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**HARM REDUCTION FROM THE PERSPECTIVE OF THE
ILLCIT DRUG USER: A STUDY**

By: Marc A. Lishchynski

A thesis submitted to the Department of Criminology in partial fulfillment of the
requirements for the degree of Master of Arts

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Abstract

The notion of harm reduction has existed in many fields of study for a considerable period of time, but it has recently resurfaced primarily in the field of public health policy since the discovery of HIV and the ensuing AIDS pandemic. Harm reduction has been identified by various authorities in health care as a policy that may help reduce the spread of HIV/AIDS among users of illicit, injectable drugs. This focus on health matters makes the development of a more holistic approach towards harm reduction for users of injectable drugs difficult.

This study seeks the perspective of users of illicit, injectable drugs in the greater Ottawa-Carleton region on existing harm reduction policies and practices, using a qualitative research design, and employing a literature review and interviews with users to gather the required data. The goal is to determine how they perceive the actual implementation of these policies and practices, what they would like to see implemented, and to see if there is a gap between the user's needs and what is currently being offered.

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INTRODUCTION

The notion of harm reduction has existed in many fields of study for a considerable period of time, but it has recently resurfaced primarily in the field of public health policy since the discovery of HIV and the ensuing AIDS pandemic. Harm reduction has been identified by various authorities in health care as a policy that may help reduce the spread of HIV/AIDS among users of illicit, injectable drugs. This group of users has seen a dramatic rise in the prevalence of HIV/AIDS, partially as a result of communal needle sharing. By, for example, providing clean needles to users of these drugs, it is thought that rates of HIV infection among this segment of the population might drop, thus reducing the risk of infection among the general population. Groups that develop harm reduction programs for users of illicit, injectable drugs consequently frame their policies and mandates with health policies in mind in order to obtain the funding and public support required for the survival of their programs. This focus on health matters makes the development of a more holistic approach towards harm reduction for users of injectable drugs difficult.

The objective of this project, therefore, is to seek the perspective of users of illicit, injectable drugs in the greater Ottawa-Carleton region on existing harm reduction policies and practices. The goal is to determine how they perceive the actual implementation of these policies and practices, what they would like to see implemented, and to see if there is a gap between the user's needs and what is currently being offered.

Simply put, harm reduction models pertaining to the use of illicit drugs seek to reduce the harmful effects commonly associated with drug consumption. While the concept of harm reduction in the field of public health came to prominence in the early 1980's when it was

identified as a possible tool that could be used in the fight against HIV/AIDS, the first modern harm reduction programs linked to drugs focused on a licit drug, namely alcohol. These programs focused on the potentially fatal consequences of drinking and driving and the harmful effects of such risky behaviour to the general public. Programs such “Operation Red Nose” focused on the act of driving while inebriated, rather than on the consumption of the drug per se. People were not encouraged to stop drinking, but rather were urged to drink responsibly by choosing not to drive with diminished faculties.

As programs evolved and expanded, however, and as the focus shifted to illicit, injectable drugs and health matters, this distinction between consumption and acts linked to consumption became far more blurred. Harm reduction programs such as needle exchange initiatives and safe injection sites are now developed by the very same governments that criminalize the non-prescribed use of drugs, including most injectable drugs. This apparent contradiction is frequently brushed aside by policy makers who suggest that health measures aimed at reducing the spread of HIV/AIDS should not be held back by policies aimed at reducing and managing criminal behaviour. Dichotomizing health matters from legal matters, however, has consequences. Can we realistically expect injectable drug users to participate, fully and willingly, in harm reduction programs designed by governments that criminalize their drug habit? Does the fact that the use of these injectable drugs has been criminalized contribute to the harm associated with their use?

A frequently used argument to support the criminalization of certain injectable drugs links the use of these drugs to escalating problematic behaviours exhibited by the user. The argument goes, for example, that a heroin user will eventually turn to property crime in order to sustain his or her habit. This drug user will consequently become marginalized from society. It could be

argued, however, that the user has turned to crime because he or she has been marginalized by society for using drugs deemed illicit, thereby being obliged to obtain his or her drug of choice on the black market, while the use of drugs such as alcohol and tobacco, which have been legalized and regulated, does not carry the same stigma and can be purchased legally. If we were to treat the user of illicit, injectable drugs simply as an individual with a recreational habit like many others, rather than a criminal, how would the relationship between the drug user and the general public change? If we were to change our ethical framework on injectable drug use, and if we were to incorporate this new framework into our public policies, what impact would this have on the harm resulting from the use of these drugs? What opinion does the user of illicit, injectable drugs have on these questions? Can harm reduction programs address issues of marginalization linked to drug use if they focus strictly on health issues?

Our position on the aforementioned questions is inevitably linked to our perceptions on the nature of addiction. If we believe addiction is predominantly a physiological phenomenon, and that addiction results when a user develops a physical need for a certain drug, then analyzing the harms associated with the use of illicit, injectable drugs that may be linked to their criminalization seems less pertinent. If, on the other hand, addiction is linked to an individual's socialization process and is primarily a psychological phenomenon, then the aforementioned questions seem important. While it is generally accepted that certain drugs are addictive for physiological reasons, essentially making addiction a disease, the academic literature is anything but conclusive on the nature of addiction, and suggests that the nature of addiction is in fact, extremely complex. Obtaining insights from users of illicit, injectable drugs on addiction, therefore, seems extremely pertinent when analyzing both harm reduction theories and practices.

In a handful of countries, particularly in Europe, some injectable drug users have, to

some extent, expressed their opinions on harm reduction. The perspectives offered, however, may not reflect the positions of illicit, injectable drug users in general. This group generally remains silent on these issues. Furthermore, in Canada, users of illicit drugs have not been particularly successful in uniting and voicing a position, particularly outside of Quebec and British Columbia. It is this unheard voice that is being explored in this study. By seeking out the perspectives of injectable drug users on how governments should address their needs, it may be possible to obtain valuable insights while avoiding some popular biases associated with illicit drug use.

In the first chapter, this project will examine the evolution of harm reduction policies and philosophies prior to and following the discovery of HIV/AIDS. This will be followed by an analysis of the focus on health issues and injectable drug use in harm reduction policies. The analysis will then shift to different harm reduction practices that evolved prior to the discovery of HIV/AIDS, particularly drinking and driving prevention programs. Harm reduction policies that evolved following the discovery of HIV/AIDS will then be explored, including methadone delivery programs, needle exchange programs and safe injection sites, and the therapeutic prescribing of illicit drugs in some European countries and in Australia. Harm reduction policies that exist in Canada will then be explored. Finally, this project will examine documented reactions from users of illicit, injectable drugs to harm reduction policies and practices both inside and outside of Canada.

Once the practices that have evolved from theoretical frameworks on harm reduction, as well as the perspectives and stated positions of users of illicit, injectable drugs on harm reduction theories and policies have been identified, a set of questions that will serve as a basis for this project's questionnaire should become evident. These questions will be utilized in interviews

with users of illicit injectable drugs in order to seek out their perspectives and positions on current harm reduction practices and policies.

The second chapter will focus on this project's methodology. It will lie out the reasons the Ottawa-Carleton region was selected for this project, the sampling method as well as the interview techniques used in order to obtain the perspectives of illicit, injectable drug users.

Chapters three and four will consist of the presentation and analysis of the obtained data, followed by concluding remarks.

CHAPTER I
LITERATURE REVIEW

This chapter will, firstly, offer a literary review of harm reduction theories, followed by a review of the harm reduction practices that have evolved from these theoretical frameworks. The documented perspectives and positions of illicit, injectable drug users, primarily from Europe, on harm reduction theories and policies will then be explored. This will lead to the development of questions that will be used in interviews with users of illicit, injectable drugs.

1.1 Harm reduction theories

From the production and consumption of beer-like beverages in Ancient Egypt, to the chewing of coca leaves in Latin America, to the elixirs concocted by so-called witches during the Middle Ages in Europe, drug use is evident throughout history. Drugs were used in various religious, ceremonial, medicinal or recreational contexts. (Escohotado, 1995.) For as long as people have used drugs, mechanisms designed to control and reduce the potential harms associated with drug use have also existed.

1.1.1 Before the HIV/AIDS pandemic

The use of mind-altering drugs in traditional cultures was controlled via various learned mechanisms. For Rastafarians in Jamaica, for example, cannabis was used within a specific political and religious context. Similarly, a Shaman oversaw the use of hallucinogenic products in aboriginal communities, and the drugs could only be used at certain specific, privileged moments, following an initiation process. (Brisson, 1997.) These control mechanisms, developed by various traditional communities, constituted, in essence, an early form of harm

reduction. Interestingly, the use of drugs in these traditional communities was not viewed as an unavoidable evil, but rather as a facet of daily life. These drugs were to be consumed within a controlled environment. Prohibiting the use of these drugs was not considered. Circumstances dictated, rather, whether the consumption of a certain drug was appropriate or not, and the adherence to specific rules pertaining to its usage made it possible for the consumer to benefit from the properties of the drug while limiting the potential harms associated with its use.

Opiates, as well as cocaine-based products, became easily accessible in Europe and America during the nineteenth century, primarily as a result of a budding pharmaceutical industry, coupled with medical practices that leaned increasingly on scientific premises. (Beauchesne, 2003; Brisson, 1997; Brochu, 1995; Brouet, 1991.) The factors that contributed to the increased availability and use of drugs for both medical as well as recreational purposes must be understood within the context of an expanding world in which the industrial countries were well entrenched in colonial ideologies and practices. The Opium Wars between Britain and China, which began in 1840 and, following Britain's victory, provided a port of entry as well as a market for the opium, which had been cultivated in India, ensured that opium would be available worldwide to the consumer. Decades later, the creation of Mariani wine and eventually Coca Cola, which both contained substantial amounts of cocaine- a drug which had been discovered by the Spanish in Latin America- played an integral role in what could only be called a boom in drug usage throughout the world. Furthermore, the extraction of morphine from opium, and later the extraction of heroin from morphine by companies such as Bayer, for both medical and commercial objectives, contributed to the enthusiasm for opiates throughout the world.¹

In Europe and North America, opiates and cocaine-based products were sold on the open market. These drugs did not become prohibited products until the beginning of the twentieth

¹ For further details on the links between colonization and the expansion of drug markets, see Beauchesne (2003).

century. Despite the fact that some cases of dependency on these drugs were noted, particularly as a result of therapeutic usage, becoming dependant on opiates in the nineteenth century did not automatically lead to becoming a marginalized, unproductive, or dangerous individual. In fact, opiate users frequently continued to contribute to society. (Escohotado, 1995.) The context in which these drugs were used seemed to limit the potential harms associated with the drug use.

...l'usage généralisé d'opium et de morphine (et de laudanum, en Grande-Bretagne) devait entraîner l'accroissement des cas d'*addiction* (dépendance physique et sevrage) dans toutes les classes de la société et à tous les âges, situation qui n'était en aucun cas accompagnée, à l'inverse de ce qui se passe aujourd'hui, d'attitudes de rejet ou sanctions morales. (Brisson, 1997:14.)

In fact, individuals such as Dr. William Stewart Halsted, a prominent surgeon, happily married for 36 years until his death at the age of 72, used morphine daily. (Brisson, 1997.) Bismark in Germany, openly injected himself with opiates in order to stay sharp and focused (Beauchesne, 2003). People easily obtained medical prescriptions for their drugs, and incorporated the use of these drugs in their lives. Dependency to these drugs did not provoke the same reactions we observe today, as the use of the drug was considered a social phenomenon, not a societal risk. (Brouet, 1991; Escohotado, 1995.) Furthermore, cases of dependency to these drugs appeared to be infrequent with users.

Although the use of opiates in the U.S. and England during the 19th century was enormously greater than it is now, both through physician-prescribed injections and ubiquitous patent medicines which were used as tonics and for recreational purposes, the incidence of dependence and addiction never reached 1% of the population and was declining at the end of the century before the restrictive laws were passed. (Alexander, 2001:4.)

Surprisingly, despite widespread use of opiates and cocaine by virtually all classes of society, addiction cases were extremely rare amongst its users, with the majority of users managing their habit quite effectively. (Alexander, 2001; Escohotado, 1995.) Finally, because the products in the nineteenth century were not sold on the black market and were, therefore, safer, and because the

use of drugs was not a reviled activity, the harms related to drug use did not encompass all the harms associated with its use today. This includes various health problems, malnutrition, and poverty, which may be attributable to the prohibitionist context within which users of illicit drugs live today. (Brisson, 1997.)

Efforts to criminalize opiates and cocaine in the late nineteenth century, initially in the United States, appear to have been motivated by politics rather than a genuine concern by government for the well-being of its citizens. (Beauchesne 2003.) As noted earlier in this text, problems linked to the use of opiates and cocaine were only rarely noted. The Puritan movement, however, which was extremely xenophobic, tended to link non-therapeutic drug use with undesirable behaviours from certain ethnic minorities, who were immigrating to the United States in droves.

Les premiers cris d'alarme coïncidèrent avec l'arrivée massive d'immigrants chinois, l'anathème de la cocaïne avec les outrages sexuels des Noirs, la condamnation de la marijuana avec l'irruption des Mexicains, et la volonté d'abolir l'alcool avec l'immoralité supposée des juifs et des Irlandais. Tous ces groupes représentaient "l'infidèle", païen, papiste ou bourreau du Christ, et tous se caractérisaient par une "infériorité" morale ou économique. (Escotado, 1995:106.)

This perspective, held by Puritans, an extremely powerful and influential group in the United States during the nineteenth century, eventually led to the creation of temperance movements, which sought to prohibit the consumption of alcohol. The birth of other organizations and societies seeking to ban the recreational use of opiates and cocaine followed. Furthermore, the medical profession, who wished to control the prescription of drugs and to push out herbalists and healers, willingly allied themselves with these prohibitionist Puritans and exerted pressure on the United States government to ban the use of these drugs for purposes other than medical ones. This pressure, coupled with other realities, including the desire by the United States to

improve its ties with China, which was battling Great Britain on issues relating to opium exports, created a prohibitionist environment in the United States. (Beaushesne, 2003; Escohotado, 1995.) By the early twentieth century, legislation in the United States would prohibit the non-medical use of morphine, opium and cocaine. Other countries, under pressure from the United States, coupled with domestic economic and political considerations, would follow suit. (Escohotado, 1995.)

In 1914, the United States government passed the Harrison Narcotic Act, marking the beginning of prohibition and, in essence, the war on drugs. While the act did not explicitly ban opium, morphine and cocaine, it prohibited the use of these drugs for purposes other than medically recognized ones. The Narcotics Control Department was subsequently created. Its mandate was to define “medical needs” in relation to these newly controlled substances. (Escohotado, 1995.) The restrictions attached to the use of these drugs became so repressive, they essentially turned the drugs into prohibited substances. Between 1920 and 1930, nearly 40 000 medical professionals were incarcerated for “intending to violate” the Harrison Act, after they prescribed drugs to their patients. (Escohotado, 1995.) These patients included soldiers who had developed a dependency after having received morphine during the First World War and whose conditions were not recognized as a disease. It is interesting to note that the Harrison Narcotic Act had actually been preceded by similar legislation in Canada in 1908. (Giffen et al., 1991.)

It is in Great Britain, however, that the first example of harm reduction practices within a prohibitionist context can be observed. Despite existing legislation effectively banning the use of many drugs, a system later labelled the Rollerston System, that promoted the medicalization of drugs for addicted persons rather than prohibition, developed. (Brisson, 1997.) The British

government opted to reduce the negative consequences linked to drug addiction in an attempt to help users lead a normal, productive life. They attempted to accomplish this by allowing doctors to prescribe drugs, and later methadone, to users of opiates. The decision to address the needs of drug users in this manner was made pursuant to a report completed by Dr. Harry Campbell for the British government in 1922 decrying the disastrous consequences of the Harrison Act in the United States. Campbell noted that criminalizing the use of opiates did not reduce consumption rates in the United States. Furthermore, Campbell found it shocking that individuals who had become dependant on opiates after they had been prescribed were now viewed as criminals rather than persons in need of medical attention. (Beauchesne, 2003.) The Rollerston system, which was tightened in the 1950's, greatly as a result of external pressures, enjoyed a great deal of success, particularly when contrasted to prohibitionism in the United States. (Brisson, 1997.)

In the 1920's and 1930's, prohibitionist laws in the United States left thousands, who had previously been prescribed drugs, without access to their substance of choice. It might be argued that the black market for drugs has grown ever since. Many of these consumers were also opium smokers of Chinese descent, who had previously smoked opium freely without fear of reprisal. Following prohibition, they were incarcerated in large numbers. (Beauchesne, 2003.) It is also interesting to note that methods of injecting drugs developed following prohibition, as it was a less visible and therefore less risky way of ingesting the drug than smoking.

In the 1960's and 1970's, with prohibitionist policies well established throughout the world, new forms of harm reduction linked to the use of illicit drugs surfaced. Despite increasingly prohibitionist rhetoric from governments, particularly in North America, the culture of drug use boomed. The consumption of products, from cannabis, to hallucinogens, to heroin and cocaine grew, leading to the emergence of a new culture of recreational and experimental

drug consumption. (Brisson, 1997.) Within this context, certain harm reduction mechanisms, frequently implemented by users themselves rather than governments, surfaced. These included the creation of rituals surrounding the production and consumption of drugs, thus reducing potential risks. Furthermore, the 1960's saw the birth of hot lines designed to assist drug users or parents of users in their time of need, crash pads -places where drug users could congregate in order to avoid loitering on the streets-, and clinics where drug users could seek help following "bad trips" after using LSD. (Brisson, 1997.) The 1960's and 1970's also saw the emergence of the very first methadone delivery programs, designed to wean opiate users from their drug of choice. It is essentially within these two decades that mechanisms designed to limit the potential harms linked to drug use within a prohibitionist context developed.

During the 1970's, the Netherlands was the only country to incorporate harm reduction strategies into public policy. This was pursuant to the recommendations made by the Baan Commission in 1972. This commission had been given the mandate, in 1968, to study the non-medical use of drugs. The commission suggested, among other things, that the non-medical use of drugs should be approached as a public health issue. Consequently, the market for drugs that presented fewer health risks to users, namely marijuana, should be separated from the market of more dangerous drugs, thus allowing the implementation of treatment and prevention programs. (Beauchesne, 1997.) What followed was a de-facto decriminalization of marijuana possession and the implementation of government-funded harm reduction mechanisms. This policy is visible in the implementation of the "Junkiebond," a peer support group for users of injectable drugs, financed by government authorities.

1.1.2 After the HIV/AIDS pandemic

Following the discovery of HIV/AIDS in 1981, cases of infections transmitted via the sharing of needles within communities of injectable drug users were quickly noted, first in Europe, and later in North America. It is within this context that harm reduction, as a model, made its way into the consciousness of governments outside of the Netherlands. The role this epidemic played in bringing harm reduction to the forefront of political thought cannot be overemphasized: "...without doubt, it was the AIDS epidemic (first widely noticed among drug users in 1983-4) that changed the terms of reference on this issue." (Drucker, 1997: Foreword.) Clearly the AIDS epidemic was of capital importance in the consolidation of the approach towards harm reduction. With the emergence and the spread of HIV/AIDS, the need for new mechanisms to control the epidemic trumped all other consideration. It is difficult to imagine that services and policies designed around harm reduction strategies could have made their way into public policy otherwise. With the exception of the Netherlands, harm reduction, from a political perspective, must be looked at in terms of pre and post AIDS. It is consequently with the emergence of HIV/AIDS that harm reduction theories entered the domain of public policy. (Mino, 1993.)

The first needle exchange program was implemented in Amsterdam in 1984. (Marlatt, 1996; Riley, 1994a in Brisson 1997.) Shortly thereafter, a harm reduction service known as the Liverpool Model was implemented in Merseyside, England. (Seymour and Eaton, 1997.) From 1990 onwards, a conference known as the International Conference on the Reduction of Drug Related Harm would be held yearly. Harm reduction, from this point onwards, would find an audience in mainstream political thought, albeit within a context clearly focused on health issues, with clear consequences to harm reduction.

1.1.3 Harm reduction: A difficult definition

Since the 1980's, harm reduction strategies that differ greatly in nature, have been tested and implemented to varying degrees and with varying success worldwide. This has occurred despite the existence of strong prohibitionist positions on non-therapeutic drug use in most countries, particularly in the United States. The initial challenge for harm reductionists, therefore, was to secure a definition of harm reduction that would enable the enactment of harm reduction policies for health purposes within this prohibitionist context. If, for example, a government's statutes made the use of certain injectable drugs illegal, how could that very same government enact harm reduction policies which could, potentially, assist the user of these illicit drugs in his or her criminal activity? A multitude of harm reduction definitions consequently emerged, most of which, in various ways, attempted to dichotomize the legal issues from the health issues surrounding injectable drug use.

Erickson et al. (1997), dichotomize legal matters from health matters when they identify the core aspects required in harm reduction policies. In their view, harm reduction, at the conceptual level, requires a value-neutral view of drug use. This leaves no room for moral interpretations of drug use. Drug use simply becomes one of many possible choices an individual can make. Harm reduction also requires a value-neutral view of the user. His or her behaviour must not be considered any less normal than the behaviour of a person who chooses not to use drugs deemed illicit. Furthermore, the drug user plays an active role in harm reduction, while focusing on the problems resulting from drug use rather than on the drug per se. Finally, harm reduction theories accept the idea that abstinence will never be possible for all drug users. At the practical level, this implies the implementation of programs in which goals are prioritized. Strategies that can achieve immediate and realizable goals, are user-centered, and emphasize the

free choice of the user are consequently favoured. These principles center around the notions of pragmatism and humanism, and the illegality of the activity becomes moot. (Brisson, 1997.)

This approach does not satisfy those who situate themselves at the extremes of the drug debate, namely the prohibitionists, who for the most part position themselves as judicial moralists, and the anti-prohibitionists, who position themselves within a context of judicial liberalism. (Beauchesne, 2000.) They are vocal critics of the context within which harm reduction policies are currently considered.

Anti-prohibitionists view the legalization and regulation of drugs as the only ultimately effective form of harm reduction because, in their mind, prohibition is a primary source of harm for illicit, injectable drug users. These harms include health-related harms such as the transmission of hepatitis and HIV, as well as societal harms, including issues of marginalization faced by the user. From an anti-prohibitionist perspective, therefore, the actual laws prohibiting the use of certain drugs must be examined and harm reduction policies which dichotomize legal and health issues do not address the underlying causes of harm for illicit drug users.

To prohibitionists, the use of illicit drugs is simply immoral, and must therefore be prohibited. Any compromise on this point leads to a slippery moral slope. Furthermore, the contraction of HIV and hepatitis, and the criminalization of the user are the direct result of the drug user's bad habits, a price they must pay if they are unwilling to discontinue using illicit drugs.

Among those who favour dichotomizing legal and health matters in harm reduction policies, there are many who feel that the negative health consequences linked to the use of illicit, injectable drugs trump all other concerns. This position is known as the sanitary approach. Other harm reductionists choose to expand the notion and incorporate all negative consequences

linked to illicit drug use. This position is known as the socio-sanitary approach.

A more thorough analysis of these four perspectives -the sanitary approach, the socio-sanitary approach, prohibitionism, and anti-prohibitionism- is crucial in understanding the current debate around harm reduction policies and practices. The next section of this project will therefore analyze these four positions individually in a more thorough manner. It is important to note, however, that these four theories are fluid rather than rigid. Many prohibitionists, for example, out of pragmatism, incorporate the sanitary approach in their thinking, while many anti-prohibitionists, also out of pragmatism, support socio-sanitary harm reduction approaches.

1.1.4 The four approaches to harm reduction

The sanitary approach towards harm reduction focuses strictly on reducing the health risks linked to the use of certain drugs, as if the use of drugs per se was the root of the problem, independently of the socio-legal context in which they are consumed. Because the sanitary perspective focuses on the risk taken by the user, those who favour this approach tend to use the moniker “risk reduction” in lieu of harm reduction. The primary concern is to protect law-abiding citizens from the harmful habits of users of illicit drugs by reducing the transmission of blood-borne viruses among users and, consequently, the entire public. This position is quite palatable to government officials. Bureaucrats can justify, for example, distributing clean needles to users of illicit drugs in order to discourage needle sharing, thus reducing the spread of blood borne viruses such as Hepatitis C and HIV in the broader community. Because the focus is on health matters, programs implemented from a sanitary perspective can exist even in the United States, despite the fact that American drug policy is one that is utterly intransigent towards non-medical, illicit drug use.

In Canada, where the health of citizens is entrusted to the provincial governments, municipalities implement harm reduction programs as agents of provincial governments. In Ottawa, for example, the city has implemented a needle exchange program in partnership with various community centers. The city of Ottawa's web site (www.ottawa.ca) clearly shows that these programs are designed to address health concerns. Health matters and legal matters have been dichotomized under the guise of protecting the health of the citizenry.

It must be noted that, while harm reduction programs implemented from a sanitary perspective are designed to reduce health problems linked to illicit drug use, these programs often have a greater scope in practice, as practitioners in sanitary harm reduction programs, more often than not, do far more than simply address the user's health-related problems.

Socio-sanitary harm reduction approaches address not only sanitary concerns, but also the negative social consequences linked to the usage of illicit drugs as well. (Brisson, 1997.) This approach acknowledges that the social characteristics inherent to a group can play a role in contributing to the harm associated with the use of illicit drugs. By addressing not only primary concerns (i.e.: health concerns) but also harms indirectly linked to illicit drug use (i.e.: marginalization issues, issues linked to criminality, socio-economics etc...), harm reduction practitioners using a socio-sanitary approach tend to look at harm reduction from a more holistic perspective.² Harm reduction programs of this type have not only the potential to address health issues, but also social problems associated with drug use, including criminal behaviour, and loss of resources. What must be noted, however, is that while socio-sanitary harm reduction theories focus on more than health-related issues, they have developed within the context of harm reduction policies designed, as demonstrated earlier in this paper, in reaction to the AIDS pandemic. Health issues remain, therefore, the primary concern. Consequently, while socio-

² These indirect harms will be explored more extensively further into this project.

sanitary harm reduction practices might attempt to improve a drug user's ability to integrate into the community, the programs fall short of debating the harms caused specifically by prohibition.

While anti-prohibitionists might view the socio-sanitary approach towards harm reduction as a strategy which might help the user of illicit drugs in a prohibitionist context, they reject the idea that it can be effective in actually reducing harms linked to illicit drug use because the root cause of the harms, namely the fact that the use of these drugs has been criminalized, thus creating a repressive environment and a dangerous black market for users, has not been addressed. Beauchesne (2000) speaks of a need for institutional mechanisms that allows for a real implementation of these harm reduction mechanisms within government policy. These mechanisms, according to Beauchesne, must incorporate the following: In order to address primary goals, governments need to implement regulations which ensure the quality of products being consumed, they must regulate sales and ensure the consumer is educated about what he or she is consuming (e.g. product labelling), governments must also regulate and, if necessary, restrict the accessibility of certain drugs from certain designated consumers, and governments must implement programs which educate consumers about the possible side effects, be they positive or negative, inherent to the consumption of the said drugs.³ In order to address secondary and tertiary goals, Beauchesne contends funding for research and treatment linked to drug use must be made available. Furthermore, if we believe that the role of the government is to maintain public order and maximize civil liberties, a perspective Beauchesne dubs "judicial liberalism," then these mechanisms are essential to the implementation of any harm reduction policy.

Among the critics of harm reduction are the hard prohibitionists, who find that harm reduction strategies are in contradiction with the law. They reject the notion, so central to harm

³ The concept of risk, as it relates to the use of illicit, injectable drugs, will be explored further into this project.

reduction theories, that a value-neutral approach to the use of illicit drugs is imperative. From this prohibitionist perspective, governments have a duty not only to protect the peace, but also to preserve and enforce the commonly held moral beliefs of a society. Adopting harm reduction theories, therefore, implies that the elimination of the cause of the harm, namely the drug itself, is no longer a goal. This compromise is unacceptable to those who feel that the use of drugs deemed illicit by society is morally wrong.

To remove the idealism that argues life should be lived without recourse to drugs, or at least the illicit drugs, is to invite more drug use. Those who indulge in such reckless and deviant risk taking behaviour must accept the harmful consequences of that behaviour. From this standpoint, assisting people to reduce the dangers of drug use only reinforces undesirable conduct. (Hathaway, 2001:13.)

Hathaway does not subscribe to this position; he simply acknowledges that this perspective is what fuels the prohibitionist rejection of harm reduction strategies and policy. Hard prohibitionists would rather focus on limiting both the supply of and the demand for illicit drugs, rather than taking the cost/benefit approach intrinsic to harm reduction policies. (Hathaway, 2001.) The “war on drugs” philosophy prevalent in the United States, which professes “zero tolerance” towards both users and suppliers of illicit drugs, imposing comparatively severe fines and jail sentences for those who break the law, is where we find most of the tenets of this prohibitionist approach towards harm reduction. The terms “war on drugs” and “zero tolerance” have in fact become synonymous with U.S. drug policies.⁴

The United Nations, under pressure from nations such as the United States, have also taken this hard prohibitionist approach towards drug policy in the three international conventions relating to drug policy ratified by a majority of sovereign nations, namely the Single Convention on Narcotic Drugs in 1961, the Convention on Psychotropic Substances in 1971 and the Convention against Illicit Traffic in Narcotic Drugs and Psychotropic Substances in 1981.

⁴ See, for example, O’Hare (1992), and Golub and Johnson (2002).

(Bewley-Taylor, 2003.) The fact that the majority of sovereign nations have ratified treaties written in the spirit of prohibitionism speaks volumes on the challenges facing harm reductionists in today's world. These challenges are even felt within countries that have a strong record of implementing harm reduction policies. Ernst Aeschbach (1999), a physician, is one of many Swiss citizens who have been extremely critical of the heroin prescription program in their country. He suggests that heroin prescription policies operate under the presumption that the fight against illicit drugs is lost, a presumption that, according to him is both defeatist and false. Furthermore, Aeschbach contends that users of illicit drugs pose an enormous threat to others, and that the costs to the health system and the criminality resulting from drug use are deliberately ignored by proponents of harm reduction.

Just as prohibitionists criticize harm reduction strategies, prohibitionists have been criticized as well. Drucker (1992) notes that the prohibitionist nature of American drug policy focuses on criminalization. He notes that, in 1992, 3.7 million people in the United States were under the control of the criminal justice system, costing the U.S. taxpayers over \$60 billion a year. Over half of those incarcerated in 1992 were there as a result of drug-related convictions. Drucker suggests that, as we extend and enforce stringent drug policies more efficiently, we increase the number of drug arrests, which come to dominate, then flood the criminal justice system, clogging city jails and delaying trials. Drucker further contends that, contrary to reaching the desired effect, the war on drugs has not decreased the availability of drugs or diminished the street trade of these illicit substances, as drug smugglers have proven to be inventive and formidable adversaries.

On perhaps a more philosophical level, Beauchesne (2000) questions the validity of the premise on which prohibitionist policies are based, a premise she labels "judicial moralism."

Judicial moralism contends that governments have a duty to enforce a common morality on all individuals within a population, irrespective of the harm an act may or may not cause to others. Beauchesne suggests such a common morality is elusive and ever-changing, and that the imposition of such a common morality “c’est refuser de respecter un pluralisme bien réel des valeurs propres aux individus ou aux groupes dans la société.” (p. 77.) Consequently, the duty of the state should be to intervene only in order to protect individuals from the harmful actions of others.

Anti-prohibitionists are just as critical of harm reduction policies as prohibitionists are, but for entirely different reasons. From an anti-prohibitionist perspective, if the harms associated with illicit drug use are in great part linked to the fact that these drugs are prohibited, then any comprehensive harm reduction strategy needs to nullify prohibitionist laws on non-medical drug use in order to be effective. Drugs should therefore be regulated in order to better prevent abuse. This perspective fits with what Beauchesne (2000) refers to as “judicial liberalism,” which contends that the obligation of the state is to maintain public order and maximize civil liberties for all. From this standpoint, the state has no business enforcing any moral convictions other than that of protecting civil liberties by protecting the public from the harmful actions of others. Furthermore, anti-prohibitionists suggest that the best way to protect members of society deemed weaker is by giving them additional tools and resources so that they may improve their ability to make decisions. The argument that certain segments of the population deemed weaker need to be protected from themselves, by force if necessary -a position Beauchesne dubs “judicial paternalism”- does not sit well with anti-prohibitionists. They contend that this discourse is one that has been used in the past to exert control over certain segments of society, be they African Americans in the United States or Aboriginals in Canada. (Beauchesne, 2000.) If we use force to

impose our will on those deemed weaker, we are in fact harming them and preventing them from becoming independent. The best way to protect individuals, therefore, is to make them more autonomous and capable of making reasoned choices. This can be accomplished by implementing proactive programs to improve their socio-economic conditions and by providing them with secure products and helpful information. (Beauchesne 2000.)

From an anti-prohibitionist perspective, meaningful harm reduction policies require that the purchase and use of drugs currently deemed illicit become legal. It would be a grave mistake to attribute this perspective solely to left-leaning academics. In 2002, a non-profit association known as Law Enforcement Against Prohibition (LEAP) was formed. The organization is mainly composed of former and current law enforcement officers who believe that the best way to manage the harms linked to illicit drug use is to ultimately end drug prohibition. LEAP's stated position is that the United State's war on drugs is the primary cause of the harms associated with illicit drug use. (www.leap.cc.) While this organization includes some Canadian former law enforcement officers, its membership is primarily American, including a multitude of high profile judges, police chiefs and commissioners.

From this perspective, studies have also been conducted that attempted to determine whether or not legalizing drugs currently deemed illicit would actually decrease criminal behaviour. What has resulted is the realization that the link between criminality and drug use is far from clear. Brochu (1995) suggests, in fact, that the notion that drug use is linked to criminality is more the product of popular media publications than scientific research. If a link exists, then the relationship is complicated and indirect. This is a particularly pertinent point when analyzing drug policies in the United States. Robert J. MacCoun (1999) suggests that Americans tend to think of drugs as a crime problem, whereas communities in Europe look at it

as an issue of public health. This explains how Americans justify their drug policies. American bureaucrats tend to subscribe to what MacCoun describes as “the notion that drug use is *mala in se*, or morally repugnant in and of itself.” (p. 203.) This perspective tends to be perpetuated by the media, making harm reduction policies, let alone anti-prohibitionist ideas, a difficult sell in the United States.

With few exceptions, anti-prohibitionist perspectives are not reflected in public policy. Health concerns, which generally discard questions relating to the potentially negative health and social effects created by prohibitionism, tend to be the main area of focus when alternative measures in drug policies are explored. If the focus lies with health issues, independently of the consequences of prohibition, the mandate is easier to identify and many political complications are avoided. Erickson et al. (1997) suggest that the success of harm reduction lies in the fact that harm reduction is: “an approach to reducing drug related harm with no strings attached. By not associating itself with specific moral, legal or medical interpretations of the phenomenon of drug use, the Harm Reduction Model releases itself from many of the unnecessary constraints on drug strategies set by existing approaches.” (p. 6.) This position is echoed by Helen Keane (2003) who suggests that value neutrality must be looked at as a tool to debunk morally invested perspectives in the drug debate. While this may be true, we must wonder what the consequences of such an attitude might be on the implementation of harm reduction practices. These consequences, perceived as negative by both the hard prohibitionists and anti-prohibitionists lie at the root of their criticisms of current harm reduction practices. This brings us to the notion of risk in harm reduction practices.

1.1.5 The notion of risk

Quirion (2002) suggests that the notion of risk has become the primary measuring device for governments when managing harm reduction policies. Modern societies increasingly demand from their governments that risks inherent to life in a community be limited and controlled. Governments, particularly in North America, have consequently begun engaging in risk management. Many problems within a community are now defined in terms of potential risks to that community, rather than considering the needs of the person at risk. Consequently, when it comes to illicit drug use, governments have appropriated harm reduction practices, formerly centered on humanism and pragmatism, and incorporated them into their risk management policies, creating a model that seeks to regulate human behaviour via a-priori neutralization mechanisms without ever seriously considering the needs of the person at risk. (Quirion, 2002.) Thus, the humanistic aspect of harm reduction practices, which was so pertinent prior to the 1980's, is gradually being lost. The consequences of this, Quirion suggests, is that the person engaging in risky behaviour with drugs is stigmatized because his or her actions become a perceived potential threat to the remainder of the community.

Harm reduction practices which have developed since the 1980's, be they needle exchange programs, methadone treatment programs, or the implementation of safe injection sites, appear to have been justified primarily within a dynamic of risk management, while harm reduction practices prior to the 1980's focused on humanism and pragmatism. In order to better understand this dynamic, a detailed analysis of these practices is required.

1.2 Harm reduction practices

Harm reduction practices have taken various forms in various countries, with varying success. While these practices are often implemented based on the sanitary perspective, some

countries have taken a socio-sanitary approach to harm reduction. The scope of harm reduction programs worldwide, in fact, varies greatly. The emergence of HIV/AIDS, however, has been the primary factor in the development or re-emergence of most of these practices, and they have developed primarily, though not exclusively, from a risk management standpoint.

1.2.1 Harm reduction programs linked to drinking and driving

Before looking at harm reduction practices linked to illicit, injectable drug use, it is useful to look at drinking and driving reduction programs. Our points of reference when comparing alcohol consumption to the consumption of illicit, injectable drugs are surprisingly similar. As is the case with opiates and cocaine, it is generally accepted that alcohol can become addictive. This addiction, referred to as alcoholism, is frequently interpreted as a physiological disease, as are cases of addiction to opiates and cocaine. This position remains popular despite existing literature suggesting psychological and psychosocial factors regarding alcoholism also exist.⁵ Furthermore, studies linking the consumption of alcohol to crime are easy to come by. And yet, despite these similarities between alcohol and illicit, injectable drugs, we choose to prohibit the recreational use of one, but preach moderation and personal responsibility when approaching risks associated to the consumption of the other. It is important, therefore, to look at harm reduction programs linked to the use of alcohol, in particular as it relates to drinking and driving, before analyzing harm reduction programs linked to the use of illicit, injectable drugs. This is important because harm reduction programs linked to the use of alcohol are not developed within a context of prohibition.

Given the fact that the consumption of alcohol is legal and regulated, it is interesting to question whether harm reduction programs linked to alcohol are more or less effective than

⁵ For details on alcoholism and its potential causes, see Lawson and Lawson (1998).

programs that focus on illicit injectable drugs. Furthermore, an understanding of the philosophy behind drinking and driving harm reduction programs is important. These programs exemplify harm reduction mechanisms that are implemented within a risk management paradigm in which the primary focus is the protection of the general public from the risky behaviours of others.

In 1980, while the HIV/AIDS virus was still being discovered, an organization known as Mothers Against Drunk Driving (MADD) was formed. Their mission was “to mobilize victims and their allies to establish the public conviction that impaired driving is unacceptable and criminal in order to promote corresponding public policy, programs and personal accountability.” (www.madd.org.) While the organization’s methods and mandate are not free of controversy, it is difficult to argue against the idea that groups such as MADD, as a result of their activism and lobbying, have played a central role in changing the general public’s perceptions about drinking and driving. While statistics are always subject to interpretation, there is solid data suggesting that drinking and driving rates in North America have declined significantly since the 1980’s.⁶

In response to concerns about drinking and driving and its potentially devastating consequences, harm reduction strategies designed to prevent drinking and driving have been implemented worldwide. A Canadian example is “Operation Red Nose.” This program, initially created in Quebec, seeks to drive intoxicated people home in their own vehicles during the festive month of December. There is no charge for the service, and the organization makes a point of being value-neutral regarding the consumption of alcohol. (www.kingston.org/rednose.) The hope is that, by offering a free service to intoxicated individuals, and by driving the intoxicated individual home in his or her own vehicle, fewer individuals will choose to drive while under the influence of alcohol. By all accounts, the service is enormously popular and

⁶ For details and statistics related to impaired driving, see Mothers Against Drunk Driving: <http://www.madd.org>.

successful.⁷

Programs such as “Operation Red Nose” and organizations such as MADD exemplify, in many ways the risk management approach that developed in public and political circles during the 1980’s. While data suggests that these programs may be successful in reducing the incidences of drinking and driving, potentially saving lives, it is interesting to note that the focus of the programs is on protecting the general law-abiding public from potentially risky behaviours of a specific group of law-breaking individuals. If we look at MADD’s mandate, for example, it becomes clear that its goal is to protect innocent victims from the criminal acts of persons who choose to drink and drive, by making them accountable for their actions. The organization’s objective is to take a-priori action against those who drink and drive by taking them off the road before an accident occurs. Exploring the root causes of drinking and driving or the needs of the individuals who partake in this risky behaviour is not considered.

One must also wonder how successful programs such as “Operation Red Nose” would be at reducing incidences of drinking and driving if the consumption of alcohol were illegal rather than regulated. How many people would choose not to call the service for assistance out of fear of possible reprisals for having committed an illegal act? How would the political and social ramifications of providing a service to people who commit an illicit act affect the program?

1.2.2 Methadone delivery programs

Methadone is a synthetic opiate created in Germany during the Second World War. (Preston and Bennett, 2003.) It is generally presented in liquid form, and its primary usefulness stems from the fact that, when ingested orally once a day, it can help curb a drug user’s urge for

⁷ For details on the number of people who have used the service, see Operation Red Nose: <http://www.kingston.org/rednose>.

his or her opiate of choice. Furthermore, methadone is able to block the effects of other opiates. Given these properties, methadone has been identified as a useful tool in weaning dependent opiate users away from their habitually used drug. Methadone treatment, however, can require years or even an indefinite period of use. (Lewis and Bellis, 2001.) As a result, various methadone delivery systems, whose end goals are quite different one from another, are implemented throughout the world. Acetylmethadol and buprenorphine are two drugs similar to methadone that have recently been approved or are in development in various countries, but methadone is currently the substitute drug most frequently being dispensed to opiate users. (Kuo et al., 2000.)

Diverse methadone treatment programs were first implemented in Europe and North America in the 1960's and 1970's, well before the discovery of HIV/AIDS. Of note is the fact that, by 1971, an estimated 25 000 people were receiving methadone in the United States. (Brisson, 1997.) Patients received their methadone primarily through free clinics and day centers, for indefinite periods of time. Methadone treatment was seen as a useful tool in managing and dealing with "drug related problems" within the country. (Brisson, 1997.) In the late 1970's, however, public opinion on methadone began to change. Within the moralistic and prohibitionist dynamic that was so prevalent in the United States, methadone was viewed as a drug that could potentially be diverted to the black market. The medical benefits of methadone treatment were less relevant. Furthermore, there was concern that opiate users, rather than being treated with methadone, were actually being supplied with a drug. Programs which supplied methadone on a reduction basis, where the dose was gradually reduced, rather than on a maintenance basis, where the dose was administered as a constant, were consequently favoured, essentially marginalizing the programs and making them inaccessible. (Brisson, 1997.)

In Great Britain, the emergence of methadone in the 1960's as a possible form of treatment for habitual users of opiates fit in well with that country's drug policy. The medical model adopted in Great Britain following the findings of the Rollerston Committee in 1926 was extremely open to the usage of a drug that could possibly re-habilitate opiate users. As noted earlier, until the 1950's, physicians could prescribe certain drugs, including opiates, to habitual users, in an attempt to limit the negative consequences associated with drug use. Pursuant to external pressures, the British government opted to limit the powers given to doctors in the 1950's, requiring that doctors who prescribe opiates obtain a special license. (Brisson, 1997.) Furthermore, prescription users of opiates would need to register with the Ministry of the Interior. Within this new context, prescribing methadone was encouraged, and by the mid 1960's physicians were, for all intents and purposes, no longer prescribing heroin, as it had been replaced with methadone. Even methadone treatment would eventually decline, primarily as a result of the international debate surrounding drugs. From 1960 to 1980, as a result of a worldwide boom in drug use, the prescribing of illicit drugs became extremely controversial and the practice was greatly reduced. (Preston and Bennett, 2003.)

The emergence of HIV/AIDS brought about a resurgence of methadone delivery programs throughout the world. With health concerns trumping all other considerations, methadone delivery programs were identified as possible tools in harm reduction. Only the distribution of clean needles is a more generalized harm reduction practice. Today, methadone delivery programs exist in most European countries, as well as Australia, Canada, and the United States. (Brisson, 1997.) Also noteworthy in Great Britain is the practice of providing an injectable form of methadone mixed with heroin to persons who have not been receptive to orally ingested methadone. (Beaumont, 2001; Ford and Ryrie, 1999; Shaw et al., 1997.)

Quirion (2003) argues that methadone programs that re-emerged since the 1980's have changed greatly from those that existed in the 1960's and 1970's. He contends that:

Methadone programmes created in the 1960's were established in order to respond to drug user's needs, such as social and professional integration into the community. By contrast, programmes that were created in the 1980's and the 1990's were above all driven by the need for the neutralization of practices that represented a risk to the community. From this perspective, we can conclude that harm reduction strategies have been diverted away from their humanistic roots and have become security-oriented strategies. (Quirion, 2003:247.)

From this perspective, methadone programs, like other harm reduction strategies, have changed their focus since the 1980's, ever since governments began practicing risk management in lieu of more humanistic strategies. In the case of methadone delivery programs, this means the focus has shifted away from the drug addict and his or her rehabilitation in favour of protecting society. Methadone programs are increasingly viewed as tools that can reduce the costs and social harms inherent to the practices of drug users that can hurt the general public. These include "reducing the risk of HIV transmission; protecting public health; reducing the costs related to health services; reducing law enforcement and criminal justice costs; reducing mortality and morbidity; reducing constraints on public safety; and reducing loss of social and economic functionality." (Quirion, 2003:253.) This focus on risk management is particularly visible in North America, where the sanitary perspective dominates harm reduction practices. Nevertheless, risk management concerns are also noticeable in countries that have taken a socio-sanitary approach towards harm reduction, such as Switzerland and Great Britain. While health issues are not the only consideration for harm reduction practices in these countries, and the rehabilitation of the drug user is of a greater concern, the protection of society remains a focal point.⁸

A notable, though only partial, exception to this risk management paradigm is the

⁸ Harm reduction practices and philosophies in these two countries will be explored further into this project.

Netherlands, likely because it was the only country to formulate a harm reduction philosophy centered on pragmatism and humanism prior to the discovery of HIV/AIDS. As noted previously in this paper, pursuant to the Baan commission's recommendations in 1972, the Netherlands implemented harm reduction programs for drug users in an attempt to integrate these users, as much as possible, into society. This process was dubbed the "pragmatic and normalizing" process. (Leuw, 1994.) Modern harm reduction policies in the Netherlands have consequently evolved from this perspective. Whereas in most countries the law is seen as a collective reference tool of socially and morally accepted premises, laws in the Netherlands are designed specifically with the purposes of adaptation and integration of its citizens in mind. (Mino, 1993.) While only the possession of marijuana has been decriminalized, Dutch drug policies tend to focus on education, prevention, protecting the youth, and assisting drug users with social assistance and psycho-medical therapy rather than repression. (Leuw, 1994; Mino, 1993; Wever, 1994.) In the instance of methadone delivery programs this position is visible in the fact that methadone is administered not only on a reduction basis, but also, and primarily, on a maintenance basis. Approximately 75 percent of methadone recipients in the Netherlands obtain methadone on a maintenance basis (Wever, 1994).

1.2.3 Needle exchange programs and safe injection sites

Needle exchange programs are the most common form of harm reduction worldwide. While they can facilitate communication between social workers and injectable drug users, the explicit goal is to provide users of illicit, injectable drugs with clean syringes in order to avoid the spread of HIV/AIDS and hepatitis. Most needle exchange initiatives also incorporate a needle collection mechanism in an attempt to reduce the number of discarded needles left behind in

parks and other public places. Needle exchange programs are generally attached to community health centers, shelters, pharmacies and other such locales. The injectable drug user can go to a designated center anonymously, and exchange used needles for clean, unused ones. Other needle exchange programs provide workers who go out into the community, offering clean needles to drug users. These various needle exchange initiatives operate in partnership with different levels of government, which provide the funding required for the purchasing and distributing of clean needles. Initial concerns among the general population as well as certain political figures that distributing clean needles would increase the number of used needles discarded in public places have, for the most part, proven to be unfounded. While needle exchange programs are most frequently endorsed by governments for sanitary purposes, the practitioners of these programs frequently go far beyond this mandate by taking the opportunity to address other needs and concerns expressed by injectable drug users during the needle exchange process.

Perhaps the most noteworthy needle exchange program originated in the United Kingdom in the mid 1980's. This program, referred to as the Liverpool model, attempted to go beyond the medical model of treating drug users with maintenance or substitution drugs by offering socio-psychological assistance to users who requested help. In the 1980's, the city of Liverpool, in Merseyside had gained a reputation as a "smack city." It was estimated that there were 20 000 opiate users in the region. (Seymour and Eaton, 1997.) Very few of those drug users sought help from medical professionals. In order to reduce the harms associated with injectable drug use, particularly health-related harms, it was felt that a more proactive approach towards harm reduction, in which public health practitioners went out into the community and made contact with injectable drug users, was needed. The objective of the Liverpool model was to impact the general population of injectable drug users, without necessarily preaching abstinence. Offering

clean injection equipment on an exchange basis appeared to be an effective way of getting in touch with users and maintaining contact with users, thus gradually changing the drug user's behaviours. Data suggest that the program was successful in reducing needle sharing among users, thereby reducing the risk of HIV/AIDS infection. (Seymour and Eaton, 1997.)

While the explicit goal of needle exchange programs is to reduce the spread of HIV/AIDS to users of injectable drugs, health officials have noted other potential benefits to these programs. In Great Britain and the Netherlands, for example, the distribution of needles is often seen as a means of coming into contact with injectable drug users, enabling professionals to reach out to users, and offer methadone maintenance programs as well as medical and psycho-social services. (Brisson, 1997; deKort, 1994.) Some drug users, however, may only want needles, not methadone or medical services, and may feel ill at ease with the health worker's approach. Consequently, many needle exchange programs will only offer other services if a drug user explicitly asks for help, respecting the drug user's right for autonomy, without moral judgment.

Needle exchange programs are ubiquitous throughout much of the world. These initiatives even exist in the United States, despite the fact that, since 1988, federal statutes have been enacted that expressly restrict or ban the use of federally appropriated funds to finance needle exchange programs. Federal laws also stipulate that a physician's prescription is required to purchase a syringe. Laws have been enacted in 47 U.S. states making the unauthorized manufacture, possession, or distribution of drug paraphernalia a misdemeanour or felony offence. (Sherman and Purchase, 2001.) And yet, in 2001, 113 needle exchange programs were operating in the U.S. These programs can operate legally in great part as a result of state Supreme Court rulings, that have determined that drug paraphernalia acts were not written with

the foreknowledge of AIDS, and that needle exchange initiatives are necessary in light of the public health emergency at hand. (Sherman and Purchase, 2001.) The focus on health concerns and the protection of the community, rather than the user, is evident when the methods by which governments justify implementing harm reduction programs, such as needle exchange programs in the United States, are analyzed.

When looking at needle exchange programs, we must inevitably look at their application in prisons. Opiates and other illicit drugs are commonly used in prisons, despite being banned substances. Studies suggest that 30-50 percent of detainees in European prisons have consumed illicit drugs while incarcerated. (Nelles et al., 1997.) Other studies have found similar rates of consumption in Canadian and Australian prisons, and even higher rates in prisons in the United States. (Jacob and Stover, 2000.) Consequently, from a sanitary perspective, needle exchange programs appear to have a place in prisons. Pilot needle exchange programs, particularly in Switzerland and Germany, have shown that needle exchange programs in both men's and women's prisons can reduce and even stop the spread of HIV/AIDS, as well as hepatitis in these controlled settings. (Canadian HIV-AIDS Legal Network, 2004; Jacob and Stover, 2000; Nelles et al., 1997.) Furthermore, attacks on staff members or other inmates by drug users with needles did not materialize, and fears that the rates of drug consumption within the prison walls might increase proved to be unfounded. (Canadian HIV-AIDS Legal Network, 2004; Jacob and Stover, 2000; Nelles et al., 1997.) Of note is the fact that needle exchange programs in which clean needles were dispensed automatically by a machine proved to be more successful than those in which a staff member dispensed the needles. Enquiries revealed that inmates were hesitant to procure clean needles from staff for fear of being identified as a user of illicit drugs. (Canadian HIV-AIDS Legal Network, 2004; Jacob and Stover, 2000.) This, of course, begs the question as

to whether or not needle exchange programs in the outer world are less effective because potential clients fear the consequences of being identified as users of illicit drugs. Also of note is the fact that needle exchange programs in prisons have been far slower in being implemented than they have been in the outside world, despite clearly higher rates of infection inside prison walls. From a risk management perspective, at least in the short term, the spread of HIV and AIDS among prison inmates would appear to present less of a physical threat to the general public when compared to users of illicit drugs who are not incarcerated. Consequently, needle exchange programs in prisons, from a risk management perspective, are a less interesting proposition to government authorities. Furthermore, attempting to implement harm reduction programs in prisons can be a politically hazardous endeavour, as governments would have to concede that inmates use illicit drugs in prison, a place that, in the eye of the public, should be drug-free.

Once governments participate in needle exchange programs, opening up controlled drug consumption rooms for users of illicit drugs, particularly illicit, injectable drugs, appears to be the next step in a natural progression. If we look at injectable drug consumption from a harm reductionist perspective, then the act of injecting drugs should be performed in a controlled setting. (Colle, 2000.) By offering a controlled setting for injection, the argument goes, it becomes possible to ensure the use of hygienic materials, limit the harms linked to overdoses, and offer valuable information relating to injectable drugs to the user. This controlled setting usually takes the form of a small, furnished room, equipped with the tools required for safe injection, under the supervision of a health care professional. (Colle, 2000; deJong and Weber, 1999.) Furthermore, there is an added potential benefit for the general public, as drug use in the streets might be reduced. (deJong and Weber, 1999.) The notion of drug consumption rooms is

generally met with public resistance, however, making the implementation of such spaces a political challenge.

Drug consumption rooms currently operate in Switzerland, the Netherlands, Germany, Australia, and Canada. In the 1960's and 1970's, several clinics where illicit drug users could inject themselves with illicit substances under medical supervision existed in London, but these clinics have since closed. (Carrier, 2003.) Perhaps most noteworthy is the Dutch experience with drug consumption rooms. The first modern drug consumption rooms in the Netherlands were opened in Amsterdam in the mid 1970's. These took the form of café-like facilities and even "drugs boats." (deJong and Weber, 1999.) These facilities, however, were met with a great deal of resistance from the public, who argued that the facilities attracted addicts and dealers from elsewhere, creating a public nuisance. Local authorities eventually closed down these facilities. (deJong and Weber, 1999.) In 1996, however, Amsterdam re-opened drug consumption rooms, primarily in an attempt to reduce the nuisance created by drug users injecting in the streets. The concern, therefore, was primarily for the well-being of the general public, not the drug user. In order to avoid the same problems identified when drug consumption rooms first opened, certain control mechanisms were implemented. These mechanisms included strict admissions criteria. Users required a magnetic card to enter the drug consumption room, and a prerequisite that partnerships between the consumption room and the police exist was imposed. (Colle, 2000.) Drug consumption rooms currently exist in Amsterdam, Rotterdam and Arnhem, and enjoy the support of municipal authorities, law enforcement agencies, as well as the judiciary. (Colle, 2000.)

The first drug consumption rooms in Switzerland were opened in Zurich in 1981 and Bern in 1986. These rooms were run by non-governmental agencies that were attempting to improve

the deeply deteriorating situation of Swiss drug users. (deJong and Weber, 1999.) The Swiss authorities did not initially support these facilities, but with the discovery and spread of HIV, the position of local authorities on harm reduction changed. (deJong and Weber, 1999.) Today, drug consumption rooms exist in Zurich, Basel and Bern. (Colle, 2000.) They are regulated by judicial guidelines requiring that medical supervision be provided and that users of drug consumption rooms be offered medical and social services. (deJong and Weber, 1999.)

In Germany, drug consumption rooms in Frankfurt, Hamburg, Bremen and Bonn were opened in the 1990's. German judicial and municipal authorities were able to justify drug consumption rooms from a public health perspective similar to the Swiss approach. (deJong and Weber, 1999.) Mirroring Switzerland, it was non-governmental agencies who initially opened safe drug consumption rooms. These facilities were legitimized at a later date, following the emergency created by the emergence of HIV/AIDS.

In Australia, the only safe injection site was opened in Sydney in May 2001, as a pilot project, under a great deal of resistance from political and legal figures. (Carrier, 2003.) While the site still exists, proposals to open sites in other Australian municipalities, notably Melbourne, have been rejected by local authorities (Carrier, 2003).⁹

1.2.4 Heroin prescription programs

In the 1980's, Swiss authorities in Zurich were facing a political dilemma in the form of "Needle Park". Roughly 3 000 injectors and dealers of illicit drugs were meeting daily at this notorious park, making the surrounding area unappealing for its residents. (Brehmer and Iten, 2001.) The deteriorating health of an ever increasing population of injectors, coupled with a rise in the rate of HIV infections required a new approach to managing drug use in the country.

⁹ Canada's safe injection site will be looked at further into this project.

(Brehmer and Iten, 2001.) Along with the implementation of needle exchange programs and safe injection sites, the Swiss government opted to experiment with prescribing illicit drugs in small, controlled settings. In 1994, small-scale heroin prescription trials in various cities throughout the country were implemented. Only long-term drug addicts over the age of twenty who injected daily and had previously attempted and failed to quit using heroin by other means, including methadone, could participate in the program. Furthermore, no center was responsible for more than 150 patients. (Killias and Rabasa, 1997.) These prescription trials ensured that injections were made on site, in a safe manner, that no product was taken back to the streets, and that users received psychosocial assistance. (Colle, 2000.) Studies conducted from 1994 to 1996 indicate that, among the users in the prescription program, their general and mental health improved greatly, there was a significant decrease in consumption rates of illicit drugs as well as a reduction in the rates of criminal behaviour. Improvements in social reintegration, including employment and housing, were also noted. (Brehmer and Iten, 2001; Killias and Rabasa, 1997.)

Swiss policy opts to address drug issues on four fronts: Prevention, treatment (or therapy), harm reduction, and law enforcement (or repression). From this perspective, harm reduction practices are implemented within a context of prohibition. In order to bypass the fact that recreational heroin use in Switzerland is illegal, the federal government enacted a by-law to the Swiss Narcotics Act, making heroin prescription an activity to be regulated and monitored by the Federal Office of Public Health, as an experiment. (Killias and Rabasa, 1997.) The trials were initially met with protests from a vocal group of citizens who managed to force a federal referendum on the issue of prescription trials. In 1997, 74 percent of Swiss voters showed their support for the trials. In a similar referendum in 1999, 54 percent of Swiss voters indicated their support for the continuation of the medical prescription of heroin. (Brehmer and Iten, 2001.)

This might suggest that, while a majority of Swiss citizens are open to the idea of heroin prescription trials, the country is far more divided on the idea of making the prescribing of heroin legal.

Swiss harm reduction practices have evolved from a decidedly socio-sanitary perspective. One of the greatest motivations behind the implementation of heroin prescription trials was the hope that the mechanism would prove useful in reducing rates of criminality among users of injectable drugs. A considerable amount of research is dedicated, in fact, to the question of whether or not heroin prescription trials have been effective in reducing crime rates by users of injectable drugs. (Brehmer and Iten, 2001; Killias and Rabasa, 1997.) While it is noteworthy that harm reduction programs in Switzerland address social issues, such as the rates of crime linked to illicit drug use, these programs still tend to focus on protecting the general public from the potentially harmful actions of a smaller segment of the population. Consequently, a risk management approach to harm reduction is very much in effect, despite the socio-sanitary context of the programs.

Following in the footsteps of the Swiss, the Dutch government approved the execution of a study on heroin prescription in the Netherlands. The objective of the study was to determine whether or not the prescription of heroin could assist in treating dependent users who did not respond favourably to methadone treatments. (van den Brink et al., 2003.) The study found that “supervised medical prescription of a combination of methadone plus heroin is feasible, safe, and effective, with clinically relevant improvements in physical health, mental status, and social functioning (including substantial reductions in criminal behaviours).” (van den Brink et al., 2003:5.) It is interesting to note that despite the fact that harm reduction policies in the Netherlands have developed from a humanistic and pragmatic approach, risk management has

also crept into Dutch political thought (i.e. protecting the general population from the criminal behaviours of illicit drug users).

Doctors in Great Britain have been able to prescribe heroin and other illicit substances since 1926. As noted earlier in this text, however, the rules and regulations surrounding the prescription of opiates has been tightened greatly since the 1950's, and the prescription of methadone over heroin is encouraged. Consequently, only approximately 3 000 people receive prescribed heroin in Great Britain. (www.abcclassics.com.) The British example represents a medicalized view of illicit drug use. In Great Britain, the reduction of crime rates among users of illicit, injectable drugs is also a political concern used in justifying harm reduction programs. (Seymour and Eaton, 1997.)

While several countries have taken steps to provide users with illicit drugs, this is done within a prohibitionist context, in the sense that the prescribed drugs still remains illicit substances. It is not surprising, therefore, that it is in the Netherlands, where the possession and use of marijuana has been decriminalized, that propositions favouring the controlled legalization of hard drugs have been forwarded, though they have yet to be seriously considered. These propositions do not favour a medicalized distribution of these drugs.

On n'achète pas des cigarettes ou des boissons alcoolisées dans des pharmacies mais dans des débits appropriés. C'est donc mettre les médecins dans un conflit de loyauté d'avoir à prescrire des drogues éventuellement néfastes pour la santé, qui ne sont pas des médicaments pour soigner ou soulager. Tout au plus, les médecins prescripteurs remplissent une fonction de conseil quant à l'usage des drogues, mais pas un contrôle, qui ne leur incombe pas, sauf exception. (Colle, 2000:177.)

The open commerce of these substances would involve regulatory mechanisms to ensure the products are not distributed to, for example, minors. (Colle, 2000.) Within this context, specialized institutions could address issues of abuse and addiction, without prohibiting the

substance, much as is currently done with licit drugs. (Colle 2000.)

1.2.5 Drug policy and harm reduction strategies in Canada

Current Canadian policies on non-medical drugs are soundly prohibitionist. (Riley, 1998; Carrier, 2003.) The primary statute addressing illicit drugs is the Controlled Drugs and Substances Act (CDSA), enacted in 1997, consolidating older statutes. It sets punishments for trafficking, cultivation, possession, importing and exporting and “prescription shopping” of illicit drugs, including cannabis. (Riley, 1997.) What is perhaps most surprising is that the Controlled Drugs and Substances Act is a poor reflection of Canada’s drug experience. In 1969, a public inquiry known as the Le Dain Commission concluded that hundreds of thousands of Canadians were being persecuted for simple drug possession to the point where their personal freedoms were being infringed upon. The commission recommended that possession of an illicit substance be dealt with in a less coercive manner and suggested that a gradual withdrawal from criminal sanction against users was desirable. (Riley 1997.) The end result of the Le Dain Commission was the implementation of Canada’s Drug Strategy in 1987, which sought to deal with illicit drugs not only by attempting to reduce supply and demand, but also by funding treatment and prevention programs. The CDSA is in sharp contrast to this strategy, focusing instead on criminalizing all aspects of illicit drug use, at great financial cost.

Harm reduction strategies in Canada are generally implemented from a sanitary, public health perspective. Within this context, needle exchange programs and methadone clinics have been implemented throughout the country, particularly in larger cities. Protecting the well-being of the general public from the harmful effects of illicit drug users appears to be the primary concern. Because managing the health of Canadian citizens is the responsibility of the

provinces, these programs vary from province to province. In Ontario, the Ministry of Health mandated in the late 1980's that:

The Board of Health shall ensure that injection drug users can have access to sterile injection equipment by the provision of needle and syringe exchange programs as a harm reduction strategy to prevent transmission of HIV, hepatitis B, hepatitis C and other blood-borne infections and other associated diseases in areas where drug use is recognized as a problem in the community. The strategy shall also include counselling and education and referral to primary health services and addiction/treatment services. (www.ottawa.ca.)

Similarly, methadone programs have been implemented throughout the province in partnership with the College of Physicians and Surgeons. Since 1996, methadone can be accessed either through clinics or by prescription from a physician. While the government is considering making other drugs, such as buprenorphine and naltrexone, available to patients as well, methadone treatment is currently the only opioid approved for long-term treatment of dependence in Canada. (www.cpsso.on.ca.)

On April 28th, 1999, Member of Parliament Libby Davies forwarded a private member's motion in the Canadian House of Commons moving that "the government should, in co-operation with the provinces, implement clinical, multi-center heroin prescription trials for injection to opiate users." (Davies, 1999.) She suggested that these trials were needed within the context of a "medicalization of addiction that allows us as a society to say that the answer is not just to throw people in jail or to criminalize them. We need to provide support, treatment, education and, in some instances, help to people who are facing a chronic addiction because treatment may have failed." (Davies, 1999.) While many warmly received the motion, it was ultimately dropped. The government's position, as iterated by Elinor Caplan who was the Parliamentary Secretary to the Minister of Health, was that:

It is Canada's stated priority to increase access to methadone maintenance. To this end, Health Canada has streamlined the authorization program and the

authorization process, allowing doctors to treat patients quickly and more effectively. The number of physicians using methadone in the treatment of their patients has also increased in this country. Furthermore, the department has undertaken consultation with stakeholders to find ways of increasing access to methadone treatment programs, and we are continuing to do so. (Davies, 1999.)

To go along with needle exchange and methadone programs, Vancouver became the venue for the first North American supervised safe injection site. The site, opened in September 2003, operates legally, as it was granted an exemption under Section 56 of the Controlled Drugs and Substances Act. The site provides an area where users can inject their own drug safely, under the supervision of nurses and counsellors. Referral and treatment services are also offered. (www.vch.ca.) This program appears to fit in with harm reduction strategies that focus on health issues and risk management. The east side of Vancouver is heavily populated with injectable drug users, and rates of HIV and hepatitis among users in the area have been on the increase since the 1980's, to the point of reaching epidemic proportions.

While the Canadian government has continued to implement harm reduction strategies from a health perspective, within a prohibitionist context, the judiciary and the senate appear to be open to a more holistic perspective. Provincial courts, in fact, have been regularly arguing that parts of the Controlled Drugs and Substances Act are unconstitutional and violate the Canadian Charter of Rights and Freedoms. (Riley, 1998.) Perhaps as a result, a Senate Special Committee on Illegal Drugs was formed in January of 2001, chaired by Senator Pierre Claude Nolin. While the committee's mandate was primarily to examine the approach taken by Canada to cannabis, the expertise offered by witnesses went well beyond this mandate. Furthermore, many of the issues addressed by the committee applied to illicit drugs in general. The committee reached two main conclusions: First, that public policies designed to reduce the supply and demand of illicit drugs were a complete failure. Second, that public policy on psychoactive

substances must be both integrated and adaptable, target at risk uses and behaviours and abuses based on a public health approach that neither trivializes nor marginalizes users. (Nolin, 2002.) In the case of marijuana, the committee determined that the best route the Canadian government could take would be to legalize and regulate its production and distribution.

In May 2001, a Special Committee on Non-Medical Use of Drugs was formed in the House of Commons, headed by MP Paddy Tornsey. Its mandate was to study “the factors underlying or relating to the non-medical use of drugs in Canada and to bring forward recommendations aimed at reducing the dimensions of the problem involved in such use.” (Tornsey, 2002.) The committee noted, interestingly, that the overwhelming majority of persons using or having used illicit drugs, including heroin and cocaine, have done so experimentally or recreationally, and that only an extremely small percentage use these substances in a pattern that causes dependency and/or health problems. (Tornsey, 2002.) Among various recommendations, the committee suggested that the harmful use of substances, and dependence, be addressed primarily within a public health framework, and that Canada’s drug strategy identify harm reduction as a core component in drug policy. (Tornsey, 2002.)

Harm reduction practices throughout the world, whether they stem from a sanitary or socio-sanitary perspective, appear to have developed, since the 1980’s, primarily from a public health perspective, in part as a result of the HIV/AIDS pandemic. Furthermore, with the partial exception of harm reduction practices in the Netherlands, harm reduction practices appear to be losing their humanistic characteristics in favour of a risk management paradigm, which focuses primarily on protecting the general population from the potentially risky behaviours of at-risk groups. Concerns for the needs and the well-being of the illicit drug user appear, for the most part, to have been by-passed. This is particularly apparent in North America, where sanitary

considerations are the primary concern. In order to understand the consequences of this focus on health matters and risk management on harm reduction practices, it is useful to explore the reactions of users of illicit drugs on harm reduction programs.

1.3 Positions of illicit drug users on harm reduction

Users of illicit drugs have organized in many countries in order to politicize their needs and interests. They form organizations that speak on their behalf to bureaucrats and law enforcement agencies. (Jauffret, 2004.) Perhaps the best known of these organizations is the “Junkiebond” (Junkie League) in the Netherlands. The “Junkiebond” was established in 1980 in Rotterdam as a type of union for drug users who were concerned their interests were not being represented. It is often suggested that pressure from the “Junkiebond” led to the development of the first needle exchange program in Amsterdam in 1984. (Weekes and Cumberland, 2004.) Since the inception of the “Junkiebond” in the 1980’s, similar organizations have developed, with varying success, in a multitude of countries including France, Belgium, Germany, Australia and Canada, to name but a few. Governments and bureaucracies have frequently been receptive to these organizations, as their existence fits in well with the harm reduction strategies that have been implemented following the HIV/AIDS epidemic. These organizations frequently receive public funding. In Australia, the active involvement of at-risk communities constitutes the hallmark strategy of the country’s response to the HIV/AIDS epidemic. (Crofts, 2004.)

In order to understand the positions taken by these organizations, it is useful to look at the contents of their publications. In France, a group known as ASUD (Auto-Support des usagers de drogues) was created in 1991. The founders, a group of active drug users, felt users of illicit drugs needed a voice in prohibitionist France. This organization prints a quarterly review

devoted to expressing the needs and protecting the interests of illicit drug users. Similarly, a publication known as LSD News expresses the positions of illicit, injectable drug users in the Netherlands. In Belgium, a publication entitled Stup & Faits is published every three months. In Australia, a journal entitled Junk Mail is printed specifically for the benefit of injectable drug users. At first glance, these publications appear to favour harm reduction policies, but a more in-depth analysis of the publications' contents reveals a more ambivalent position. (ASUD, 1998; LSD News, 2000; Stup & Faits, 1993.) In these publications, articles promoting safe injection practices and information about methadone clinics and various support groups are provided. Furthermore, articles about HIV/AIDS and hepatitis, and how injectable drug users can protect themselves from contracting these diseases can also be found. In this sense, injectable drug users appear to favour harm reduction mechanisms. The underlying theme in all publications, however, does not mesh as well with harm reduction practices and philosophies.

While publications from injectable drug users promote safe injection and other harm reduction practices, they do so from the standpoint that using drugs, illicit or not, is a valid, personal choice that any adult can make freely. (ASUD, 1998; LSD News, 2000, Stup & Faits, 1993.) Recreational use does not automatically lead to addiction, and users of illicit drugs are quite capable of leading normal lives and contributing to society. From this standpoint, these organizations contend that the user is responsible for his or her own health and the environment he or she lives in. (LSD News, 2000.) The biggest harm illicit drug users face, therefore, comes from their inability to freely consume their drug of choice. Users of illicit drugs are reviled and marginalized and have consequently become de-politicized. This, in turn, makes it difficult for users of illicit drugs to obtain employment and find adequate housing. The biggest harm linked to illicit drug use comes from the fact that the activity has been criminalized. (ASUD, 1998.)

Balian and White, self-professed users of illicit, injectable drugs, echo this position in Canada:

Drug user's lives revolve around securing sufficient supplies of drugs, obtaining and using these drugs without getting arrested, dodging physical harm when procuring or using drugs, evading or recovering (or dying) from overdoses, obtaining or holding on to jobs/educational status, manipulating physicians to secure additional medical aid in the face of systematic medical discrimination against users, maintaining relationships or disengaging from them, sorting out the logistics of traveling in terms of being away from their source or supplier (including methadone clients), and trying to get benefits if they are employed in a place that offers such coverage. (Balian and White, 1998:393.)

Consequently, "the services and supports needed by illicit narcotic users go far beyond the needs of alcohol consumers, prescription drug users and cigarette smokers. Otherwise, decriminalization (as a precursor to legalization) would not be the most pressing prerequisite of harm reduction strategies." (Balian and White, 1998: 394.)

Illicit drug users who have spoken out, as can be expected, tend to take an anti-prohibitionist stand on harm reduction. While needle exchange programs can be useful in reducing the spread of HIV/AIDS among users of injectable drugs, and while methadone programs can help wean opiate users away from opiates if they so choose, the greatest harm to users of illicit drugs comes from the marginalization they suffer for choosing to use illicit drugs recreationally. The greatest concern of these groups, therefore, is to politicize and empower users. They suggest that people should have a right to choose to use drugs recreationally, and they should not be marginalized for their decision if they become dependent. In this sense, harm reduction programs are inadequate because, while they seek to make injectable drug users responsible for their health, they do not enable them to take ownership of their lives.

In Canada, an organization known as VANDU (Vancouver Area Network of Drug Users) was founded in 1998, in Vancouver, B.C. Its objective was to bring together people who use heroin and cocaine, and give them the tools required to lead healthy, productive lives.

(www.vandu.org.) The organization has a membership of approximately 500 people, prints out a monthly newsletter and maintains a website. While the organization supports harm reduction programs, VANDU contends that illicit drug use can range from near total abstinence to severe abuse, and believes that drug users have the ability to protect themselves, their loved ones and their communities from harms associated with illicit drug use. (www.vandu.org.) Within this context, VANDU feels harm reduction mechanisms would be more effective if they focused on providing drug users with employment opportunities and housing. The “War on Drugs”, and the criminalization of certain drug users, according to VANDU, makes it easier for traffickers to prey on the weaknesses of illicit drug users. In Quebec, a publication entitled “Pusher d’infos” claims to speak for illicit drug users in Quebec. The publication claims that its mandate is to empower users of illicit drugs to take charge of their health and their environment, and to reclaim their self-esteem. The publication focuses almost exclusively on topics related to harm reduction.

While these publications may help us understand the perspectives of some illicit, injectable drug users, it is unclear whether or not the opinions and positions expressed by these organizations actually reflect the beliefs of the majority of drug users. We cannot state with certainty, for example, that the 500 highly motivated members of VANDU share similar beliefs and interests with the much larger segment of injectable drug users who are silent, either because they have been unable or have chosen not to express their views. Consequently, reaching out to illicit drug users who would otherwise remain silent, and asking them about their positions on harm reduction practices may or may not reveal a position similar to those expressed by organized users.

1.4 Summary of literary review/concluding remarks

Prior to the discovery of HIV/AIDS in the 1980's, harm reduction practices were generally implemented from a socio-sanitary perspective in which the physical and social well-being of the user within his or her community was the primary concern. From this standpoint, harm reduction practices were implemented within a humanistic perspective. Following the discovery of HIV/AIDS, however, health concerns became a primary focus. Even in countries where a socio-sanitary approach to harm reduction was adopted, reducing the spread of HIV/AIDS remained a focal point.

Furthermore, from a political perspective, a shift away from humanism in favour of risk management began to take place. From this standpoint, the well-being and integration of the drug user became a lesser concern. The primary goal of harm reduction practices either from a sanitary or socio-sanitary perspective, was to protect the general, law-abiding citizens from the risky behaviour of specific groups. Users of illicit, injectable drugs who have spoken out have responded negatively to this paradigm shift, as they have now become a target group that is discriminated against for its choices. Furthermore, harm reduction policies have generally not explored the harms associated with the criminalization of certain drugs. Even practices that seek to provide users with an illicit substance do so from a prohibitionist perspective with the goal of containing the harms associated with illicit drug use. What are the consequences of this perspective on harm reduction practices, and how do the clients of harm reduction programs perceive these consequences? In Canada, where harm reduction practices are implemented from a sanitary perspective, where do users of illicit, injectable drugs situate themselves in this harm reduction debate? Do they feel that harm reduction practices should focus strictly on sanitary concerns? Would they like to see the implementation of a more socio-sanitary approach, or do

they feel that harm reduction should also focus on legalizing drugs currently deemed illicit?

Furthermore, do users of illicit drugs feel harm reduction mechanisms should focus on the needs of the user before the protection of society? By obtaining insights from users of illicit, injectable drugs, it might be possible to evaluate the strengths and weaknesses of harm reduction practices.

CHAPTER II
METHODOLOGY

As stated in this project's literary review, the objective of this research project is to obtain insights from users of illicit, injectable drugs in the greater Ottawa-Carleton region on harm reduction policies. My experience and background in the field of law enforcement made me sensitive to the fact that this group is rarely consulted when decisions directly affecting their welfare are made. This chapter will explain the researcher's selected approach, along with the method used for collecting data. The research sample, along with the participant recruitment and interview process will then be discussed. Ethical and anonymity concerns will also be explored. Finally, the method used for analyzing the obtained data will be explained. The chapter will conclude with some general information about the participants.

2.1 Choice of approach

This project seeks out the perceptions and beliefs of users of illicit, injectable drugs. The specific focus is to determine where drug users position themselves within the four harm reduction approaches depicted in this project's literary review -namely the sanitary, socio-sanitary, prohibitionist and anti-prohibitionist approaches- and how they perceive the implementation of harm reduction programs within the context of these four competing, often conflicting approaches. Ultimately, this research seeks to identify the kinds of services users of illicit, injected drugs feel entitled to, and whether or not they are receiving these services. Because this research focuses on the perceptions and feelings of users, a qualitative rather than quantitative approach was chosen.

2.2 Method used for collecting data

In order to generate the qualitative data required for this study, interviews with users of illicit, injectable drugs who also use needle exchange programs in the greater Ottawa-Carleton region were conducted. Because the objective of this research is to obtain perspectives and insights on drug-related harm reduction programs from actual drug users, using interviews to obtain the information was deemed to be appropriate.

If users of illicit, injectable drugs are privy to unique information and perspectives because of their different perspective, it is important to give users a voice that is as unrestricted as possible. Consequently, allowing participants to speak freely, without too many constraints, in order that they may share their positions within the context of their own experiences and realities, becomes imperative. An overly structured interview would therefore have been inadequate because it would not have afforded participants the opportunity to elaborate on their perception of harm reduction policies and programs. Ideally, an interview that consisted of only one open ended question, where participants would be asked to express and then elaborate on their opinions about harm reduction programs in Canada would have been conducted. Such a question, however, might have led the participants astray, as they could have interpreted the question in many different ways, and spoken about subjects that are not the focus of this research. Consequently, the interview needed to be conducted in a fashion that allowed participants to speak of their own experiences and positions, while understanding the fundamental questions being explored in this research. For these reasons, a semi-structured interview consisting of five partially directive questions, followed by one open-ended question, was designed.¹⁰

The five partially directive questions were designed to solicit where, among the sanitary,

¹⁰ For the exact wording of the interview questions, please refer to appendix #1.

socio-sanitary, prohibitionist and anti-prohibitionist perspectives on harm reduction the participants situated themselves, as well as where they perceived the Canadian government to be situated. Rather than explain the four perspectives to the participants and ask for their opinions of these perspectives -which may have led to misperceptions or misunderstandings- the participants were asked to state their opinions on five scenarios or questions. Each of these scenarios touched on one or more of the four perspectives on harm reduction, thus allowing the researcher to infer from the participants' answers which of the four perspectives, if any, they tended to favour.

In the first question, participants were asked whether or not they believed the Canadian government would continue financing the harm reduction services they were benefiting from if a cure for HIV/AIDS and hepatitis were found. The idea behind this question was to attempt to determine whether or not users of harm reduction programs perceived that the Canadian government approaches harm reduction from a sanitary perspective. Presumably, if health concerns directly linked to injectable drug use (i.e. the spread of HIV/AIDS and hepatitis) were no longer a concern, then harm reduction programs, from a sanitary perspective, would no longer be required.

The second question asked participants whether they felt harm reduction programs associated to the use of illicit drugs should focus strictly on health matters (i.e. preventing the transmission of blood borne viruses), or if harm reduction programs should address users' needs to obtain employment, housing and medical services as well. The idea behind this question was to attempt to identify whether participants favoured a socio-sanitary or a sanitary approach to harm reduction.

The third question asked participants whether they felt that laws that make the recreational

use of certain drugs illegal was helpful in protecting the public from the harms associated with certain drugs. Law enforcement is at the core of “War on Drugs” policies and, consequently, prohibitionist approaches towards illicit drug use. Conversely, anti-prohibitionists feel that the laws prohibiting the recreational use of certain drugs are the most harmful elements of illicit, recreational drug use. Asking this question, therefore, seemed pertinent in attempting to identify where on the spectrum from prohibitionism to anti-prohibitionism, including sanitary and socio-sanitary harm reduction mechanisms, participants situated themselves on the issue of illicit drug use.

The fourth question asked participants whether they felt the biggest harms associated to drug use came from the actual drug or from the marginalization the recreational user of illicit drugs might experience as a result of having to procure drugs on the black market, thereby putting themselves at risk. This question was a further attempt to determine where participants situated themselves within the four harm reduction theories explored in this research. If the illicit drug itself is the greatest cause of harm, then the socio-sanitary and anti-prohibitionist perspectives become less pertinent. If, on the other hand, the marginalization experienced by illicit drug users causes the greatest harm, then the prohibitionist and sanitary perspectives might appear more flawed.

The fifth question briefly outlined the history of alcohol prohibition in the United States before asking participants whether they felt legalizing drugs currently deemed illegal would have a similar effect to the re-legalization of alcohol in the United States in 1933. When alcohol was legalized again in 1933, the quality, concentration and distribution of alcohol became better regulated and organized crime related to the production and sale of alcohol essentially disappeared. Asking participants whether they thought the same thing would happen if drugs

currently deemed illegal were legalized seemed pertinent in identifying the participants' positions on the greatest causes of harm linked to illicit drugs.

Once the five partially directive questions were asked and answered, the participants were asked to elaborate on their perceptions of harm reduction programs as well as their needs. Asking the open-ended question at the end of the interview was done purposefully. The hope was that participants, after answering the five partially directive questions, would have a better grasp of the researcher's goals, without being swayed to answer in any specific way. In this sense, the final question was an open ended one, allowing participants to offer insights the researcher might not be privy to, and allowing for a dialogue between the researcher and the participants to ensue, whereas the researcher only intervened in the five partially directive questions if clarification was required.

It was hoped that by giving participants a great deal of latitude, while attempting to keep the scope of the questions relatively narrow, the participants would become an active part of the research process, rather than passively answering short questions in which they might have little or no interest. By empowering participants in such a way it was felt that their unique insights on the subject of harm reduction were more likely to come to the forefront.

2.3 Research sample

A total of 14 participants were interviewed in this research project in order to obtain the required data. Only one participant asked that the interview not be audiotaped. It should be noted that the objective was not necessarily to identify the commonalities between all participants, but rather to identify the various perceptions and insights of a specific group on a specific subject. The possibility that perceptions among the participants might differ greatly was

not lost on the researcher.

Participants for this research had to meet certain criteria. Firstly, all participants needed to be regular users of illicit, injectable drugs. By regular use, it is understood that the participant uses illicit, injectable drugs at regular intervals. The duration of the intervals was irrelevant. This criterion was required because this project seeks out the perceptions and insights of members of a group, namely illicit, injectable drug users. Persons who have experimented on one or even several occasions with illicit, injectable drugs may not necessarily be included in this group, and their perceptions may come from an entirely different experience. The term “regular” rather than “dependent” user was chosen because dependency is a somewhat clinical condition.

Furthermore, users who may seem dependent to the average person may not perceive themselves as such. Consequently, it was simply asked that the participants be regular users of illicit drugs. The type of drug used by the participants was irrelevant, as long as its use was prohibited and as long as the drug was injected. These two criteria were important because this research seeks out the perspectives and positions of illicit injectable drug users on harm reduction programs. It was decided that participants must all be users of needle exchange programs. Needle exchange programs, along with methadone delivery programs, are the only two widely available harm reduction mechanisms throughout Canada. Accessing methadone users, however, would have proven to be extremely difficult given patient/doctor confidentiality realities. Furthermore, this research seeks out the perspectives of illicit drug users who may or may not wish to cease using their drug of choice.

The gender of the user was not a consideration in this research. It was decided, however, that all participants in this research must be at least 18 years of age. This was done primarily for ethical, as well as practical, considerations. Issues of consent for minors would have been murky

at best, and obtaining consent from the minor's parents to interview their child would have proven to be a logistical nightmare. Finally, it was decided that all participants must be situated in the greater Ottawa Carleton region. This was also decided for practical reasons. Had the participants been recruited from needle exchange programs in various different cities, their needs might have been different because of geographical reasons. Users in Vancouver, where the temperature rarely drops below freezing, or in Toronto, where a large percentage of the population lives in the city's core, may vary simply because of where they live. Consequently, in order to ensure some geographical homogeneity among participants, it was decided that all participants would be users of needle exchange programs in the greater Ottawa-Carleton region.

2.4 Recruitment and interview process

In order to determine the feasibility of this project, counsellors and support workers at various centers that offer needle exchange programs in Ottawa were contacted before this research was initiated. When asked about the feasibility of accessing users of needle exchange programs, these counsellors responded with optimism. While persons who obtain clean needles are not obligated to divulge their identity, a relationship frequently develops between users and social workers. Many of these users are more than willing to share their personal experiences and perceptions. The support workers were more than happy to speak to users on the researcher's behalf and to facilitate a meeting between the two parties if the user expressed a willingness to participate in this research.

Consequently, upon the completion of this research's literary review and methodology, and after the methodology was approved by the University's Ethics Committee, various needle exchange programs were contacted once again. All needle exchange facilities that were

contacted were situated within the Lowertown and Centertown areas of Ottawa. The decision to operate in this fashion was made for two reasons. Firstly, the overwhelming majority of street users of illicit, injectable drugs in Ottawa tend to congregate within these two areas. The chances of obtaining participants for this research were therefore increased by focussing on these two areas. Secondly, it was feared that if attempts were made to interview participants who tend to use needle exchange programs on the outskirts of the city, opportunities to interview a greater number of participants within the city's core would be lost. It was felt, after consulting with various counsellors and social workers, that potential participants who showed an interest in this research would likely be interested in participating in the research immediately upon learning about the project. This presumption proved to be correct. By focussing all recruiting energies on Ottawa's Lowertown and Centertown, it was possible to meet with interested participants very quickly once they had expressed an interest in the research.

Ultimately, assistance in recruiting participants was requested from six needle exchange programs. These were the Sandy Hill Community Health Centre, Centre 454, the Shepherds of Good Hope, Centre 507, Oasis, and the Ottawa Healthy Sexuality Centre, which provides both a needle exchange service on site, and a needle exchange van during the evenings. It was hoped that these centres would be willing to post advertisements on their bulletin boards seeking users of illicit, injectable drugs who are also users of needle exchange programs. It was also hoped that the support workers who provide clean needles to illicit drug users might speak to potential participants on the researcher's behalf. An introductory letter that the support worker could give to the potential participant was prepared to that effect.¹¹ Irrespective of whether potential candidates learned about this research from the posted advertisement or from a support worker,

¹¹ For the exact content of both the recruitment advertisement and the introductory letter, please refer to appendix #2 and appendix #3.

all were asked to call the researcher directly to set up an interview time and place. A follow-up sheet outlining the questions and issues that may need to be addressed following the initial contact between the researcher and potential participants was therefore prepared.¹²

All six needle exchange centres that were approached showed some willingness to assist in this research. Ultimately, however, only three centres gave written consent to the researcher to post advertisements and seek assistance from support workers. These were Centre 454, the Shepherds of Good Hope, and Centre 507. Consent was given following face-to-face interviews between the researcher and those in charge of the centres. During these interviews, questions on the nature of the research, measures taken to protect the participants, and the recruitment process were asked and answered. All three centres offered their facilities for the purpose of interviewing participants. It should be noted that Centre 507, rather than have its support workers speak to potential candidates on an individual basis, opted to make a general announcement about the research during one of the centre's weekly bingo games. Interested potential participants were invited to refer to the posted advertisement for further information. This did not affect this research's methodology in any significant way. The University's Ethics Committee was apprised of this slight change in plan and had no ethical objections.

It is likely that the other three centres would have eventually assisted in this research as well. The process was delayed in all three instances, however, for reasons that were out of the researcher's control. In two instances, the centres' directors were not readily available. In the third instance, the centre asked that an information package regarding the research be completed, which would be sent to the centre's ethics committee for further review. This package was forwarded as requested, but by the time all 14 interviews for this research had been completed, consent to recruit from that particular centre had not yet been received. This proved to be a moot

¹² For the exact content of this sheet, please refer to appendix #4.

point as this research showed that most participants regularly used more than one needle exchange centre in order to obtain their needles, including centres from which no consent to recruit was given. For the sake of protecting the anonymity of participants, the centres participants tend to use has not been divulged, as it might be possible to identify a participant from his or her patterns when selecting needle exchange sites. Answers given by participants in the research did not appear to vary on the basis of which needle exchange program was used.

Once advertisements were posted, and support workers began spreading the word about this research, participants quickly came forward and called the researcher to participate. In fact, four participants called to offer their insights the day after the first advertisements were posted. The remaining interviews were completed within the week following the first calls. For the most part, meetings with the participants were set up at one of the needle exchange sites within minutes of participants' calls to the researcher. All three centres willingly offered quiet and private interview rooms. It should be noted that the sum of \$10.00 was offered to each participant for his or her time. The idea behind compensating participants was not an attempt to encourage them to participate, but rather an attempt at making them feel comfortable and less rushed during the interview process. There was no mention of the compensation on the advertisement sheet, and support workers were asked to advise the participants of the compensation only if the participant initially showed interest in the project and later asked about compensation. This was done in the hopes that all participants, at least initially, showed an interest in the project, not just in the money being offered. It was also felt that offering \$10.00 to each participant for one to two hours of time qualified as compensation rather than payment. The University's Ethics Committee did not object to this compensation.

Before being asked formal questions, participants needed to answer a series of

standardisation questions. An information sheet was then read to participants, ensuring they understood the nature of the research and consented to participate.¹³ All but one participant agreed to be audio recorded. In the one instance where the participant opted not to be audio recorded, the participant's answers and comments to the information sheet, along with the content of the interview, were recorded by pen and paper by the researcher.

2.5 Ethical, anonymity considerations

Protecting the anonymity of the participants, and thus ensuring their safety was of principle importance in this research, given the fact that participants regularly participate in an illicit activity. In order to protect the anonymity of participants, individuals were assigned pseudonyms of their choice, to be used in the course of the interviews. Any information offered during an interview that may have identified a participant was either deleted or altered in order to protect that participant without altering the integrity of the content of the interview. This included names of places as well as persons mentioned during the interviews.

One potential ethical concern which needed to be addressed in this research came from the fact that the users of needle exchange programs may initially be approached by social workers and counsellors who are in a position of trust with their clients. It was important that participants be aware that their relationships with counsellors would not change in any way should they choose not to participate in this research. The counsellors approaching users on the researcher's behalf were therefore directed not to follow up with potential participants after they had been invited to participate in the research. The counsellors were to invite potential participants to call the researcher, and do nothing else, thus empowering users to make their own decisions without

¹³ For copies of this standardization questionnaire and information sheet, please refer to appendix #5 and appendix #6.

being pressured to act one way or another.

2.6 Analysis of interview data

In order to properly analyze the data obtained from the researcher's interviews, it was necessary to transcribe the recorded interviews to paper. This transcription took note of participants' pauses, hesitations and changes in tone. These interviews were then re-read and the audio re-listened to simultaneously. The purpose of this initial analysis was to identify the various themes and notions expressed by participants. The interviews were subsequently re-read and re-played simultaneously on multiple occasions in order to identify and analyze the participants' positions and perceptions relating to the identified themes and notions. This project's chapter entitled "analysis" is the researcher's interpretation of the gathered data.

2.7 General information about the participants

A total of 14 participants were interviewed, 10 men (code M) and four women (code F). While participants were offered interviews in French or English, all participants chose to be interviewed in English. The participants ranged in age from 26 to 49. Three of the participants were 30 years old or younger (code -30), six participants were between the ages of 31 and 40 (code -40), and five participants were between the ages of 41 and 50 (code -50). While it was not a prerequisite for this research, it is interesting to note that all participants were in what could be considered their best employable years.

The participants' levels of education varied moderately. Five of the participants had never completed high-school (code -HS), five had completed high-school or an equivalency, but never attended any post-secondary institution (code HS), and four had attended a post-secondary

institution for at least one year, though none had completed any post-secondary program (code +HS). All participants were unemployed at the time of their interview. All had been employed in the past, though always sporadically. Nearly all participants had been employed in the service industry, sales, or construction. Past employment was not coded; links between participants' former professions and their answers to various questions were not identified.

Of the 14 participants interviewed for this study, two were married or common-law (code MCL), 10 were separated or divorced (code SD), one was single (code S), and one participant was widowed (code W). Three of the participants had no children, six had one child, and five participants had two children. The ages of the participants' children ranged from infants to adults in their mid-twenties. No patterns were identified between the age or number of children the participants had and their answers to various questions. The data was, consequently, not coded.

Of the 4 participants in this research, eight had been using illicit drugs for more than 10 years, four had been using drugs for six to 10 years, one had been using drugs for two to five years, and one had been using illicit drugs for one year or less. Four of the participants had been obtaining their clean syringes from needle exchange programs for one year or less, two had been using needle exchange programs for two to five years, and eight participants had been using needle exchange programs for six to 10 years. No links between the duration of illicit drug use and the answers given by participants to various questions were identified. In addition, no links between the length of time the participants had been using needle exchange programs for and their answers to various questions were identified. Consequently, these data were not coded.

The participants could be divided between users of primarily opiates (code O) and cocaine (code CC). Nine of the participants were opiate users, while five preferred cocaine. Of note is

the fact that all opiate users had either used cocaine in the past or still used cocaine occasionally. The reverse was true for all but one of the regular users of cocaine. Morphine was the most commonly used opiate, though many also used heroin or oxycontin either regularly or on an occasional basis. Among the users of cocaine, the preference for either crack or powder cocaine was evenly divided. All participants mostly injected their drug of choice. Differentiating more thoroughly between the types of opiates and cocaine products used by the participants would have required a more in-depth analysis of the participant's habits. This would have gone far beyond the scope of this research. Finally, it should be noted that nearly all participants either used marijuana regularly or had done so in the past. Two of the participants, both opiate users had also experimented with methamphetamines in the past.

The aforementioned information relating to the participants in this research has been inserted into a table for reference purposes:

NAME	GENDER	MARITAL STATUS	RANGE OF AGE	LEVEL OF EDUCATION	DRUG USED
DAN	M	SD	-40	+HS	O
RICHARD	M	SD	-50	-HS	CC
JOLLY	M	SD	-50	+HS	O
ULRIKA	F	SD	-40	-HS	O
DEBBIE	F	SD	-50	-HS	CC
CARLI	F	SD	-40	-HS	O
JOHN	M	SD	-30	HS	O
GEORGE	M	SD	-30	-HS	O
JACK	M	W	-40	+HS	O

MARTHA	F	MCL	-30	HS	O
KELLY	M	MCL	-40	HS	O
PETER	M	SD	-50	+HS	CC
GARY	M	SD	-50	HS	CC
IKE	M	S	-40	HS	CC

Furthermore, a reminder of the codes used and their meaning follows:

Gender:

M= male.

F= female.

Marital status:

SD= separated or divorced.

MCL= married or common-law.

S= single.

Range of age:

-30= 30 years old or younger.

-40= between the ages of 31 and 40.

-50= between the ages of 41 and 50.

Level of education:

-HS= high-school not completed.

HS= high-school completed, no post-secondary institution ever attended.

+HS= post-secondary institution attended, no post secondary degree or diploma awarded.

Drug of choice:

O= opiate products favoured.

CC= cocaine products favoured.

The quality and content of the interviews varied somewhat from participant to participant. All of those interviewed, however, showed a surprising openness and willingness to share not only their opinions and experiences but also their feelings and frustrations. The information they volunteered has been used in the next chapter of this project. The codes used helped in understanding, dissecting and analyzing the information obtained from the participants. In order to protect the anonymity of the participants it should be noted that codes were only attached to the pseudonyms of the participants in this project's analysis when it was pertinent for the analysis. The analysis of the interviews follows.

CHAPTER III
DATA AND ANALYSIS

The purpose of this chapter is to present and analyze the data obtained from interviews with users of illicit, injectable drugs. This chapter will begin by outlining the answers given by participants relating to the first five questions that were asked in this research, as explained in the methodological chapter of this research. Additional perspectives and opinions identified during the dialogue that ensued between the researcher and the participant after the initial five questions were asked and answered will then be outlined. Finally, all the information will be interpreted, put into context and the coding will be discussed.

3.1 The user's perspective on government's motivations in harm reduction

The first question this research attempted to answer was whether or not users of illicit, injectable drugs who used harm reduction services perceived that government was implementing these services from a sanitary perspective. The participants in this research were therefore asked if they believed that government would continue funding the harm reduction programs they were currently privy to -in this instance, needle exchange programs- if cures for HIV/AIDS, as well as all forms of hepatitis were found.

Of the 14 participants interviewed, eight felt that government would continue financing harm reduction programs if a cure for HIV-AIDS and hepatitis were found. Of these eight participants, two distinct subgroups were identified when the participants elaborated on their rationale. The first subgroup, which included four participants (Dan, Richard, Jolly, Ulrika), identified socio-sanitary applications for needle exchange programs, and felt that government was cognizant and respectful of these applications. The participants felt needle exchange

programs were useful not only in reducing the spread of HIV/AIDS, but also helped either directly or indirectly in reducing crime rates as well as rates of addiction among illicit, injectable drug users. These four participants felt that government would consider these socio-sanitary applications for needle exchange programs and would, therefore, continue funding these initiatives even if concerns over communicable diseases among injectable drug users were eliminated.

“There’s more than that reason [reducing the spread of communicable diseases] for harm reduction...I think the government realizes that. If they don’t, they’re stupid.” (Jolly.)

Among those who felt that government would continue financing needle exchange programs if cures for HIV/AIDS and hepatitis were found was a second subgroup of four participants (Debbie, Carli, John, George). These participants felt that government was not implementing needle exchange programs from either a sanitary or a socio-sanitary perspective. In their minds, government profits, financially, from the illicit drug trade. Needle exchange programs simply serve as a façade in order to divert attention away from government’s involvement in the illicit drug market.

“The government is the mafia. It just seems to be this way. You know what I mean?...I am not stupid, I am not smart and I am not political, but if you look at it, no matter what, that’s [the illicit drug market] the biggest money making thing here for the government. The government has their money. The government is making money on the streets right now. All this dope that’s on the street right now, the government puts it there. How else do you think all this dope gets into Canada? The government lets it in. You know what I mean? You’ve got all these corrupt cops, you’ve got all these federal agents, whatever the heck they are...they are letting it [illicit drugs] all in. You got to be stupid to think all this dope can just end up here. Now, they send a couple of barrels of hashish across and they will botch stick fifty kilos of hash, but who cares about the hash? Meanwhile, you get seventy thousand kegs of crack cocaine flying across the border...it’s a multi-million dollar industry and the government gets theirs [share]. It’s amazing.” (John.)

This position was strongly held by all four participants in this subgroup. From this perspective, harm reduction initiatives such as needle exchange sites were simply implemented with no specific goal in mind other than to create the appearance that the government was addressing harm issues related to illicit injectable drug use. Carli even suggested that if a vaccine for HIV/AIDS were found, the government would likely use needle exchange sites as a means to distribute and profit from the vaccine.

The remaining six participants (Jack, Martha, Kelly, Peter, Gary, Ike) felt that needle exchange programs would likely cease to exist if cures for HIV/AIDS and hepatitis were discovered. All six clearly expressed the belief that government was implementing harm reduction programs from a sanitary perspective. Martha expressed herself as follows when asked if government would continue funding harm reduction programs following the discovery of a cure for HIV/AIDS and hepatitis:

“No, probably not. Probably not because the reason they do that [implement harm reduction programs] is to stop the spread of diseases. So if there’s a cure, there’s no need to help us get high. That’s how they would see it. That’s what I think.” (Martha.)

3.2 The user’s perspective on sanitary vs. socio-sanitary concerns in harm reduction

In this project’s second question, participants were asked whether they felt harm reduction program should focus on health issues or also help users of injectable drugs secure housing, employment, medical services and the like. The objective was to attempt to identify whether participants felt harm reduction programs should be implemented from a sanitary perspective or a socio-sanitary perspective. Of the 14 participants interviewed, 11 felt that harm reduction practices should be implemented from a socio-sanitary perspective and address social harms linked to illicit drug use along with health-related concerns. The social harms specifically

linked to illicit, injectable drug use that were most commonly identified were the inability for illicit drug users to obtain housing, the inability to obtain employment, and, on occasion, the necessity for illicit drug users to commit crimes. Participants felt that by addressing these three areas, harm reduction programs would help the illicit drug user become more independent and less marginalized and thus face fewer harms linked to their drug use. Debbie, whose principle concern was housing issues, best expressed this perspective:

“You need housing. Like, half of these people [illicit, injectable drug users] could be in housing, but because you have five, 10 year waiting lists, you sit in a shelter and you have to wait. Most people...won't rent to you. So they discriminate against us as well...you know, I love having my own place. You know, because I can go home, and I can leave all the addicts behind, people don't have to deal with my dope, you know what I mean?...There's a lot of smart people out there, but they just don't have the help that they need to get to where they want to go.”
(Debbie.)

This perspective was echoed time and again. An additional potential benefit of addressing housing issues identified by several of the 11 participants who favored a socio-sanitary approach to harm reduction was the fact that there would likely be fewer needles left in parks and fewer users loitering in the streets and alleys of the city.

Among the 11 participants who favored a socio-sanitary approach to harm reduction, two subgroups were identified. The first group, which included eight participants (Dan, Ulrika, George, Carli, Debbie, Richard, Jack, Peter), felt that a socio-sanitary approach should be favored in harm reduction, with the ultimate goal of weaning users off their drug of addiction. In other words, from the perspective of the above-mentioned eight participants, harm reduction practices should address social as well as health harms linked to illicit, injectable drug use, in an attempt to re-integrate users into society and ridding users of their drug addiction. To the above-mentioned eight participants, as a general rule, living a productive, balanced life while regularly consuming an illicit drug is impossible and will always incorporate great harms. From this

perspective, socio-sanitary harm reduction programs are tools for the illicit drug user to manage those harms in order to ultimately walk away from illicit drugs.

“I think they [illicit, injectable drug users] can’t only depend on you [harm reduction programs]. They should be on their own after a while...like with someone that’s hooked on like, morphine, you should get a doctor that could help you out, that would give you a pill a day. Just to regulate. And then that would be that. Bit by bit you’d get off it [the morphine].” (Ulrika.)

Among those who favored socio-sanitary harm reduction mechanisms, a second subgroup consisting of three participants (Kelly, Gary, Martha) was identified. These participants felt that socio-sanitary harm reduction programs could assist users of illicit, injectable drugs in reducing the harms associated with illicit drug use while illicit drug users continued consuming their drug of choice. While help should be made available to those who wished to quit using illicit drugs, this subgroup felt that users of illicit drugs could lead a healthy, productive life while consuming illicit drugs, as long as social mechanisms were in place to assist them.

“I think it’s possible for someone to have a drug habit and lead a normal life and contribute but, to some extent, that would still require a great deal of supervision and assisting. There would have to be a structured way of distributing [the drug], penalties for public intoxication and so forth.” [Gary.]

The remaining three participants (Ike, John, Jolly) believed that harm reduction mechanisms for illicit injectable drug users should focus strictly on health matters as any other applications would be ineffective. All three participants were adamant in their positions. Jolly compared socio-sanitary harm reduction practices to social welfare and expressed, to put it mildly, serious displeasure with the notion. Ike expressed himself somewhat differently:

“I think that it [harm reduction mechanisms] should be strictly on health matters because if you’re a user, you can’t hold on to a regular job or anything, you’ll try and scam that company, you’ll try to do whatever you can to make more money because your priority is to get drugs. So I think it’s pointless. Doing anything other than just health problems. There’s enough problems in that anyways.” (Ike.)

Ike, in fact was somewhat torn about the whole notion of harm reduction. While he recognized that harm reduction programs could potentially assist illicit, injectable drug users in many ways, he also felt that harm reduction programs such as needle exchange initiatives might actually encourage certain individuals to use illicit drugs. He explained his point of view as follows:

“I think, already, you’re receiving too much services. I think Canada makes it a lot too easy for a drug user to help himself. I would not even have started injecting [illicit drugs] if they didn’t give away free needles. It would have been too much of a hassle to get. All this, the availability of this [clean needles], in a way it’s good, but in a way, it’s bad. The help you’re giving. You know? Needles should be illegal...you should need a prescription [to get a clean needle].” (Ike.)

Among the 14 people interviewed, Ike was the only participant who had reservations about the notion of harm reduction, despite the fact that he uses needle exchange programs.

One final perspective that was identified while discussing the benefits and disadvantages of sanitary and socio-sanitary harm reduction mechanisms was the need to analyze the needs of illicit, injectable drug user individually. Three participants who favoured socio-sanitary harm reduction mechanisms (Peter, Kelly, Dan) were of the opinion that harm reduction practices would be more effective if they were tailor made for each illicit, injectable drug user.

“When I was a resident across the street [Shepherds of Good Hope], they did an assessment of my complete life history. I had, basically, from day one, to the best of my recollection, my life history, as pertaining to alcoholism. And I think to fully get a grasp of each person’s addiction, it has to be done for each individual. And then you can probably assess what that person’s needs are...So I think to probably help each addict, you are going to have to get in there with each addict. Like, I am not saying you should pamper to every addict’s every need, but if you want to help them, then that’s what it’s going to take. Because I mean, take a look at the person. Why are you the way you are? Not only what are you?” (Dan.)

Dan was referring to a program he underwent to treat his alcoholism, but he felt the same rules applied when dealing with drug addiction and harm reduction.

When looking at the participants’ general information as it related to their answers to this

second question, it was noted that, among all participants, the only two that were married or in a common law relationship shared the view that, with the help of certain social mechanisms, it was possible to live productive lives while regularly consuming an illicit drug. While there were not enough married or common-law participants among those interviewed to confirm that this correlation was statistically significant, the possible correlation should be noted.

Among the six participants who, in the first question, felt that government was approaching harm reduction from a sanitary perspective, all but one (Ike) were among the eleven participants who favored a socio-sanitary approach towards harm reduction. This potential conflict between their needs and government's motivation was explored further in their interviews and will be explored further into this project. In addition, among the four participants who, in the first question, identified useful socio-sanitary applications for needle exchange programs, and felt government was cognizant of these applications, all but one (Jolly) favored a socio-sanitary approach towards harm reduction. Jolly's two perspectives, in fact, appeared, at least initially, contradictory. Jolly felt that there were useful socio-sanitary applications for needle exchange programs. In addition, he felt that the government was implementing needle exchange programs, rightfully so in his mind, with these socio-sanitary benefits in mind. And yet Jolly argued that governments should focus strictly on sanitary concerns when implementing harm reduction programs. This apparent contradiction was explored later into Jolly's interview and will be explored further into this project.

3.3 The user's perspective on the usefulness of the law in protecting the public from drugs

The third question this study's participants were asked was whether or not they felt that making certain drugs illegal was useful in protecting certain people from the harms associated to

drug use. The hope was to identify where on the spectrum between prohibitionist theories and anti-prohibitionist theories the various participants situated themselves. Nine participants (Dan, Peter, Ike, Jolly, Gary, Carli, Jack, Debbie, Richard) expressed the belief that law enforcement was an effective mechanism in protecting the public from illicit drugs, and five participants (Kelly, John, Ulrika, George, Martha) suggested that laws were ineffective.

Among those participants who felt that laws were useful in protecting the public from drug use, two (Peter, Ike) were particularly adamant about their position, suggesting that sentences for drug-related offences should be far more severe.

“My opinion, with crack cocaine should be a lot harsher penalties...the dealers should be considered like, close to manslaughter...in talking the good of society, it should be like in China and Saudi Arabia where it's almost like a capital offence to deal drugs.” (Ike.)

The remaining six participants who felt laws were useful in protecting the public from certain drugs were less emphatic in their positions, identifying the law as either a regulatory or control mechanism that was more or less effective in managing drug-related harms. When asked if he thought laws were useful in protecting people from the harms associated with drugs, Jolly expressed himself as follows:

“Of course it helps. If it [certain drugs] wasn't illegal, you'd have a crazy world altogether. You have to police it. Drugs are there, every day. By keeping them illegal, we keep control of one aspect of it.” (Jolly.)

The remaining five participants believed that making certain drugs illegal was not an effective method of protecting the population from the potential harms linked to drug use. The general consensus among these participants was that those who wished to use certain drugs would do so regardless of the laws surrounding the purchase, sale and consumption of those drugs.

Furthermore, despite existing laws prohibiting the sale and use of certain drugs for recreational purposes, these drugs remained readily accessible.

“People do it [drugs] anyways [despite the fact that the drugs are illegal]. How do you think I get my drug? From other people...Nothing is going to stop anyone from doing what they want to do.” (Ulrika.)

Kelly offered an additional perspective worth noting. He suggested that in order to determine whether or not laws can help protect people from the potential harms of illicit drug use, it was necessary to determine whether people who use and become addicted to illicit drugs do so because they are genetically predisposed to addiction or, rather, that illicit drug use and addiction is the result of a certain socialization process. In Kelly’s mind, if certain people are genetically predisposed to drug use and addiction, no law will ever keep those people from consuming their drugs of choice. If, on the other hand, illicit drug use and addiction is the result of a socialization process, then making drugs illegal may prevent certain people from experimenting and ultimately becoming addicted to drugs. Ultimately, Kelly was of the opinion that laws are generally ineffective in protecting society from the harms linked to drug use.

When looking at participants’ general information as it related to their answers to the third question, it was noted that male participants and participants who used cocaine were more likely to identify laws as a useful tool in protecting certain people from the potential harms of drug use. In fact, all participants in this research who used cocaine products rather than opiates regularly fell into this category. Female participants and opiate users were evenly divided on the issue. In addition, the participants who felt that laws were not useful in protecting certain people from the potential harms of drug use were on average much younger than their counterparts, and included all three participants that were 30 years of age or younger.

3.4 The user’s perspective on the source of the harms associated with illicit drug use

The fourth question asked participants in this project whether they thought that the greatest

harms associated to illicit drugs came from the contents of the drug itself or whether the greatest harms associated with illicit drug use came from the marginalization experienced by illicit drug users as a result of the criminalization of their drug of choice. All 14 participants agreed that there were potential harms linked to both the use of the drug as well as the criminalization of recreational drug use. Eight participants (Peter, Ike, Jack, Dan, Carli, Gary, Jolly, Richard) felt the greatest harm associated with drug use came from the potential harms associated with consuming the drugs. Six participants (Kelly, Debbie, George, Martha, Ulrika, John) felt the greatest harm associated with illicit drug use came from the fact that the user had been marginalized because their habit had been criminalized.

Participants who felt the greatest harms associated with illicit drug use came from the dangers of the drug itself explained their positions in similar ways. Participants felt that consuming drugs deemed illicit was simply physically harmful to the user.

“There should be a bright sign [on illicit drugs] saying: Harm! These are very hard drugs. They’re potent, they’re raw. If you have [some], you’re screwed.” (Jolly.)

Conversely, those who felt that the greatest harm associated to illicit drug use came from the fact that the recreational use of these drugs had been made illegal emphasized the dangers of illicit drug use linked to the black market.

“Of course you’re [the law] putting us at risk [by criminalizing the drug], especially if you don’t know what you’re buying. You know what I mean? If you’re an addict, and you’re looking for morphine and stuff, if you don’t know what morphine is, and someone sells you a pill, if you’re not sure what it is, you don’t know what you’re doing....you have to be so careful. There’s a lot of people out there that want to scam you.” (Debbie.)

The participants’ positions in question number four, with the exception of Debbie, mirrored their positions in question number three. With the exception of Debbie, all those participants who identified the law as a useful tool in protecting the public felt that the greatest

harm associated with illicit drug use came from the drug itself rather than the criminalization of its use. Conversely, those who felt that the law was not useful in protecting the public from the harms associated with illicit drug use were of the opinion that the criminalization of drug use was responsible for the bulk of harms linked to illicit drug use. With the exception of Debbie, all illicit drug users who preferred cocaine products identified the drug itself as the greatest cause of harm linked to illicit drug use. Opiate users were more split on the matter. Furthermore, men were more likely to identify the drug as the greatest cause of harm linked to illicit drug use than women were. With the exception of Carli, all women identified the criminalization of drugs as the greatest harm linked to illicit drug use. Finally, those who identified the criminalization of drugs as the greatest harm linked to illicit drug use were, on average, considerably younger than their counterparts and included all three participants aged thirty years or younger.

It seemed cogent that participants who felt that laws were useful in protecting the public from the potential harms linked to illicit drug use would not identify those very laws as the greatest cause of harm linked to illicit drug use. When Debbie took this position, therefore, it was felt clarification of her position would be required. Her rationale for adhering to these two apparently contradictory positions was explored further into her interview and will be explored further into this project.

3.5 The user's perspective on legalizing the recreational use of illicit drugs

The final prepared question that was asked of participants before a real dialogue was initiated was whether or not a comparison could be drawn between prohibition and the current criminalization of recreational drug use. The participants were asked whether they felt that drugs currently deemed illicit could be legalized and regulated, just as alcohol was in the United States

in 1933. Would managing the quality, distribution and regulation of these drugs be more effective in reducing the harms linked to their consumption, just as it was with alcohol in 1933, or did the comparison not apply? The objective of this question was to determine how participants felt about anti-prohibitionist perspectives on harm reduction.

Of the 14 participants interviewed, eight participants (Jolly, George, Richard, Ike, Carli, Peter, Jack, Ulrika) felt that a comparison between alcohol and other drugs could not be effectively made. These participants felt that legalizing drugs currently deemed illicit would do far more harm than good. Most felt that legalizing drugs currently deemed illicit would make them more accessible, and that more people would experiment and ultimately become addicted. This would lead to more crime, more disease, a greater need for law enforcement and, ultimately, more drug use and death.

“I don’t know, but what came to mind is that it would be worse than it is [if we legalized the recreational use of hard drugs]. You know? Why that came to mind, I am not sure, but that is what came to mind when you asked that question...The world would get darker. That’s the picture that went through my mind when you asked that question.” (George.)

In fact, Jack suggested that legalizing and regulating hard drugs would only benefit the government:

“The only people that it [legalizing and regulating hard drugs] would help would be the government. They’d be taxing it, because, I mean, two weeks ago I got a prescription [of morphine] from someone. I got fourteen 100 mg morphine pills from a doctor in emergency. Those pills, were thirty six dollars. Well, on the street, one of those pills, it’s twenty bucks. You know, so if the government was to legalize it and to sell it, they’d be selling, you know, each pill for probably fifteen to twenty dollars. You know, but meanwhile, the manufacturing cost for that is probably, you know, thirty cents. You know, they’d be making a killing. Meanwhile too many people [who would be using the legal drugs] would start to drop dead.” (Jack.)

Six candidates (John, Gary, Dan, Kelly, Martha, Debbie) felt that legalizing drugs currently deemed illicit would be a useful endeavor. They felt that, by consuming products that were

regulated, users would be consuming a safer product and organized crime around the sale of these drugs would disappear. This transition, however, would have to occur gradually.

“If it [legalizing hard drugs] was just brought out like that, let’s just make everything legal, it would be chaotic. It would be very chaotic. You have to do things in a structured way. You know. When you give somebody certain freedoms, you also have to give them certain life lessons to be able to control that [freedom]. Or else, you just, you’d have too many problems. With people being people, you know, I think that’d be pretty dangerous. It’d be better if there was a social net set up. There has to be certain guidelines.” (Kelly.)

Interestingly, the participants did not feel that legalizing drugs currently deemed illegal would reduce crime rates among users.

“You [the user] would still have to be out robbing, stealing, cheating, selling their bodies to get the money to buy it [the drugs], whether it’s from the government or a dealer.” (Martha.)

In other words, those participants who felt that legalizing hard drugs would be beneficial did not seem to feel they would be less marginalized, only safer from bad drugs. Furthermore, participants did not feel that rates of addiction would decrease if hard drugs were legalized.

It should be noted that, among the six participants who felt that legalizing drugs currently deemed hard would be beneficial, three participants (Kelly, Martha, Debbie) drew the line at cocaine products. All three felt that legalizing opiates was a good idea, but cocaine should remain illegal.

“We have enough crackheads in this city...you’re trying to get rid of that...if you’re selling cocaine that’s legal, then that would be the worst thing in the world...I see a lot of young girls out there hooking. You know it’s scary. If you’re going to get in a car with a guy for twenty dollars, just to get a rock, I mean, what if something happens?” (Debbie.)

On the other end of the spectrum, it should be noted that all participants, without exception, felt that marijuana should be legalized, arguing that it was, in their mind, less harmful and less addictive than tobacco. Also of note is the fact that while Debbie encouraged the legalization of

opiates, she felt a doctor should control the distribution, and that a prescription should be required to obtain the drug, even when consumed for recreational purposes, similarly to existing policies in England.

It was noteworthy that both participants who were in common law relationships once again shared similar perspectives on this question. No other similarities linking participants with similar views were noted.

Of the six participants who saw value in legalizing the recreational use of hard drugs, all but one (John) favored socio-sanitary approaches towards harm reduction over sanitary approaches. John's perspective, which favored legalizing the recreational use of hard drugs even though he favored sanitary rather than socio-sanitary mechanisms in harm reduction, was explored further into his interview and will be explored further into this project. Also initially perplexing was the fact that two participants who saw value in legalizing the recreational use of certain drugs had previously identified the drug content as the greatest cause of harm linked to illicit drug use (Dan, Gary). Their rationale was explored further into their interviews and will be explored further into this project.

3.6 Additional perceptions and explanations offered by the participants

Once the initial five questions were asked and answered participants were given the opportunity to elaborate on previous questions and expand on certain ideas. A sixth question asked what services, as users of illicit drugs, they felt they were entitled to. This opened the door for an open dialogue. It should be noted that, during this segment of the interview, the subjects explored differed from one participant to another, depending on what a participant felt was important. Examined below are some of the more common themes.

3.6.1 Services users would like to access

The sixth question, which was designed to initiate a dialogue with the participants, asked what services, as users of illicit, injectable drugs, participants felt they were entitled to, and also asked participants whether they believed they were receiving these services when it came to harm reduction programs. The participants were specifically asked what services they felt they were entitled to receive, rather than asking them what services they wished to receive. The objective of the question was not to obtain an illicit drug user's wish list, but rather to further identify what harm reduction perspective the participant aligned him or herself with. With the exception of Ike, who was conflicted about the program, all participants spoke positively about needle exchange programs. All identified useful sanitary applications for the program, and several (Dan, Richard, Jolly, Ulrika) identified useful socio-sanitary applications for the programs such as reducing crime rates for users and addressing issues of addiction.

In addition to needle exchange programs, the service most frequently identified by users as one they would like to have access to was a safe injection site. Seven participants (Debbie, Kelly, Ulrika, Carli, Jack, Richard, George) suggested that the implementation of a safe injection site would go a long way to making recreational injectable drug use safer for the user and more palatable for the general public.

“I think that, especially in neighborhoods like this, that there should be a safe injection site. I believe that would keep a lot of people out of the back alleys, and keep the neighborhoods around here from freaking and I think, you know, if there was a safe injection site somewhere in the neighborhood, they would get a lot of syringes off the street, you'd get a lot of addicts that'd have the time to do their hit and not just come out into society bugging out, so to speak, or, you know, a little too high to have a chance to sit and, you know, put the drug into them and then, you know, continue their day. It would keep people off the street and using, you know, in places like parks and what not.” (Kelly.)

In addition, participants felt safe injection sites would keep parks and streets cleaner and safer for children and the general public.

“I think Ottawa needs one [a safe injection site]. There’s lots of junkies in this city, and they wonder why they have to pick up needles on the street corner or in parks because 80 per cent of these drug addicts don’t have a home so they don’t have a safe place to go and use...so I think that, at least, if there was an injection safehouse for, you know, you to use your dope, there wouldn’t always, you know, some of these families, they take their kids out at the park, they wouldn’t have to go and comb the playground before their child could go and play in it, because there’s you know, dirty needles in it.” (Jack.)

All participants who identified safe injection sites as a useful harm reduction mechanism took a socio-sanitary stance towards harm reduction in their interviews. In addition to safe injection sites, other desirable programs that were identified were counseling programs for illicit drug users (Peter, Carli, Martha), and detoxification programs (John, Jack). Only five participants (Ulrika, Debbie, Jack, Dan, John) spoke of methadone programs. All five had been on methadone in the past and, with the exception of Dan, did not speak of it favorably. Participants felt that the accessibility and rules surrounding methadone treatment were too restrictive.

Marsha suggested that a heroin prescription program, such as the one which currently exists in Switzerland, might help opiate users control their usage, enabling them to lead normal lives. In addition to this, Debbie, Dan and John felt that a system in which doctors could prescribe opiates to recreational users would be a beneficial. Only Dan explicitly identified the gradual legalization of drugs as a harm reduction program that would be worthwhile.

3.6.2 The user’s perspectives on addiction

A notion discussed at length with many of the participants was addiction. This topic was explored only with participants who voluntarily raised it as relevant to the subject of harm

reduction mechanisms. Nine participants (Jack, Kelly, Dan, George, Carli, Peter, Ulrika, John, Debbie) spoke about addiction. Of these, five (Ulrika, John, Dan, George, Kelly) suggested that the nature of addiction differed between opiate users and users of cocaine products. For these participants, addiction to opiates was physiological in nature, while addiction to cocaine products was psychological in nature. These participants felt that consumers of opiates continued consuming because their bodies had developed a physiological need for the drug in order to function, while consumers of cocaine products continued consuming because they had developed a psychological desire for the feeling the drug created. George explained the difference between the two as follows:

“For starters, crack cocaine, you do crack, you do cocaine, you run out and you might jones for a few hours. And then, you get over the jonesing, and then sleep or eat or whatever. Do something else. With the morphine, the jones is completely different. It’s like you get sick and you get sicker. You don’t come off it in a couple of hours. You need to have more. Your body is physically addicted and you must have more in order to feel normal. To feel better. Whereas with crack cocaine, you smoke a ball or whatever, and when you are done, you jones. You jones for a couple of hours. And when that time expires, you sleep, you wake up the next day, you are sober again.”

Kelly, in fact, went so far as to suggest that users of cocaine products were not real addicts because they did not have a physiological need for the drug.

The remaining four participants who spoke about addiction (Carli, Peter, Jack, Debbie) chose not to differentiate between different types of drugs. To these participants, the drug consumed was irrelevant. They felt addiction was either exclusively or nearly exclusively a psychological phenomenon. While all four conceded that the effects on the body differed between opiates and cocaine products, the nature of addiction was the same.

“It’s the behavioral compulsion that when I don’t, I don’t have narcotics, that’s everything in my mind. Everything, every action I make is to obtain narcotics. You know, that’s obsession and the compulsion...As far as the addiction goes, the high you get [depending on the drug you use] is completely different, but

addiction is addiction. It doesn't matter [what drug you use]. Addiction is obsessive compulsive thought." (Jack.)

Carli even suggested that opiate users were frequently addicted to what she termed "the syringe," meaning illicit drug users could be physiologically addicted to the act of injecting rather than the drug itself. Peter suggested that, with the right personality, a person could become addicted to anything, be it food, sex, or anything else.

It was noted that those participants who spoke of psychological addiction had all positioned themselves as supporters of socio-sanitary harm reduction mechanisms in which the ultimate goal was to abstain from using illicit drugs.¹⁴ Furthermore, it was interesting to note that the only two participants who addressed issues of addiction and were regular users of cocaine did not differentiate between drugs and felt all drug addictions were primarily psychological in nature.

3.6.3 The participant's displeasure with government

A number of participants (Debbie, Carli, John, George, Jack, Dan, Ike) spoke of government. The common thread among all seven participants was a general displeasure with bureaucracies and politics. The participants felt that politicians rarely, if ever, made decisions for the good of the public, and certainly not for the betterment of injectable drug users. As stated previously in this research, a number of participants (Debbie, Carli, John, George) believed that government implemented harm reduction policies in an attempt to divert attention away from the large sums of money government was allegedly making from illicit drugs. Others identified different interests government was trying to protect, preventing it from addressing the real needs of drug users. These varied from the need for politicians to protect their careers (Ike), to the

¹⁴ The possible explanations for this will be explored further into this project.

need to cater to U.S. demands for economic and political reasons (Dan, Jack).

“I don’t think we’re the ones making the decision here [on whether or not Canadians should legalize marijuana]. It’s mostly in the States that they make these decisions. They may decide that it’s not a good idea.” (Ike.)

While participants identified different motivations for government, the general consensus was that government would not consider the interests of injectable drug users because they were more concerned with protecting other interests, which often competed with the injectable drug users’ needs.

3.6.4 Explanations and elaborations on apparent conflicts and contradictions

The dialogue that ensued between the participants and the interviewer after the sixth question was an opportunity for participants to- elaborate on positions they held that appeared contradictory or difficult to reconcile. It was also an opportunity to ask participants about their feelings relating to conflicts between users’ priorities and governments’ priorities, as felt by the users. It should be noted, however, that the participants were not always able to fully explain apparent contradictions in their answers. Many participants expressed surprise at the types of questions being asked in this research. Several conceded never really having thought about the issues explored in this research. Consequently, participants were conflicted and frequently struggled with many of the questions put forward. Considering this reality, very few contradictions were identified.

The first issue that merited further exploration was identified in interviews with Martha, Jack, Kelly, Peter and Gary. All five participants favored a socio-sanitary approach towards harm reduction, but were of the opinion that government was implementing harm reduction programs from a sanitary perspective. In their interviews, the participants were asked how this

made them feel. While participants were grateful for the existence of needle exchange programs, they expressed frustration at the fact that little else was available. The participants contended that needle exchange programs implemented from a sanitary perspective were a good starting point, but that more was required. They hoped that, with time, the government might adopt a socio-sanitary approach, though most were not optimistic. Jack was somewhat more frustrated than the other four participants, explaining that government was lagging behind and didn't really understand illicit drug users' needs.

A second issue that merited further exploration was identified in Jolly's interview. Jolly was one of four participants who believed that government would continue funding needle exchange programs if cures for HIV-AIDS and hepatitis were found. Jolly identified socio-sanitary applications for needle exchange programs, believed government was cognizant of these applications, and thought that government would, consequently, continue funding these programs. Furthermore, Jolly felt this was a good thing. Jolly later expressed the opinion, however, that harm reduction mechanisms should focus strictly on sanitary matters. When Jolly was asked to elaborate on this apparent contradiction he explained that he believed that harm reduction mechanisms should focus strictly on health matters because government was operating with limited funds. Given these constraints, harm reduction programs should focus on health matters.

The third issue that required clarification was identified in Debbie's interview. Debbie was the only participant who had identified the law as a useful tool in protecting people from the potential harms linked to recreational, injectable, drug use. Debbie had also identified the law as the greatest cause of harm linked to recreational drug use. This apparent contradiction required clarification. Debbie explained that, in her mind, the greatest harm to the user resulted

from the fact that drugs were illegal, but that laws were useful in protecting the public, including persons who might otherwise experiment with illicit drugs from the harms linked to illicit drug use.

The final matter that required clarification was identified in interviews with Dan and Gary. Dan and Gary both thought that legalizing the recreational use of hard drugs could be beneficial, yet they had identified the drug as the greatest cause of harm linked to illicit drug use, not the law. In addition, they had identified the law as a useful tool in protecting the public from the harms attributed to injectable drug use. Dan and Gary explained their positions in relatively similar fashions. They suggested that, within the prohibitionist context that currently exists, the law serves as the main regulatory mechanism for recreational injectable drug use. The law is therefore required and serves a purpose. If, on the other hand, the recreational use of drugs became regulated, then new, perhaps more effective mechanisms could replace the law. For Dan and Gary, drugs could still remain extremely harmful.

This concludes the overview of the opinions and positions expressed by the participants in their interviews. The ensuing analysis of the data attempts to make sense and interpret this data within the context of the questions being explored in this project.

3.7 Analysis of the data obtained

The data obtained from the interviews with participants has been outlined in this chapter. An analysis of this data follows. This analysis gives us insight into the perspectives of illicit, injectable drug users in Ottawa on harm reduction.

3.7.1 Where users situated themselves on the spectrum of harm reduction theories

It was interesting to note that, despite the fact that nine participants identified the law as a useful tool in protecting certain individuals from the harms associated with injectable drug use, and despite the fact that eight participants were of the opinion that the contents of the various drugs were primarily responsible for the harms associated with its use, none of the participants, with the exception of Ike, aligned themselves with prohibitionist theories. With the exception of Ike, participants did not express the opinion that injectable drug use should be dealt with primarily via law enforcement mechanisms, and they rejected the notion that implementing harm reduction programs implied governments were somehow giving up on attempting to eliminate the cause of the harm associated to injectable drug use, which from the prohibitionist perspective is the drug itself. In addition, the prohibitionist notion that governments are somehow responsible for preserving and enforcing common moral beliefs was generally not accepted. Conversely, albeit to a lesser extent, while five participants did not feel the law was a useful tool in protecting segments of the public from injectable drug use, and while six participants identified the law as the greatest cause of harms associated to injectable drug use, most participants, with the exception of John, Gary, Dan, Kelly, Martha and Debbie did not align themselves with anti-prohibitionist theories. The participants, for the most part, rejected the idea that the use of drugs should be legalized and regulated because criminalizing the activity is what causes the greatest amount of harm to injectable drug users. Even among the few who favored the gradual legalization of injectable hard drugs, three participants (Kelly, Martha, Debbie) felt the paradigm only applied to opiates, not cocaine products, a proviso that distances them, to a great extent from anti-prohibitionist theories.

What was observed was that an overwhelming majority of the study's participants favored the implementation of harm reduction mechanisms from a socio-sanitary and occasionally

sanitary perspective, while distancing themselves from both hard prohibitionist and anti-prohibitionist arguments. All the participants acknowledged that the criminalization of injectable drug use caused certain harms, though they disagreed on the extent to which this was the case. This knowledge was tempered for many by the feeling that criminalizing injectable drug use also presented certain benefits, particularly as a deterrent for potential first time users. Consequently, most participants ultimately felt that legalizing the use of drugs was not desirable. Even those who expressed the opinion that the law was essentially ineffective in protecting people from the harms associated with injectable drug use, for the most part, rejected the idea of legalizing and regulating drugs such as cocaine. Conversely, all participants acknowledged the drug itself was responsible for many harms linked to its consumption, though they again disagreed on the extent to which this was true. Most felt, however, that mechanisms that could assist the user in managing those harms should be made available to the user while governments continued to enforce laws criminalizing their habit.

It was interesting to note that the opinions expressed by the participants in this research were not consistent with the positions expressed by users of illicit, injectable drugs who have organized themselves in order to have their voices heard. As stated in this project's literary review, the opinions and positions expressed by users of injectable drugs in publications tend to promote anti-prohibitionist theories, suggesting that the user of injectable drugs is a citizen like any other, whose habit has been arbitrarily criminalized. Participants in this research, however, favored harm reduction mechanisms while rejecting, for the most part, the idea that continuing and managing their drug use was a desirable, let alone possible, option. In attempting to explain why the positions of these two groups vary, it might be useful to identify what characteristics differentiate them. Participants in this project had, for the most part, never taken the time to

seriously think about harm reduction theories and practices prior to being interviewed for this research. Conversely, injectable drug users who have organized and spoken about harm reduction have likely had a greater opportunity to cogitate on the relevant issues and discuss matters amongst themselves and researchers. This may well explain the difference in the positions, though additional research would be required to validate this hypothesis.

The information gathered in this research suggests that people in this sample, who actually have the experience of consuming illicit, injectable drugs on a regular basis and who regularly use harm reduction programs tend to look at socio-sanitary harm reduction theories favorably. They also tend to reject positions that would see harm reduction programs disappear, irrespective of what these programs might be replaced with.

Attempting to answer why participants in this research generally rejected prohibitionist and anti-prohibitionist perspectives on harm reduction while favoring socio-sanitary mechanisms is a difficult task. It would seem that the harms the illicit drug users have experienced as a result of their regular drug use has made them weary of the harms that they perceive as intrinsic to the drug. This experience leaves them fearful of any attempts to legalize illicit drugs. This would also explain why injectable cocaine users, who generally identify greater harms linked to their drug of choice, are more supportive of prohibitive mechanisms limiting injectable drug use. Furthermore, even those participants who saw potential benefits in legalizing injectable drugs only felt it would make access to drugs safer by eliminating organized crime linked to illicit drugs. They did not believe it would help users with their addiction or needs. This may also explain why the two participants in this research who were married or in a common-law relationship were more open to the idea of legalizing hard drugs currently deemed illegal. If their relationship brings them satisfaction, then the harms associated with their drug use may

seem less overwhelming. In order to verify this hypothesis, however, a greater amount of research would be required. It is not clear why men in this research spoke more favorably of the law. Also unclear is the reason younger participants spoke less favorably of the law as a tool in protecting the public from illicit drugs. It was initially thought there might be a correlation between youth and inexperience, but the data showed that, on average, younger participants had not been consuming illicit drugs for shorter periods of time than their older counterparts, nor had they been using needle exchange services for a shorter period of time. Additional research beyond the scope of this project would have been required in order to address these issues.

3.7.2 The participant's perspective on government's motivation in harm reduction

On the whole, participants in this research did not feel that government was meeting their needs, wishes and desires when it came to harm reduction programs. 10 of the 14 participants in this research felt government was implementing harm reduction programs either from a sanitary perspective or in an attempt to divert attention away from the fact that, from the perspective of the participant, government was profiting financially from the illicit drug trade. By contrast, the majority of participants desired harm reduction mechanisms that were implemented from a socio-sanitary perspective in which users' housing needs, employment needs, and tendencies to commit illicit crimes were addressed. Furthermore, while participants were grateful for the existence of needle exchange programs, they believed they were entitled to a greater range of services such as a safe injection sites, counseling, detoxification centers and heroin prescription programs. The participants felt they did not have access to such services in the city.

What was observed was that the participants felt a general distrust or frustration towards government. While all participants acknowledged the importance of addressing sanitary issues

linked to injectable drug use, most believed that a more holistic approach towards harm reduction for injectable drug users would better address their needs. Consequently, most participants did not feel that the harm reduction mechanisms put in place for their use were implemented with users' needs in mind. This led to frustration and anger. This may explain why several participants felt that their needs were not being addressed because governments profited from the illicit drug trade. When participants spoke of governments' motivations, they expressed a feeling of helplessness. It was generally believed that the government did what was good for its elected officials and cared precious little about the plight of injectable drug users. Clearly, the participants in this interview did not feel government was meeting their harm reduction needs. Participants wished to have access to services that, for the time being, government is not prepared to implement.

3.7.3 The user's perspectives on the harm of addiction

Among the nine participants who brought up issues of addiction, all argued that addiction to cocaine products was psychological in nature. Four participants suggested the same was true with opiates. The remaining five participants argued that while addiction to cocaine was primarily a psychological phenomenon, addiction to opiates was physiological. What was particularly interesting to note was that participants did not necessarily link the addictive properties of a drug to the harms associated with its use. Among those, for example, who felt that cocaine addiction was psychological while opiate addiction was primarily a physiological phenomenon, most felt that the harms associated with cocaine use were far greater than those associated with opiates, despite the fact that opiates created a greater addiction. These participants felt that the harms associated with injectable drug use had little to do with the

dependency the drug created and far more to do with the effect the illicit drug had on the behavior of the user. To these participants, therefore, addiction was not synonymous with harm. This explains how some participants believed it was possible to lead a normal life as an opiate addict, as long as the user had easy, regular access to opiates along with the funds to purchase them. The same was not felt to be true for cocaine users, because of the perceived effects its consumption had on behavior.

It was also noted that participants were less likely to blame their addiction and negative behaviors on a physiological predisposition to addiction and generally favored psychological explanations of addiction. This may be explained by the fact that most participants in this project were still trying to take control of their addiction and behaviors. By attributing and defining addiction in psychological terms, they may have felt that they still had the ability to take ownership of their addiction, and walk away from their drug of choice, a desire that was expressed by most participants. All five participants who felt that addiction to opiates was physiological in nature were regular opiate users. From this perspective, treating their addiction problem would require outside help. In addition, if people were genetically predisposed to addiction, then addiction may be inevitable. This may help explain why Kelly, who ultimately believed certain people were genetically predisposed to addiction, was open to the idea that an opiate user could lead a normal, productive life if he or she had access to a quality, regulated product.

It was noted in this research that all participants who believed that addiction to all drugs was primarily a psychological phenomenon also favored socio-sanitary harm reduction mechanisms. This suggests that the participants felt that socio-sanitary harm reduction mechanisms were more effective at addressing psychological aspects of addiction than sanitary

harm reduction mechanisms were. The reason for this seems clear: Sanitary harm reduction mechanisms address only health concerns linked to illicit, injectable, drug use. Therefore, they need not necessarily address issues of addiction. Socio-sanitary harm reduction programs, on the other hand, take into account the needs of the user. If users wish is to rid themselves of their addiction, then mechanisms that address this need may be considered.

3.7.4 Final comments on the analysis

This concludes the analytical segment of this research. While overwhelming consensus was not reached on most issues explored with participants, certain realities were noted. Firstly, while most participants were generally displeased with government and felt that the harm reduction mechanisms that were in place were insufficient, most were grateful for the existence of needle exchange programs and most spoke favorably of harm reduction. Secondly, all participants felt that there were harms linked to drug use resulting from its criminalization as well as harms related to the drug itself. While participants disagreed on the extent to which each was true, most agreed that eliminating harm reduction programs would not be desirable, nor would legalizing and regulating hard drugs. Finally, many participants did not necessarily feel that there was a link between addiction and the harms associated with illicit drugs. The behavioral effects of the drug on the individual were frequently perceived as a great source of harm.

It was noted during the analysis of this project's data that a more thorough exploration of the participant's socio-economic status could have been useful. It would have been interesting to see, for example, if a participant's contact with police might have affected his or her perceptions on the usefulness of the law in protecting people from the harms commonly associated to illicit

drug use. In addition, determining whether participants had fixed addresses or where transient might have been useful as well, as this might have affected their perceptions on the harms associated to illicit drug use. Finally, the fact that participants who were in common-law relationships were more open to the possibility of leading a normal life while still consuming illicit drugs was also interesting. One wonders whether or not these participants may feel more positively about their drug habit because they are more satisfied with their lives, as a result of their relationships. These issues would all be worthy of additional exploration in a more extensive research project. Concluding remarks will be outlined in the final section of this project, which follows.

CONCLUSION

In the introductory part of this project, several questions linked to harm reduction were raised. The objective of this project was to identify the positions of illicit, injectable drug users in the greater Ottawa-Carleton region on the questions being raised. It seems fitting, therefore, to re-visit those initial questions and attempt to identify what the interviews in this research allows us to conclude regarding the participants' perceptions on these questions.

The first question that was raised in the introduction was as follows: How do users of illicit, injectable drugs in the greater Ottawa-Carleton area perceive the actual implementation of harm reduction policies and practices, what would they like to see implemented, and is there a gap between what the users would like to see implemented and what is being offered? The data gathered in this project would suggest that, indeed, a gap does exist between the user's desires and the harm reduction mechanisms being implemented. While users would, for the most part, like to see harm reduction mechanisms implemented from a socio-sanitary perspective, with the users' needs in mind, most participants felt that harm reduction mechanisms were being implemented from either a sanitary perspective or as a façade. The users in this project wanted help with their drug use. They not only wanted to be protected from communicable diseases, but also wished to be safe, have access to housing, employment and counseling. For the most part, participants felt those needs were not being satisfied.

The second question that was raised in the introductory segment of this project was as follows: Can we realistically expect injectable drug users to participate, fully and willingly, in harm reduction programs designed by governments that criminalize their habit? The data gathered from the participants suggests that most participants desire, and likely would use, any

harm reduction mechanisms that might be implemented, irrespective of government's motivation in implementing such programs. Furthermore, most participants believed the criminalization of hard drugs was a useful endeavor. What this research did not address, however, was whether or not illicit drug users who choose not to use harm reduction programs such as needle exchange services do so because they feel marginalized. This would have required an entirely new set of participants to interview.

The third question that was raised in this research was whether or not the fact that the use of injectable drugs has been criminalized contributed to the harm associated with the drugs. All participants in this research felt that there were certain harms associated with illicit, injectable drug use that resulted directly from the fact that the drug had been criminalized. Nevertheless, most rejected the idea of legalizing and regulating hard drugs because they also identified potential benefits to the criminalization of hard drugs. On the whole, the benefits linked to the criminalization of hard drugs outweighed the harms caused by criminalization. This perspective did not apply to marijuana, which all participants felt should be legalized.

The fourth question that was raised in this project was rather theoretical in nature. The following was asked: If we were to consider the user of injectable drugs simply as an individual with a recreational habit like many other habits, how would the relationship between the injectable drug user and the general public change? This question was, for the most part, left unanswered. The data gathered, however, would suggest that, for the most part, the user of illicit injectable drugs in this study does not perceive him or herself as an individual with a recreational habit like many other habits, but rather as an individual in need of assistance.

The fifth question that was raised in this project's introduction was as follows: If we were to change our ethical framework on injectable drug use, and if we were to incorporate this new

perspective into our public policies, what impact would this have on the level of harm associated with the use of these drugs? Data gathered in this project indicated that most participants wished to have access to socio-sanitary harm reduction mechanisms. One of the notions inherent to socio-sanitary harm reduction is taking a value-neutral approach towards illicit drug use. From a social perspective, therefore, it is reasonable to conclude that changing our ethical framework on injectable drug use and adapting our public policies accordingly might improve the relationships between users and those who deliver harm reduction services. This may in turn improve the effectiveness of harm reduction programs. Users did not appear to believe, however, that changing our ethical framework on illicit drug use should translate into laxer laws regarding illicit drug use. As mentioned previously in this project, it would be interesting to study whether or not the participant's positions on this issue may change once they have had an opportunity to think more extensively about the issues.

The final question that was asked in this project was whether or not harm reduction programs can address issues of marginalization linked to illicit drug use if they focus strictly on health matters. The data gathered from the sample in this project would indicate that, from the drug user's perspective, issues linked to marginalization can only be addressed from a socio-sanitary approach. This explains, in part, the frustration felt by users towards government. Additional research linked to the participant's socio-economic status would help clarify this point.

The participants in this research were not, for the most part, anti-prohibitionist. Furthermore, it was interesting to note that those users who organize and speak out on issues relating to illicit injectable drugs and the perceived harms linked to their usage do not in fact reflect the positions of the participants in this research. Whereas those who have organized and

spoken out generally support anti-prohibitionist theories, it would appear that the participants in this research would rather be helped, with the final objective of getting off the drug, while government continued criminalizing injectable drugs in order to protect those who can still be saved.

If we decide that drug users' positions on harm reduction have legitimacy on the basis of their experiences, we might do well to take the data gathered in this research into consideration when designing and implementing harm reduction mechanisms. Perhaps we would do better to shift away from risk management and focus on the actual needs of illicit drug users, likely from a socio-sanitary perspective. At the very least, illicit drug users may feel like citizens, whose voices can be heard, rather than feeling like marginalized individuals.

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Canadian Foundation for Drug Policy: www.cfdp.ca

City of Ottawa- Health: www.ottawa.ca

College of Physicians & Surgeons of Ontario: www.cpsso.on.ca

Law Enforcement Against Prohibition: www.leap.cc

Mothers Against Drunk Driving: www.madd.org

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Appendix 1

Interview guide:

-The purpose of this research is to try to understand how people who actually use harm reduction programs feel about these programs. I would like to start by asking you five questions, and then discuss your impressions a little more.

-If a cure or vaccine for HIV-AIDS and hepatitis were discovered tomorrow, do you think governments would continue financing the harm reduction services that you receive?

-Do you think that part of the harms associated to the use of illicit drugs which harm reduction programs should address is the fact that users of illicit drugs find it difficult to obtain employment, housing and medical services, or do you think harm reduction programs should focus strictly on health matters?

-Do you think that the fact that certain drugs are illegal is useful in protecting certain people from the harms associated to drug use?

-Do you think that the greatest harm associated to the use of illegal drugs comes from the drug itself, or rather from the fact that the use of certain drugs has been made illegal, thereby marginalizing the drug user, and forcing him or her to obtain drugs on the black market, thereby putting him or her at risk?

-From 1920 to 1933, alcohol was illegal in the United States. During that time, a lot of organized crime developed around the illegal sale of alcohol. In addition, a lot of makeshift, highly potent and dangerous beverages were made and sold on the black market. Once the sale and consumption of alcohol was legalized again, the black market and organized crime relating to alcohol essentially disappeared. Furthermore, the quality, concentration and distribution of alcoholic beverages were better regulated. Do you think the same thing would happen if we legalized drugs that are currently illegal, or do you think the comparison does not apply?

-Which kinds of services, as a user of illicit drugs, do you feel you're entitled to, and do you think you're receiving these services in harm reduction programs?

Appendix 4

Recruitment script (upon receiving a phone call from a potential participant):

- 1) Thank potential participant for his-her interest in the research project.
- 2) Ask if he-she was recruited by a counselor or if he-she saw the posted advertisement.
- 3) Ask what he-she already knows about the project (if he-she was recruited by a counselor then he-she is likely to know a great deal about the project already)
- 4) Make sure the potential candidate meets the required criteria to participate in the interview (must be at least 18 years of age, must reside in Ottawa, must use needle exchange services on a regular basis for him-herself).
- 5) Make sure the potential candidate is aware of the following facts:

-I am attempting to understand how people who actually use harm reduction programs (in this case, needle exchange programs), actually perceive these programs, and to understand what kind of services users of harm reduction programs would like to have access to.

-In order to obtain this information, I actually need to interview users of injectable drugs who use needle exchange services, because they are the only ones with “inside experience” of these programs.

-What I would like to do is meet with him-her, and ask him-her a set of five questions relating to harm reduction, and note his-her responses. Ideally, I would like to audio-record the interview, but if this makes him-her uncomfortable, I can just take notes. He-she is in no way obligated to participate, could end the interview at any time, even once the interview had begun, and would not be obligated to answer any questions which make him-her uncomfortable, though the questions are not personal in nature.

-This research is part of the requirements for my Master’s degree at the University of Ottawa. The hope is to improve our knowledge about drug user’s perceptions of harm reduction. All information gathered would be kept in a safe for a period of five years. The participant’s anonymity is ensured. The project has been approved by the university’s ethics committee.

-Ask the potential participant if he-she has any additional questions.

-Ask if he-she would like to meet for an interview. The time and place must be suitable for both the participant and myself, must be safe for both parties, and will ensure confidentiality for the participant.

Appendix 5

STANDARDISATION QUESTIONNAIRE-QUESTIONNAIRE DE STANDARDISATION:

Interview number- numéro d'entretien :

Date :

Pseudonym- pseudonyme :

Age :

Education :

Marital status- statut civil :

Number of children- nombre d'enfants :

Profession:

How long have you been using illegal drugs for- depuis quand utilisez vous des drogues illégales?

How long have you been using harm reduction programs for- depuis quand utilisez vous des programmes de reduction des méfaits?

What types of illegal drugs do you use- De quelles drogues illégales vous servez vous?

Appendix 6

INFORMATION SHEET

Did the participant agree to have the interview tape recorded? Yes__ No__

Title of the study:

HARM REDUCTION PROGRAMS FROM THE DRUG USER'S PERSPECTIVE: A STUDY.

Invitation to participate:

You are invited to participate in the abovementioned research study conducted by Marc Lishchynski.

Purpose of the study:

The purpose of the study is to understand how people who actually use harm reduction programs feel about these programs, and to understand what kind of services users of harm reduction programs would like to have access to.

Participation:

Your participation will consist essentially of answering five short questions, and then making additional comments about your answers. These comments will be recorded unless you ask that they not be recorded, in which case the researcher will note down your comments by pen and paper. You will only be asked to participate in one session, which has been scheduled at a time and place of your choosing which is also convenient to the researcher. The interview will take anywhere between one and two hours, depending on how much you wish to contribute. To thank you for your time, the sum of ten dollars is being offered to you.

Risks:

Since your participation in this study will entail that you speak about your personal experiences with harm reduction programs as well as your personal needs, it may cause you to feel somewhat uncomfortable or emotional. Be assured that every effort will be made to minimize these risks. You can ask at any time to stop the interview in order to regroup. Furthermore, you are in no way obligated to answer any questions that make you uncomfortable, and can terminate this interview at any time.

Benefits:

Your participation in this study will give you a say in what services you believe users of harm reduction programs need. This can help in the advancement of knowledge about harm reduction.

Confidentiality/anonymity:

The information you will share will remain confidential. The contents will be used strictly for the purposes of this research and your confidentiality will be protected. Your name and any other details as required will be altered in order to preserve your anonymity.

Conservation and use of data:

The data collected, both on paper and on audio tape, including the questionnaires and transcripts of the interviews will be kept in a secure safe belonging to the researcher's supervisor for a period of five years, after which all data will be destroyed. No one except for the researcher, Marc Lishchynski, and his supervisor, Line Beauchesne, will have access to this data. The information obtained from this interview may be used for publication.

Voluntary participation:

You are under no obligation to participate and if you choose to participate, you may withdraw from the study at any time. You may also refuse to answer any questions, without suffering any negative consequences. If you choose to withdraw, all data gathered until the time of withdrawal will be kept by the researcher unless you ask that all materials be destroyed, in which case, all data will be destroyed on the spot.

Do you agree to participate in the above research study conducted by Marc Lishchynski of the University of Ottawa, Faculty of Social Sciences, Department of Criminology, which research is under the supervision of Line Beauchesne? Yes__ No__

Do you understand that by accepting to participate you are in no way waiving your right to withdraw from the study? Yes__ No__

If you have any questions about the study, you may contact the researcher or his supervisor at the