighbors of the Doukhobors (spirit wrestlers) and the Ikonobors (image wrestlers) as well as the Jumpers, who immigrated in waves in 1905. Adherents of the Jumper faith believed in the apocalypse, prophesy, pacifism, simple living, singing, and spiritual dancing. They abjured preachers, decoration, and images of God. Jumpers were described at the time as “leapers, dancers, prancers, and noisy nose-breathers.”

Grafters: Corrupt public officials and unscrupulous people in a position of trust who exploit their position for fraud or who violate confidence through thievery.

14. Useless Eaters

The term, useless eaters, was used during the Third Reich in Germany, which spanned the 12 years from 1933 to 1945 during which the Nazi party dominated the country, to describe people living with a disability or who were felt to not contribute to Nazism (Mostert, 2002). About 170,000 people with physical, emotional, and intellectual disabilities were killed or forced to live in conditions that caused their death. About 1 million children under 18 years of age are believed to have been killed, together with people unpopular with the Third Reich for a variety of reasons. Such deaths included those of about 5,000 bibelforscher: Jehovah’s Witnesses, bible students, or members of religious groups (Catholic, Lutheran) who refused to acknowledge any authority but God. Roughly ¼ million men found guilty of sex with other men (Rummel, 1992, Chapter 1), who the authorities felt could not be expected to contribute to the building of a healthy race, were killed. An estimated ¼ million Freemasons and nacht und nebel/political prisoners, who were believed by the Nazis to have conspired to undermine the regime, lost their lives. Approximately ¼ million Romani and Sinti Gypsy people, who were felt to be not properly dedicated to the work ethic, died. About 3 million of 6 million Soviet prisoners, who were guilty of being Communist, and ½ million Spanish freedom fighters taking refuge in France were killed (Silverstrim). And 5¼ million Jewish people, who, the politicians said, siphoned off the best in the economy, were exterminated. Rummel estimates that 10½ million Slavs altogether were killed, including 2½ million Poles, 3-7 million Ukrainians (7 million - Silverstrim, no date), 1½ million Russians, and 1½ million Byelorussians (Rummel). The Nazis had to form
special units, *Einsatzgruppen*, headed by physicians, to carry out the killings, since the army could not be trusted to kill civilians.

Before the outbreak of World War 1, Germans living with disabilities were cared for in asylums where the expected annual death rate was about 5 percent. With the hardship brought by World War I, the annual death rate in asylums had risen to 30 percent, leaving about 140,000 patients dead as a result of the rationing of food, clothing, and fuel, as well as medicine, needed at the front. The War effort came to an ignominious close in November of 1918 in the wake of epidemic influenza, *Flanders Fever*, thought to have come together with the Chinese workers brought in to dig trenches cheaply. The *Spanish Flu* went on to infect about one third of the world's population and ended in the deaths of about 50 million people over the year in which it ran rampant (Taubenberger & Morens, 2006). Many Germans believed the war effort that closed with starvation, influenza, and the treaties of 1918 had been stabbed in the back (*dolchestossiegend*) (Schivelbusch, 2001, p. 207) by a Bolshevik-Jewish conspiracy (Valentino, 2004, p. 168), aided by certain civilians (such as Freemasons) who were thought to be hand-in-glove with the Jews. After World War I, disabled patients were assessed for their ability to contribute in any way to rebuilding Germany, and those who could work were placed in the community. Those left behind, the *incurables*, remained in institutions. But beds for the returning soldiers were needed, and those who had fought for their country had priority over people who were not able to contribute anything and whose need for care, in fact, constituted a drain on the economy. The former patients, now placed in the community where they were in the public eye, were dealt with by the police when their behavior became disruptive or disturbing, resulting in a link in the mind of the public between disability and criminality.

When the Depression hit in 1929, many families who had been supporting disabled members in the community were not able to provide for them any longer, and patients had to go back into institutions. The authorities, struggling with the post-war austerity needed to finance reparations exacerbated by the privation of the Depression, opened a discussion about ending the lives of those patients seen to be burdening the system inordinately. Such *useless eaters* were deemed to be those who would never work or contribute, those whose quality of life was deemed to be so limited that even the value of life was dubious, and those who were considered nothing but empty human husks. German movies dramatized the ethics of ending useless lives, *lebens unwertes leben*, initiating public debate and swaying opinion (Mostert, 2002). Such consideration was taking place also in Canada and other “civilized” countries that endorsed eugenics. In the US, Justice Oliver Wendell Holmes ruled in the sterilization case of Carrie Buck, an intellectually limited American:

> The public welfare may call upon the best citizens for their lives. It would be strange if it could not call upon those who already sap the strength of the State for these lesser sacrifices [sterilization] . . . in order to prevent our being swamped with incompetence. It is better for all the world, if instead of waiting to execute degenerate offspring for crime, or to let them
starve for their imbecility, society can prevent those who are manifestly unfit from continuing their kind. Three generations of imbeciles are enough (Buck v. Bell, 1927).

Science was triumphant following the exposure by microbiology of the biological roots of disease, leading to the conquest of yellow fever, malaria, break-bone fever, typhus, and so on. The zeitgeist of planned improvement led by the science of eugenics, was born in Britain, gained impetus on the eastern seaboard of North America, crossed back to Europe, and swept the globe, capturing the imagination of many of the world's leading intellectuals including those of Germany. Eugenics, which had brought bumper crops of grain, improved livestock, better babies contests, and beauty pageants to America, was the pied-piper of the time. Survival of the fittest was the order of the day and the Great Chain of Being set out the universal pecking order in which all had a place, with the Nordic phenotype held to be superior to all others (Galton, 2001, p. 100), a conceit leading to the übermensch of Aryanism.

Social Darwinists understood behaviors such as alcoholism, promiscuity, and criminality to be manifestations of genetic feeblemindedness, leading to the popular idea that there is a class of people who are natural degenerates and a type of person who is a born criminal. Physicians undertook the sterilization of about 400,000 Germans in the hopes of preventing reproduction by the erbkrankheit, the hereditarily-diseased mentally unfit: those diagnosed as mentally retarded, schizophrenic, epileptic, alcoholic, or senile, as well as the blind, deaf, or deformed (Mostert, 2002).

In the scientific spirit, German parents of disabled children were surveyed such that they seemed to support the proposed killings of incurables. By 1938, under the supervision of the General Foundation for Welfare and Institutional Care, disabled hospitalized children were killed by hospital staff through starvation and exposure to cold or by overdoses of barbiturate or narcotic. In an effort to keep the killings from reaching public attention (Valentino, 2004, p. 24), parents were advised by mail of their child's sudden overwhelming illness and death followed by immediate cremation, said to be intended to prevent the spread of an epidemic.

Disabled adults were added to the list to be killed from 1940 on, both within the homeland and in the countries subdued by Germany. Of Germany's population of 70 million, based on a rate of 1 incurable per thousand people, as calculated by the Sub-department of Heredity and Race located in the Interior Health Department, the science of eugenics targeted about 70,000 Germans for culling. After a number of methods of mass killing were tried out, gas was selected as least traumatic to the staff and most effective for such large numbers (Mostert, 2002).

Patients were transferred to one of six select state hospitals that housed the gas chambers of Aktion T4. It was the hands of nurses that held the needles and the hands of doctors that turned on the gas which killed their patients (Mostert, 2002). After frugally being relieved of their gold teeth, the patients
would go on to their final destination, the crematorium, typically located next door to the gas chamber. Medical students might first take advantage of the opportunity to gain additional academic credit by performing autopsies, providing the medical departments of many German universities with the brains of these dead incurables, so that the academics could determine the physical cause of mental illness (Galton, 2001, p. 99).

By 1941, the public had become generally aware that their relatives were not dying while supported by medical care, but were being deliberately killed. They raised an outcry sufficient to stop gas chamber killings of the disabled. Patient killings were returned to local hospitals, where hundreds of thousands more patients are believed to have died from wild euthanasia. Expert medical staff were thereby freed up to orchestrate the killing process in the death camps. It was the deaths early in the regime of these estimated 70,000 unfortunates that enabled the Nazis to get the kinks in the killing system ironed out. After 1941, the social apparatus bringing death was expanded and it spun along like a well-oiled machine tended largely by ordinary Germans in the usual conduct of their everyday lives (Valentino, 2004, p. 38). The final solution of the Nazis would not have been possible, in all likelihood, without the added expedience brought by the Hollerith device developed by Industrial Business Machines (IBM), an early computer that kept track on punch cards of people bearing a number on their arms (Black, 2001). With that, the lives of millions of Jews, Slavs, Gypsies, Freemasons, and others came to a particularly vicious and untimely end. IBM, working both sides of the ocean with bases in Geneva and New York, also made a killing: Profits were out of sight, soaring together with the mounting efficiency in killing people—soldiers and simple citizens alike.

15. Industrial Disease

Warning lights are flashing down at Quality Control
Somebody threw a spanner and they threw him in the hole
There's rumors in the loading bay and anger in the town
Somebody blew the whistle and the walls came down
There's a meeting in the Boardroom. They're trying to trace the smell
There's a leak in the washroom. There's a sneak in Personnel.
Somewhere in the corridors, someone was heard to sneeze.
Golly gee, could this be Industrial Disease?

The caretaker was crucified for sleeping at his post
They're refusing to be pacified. It's him they blame the most
The watchdog's got rabies, the foreman's got fleas
And everyone's concerned about Industrial Disease.

The workforce is disgusted, downs tools and walks
Innocence is injured, experience just talks
Everyone seeks damages, and everyone agrees
These are classic symptoms of a monetary squeeze
Philosophy is useless, theology worse
History boils over, there’s an economics freeze
Sociologists invent new words that mean Industrial Disease.

Doctor Parkinson declared, “I’m not surprised to see you here.
You've got smoker’s cough from smoking, brewer’s droop[^1] from drinking beer.
I don’t know how you came to get those Bette Davis knees.
But worst of all young man, you’ve got Industrial Disease.”
He wrote me a prescription. He said, “You’re just depressed.
But I’m glad you came to see me to get this off your chest.
Come back and see me later.” “Next patient please.
Send in another victim of Industrial Disease.”

I go down to Speaker’s Corner. Speaker’s Corner sucks
They got free speech, tourists, police in trucks
Two men say they’re Jesus. One of them’s gotta be wrong
There’s a protest singer, singing a protest song. He says
“They wanna have a war to keep us on our knees
They wanna have a war to keep their factories
They wanna have a war to stop us buying Japanese
They wanna have a war to stop Industrial Disease.”
They’re pouring out the energy to keep you deaf and blind
They wanna sap your energy, incarcerate your mind
They give you *Rule Britannia*, gassy beer, page 3,
Two weeks in *España*, and Sunday striptease

Meanwhile the first Jesus says, “I’d cure it soon.
I’d abolish Monday mornings and Friday afternoons.”
The other one’s on a hunger strike. He’s dying by degrees
How come even Jesus gets Industrial Disease?

Mark Knopfler. (Track 3 from *Love over gold* by Dire Straits)

[^1]: brewer’s droop - erectile dysfunction
Creature Comforts

It is the small everyday creature comforts of life that help us cope with stress and dis-stress, but these comforts can bring problems of their own. This thesis is testament to those who have gone before and those who have taught me how to sustain adversity and how to reject unexamined compliance, unquestioning conformity, and control in the service of exploitation.

Charcoal on paper (Polych, 2010)
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Note: Some notes draw upon material outlined in Wikipedia. Material that draws upon Wikipedia has been verified from other sources and is used with caution, only to provide supplemental or background information on topics that are common knowledge in certain circles but that may not be familiar to some readers. Material presented in the footnotes is entirely peripheral to the topic of this thesis, yet it may enrich understanding of some of the thesis content.
Stonehenge
It is the foundation of a work that makes it timeworthy. But even should the work stand the test of time, an understanding of how it was crafted does not bring an appreciation of its purpose, how it was animated, what it meant to those who made it, or how others are affected by it. Structure does not confer spirit.
Watercolor on manila (Polych, 2010)
APPENDIX A

The Research Process

In this appendix, I will describe the details of the research process leading to a better understanding on my part of the dynamic of help-seeking / helping relationship in illegal drug use from the perspective of the professional. This research represents, not a straightforward examination, but rather a matter of induction, based upon the narratives shared by the professionals interviewed and then considered in light of available literature. Each participant in each interview presents only a facet of the complex whole person working in addictions and of the phenomenon of addictions. Still, this facet alone is worth study and brings more understanding than the intuition on which one must otherwise depend.

As with any research approach, heuristic research techniques spotlight particular aspects of a problem and deemphasize others. It is the researcher alone in heuristic analysis who processes the data and selects certain information which is designated as important. There always is the possibility that significant findings may have been downplayed, that meaningful data were overlooked, that the trivial was accentuated, or that the fundamental elements were not brought forward and therefore key issues were not identified. By definition, the heuristic researcher’s perception and interpretation color any findings coming from the research. In the writing of this thesis, I have tried to give a clear picture of my background, in the hopes of helping the reader better understand my biases and my concern about the dynamic activated when illegal drug users need health care or social services.

Background and Participants

Having been heavily involved with the establishment of the harm-reduction approach to addictions treatment, I was well aware of the contribution of a number of professionals who are recognized as leaders practicing in the field of addictions. I believed that the insights of these well-established, key people into what they believed was going on in addictions would provide considerable insight into the dynamic operating within the help-seeking / helping
relationship in illegal drug use. I was looking to answer a number of questions about Anna’s death. Where did things go wrong? Why did Anna’s death not make the news? I hoped to answer these questions for myself through a searching consideration of the analyses provided by these seasoned leaders in the field in light of the insider knowledge I had personally developed over the years through my own work with folk who struggled daily to live with their addictions and with the assistance of what literature is available to me. The key question I hoped to answer though this research was, “How do professionals explain the actions and inactions of professionals that are meant to help people who use an illegal drug.” This answer depends upon the explanations related to a more basic question, “How do professionals make sense of illegal drug use?”

As I considered who I might approach for help in exploring the help-seeking / helping relationship, I had certain ideas in mind about the characteristics of the participants that might best position them to shed light on the dynamic. I hoped to speak with professionals who had face-to-face experience with helping illegal drug users, and who had worked long enough in addictions to develop both the breadth of experience and depth of knowledge such that they would be widely regarded in their field as having a high level of expertise. I felt it was important to interview professionals who likely would have a well-developed philosophy of addictions, with which I might personally agree or disagree, upon which they could base their approach to practice and who would be willing to share their understandings openly. My final consideration was that of geographical accessibility.

Further, it was important to me to interview professionals from different backgrounds. The professionals who agreed to participate represented a range of professions, practicing either in-town or out-of-town, using abstinence-based and other approaches. Employed in roles that ranged from management to front-line, participants worked in agencies that varied from well-established, well-funded operations located in large institutions to small, community-based, shoestring programs, with a focus that varied from withdrawal management (detoxification) to methadone maintenance. Because I also hoped for ideas
about how to structure professional training such that graduate practitioners are able to sustain healthy dynamics, I sought out professionals who were involved in some way with teaching.

In recognition of the competing priorities of busy professionals, I offered to conduct the interviews at the workplaces of the participants, a plan wholeheartedly welcomed with one exception, when it worked better for the interview to take place at the home of the participant. By locating the interviews in the settings in which the work of the participants was embedded, I expected that the participants would gain confidence from local cues as they indulged their analysis of the dynamic of help-seeking / helping as it was known to them. I also expected that the worksite location would encourage the participants to stay focused on their particular practice as it actually took place.

Taking these considerations into account, I approached the participants and a number of other practitioners spanning a range of occupations and areas of involvement. Many were very happy to discuss their opinions, philosophies, perceptions, and participation in addictions and helping in illegal drug use, but were reluctant to engage in a formal interview about it. A number of professionals were highly conflicted about their approach to illegal drug users, and took this conversation as an opportunity to address some of their own confusions. On the whole, contacts seemed to be open and as honest as they could be about their role in helping people involved with illegal drugs, but many also seemed to feel less than proud of their actions. Just the same, all of those who declined an interview were encouraging and supportive. All of those who declined were at a significantly lower level of expertise than those who ended up agreeing to take part.

At the end of this screening process, six seasoned professionals: Aldo, Doug, Harry, John, Max, and Neal, all of whom work in health care or social services across a range of settings (see Table 6) agreed to share their analysis of the dynamic operating in help-seeking / helping in illegal drug use. As experts in the field of addictions, each participant had worked at length with those living with an addiction, was well familiar with the usual treatment of addictions, had
strong opinions about the usefulness of different interventions, and had
developed their own theories about addiction. I was aware that each
professional interviewed had a unique approach, based upon his personal
experience with substances, his analysis of using, and his theory of addiction.
Further, I realized that each professional was more or less fully aware of
contradictions between his intention going into an interaction with a patient and
the conduct and outcome of the intervention; his account might or might not
illuminate any such incongruity.

Table 6.

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<th>Participant Characteristics</th>
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<td>Informal role</td>
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Ethics

The work of all but one of the participants was known rather well to me
prior to our contact related to the interviews that constitute the data of this study.
My past work, based on the theory of the Primacy of Caring (Benner & Wrubel,
1989), was compatible with what has become known as the continuum within harm-reduction, itself in no way incompatible with the abstention endpoint. My work actively complemented the approach expressed by some of the participants, while the approach of others was expanded based in part on work in which I was involved behind the scenes. I carried respect for each participant, and found, as the interviews unfolded that generally my respect became both deeper and richer. At the same time, with some participants, there were areas of their practice that puzzled me or that had caused me concern.

Together, in our interviews, the participant and I were able to establish rapport and develop an informed conversation about their field of work and their views. While the participant generally placed a cautious bound on the time for the interview, it was my stance that I would be available to talk with each participant as much or as little as the participant wished. At the participant's discretion, in three interviews, the time allotted was markedly extended over lunch or well into the participant's workday, and in another, a second day was needed to cover the material.

All of the participants reviewed a number of difficult events in the course of their careers; some of the participants became very intense and excited or agitated as they related these scenarios. From the intensity of emotion that they expressed, it was clear that they still felt strongly about these incidents. At these times, I relied heavily on active listening, to better understand the conflict, to bring out further analysis by the participant, to validate the emotions surfacing from the past, and to affirm their worth in the present.

One participant, who had a key role in an agency founded by a group that included one of my long-term patients, expressed concern about his safety in opening to me about his philosophy, based on a heated disagreement shortly after this patient's death in the past from overdose while under his care. This generated an extensive discussion in and of itself, which took place prior to the interview and resulted in some expression of remorse and a measure of resolution on the part of the participant and myself. We then undertook the interview with the understanding that, should there be any further discomfort, we
would directly discuss it immediately and shelve the interview for renegotiation or
cancellation it if we were not able to clear up the discomfort. As it turned out, this
interview was one of those extended by the participant well into his workday and
it included a tour of the facility and some lengthy discussion with a number of
other staff.

Poem 11: Fault

Your eyes are on my face,
Seeking, weighing, judging.
Dare you speak freely?
Estimate the risk.
Do what you need to do,
So long as you save face.

Can you face the unease of looking back
Retrace your memory, collect your thought
Rationalize, revise, edit for the press.
And I will do my part,
You'll not know it's pain has frozen my face.

Tell me how you face unnamed fear
I share your fallibility.
What if someone came to see you
As you never appeared to be.
Would you know yourself who it is you face?

Do you regret what you've left undone?
Do you miss the ones who you let fall?
You know I know you never meant it.
Validate, reassure, soothe, and lull.
You tell your story, I nod with grace
As though I knew you never meant it.

Gap in the teeth of a smiling face.
I know that one missing from her place,
Custom-stolen earrings sent in thanks.
Does her name halt on your tongue?
Does your eye slip past her face?

I wear the weight of her memory
Heavy gall thick upon my shoulders
Black void of her in time.
Do what you need to do,
So long as you save face.

Carol Polych (2002)
Another participant had taken part in some highly controversial confrontational interventions that were partly responsible for improved conditions for people who use an illegal drug, but which, if generally known, could have exposed him to negative repercussions. His concern focused on the possibility that he might be identifiable though the interview material, and that the content of the interview might then be used by unknown readers in positions of power to sanction him. The participant felt it likely that his part in the action would be irrelevant given time and that the interview would come to pose no threat to him, as the situation for which he advocated showed every indication of becoming accepted. Nevertheless, the participant and I together carefully reviewed the provisions for confidentiality, safekeeping, and anonymity built into the study.

Some of the safety features of this research were the removal of identifiers at the point of transcription, including unique characteristics of speech, substitution of names, and use of general terms, as well as clouding of particular situations and identifiable places. I taped and transcribed each interview myself. After I listened to the tapes, pulled the data off, and replayed each interview three times, I demagnetized the tapes, tore them apart, and incinerated them. As such, each participant is identifiable only to me, depending upon my memory of the individual situation and story.

There was some rather detailed discussion with each participant at the time of booking the interviews about the purpose of the research and how it would be carried out. My first Committee approved the plans for this study, the proposal cleared the Ethics Committee with no changes. Some of the participants discussed their concerns, as reported above; there were no other concerns expressed. All participants willingly undertook the interviews as part of their daily professional duties, and some of them outlined their preferred approach to the interview. A number were interested in the way the analysis would be conducted. All of the participants, as professionals, were well versed themselves with research.

An unexpected finding from this research was the realization of the emotional impact that engaging in this study had upon me as a person. I found it
a heavy emotional strain to entertain the accounts of those in key positions as we calmly discussed the systemic blocks that resulted in hardship or death for some of the patients for whom I had cared.

I did review the preliminary findings of the research at about the 6-month mark with one participant. Since, I have not had contact with any of the participants, but I am aware that all participants have continued to flourish in their careers and have gone on to make some very interesting contributions to the field of addictions. One participant's work was interrupted by a bout of using, unrelated to this study, and the associated recovery.

**Definition of Terms**

Terms used to describe the person who seeks health, addictions, or social service care include clients, patients, consumers, and survivors. Each term carries connotations related to health, autonomy, roles, expectations, and activity vis à vis illness, dependence, and passivity (Covell, McCorkle, Weissman, Summerfelt, & Essock, 2007), and participants had strong feelings about naming and potential influences upon help-seeking / helping relationships. In this thesis, the term, *patient*, was chosen both to foreground the power gradient that typifies the relationship between the person seeking help and the professional, and to highlight the fiduciary nature of the involvement by the professional in the ideal help-seeking / helping relationship. Doug has intense feelings about the commodification of care:

I don’t like the term, “client,” because it reminds me of someone who’s going to buy shoes somewhere. *Client* is a corporate term that I think is bad, because it implies that people have to pay money for something, whereas I think that health care should come from taxes. I use the term, *patient*.

Providers of care will be referred to as professionals, clinicians, therapists, workers, providers, or helpers unless the research participant makes a point specific to a particular occupational group.

The value-laden vocabulary of drug use is known to be drenched in power, and the plain term, *use*, has been chosen in an attempt to sidestep some of the more blatant moral judgments implicit in terminology. This thesis will not deal with the distinctive nuances among abuse, misuse, overuse, use, and so
on, unless the point is necessary for clarity in the immediate discussion. The term, *drug use*, will be understood to refer to the ingestion, injection, inhalation, or administration of any substance including both illegal and legal drugs such as alcohol and prescription drugs, taken in excess or in a manner for which they were not intended, but for the purpose of affecting mood or altering mind.

**The Interviews**

As a professional with experience working with people who are affected by the use of illegal drugs, I have developed a certain understanding about how I can help people, how my colleagues typically approach helping, what my patients report as helpful and unhelpful, and what I believe might generally be helpful when working with those who use an illegal drug. This background is very useful in dialogue with other practitioners working in addictions, and the understandings that come from experience in the field lend themselves to a richer interpretation of the perspectives of others. My immersion in the field of addictions placed me in a position of advantage, using Moustakas’ (1990) approach to heuristic research, to explore the generally private sphere of help-seeking / helping in illegal drug use. Based on the credibility that comes with time and shared experiences, I could expect open dialogue with colleagues and expect straight talk. I knew something about the vulnerability that comes with sharing secret musings; I knew some of the tender spots, and believed that I could support my colleagues in a caring and respectful way while tighter we explored troubling issues.

Moustakas’ (1990) technique of heuristic research guided this exploration of professionals’ perspectives on the help-seeking / helping dynamic in illegal drug use. Moustakas describes heuristic research as a process of internal search through which the nature and meaning of experience is discovered. The corollary to this discovery is that the investigator also experiences a growing self-awareness and self-knowledge. Such discovery is open only to the researcher who has had a direct, personal encounter with the phenomenon under investigation and who has experienced a personal challenge and puzzlement in the search to understand it. In the discovery of the phenomenon under
investigation, the researcher creates a story that is also his or her own, portraying the qualities, meanings, and essences of the experience (p. 11).

Experience is illuminated through uncovering the perceptions, feelings, intuitions, beliefs, and judgments housed within the internal frame of reference of a person, and the meaning of his or her behavior is clarified. Heuristic research proudly emphasizes connectedness and relationship, and leads to depictions of the intrigue, personal significance, and essential meaning surrounding and permeating the phenomenon of interest from the frame of reference of the person who experiences it (Moustakas, 1990, p. 38). Such understandings develop through cooperative sharing and dialogue, leading to greater complexity and particularity of understanding on the part of both the interviewer and the participant. In discovering greater understanding, the researcher creates a story that is also her or his own, bringing out the qualities, meanings, and essence of the experience.

The techniques of heuristic research are well suited to investigating a relational phenomenon that takes place in private, such as that in the help-seeking / helping encounter between illegal drug users and professionals. Professionals enter their field of study, often devoting years to assure themselves of the skill to undertake practice, and enter into their work with good hearts and the best of motivation. Yet, many of the patients who seek help report unprofessional, unfriendly, inhumane, and sometimes even lethal treatment. It is only by entering into an investigation on the terms of the professional that the path taken by that professional can be traced from the place at which they started to such an endpoint. Heuristic research provides the researcher and the professionals the tools needed to undertake such a journey of exploration within a caring and supportive relationship.

The interests and concerns of the participant related to the topic area of helping in illegal drug use guided the interview. As the interviews went along, the participants dominated the conversation, which took on a largely informal dialogic quality. Follow-up questions came out of immediate content and from my observations or understanding gained at the intersect of that participant’s
practice with mine. Occasionally, I would ask a participant to express an opinion about a point voiced by someone else. I did ask some participants about specific events, to help me better understand otherwise puzzling circumstances.

A modified problem-centered interview (Witzel, 2000) was prepared to help me keep the discussions with the participants focused on the area of interest. Two main questions organized the interviews: a) How do professionals explain their actions and inactions in helping people who use an illegal drug? and b) How do professionals make sense of illegal drug use? Questions that are more detailed were there as prompts in case the participant had difficulty in organizing their thoughts; they mostly were not needed. The guide questions and probes are presented in Appendix B. A wide variety of active listening techniques were used to keep the interviews flowing, including:

- good eye contact,
- open or parallel posture,
- using verbal encouragers,
- acknowledging,
- repeating remarks,
- seeking clarification,
- restating what I thought I heard the participant say,
- validating,
- summarizing, and
- some limited sharing of pertinent personal experience

Toward the end of the interviews, I asked each participant their advice about how professionals might better be assisted to learn how to provide quality help in illegal drug use. Closure took place at the discretion of the participant. All participants expressed an interest in receiving a summary of the research findings upon completion of the study.

**Working with the interview material.**

I transcribed each interview, removing identifiers at the point of transcription, then destroyed the tapes, leaving no other record. As I typed each interview, I listened to the nuances of expression of each participant, and was able to reflect on the connotations of the words and phrases as well as the denotative content. Reading and re-reading each interview took me back to the actual interview, to hear again the emphasis placed on particular points and the
stresses on certain words, and to see again the non-verbals that accompanied the discussion. Issues of importance to the participants were flagged for the researcher, partly by the intensity of communication by the participant, through repetition of the point, and by exampling on the part of the participant. Some time later, I analyzed the transcribed interview material using grounded theory approaches, which resulted in the identification of core themes and common understandings.

The participants, experts in the field, shared their thoughts about addiction: its roots, nature, function, how it is sustained, and the problems associated with using. Participants reflected on what they see in current general practice, and what they believe to be essential about the treatment of addictions:

- the goals of treatment,
- treatment techniques,
- role of professionals,
- ways of relating,
- rewards of addictions work,
- the motivations of workers,
- views of colleagues,
- the problems with professionalism, and
- the difficulties of work in addictions.

Finally, the participants shared their recommendations about how addictions can more clearly be understood and how to more productively address addictions.

After I had identified the core themes and key issues, a less active stage of analysis followed, during which time I considered the data and initial analysis in the light of personal knowledge, discussion, intuition, and more discussion. This incubation stage alternated over the next 10 years with review of the literature, discussion with colleagues, re-examination of the interview material, analysis and reanalysis, and careful reflection. This stage was extended well past the expected time due to a protracted serious illness of a family member that demanded my attention and care. The next phase in this heuristic study after this incubation was that of clarifying theory. As I reviewed the theories that I found helpful to my analysis of this research, I produced a number of working graphic models outlining the interplay of process and development of my understanding (see Appendix C). Helpful theories included those related to
Wittgenstein's philosophy as it relates to emerging knowledge and led to the development of models of the dynamics of addiction and of scapegoating. Original graphic models developed for this thesis are outlined below:

**Appendix C:**

Panel | Original Graphic Model
---|---
A | Assessing a Claim and Truth-Telling
B | Trustworthiness of Research
C | The Legitimacy of our Conclusions
D | Heuristic Knowledge
E | The Process of Heuristic Research
F | Wittgenstein’s Philosophy and Bioethics in Addictions and Health Care
G | The Dynamic of Addiction
H | The Primacy of Caring
I | Post-Modernist Scapegoating

Brief thumbnail sketches of the participants, outlining their unique insights as well as their common understandings, were presented, together with a brief overview of that person’s approach to addictions, in Chapter V. Data were analysed, and the main concepts that underlie the help-seeking / helping dynamic in illegal drug use were identified as stigma, socialization, and caring. Meaning units of special importance to the participants, were extracted using grounded methodologies, and were analysed in accord with the framework provided by the theory (Appendix 3, Panel H) of the Primacy of Caring (Benner & Wrubel, 1989).

As the work on this thesis about the help-seeking / helping dynamic in illegal drug use took place, a series of poems reflecting a variety of considerations and perspectives came into being. These are shared throughout the body of the thesis in the spirit of hope that, through metaphor, they may bring yet another way to understand the help-seeking / helping dynamic. Art work was
also included as a non-verbal means to present the fundamental dynamic of *recursivity* in life, one of the key understandings that I developed about illegal drug use, the (mis)treatment of stigmatized individuals, and the well being generally of all Canadians.

**Trustworthiness in Research**

The knowledge generated by qualitative research generally is more multifaceted, provisional, context-bound, and specific than that offered by quantitative research where the goal is generalizability. Still it is qualitative research that brings us closer to understanding the deeper truths and experiences in life: the unique within the universal. Qualitative research takes in stride the fact that there is no such thing as absolute truth. As a result, many viewpoints may be simultaneously legitimate. Some people wonder how we can believe what participants say in qualitative research (Appendix C, Panel A). Nelson Hagemaster (1992) points out that a participant’s version of truth is necessarily more self-oriented than other-defined. To discuss their experience, people must reflect on that experience, and reflection involves awareness, necessitating other processes over and above memory alone (Oiler-Boyd, 1989) (see Appendix C, Panel C). Relating the meaning of an experience to another involves the synthesis of conception and perception by the person telling the story, and is personal and specific (Smith, 1989). It is experience that mediates knowledge.

**Poem 12: Expert**

We sit to talk
From heart to heart
From in the know.
I take up my pen
Ready to write down
Everything you say.

Yes, this is surely research
Dedicated to science
The basis of all we know.
I sit here at your right knee
And wonder who to trust.
I know you’d never lie to me.
You only talk of what you know
It's only what you say is so
And how does that prove anything?
Some say you carry wisdom
Gained from life in review.
Some say you just make it up
As you go.

I struggle through understanding.
How can you speak of need,
The kind you'll never know?
Explain to me those broken ones
Waiting for your time, your glance,
Your word to make them whole.

Carol Polych (2007)

Heidegger (1927/1977) states that the essence of a phenomenon may be undiscovered, concealed, covered up, distorted, or buried over by accident or by design (p. 84). The goal of research is then to dis-cover what is being talked about, to let it speak for itself about its meaning and ground, and further, to observe when it points to what may underlie it yet not be obvious (p. 73). Heidegger also believes that truth in a matter may refer to an open engagement with others such that one lets them be, bringing them into accord with others and themselves (p. 131). Heidegger points out that error consists, not of a single mistake, but of the realm of history of those entanglements in which all kinds of erring are interwoven. These errors may include not attending to a matter, miscalculating, and going astray in one's essential attitudes and decisions (p. 136).

The job of the qualitative researcher is to locate, observe, and describe the individual's perceptions of their experience, then engage in disciplined reflection about the data. Because the researcher is always part of the interaction, influencing the people taking part in the research and being influenced by their stories, the researcher's response is also a valid part of the research (Drew, 1989). Neutrality on the part of the researcher is not sought after in qualitative research, which recognizes that all researchers necessarily
come with biases; it is the job of the researcher to disclose those biases to the
reader, enabling the reader to appreciate the perspective of the research.
Indeed, qualitative research hinges upon the ability of the researcher to function
as the primary analytic tool, a dependency that obviates neutrality. While
neutrality is not emphasized in qualitative research, trustworthiness is (Appendix
3, Panel B); trustworthiness hinges upon fittingness or transferability, credibility
or believability of findings, and auditability or dependability of the data.

Synthesis

The interviews in this study were all taped in their entirety, and were
analyzed using grounded methods shortly afterwards. One of the participants
with experience in qualitative analysis reviewed his own transcript shortly after
the interviews were completed, finding himself generally in agreement with the
analysis to that point. An independent colleague with a background in qualitative
research, but no particular experience with helping in illegal drug use, also
reviewed the raw data from one transcript and the analysis that related to that
interview, agreeing broadly with the findings. Graduate student colleagues
further engaged in line-by-line analysis of a very limited portion of one interview,
arriving at generally shared conclusions about the segment.

The use of a theory to frame data analysis has its pros and cons. Just as
it may foster a clearer understanding of the material, it also may block the
recognition of original content that the theory may not take account of. For that
reason, the data were first analyzed using grounded theory approaches, which
resulted in the identification of core themes. Once the key issues were identified,
and I had a chance to let the data incubate, I found I needed to clarify for myself
how we know we can rely on the statements of another, what composes truth,
how the particulars of the lives of individuals condition truthfulness, how heuristic
research (Appendix C, Panel E) can add to knowledge (Appendix C, Panel D),
and how an ethical response comes about (Appendix C, Panel F). I then
developed an original graphic model of the dynamic of addiction from a more
intuitive secondary reading and analysis of the data (see Appendix C, Panel G).
Further reflection, literature review, and rereading brought the development of an
original graphic model of the scapegoating process and its place in postmodern society (Appendix C, Panel I).

As I undertook this instructive exhausting and exhaustive analysis, I was aware of the need for care with control of the material and of the importance of balance, letting the material speak for itself. I struggled to keep a light touch on the reins of this research, for fear on the right of overly constructing the analysis, and on the left, of letting the participants ride off in all directions with their stories. At the same time, I had to discipline myself to ensure that the thesis generated was mine, speaking to the issues I judged to be most pressing and carrying the focus I believe to be most helpful in addressing them.

Poem 13: Biology

Summer come; soon to fly:
Ova, larva, pupa, butterfly.
Proboscis, antennae,
Wings, abdomen, tracheae,
And, oh yes, those wings
But why?

Heart-stopping beautiful:
Fluttering, frivolous, frail.
Feeds on Asclepiadaceae,
Diet for Danaidae,
Milkweed for the Monarch,
Haemolymph laced with cardenolide.

Bright-eye boy, Robin Red-beak,
loves his well-dressed Queen;
grabs her right around the waist
She flies away: he pecks her cheek
Sorry now, up he chucks and dies.

Take these parts,
Now make her whole
Tell me where she goes
Tell me how she knows
Samoa, Tonga, Mexico.
Let me see her fly.

Carol Polych (2007)
Qualitative research highlights the *transferability* of understanding from one experience to another, where quantitative research relies on external validity to generalize findings. Because of the principle of recursivity in social relations, the reader, examining a particular instance at the local level, can come to understand a more general form of social organization (Smith, 1990). Beck (1993) suggests readers ask some questions to help them judge how well a theory arising from a particular qualitative study might fit into another context:

- Are the participants generally typical of the population of interest?
- Were participants with a range of experiences included in the study? and
- Do the results of the study seem to fit the data from which they came?

In this study, participants were not typical of the majority of professionals who provide help in illegal drug use since they were highly experienced in the field and would be widely regarded as experts and teachers, but otherwise, they could be considered representative of workers in the area of addictions. One of the main caveats of this study centers on the homogeneity of gender, age, race, class, and geography of the participants, which in turn reflects actual mainstream leadership reality in addictions.

The focus of qualitative researchers is on experience, which takes account of causation as a partial understanding of multi-faceted, historical, contextual, contingent, and tentative processes of pressure, motivation, ability, capacity, possibility, and response. Quantitative researchers, striving for internal validity, also concern themselves with causation, but typically limit their inquiry to finding a particular cause for a specific outcome by controlling confounding variables while manipulating one variable independently of other considerations and observing the effect upon a dependent variable. In qualitative research, to judge the *believability* of the findings, the reader looks for a vivid and faithful description of the participant's experience, which may resonate with his or her own experience (Beck, 1993). Beck (1993) suggests some questions to help the reader assess the *credibility* of the research:

- Are rich excerpts from transcripts provided?
- Were the findings validated with the participants? and
- Do the findings seem meaningful and useful, judging from the reader’s own experience?
In this study, I have made a special effort to ensure that the voices of the participants come through, loud and clear. One participant reviewed the preliminary findings of the study based on the grounded analysis about 6 months after the interviews were completed, and gave his feedback. He confirmed that the grounded analysis had actually captured the themes that he felt were most important to him in the dynamic of help-seeking / helping in illegal drug use.

In qualitative research, the question of reliability relates to how dependable the data is and how reliable the researcher is, whereas in quantitative research, reliability refers to the likelihood that similar findings will result from repeated tests. One question to bear in mind when assessing the reliability and dependability of qualitative research might be: Would others agree with the researcher's analysis, or did the researcher's biases color the analysis too heavily to be trusted? The ability of another researcher to follow the decision trail of the researcher at every stage of analysis is termed auditability (Beck, 1993). Two questions to help the reader assess auditability could include:

- Was a tape recorder used? and
- Would other researchers identify similar concepts and categories as the researcher if they analyzed the raw data themselves?
APPENDIX B
Interview Guide

Focus Questions

1. Would you focus for a minute on a particular time when you offered health care or social services to an illegal drug user; Can you tell me about this experience?

2. Would you tell me about your understanding of the usual help-seeking / helping process in illegal drug use?

3. What is your usual approach to illegal drug use?

4. Can you tell me about your philosophy of helping a person who uses an illegal drug?

5. What do you believe is the philosophy of others who work in the illegal drug field?

6. What do you believe would be most helpful in improving the situation with illegal drug use?

7. Is there anything else you want to tell me or ask about?

Additional Question

1. What do you believe underlies or causes addictions?

Probes

a) Can you tell me more about that?

b) How was that for you?

c) How did that affect others?

d) Do you see any other way that could have played out?

e) In hindsight, what is your opinion about that now?
APPENDIX C

Process and Development of Understanding

Panel A outlines my understanding of how people become aware of the meaning of their experiences in life, and some of the factors that affect how and what they communicate about these issues to others.

Panel B: Trustworthiness of Research (Polych, 2007).
This panel represents what tools and criteria are left by which to judge the trustworthiness of research once the idea of objective, comprehensive, definitive truth is set aside.

Panel C: The Legitimacy of our Conclusions (Polych, 2007).
This model addresses the grounds on which one may assess the believability of what people say, and under what conditions our conclusions about what people say may be legitimate.

Panel D: Heuristic Knowledge (Polych, 2007).
This graphic depicts my understanding of how knowledge, developed through an heuristic approach to an area of interest, may result in behavioural change, following increased awareness and a shift in attitude.

Panel E represents the process of heuristic research that begins with access to a site of interest and engagement with a dynamic, which leads to identification of an issue and results in a careful exposition of the phenomenon.

This panel was developed from reflection about the ethical foundations of different analyses of life, conflicting tensions set within the dynamic of help-seeking / helping, and how these manifest in different professional approaches to illegal drug use.

This model illustrates some of the important factors to consider in illegal drug use, beginning with individual suffering as conditioned by social dynamics, and as addressed according to social analyses.

This panel graphically presents the centrality of caring and the way in which I came to understand how Benner and Wrubel’s (1989) theory of the Primacy of Caring applies to the dynamic of help-seeking / helping in illegal drug use from the perspective of professionals.


This graphic is based on the understandings of scapegoating in illegal drug use that I developed from wide reading and from analyzing the research material. It features the ethical split between social inclusion and exclusion.
Panel A: Assessing a Claim and Truth-Telling

Panel B: Trustworthiness of Research

Panel C: The Legitimacy of our Conclusions

Panel D: Heuristic Knowledge

Panel E: The Process of Heuristic Research

Panel F: Wittgenstein's Philosophy and Bioethics in Addictions and Health Care

- Meaning of life
- Worthwhileness of life
- Particularity
- Insight
- Clarity
- Decency
- Socially reinforced, rules-of-thumb, behavior patterns, limitations, sensitivity, how-we-go-on
- People as "with us," loving, trust, expertise, authority, knowledge, mastery, moral code, pretension
- People as strange and other, elitism, exploitation
- Beneficence, compassion, oppression, forgiveness, tolerance, justice, rights
- Detail, context, continuity, pattern, inference, nuance, induction, projection
- Profile phenomena: logic, ethics, life as it is, itself, nature
- Vulnerability, clarity, value judgments, understandings of the world
- Consistency, correct way, preset boundaries
- Right conduct, good character, obligations, duty
- Social training, rule following, aggregate outcomes, judgment, change beliefs
- Correct way, consistency, understanding of the world, power control, generalize false beliefs
- People as strange and other, elitism, exploitation
- Ritual, solidarity, language, consolation, confidence, meaning, power, control
- Facts, reason, motivation, beliefs
- Action, authority, knowledge, mastery, moral code, pretension
- Practice, fitness, value judgment, nuanced sense interpretation
- Expertise, authority, knowledge, mastery, moral code, pretension
- Social, training, rule following, aggregate outcomes, judgment, change beliefs
- Principles, codification, moral categories, knowing how moral weight conviction

Panel G: The Dynamic of Addiction

- spirituality
- become the best you can be
- address multiple problems
- expert staff
- respect
- repeople
- brother's keeper
- collateral damage
- degrees of use
- pleasure-relief
- self absorbed
- hit bottom
- just deserts
- punish
- protect
- harm reduction
- supportive care
- cooptation
- marginalization
- paternalism
- hierarchy
- rules
- status
- exclusionism
- just deserts
- punish
- emotional arrest
- fear
- individualism
- family
- culture
- exploitation
- family
- greed
- demonization
- mythology
- elitism
- exploit
Panel H: The Primacy of Caring
(Inspired by Benner and Wrubel (1989))

- Mastery
- Possibility
- Accommodate
- Control
- Coping
- Competence
- Information
- Seek new skills
- Power
- Expertise
- Situation
- Knowledge
- Situated
- Freedom
- Lived experience
- Being
- In-the-world
- Doing
- For
- Self-image
- Culture
- Competence
- History
- Involvement
- Temporality
- Context
- Respect
- Stigma
- Presence
- Empathy
- Humor
- Support
- Connecting
- Relating
- Better off
- Sharing
- Fairly
- Constitution
- Altruism
- Identity
- Intention
- Pattern
- Justice
- Denial
- Despair
- Anger
- Sorrow
- Hope
- Fear
- Agency
- Direction
- Motivation
- Interpretation
- Emotion
- Validation
Panel I: Post-Modernist Scapegoating

- Post-Modernist Scapegoating
- Mystery Enigma
- Industrial Technologic Economic Political
- Unintended Side Effects of Connection
- Backlash Compression of Time Space Human Drama Knowledge Values
- Stability Sharing Belonging Comfort Coherence Cooperation Pleasure Resolution Trust Solidarity
- Personal Entertainment Hiatus from Hardship Usual Normal
- Media Depoliticized Spectacle Pacify the Mob Focus on Unusual
- Contingency Uncertainty Dissatisfaction Competition Containment Consumption Want Advertising Manufactured Growth Status Anxiety Fear Terror Freedom Individual Apolitical
- Myth
- Purpose Fulfillment
- Stranger Other
- Now Where?
- No Shared Past Projected Stereotypes
- Deliverance
- Flight