A Critical Ethnography of the Ottawa Drug Treatment Court: Linking Discourses of Addiction, Addicted Subjects & Treatment Practices

by

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Abstract

This work is based on data from a 25-month critical ethnography of the Ottawa Drug Treatment Court (ODTC), interviews with former participants of the ODTC and analysis of ODTC documents. Feminist and foucauldian theoretical approaches are used to examine the discourses of addiction, constitution of subjects and treatment practices of the ODTC.

The ODTC positions addiction as a life-long, chronic disease. I explore four principal consequences of this approach: (1) the rigid requirement of abstinence; (2) the construction of certain substances as dangerous; (3) a discourse of *clean* versus *dirty*; and (4) a perpetual fear of relapse. Despite the notion that addiction is a life-long disease involving repeated relapses, the ODTC constructs a problematic contradiction in viewing participants as having a *choice* not to use drugs.

Furthermore, the discourse of addiction-as-a-disease in the ODTC requires the construction of a specific addicted subject with four key attributes: (1) universal and genderless; (2) treatable; (3) criminal; and (4) dishonest. These addicted subjects are compelled to engage in a variety of techniques of the self in order to transform into *recovering* subjects.

The ODTC's discourse of addiction-as-a-disease and its construction of the addicted subject presents serious implications: (1) the blurring of traditional boundaries of punishment and therapy; (2) the re-definition of roles of judicial and treatment providers, resulting in a widening net of criminalization; and (3) the implementation of a system whereby individuals must be criminalized to access voluntary treatment programs and housing services. Throughout, I demonstrate how some participants negotiated and contested the discourse of addiction-as-a-disease and treatment practices in the ODTC.

I argue that the ODTC's approach conceals and ignores gendered and structural factors in drug use. In response, I argue that Alexander's social dislocation theory of addiction and a feminist approach can be combined to examine structural issues such as poverty, child apprehension and marginalization which contribute to gendered dislocation. I conclude the thesis with policy considerations and recommendations based on my findings. These recommendations are broken into two sections: (1) broader drug policy and treatment reform recommendations, and (2) specific recommendations to improve drug treatment courts in Canada.

Dedication

To those who have lost their lives; to those who are or have been imprisoned; to those denied access to health care; and to those facing unnecessary obstacles and marginalization as a result of drug policies, laws and practices based on stigma, racism, and conditions of poverty.

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I am tremendously grateful to the participants in the Ottawa Drug Treatment Court who allowed me to observe their lives and share their stories and experiences. You have taught me precious lessons about the meaning of justice and you inspire me with your strength.

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Table of Contents

List of Tables

Chapter 1: Introduction

"All rise." The judge enters the courtroom and sits at the bench. "Court is now in session, please be seated." So begins one of the bi-weekly Ottawa drug treatment court sessions. The clerk calls Sophie to appear before the judge, who asks Sophie if she has used drugs over the weekend. Sophie reports having used drugs and alcohol every day since the last court appearance. As with every participant who appears before the judge, the treatment liaison provides a treatment report to the court:

> She had been very solid in program for a very long time...until recently...She's back in her old lifestyle. We've been suggesting detox over the weekend but there's no beds available.

The Crown counsel speaks next and recommends revoking Sophie's bail since there are currently no beds available at the detoxification centre. He notes, "I'm more concerned about the breaches [of her bail conditions]. Sophie has been using quite heavily." The Duty counsel contests the recommendation that Sophie should have her bail revoked because no beds are available at the detoxification centre: "I don't think that we'd be considering bail revocation if detox beds were available." The judge asks Sophie if she's been to any 12-step meetings since the last court appearance. Sophie says "No but I'm gonna go tonight." The judge makes her final comments to Sophie:

> You did well and hit a snag or something in your recovery...You've been found in the market area [an area of the city known for drug use], you were told to go to detox and didn't, you made up your own rules since Thursday and it's for that reason I'm gonna revoke your bail until Thursday.

Sophie is immediately taken into custody.

* * *

Drug treatment courts (DTCs) are specialized courts set up to address the perceived connection between drug addiction and crime by providing non-violent drug dependent individuals with intensive, supervised treatment. Drug treatment courts have become a

popular intervention around the world in countries such as Australia, Barbados, Chile, Jamaica,[1] Scotland, Ireland and the United States. The first American drug court[2] was established in Florida in 1989 and there are currently over 2100 DTCs operating in the USA (Drug Policy Alliance 2011). The first DTC in Canada was established in Toronto in 1998, and there are now six federally funded DTCs operating across the country in Toronto, Vancouver, Edmonton, Winnipeg, Ottawa and Regina. DTCs are rooted in the notion of *therapeutic jurisprudence*, where the law and its systems are conceptualized as therapeutic ways to treat drug addiction (Hora, Schma & Rosenthal 1999; Wiener et al. 2010). This thesis focuses on the Ottawa DTC. In this introduction, I present the research objectives, research questions and principle approaches of this work before reviewing the relevant bodies of literature with which I engage as well as highlighting some of this work's contributions to the field.

1.1 Research Objectives and Scope

At its core this is a study that is concerned with advancing social justice for individuals who use drugs. The intention is to propose alternatives to the current punitive, prohibitionist approach to managing drug users that are embedded within particular discourses of addiction and related treatment practices. The purpose of this research is thus to problematize status quo understandings of addiction and treatment and to suggest alternatives that are less likely to stigmatize and harm drug users and communities. This

[1] Canadian DTC team members provided training to the Jamaica DTC team (Cooper, Franklin & Mease 2010).

[2] *Drug treatment courts* is the term used for the courts in Canada. In the United States they are usually called *drug courts*.

thesis is rooted in the desire to create better conditions for drug users and to challenge contemporary Canadian drug policy.

How we look at problems determines how we decide to attempt to solve them. In other words, "social problems and their remedies are reflexively related—the 'problem' at issue delineates the remedy (or remedies) undertaken in response—and the remedy which is implemented affects the definition of the problem being addressed" (Burns 2010: 85). In addiction treatment approaches, media coverage of drug use and addiction, and in North American drug policies, the relationship between addiction (the problem) and treatment inventions (the solution) is largely overlooked. The process of defining problems and prescribing solutions is infused with power relations (Malloch 2000); defining the problem as addiction and the solution as treatment has serious and often negative impacts on certain populations of drug users, even if they are well-meaning. It is therefore important to examine *addiction* and *treatment* through their sociopolitical contexts in order to create space for change in treatment practices and policies.

Specifically, this thesis is a study of the Ottawa Drug Treatment Court (ODTC), and how its discourses of addiction and its treatment practices fit into larger contemporary sociopolitical contexts and policy. My research takes particular interest in treatment practices and their consequences, which are often positioned as value-neutral. While conducting my research, I discovered that in order to understand contemporary treatment practices and their alternatives, I first had to address how the Ottawa DTC constructed and understood addiction. In other words, contemporary treatment practices can only operate and make sense in the context of specific constructed understandings of addiction. As I demonstrate in this research, the construction of addicted subjects, and

addiction-as-disease discourses, directly influences treatment practices. In this thesis I examine how Ottawa's DTC reproduces and maintains *truths* of addiction, recovery and treatment. I argue that there are negative social consequences to how addiction is constituted in the Ottawa DTC, and in DTCs in general. I discuss some of these consequences in the upcoming chapters.

It is important to note early on how I define the term *drug user.* One way to conceive of drugs is to include all substances, and even practices, that change a person's physiology; this conception would include caffeine, tobacco, alcohol, and even social behaviour such as shopping and gambling. From this perspective, the majority of individuals are drug users (Hammersley & Reid 2002). However, reference to drug users in popular discourse is not meant to include casual drinkers or individuals who are addicted to caffeine. Therefore when defining who is a drug user, it is important to note that "the use of drugs is not the central distinguishing characteristic" (Stafford 2007: 90). The drug users in this study are generally those who are stigmatized and criminalized.[3] A number of social factors play into the construction of drug users, in particular racism and access to economic and housing resources. Furthermore, "marginalization is closely tied to the process of criminalization, affecting policing and law enforcement practices and priorities" (Malloch 2000: 47). Therefore, the objective of this work is to put forth a different lens through which to examine addiction in order to facilitate a discussion of treatment practices and policies that is not rooted in a process of criminalization. In other

[3] The terms *criminalization* and *criminalize* refer to the larger process by which individuals first come into conflict with the law as well as their experiences within the criminal justice system. For example, the term criminalization of women is new in the literature and is intended to move discussion away from women's *criminality*. Talking about the criminalization of women "provides space for analyses of state actors in the criminalization process (for example, policing practices, immigration laws), and allows for a more complex understanding of how processes of racialization, poverty, gender, nation-state governance, globalization, and violence function to shape and regulate marginality" (Pollack 2006: 247-8).

words, this project examines alternative ways of conceptualizing addiction in order to propose alternatives to prohibition and its related treatment practices.

1.2 Research Questions and Approaches

This research is driven by a number of specific but interrelated questions. First, what are the discourses of addiction in the ODTC? Two, how do the discourses of addiction in the Ottawa DTC relate to its treatment practices? Three, how are addicted subjects constituted in the Ottawa DTC? Four, how are discourses of addiction and treatment practices gendered in the ODTC? And finally, what are the implications of these conceptions of addiction, addicted subjects and corresponding treatment practices?

In order to answer these questions, I undertook a 25-month critical ethnography from December 2005 to January 2008 in the Ottawa Drug Treatment Court (ODTC). After the fieldwork was completed, I conducted interviews with eleven women and men who had participated in the ODTC. In addition, I also carried out a review of ODTC policy documents.

In this thesis, critical ethnography, discourse analysis, and feminist and foucauldian theoretical approaches are used to examine the discourses of addiction and treatment practices of the Ottawa drug treatment court. Specifically, I adopt a blend of feminist theory and governmentality approaches as points of departure for my analysis, an extensive account of which can be found in Chapter 2. As discussed in Chapter 3, critical ethnography as a research method provides me with the tools necessary to challenge dominant ways of thinking about addiction, drug users and treatment, while also allowing me to propose meaningful alternatives. While I engage with foucauldian

and feminist theoretical approaches, it is particularly important to note that my methods move beyond the strictly textual analysis that is characteristic of governmentality approaches. In other words, this thesis works towards an examination of both discourse and practice. Employing multiple methods, in particular combined with critical ethnography, also demonstrates how governmentality analyses can be enriched by the inclusion of other research methods. In this way, this thesis adds to a small body of work that argues for the importance of ethnographies in strengthening governmentality analyses (see Bourgois 2000; McKee 2009).

1.3 Location in the Literature & Contributions to the Field

While conducting this research project, I have become a respected expert on Canadian drug policy. Working on the ground in Canadian drug policy since 2006 has provided me with knowledge that is vital to this research, allowing me to forge links between drug treatment courts and contemporary Canadian drug policies. My role as a drug policy reform activist permeates the research questions I pose, my chosen research methods, and the analysis of the findings. Gerstl-Pepin argues that research should be used as a tool for activism, "a form of applied research, in which critical theories inform our research and lead to informed action" (2004: 368). Accordingly, this project is also a concrete example of how to use research as activism and of how to overcome some of the challenges of combining these two aspects.

This thesis is in dialogue with, and contributes to, a number of academic fields. Here I detail how this thesis addresses a gap in the current drug treatment court literature,

in the gender and punishment literature, in the critical sociology of addiction literature as well as in the feminist theories of addiction literature.

Drug Treatment Court Literature

The American DTC literature tends to focus on the effectiveness of the specialized courts (Gottfredson & Exum 2002; Hora 2011; Nored & Carlan 2008), in particular rates of recidivism (Wilson, Mitchell & MacKenzie 2006) and costs (Carey & Finigan 2004; National Institute of Justice June 2006). Within this literature, on the one hand, exists a body of research that is primarily supportive of DTCs and of their framework of therapeutic jurisprudence (combination of therapy and legal measures) (Hora 2008; Nored & Carlan 2008). Critics of DTCs, on the other hand, have pointed to the coercing of individuals into treatment (Seddon 2007; Tiger 2011; Whiteacre 2007) as well as their lack of effectiveness (Anderson 2001; Werb et al. 2007). Tiger's (2011) study of drug courts is unique as it is based on document analysis and interviews with proponents of drug courts. Two recent reports were published critiquing drug courts in the United States; they argue that drug courts in the US are not as cost-effective or appropriate as much of the DTC literature claims (Drug Policy Alliance 2011; Justice Policy Institute 2011).

For their part, Canadian DTCs are newer and have been examined much less. Thus far, the literature on the Canadian courts has focused on how drugs are understood in the courtroom (Moore 2004), on concerns about the courts' effectiveness and appropriateness (Chiodo 2002; Christie & Anderson 2003; Werb et al. 2007) and on descriptions and costs of the courts (Bentley 2000; Evans 2001). However, there is also a

growing body of literature that is critical of drug treatment courts in Canada (Christie & Anderson 2003; Fischer 2003; Moore 2007). For example, Moore (2007) has voiced concern over the marriage of treatment and the criminal justice system, while Christie and Anderson (2003) argue that how addiction is criminalized in the DTCs has the potential to create harms for participants. Several evaluations of the Canadian DTCs have been conducted, and I engage in a lengthy discussion of these evaluations and raise concerns with their methodological approaches in Chapter 5.

Gender issues permeate drug use and treatment. However, it has been documented that men have traditionally been the focus of research into drug use and treatment (Litzke 2004; Measham 2002; Peralta & Jauk 2011), and unfortunately, gender continues to be overlooked in much of the DTC literature. Some research on gender and DTCs does exist (e.g. Grella 2008; Moore & Lyons 2007; National Institute of Justice 2006; Turner et al. 2002); for example, Shaffer et al. (2009) conducted a study of women's rates of recidivism in a US DTC and found that women had a lower rate of recidivism than that of their control group. However, the results of this study were limited since an appropriate control group for comparison or random sampling was not used. Notably, there is much less research on the gendered impacts of treatment as required by DTCs. On this point, Shaffer et al. note a limitation of "lack of detailed treatment data" (2009: 818). Grella's (2008) research on gender and treatment in American DTCs is one important exception; she concludes that providing childcare for women can lead to improved treatment outcomes. She also outlines seven recommendations for making DTCs more gender sensitive, including referring women to treatment programs that focus on women as well as screening women for trauma and mental health issues. There remains scant research,

however, on discourses of addiction, treatment practices and gender in DTCs, and in the majority of the DTC literature. My research thus attempts to fill an important gap in the DTC literature with regards to gender and drug treatment courts.

Several ethnographies of drug courts have been conducted in the US. For example, Miethe, Lu and Reese's (2000) study included three months of fieldwork observation in the Las Vegas Drug Court. These observations significantly shaped their research conclusions and demonstrate the importance of courtroom observation. Burns and Peyrot (2003) conducted an ethnography of DTCs in California. I dialogue with their work in Chapters 7 & 8 in order to enhance and support my findings and analysis. Likewise, Mackinem and Higgins (2007) conducted a lengthy study of drug courts in the South East US, and their findings are explained in Chapter 6. Whetstone and Gowan (2011) completed an ethnography comparing a drug court in the U.S. and a treatment centre used by the drug court. Having conducted the first lengthy critical ethnography of a Canadian drug treatment court, my research adds important data and analysis to the burgeoning literature on Canadian drug treatment courts, particularly in the area of how treatment practices are deployed and engaged within a DTC program. While research that relies strictly on court observation is limited since it only examines what is presented in court, the relationships that I developed with participants during the critical ethnography allowed for a more comprehensive examination of the discourse of addiction and treatment practices of the Ottawa DTC. Thus, this work contributes to both American and Canadian research on drug treatment courts.

Gender and Punishment Literature

The literature demonstrates that punishment is gendered, racialized, and class-based (Bertrand 1999; Boyd 2006; McCorkel 2003; Sudbury 2005). Punishment is racialized in that the criminal justice system targets people of colour (Sudbury 2005). For example, women of colour, particularly lower-income Black and Hispanic women, are disproportionately criminalized for drug use while pregnant (Armstrong 2005; Boyd 2007; Flavin & Paltrow 2010). Punishment is gendered in and outside of the Ottawa DTC in that women face criminalization for lifestyles and behaviours that are not considered feminine. Women who use drugs, particularly *hard* drugs face greater social sanctioning because this behaviour is viewed as unfeminine and breaking (or transgressing) gender roles (Boyd 2004; Bush-Baskette 2004; Dell, Fillmore & Kilty 2009; Malloch 1999). For example, the stigma of injecting drugs and engaging in sex work can result in women losing their children because these behaviours are seen as *unmotherly* (Boyd 1999; 2004; Bogart et al. 2005: 78). As Litzke reminds us, "Men are never referred to as 'substance-abusing fathers'" (2004: 54). Furthermore, Pollack argues that we must consider the context in which women are criminalized, and that this context is one "of poverty, racism, addictions, lack of community supports and violence against women" (Pollack 2008: 14). For example, women living in poverty are more likely to be criminalized because they are subject to more surveillance and state interventions (e.g., child apprehensions) (Boyd 2006). McCorkel's (2003) study on drug therapy in a woman's prison found that wardens and therapists recognized differences between women and men; however, they did not consider these differences to be a result of structure and context but of women's psychology (McCorkel 2003). Thus if women's experiences are

not situated in broader contexts, the result is that women are blamed for their own criminalization.

In Canadian prisons, it is reported that women are sentenced to longer prison sentences for less severe drug offences than men and are punished and sent to solitary confinement for minor infractions more often than men (Boyd 2004; Dell, Fillmore & Kilty 2009; Martel 2000). Also, in and outside of Canada, women drug offenders are punished more harshly in prison than are nondrug users (Malloch, 2000). Women are viewed as more disruptive, anti-authoritarian and devious than their male counterparts in prison (ibid.). For example, in Malloch's study of the impact of drugs and drug policy on women in prisons in England and Scotland she concluded that "It is clear that professionals – social workers, psychiatrists, and the judiciary – define certain 'types' of women as suitable candidates for punishment" (2000: 40).

Here I would like to specify that there are multiple genders, not just two genders of *men* and *women*; however, the gender binary remains entrenched in our culture (Sudbury 2011). I have struggled in this project with naming women and men without perpetuating gender binaries. Yet it is important to be forthright about the naming because as Hunter reminds us, "All researchers should allow themselves to...acknowledge how their epistemologies, identities, ideologies, discourses and power affect the knowledge they create about the world" (2002: 135). In this thesis it is recognized that "gender identification is always formed in relation to other forms of power and thus the words we use to identify others and ourselves are culturally, generationally, and geographically situated" (Stanley 2011: 5). Thus in this project, which is about criminalized women and men, it is important to note that not all

individuals in women's prisons are women (Girshick 2011; Sudbury 2011). Likewise transgendered women are often incarcerated in men's prisons and in men's units of jails (Heidenreich 2011). Prisons thus constitute one site where the gender binaries of male/female are reproduced. As Sudbury argues, this "is achieved at the expense of transgender and gender nonconforming prisoners" (2011: 177). In this thesis, I argue that DTCs are another such site that reproduces this gender binary, and I give examples in Chapters 7 and 8 of how women negotiated and resisted prescribed gender roles.

Critical Sociology of Addiction Literature

This work is located within a particular sociology of addiction literature that takes a critical approach to theories of addiction, practices and policies that have developed to regulate drugs and drug users. Lindesmith's (1938; 1940) work is largely noted as the beginning point for thinking about drugs and addiction as not reducible to biology and physiology and for acknowledging the roles of social factors and practices. Lindesmith's approach can also be placed within what is referred to as *social constructionist contributions*, which "argue that addiction is not only influenced by social factors but is also fundamentally a culture-bound phenomenon" (Weinberg 2011: 304). For example, Severns (2004) argues that not only are the concepts of *drugs* and *addicts* socially constructed, but these concepts also function to maintain certain cultural ideals. In other words, the concept of addiction is thus used to describe behaviours that are deemed problematic and that violate certain cultural norms and ideals, such as productivity and individual responsibility. Keane argues that "Discourses of addiction appear, in part, as a response to anxieties about the regulation and containment of intimate attachments within socially acceptable boundaries" (2004: 191).

Therefore this thesis contributes to the body of literature which argues that the concepts of drugs, addiction, recovery and treatment are socially and culturally constructed and embedded within cultural and political practices and discourses (Acker 2010; Boyd & Faith 1999; Boshears, Boeri & Harbry 2011; Cohen 2000; Etter 2008; Hallam & Bewley-Taylor 2010a; Keane & Hamill 2010; Larkin & Griffiths 1998; Malloch 2000; Reinarman 2005; Room 2003; Weinberg 2000). The definitions of illicit substances and those who use them are thus rooted in complex sociopolitical contexts and processes. Meaning and experiences are shaped by various discourses and practices, and any form of knowledge is always partial and derived from specific perspectives (Campbell 2007; Larkin, Wood & Griffiths 2006). As Weinberg argues, "people do literally *use* drugs in ways that are always personally meaningful to them. And this meaningful use of drugs is always embedded in, and at least to some extent, practically responsive to, socially structured contexts of action" (2002: 16). The findings of this thesis thus also work to further illustrate the socially constituted character of illicit substances and of the definitions of addiction. The intention of this project, however, is not simply to illustrate the unstable character of concepts and discourses but to emphasize that the discourses used in the Ottawa DTC have serious implications for the women and men who participate in the program.

Feminist Theories of Addiction

Perhaps most importantly, this research opens up space for an alternative theory of addiction drawing from both Alexander's (2008) social dislocation theory of addiction and from feminist theory. There does not currently exist a comprehensive feminist approach to addiction. For example Comack's (1996) work links addiction with coping to

trauma, which is linked to gendered social relations and conditions. While some argue that patriarchy results in social conditions that contribute to addictions (Grant 2006). For example, consider the following statement by Grant, which reinforces a neoliberal conception of the subject and entirely overlooks the role played by constrained choices and structural factors in women's lives:

> This means that addicts, particularly women, need to *take responsibility* for making things happen in their lives rather than being reactive, thus helping them build more of an *internal loci* of control within recovery, along with the building of feelings of *autonomy* in their lives (emphasis added) (2006: 185).

In contrast, valentine and Fraser caution against removing agency from individuals who use drugs:

> Choice and agency are always constituted socially, and are always constrained. Socially marginalized people who use drugs in harmful ways are much more constrained than others. However, it is possible to recognise constraints on agency while also recognising people's inherent *capacity* for agency; to do otherwise is to risk further marginalising them (2008: 411).

Valentine and Fraser also argue that it is important to be cautious in our constructions of drug users as victims of trauma and as therefore "*deficient*, where problematic drug use represents proof of trauma and nothing else" (2008: 411). I would argue that this is especially important in our work with women drug users as the portrayal of victimhood is already always gendered.

Alexander outlines a definition of addiction that does not rely on medical symptoms or conditions and "is not a pathological invasion of an otherwise healthy person. Rather, it is a state of a person as a whole. Unlike a disease, there is no diagnostic rule that separates mild instances from severe ones that warrant intervention" (Alexander 2008: 36). In this sense, addiction "is overwhelming involvement with any pursuit whatsoever that is harmful to the addicted person and his or her society" (2008: 48). This

definition is based on a continuum of addiction from mild to severe and includes activities outside of the consumption of alcohol and drugs. An important aspect of this definition is the acknowledgement that most individuals who use alcohol and drugs do not become addicted to the substances. Likewise, most individuals do not become addicted to activities and habits. Alexander's central argument is that free market capitalism has produced severe social dislocation, which "is the root cause of the current proliferation of addiction across the globalising world" (Alexander 2008: 20).

Alexander's social dislocation theory of addiction meshes well with a feminist approach. He gives us a concrete theory of the social and structural conditions associated with substance misuse that is located outside of individuals and within broader social contexts. In this thesis, I thus demonstrate how Alexander's social dislocation theory of addiction and a feminist approach can be combined to examine the gendered social conditions that contribute to gendered social dislocation. This approach positions structural factors such as poverty, child apprehension and marginalization as contributing to social dislocation and argues that such factors need to be addressed in order to formulate alternatives to the current treatment models that are rooted in criminalization. This is a significant contribution to the literature, and I discuss the importance of this contribution at length in the conclusion of the thesis.

1.4 Map of Dissertation

This research examines how addiction is constituted through the discourse of the Ottawa Drug Treatment Court, illustrates how the discourse in the specialized court maintains and reproduces conceptions of addiction-as-disease, and explores the implications of this

conception of addiction. Chapter 2 introduces the theoretical framework of foucauldian and feminist theories. I introduce key concepts including power, governmentality and subjects while highlighting the importance of feminist theories to overcome some of the limitations of traditional governmentality approaches. In Chapter 3 the methodological approach and research methods of this thesis are established. Building on critical ethnography and feminist research, I engage in discussions regarding my relationships with participants, and how I juggled different identities while in the field. I then detail my methods of data collection and analysis and address ethical considerations. Chapter 4 outlines the historical context of drug policy in Canada; here I focus on key historical drug policies to situate Canada's current drug policies. In Chapter 5, I detail the emergence of drug treatment courts in Canada and the policies, features and procedures of the Ottawa DTC. Chapter 5 also summarizes the evaluations that have been conducted on Canadian DTCs to date and addresses claims that DTCs are effective and appropriate.

In Chapters 6, 7 and 8, I provide analysis and detail my major findings and arguments. Chapter 6 concentrates on discourses of addiction in the Ottawa DTC and the characteristics of the addicted subject in the court; Chapter 7 focuses on discourses of recovery and treatment in the ODTC; and Chapter 8 examines the implications of blurring therapy and punishment in the ODTC. Throughout these chapters, I provide rich ethnographic examples while highlighting the gendered practices of the ODTC, and discuss the various ways in which participants in the ODTC resisted and contested discourses of addiction and treatment practices.

In Chapter 9, I outline my findings based on the research questions posed in this work. I conclude the thesis with policy considerations and recommendations based on my

findings and based on my formulation of a feminist theory of addiction. These recommendations are broken into two sections: (1) broader drug policy and treatment reform recommendations, and (2) specific recommendations to improve drug treatment courts in Canada.

Chapter 2: Theoretical Framework: Governmentality and Feminist Lenses

2.1 Introduction

Social constructionist and poststructuralist approaches view truth and knowledge as being constituted through discourses and practices such as science (Campbell 2007; Hallam & Bewley-Taylor 2010a), and popular culture (Boyd 2008). The discourses and practices that produce truth and knowledge also act to maintain power relations, promote specific ideals, and create *Others* (Severns 2004; Weimer 2010). Within this perspective, the concepts of drugs addiction, recovery and treatment are socially and culturally constructed and embedded within cultural and political practices and discourses (Acker 2010; Boyd & Faith 1999; Boshears et al. 2011; Cohen 2000; Davies 1992; Etter 2008; Hallam & Bewley-Taylor 2010a; Keane & Hamill 2010; Larkin & Griffiths 1998; Malloch 2000; Reinarman 2005; Room 2003; Weinberg 2000). Etter sums up this position:

> Because the concept of dependence is socially constructed, its definition will inevitably be influenced by who produces it, by the current state of research, and by the status of addictive substances in a given society at a given point in time. The way dependence is defined and understood by health professionals, legislators, policy makers, law enforcement agents and by the public has immense consequences on how addicted individuals are considered, treated, and dealt with (2008: 1124).

The definition of illicit substances and those who use them are rooted in complex sociopolitical contexts and processes. Meaning and experiences are shaped by various discourses and practices, and any form of knowledge is always partial and derived from specific perspectives (Campbell 2007; Larkin, Wood & Griffiths 2006). Thus concepts such as addiction and treatment have meaning "only within a specific historical context" (Hall 1997: 46). Keane reminds us that drinking, using drugs, and behaviour now considered to be addictive—such as gambling or sex—"have different social meanings and cultural significance" in different times or places (2004: 1919). For example, the

concept of *drugs* in Canada has had different meanings depending on (1) how drugs are classified in the *Controlled Drugs and Substances Act*, (2) how such substances are used, (3) who uses them, and (4) how they are categorized within medical and policing systems. Kushner argues that "the classification of certain substances as illicit or licit tells us more about social norms and power relationships than about the psychopharmacological properties of the substances themselves" (2010: 8). Furthermore, the social construction of drugs cannot be separated from concepts such as *addiction*, *recovery*, and *treatment*, which are also historically and culturally constituted (Keane 2002; Keane & Hamill 2010) and which have different meanings in different contexts. As Hallam and Bewley-Taylor explain, "all these terms lack the innocence with which they are often clothed and are the result of complex and conflicted relations of politics, power, economics, ethnicity, culture and language" (2010a: 5-6).

To claim that addiction, recovery and addicted subjects are socially constructed does not deny the reality of these constructions, nor that their effects are felt by those defined as addicts. As Fine and Weis explain in their work on the social construction of race, "race is a social construction, indeed. But race in a racist society bears profound consequences for daily life, identity, social movements, and the ways in which most groups 'other'" (1996: 256). Like race, addiction as a social construct has embodied, tangible impacts on peoples' lives. In this thesis, I am therefore not assuming that addiction and addicted subjects are simply reducible to social constructs and discourses. Rather, the effects of these social constructs are experienced, felt, and have powerful implications. This thesis will explore some of these effects, notably incarceration and stigma.

The production of addicted subjectivities is a complex process and is one in which the Ottawa Drug Treatment Court actively participates. This work focuses on the serious social consequences that arise from the medical and legal practices deployed in the production of addicted subjectivities. Throughout this work, I employ foucauldian governmentality and feminist theoretical approaches to examine how addiction is constructed and how people who use drugs are governed through treatment practices in the Ottawa Drug Treatment Court. This chapter introduces key concepts of my approach: feminist legal theory, the law as gendered, power, biopower, government, governmentality, subjectivity and techniques of the self.

2.2 Feminist Legal Theory

Feminist scholarship, including feminist legal scholarship, fundamentally guides this research.[4] Feminist legal scholarship has challenged the discourses of blind justice, objectivity, rationality, and legal neutrality (Chunn & Lacombe 2000; Comack 1999; Naffine 1990). One of the law's central premises is its capacity to apply impartial justice. Naffine (1990) argues that this premise assumes that a universal subject can exist apart from social-cultural-historical contexts.[5] However, the law's application is deeply connected to the values, beliefs and assumptions of those who practice and apply the law (Majury 2002). Feminist research has demonstrated that gender has a significant impact on experiences within the Canadian legal system (Boyd 2004, 1989; Chunn & Lacombe 2000). For example, Boyd (2004) discusses how drug laws that ignore social contexts,

[4] Feminist legal theory is not a unified body of scholarship (cf. Chunn & Lacombe 2000; Comack 1999); however, I am following a certain feminist legal perspective inspired by Crenshaw (1991), Naffine (1997; 1990), Razack (2002; 1998) and Smart (1995).

[5] Hyphenating these terms is inspired from Foucault's concept of knowledge/power. It is intended to imply connectivity (i.e., history and culture are inseparable).

such as poverty, childcare, and pregnancy harm women. Following these authors, this work assumes that law cannot be separated from the social-cultural-historical conditions in which it is deployed, nor can it be separated from the legal actors themselves and the individuals appearing before the law. In other words, the social status of the person being judged before the law matters, as do assumptions about them.

The particular strategies embedded within the Canadian legal system directly impact the lives of individuals. For instance, feminist legal theorists challenge the individualistic and comparative approaches embedded within the legal system, which result in erasures of difference (Majury 2002; Naffine 1990). For example, Majury (2002) highlights the distinction between formal equality and substantive equality. Formal equality focuses on treating persons as equal and the same, while substantive equality acknowledges social-cultural-historical differences between peoples and suggests that equality requires differential treatment of marginalized groups. The essentialism inherent in formal equality overlooks differences among women and privileges gender as the only site of oppression. In other words, feminist legal theory draws attention to the complexities of the category *woman* and the complexities of individual women's lives, which are mostly ignored in the legal system. Feminist legal theory is useful in analyzing how discourses of addiction and treatment practices are gendered in the Ottawa DTC and how the court and its treatment program are located within law and broader social-cultural-historical contexts.

2.3 Law as Gendered

There is a debate in feminist legal theory over the conception of the law as an instrument—as a tool that is used by men to oppress women—and the law as a discourse (Chunn & Lacombe 2000; Smart 1995). Like Chunn and Lacombe, I do not locate my work firmly on one side or the other of this debate since I do not wish to engage in dichotomies that are divisive and somewhat arbitrary. I am, however, positioning this work theoretically in an approach that conceives of the law as partially comprised of discourses. I assume that there are a multitude of legal strategies (such as Charter challenges, court rulings, forced drug treatment and the removal of children from homes), which are embedded within and shape discourses inside and outside of the law. These strategies have various and contradictory effects and impacts (Chunn & Lacombe 2000; Majury 2002). What is important here is to locate the law and its strategies within broader social-cultural-historical contexts. Thus the law, as comprised of discourses and practices, does not stand alone; rather, it intersects and engages with other discourses—discourses of addiction, discourses of health, discourses of psychiatry, discourses of risk, discourses of sexuality, discourses of rationality and objectivity, discourses of the family, etc.

Thus, I adopt a theoretical perspective, following Carol Smart, of the law as gendered. This is not to say that the law is male, where the values of law are masculine and the legal actors are mostly male; nor is it to say that the law is sexist, where women are in a subordinate position before the law (i.e., they are judged differently) (Smart 1995). Smart critiques the latter two approaches for putting forth a unified conception of both the law and of women and men (Smart 1995 cf. Chapter 11). The approach of law as

gendered does not require a universal female or male subject. Instead, we can "analyse law as a process of producing fixed gender identities rather than simply as the application of law to previously gendered subjects" (Smart 1995: 191). This approach allows for an exploration of how the law constitutes gendered subject positions and of the implications of these legal positions in the deployment of drug use management strategies.

Adopting a conception of the law as gendered allows for analyses of how strategies of law and legal practices (such as sanctioning participants in drug treatment courts for not remaining abstinent from drugs and alcohol) constitute legal subjects, and more specifically gendered subjects. Such an approach is important because it allows for an exploration of how the strategies used by the law are gendered. For example, McCorkel argues that

> punishment and surveillance are gendered concepts in the sense that they are enacted differently in men's and women's institutions and that differences in penal practice are legitimated within the prison organization by conceptualizing female inmates as both 'gender deviants' and 'deviant criminals' (2003: 44).

Of course these subjects of the law are not only gendered; gender does not stand apart from other subject locations and positions such as age, able-bodiedness, race, religion, and class. Thus, the law is a gendered technology which encompasses a variety of techniques not only based on gendered assumptions, but also on assumptions of race, colonialism, class, and heterosexuality. These assumptions do not stand alone, but intersect, overlap, and engage with one another in various (perhaps unlimited) ways.

2.4 Foucauldian Approaches

Power

Foucault defines power as "an action upon an action" (Foucault 1982: 789). For Foucault, social structures, institutions and the state are not power but are the "forms power takes" (Foucault 1990: 92). To incorporate this definition of power into his work, Foucault analyzes power by asking the question *how?*, thereby placing the focus not on abstract conceptions of power, but on power relations (Foucault 1982: 785-786). Foucault views power as a technique that is not to be had or owned, but to be carried out. Power is productive and "exists only when it is put into action"; it is not an essential, reified concept based upon one's will (Foucault 1982: 788). Power is also conceptualized as ubiquitous: "Power is everywhere; not because it embraces everything, but because it comes from everywhere" (Foucault 1990: 93). There is no one source of power; it is not localized in structures or institutions, but rather "runs through ideologies, truths, discourses, institutions, practices without being equated with any one of them" (Grosz 1990: 88). Relations and exercises of power are therefore central: "what characterizes the power we are analyzing is that it brings into play relations between individuals (or between groups)" (Foucault 1982: 786). Power is not only imposed upon people, but is "a way of acting upon an acting subject or acting subjects by virtue of their acting or being capable of action" (Foucault 1982: 789).

Knowledge

The relationships between knowledge and government are central in analyses of governmentality. Practices and rationalities of government are intimately connected to

knowledge of the state, individuals, populations and society as a whole. This is one of the most important contributions of Foucault's work. It is necessary to explore the knowledges that guide particular practices of government in order to reveal that practices of government, such as legal interventions, are deeply political, not neutral or guided by some sort of natural or divine justice. Coming to understand how these knowledges impel government interventions allows the disruption of dominant discourses that continue to reinforce status quo power relations (that judges are able to deliver value-free justice, for instance), and the practices justified by these discourses. Demonstrating how knowledges are socially constituted is powerful in deconstructing *truths* (e.g. "addiction is a disease") and posited *realities* (e.g. "drug users need to be governed by the legal system"). For example, the Local Practice Memorandum between the Crown Attorney's Office and the Ottawa Drug Treatment Court states that "the foundation for the Drug Treatment Court is that the criminal act is symptomatic of the addiction" (Ontario Provincial Crown 2006: 2). This statement assumes a relationship between crime and addiction, and knowledges about this relationship are deployed in court. It is imperative to examine the knowledges upon which the Ottawa DTC is based in order to contest its underlying assumptions and resulting treatment practices.

This examination of the relationships between knowledges and practices also opens space for considerations of resistance. Underlying rationalities can be resisted and challenged using other knowledges and discourses. Sawicki argues that "the practical implication of [Foucault's] model [of power] is that resistance must be carried out in local struggles against the many forms of power exercised at the everyday level of social relations" (Sawicki 1991: 23). Defining power as operating at the level of relations, as

bottom-up, and as complex is useful for understanding how individuals are subjected and subject themselves to power. Conceptualizing power in this way allows for an examination of how disciplinary practices are deployed and of how people interpret and react to these practices. The assumptions that carry us through everyday life, such as those prompting people to be responsible for their health and happiness, can be critically examined and reinterpreted. In this view, power is understood to operate subtly and in diverse ways. Likewise, resistance is not confined to a total overthrow of the capitalist system; instead there are many different ways to engage in resistance, which can be carried out at the level of individuals and their relations.

Biopower, Bodies and Discipline

Biopower, bodies and discipline are important concepts in this project given that the Ottawa DTC explicitly targets individuals and bodies with the intention of disciplining them. The concept of biopower focuses on forms of governance that regulate populations and individual bodies simultaneously. Unlike earlier forms of governance that regulated populations through death—public executions or torture—biopower refers to regulation of populations and their individual bodies through life (such as the regulation of reproduction and sexuality) (Foucault 1990).

Foucault suggests that docility, or taking the body as something to be molded and formed, was of great interest in 18th century Europe (Foucault 1995: 136). Bodies were of interest before this time, but in the 18th century control began to be exercised not on the body as a whole, but on the body's "movements, gestures, attitudes, rapidity" (Foucault 1995: 137). This form of discipline operated on the body and its aspects thus "produc[ing] subjected and practiced bodies, 'docile' bodies" (Foucault 1995: 138).

The *natural body*, Foucault argues, became the new object of subjection, and thus of power. During this time, there occurred a shift from an understanding of the body as rational or as possessing spirits, to a conception of the body as malleable and as composed of elements to be trained (Foucault 1995: 155). The body was subjected to new techniques of power and "offered up to new forms of knowledge" (Foucault 1995: 155). In terms of practices, this shift resulted in the body and its elements becoming targets of management and discipline, which came to correspond to increasingly particularized knowledges. Knowledges were formed about the body and its processes, and these knowledges were connected to how bodies were to be disciplined. These processes continue through contemporary scientific knowledge production; for example, interrogations into drug use result in particular medical knowledges of addiction-as-disease. This knowledge is then used to enact specific disciplinary techniques, such as the requirement of abstinence.

As mentioned previously, the materiality of the body is of great significance to this work. In *Bodies that Matter* (1993), Judith Butler questions the materiality of the body, specifically how we understand the body and the subject, and avoid cultural determinism and a humanistic understanding of the body. Butler answers these questions by linking the materiality of the body to the performativity of gender. Sex functions as a norm and is part of a regulatory practice that produces the bodies it governs. Therefore, what constitutes the body is material—but materiality itself is the effect of power.

In sum, individuals and their bodies are targets of disciplinary power and techniques. Foucault describes the different ways in which bodies are managed, ranging from confinement to the ranking of individuals through diagnosis, categorization, and

distinction from established norms. Paradoxically, individuals are treated both as unique and simultaneously subjected to practices that work to homogenize populations. These processes are at work in the Ottawa DTC, regulating and disciplining bodies and subjectivities.

Government and Governmentality

Intertwined with this conception of power is the foucauldian notion of government. This conception of governing is not about control, but about governing actions and conduct with the goal of maximizing the *well-being* of a population (Coveney 1998; Greco 1993; Rose 1996). The distinction between government and domination is that the goal of government is to act on individuals' actions and behaviours, whereas the goal of domination is to remove the ability to act (Foucault 1982, Rose 1999). This is an important distinction; rather than conceiving of individuals as being governed solely through repression and violence, it allows for an exploration of how individuals participate in their own government and self-regulation.

Foucault argues that government not only governs citizens, but also the relationships between people and between people and things (Foucault 1991: 94). There are multiple forms, tools, and techniques of government, which are situated within historical, political, and social contexts. Following Foucault and Rose, government in this thesis is defined as "all endeavours to shape, guide, direct the conduct of others...And it also embraces the ways in which one might be urged and educated to bridle one's own passions, to control one's own instincts, to govern oneself" (Rose 1999: 3).

This notion of government stems from the governmentality perspective, originating in Foucault's 1991 article "Governmentality." This perspective focuses on the

"conditions of possibility and intelligibility for certain ways of seeking to act upon the conduct of others, or oneself, to achieve certain ends" (Rose 1999: 19). Specifically, governmentality is defined as

> a way or system of thinking about the nature of the practice of government (who can govern; what governing is; what or who is governed), capable of making some form of that activity thinkable and practicable both to its practitioners and to those upon whom it was practiced (Gordon 1991: 3).

A governmentality analysis can be broadly or narrowly applied; however, Foucault argued for less emphasis on the state (since the state is not a unified entity) in favour of more focus on widespread social and political practices (Gordon 1991: 4). This is an important aspect of a governmentality analysis. This shift away from institutions to practices allows for a space in which to explore intricate relations of power as well as how these relations of power are situated within broader relations and rationalities, including resistance to them. Strategies of managing individuals and populations are not isolated, occurring outside of politics, history, or power relations. Here, governmentality allows for an examination of how DTCs arose within a specific context.

Examining power through relations and practices of government moves beyond attributing a unitary oppressive force, such as patriarchy, to the state. In contrast to such an approach, a governmentality analysis can get at the intricacies of relationships between individuals, states and societies, revealing the interests that lie behind particular practices of government. How and why specific populations and individuals (such as *addicts*) are governed in particular ways (incarceration; forced treatment) can be explored in order to challenge such practices. Individual responses to practices of government—how individuals take on, engage with, and resist particular forms of government—are also open to analysis, which is something that analyses of the state as unitary overlook

entirely. Further, a governmentality analysis accounts for changes over time, therefore demonstrating how practices and rationalities of government are socially, culturally and historically situated and fluid.

Practices that target specific population, such as women and men who use drugs, are embedded within particular knowledges and power relations. I am interested in how these practices are deployed and engaged with, factors not usually addressed by governmentality analyses. There are important gaps in the literature between practices of government, how they are interpreted, and how they are acted upon by people applying them and by the population they are applied to. Thus, in this thesis I am making an important contribution to the literature by using a governmentality lense, alongside a lengthy critical ethnography (see Chapter 3), in order to examine how practices of government are deployed, as well as how they are interpreted and resisted by participants in the Ottawa DTC.

Rationalities of Government

Gordon (1991) clarifies how the terms *art of government* and *rationality of government* are used in Foucault's work. Art of government refers to the practices of government, whereas rationality of government is how such practices are understood in terms of "who can govern; what governing is; [and] what or who is governed" (Gordon 1991: 3). A rationality of government makes the art/practices of government understandable to both the governed and governing actors (Gordon 1991: 3). This approach to government is useful because it allows for a separation between art of government (such as forced drug treatment) and the rationalities underlying/embedded within practices/techniques of government (such as placing judges and parents in positions to govern treatment;

governing as forced treatment and as protection; understandings of persons under the age of 18 as governable). It also demonstrates how practices of government are complex and guided by specific principles and knowledges. In other words, practices of government are not natural or neutral, but political. Following Foucault and Lemke, in this thesis, political rationality does not signify a reality; instead it is "an element of government itself which helps to create a discursive field in which exercising power is 'rational'" (Lemke 2002: 55).

Governmentality analyses often reify neoliberal rationalities. In response, O'Malley (2001) cautions against constructing neoliberal rationalities as ideal types.[6] He states that "the deployment of either 'advanced liberalism' or 'neoliberalism' readily slips into the mode of treating these second order constructs as real rationalities that are, in a sense, immanent in the present, either already established or—perhaps more frequently—unfolding" (O'Malley 2001: 17). In other words, it is problematic when political rationalities are constituted as ideal types, not as constructs, because inconsistencies, dissentions, and other rationalities can be overlooked.

Another way to avoid focusing on political rationalities as ideal types is to incorporate other research methods beyond discourse and textual analysis. I have incorporated a critical ethnography approach combined with interviews and discourse analysis of policy documents into my research, allowing for a rich analysis of the complexities in the Ottawa DTC. I was thus able to observe both the art and rationality of government through how they played out inside and outside of the courtroom. If I had

[6] Neoliberalism is a broad term with varying definitions. Some define neoliberalism as an economic philosophy (Navarro 2002), whereas others define it as a political, social and economic philosophy that arose as a response to challenges posed to the welfare state (MacGregor 1999). Although governmentality approaches incorporate economic, political, and social contexts in the definitions, the focus is not on neoliberalism as a political or economic philosophy, but as *rationality of rule* (Rose 1993).

limited the research method to a text-based discourse analysis, which is common in governmentality analyses, incorporating gender analysis would have been far more difficult, since gender was absent from the policy documents.

Critiques of Governmentality

A governmentality approach is useful in attempting to understand what knowledges and rationalities underlie specific technologies of government. Once the underlying assumptions and rationalities are understood, these can be challenged and become sites of resistance. A governmentality perspective is also important in challenging the assumption that practices of government are neutral. Therefore, a governmentality approach is useful in understanding the discourses of addiction and the subsequent treatment practices that are deployed in the Ottawa DTC because it allows for an examination of multiple forms and understandings of government, including the government of oneself.

However, governmentality approaches face criticism for principally analyzing ideologies, and for relying heavily on texts, manuals, and policy documents that proscribe conduct (Dupont & Pearce 2001; Garland 1997). Analysis of these texts uncovers that which is deemed problematic and therefore requiring regulation, thereby assembling a view of the social field, who and what is to be governed and how. How these practices are deployed and engaged with is an important matter; however, this is not often addressed in governmentality analyses since texts alone cannot provide such insights. Therefore, ethnographic projects such as this work are "well suited to the challenge of politically engaging Foucault's critical insights and rendering them concretely relevant" (Bourgois 2000: 188).

Feminist scholars have also criticized governmentality for overlooking the questions of *Why?* and *What can be done?* and therefore removing political action from analysis (Deveaux 1994; Hartsock 1990). This work responds to this critique by combining textual and discourse analysis with 25 months of field research in the Ottawa DTC, where I was able to observe how power/knowledge functioned, as well as compare discourse analysis to empirical observations. This approach takes seriously McKee's suggestion that combining governmentality theory with discourse analysis and ethnography is important "to render visible the concrete activity of governing, and unravel the messiness, complexity and unintended consequences involved in the struggles around subjectivity" (2009: 465). I made the theoretical and methodological decision to focus on practices as well as discourses because I believe that it is important to understand lived realities in order to work towards viable, meaningful social change for people who use drugs.

Feminist Foucauldian Approaches

Some feminist scholars are critical of foucauldian approaches. For instance, Hartsock (1990) provides a strong critique of Foucault's theory of power, arguing that it does not advance social justice. According to her, this conception of power is not tangible and cannot be resisted with tangible effects because, for Foucault, "power is everywhere, and so ultimately nowhere". Similarly, Deveaux is critical of using Foucault's work for feminist projects because of "the tendency of a Foucauldian conceptualization of the subject to erase women's specific experiences with power" (1994: 224). She argues, for instance, that the concept of biopower understates how women engage in resistance. Thus

Deveaux (1994) argues that Foucault's concept of power does not allow for feminist considerations of women's empowerment and resistance.

In contrast, Naffine critiques standpoint theories by contrasting them to a foucauldian approach where "neither 'the powerful' nor 'the powerless' are free from the constituting effects of knowledge" (Naffine 1996: 69). For Naffine, power and knowledge cannot be separated, and it is necessary to follow a foucauldian conception of power as dynamic rather than rigid. She argues that individuals are unable to produce an "unvarnished truth of crime" because an individual's understanding of the world and understanding of herself have "already been constituted for her by the world she then apprehends" (ibid: 72).

Likewise, Hannah-Moffat argues that feminists can benefit from Foucault's work "because it allows for a more complex and detailed understanding of the gendered nature of knowledge and of the disciplining of female bodies" (2001: 5). She suggests that Foucault's concept of power and his understanding of the state as a consequence of the broader relations in which it is embedded is also useful for feminist work. Hannah-Moffat uses the concepts of pastoral power, disciplinary power and governmentality to understand the techniques used to discipline women prisoners. Foucault's concept of power-knowledge is also used in her study to demonstrate the impacts of expert knowledges on how women prisoners come to be understood.

Sawicki (1991) places herself between these two factions, underscoring many of the theoretical contributions Foucault has made, but also recognizing some of the limits of his theories. She outlines the compatibility of Foucault for feminist work, specifically his conception of power and critique of humanism. However, she argues that there are

limits to foucauldian theories for feminism stemming from the boundaries of his project, his levels of analysis, and his androcentrism. Because she regards some of Foucault's work as dangerous, she urges feminist scholars to critically engage with it: "as Foucault himself urged, one must look for the effects of power produced by all discursive practices, including his own" (Sawicki 1991: 98). She also states: "Feminist practice must inevitably be negative and, I believe, skeptical" (Sawicki 1991: 102). Feminists thus endeavour to challenge dominant theories, including foucauldian and feminist theories, and their attendant practices: "It is just as important to use Foucault against himself, and against the use of his work to undermine the very struggles he claimed to support, as it is to criticize dangerous tendencies within feminism" (Sawicki 1991: 108). I position my theoretical approach within Sawicki's, understanding the importance and utility of Foucault's theories but while being cautious in their application.

2.5 Subjectivity & Subjects

The contemporary Western legal system is based on a conception of woman as a universal subject with no cultural or historical context (Laster & Raman 1997; Naffine 1990). In contrast to this universal conception, subjects in this thesis are understood to be products of history and culture. Feminist theory has given great consideration to the dilemma of essentialist categories. Poststructuralist feminist theories emphasize that the feminine subject is not biologically, naturally pre-determined, but is constituted through contextual factors (Ettore 2004; Grosz 1990).

In her influential and challenging work, Judith Butler argues that the feminine subject is conceived of as fixed and unchanging, which she views as problematic both

theoretically and politically. Therefore, she attempts to move beyond this conception of a fixed subject to a notion of the subject as comprised of a bundle of practices (Butler 1993). For example, gender is not constituted in a vacuum; it is constituted via historical, political and cultural contexts, techniques, technologies and practices. Butler argues that we need to question how subjects are constituted, not simply how they are represented.

Butler challenges the stability of identity categories by arguing that these categories are constituted by repeated performances and by the exclusion of other identity categories. Therefore, selves originate from the process of performance, and the repetition of performances both produce and challenge identity itself (Butler 2001). For example, there are many different ways to perform lesbianism (butch, femme), and if we regard certain performances as lesbianism and others as not, those others will be excluded from lesbian identity. Furthermore, Butler (1993) argues that it is not only that there are constraints to performativity, but that the rethinking of these constraints is the very condition of performativity. Constraint is what impels and sustains performativity. Hence, Butler gives discourse a powerful role in the construction of subjects.

In this thesis, I combine this conception of the subject as performative with work on subjectivity from Foucault and Rose. Rose argues that new forms of governance and subjectivity have emerged and emphasizes how "regimes of truth" (1990: 4) and technologies of government contribute to the construction of selves. There are two aspects to Rose's argument. First, *psy* technologies and sciences are pivotal in the formation of modern subjectivities, and they are necessary for the governance of individuals. The roles of expert knowledges, especially the *psy* knowledges and sciences, have central roles in this new form of governance that requires individual self-regulation.

Second, the "expertise of subjectivity has become fundamental to our contemporary ways of being governed and of governing ourselves" (Rose 1990: 10). I will speak further to the idea of governing oneself below, when I introduce techniques of the self.

The conception of subjectivity mobilized in this project asks how an individual comes to think, understand, and learn about oneself (Rose 1996). Central to the answer is Foucault's definition of the subject as "subject to someone else by control and dependence, and tied to his [*sic*] own identity by a conscience or self-knowledge" (Foucault 1982: 718). This definition has two components: not only are people subject to external power relations, but they also are subject *to themselves* through various techniques. In other words, individuals participate in the formation of their own subjectivity.

Before an individual can be produced as a subject, she/he must be produced as an object (a process called objectification). Foucault (1982) identifies three modes of objectification of the subject. The first mode is objectification through the sciences. Scientific disciplines have different conceptions of the subject. For example, psychology conceptualizes subjects as having a psyche, and this conception affects both how people are governed (for instance, being prescribed psycho-pharmaceutical medications) and how they govern themselves (for instance, undertaking self-help projects). The second mode of objectification is division, where "the subject is either divided inside himself [*sic*] or divided from others" (Foucault 1982: 777-8). For example, people are divided into categories—homosexual versus heterosexual, addict versus non-addict—all of which have normalizing effects. As May states, "aberrant groups remained a vital component of inter-war thinking about addiction. They—often foreign and often black—offered the

possibility of 'infecting' the 'normal' (white) population and of actualizing risks to the vulnerable (especially the young)" (2001: 390). The third mode of objectification is the transformation of the self into a subject as something to be known and mastered. This mode encompasses practices that individuals perform on themselves, called techniques of the self.

From this perspective, I understand discourse to have a central role in the constitution of the subject. Subjects engage with—constructing, reinforcing, resisting, challenging—a variety of ever-changing discourses. However, some feminist scholars have highlighted concerns over the potential erasure of the subject stemming from a focus on discourse. For example, Sawicki is wary of Foucault's calls for "self-erasure and self-refusal" (1991: 104). Foucault's erasure of the subject is also indicative of the very specific, androcentric origins of poststructuralism: "poststructuralist literary theory, for all of its potential, is an invention of disenchanted white males. It is not surprising that it should become more important than the subjugated discourses of the 'other' about which it speaks" (Sawicki 1991: 105-6). Self-refusal is anathema to feminist projects, putting up obstacles to the building of bridges between women and feminists in order to mobilize politically (Sawicki 1991: 106).

However, it remains essential to engage with how our identities are constructed, and question why certain identities are privileged as well as who determines this privilege. For instance, Butler (1993) argues that to call the category of woman into question is not to do away with it, but to understand what political interests are secured by it. Thus the tension and lack of comfort Foucault speaks of may be permanent because "identity formation is both strategically necessary and dangerous. And, as feminists we

must live within the tension and uncertainty produced by our oppressive situations" (Sawicki 1991: 108). I will further discuss subjects and subjectivity, and give examples of how participants in the Ottawa DTC engaged and resisted the imposition of *addicted* and *recovery* subjectivities at length in Chapter 7.

2.6 Techniques of the Self

Central to the concept of subjectivity in this work is Foucault's theory of techniques of the self, which is the basis of the analysis in Chapters 7 and 8. A *technique* of the self is made up of techniques or practices through which individuals seek to achieve desired goals, whereas a *technology* of the self is a broader system that encompasses various, diverse techniques of the self. Foucault defines technologies of the self as those

> which permit individuals to effect by their own means or with the help of others a certain number of operations on their own bodies and souls, thoughts, conduct, and way of being, so as to transform themselves in order to attain a certain state of happiness, purity, wisdom, perfection, or immortality (Foucault 1988: 18).

These technologies and techniques of government do "not seek to *crush* subjectivity but to produce individuals who attributed a certain kind of moral subjectivity to themselves and who evaluated and reformed themselves according to its norms" (Rose 1996: 78).

Under this mode of governing, individuals become responsible for their happiness and it becomes an individual's obligation to work towards personal, emotional well-being. In other words, the relationship to oneself becomes subject to practices of government (Cruikshank 1993; Foucault 1988). Cruikshank (1993: 331) argues that this means of linking personal and political goals in the name of the *social good* traverses "the line between subjectivity and subjection." We see this reflected in the ODTC where participants are required to engage in self-governance in the form of self-improvement

and working to enhance their well-being (as defined by the court). However, participants remain under intense surveillance by their counsellors, the ODTC team and the judges, with severe therapeutic and legal sanctions imposed in cases where they do not engage in the specified techniques of the self.

Health and well-being have become individualized and moralized. Those who do not engage in socially prescribed techniques of the self are seen as immoral and, in some cases, in need of intervention. Certain individuals, like the participants in the ODTC, are intervened upon when they are seen as not caring for themselves or as not acting in their own best interests. Our health, bodies and souls are thus politicized and normalized. In other words, our relations with ourselves have become tied to political goals and subject to practices of government.

Individuals are "governed not *against* but *through* their freedom" (Reith 2004: 294). Hence the contemporary subject's objectives are to be autonomous, to manage risks and to achieve fulfillment in the areas of health, success and happiness, as well as to be individually responsible for this fulfillment by making appropriate choices (Robertson 2001; Rose 1996). Thus individuals who strive towards established definitions of *good health* are demonstrating and fulfilling the norm of "taking responsibility for determining one's future" (Crawford 1994: 1352). Pursuing one's health is a rational goal in neoliberal cultures, and it is the individual who is personally responsible for this pursuit. Those who do not engage in taking responsibility for their health are deemed irresponsible and dangerous. Crawford (1994) argues that the notion of the *unhealthy other* is placed in opposition to the *healthy self.* The *unhealthy other* lacks self-control, is dangerous to the healthy self and is responsible for his or her own disease. This is

precisely the process through which *addicts* and *recovering addicts* in the Ottawa Drug Treatment Court are produced. Participants are required to replace one identity (addict) with another (recovering addict). The two identities are opposed to one another and the identity of recovering addict is valued over that of the addict. In the drug treatment court's perspective, one cannot have both identities at the same time, but it is possible to move between the categories. The move from addict to recovering addict is the goal of the DTC program (though most participants do not achieve this goal) while the reverse transition—from recovering addict to addict—is punished through criminal and therapeutic sanctions and eventual removal from the Ottawa DTC program. I discuss this process at length in Chapter 8.

2.7 Conclusion

A governmentality perspective is useful in understanding the construction of knowledges of drugs, addiction, addicted subjects, recovery and treatment in the Ottawa DTC. It allows for an examination of multiple forms and understandings of government, including the government of oneself. This thesis is based on the assumption that different knowledges and truths about drugs, addiction, recovery and treatment are produced through continuous processes involving discourses, social institutions, beliefs, behaviours and power relations within social, economic and historical situations. *How?* is the central question to ask in a governmentality analysis. In this work, I am thus asking: (1) how are discourses of addiction and treatment practices gendered in the ODTC? (2) how are addicted subjects constituted in the Ottawa DTC? and (3) how do the discourses of addiction in the Ottawa DTC relate to its treatment practices? Asking *how* allows me to

situate the Ottawa DTC in a historical-political-cultural context, which emphasizes the constructed nature of the methods used to govern.

Using feminist theories and critical ethnography, which I discuss in the next chapter, enriches the governmentality approach and allows for an examination of treatment practices alongside discourses and texts. This combined method enables an analysis of addiction, recovery and treatment practices in the Ottawa DTC that also takes into account how these discourses are gendered and how the specialized court is located within current Canadian drug policies as well as within current political responses to drugs and drug users. Now I move onto a description of my methodology, research and data collection methods. I also discuss how I juggled identities in the field and give consideration to institutional ethics and ethics in practice.

Chapter 3: Methodology: An Accidental Ethnography

3.1 Introduction

As the title of this chapter suggests, I did not initially set out to conduct an ethnography of the Ottawa DTC for this thesis. I also began my fieldwork before writing my thesis proposal; in fact, my fieldwork was complete by the time that I defended my proposal. Thus instead of the traditional research route of choosing and planning a method and then carrying out data collection, this project is best described as somewhat of an ethnographic journey. Although this may seem like a counterintuitive approach to research, this approach allowed me to engage in a research project from the ground up without any pre-conceptions as to the kind of data and results that I would discover. As a result, this project is rich and unique, as I will illustrate in this chapter.

This chapter contains five sections. First, I outline my research method and methodology. Here I discuss how critical ethnography and feminist methodology provided me with the tools necessary to challenge dominant ways of thinking about addiction, drug users and treatment. Second, I provide details of my fieldwork including entry into the field and negotiation of research identities and relationships as well as an illustrative example of the complex character of my ethnography. Third, I outline my four methods of data collection and discuss how these multiple methods made for a richer, more contextualized approach to the research. Fourth, I detail my method of data analysis and address the question of omitted data, and how I went about ensuring the validity and reliability of my analysis. Finally, in the concluding section of this chapter, I review the ethical considerations of this thesis and the question of emotional involvement in one's research. However, by way of completing this introduction, I now move on to provide a

brief sketch of who I am as a researcher and activist as well as introduce some key information about the participants of this research.

My Work as an Activist

I came into graduate school determined not to lose my activism or feminism. For this reason, I spent much time and energy engaging with feminist and activist communities outside the walls of the university. By the time I entered the field, I was working with three organizations. First, Books to Prisoners Ottawa, a prison abolitionist organization that supplies books to the Ottawa Jail, several federal prisons, as well as prisoners in Canada and in the US. Books to Prisoners also hosts public education events and supports various legal and political campaigns that aim to undo or disband elements of the prison industrial complex. Second, the Ticket Defence Program, an organization that provides representation to people who have received tickets under the Safe Streets Act and bylaws that target homeless people and panhandling. Third, the Justice for Mohammed Harkat Committee, an organization that fights to abolish Security Certificates. During my time in the field, I was also a founding member of a graduate feminist reading group and served on the board of the Amethyst Women's Addiction Centre.

A year into my fieldwork, I co-founded a national youth and student drug policy reform organization called Canadian Students for Sensible Drug Policy (CSSDP). I acted as Chair of the Board of Directors and then as Executive Director, a position I held until November 2010. During this time I became active in the drug policy movement internationally and in Canada, working against the criminalization of drugs and drug users. This hands-on experience with drug policy at the local, provincial, federal and international levels significantly informs the discussions of drug policy in Chapters 4 and

8. In both my activist and academic work, I challenge punitive drug laws and approaches because I see the impacts of harmful drug policies on both drug users, people who do not use drugs, and on our local and international communities.

Participants in my Research

The individuals who participated in this project were clients in the Ottawa DTC from February 2006 to January 2008. In the first year, the majority (80%) of the 43 total participants in the Ottawa DTC were men (Dowden 2007).[7] At entry during the first year, 72% did not have housing and for 61% some high school was the highest education attained (Department of Justice 2009). Only 13% of participants came into the ODTC with drug-related charges; the largest number (41%) were charged with administration of justice (i.e., breach of probation) and property offences (29%) (ibid.). The drugs of choice of participants entering the ODTC during the first year as outlined in the Department of Justice summative evaluation are (2009: 28):

82% Crack Cocaine
66% Marijuana
27% Cocaine (powder)
20% IV Opiates
13% Oral Opiates
10% IV Cocaine

The program evaluations described the participants based on these statistics; however, what drugs participants preferred to use, whether they completed high school, and what crimes they committed tell us little. When I think about the Ottawa DTC participants who I had the opportunity to meet and interact with, I think less in terms of numbers and more in terms of their lived experiences, and how they moved through the

[7] This data comes from the first year evaluation of the ODTC; gender is never mentioned in the 2009 outcome evaluation.

drug treatment court. I easily forgot what crimes people were charged with, and usually did not write their charges down in my field notes, since I did not want to reduce them to their criminal charges.

3.2 Research Method and Methodology

Ontological and Epistemological Approach

Ontology is the theory of reality (Stanley & Wise 1993); epistemology is a "theory of knowledge" (Harding 1987: 3). Central to epistemology are questions of what is assumed to be true, what can be known, how we know what we know, and who can be a knower (Doucet & Mauthner 2008; Hesse-Biber & Levy 2006; Maynard 1994; Stanley & Wise 1993). Further, epistemology asks "how does the knower come to understand and interpret the nature of reality?" (Fonow & Cook 2005: 2212).

Within the epistemological and ontological approach I am working with there is no absolute verifiable truth about the world, humans, subjects or the law to be discovered. This is in contrast to a positivist approach that assumes that knowledges can be objective and neutral, that there is a verifiable reality to discover, and that there is a "homogeneous 'human nature'" (Code 1995: 16). In other words, as Law states, "there is no universal reality. Realities are not secure but instead they have to be practiced. And the world is not passive, waiting to be seen by people" (2004: 15). Rather social meanings are created, reinforced and constructed through various interactions (Hesse-Biber & Leavy 2006). This is not to assume that something or someone is blinding us from objective reality. On the contrary, it is to assume that knowledges and truths are constituted through discourses

and practices and that everyone participates, in differing and unequal ways, in the production of knowledges.

Different knowledges and truths are produced through the continuous construction of discourses, social institutions, beliefs, behaviours and power relations within social-cultural-historical contexts. Where knowledges and truths are situated has meaning. As Maidment states,

> It is important to recognize that knowledge in the everyday world is socially constructed and that the political, economic, social, and cultural contexts of knowledge generation, acquisition, and transmission have to be taken into account. Whose knowledge comes to be accepted as the "truth," who has a voice in the creation of knowledge, and what the intervening factors are that play into the legitimation process of knowledge are important tenets of feminist methodology (2008: 51).

Accordingly, instead of a perspective that sees knowledges and truths as givens that exist independently of individuals, I emphasize the historical specificity and social construction of knowledges.

It is important to note that as a researcher, I am not outside of social-cultural-historical contexts. Epistemology includes questions of research methods and methodologies (Code 1995). For instance, what are the consequences of my chosen research methods? What are the consequences of the knowledge I will produce? Will these knowledges further marginalize individuals who use drugs? Or will they challenge dominant stereotypes of people who use drugs and dominant practices of drug treatment? Are my research methods in line with my political activism and feminist orientation? Because I finished my ethnography before writing the research proposal for this thesis, I did not explicitly consider these questions before entering the field. However, I have given extensive consideration to the implications of my data collection, to the choices I

made while in the field and to what data I excluded. These questions inform my analysis, which I discuss later in this chapter.

Feminist epistemologists question how gender impacts knowledge and knowing (Code 1981; Doucet & Mauthner 2006; Grasswick & Webb 2002). Consequently, it is not my intention to put forth a truth about women, men, or women's experiences in the Ottawa DTC. Rather, I hope to add my thoughts to a discussion that is only just beginning. Throughout this research, analysis, writing and dissemination, I see myself as engaging with, contesting and producing knowledges about addiction, treatment, recovery, gender, DTCs, the Ottawa DTC, and the actors and their relationships within the ODTC. My history and current social-cultural-historical locations impact my choice of topic, what I find interesting, as well as my analysis and conclusions. My subjectivity is also being impacted throughout these processes. I am within this process, and my experiences shape what I conceive of as knowable.

Critical Ethnography as Research Method

Ethnographies study people in their natural environments, meaning that ethnographers do not create the settings for their research (LeCompte & Schensul 1999). Ethnography gathers data based on observation and interaction with people in their daily lives (Albertín & Iñiguez 2008; Jordan & Yeomans 1995). LeCompte and Schensul argue that ethnography is "writing about the culture of groups of people" (1999: 21). A traditional ethnographic approach often assumes a detached, objective posture; critical ethnography, on the other hand, demands that the ethnographer be engaged and subjective (Bhattacharya 2008). Traditional ethnography has been criticized as a research method for being embedded within positivist methods, overlooking factors of capitalism (Jordan

& Yeomans 1995), and engaging in othering (Baumbusch 2011: 185) and other colonial practices (Hörschelman & Stenning 2008; Jordan & Yeomans 1995).

Jordan and Yeomans argue that "the connections between contemporary ethnography and its antecedents, anthropology and sociology, are enmeshed within the historical development of state forms of power, control and regulation of collective (class, gender, race) and individual identities" (1995: 393). Gerstl-Pepin argues against a traditional ethnographic approach because its "objectification of research subjects creates not merely potential exploitation, but also cultivates a sense of detachment from the issue at hand, draining from the research the passion necessary to motivate researchers to seek change" (2004: 387). Furthermore, traditional, positivist ethnography tends to reproduce assumptions about the subjects under study. As Agar argues, ethnographic research on drugs in the 1960s and 1970s relied on positivist models and thus "it is no surprise that research assumptions in the mainstream literature matched assumptions of drug policy" (2002: 251). Critical ethnography has been proposed as a way to address some of these critiques of conventional ethnography (Jordan & Yeomans 1995).

Critical, or applied, ethnography (LeCompte & Schensul 1999) is different from conventional ethnography as it "seeks to do more than just describe and interpret culture and cultural phenomenon. Critical ethnography seeks to change it" (Bransford 2006: 177). As such, critical ethnography is political research, and one of its central facets is for research to make positive social change (Anderson 1989; Gerstl-Pepin 2004; Quantz 1992; Thomas 1993). Feminist ethnographers were instrumental in the development of critical ethnography as a research methodology (Bhattacharya 2008). Goals of critical ethnography include unveiling social constructions, examining who benefits from these

social constructions, challenging injustices and putting forth alternative possibilities. In other words, "critical ethnography aims to expose power relationships through in-depth and sustained involvement in a research setting" (Fitzpatrick 2011: 176). As Thomas states, "Ethnographic researchers are active creators rather than passive recorders of narratives or events" (1993: 46); thus the critical ethnographer challenges traditional scientific methods, which require separation of research subjects and researchers.

Within a critical ethnographic approach, meaning is understood as political: "For the critical ethnographer, the cultural construction of meaning is inherently a matter of political and economic interests" (Anderson 1989: 254). Such an approach fits well with my theoretical framework of foucauldian power/knowledge, which as discussed in Chapter 2 posits that practices and rationalities of government are intimately connected to knowledges about the state, individuals, populations and society as a whole. Demonstrating how knowledges are socially constructed is powerful in deconstructing truths (such as that addiction is a disease) and posited realities (that drug users need to be governed by the legal system). Hörschelman and Stenning argue that ethnographic research methods have an important role to play in making policy more relevant and in promoting social change because these "accounts are able to demonstrate how macropolicies resonate with local power structures, to show how they affect people and are negotiated by them" (2008: 354-5). Furthermore, a guiding question of critical ethnography is "how does the research challenge injustice and what are the implications for action?" (Bransford 2006: 183), which complements my activist orientation and the goals of this project.

Feminist Methodology

Research methods are tools used to investigate, examine and analyze the social world (e.g. interviews, observations, questionnaires); methodology is the theory that guides decisions on which methods to mobilize. According to Harding, "a research method is a technique for gathering evidence" whereas a methodology is "a theory or analysis of how research does or should proceed" (Harding 1987: 2-3). There is no clear definition of feminist methodology (Doucet & Mauthner 2006; Maynard 1994), with a debate taking place over what feminist methodology is, what makes feminist methodology unique and even whether it exists. Chafetz (2004) argues that there is no such thing as a feminist methodology and that feminists should use all and any research tools necessary to further research on gender/women. In contrast, Baber (2004) argues that there is such a thing as feminist methodology and that some research tools are not appropriate for feminist research. Baber (2004) argues that feminist methodology is distinct in its assumptions and goal to make women's lives better. Kelly, Burton, and Regan argue that "what makes research 'feminist' is not the methods as such, but the framework within which they are located, and the particular ways in which they are deployed" (1994: 46). I would argue that methods themselves are not necessarily feminist or not. However, a distinctive feminist methodology can be seen to exist.

Such a methodology begins with the assumption that knowledge is inherently political. Feminists have criticized claims that knowledge production is neutral and that research can be objective (Code 1995; Harding 1990; Nicholson 1990; Tanesini 1999). To this end, feminists have also criticized "modern foundationalist epistemologies and moral and political theories, exposing the contingent, partial, and historically situated character of what has passed in the mainstream for necessary, universal, and ahistorical

truths" (Fraser & Nicholson 1990: 26). Below I outline five principles of feminist research based on a literature review in order to better situate my methodological approach.

Improving Women's Lives

Feminist scholars often posit that social change is central to feminist research (Fonow & Cook 2005) and that feminist research is about improving women's lives (Doucet & Mauthner 2006; Harding & Norberg 2005; Ramazanoglu 1992). Reinharz notes the crucial link between feminist scholarship and activism: "the purpose of feminist research must be to create new relationships, better laws, and improved institutions" (Reinharz 1992: 175; c.f. also Ettore 2007). Likewise, Ramazanoglu argues that "there is no alternative to political commitment in feminist or any other ways of knowing. Since knowing is a political process, knowledge is intrinsically political" (1992: 210). Referring back to my discussion of ontology and epistemology, we must raise the question of who decides what part of women's lives need improving? Who is permitted to produce this knowledge? For example, anti-racist feminists have long contested branches of feminist work that attempt to save women of colour (Mohanty 1991; Razack 1998; Syed & Ali 2011).

Carol Smart argues that using the law as a feminist site in order to improve the lives of women is problematic because it uses a unitary conception of woman. Importantly, the law also fails "to challenge not only law's inflated vision of itself and thus empowers law" (1995: 187). She urges us to approach "law as a site of struggle" while recognizing that the law "is not a set of tools or rules which we can bend into a more favourable shape" (ibid: 198). An extension of this approach is thus to attempt to

change laws in order to make them better for people who use drugs while recognizing that the system itself is a problem and that ultimately the goal should be to overcome the system through, for example, the abolition of prisons. I discuss policy changes at length in the concluding chapter of this thesis. However, it is important to note here that an approach that focuses on reform of policy and legislation is contested in some feminist literature, and that I struggle with this approach because I recognize that in using legal and political systems, I work to legitimate and reinforce these same systems.

Relationship Between Participants and Researcher

The research process is infused with power inequalities. This is most evident in the relationships between participants and researcher(s). Feminist research attempts to acknowledge and disrupt these power inequalities (Deutsch 2004; Hunter 2002; Shope 2006). Thus the goal is for participants' experiences to be central, and the interests of the researcher to be less important (Fitzgerald 2004). Even given these attempts, however, the researcher holds significant power over how the results are disseminated and over how the research is conducted. Shope (2006) argues that equality between researchers and participants is not possible until broader power inequalities, such as inequalities based on class and ethnicity, are changed.

In the interest of reflexivity I want to address this principle of feminist research. Because I went into the field without a research plan or proposal, I had not given thought to how I would attempt to decrease the power inequalities between myself and the participants in the ODTC. Herein lies an aspect of the research that I would do differently if given the chance. For example, I could have taken my research results to the ODTC community to be validated by them, and to offer participants the opportunity to give

feedback on the research (Hunter 2002: 128). Fitzgerald's work (2004) is a good example of this course of action. The women in her study were asked for permission to publish writing about them: "While I may have been the author of the published work, the authority to produce such accounts was vested in the participants" (Fitzgerald 2004: 237-8). Unfortunately, by the time I had begun writing, this was not possible since I had been out of the field for a number of months and had lost touch with many individuals.

However, I did attempt to minimize power inequalities in other ways. For example, I was very careful not to compromise any participant's standing in the ODTC. When I learned of participants who had breached their bail conditions, including substance use that was not reported to the court, I did not disclose this information to any of the legal or treatment team members. Part of the tensions that I experienced with the treatment team was due to the fact that I was protective of this type of information and that I never betrayed the confidences of the participants. Furthermore, I have omitted this type of data from this work, which is line with Taylor's work on queer scenes where she left out information on promiscuity and substance use in order to avoid jeopardizing the trust of her participants and in order to avoid causing them any harm. She concludes, "Omission is political; it is also tricky, yet it is often necessary" (Taylor 2011: 14). I discuss the data I omitted later in the chapter.

Privileging Women's Experiences

Privileging women's experiences is a response to women's experiences so often being silenced or misconstrued (Doucet & Mauthner 2006; Harding 1990; Mulinari & Sandell 1999). Focusing solely on women, however, does not ensure that the women being researched will have power in the research process (Shope 2006). There is an ongoing

debate in feminist and critical race research as to whether research can and should be conducted by people who are socially located outside of the group they are researching. Is it appropriate for men to do research on women, or for white women to research indigenous women's lives? Is experience in certain groups, such as drug using communities, necessary for one to do research with individuals who use drugs?

Standpoint theories place women's experiences and lives at the centre of research (Comack 1999; Fawcett & Hearn 2004; Smith 1999). A standpoint perspective assumes that "experiences produce knowledge and knowledge divorced from experience is colonizing, appropriating and oppressive" (Fawcett & Hearn 2004: 209). According to Walby (2001), two assumptions underlie the standpoint perspective. First, those in marginalized positions are better able to see and understand their marginalization. Second, it is assumed that having been marginalized and oppressed produces knowledge that is more accurate than if it had come from those who have not had such experiences. A concern of standpoint feminist work is for women to speak with their own voices, rather than "others speaking for them," thus spurring a shift in women "from the known to the knower" (Naffine 1996: 60). This is based on an epistemological approach which assumes that "the social location of knowers...make[s] a difference to the processes they employ to acquire knowledge, and some of these processes are more reliable than others" (Tanesini 1999: 47). In other words, the knowledge produced by those in privileged positions will be less objective because they are not forced to question their place in the world (Pohlhaus 2002).

Standpoint approaches, however, become difficult to maintain in the face of multiple identity categorizations. Women are not a unified category; they occupy

different social, economic, ethnic and power positions. For instance, Chafetz (2004) disagrees with the standpoint claim that persons in marginal positions have better knowledge than those outside of such positions. She argues that all knowledge is partial; therefore, those in marginalized positions do not speak from the true perspective, but rather from simply a different perspective. Naffine criticizes standpoint feminists for taking categories for granted and for not deconstructing the categories of race and class that have been deemed "aspects of female identity that were said to make one woman's perspective clearly distinguishable from another's" (1996: 61). Furthermore, she argues that standpoint feminists use a simplistic notion of power as top-down and oppressive. Another critique of standpoint approaches is that they have tended to collapse the differences among women, consequently focusing primarily on the experiences of privileged women (Pohlhaus 2002; Tanesini 1999).

My theoretical approach understands the importance of experience but also recognizes the importance of not limiting feminist research to women's lives. This is in line with Kelly, Burton and Regan (1994), who argue that feminist research should focus on women even while such a focus should not be strictly limited to women's lives and experiences given that women are situated within larger structures and within relation to men and men's experiences. Likewise, Mulinari and Sandell (1999) argue that a concept of experience that accounts for women's lived experiences and the social structures that shape these experiences is important and necessary for feminist work. Comack argues for the importance of discursive and experiential impacts on women's lives: "This involves acknowledging that there are experiences which women encounter in their lives (the 'nondiscursive') as well as women's ways of making sense of those experiences and their

effects (the 'discursive')" (1999: 294). Stemming from these perspectives, this project examines lived experience, discourses and social structures through critical ethnography, feminist methods and foucauldian theoretical approaches. This combination of methods and theory allows for a rich examination of the discourses of addiction and treatment practices in the Ottawa DTC, how these discourses and practices are gendered, and how they play out both inside and outside of the courtroom.

Intersectionality: Looking Beyond Gender

Another aspect of current feminist research is an acknowledgement and examination of multiple, connected sites of oppression. It is not enough to look at gender alone; it is also necessary to consider race, class, age, sexuality, ability, etc. This emphasis on intersectionality is a response to feminist research that focuses solely on white, middle-class women, which has been taken to be representative of all women's experiences.

Intersectionality originates from postcolonial and critical race studies critical of feminist construction of a unitary (read white middle-class) woman who spoke for all women's experiences. The term was first coined by Crenshaw (1991), and there is now a growing body of literature addressing intersectionality. Such research focuses on points of intersection that reflect multiple marginalized social positions (e.g., Arab women's experience/Jewish lesbian experience/elderly, non-able bodied experience). Intersectionality assumes that multiple subject positions bring with them different experiences that deserve to be reflected in research. Furthermore, oppressions are not equal and do not have equal effects (Andersen 2005). For example, being a queer woman is not equal to being a woman living in poverty. Thus, oppressions are not subject to comparison; nor does intersectionality work through additive analysis, piling oppressions

one on top of the other (Majury 2002; Maynard 2001). Additive analysis ignores how social structures (government, policies, laws, history) are tied, in complex ways, to race, class and gender. Intersectionality is an approach that provides the necessary theoretical tools to address the complex ways that identity categories relate to each other without reducing women to humanist understandings and without losing the subject to complete fragmentation, as with extreme postmodern approaches.

Reflexivity

Reflexivity is central to both feminist methodology (Mauthner & Doucet 1993) and critical ethnography (Berry & Clair 2011; Madison 2005). Reflexivity is tied to epistemology, and refers to a researcher's examination of her chosen methods, her role in the research, her relationships with participants, and how her social positions affect the research process (Deutsch 2004; Duncan 2002; Fitzgerald 2004). Reflexivity also refers to how researchers include themselves in writing about the research, and their emotional reactions to the research (Fonow & Cook 2005). Incorporating reflexivity into research brings attention to a researcher's biases and assumptions (Hunter 2002; Madison 2005). If researchers do not critically examine their own social positions and that of their research subjects (current and past socioeconomic status, gender and racial categorization, sexuality, etc.), biases and preconceived assumptions will mark their work (Shope 2006). However, reflexivity can never completely erase bias, assumptions, and power inequalities from the research (Shope 2006). Furthermore, certain practices of reflexivity have been criticized for focusing too heavily on the researcher, and thus drowning out the voices of the participants (Doucet & Mauthner 2006; Fonow & Cook 2005; Shope 2006).

Like other social institutions (law, education, etc.), academic research has the potential to further marginalize certain individuals while reinforcing the privilege of those in positions of power (Harding & Norberg 2005; Thomas 1993). Reflexivity recognizes that researchers have opinions, assumptions and value judgments, and that these cannot be separated from the research itself, or the methods used to carry it out. Researchers' previous experiences affect the research topics chosen, the methods used, and how findings are interpreted (Deutsch 2004). Therefore, reflexivity is an important principle of both critical ethnography (Jordan & Yeomans 1995) and feminist methodologies because it allows for an examination of the researcher's role in the research process:

> Reflexivity involves critical reflection of how the researcher constructs knowledge from the research process—what sorts of factors influence the researcher's construction of knowledge and how these influences are revealed in the planning, conduct, and writing up of the research (Guillemin & Gillam 2004: 275).

As a researcher, I am implicated in the construction of knowledge about addiction, recovery and treatment practices. What questions I ask, what data I include or exclude, and the arguments I construct are all part of this process. In incorporating reflexivity into my work, I do my best to avoid reproducing conceptions of the *Other* (Fine & Weis 1996) or reinforcing negative stereotypes about women or individuals who use drugs.

3.3 Fieldwork Details

Entry into the Field

I was first introduced to the ODTC when I took on a three-month research assistant contract. Given that I was searching for a dissertation topic, my supervisor at the time encouraged me to consider studying the ODTC. I was then introduced to the two judges responsible for the ODTC, Justice Judith Beaman and Justice Peter Wright,[8] at a lunch meeting. In December 2005, prior to the ODTC commencing operations, I was invited to attend a two-day training session for treatment providers at the courthouse during which judges, defence lawyers and Crown counsels spoke to participants about the criminal justice system and their specific jobs and roles. During this training, I met counsellors from the Rideauwood Addiction and Family Services (the ODTC treatment provider), most of the ODTC legal and treatment team members and the staff from Public Safety and Emergency Preparedness Canada who conducted the first year evaluation of the ODTC. This marked the beginning of my fieldwork.

Juggling Identities

While undertaking this ethnography I occupied numerous and overlapping identity positions, which is a common experience (Baumbusch 2011; LeCompte et al. 1999; Murray 2003). For example, in one situation I could be a researcher, a student and an activist, while in another I could be a researcher, friend and a queer woman. Often juggling identities was a part of impression management, which, along with protecting participants' confidentiality, "are necessary tools for the field researcher" (Murray 2003:

[8] Occasionally there were other judges sitting if both Justices Peter Wright and Judith Beaman were unavailable. Currently, however, five judges rotate through the ODTC (Department of Justice 2009).

386). Baumbusch explains that the process of negotiating identities is not one-sided: "we are not only positioning ourselves in relation to these multiple selves but also we are constantly being positioned by those we are engaging with in the research process" (2011: 187). Below I outline some of the specific identities and roles I negotiated while conducting an ethnography of the Ottawa DTC.

I did not hide my sexuality as a queer woman during my fieldwork; however, when I first went into the field I was nervous about my performance of gender. I understood that my "gender and other social statuses influence esteem, trust, and rapport, which facilitate or thwart access to data" (Presser 2005: 2021-2). At the time I was often mistaken for a male, and I was nervous about this happening in court, and how it would impact my experiences and relationships with people in the ODTC. Here is an excerpt from my field notes:

> I am also playing gender differently. I am more of a girl I think. In this conservative environment I feel like people being uncertain about my gender would not work in my favour.

In response to this, I began to dress in ways that performed gender in less masculine ways, playing up both traditional feminine and student performances. Particularly in the beginning I searched my closet for clothes that would be interpreted as feminine. I never dressed professionally (i.e., in dress pants, blouses or skirts); instead, I usually wore jeans or shorts and t-shirts without political slogans (those stayed in my closet). Thus my style of dress fit more with ODTC participants than with staff, who wore business attire. My backpack and bike helmet were also a part of my daily apparel and fit with my student identity; as one of the evaluators commented on the first day of ODTC "You have that student look." Perrone supports these experiences and argues that

> As embodied researchers, we influence our social interactions. We negotiate

> our gender and sexual identities, and shift our personalities and style of dress to represent ourselves in the most appropriate and comfortable manner for gaining access and establishing rapport throughout the fieldwork (2010: 730).

Because I went into the field with no prior fieldwork experience and because I was not planning to conduct an ethnography, these negotiations happened organically as part of my negotiating the research process.

I was a student for the entire time that I was doing fieldwork in the Ottawa DTC; however, this was not a straightforward identity. In the beginning I was taken to be a member of the treatment staff by some of the court staff. A section from my field notes describes negotiating my student identity early on:

> I feel vulnerable in the courtroom. I am out of place and don't know the norms to abide by. As I walk in the courthouse Tuesday and Thursday afternoons I change my demeanour to a naïve, apolitical student. This is assumed of me and I play into it. It gives me more room to manoeuvre. I think a lot of [the ODTC team members] think I am studying psychology or social work and assume that I see the court and the clients in the court in ways similar to them.

I was cautious about how I performed identity from the beginning of my fieldwork, even though I had not given this conscious consideration. Rather, the caution was triggered by not knowing what I was walking into or how to present myself. The student identity initially shielded me from criticism by the ODTC team members. However, this safety gradually diminished over time when ODTC staff began to see me as "too close" to participants. I was also different from other students who came into the ODTC to take notes and observe:

> There is a student here, sitting with us. I don't like this since she is listening to what we [myself and some of the participants] are saying. I ask her if she is here for drug court. She says she's a student at Carleton in Law and taking notes for a professor. She eventually moves. It's obvious how I'm a part of the group [of ODTC participants] by the way we talk and laugh, whereas new people are not even acknowledged by others. I'm so not a student in a way.

This discomfort arose from the student overhearing my conversation with participants

before the start of the court session. Often these conversations included participants talking about their drug use and/or breaches. In an interview, Clyde[9] spoke about how he was uncomfortable when other people took notes in court and how he was reluctant to discuss things in front of them. However, he considered me to be different because I was present from the beginning of the ODTC's operation and because he trusted me.

Negotiating Relationships with Participants

For me, establishing friendly relations with participants (Adler 1993) occurred organically. For approximately the first year of fieldwork, the pre-court meetings ran late and participants and I often waited up to an hour for court to start. This time together before court, without the presence of the ODTC legal and treatment teams, allowed the participants and I to develop a rapport. We came to know one another, and in some cases trust was developed and tested. My attire and genuine non-judgemental attitude likely helped in this regard; it was also clear that I did not work for the ODTC or for the treatment provider.

I was in a unique position as a researcher in the ODTC. My fieldwork began on the opening day of the ODTC. Over time I became embedded within the court to such an extent that I learned of confidential information about participants and formed relationships, both positive and negative, with the ODTC team and participants. It had been suggested to me that I was doing an ethnography while I was in the midst of fieldwork, but at the time, I did not have an understanding of what that meant or what the implications of it would be. I was so immersed in the ODTC that it was difficult for me to step back and reconceptualize my project at that time. I suspect that if I had gone into the

[9] Pseudonyms are used throughout the written work.

ODTC with a plan to develop relationships and to do an ethnography, it would have played out differently. Perhaps people would have sensed that I wanted something from them. Given that I went into the field with no expectations, my relationships with participants developed honestly, casually and simply. My relationships with the ODTC staff, on the other hand, were complicated and sometimes confusing, which I discuss further later on in the chapter.

One way in which I gained the trust of participants was by not reporting their court breaches to the ODTC staff. Given the small size of the city of Ottawa, it did not take long before I started running into participants outside of court, sometimes while they were breaching their bail conditions. It had not occurred to me that this might happen, and I had not considered how I would deal with such situations. I thus quickly and easily adopted some anonymity principles. I told participants that if I saw them outside of court, whatever they were doing, I would not tell anyone, whether they were part of the ODTC or not. I framed it in terms of 12-step anonymity: "What you see here and what you hear here stays here." Since I have spent time in 12-step rooms and because all of the participants had been ordered to 12-step meetings, there was a common, understandable language of anonymity that I could speak to. This principle became integral to how I introduced myself and my research to new participants. This is not to say that everyone trusted me; rather, I developed trust with some individuals quickly, while I had limited contact with others. And still other participants, whom I knew for two years, shocked me with information they disclosed to me after they left the ODTC.

Over time, many participants trusted me to "have their backs" and "not rat on them." For example some participants confided in me when they lied to their treatment

counsellors and/or the court, when they used drugs, when they were staying somewhere they were not supposed to be staying, when they committed crime and/or when they violated bail conditions. In an interview, Ben talked about how I was trusted and that as a result participants disclosed confidential information to me:

> I'm sure a lot of information that you were given, you were probably given some information that was much more personal than some would have given um, to their workers.

Sometimes participants even told me how they were producing false negatives on their urinalysis tests. Participants also discussed how they were afraid of being caught in a lie at court.

In not reporting court breaches or deception by participants, I was upholding standard research ethics guidelines. I made anonymity and confidentiality agreements with participants in the Ottawa DTC which I honoured and continue to honour. To report information provided to me in good faith by participants would have harmed participants, and would have violated both institutional and personal ethical agreements. But beyond simply upholding personal ethical principles and institutional ethical guidelines, I often took the side of participants in the ODTC, personally identifying with them. On this point, Maher (2002: 315) argues that "the nature and dynamic of ethnographic fieldwork and its demand for shared experiences dictate that the researcher must decide—at least temporarily—whose side she is on." Therefore, placing myself on a side—if it must be referred to in this manner—did not violate my ethical agreements. Rather, from a critical ethnography and feminist methodology standpoint, it may have been required.

Thomas (1993) discusses his experience studying prisoners and how relationships with participants impacted his research. Since Thomas was inducted into prisoner society, he came to have rich understandings of prisoners' perspectives. However, this also led

him "to a view of prisons from the prisoners' perspectives, and...there was a danger that I might begin to romanticize the population and be excessively critical of the capturers and prejudge their behavior as unnecessarily repressive in situations where it was not" (1993: 46). I had a similar experience during my own fieldwork. For instance, near the end of my fieldwork I was more likely to be critical of the ODTC staff, particularly the treatment team. In the beginning, however, I did not have a negative perception of the ODTC or of DTCs in general. The first time I had ever been in a courtroom was during the training sessions held for ODTC and treatment staff, and I had not yet become active in prison or drug policy reform. Learning about the lives of participants in the ODTC but never experiencing camaraderie with the ODTC legal and treatment teams had an impact on my observations as well as on what data I focus on in my analysis. Nevertheless, ODTC participants and I disagreed on various aspects of the court and the prison system in general. Thus, although I developed concerns with the ODTC and its practices, this was not only due to my relationships with participants.

Research relationships are not one-sided but are reciprocal (Adler 1993), and this is evident in my field notes. I gave advice when asked, I bought coffee when money was tight for participants, I was emotionally supportive, I talked on the phone with some participants, and I met their babies before Children's Aid took them away. I was involved in participants' lives, I helped them move, I gave references for housing applications, I visited participants in jail, and I knew that confidential information was only provided to me because I earned participants' trust. None of this was done in order to further my research goals or to wheedle information out of participants. Furthermore, I did not

include the majority of this information in this thesis; in fact, I have excluded much of it due to ethical considerations.

Seating Arrangements in Court

Seating arrangements were one of the indications of my position and role in the court and of my relationships with participants and ODTC staff. The ODTC courtroom is set up like a regular courtroom, with the judge sitting at the front, the defence on the left side of the room and the Crown on the right side. The participants were told to sit on the left (defence) side of the courtroom while Rideauwood staff, the ODTC manager, treatment counsellors, probation officer and federal Crown sat on the right side. Also sitting with the Crown were two Rideauwood liaison officers. I always sat on the left (defence) side of the room. Here is an excerpt from my field notes on the second day of the Ottawa DTC proceedings that speaks to the importance of seating arrangements in the court:

> The entire Rideauwood staff [including the Executive Director, ODTC manager] and the probation officer and the crown counsels are sitting on the Crown/state side of the room. At recess [the evaluator] calls the ODTC Manager over and tells the manager that he should think about re-arranging the seating positions of the two Rideauwood treatment liaisons on the crown side. The evaluator asks what message they want to send about the court. The Manager responds by saying that they are there because of space and that they need to sit together. The evaluator re-iterates that this should be addressed, not necessarily now, but in the future. The ODTC Manager says the two Rideauwood people wouldn't have thought about this.

Initially the only rule regarding where people sat in the courtroom was that participants sat in the front rows on the left (defence) side. Myself, the evaluators and some other observers sat on the left side, while the Rideauwood and legal staff continued to sit on the right side of the courtroom. There came a point when one of the evaluators moved to the other side of the courtroom; when I asked the evaluator the reason for the move, I was

told that it was easier to hear on the right side, and that it was more professional not to be sitting with clients.

Soon after, one of the treatment liaison officers advised everyone on the left side of the courtroom that only participants in ODTC are allowed to sit on the left side of the courtroom. ODTC staff and participants strictly enforced this rule; however, I was exempted and continued to sit with participants until I left the field. Here are two examples from my field notes that demonstrate how my unique position played out in the seating arrangements:

> A former ODTC participant comes to court and sits on our side and [a treatment liaison] tells him he has to sit on the other side. In my field notes I note: "I get nervous that I'm going to be asked to move, but I'm not."
>
> Allan [a former ODTC participant] is here and he comes to sit with us on our side of the courtroom. Roland says "only Tara's allowed on this side, beat it." Allan goes to sit on the other side.

Note that I refer to "our side" of the courtroom. This was often how I wrote about seating arrangements in my notes. For example, "There is a young girl in the courtroom, sitting on our side." This demonstrates that, in my own perception of my place in the court, I was not a detached observer but positioned myself with the participants and not ODTC staff.

Another example from my notes demonstrates how participants also viewed me as different than other outsiders and students who came into the courtroom:

> Before court Roland says students came into court and he got mad at them and told them to sit on the other side of the courtroom. He says he feels like a lab rat and he is upset since he doesn't know what they're writing and he doesn't want them writing his name or about his issues. He says he doesn't mind me writing my notes or being there. He gets more upset when 6-8 students come in today after court has started. He tells them they can't sit on this side. After court we talk about this more and he says it's hard to stand up there and be honest when people are writing about him and he doesn't know who they are.

I was thus not a stranger to participants, who were fully apprised of my research.

Going out for Coffee with Participants

Another aspect of my fieldwork that differentiated me from other students and observers, as well as from ODTC staff, was discussions had over coffee. Approximately halfway through my fieldwork, I started going out for coffee with some of the participants after court. This occurred organically. I did not plan to have informal discussions with participants after court; rather, a participant initially suggested going for coffee, and it turned into a regular event. While some ODTC staff seemed bothered by the participants spending time with me, one of the treatment counsellors often encouraged other participants to join us for coffee:

> Stanley is talking to [a treatment counsellor] and she asks him whether he's coming with us and I invite him to come with us and he does. I'm glad she's not threatened about us going for coffee.

During these times together, participants and I discussed events in court, what was happening in their lives, their relationships with treatment and ODTC staff as well as many things not related to the ODTC. These occasions also fostered friendships with some of the participants as we learned about each other and our lives outside of the courtroom setting.

Relationships with ODTC Staff

At certain times in the beginning of my fieldwork, it felt like the ODTC staff were accepting of the research that I was conducting and of my role as a researcher. For example, there were times when the treatment and legal staff revealed personal information about the participants to me. In one instance, I asked the Crown counsel for some ODTC documents for my analysis. We went up to the Crown counsel's office after court to fetch the documents. While I was there, we had a discussion about the court day

during which he disclosed one participant's positive HIV status and another participant's diagnosis of fetal alcohol spectrum disorder.[10] Here is an excerpt on this from my field notes:

> I cannot believe that the Crown disclosed someone's HIV status and someone's FASD with me today. The ODTC team continues to surprise me by disclosing things to me.

Similarly on another occasion, a treatment counsellor revealed a participant's experience of sexual abuse to me:

> I am talking with an outreach worker and a ODTC counsellor inside the courthouse outside of the courtroom. [The counsellor] starts talking about why she thinks Kelly isn't doing good (I wasn't listening to this part). [The outreach worker] suggests Kelly needs treatment for her eating disorder and that's a part of her using. [The counsellor] says her sexual abuse is a huge issue. I feel uncomfortable about her disclosing this to me, because by this time I'm a part of the conversation. [The outreach worker] tries to change the subject and [the treatment counsellor] goes on about Kelly's terrible sexual abuse.

While these instances show that some ODTC staff likely initially trusted me with confidential information, as my relationship with the ODTC participants grew, tensions with staff developed. During the latter part of my fieldwork, ODTC staff did not divulge any more of the participants' personal information. However, I believe that a larger reason for being given access to this information was that some of the ODTC staff did not respect the confidentiality of participants' personal and medical information. The ODTC is not based upon client confidentiality; rather, participants must sign waivers that allow their treatment counsellors, other ODTC staff and their medical doctors to disclose information about them to the ODTC.

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[10] See Chudley et al. (2005) for an example of how fetal alcohol spectrum disorder is currently diagnosed in Canada. However, it is noted that "studies on drinking during pregnancy have focused disproportionately on Aboriginal women and the geographic areas in which they live" (Dell & Lyons 2007: 6).

Tensions with ODTC Staff

It is difficult for me to pinpoint a timeframe or an event that created a shift in my relationship with the ODTC staff, particularly the treatment staff's perception of my role and the work that I was conducting. However, there was a gradual shift in their approach to me. Early on, the staff was supportive of my research, while later in the fieldwork some staff were actively hostile towards me. Part of the difficulty in pinpointing what happened is that no ODTC team member spoke to me directly about their concerns. Rather, they began to treat me differently and to complain about me to others. For instance, partway through my fieldwork I noted that "I almost ran into [treatment liaison] coming through the [courtroom] doors and I say, 'Oh sorry'. We are face to face and he looks away, doesn't smile, doesn't talk to me."

More troubling was the way the drug treatment court manager attempted to intervene in my relationships with ODTC participants. The manager actually contacted one of my thesis committee members at the time and relayed concerns over my rapport with participants. The ODTC manager and my former committee member felt that I was "too close" to participants. The tension came to a head when I was informed by a member of the ODTC team that the ODTC manager was telling others that I was unprofessional, specifically claiming that I was getting into hot tubs with clients. I informed the team member that this was patently false. The team member then informed me that the ODTC manager said that he was going to speak to my supervisor about my behaviour and that the team member suggested to him that he speak to me first. The team member also informed the manager that the relationship between academic supervisors and students is not analogous to the relationship between employers and employees, but

that supervisors are more like advisors. To this the manager responded "Can't her supervisor control how Tara collects her data?" The team member also told me that the ODTC manager complained that I went for coffee with participants and that I took their phone calls; the team member warned me to "watch out."

I was deeply concerned by this information, as there was no instance of me going into a hot tub with any participant. The accusation was completely unfounded, and it represented a malicious attempt to undermine my credibility. It became obvious from this and other examples that ODTC officials were developing concerns about what participants were telling me, and perhaps what I was telling them.

Some of this tension relates to (mis)understandings of what academic research is and how researchers and students should conduct research. As seen in the above quote, the ODTC staff had certain ideas about how I should be conducting research, and they did not want me, as a researcher, forming relationships with their clients. However, forming relationships is a critical aspect of an ethnography (Gatenby & Humphries 2000; LeCompte et al. 1999); furthermore, some of the ODTC staff had no problem with these relationships.

I never spoke to participants about these tensions in the field because I was conscious of the power the ODTC manager and team had over them, and I did not want to involve them in such struggles. In one interview, however, Blake spoke about how he picked up on some of the tensions:

> I always wondered though, I would mention your name to like to say [a ODTC counsellor] and I always got this, there was a vibe there that wasn't always positive. I don't know if you were a distraction to them or something that, or if you were a positive for them, I really don't know, but sometimes I would mention, I don't know what it was....there was something that was just a little off.

Complex Interactions

The best way to illustrate how my differing identities played out during my fieldwork is to describe one instance that demonstrates the complexities and tensions of my identities as student, activist and researcher. One day, I received a Facebook message from Chad, a ODTC participant, saying he was going to be in trouble with the court. I called him, and he told me that he had tested positive for cocaine metabolite. During his appearance before the judge that day, the treatment team reported that two recent urine tests came back positive for cocaine and cocaine metabolite, which was contrary to his reports of non-use on previous appearances. The judge revoked his bail for two days as punishment for this breach. I stood up to get Chad's keys and money because he had asked me in advance to take his belongings and to take care of his car were he to be incarcerated. The following is an excerpt from my field notes about what happened next:

> After the judge says his bail is revoked and I go to get his belongings. We are standing in the aisle of the courtroom for a couple of minutes and then Chad grabs his keys from me and says he's not staying and leaves. Oh no! The ODTC manager follows him out and talks to him. Allan [a ODTC participant] catches up to him saying I have his money. I tell Chad he's crazy for running and he leaves.
>
> Allan and I walk outside and the ODTC manager, one of the evaluators, and one of the case managers are there. The ODTC manager and evaluator are laughing and the evaluator says "You were right [that he was going to run], you called it." The Crown comes out and says "If anyone talks to him tell him to turn himself in. He's facing a charge of escaping lawful custody." Allan and I say we will call him. The ODTC manager says, no he will call Chad. The evaluator and case manager respond and say "He won't answer your call, Tara you call him." The ODTC manager says "Oh my phone battery is dead." The Crown comes out again and tells me to tell Chad that he has about an hour to turn himself in.

As this example demonstrates, I was not simply a student making observations in the ODTC. I had varied and complex interactions with staff and participants, including

this instance where Chad contacted me in advance, letting me know that he was in trouble and asking for my help in taking care of his car and other belongings. After he fled, I was asked to call Chad and to get him to turn himself in to police by treatment staff. It was clear from the tension in the exchange noted above that the ODTC manager did not appreciate my role. The story continues:

> I call Chad, and he doesn't answer. I call him again and he answers. I tell him what the Crown said and tell him to turn himself in. Allan talks to him and Chad agrees to come meet us for coffee. Chad decides to turn himself in and we go back to the courthouse. Duty counsel is still there thankfully and she says to Chad, "very bad idea" and tells him the charge of escaping lawful custody. She gets the bailiffs to take him in. He gives me his keys and money and gives us hugs before he goes.

Although this event was certainly stressful and disturbing, and I worried about what would become of Chad, I was integrated into the life of the ODTC to such a degree that at the time it did not seem exceptional or strange to me. It is a clear example of how entrenched I was in the fieldwork, how I was perceived to be a part of the ODTC by some of the team members, and how my presence and role was resented by others. I concluded my field notes from that day by writing about my conflict between my roles as researcher, student and activist:

> It was such a weird role to be in and again shows how I'm such a part of the ODTC. I'm not just in there taking notes. It's hard for me to see anyone go to prison much less someone I care about who's terrified about going in. And I spend hours trying to persuade him to go to jail.

Afterwards in an interview Chad told me that "there was nobody else there I would've trusted to take my car. They probably would've friggin' searched the whole car or something 'cause I remember [the ODTC manager] saying 'We'll take care of your stuff' and I was like 'No, it's okay.'" This example not only demonstrates the complexity of my

role within the ODTC and some of my relationships with ODTC staff and participants, but once again the high level of trust I had developed with some of the participants.

3.4 Data Collection

Data was collected from four different sources for this project: (1) participant observation; (2) informal conversations; (3) formal interviews; and (4) textual analysis. By collecting data from multiple sources, I was able to provide a richer analysis, examining the ODTC from different angles. In collecting data, I was never aspiring to find the truth about the ODTC; however, combining methods allowed me to check my interpretations of observations (Adler 1993). Thomas states that because data varies in its significance and quality, critical ethnographers "should continually be alert for additional sources of information that reveal the details and nuances of cultural meaning and process" (1993: 38). For example, if I had only examined the documents of the ODTC, I would have missed out on key data. Likewise if I had only conducted interviews, I would have missed out on the rich, complex interactions that occurred in the courtroom.

Participant Observation

I spent approximately 3 to 20 hours per week in the field. Each court session ran for 1 to 4 hours, with the Tuesday court sessions lasting longer than the Thursday session because participants with early leave did not attend the Thursday court sessions. On average I spent an additional 7 hours per week with participants outside of the official court sessions, ranging from 1 hour to 15 hours per week. I spent just over 100 weeks in the field with approximately 900 hours of fieldwork.

My participant observations focused on verbal exchanges in the court, which I recorded verbatim during the Tuesday and Thursday afternoon court sessions in a notebook. I also documented events and conversations that occurred before and after court sessions, summarizing such interactions afterwards. Most days I would go to a nearby coffee shop and type up my written notes after court or after everyone had parted ways. While typing the notes I added in more context, such as making connections between what a participant told me before court and what was said or not said in court to the judge. Pseudonyms were always used in the field notes. Field notes from 23 months of court sessions (February 2006 to January 2008) comprise the majority of the data analyzed here.

Just like other forms of observation and representation, field notes are socially constructed, partial and biased (Goodall 2000). In keeping my field notes, I focused on what I found interesting, important and meaningful. I paid far closer attention to participants in the Ottawa DTC than to the ODTC staff, usually only observing ODTC team members through their interactions with participants in court. In doing so, I hoped to keep the experiences and voices of drug users at the forefront of the data. And, of course, the field notes I wrote were written through my own perspective, knowledge and experiences as a feminist, activist and drug policy reformer.

Informal Conversations

The second most significant source of data were the informal conversations—sometimes called "informal interviews" (Bungay 2008)—that occurred outside of the ODTC sessions. These conversations happened spontaneously inside and outside of the courthouse in conjunction with my participant observations. Initially, I would have

conversations with ODTC participants before court; after we had developed some rapport, these conversations occurred after court as well. Sometimes they were private one-on-one conversations; and at other times, we talked as a group. These conversations also occurred when we went out for coffee after court as a group. Sometimes these conversations would happen away from the ODTC sessions, for example, after participants quit or were removed from the ODTC, or when I was otherwise interacting with participants outside of the context of the ODTC. For example, I helped Sonja move into a rooming house when she was nine months pregnant, and we discussed her possible options, what would happen to her baby, and what she could do next. Sometimes the conversations happened at the jail when participants had been remanded and I went to visit them, or when I was running the Books to Prisoners program with women at the Ottawa Carleton Detention Centre. While we did not always talk about the ODTC and their experiences there, the court was always a large part of these conversations as it formed the basis of our relationship.

I also had informal conversations with ODTC team members such as the Crown counsel, the first year evaluators from the Department of Public Safety and Emergency Preparedness, and defence lawyers whose clients were participating in the ODTC. I did not take notes in my notebook during these conversations; instead, I documented them after the fact. This is common practice in ethnography where conversations are used as a form of data collection (Jergensen et al. 2007).

Formal Interviews

I conducted eleven individual interviews (seven men and four women) with participants in the Ottawa DTC. I also conducted two interviews with young adults who were asked to

participate in the ODTC but who refused. The interviews were semi-structured, and the questions were open-ended. The interviews took place in the interviewee's dwelling or in a public location where we would not be overheard (such as on the mostly empty patio of a restaurant). Like all aspects of this research, the interviews were confidential and the participants remain anonymous by my having changed or removed names, dates and any identifying information. Participant responses are non-attributable, and participants have anonymity in this written work. It was clearly explained to all participants that their participation was voluntary, that they were not under obligation to answer all of the questions asked, that they could end the interview at any point and that there would be no repercussions in any way for choosing to participate or not. Since the participants I interviewed were no longer in the ODTC at the time of the interviews, I was under no obligation to ask permission from the ODTC to conduct the interviews. I gave a $40 gift card to each person I interviewed as an honorarium for participation.

While the small number of interviews may pose a limitation to the data, they do not form the sole basis of this study. Rather, they allowed me to get into more in-depth details on some issues with participants, helping me to flesh out discourses of addiction. Of course much of the information was already obtained from participant observations and conversations with participants. Also, it was never my intention to use the interviews to generalize about participant experiences in the ODTC or about the experiences of individuals in drug courts in Canada as I am aware that the courts are complex and that they diverge greatly in how they operate across the country. However, the data I collected do allow me to address (1) how the ODTC frames and practices addiction and treatment; (2) how participants in the ODTC frame and practice addiction and treatment; (3) how

these framings relate to current forms of drug treatment; and (4) how addiction and treatment practices are gendered in the Ottawa DTC.

ODTC Documents

I conducted discourse analyses of the following ODTC materials:

- Consent and Waiver Form;
- The Rules and Obligations (for participants);
- Application Form;
- Local Practice Memorandum;
- Drug Treatment Court Ottawa pamphlet;
- Rideauwood Case Management Practice Guidelines for the ODTC.
- Evaluation of the Drug Treatment Court of Ottawa: Year One: February 2006 to February 2007 (Bourgon & Price 2007).
- Supplement to the Year One Evaluation: Report for the Ottawa Drug Treatment Court: Correctional Program Assessment Inventory-2000 (Dowden 2007).
- Outcome Evaluation of the Ottawa Drug Treatment Court Pilot Project (Rideauwood Addiction and Family Services 2009).

I also analyzed the first draft, and later the finalized draft, of the first year evaluation of the ODTC by the Department of Public Safety and Emergency Preparedness. Most notably, the data contained in these documents demonstrated the tension between treatment providers' understandings of addiction and treatment and the expectations of the court.

3.5 Data Analysis

Discourse Analysis

In this thesis, I employed discourse analysis as one of my methods of analysis. The questions shaping my analysis were: (1) What do these discourses render visible and invisible? (2) What do the discourses shape and what are they shaped by? and (3) What work are the discourses doing?

Discourse is used to classify, convey, represent, perceive and interpret ideas, beliefs and thoughts. The concept of discourse differs from language in that discourse includes actions (or "practice") as well as language (Hall 1997). At a basic level, discourse is defined as "a process resulting in a communicative act" (Chimombo & Roseberry 1998: ix). Hallam and Bewley-Taylor define discourse as "an organized field of writing and speech, embedded in institutions, buildings, timetables, offices, statuses, maps, codes, regulations and so on that functions to define what is and is not real, true and valuable" (2010a: 7). Therefore, the workings of discourse are closely related to the production of knowledge.

Thus discourse analysis can challenge socially accepted understandings of addiction and laws governing drug use and drug users. Hallam and Bewley-Taylor argue that socio-linguistic approaches, including discourse analysis, "help to render the apparent givenness of things open to critical scrutiny as the contingent outcome of processes of power and history" (2010: 5). Discourse and discourse analysis allow for language and other forms of communication to be conceptualized as central to the formation of subjects and the production of knowledge (Purvis & Hunt 1993). The role of discourses is central in subjection and subjectivation. Our subjectivities and identities are "brought into play by discursive strategies and representational practices" (Martin 1998: 9). Therefore, discourse analysis examines how social truths are legitimized and accepted (Davis & Anderson 1983) as well as how subject identities are produced, shaped and reinforced.

Once my fieldwork was completed, I transcribed the interviews. The transcripts of the field notes and interviews were imported into the NVivo qualitative data analysis

software. My research questions were a starting point for the initial round of coding within NVivo. For example, the concepts of gender, discourses of addiction, discourses of recovery, addict identity and treatment practices became codes. As I made my way through this large amount of data, I created more codes and subsets of codes. For example, the "addict identity" code was broken into 12 subset nodes including "unhealthy," "in need of help," "unreliable" and "weak." After this process I identified what I called prominent discourses of addiction, recovery and treatment based on the quantity of data covered by the node. I also used this technique to analyze how I negotiated my research, student and activist roles in during my fieldwork.

One aim of my analysis is to deconstruct how discourses of addiction, recovery and treatment are conceived of as value-neutral. The concepts used by researchers, such as addiction, exist within the same social context as the ODTC, and their uncritical use can reproduce inequalities: "according to critical ethnographers, analytic categories that are not viewed holistically become ideological in that they lead to the reproduction of a particular set of social relationships" (Anderson 1989: 253). Categories and concepts are contextualized to demonstrate who and what benefits from maintaining the current understandings. I was able to deconstruct and contextualize the central concepts of this work because of my extensive and diverse data collection. Working in the fields of drug use and activism in Ottawa also provided me with important contexts of drug use and treatment practices in Ottawa. Another important aspect of my analysis was the time that passed between collecting data and beginning to analyze it; I only began to analyze the data nine months after my fieldwork was completed, which was important in creating some distance from the site and for my analysis.

Omitted Data

Here I would like to briefly discuss data that I left out of my analysis, as these choices can be as important as the data that is ultimately analyzed (Fine & Weis 1996). Because I was in the field for an extended period of time, I have a tremendous amount of data. While the shear amount of data played a role in what I excluded, deciding what data to exclude was primarily informed by my research interests, ethics and my political, activist orientation. Reflecting back on this, I believe that withholding certain information was also ethics in practice in order to protect participants from any harms. As Bhattacharya argues, part of our ethics as ethnographers and researchers is to ask "How much of the experiences of the researched do we tell?" (2008: 312).

I excluded much of the data on legal actors based on my research interests. During my fieldwork I focused on what participants said in court, ensuring that I wrote their words down in my notebook verbatim. Because my focus was on understanding treatment, I also paid close attention to not only what treatment providers and actors said in open court, but also how they interacted with participants outside the courtroom. I was less focused on legal actors, in part due to having less interest in their role, and in part due to their lack of accessibility. For example, I did not have interactions with the judges because I was not in pre-court meetings and because judges did not interact with participants or the treatment team in public outside of the courtroom.

In terms of ethics, I also excluded data that I felt could be detrimental to participants. For instance, I have not included many rich examples of how participants resisted the strict requirements and bail conditions of the ODTC in order to ensure that

this information neither harms the specific participants in this study nor current and future participants in Ottawa and other Canadian drug treatment courts.

Reliability and Validity

Thomas (1993) suggests five ways to help ensure accuracy of ethnographic data: (1) careful recording and analysis of data; (2) triangulation of data collection; (3) review of data and/or drafts by colleagues or participants; (4) replication of the study; and (5) researcher reflection. With the exception of replicating the study, I have engaged with all of these means. I put much energy into—and suffered many hand cramps from—recording in-court exchanges verbatim, as well as recording my conversations promptly after they occurred. As described above, I used a variety of data sources to enrich my analysis, and I engaged with reflexivity and my own position throughout my fieldwork and during data analysis.

I also asked two individuals to review my data for accuracy. My data codes and themes were reviewed by a drug user in Ottawa, whom I'll call Matthew, who had not been in the ODTC, but who is familiar with the legal system and the drug using community in the city. The second reviewer was a fellow Ph.D. candidate who had conducted fieldwork and employs governmentality analysis but was not familiar with drug use, treatment or drug policy literature.

I gave the two reviewers randomly selected transcripts from my field notes, together with my research questions, for them to code. I removed all information that could have identified participants, including what charges they faced and what shelters they were staying at, and I changed pseudonyms to a participant number on the transcripts. I also removed the dates on the transcripts and did not compile them

chronologically. I did not give Matthew interview transcripts because the interviews contained more personal information about participants, and I was concerned about maintaining confidentiality. I did, however, give my academic colleague a copy of some of my interview transcripts. While I paid Matthew for his time as a reviewer, I offered to review my colleague's data in the future in return for her time. Feedback from both reviewers indicated that my findings are consistent and valid. For instance, Matthew noticed how women were treated differently in court appearances, and my colleague coded numerous ways in which participants were required to engage in self-government in the court.

Matthew had a police encounter while working on the data, and this event illustrated the importance of protecting participants' information. He called me from a pay phone and was very upset and crying. He explained that he had been panhandling when two police officers took him to a side street, punched him twice in the stomach and went through his bag. They took his needles, threatened to stab him with them, and then laughed at him as they deposited them in a sharps container. They threatened to drive him out to the country, beat him and leave him there if they saw him again. They also took his notes on my field notes and the field notes themselves. When he explained that he was working on a university project, they laughed at him and threw all the papers in a garbage can. Matthew later went back to retrieve the papers from the garbage. This event exemplifies the importance of a careful use of pseudonyms.

3.6 Conclusion

Ethical Considerations

When I entered the field I had Carleton University ethics approval under a research assistant contract. Once the contract was completed I obtained my own Carleton University ethics approval, which I held until 2011. I obtained ethics approval to conduct my field research in the ODTC despite it being held as open court, meaning that ethics was not obligatory for participant observation. All participants were given pseudonyms in my field notes and interviews, with responses non-attributable and participant anonymity guaranteed throughout the process. To ensure anonymity in the written work, I changed the pseudonyms I had used in the field notes since some participants knew the pseudonyms of other participants. The decision to interview participants after they had completed the drug treatment program was made to minimize the risk of potential backlash from the ODTC team for participating in the interview. In earlier drafts I had included the date reference in quotes and examples from my field notes. After consulting with my committee, I decided to remove the dates from the written work to ensure anonymity since they could be traceable to court records.

I encountered ethical dilemmas while conducting my fieldwork in the Ottawa DTC. This is not unusual according to Guillemin and Gillam who argue, "Ethical dilemmas and concerns are part of the everyday practice of doing research—all kinds of research" (2004: 26). To address ethical dilemmas this project also required what Guillemin and Gillam call "ethics in practice," which "pertain to the day-to-day ethical issues that arise in the doing of research" (ibid: 264). There were many instances where I intuitively engaged in ethics in practice. These practices dictate interacting with participants "in a humane, nonexploitative way while at the same time being mindful of one's role as a researcher" (Guillemin & Gillam 2004: 264). While in retrospect I would

have made some decisions differently, my instincts and the advice that I was given from committee members allowed me to make appropriate ethical decisions while simultaneously juggling my roles as researcher, student and activist.

Research and Emotional Involvement

I could have completed a research project on the ODTC without conducting an ethnography, without spending nearly two years in the court, and without becoming emotionally involved in the lives of participants. However, I committed to carry out a critical ethnography because I was interested in the lived experiences of drug users and the concrete implications of the ODTC for their lives. As Ferrell, Hayward and Young explain, when researchers do this kind of work, they "are less likely to find themselves sorting statistics or mailing surveys, and more likely to get caught up in the dirty ambiguities of daily transgression, the dangerous details of criminal acts" (2008: 159). I became a part of some participants' lives, and they became a part of mine. I shared some of my own experiences with them as I engaged in research that dove into "cultural and emotional knowledge" (Ferrell, Hayward & Young 2008: 177). This is a messy form of research to say the least.

Although there was some concern that my emotional involvement was too close to ODTC participants, Ferrell et al. back up my approach, claiming that "Rather than 'objectivity' guaranteeing accurate research results, it is in fact emotional subjectivity that ensures accuracy in research; without it, the researcher may observe an event or elicit information, but will have little sense of its meaning or consequences for those involved" (ibid).

While I could have gone to court and taken notes without engaging with participants or staff outside of the court, in that case I would only have my own isolated perspective on the events occurring in the courtroom. I would have missed, for example, a participant telling me that they had lied to the judge and did in fact use drugs the night before. Or I would have missed hearing the context of what happened in the pre-court meeting where it was decided that a certain situation was not to be discussed in court. I would have also missed participants' frustrations with their treatment counsellors and colleagues. I would have missed the role that service providers play in perpetuating criminalization. Such an approach would have been easier and less messy, but it would have missed so much of the crucial context that frames events in the courtroom. I will conclude this chapter with a final note: "qualitative research is a social process and, as feminists methodologies remind us, is both personal and political" (Tunnell 1998: 217).

Chapter 4: A Brief History of Canadian Drug Policy

4.1 Introduction

Canadian drug policies are based on particular conceptions of drugs and drug users and on how best to manage them. The contemporary categorization of certain substances as illicit and the strategies implemented to enforce their prohibition has a history dating back to the *Opium Act of 1908*. Therefore in this chapter and in Chapter 5, I contextualize DTCs within the broader history of Canadian drug policy. Here I discuss (1) the history of Canada's drug control statutes, (2) the events, political debates and key actors involved in shaping and reshaping drug policy and interests in addiction and treatment, and (3) Canada's national drug strategies from 1987 to present day. I conclude the chapter with a critique of legislation which is currently before parliament—Bill C-10—and its connections to mandatory minimum sentencing and drug treatment courts. This chapter also gives context to my conclusions and recommendations as discussed in Chapter 9.

4.2 Canadian Drug Policy Statutes

Opium Acts of 1908 and 1911

The *Opium Act, 1908* marks the moment drug use and drug users became criminalized in Canada and laid the foundation for our current prohibitionist drug policies. This legislation was spurred by what Giffen, Endicott, and Lambert call a "historical accident" (1991: 45). There was an anti-Asiatic riot in 1907 in Vancouver during which properties in Chinese and Japanese neighbourhoods were damaged (Boyd, MacPherson & Osborn 2009; Carstairs 2006; Giffen, Endicott & Lambert 1991). Then Deputy Minister of Labour, William Lyon Mackenzie King was sent to British Columbia to "assess claims for damages arising from the anti-Asiatic riots" (Giffen, Endicott & Lambert 1991: 45;

Carstairs 2006). Two of the claims submitted to the government for compensation were from opium manufacturers, which led members of a Chinese anti-opium league to ask Mackenzie King to curb opium trade and manufacture (Boyd, MacPherson & Osborn 2009; Carstairs 2006). Also during this visit, Mackenzie King became concerned that white people were smoking opium, and in particular, that white women were being corrupted and that Chinese labourers were profiting from this situation (Boyd 2006; Boyd, MacPherson & Osborn 2009; Dias 2003; Solomon & Green 1988). Therefore, the *Opium Act of 1908* "was fuelled by moralism, racism, gender, and class conflict" (Boyd 2006: 133) and not unlike our current drug policies, the opium act was passed in Parliament on the basis of morality and on claims of dangerousness that were not demonstrated (Boyd 2006).

The resulting *Opium Act of 1908* thus placed limits on the importation of opium and restricted opium for medical use only (Ogborne, Smart & Rush 1997). The *Opium Act of 1908* was followed by the *Opium Act of 1911* (renamed the *Opium and Narcotic Act, 1911*), which had a stronger enforcement emphasis. Some argue that this legislation marked a turning point in Canadian drug policy towards the enforcement of prohibition (DeBeck et al. 2006; Dias 2003). It is important to note that alongside this criminalization, services such as treatment or detoxification were not made available (Boyd, MacPherson & Osborn 2009).

The *Opium Acts of 1908 and 1911* resulted in fines for the majority of drug-related offences. This changed in the 1920s when anti-drug campaigns contributed to legislation that increasingly criminalized drugs and drug use. For example, legislation was passed that increased sentences for drug possession and trafficking and allowed for

deportation of immigrants charged with drug crimes (Carstairs 2006; Solomon & Green 2005). Further, marijuana was added to the schedule of the *Opium and Narcotic Drug Act* without debate in 1923 (Carstairs 2006; Erickson 1990). The *Opium Acts* were also based in class biases and racism towards Chinese immigrants and concern that white people, particularly women, were using opium (Berridge & Edwards 1981; Boyd 2006; Carstairs 2006; Comack 1986; Dias 2003; Solomon & Green 2005). For example, in 1922 Emily Murphy published *The Black Candle,* which warned against the dangers posed by racialized men, who were associated with drug use, to white women (Murphy 1922). Consequently, both historical and contemporary Canadian drug policies cannot be said to be neutral; history has demonstrated that "attempts to regulate the use of specific drugs can be linked with attempts to regulate certain populations" (Malloch 2000: 44).

The *Opium Acts* also resulted in substantial changes in the government's role in dealing with drugs. The Department of Health was established in 1920, and the Narcotic Division was established within this department to oversee the *Opium and Narcotic Act.* That same year also saw the formation of the Royal Canadian Mounted Police (RCMP), with these two new entities now working together to influence drug policy (Carstairs 2006; Solomon & Green 2005). Some scholars argue that enforcement of drug legislation and policy was the primary justification for the establishment of the RCMP; according to Solomon and Green, "by the early 1930s, federal police and drug officials emerged as Canada's only drug experts" (2005: 353). Thus the *Opium Acts* initiated and reinforced a punitive approach towards people who use drugs that continues to this day.

Narcotic Control Act & the Food and Drugs Act

The 1961 *Narcotic Control Act* replaced the *Opium Acts* and reflected the goals of enforcement and incarceration for drug users and dealers (Erickson 1990; Solomon & Green 2005). Under the *Narcotic Control Act*, "anyone convicted of possession, trafficking, or importation could be sentenced to an indefinite period of custody for 'treatment'" (Carstairs 2006: 156). Thus, possession could result in indefinite institutionalization. The *Food and Drugs Act of 1970* was Canada's second drug control statute that paralleled the *Narcotic Control Act* until the *Controlled Drugs and Substances Act* was enacted (Erickson 1990; Giffen, Endicott & Lambert 1991). The *Food and Drugs Act* was employed to manage changes in drug use patterns. For example, amphetamines and barbiturates were first added to the *Food and Drugs Act* in 1961 instead of the *Narcotic Control Act*. Giffen, Endicott, and Lambert argue that the reason for which the *Food and Drugs Act* was employed in this manner was in part because amphetamines and barbiturates were already prescribed for medical reasons and that "a large number of respectable users" were implicated (1991: 471). In addition, using the *Food and Drugs Act* was seen as appropriate for substances considered to have medical applications or to be less *dangerous*, and as such, deserved less severe punishment (Giffen, Endicott & Lambert 1991). Giffen, Endicott, and Lambert conclude that the use of the *Food and Drugs Act* alongside the *Narcotics Control Act* "marked a new divergence between Department of Health officials and the enforcement authorities" (1991: 472). These sections of the *Food and Drugs Act* were later incorporated into the *Controlled Drugs and Substances Act*.

Controlled Drugs and Substances Act (CDSA)

The *Psychoactive Substance Control Act* was tabled in 1992 by the then Conservative Government to replace the *Narcotic Control Act* as Canada's drug control statute (Fischer 1999). It was criticized from the outset because it focused on criminalizing drug users and prohibition and did not incorporate harm reduction approaches (Fischer 1999). The potential legislation died when an election was called in 1993. The Liberals emerged victorious from the 1993 election and tabled the *Controlled Drugs and Substances Act,* which was nearly identical in approach to the *Psychoactive Substance Control Act* (Fischer 1999). The *Controlled Drugs and Substances Act* was passed on October 20, 1995, the day of the Quebec referendum when the *Bloc Québécois* (the federal opposition) was not present in the House of Commons (Erickson 1998; Fischer 1999). The *Controlled Drugs and Substances Act* became law in 1997 (Erickson 1998; Fischer 1999) and remains Canada's current drug control statute. The *Controlled Drugs and Substances Act* is described as legislation "which modernized and consolidated the existing legislation and provided the police with additional tools to combat illicit drug-related activity" (Health Canada 1998: 10).

International Drug Control Treaties

Canadian drug policy is also situated within international drug control treaties. There are three current international treaties in place: (1) the 1961 Single Convention of Narcotic Drugs, amended in 1972; (2) the 1971 Convention on Psychotropic Substances; and (3) the 1988 Convention Against Illicit Traffic (Babor et al. 2010; Buxton 2010). Canada's drug policies are guided by these treaties (Health Canada 1998). The UN International

Narcotics Control Board (INCB) oversees the implementation of the international drugs treaties.

Without going into the specific details of these treaties, it is important to note that international drug control frameworks impact how countries apply drug policy by providing a normative context for implementation (Hallam & Bewley-Taylor 2010b). For example, it has been argued that the conventions contribute to human rights abuses by setting the broader normative context in which nation states can engage in such abuses (International Harm Reduction Association et al. 2009; Lines 2010).[11]

4.3 Key Events and Influential Actors

Prior to World War II little attention was paid to drug addiction; rather, society's focus was on alcoholism. It was during this time that the temperance movement rose to prominence. Alcoholism was perceived from a moralistic standpoint and alcoholics were seen as weak-willed (Roberts & Ogborne 1999). There was an attendant lack of access to formal drug treatment during this time and no formal treatment institutions. One factor in the emergence of the concept and practices of treatment was the change in the racial makeup of those arrested on drug charges. By the 1950s, after many Chinese people had been deported and refused entry into Canada, the majority of people being charged for drug offenses were white. This increased the interest in causes of addiction and its treatment (Carstairs 2006). In this section, I briefly outline what is known as the *cannabis controversy* and its impact on drug policy, as well as the influence and role played by the

[11] For more information on Canada's participation in international treaties and roles within the United Nations Office on Drugs and Crime see Health Canada (1998: 13-14).

enforcement lobby and medical doctors on early, post-World War II Canadian drug policy.

The Cannabis Controversy

The cannabis controversy of the 1950s and 1960s is illustrative of changing social landscapes and subsequent changes in drug policies. During this time there was an increased use of marijuana among young people; under the drug laws of the time, 50 percent of individuals convicted of cannabis possession were imprisoned (Erickson 1992). The majority of individuals arrested on drug charges were young, white, and of middle class backgrounds (Carstairs 2006; Dias 2003; Giffen, Endicott & Lambert 1991). This ran counter to the media's portrayal of *drug addicts*, who were meant to be from lower socioeconomic backgrounds and who were often racialized. In 1964 there were 28 marijuana convictions in Canada. In 1969 there were 2,964 convictions, and in 1970 6,292 convictions (Giffen, Endicott & Lambert 1991). This influx of middle class youth into the criminal system resulted in "the emergence of competing interest groups vying for the right to define 'the drug problem'" (Erickson 1992: 245) as well as changes in sentencing. Specifically, the *Narcotic Control Act* was amended so that judges could give fines for possession instead of jail time (Carstairs 2006; Fischer 1999; Solomon & Green 2005).

Until the cannabis controversy of the 1950s and 1960s, the public and governmental responses to drug *problems* were to increase enforcement and enact harsher criminal punishments. The change in the demographics of those entering the criminal justice system during the cannabis controversy changed this approach and in part spurred those in positions of power and influence to question the effectiveness of the law-and-

order approach to drug use (Giffen, Endicott & Lambert 1991: 360). After the cannabis controversy, sentences for cannabis possession decreased and this resulted in less pressure for policy changes (Erickson 1992). As the larger population became more familiar with drugs and more young people started using them, there was a "narrowing of the social distance between drug users and the mainstream society" (Erickson 1992: 247). Many were seen as using illicit substances, including the friends and family members of the white middle class, which made it more difficult to argue that drug use was a crime. The cannabis controversy, and the sociopolitical context of the 1960s, thus propelled the larger society to question the effectiveness of Canada's punitive approach to drug policy (Giffen, Endicott & Lambert 1991; Thomas 2003). Also during this time, research and government reports indicated that the harms of drug use were much less serious than what was previously thought (Erickson 1992: 247). One such report that contributed to opening the debate on drugs, addiction and appropriate responses was the Le Dain Commission.

Le Dain Commission of Inquiry into the Non-Medical Use of Drugs

The Commission of Inquiry into the Non-Medical Use of Drugs, known as the Le Dain Commission, ran from 1969-1973 and issued four reports. The Commission recommended a shift from criminalization to a health "approach as the appropriate policy response to drug use and addiction. Moreover, it suggested that cannabis should be regulated outside the criminal law" (Fischer 1999: 199; Canadian Nurses Association 2011). The Le Dain Commission interim report rattled the Canadian government in June 1970 when it recommended that using and possessing drugs should not result in incarceration but rather a $100 fine. CBC Radio called the report "one of the most

politically explosive documents ever put before the government" (June 21, 1970). The report recommended that psychotropic drugs be moved from the *Narcotic Control Act* into the *Food and Drug Act.* Liberal Health Minister John Munro stated that the government would consider such a move for marijuana. However, this resulted in conflict between Munro and John Turner, then Minister of Justice, who was furious at the announcement. In an interview on CBC Radio, Dean Le Dain argued that we should look beyond law as the only response to drug use, claiming that we must "...not deceive ourselves as to the extent to which we can confine this problem to the law or suppression as a solution" (CBC Radio, June 21, 1970).

Despite the findings of the Le Dain Commission, there were no changes to Canada's drug laws, and drug users continued to be treated punitively (Erickson 1990; Erickson & Smart 1988; Fischer 1999; Solomon & Green 2005). The Commission was important not only because of its breadth of scope, but also because it demonstrates that drug policies are not necessarily based on research and public consultations. Therefore, it is important to look at key actors in the development of drug policies and constructions of addiction and addicted subjects.

The Enforcement Lobby and the 1955 Senate Special Committee

Arguably the most influential group of actors in drug policy development is the *enforcement lobby.* From 1908 to 1969 the primary actors in Canadian drug policy "were those charged with its execution" (Erickson 1992: 245).[12] Carstairs argues that "the leading role in enforcing Canada's harsh drug laws fell to the police, and they exerted

[12] For a full history see Giffen, P.J., Endicott, Shirley & Shirley Lambert (1991).

tremendous power over drug users' lives" (2006: 92). Police officers, and in particular the RCMP, were influential in drug policy discussions at the legislative level as well as at the local level where they disseminated information to the public and the media about drugs and drug users (Carstairs 2006). The enforcement lobby was also extremely influential in debates over the character of drug addicts and the appropriate manner in which to treat them. Thomas identifies central actors in the enforcement lobby as "the Canadian Police Association (CPA), The Canadian Association of Chiefs of Police (CACP), the RCMP, provincial police, municipal police, [and] The Bureau of Customs and Immigration" (2003: 29). The enforcement lobby was generally not in favour of a treatment-based approach to drug users. Instead they argued that increased enforcement and forced treatment would be more effective (Giffen, Endicott & Lambert 1991; Solomon & Green 2005).

The 1955 Senate Special Committee on the Traffic of Narcotic Drugs in Canada is an excellent example of the influence of the enforcement lobby on Canadian drug policy and on how drug users have come to be conceptualized. The Committee heard from the RCMP and others, including the Executive Director of the John Howard Society of British Columbia, that individuals with addictions had personality defects and were above all else criminals (Giffen, Endicott & Lambert 1991). It is important to note that the enforcement lobby propagated a conception of the addict as criminal to contradict claims that addiction was a disease and that the legalization of drugs would work towards decreasing crime (Fischer, Roberts & Kirst 2002; Giffen, Endicott & Lambert 1991). From this perspective there was little hope that addiction could be treated. Treatment advocates disagreed and argued that the relationship between criminality and addiction

should be inverted. They held that drug addiction resulted in criminal behaviour (Giffen, Endicott & Lambert 1991). The 1955 Senate Special Committee on the Traffic of Narcotic Drugs in Canada "ended up favouring the view of the law enforcement community and this was eventually reflected in the highly punitive 1961 *Narcotic Control Act*" (Dias 2003: 11). In this case, the enforcement lobby won against pro-treatment advocates in the debates over how to conceive of addiction and the best way to manage drug users.

Medical Doctors as Key Actors

Medical doctors are another set of key actors in the Canadian drug policy landscape. Unlike enforcement actors, doctors have historically faced persecution based on their desire to treat drug users medically. The *Opium and Narcotic Act of 1911* put restrictions on how doctors could prescribe certain medications (cocaine, opiates and morphine). The *Act* was amended in 1925, making it illegal for doctors to prescribe opiates as treatment for addiction (Carstairs 2006; Dias 2003; Ogborne, Smart & Rush 1997). However, during this time doctors were monitored and persecuted. For example, there are many reported cases where the RCMP would send drug users to obtain doses of opiates from doctors and then lay criminal charges against the doctors (Carstairs 2006; Giffen, Endicott & Lambert 1991). Ultimately, the *Opium Acts* resulted in the exclusion of medical professions from treatment of drug users (White 1998). Because drug use came to be considered exclusively a law-and-order issue, the medical profession "came to accept the view that prescribing drugs to addicts was not proper medical practice" (Giffen, Endicott & Lambert 1991: 359), although this had been acceptable medical practice in the past.

With the 1961 *Narcotic Control Act* it once again became legal for doctors in Canada to prescribe medication to drug users as treatment (Carstairs 2006; Ogborne, Endicott & Lambert 1997). As a result, in 1963 a methadone maintenance treatment program came into being in British Columbia (Giffen, Endicott & Lambert 1991). Methadone maintenance treatment then became increasingly available throughout Canada; however, the prescription of opiates remains highly regulated. For example, doctors require an exemption from the *Controlled Drugs and Substances Act* to prescribe methadone (Health Canada 2002) and the onerous requirements and fear of persecution entail that most physicians do not in fact dispense methadone (Ogborne, Smart & Rush 1997).

4.4 National Drug Strategies

National drug strategies are a relatively new tool meant to outline the Canadian government's priorities and approaches to addressing substance use. The government allocates funding to the strategies which carries implications for what practices are funded (e.g., drug prevention, enforcement). The national drug strategies involve federal, provincial and local levels of government, as well as NGOs and international partners (Collin 2006). In this section, I briefly outline the multiple national drug strategies that have been deployed in Canada, ending with our current National Anti-Drug Strategy.

In 1987 the National Drug Strategy, the very first of its kind, was released. The Mulroney Conservative Government allocated 210 million dollars to the strategy over 5 years (Erickson 1992). In 1992, another five year drug strategy was created and called Canada's Drug Strategy (CDS). The CDS was "conceived as a multisectoral

partnership...and served to stimulate a range of activity, including the support of innovative treatment and rehabilitation services across the country" (Roberts & Ogborne 1999: 5). However, despite the focus on treatment and prevention, "the practices of Canadian drug enforcement only minimally changed in the years after the launch of CDS, and maintained their basic focus on drug user repression" (Fischer 1999: 201-2). The launch of Canada's Drug Strategy corresponds to what Erickson (1992) calls a resurgence in prohibitionism. The result was that "the net of criminalization widened to include drug pipes, literature, and steroid dealers [and] more of the assets of those suspected of profiting from drug selling were confiscated" (Erickson 1992: 249). There was also more surveillance of people who used and sold drugs, as well as an increase in drug testing at work (Erickson 1992: 249).

Within the CDS, "[f]ive priority populations were identified: youth, women, seniors, Aboriginal peoples, and driving-while-impaired offenders" (Health Canada 1998: 18). The CDS was renewed in 1998, but funding to the strategy was decreased (Collin 2006). There were concerns raised about the CDS, in particular by the Auditor General over the allocation of funds, which I discuss below (Auditor General 2001; Collin 2006; DeBeck et al. 2006). In 2003 the CDS was renewed once again and remained the national drug strategy until it was replaced by the National Anti-Drug Strategy in 2007.

The National Anti-Drug Strategy (NADS) was introduced in 2007 by the Harper Conservative Government. Aside from the change in name, what was amended in the new strategy was the removal of harm reduction from the scheme. Prior to NADS, harm reduction had been an official part of Canada's Drug Strategy (Marlatt 2002), comprising one of its four pillars alongside enforcement, prevention and treatment. Furthermore, the

NADS also currently makes no reference to Canada's two largest drug problems, tobacco and alcohol, which between them account for high rates of death and injury (Rehm et al. 2006). For example, in describing the goals of Canada's Drug Strategy in 1998, Health Canada states:

> The long-term goal of Canada's drug strategy is to reduce the harm associated with alcohol and other drugs to individuals, families, and communities. Harm associated with alcohol and other drugs can be physical, psychological, societal, and/or economic. Because substance abuse is primarily a health issue rather than an enforcement issue, harm reduction is considered to be a realistic, pragmatic, and humane approach as opposed to attempting solely to reduce the use of drugs" (Health Canada 1998: 4).

Because harm reduction is not included in NADS, there is no current funding available for harm reduction programs under the strategy.

This is not to say that the previous Canada Drug Strategies were not problematic. Despite calling for four pillars to address substance issues—enforcement, prevention, treatment, and harm reduction—the four pillars were never evenly applied. In 2000, 94% of federal government financial resources for the management of illicit drugs was allocated to enforcement measures (Auditor General 2001; DeBeck et al. 2006). In 2005, the percentage of funding allocated to enforcement decreased to 73%; however, this remains a high percentage of funds (DeBeck et al. 2006). Thus, despite the CDS allocation of funds to treatment, prevention and in some years harm reduction, enforcement has received, and continues to receive, far and away the most funding, underscoring the success of the enforcement lobby in determining the terms of drug policy discourse.

4.5 Conclusion: The Current Drug Policy Context

The history of Canadian drug policy is replete with examples of policy and legislation that can be seen to emanate from knee-jerk political reactions instead of from well thought-out, evidence-based interventions.[13] And with the Harper Conservative Government ushering in a *tough-on-crime* approach with renewed energy and vigour, Canadian drug policy continues to treat addiction and drug use as criminal matters. This approach to drugs and drug users is misguided especially given that the crime rate in Canada continues to decline and in 2009, the crime rate was the lowest recorded in the last 25 years (Dauvergne & Turne 2010). Yet punitive responses continue to be the norm when addressing drug-related issues. In this concluding section of the chapter, I discuss the recent history and status of a controversial piece of legislation that is currently before Parliament, Bill C-10, *The Safe Streets and Communities Act.* I then explore the problematic manner in which the provision of mandatory minimum sentencing contained within this legislation is being justified through and propped up by proponents of drug treatment courts in Canada.

A Recent History of Bill C-10

In addition to the NADS and as part of the Harper Conservative Government's *tough-on-crime* approach Bill C-10, *The Safe Streets and Communities Act,* stands currently before Parliament. The first incarnation of Bill C-10, Bill C-26, *An Act to Amend the Controlled Drugs and Substances Act and to Make Consequential Amendments to Other Acts*, had its

[13] It is important to note that *evidence-based* approaches have been criticized for being entrenched in a positivist approach that conceives of science and the scientific method as the only appropriate way to determine evidence and facts (Neale, Nettleton & Pickering 2011). Only certain information, acquired through specific methods is considered evidence-based and only certain people can produce this knowledge.

First Reading in the House of Commons on November 20, 2007. The bill proposed three major revisions. First, it introduced mandatory minimum sentences (MMS) for drug offences by proposing changes to the *Controlled Drugs and Substances Act* (CDSA). Second, Bill C-26 also proposed to double the maximum penalty for marijuana production from 7 to 14 years imprisonment. Third, the bill aimed to reschedule certain substances, such as amphetamines, from Schedule III to Schedule I, making the penalties for possession and trafficking significantly more severe (Dupuis & MacKay, May 1, 2008). The bill passed Second Reading in the House of Commons and then died on September 7, 2008 when Parliament was dissolved.

After Stephen Harper's Conservative Party of Canada was re-elected to a second minority government in 2008, Bill C-15, almost identical to Bill C-26 was tabled in the House of Commons. Again, the legislation was presented as part of the Harper Conservative Government's tough on crime platform as a way to protect communities and young people. Strategically, Bill C-15 was introduced with Bill C-14, *An Act to Amend the Criminal Code*, which targeted organized crime and aimed to improve protection of justice system participants after high-profile gang-related murders in British Columbia in 2009.[14]

As with Bill C-26, Bill C-15 introduced mandatory minimum sentences for certain drug offences, increased maximum punishments for marijuana production, and rescheduled certain substances from Schedule III to I thereby increasing associated penalties. Bill C-15 also contained several aggravating factors which would automatically increase the minimum sentence for the individual charged. For example, section

[14] In the Greater Vancouver area there were 24 gang-related shootings in less than 2 months alone, between January 20 and March 5, 2009 (Urban Health Research Initiative, March 2010).

1(a)(ii)(C) of the bill proposed that a mandatory minimum sentence of two years be given if "the person used the services of a person under the age of 18 years, or involved such a person, in committing the offence." Clearly, this clause was added with the intent to protect youth, but the vague language of such clauses meant that a young person giving a pill of MDMA (aka ecstasy) to a friend would face a mandatory sentence in a penitentiary, even if it was their first charge. Bill C-15 had its First Reading on February 23, 2009 and was passed in the House of Commons and the Senate after both the Parliamentary and Senate Committees made amendments to the bill. Bill C-15 died when Prime Minister Stephen Harper prorogued Parliament for the second time on December 30, 2009.

During the prorogation of Parliament, the government promised to re-introduce this legislation. Holding to this promise, Bill S-10 was introduced into the Senate on May 5, 2010. The new Bill S-10 was identical to Bill C-15 *prior to* the amendments made by the Senate based on their study of the bill and the testimony of witnesses, myself included. The now lost amendments included, for example, "potential relief from a mandatory minimum sentence for an Aboriginal offender," which was added by the Senate Standing Committee on Legal and Constitutional Affairs (Dupuis & MacKay 2009). Bill S-10 died when the government fell on March 22, 2011. The government characterized this legislation (as with all of its crime bills) as getting tough on serious drug crimes in order to ensure the safety and security of neighbourhoods and communities.

During the 2011 election campaign, the Conservative Government promised to bundle the crime bills they had tabled over the years into an omnibus crime bill and pass

it within 100 days of the return of Parliament. On September 20, 2011 the Conservative Government, now a majority, introduced Bill C-10 into the House of Commons. Bill C-10 is called the *Safe Streets and Communities Act* (Parliament of Canada, n.d.) and includes all aspects of the former Bill S-10. Bill C-10 is expected to be passed into law swiftly.

Bill C-10, Mandatory Minimum Sentences and Drug Treatment Courts

In all incarnations of Bill C-10, drug treatment courts have been included as a clause for which people facing a mandatory minimum sentence (MMS) could instead opt. In other words, upon successfully graduating from a DTC, participants would no longer have to face a MMS. Bill C-26, the first incarnation of this legislation, included a provision that:

> a sentencing court may delay sentencing to enable the offender to participate in a drug treatment court program approved by the Attorney General of Canada. If the offender successfully completes the drug treatment court program, the court is not required to impose the minimum punishment for the offence for which the person was convicted (Dupuis & MacKay, May 1, 2008: 18).

However, only those individuals without certain aggravating factors would be eligible to participate. Aggravating factors that preclude participation in DTCs for the purpose of avoiding a mandatory minimum sentence include (1) the use or threat of violence in the offence, (2) offences having occurred in or near any public place usually frequented by persons under the age of 18 years, and/or (3) offences having occurred in a prison.

During my work with the organization Canadian Students for Sensible Drug Policy and as part of our opposition to Bill C-26, we noted the various manners in which this provision was problematic. First, there were only six DTCs in operation in Canada and therefore only people facing MMS in these six urban areas could be eligible for this provision. Second, to avoid the MMS one would have to complete the DTC, while

research demonstrates that graduation rates are very low, particularly for women, Aboriginal people and young people (more on this in Chapter 5). Third, we argued that the list of aggravating factors that disqualified individuals from participating in a DTC, as well as the eligibility criteria set out by DTCs themselves, would mean that very few people in the limited six urban areas would be in fact eligible for participation. As a result, in its incarnation as Bill C-15, Clause 5 of this legislation was expanded by the Parliamentary Committee on Justice and Human Rights to include:

> or attend a treatment program under subsection 720(2) of the *Criminal Code*. If the offender successfully completes either of these programs, the court is not required to impose the minimum punishment for the offence for which the person was convicted (Dupuis & MacKay 2009: 20).

However, as noted previously, such crucial amendments to the bill died with the bill itself and were not included in the legislation that was recently re-introduced as Bill C-10.

Politically, what links proponents of drug treatment courts and mandatory minimum sentencing (and thus proponents of Bill C-10) is that together they allow political leaders to position themselves as being both tough on crime *and* as coming to the aid of those who suffer from drug addiction. During my appearance before the Justice and Human Rights Parliamentary Committee on April 27, 2009, Member of Parliament Brian Murphy (Liberal) made a statement that was very telling in this regard:

> I do want to talk about drug treatment courts because I think the saving grace of this bill is that it's one of these rare cases where even though people have said that mandatory minimums do not deter people from committing the crime, this is a unique situation where people have the option of avoiding a mandatory minimum after a conviction or in the process of being sentenced. It is a bit unique. In other words, the mandatory minimum on the books might serve to get more people into drug treatment courts (Parliament of Canada, April 27, 2009).

But as I will show in the following chapters, the effectiveness of drug treatment courts in treating drug users is far from clear-cut, and the punitive character of DTCs remains largely overlooked.

In the next chapter, I provide an overview of drug treatment courts in Canada. As such I chart the emergence of DTCs in Canada, explore their aims and principles and discuss whether their approach to treatment can be considered voluntary, mandatory or coercive. I also identify and discuss the roles of key DTC actors and put forward an in-depth description of DTC practices, in particular focusing on examples drawn from my time in the Ottawa Drug Treatment Court. Questions of success rates, effectiveness and cost-effectiveness of DTCs are also broached in the next chapter.

Chapter 5: Drug Treatment Courts: An Overview

5.1 Introduction

As punitive approaches continue to dominate the landscape of official Canadian drug policy, drug treatment courts (DTCs) have emerged as central components of the implementation of such policy strategies. This chapter details the emergence of drug treatment courts in Canada and examines their principles and objectives. I then turn to a discussion of the key actors within drug treatment court programs and provide an in-depth description of DTC processes, from eligibility and entrance to graduation and exit from such programs. Where appropriate, I supplement these descriptions with more thorough examples, drawing from my time at the Ottawa Drug Treatment Court (ODTC). I conclude the chapter by exploring the question of drug treatment court success rates and effectiveness, including discussion of its internal evaluation processes.

5.2 The Emergence of Drug Treatment Courts

What Are DTCs?

Drug treatment courts (DTCs) are specialized courts set up to address the perceived connection between drug addiction and crime by providing non-violent drug dependent people with intensive, supervised treatment. People who enter DTCs "enter into a behavioral contract in which they agree to participate in treatment, to be monitored for compliance, and to report to court periodically to discuss their progress" (Wiener et al. 2010: 424). Participants are to abstain from drug use and become productive, non-criminal citizens. As Justice Bentley, the judge behind the Toronto DTC, states:

> Participants are also required to demonstrate a fundamental lifestyle change including improved interpersonal skill development, stable and appropriate housing, and education and vocational skills. It is the belief of the Toronto DTC

> that these requirements are necessary to improve the likelihood that offenders will remain drug and crime free (2004: 9).

Most DTCs in Canada follow similar legal processes and treatment programs. However, differences do arise given the liberty that they have in developing particularized treatment programming and court proceedings. The eligibility criteria are quite similar among the six federally funded DTCs, including (1) the type of charge, (2) the type of substance use, (3) therapeutic needs, and (4) personal motivation. Once guilty pleas are entered and applicants become DTC participants, they must contend with a rigorous program including onerous bail conditions such as observing curfews, maintaining or finding safe and secure housing, abstaining from intimate relations with other DTC participants, staying out of assigned areas (known as *red zones*) and participating in treatment to the satisfaction of the treatment providers. These stringent conditions have led some to argue that drug treatment courts "can actually be more tough and intrusive than traditional criminal justice processes" (Nolan 2002: 1737-8). While the drug treatment courts have different criteria for graduation, they generally require a minimum length of time in the program, a period of abstinence, and some evidence of stability (i.e., stable housing and attending school or work) (Department of Justice 2009; Gorkoff, Weinrath & Appel 2007).

Drug Treatment Courts in Canada

The first DTC in Canada was established in Toronto in 1998, and there are now six federally funded DTCs operating across the country in Toronto, Vancouver, Edmonton, Winnipeg, Ottawa, and Regina. Drug courts in the US were established in response to the soaring number of arrests and incarcerations as a result of the continued and vigorous

prosecution of the War on Drugs (Miller 2009; Rosenthal 2002). In contrast, DTCs in Canada were established at a time when the overall crime rate was declining and incarceration rates were relatively stable (Fischer 2003). Nevertheless, the stated goal of such courts in both Canada and the US is the same: to break the cycle of drug use and criminal recidivism, as well as to reduce over-reliance on the costly prison system.

In the early 2000s, Canada's federal government established the Drug Treatment Court Funding Program (DTCFP), a partnership between Justice Canada and Health Canada. The program's stated objectives are to:

- promote and strengthen the use of alternatives to incarceration (with a particular focus on youth—operationalized as 18 to 24 year olds—Aboriginal men and women, and street prostitutes)
- build knowledge and awareness among criminal justice, health and social service practitioners and the general public about DTCs
- collect information and data on the effectiveness of DTCs in order to promote best practices and the continuing refinement of approaches (Department of Justice 2009: 3).

Following a call for proposals in December 2004, four DTCs were granted funding in addition to the two DTCs already in operation in Toronto (as of 1998) and Vancouver (as of 2001). There has not been another call for proposals since. The Ottawa DTC was modeled after the Toronto DTC, with the Toronto DTC providing training for Ottawa actors (Dowden 2007). The Ottawa DTC applied for $649,000 of federal funding per year to operate a youth and adult drug treatment court and ultimately received $515,000 from the Drug Treatment Court Funding Program (Dowden 2007). Currently, the DTCFP funds six DTCs in total; in 2010, each court had its funding renewed for two more years, until March 31, 2012. The courts are still described as *pilot courts* as they do not have long-term funding commitments (Department of Justice Canada 2009). These six DTCs receive a total of approximately $3.5 million per approved year from the

Treatment Action Plan of the National Anti-Drug Strategy introduced in 2007 (Department of Justice n.d.).

Table 5.1: DTCFP Contribution Funding

	Toronto	Vancouver	Edmonton	Ottawa	Regina
2005-2006	$750,000	$232,500	$583,760	$519,869	$293,000
2006-2007	$750,000	$750,000	$583,760	$550,000	$446,500
2007-2008	$750,000	$750,000	$583,760	$550,000	$446,500
2008-2009	$750,000	$750,000	$583,760	$550,000	$446,500

(Department of Justice 2009: 6)

There are also four other DTCs not funded under the DTC Funding Program located in Durham, Ontario, London, Ontario, Moose Jaw, Saskatchewan and Calgary, Alberta. These courts receive their funding from a variety of sources outside the federal government. For example, the Calgary DTC secured funding from the City of Calgary and later provincial funding through the Safer Communities Fund (Cooper, Franklin & Mease 2010). There is much less readily accessible information about non-federal funded courts and, consequently, it is not clear whether they conduct regular evaluations or how they compare to the federally funded courts. The available information on the Calgary DTC indicates it may be more punitive than the federally funded DTCs. For example, when asked what sanctions are used in the Calgary DTC the executive director of the program responded that "being sent back to jail is the most common sanction used by our court for relapses and bad behaviors while in the residential treatment centers" (Cooper, Franklin & Mease 2010: 72). The London DTC has some limited information available through the website of Addiction Services of the Thames Valley (Addiction Services of

Thames Valley n.d.). The website notes that the London DTC is modeled after the Toronto DTC and currently has only 8 active participants, all male. Data has been collected (if the specified timeline is correct) and the first year evaluation is expected on September 30, 2011 (London Drug Treatment Court n.d.). An evaluation of the Durham DTC is available; however, the evaluators caution that their findings are not generalizable due to a very small sample size (28 participants) and no comparison groups (Heagle & Scott n.d.: 6). We do know that the Canadian Association of Drug Treatment Court Professionals (CADTCP) includes the four non-federally funded courts in the list of Canadian DTCs.[15] But other than that, it is unclear how the non-federally funded courts relate to the federally funded DTCs and the CADTCP.

Reducing Crime and Increasing Public Safety

The judicial system's primary mandate is to reduce crime and increase public safety. In an effort to achieve this end, the DTC system has been put in place alongside the traditional court system with a particular focus on drug-related crimes. As the federal Department of Justice states:

> The fundamental intent of the DTC program is to divert serious drug-addicted offenders out of the correctional system and into treatment in order to halt the cycle of addiction and criminal behaviour. Also at the core of the program is that offenders admitted to the program should not pose a public safety threat (2009: 28).

While DTCs vary in their policies and treatment practices, it is clearly established that the goal of DTCs is to stop drug dependent individuals from using drugs, thereby reducing recidivism and increasing public safety. Consequently, participants are to become, and

[15] The Department of Justice also funds the Canadian Association of Drug Treatment Courts (CADTC) meetings and conferences.

remain, abstinent from all mood-altering substances and become or re-establish themselves as productive, non-crime committing citizens. In speaking to a new participant, still sitting in the prisoner's box, one judge in the Ottawa DTC stated that "We want people to stop using drugs and help them get recovery...I want to encourage you on your decision...to make important changes in your life and I hope drug court helps you achieve your goals."

The underlying principles of the DTCs and their accompanying goals are premised on the following four central assumptions: (1) individuals who are dependent on substances commit crimes; (2) DTCs are effective at reducing rates of drug use and drug-related crime; (3) judicial interventions and monitoring result in increased treatment and court compliance; and (4) DTCs are effective at reducing costs of the criminal system (Darbro 2009; Dowden 2007; Weekes et al. 2007; Werb et al. 2007). The link between drug use and crime is often cited in the literature as the justification for drug courts; however, the relationship, direction and details of this link need further examination (Department of Justice 2009; Hough 2002; Seddon 2007; Stevens 2007; Stevens et al. 2005).

The principles guiding the DTCs are based on the assumption that DTCs are an effective way to treat addiction. This assumption is based on a particular understanding of addiction and addicted subjects, which is examined in detail in Chapter 7. In particular, it is clearly established that the goal of DTCs is to stop *addicts* from using drugs and from recommitting crimes (Fischer 2003; Miethe, Lu & Reese 2000; Rideauwood Addiction and Family Services 2009). For example, in Dowden's evaluation of the Ottawa DTC, he states:

> The hope is to reduce the emotional and physical harm substance-involved offenders cause to themselves and to others by eliminating their dependence on drugs. Desired financial benefits are also accrued through improved physical health (e.g., lower medical costs) and decreased criminal activity (e.g., lower court costs) (2007: 5).

These assumptions contribute to DTCs being heralded as a solution to drug and addiction problems in Canada (Dupuis & MacKay 2010; Nolan 2002).

Therapeutic Jurisprudence

The central philosophy underlying DTCs is therapeutic jurisprudence, an approach that examines "the health-promoting (or -impeding) consequences not just of our laws but also our legal procedures and lawyering processes" (Campbell 2010: 281). Therapeutic jurisprudence is a legal philosophy initially developed in the realm of mental health law (Bentley 2004; Nolan 2010). Its proponents claim that the law can and should be used in therapeutic ways (Hora 2008; Nolan 2001) and that it is appropriate and effective for courts and legal actors to be "coercive therapeutic agents" (Vrecko 2009: 222). Nolan argues that the intention of therapeutic jurisprudence "is to identify and enhance legal processes determined to be therapeutic and alter or reduce legal processes determined to be antitherapeutic" (2010: 67).

Abstinence

A second fundamental principle of drug treatment courts, which I will discuss at length in Chapters 6, 7, and 8, is abstinence. DTCs in Canada and drug courts in the US generally conceive of addiction as a chronic disease whose only treatment solution is complete, life-long abstinence (Cooper, Franklin & Mease 2010; Fischer 2003; Nolan 2001). The

overall objective of the ODTC is to "promote the goal of abstinence from all illegal drugs with program participants" (Dowden 2007: 9). Nolan (2001: 133) argues that drug treatment court's adoption of the disease model of addiction "fundamentally depart[s] from the justice system's historical position."

The principle of abstinence is reflected in the DTCs' approach to defining successful outcomes. With a few exceptions as noted below, the only acceptable treatment outcome for Canadian DTCs is complete abstinence from drug use (Cooper, Franklin & Mease 2010; Fischer 2003; Nolan 2001). A period of abstinence from all or some substances, the length of which varies by courts, is also required to graduate. For example, complete abstinence for two months is required by the Ottawa and Toronto DTCs, while four months is required by the courts in Winnipeg and Regina. The Edmonton DTC requires a four-month period of abstinence from all substances except cannabis, while the Vancouver court requires three months' abstinence from cocaine, heroine and crystal methamphetamine (Department of Justice Canada 2009). However, literature has shown that very few people maintain long-term abstinence following addiction treatment (O'Brien & McLellan 1996; Sellman 2009). Despite this low rate of success, abstinence remains a central principle in the Canadian DTC system. While the Ottawa DTC policy is not to impose penalties for relapses in drug use, abstinence is nonetheless required for continued participation in the DTC.

Because most DTCs operate on a complete abstinence model, they leave no room for reduced or moderated drug use as an acceptable measurement of progress. While harm reduction may be ostensibly embraced by DTCs, their definitions and practices of harm reduction remain questionable. For example, the Winnipeg DTC "uses a 'harm

reduction' approach that recognizes that participants may relapse at various times in their struggle against addiction" but maintains a focus on abstinence (Gorkoff, Weinrath & Appel 2007). Simply recognizing that relapses are a part of addiction does not qualify as harm reduction and harm reduction practices (i.e., promoting different routes of administration and/or reduced doses) are rarely promoted or used in the DTCs. I will discuss which individuals in the Ottawa DTC engage in harm reduction practices in Chapters 6 and 7. In general, the conception of addiction used in drug treatment courts assumes that abstinence is the only acceptable form of treatment.

Voluntary, Mandatory & Coerced Treatment: Where Do DTCs Fit In?

Treatment programs can be categorized as either voluntary, mandatory or coerced. Voluntary treatment involves the participant making a fully informed decision free of pressure or constraints to enter treatment (Mugford & Weekes 2006). In contrast, in mandatory (also called compulsory) treatment, subjects are forced to participate. Mugford and Weekes define mandatory and compulsory treatment as "the legislated forced confinement (non-criminal) or civil commitment of individuals for assessment or treatment of their substance abuse problems" (2006: 1). A Canadian example of mandatory treatment is the case of *Winnipeg Child and Family Services v. G. (D.F.)* where a young woman addicted to solvents was forced into treatment (Boyd 1997); the Supreme Court later overturned the decision (Capen 1997). Another important example of mandatory treatment in Canadian history is the *Heroin Treatment Act of 1978* which introduced legislation to force people who were addicted to heroin into government-funded treatment against their will (Mugford & Weekes 2006; Roberts & Ogborne 1999). In introducing the bill the Minister of Health, Robert McClelland said it would

"emphasize treatment of the addict as a sick person needing help rather than as a criminal" (quoted in Boyd et al. 1985: 196). The *Act* was ultimately ruled unconstitutional by the Supreme Court of British Columbia in October 1979, a decision upheld by the Supreme Court of Canada (Roberts & Ogborne 1999) following protests from the BC Bar Association and a court challenge by a woman in methadone treatment supported by the BC Civil Liberties Association (ibid; Boyd et al. 1985).

In coerced treatment, participants are technically given the choice to enter treatment or not (Mugford & Weekes 2006). However, in coerced treatment, refusing to participate is not always a viable choice. For example, women with children are often given the choice to either accept treatment or to lose custody of their children (Boyd 1999; Vaillancourt & Keith 2007). Therefore, DTCs are an example of coerced treatment in that potential participants apply to the program from jail; upon being accepted into the program, they are released. Thus, even while the DTC is presented as a choice, there is a very strong incentive to participate. The decision to enter into the DTC, engage in recovery, and transform one's life *for the better* is regarded as one people should opt for. In speaking to a participant in the Ottawa DTC, one judge said, "everyone hopes participants in drug court will make the decision for themselves."

5.3 The Drug Treatment Court Actors

While DTCs take place in a courtroom and many of the same legal actors are present, there are stark differences between DTCs and traditional courts. The Canadian judicial system is based on an adversarial model in which judicial actors represent the interests of various stakeholders: the Crown prosecutor represents the state's interest, defence

counsel advances and protects the interests of the defendant, and the judge is intended to be a neutral arbiter between the two parties. In the traditional judicial system, drug treatment can be ordered through probation orders; however, in using this approach the court remains at arms-length from therapeutic treatment. Treatment providers are only required to report whether the client is participating in and/or attending treatment sessions. The therapeutic assessment of progress and success is left in the hands of the treatment providers.

Drug treatment courts, however, are based on a non-adversarial model (Hora 2002; Nolan 2001). Each DTC has a team of legal actors and a treatment team that remain constant at each court appearance. The court teams in each DTC include judge(s), provincial and federal Crown counsels[16] and duty counsel. The treatment teams consist of treatment counsellors (also called case managers); three of the courts (Toronto, Vancouver and Regina) also include psychologists and nurses who specialize in addiction in their treatment teams (Department of Justice 2009). In the Vancouver and Regina DTCs, probation officers are considered a part of the treatment teams, while in the other DTCs the probations officers are a part of the legal teams (Department of Justice 2009). DTCs change the "traditional roles of lawyers and judges in the judicial process and link them with probation officers, social workers, and other justice system partners to form a treatment team for each individual offender" (Wiener et al. 2010: 417).

[16] The exceptions are Vancouver and Winnipeg DTCs, which do not have a provincial Crown, and the Regina DTC, which does not have a federal Crown.

Duty Counsel/Defence Counsel

As noted above, DTCs do not use the adversarial approach of traditional Canadian courts, and "one of the key procedural aspects where this becomes relevant is the role of the defence counsel" (Fischer 2003: 239). Defence counsel's traditional role is to advance her or his client's interest by minimizing punitive measures imposed by the court, ideally attaining acquittal from criminal charges for the client. DTCs have a regular duty counsel as part of the legal team; additionally, in the case of the ODTC, participants usually retain their own defence lawyers prior to entering the DTC. Once a person is accepted into the court, duty counsel takes over as defence counsel and the lawyer who was initially involved in the case usually only returns if the participant receives a sentence. Unlike in their traditional role of limiting punishment imposed on their clients, as a member of the DTC team the duty counsel encourages participants to achieve a drug- and crime-free life, even if that involves punitive measures as part of the DTC process.

Judges

Within the traditional adversarial system, judges are ostensibly neutral arbiters who do not necessarily interact directly with defendants (Nolan 2001). In a DTC, however, the judge's central role within the courtroom is maintained, but they are also expected to work closely with the treatment and legal teams and oversee participants' treatment programs (Hora 2002; Nolan 2002). Justice Bentley, a judge in the Toronto DTC states that, "The judicial role has been transformed from detached, neutral arbiter to the central figure in a team, which in the drug court context, focuses on the participants' sobriety and accountability" (2004: 14).

However, the DTC's therapeutic practice blurs the roles of treatment provider and judge. Judges "actively preside over and direct the goal-oriented enterprise of the DTC working towards the reformation of the offender" (Fischer 2003: 239). They give therapeutic orders and attempt to engage participants in therapy, despite not having therapeutic qualifications or training. Hora discusses the transformation of the role of judges in drug treatment courts: "The role of judges as neutral arbiters has been redefined, as they are now leaders of a treatment team" (2011: 52). In other words, judges in the DTC act as therapists (Nolan 2002) and problem-solvers (Hora 2002). For example, participants in the DTC are referred to as *clients*, and judges provide specific therapeutic directives, such as instructing participants to attend 12-step meetings. It has been noted that the relationship between judges and participants in the DTC is "similar to a therapeutic alliance" and is more successful if there is a good rapport (Bourgon & Price 2007: 35). The judges refer to participants on a first name basis as a method of developing rapport. During the opening weeks of the Ottawa DTC, *clients* were addressed by a salutation and their last name (i.e., Ms. ___) when they were called before the judge and when the judge spoke to them. While addressing a client, one of the judges discussed the change in approach to addressing people by their first names in the first weeks of the court's operation:

> It was suggested to me in a meeting on Monday that since we are going to be seeing each other often that it might be beneficial for judges to refer to people by their first name. I'm a bit uncomfortable with doing so and have never done so before...I may make mistakes because old habits die hard.

Treatment Providers

Treatment providers play a central role in the courtroom and are more visible and present than defence lawyers (Nolan 2001); in fact, they sit at tables designated for lawyers in the courtroom. They present treatment reports to the court and make comments on individual participants' progress in the DTC program and in treatment sessions. Treatment counsellors in the DTC are given powers of enforcement and judgment, recommending criminal sanctions for participants who do not follow treatment. Some DTC actors who have identified issues with the blurring of roles and responsibilities point out that "the relationship between court and treatment teams [are] 'not well-defined,' 'lacking effective collaboration,' and 'not consultative'" (Department of Justice 2009: 35). Treatment teams have indicated that they believe that "their professional judgment is not properly considered" (ibid.).

In Chapters 7 and 8, I discuss at length the role of treatment in the ODTC as well as the role of treatment providers in the court. At this point, however, I would like to note that the treatment counsellors in the Ottawa DTC are not registered psychologists (Dowden 2007). I argue that this is one of the ways in which professional standards, such as confidentiality between therapists and clients, are effectively bypassed in the Ottawa DTC. Therefore it is important to consider the training of the treatment counsellors as well as the treatment practices deployed by them in that they are non-negotiable and factor heavily into one's experience of the ODTC. Limited information is available on the qualifications of Rideauwood employees and its treatment providers in the ODTC; however, one key evaluation was conducted by Dowden (ibid.) and is discussed at length in Chapter 8.

5.4 The Drug Treatment Court Process

In the Ottawa DTC (ODTC), participants are required to attend court on Tuesday and Thursday afternoons, as well as attending regular treatment sessions. These sessions include individual counselling, group counselling carried out by Rideauwood Addiction and Family Services counsellors, and attendance at workshops where participants learn about health and nutrition and recreational activities with other participants and Rideauwood counsellors. Participants must also give samples of their urine for testing on demand and abide by a long list of bail conditions.

Entering the DTC Process

In order to be eligible to enter the Ottawa DTC, participants must have been charged with a criminal offence and must demonstrate that they have an addiction that leads to criminal activity. Violent offences and major trafficking charges disqualify people from entering DTCs (Department of Justice 2009; Dowden 2007), which means that most of the DTC participants have been charged with minor possession or breach of bail or probation conditions. This means that participants may serve more time incarcerated or under probation orders in DTCs than they would have under their original sentence. In an interview with Rebecca, a participant in the ODTC, she said "So after all the time I did. I did like three times the amount of time."

Once the Crown approves an applicant to the DTC program, a member of the treatment team conducts an interview while the applicant is in custody. This interview assesses whether the applicant has an addiction, her or his level of needs and risks, and suitability in terms of motivation and willingness to engage in treatment. Even when all legal criteria are met, if the applicant is found to lack the motivation necessary to abstain

from drugs or to engage in treatment, he or she is disqualified from the program. The DTC team discusses potential applicants in pre-court meetings and a judge makes the final decision in court. Once approved by the judge for admission into the DTC, applicants appear before the judge and are required to plead guilty to their current charges, as well as to any other outstanding charges (Bentley 2000). As stated in the Ottawa DTC waiver, a participant must be "prepared to give up my rights to plead 'not guilty' and to have a trial. I am willing to give up these rights in order to try and benefit from the ODTC Program" (Ottawa Drug Treatment Court n.d.a: 4). Fischer (2003) argues that the requirement to plead guilty contravenes an individual's legal rights, including the right to due process. In addition, each applicant must agree to a series of bail conditions and submit to an intensive treatment program before the judge formally approves the application and admits him or her into the DTC.

After entering a guilty plea, Ottawa DTC participants are given 30 days to decide whether they want to continue in the DTC. During this time, they can withdraw from the program and have their guilty plea struck from the record. The DTC team is also given the opportunity to determine if the person is not a suitable fit for the program and remove them from the DTC during this 30-day trial, in which case the applicant's guilty plea is also struck form the record. While duty counsel or defence counsel can make a case against removal of the applicant before the DTC judge, there is no formal appeal process to challenge the judge's decision. Below is an example of an exchange between a judge and an applicant ready to enter the Ottawa DTC:

> **Judge**: I understand you are interested in coming into the drug treatment court program, that you want to tackle this drug addiction you have. Is this correct?
>
> **Lenora**: Yes.

Judge: Are you willing to work hard?

Lenora: Yes.

[The judge emphasizes that the expectation of the court is for Lenora to stop using drugs and alcohol, but if she does use she needs to be honest with the treatment providers and the court.]

Judge: Are you willing to agree to that?

Lenora: Yes.

Confidentiality Issues

Participants in the ODTC are required to sign release of confidentiality forms upon entry into the program. As a result, their individual and group treatments are discussed in both pre-court meetings with the entire DTC team and in open court to which the public has complete access. This lack of confidentiality raises concerns about the right to confidentiality between participants and therapists. For instance, *The Ottawa Drug Treatment Court Consent and Waiver* instructs participants that "any statements made during the counseling sessions may be reported to the Court, which monitors my progress in the Program" (Ottawa Drug Treatment Court n.d.a: 6). The Drug Treatment Court Funding Program's summative evaluation of the six federally funded DTCs found that "some treatment team members perceive the court team as wanting more information than they would share at case management meetings" (Department of Justice 2009: 36).

Sanctions and Rewards

DTCs, including the Ottawa DTC, function on a system of sanctions and rewards designed to help people stay engaged in their treatment process. Thus, individuals doing well in the program (attending treatment groups and court, slowing down or stopping

drug use, actively engaging in their treatment process) can be rewarded through being required to appear in court less frequently, or receiving bus passes and coupons for coffee (Rideauwood Addiction and Family Services 2009). Likewise, those who fail to engage in their treatment, continue to use drugs, and/or fail to attend treatment face a range of sanctions including increased court appearances, community service hours, stricter bail conditions and/or therapeutic remands to jail or to treatment centres. These sanctions and rewards are techniques used by the court to urge participants to improve themselves and their lives to fulfill DTCs' "aim to transform drug-using criminal offenders into drug-abstinent, non-criminal citizens" (Mackinem & Higgins 2007: 243). I will discuss these aims at length in Chapter 7.

Pre-Court Meetings

An important and unique feature of DTCs is the closed pre-court meeting held before every bi-weekly court session. Judges, treatment liaisons, duty counsel, and Crown counsels attend every meeting, with treatment counsellors and defence lawyers sometimes in attendance. During pre-court meetings the ODTC team members discuss new applicants and current clients, and make decisions about who should receive sanctions or rewards during that day's court appearances (Bourgon & Price 2007; Rideauwood Addiction and Family Services 2009). Unlike the traditional judicial process where defendants are present at all judicial hearings, DTC participants are not allowed to attend pre-court meetings. One participant described the pre-court meetings as follows: "They have two courts, one with us there, one without us."

A crucial aspect of pre-court meetings are *progress reports*, written reports provided by treatment counsellors on each participant to be reviewed. According to the second evaluation of the ODTC:

> These reports track participants' overall progress in treatment and overall compliance in the time intervening the last court session and the current, and form the basis of discussion and decision-making regarding how each participant will be dealt with in court (Rideauwood Addiction and Family Services 2009: 16).

Treatment progress reports are used to determine whether participants warrant sanctions for failing to progress appropriately or rewards for progressing in recovery in acceptable ways (i.e., total abstinence). An example of a positive progress report by the treatment liaison is:

> He's had three contacts since the last court date. Tyler remains very positive, reliable and supportive of others. He continues to demonstrate good insight in his therapy. He's changing attitudes and behaviours.

Reporting Drug Use and High-Risk Situations

At the beginning of every participant's court appearance, the judge asks whether he or she has used drugs or alcohol and whether they have been in any high-risk situations. Below is an example of a typical exchange in which the participant does not report drug use or specific high-risk situations:

> **Judge**: Do you have any drug or alcohol use to report?
>
> **Sam**: No.
>
> **Judge**: Any high-risk situations?
>
> **Sam**: They're all over the place.
>
> **Judge**: Nothing out of the ordinary?
>
> **Sam**: No.
>
> [The Judge asks for the treatment report.]

> **Treatment liaison**: Sam's had a lot of contact with treatment...Very pleased to hear he's alcohol and drug-free. There was a missed urine test but he was in detox so we don't consider it missed...He's meeting with his case manager after court about some residency issues.
>
> [Applause by participants and ODTC team members sitting in the courtroom.]

Honesty in reporting drug use and high-risk situations to the ODTC is central to the program's functioning. When participants are admitted to the ODTC, the judge emphasizes the importance of honesty and explains that random urine tests are used to reveal any dishonesty. In speaking to new participants, a judge gave the following speech:

> You understand there'll be a lot of conditions you'll be expected to comply with. You'll be in the program 12 months or more to graduate...I want to reiterate that although the expectation is that you'll stop using drugs—that's the main objective of the program—we expect that you'll stop using today, but if you do slip up you have to be honest with treatment and the court.

If a participant is dishonest in reporting alcohol or drug use to the court, they are punished and verbally reprimanded. And although under official ODTC policy, sanctions are not imposed on participants for using drugs, some participants felt that they were punished for drug use. For example, when discussing this policy, a participant told me "Yeah right, they find ways to get around that and still sanction you." The reasons for which participants were sometimes dishonest about substance use with the ODTC are complex and include confusion about changing ODTC policies, inconsistent application of sanctions by the court, and decisions to keep their housing and/or employment. I will examine these complexities further in later chapters.

Exiting the DTC Process

There are four ways in which a participant may leave the Ottawa DTC after the initial 30-day grace period: (1) they are removed from the program and sent back to regular court for sentencing; (2) they quit and are sentenced; (3) they graduate; or (4) they flee (Rideauwood Addiction and Family Services 2008). In order to graduate from the program participants must have:

- a period of six months free from new criminal charges
- at least three months of compliance (i.e., attending all appointments, urinalysis, and abiding by treatment and the court's orders)
- have stable housing for at least two months
- be engaged with school, work or volunteering for at least two months
- abstinence from all substances for at least three to six months depending on the level of graduation

(Rideauwood Addiction and Family Service 2008).

There are three levels of graduation in the Ottawa DTC; however, the graduation criteria changed often during my fieldwork, and these levels are not mentioned in the ODTC's 2009 outcome evaluation. The three levels of graduation are outlined in the *Ottawa Drug Treatment Court Program: Case Management Practice Guidelines* (Rideauwood Addiction and Family Service 2008: 24) and the Department of Justice Summative Evaluation (2009: 79). However, discrepancies exist within the criteria, which indicate a degree of flexibility. This raises ethical questions over changes to the graduation criteria after a participant has consented to enter the ODTC based on prior established graduation criteria. In the table below, I outline the graduation requirements for the Ottawa DTC, highlighting the discrepancies between the Rideauwood and the Department of Justice summative evaluations.

Table 5.2: Discrepancies in the Ottawa DTC Graduation Criteria

Level	Minimum Required Time in ODTC	Length of Consecutive Abstinence Required	Sentence
1	12 months according to Department of Justice Report; 9 months according to Rideauwood report.	6 months	1 day of probation maximum
2	12 months according to Department of Justice Report; 9 months according to Rideauwood report.	3 months	12 months of probation maximum
3	16 months (both reports have same information for Level 3 on this criteria)	3 months according to Rideauwood report; no mention in Department of Justice report.	18 months probation maximum (according to Rideauwood report)

5.5 Conclusion: Questioning the Effectiveness of Drug Treatment Courts

While this research does not set out to evaluate the Ottawa DTC's effectiveness, it is important to consider the available evaluations of Canadian DTCs to contextualize the research project. The United Nations Office on Drugs and Crime proclaims "Drug Treatment Courts Work!" (UNODC 2005). On the other hand, assessments of the effectiveness and appropriateness of these specialized courts offer mixed results. The following section addresses the claims that DTCs are successful at reducing drug use and drug-related crime, and that DTCs are cost-effective endeavours. Graduation rates reported in the DTC evaluations are reviewed and close attention is paid to the particular data related to women and Aboriginal peoples. I also argue here that the quality of science in DTC research varies and that the majority of studies contain serious

methodological flaws which work to further challenge claims that DTCs are cost-effective, appropriate and successful.

Low Graduation Rates

In general, DTCs in Canada have low graduation rates. The latest Department of Justice summative evaluation found that DTC graduation rates range from 6% (Toronto) to 36% (Winnipeg). Ottawa and Regina DTCs have a graduation rate of 11% (Department of Justice 2009). From the Ottawa DTC's inception in 2006 to the 2009 evaluation, 106 participants entered the court and only 8 participants have graduated (Rideauwood Addiction and Family Services 2009). Whether any of these graduates were women has not been disclosed (Rideauwood Addiction and Family Services 2009). In the Vancouver DTC, from 2001-2005, a total of 322 individuals were admitted with only 34 having graduated, a rate of 10.6% (Millson et al. 2005). Of those who did not graduate, 13.7% withdrew of their own accord and were sentenced, and 43.8 % were removed from the program at the request of the Crown and/or the treatment team and transferred to sentencing (Millson et al. 2005). In the Toronto DTC, between 1999-2003, 15.6% of participants graduated from the program (Gliksman et al. 2004), while only 3 individuals graduated between April 2007 and September 2008 (Department of Justice 2009). Of the total of 365 individuals admitted to the Toronto DTC until 2004, 308 participants (84%) were expelled with close to half (46.8%) of expulsions occurring in the first two months of participation (Gliksman et al. 2004: 84). Only 6 of 31 participants made it to the six month mark in the first year of the Ottawa DTC (Dowden 2007).

Women are less likely to apply to DTCs, are less likely to be accepted by the court, and if they do apply and are accepted, are much less likely than men to graduate

from the program (Department of Justice 2009; Gliksman et al. 2004; Gutierrez & Bourgon 2009). Women make up 42% of participants admitted into the Vancouver DTC, 24% of those admitted to the Toronto DTC, 23% of those admitted in the Ottawa DTC, and 36% of those admitted in the Winnipeg DTC (Department of Justice 2009; Gliksman et al. 2004; Millson et al. 2005). In the Toronto DTC women are less likely than men to attend their first court appearance after their clinical assessment (Gliksman et al. 2004). In Vancouver, women completed fewer total treatment hours and were less likely to complete the initial assessment (Millson et al. 2005). In Edmonton, women were more likely to graduate than in other DTCs; however, women were also more likely to withdraw in less than 28 days (Department of Justice 2009). The Ottawa DTC outcome and process evaluations do not currently break down figures based on gender.

Some DTCs are currently working to increase the number of women participants and graduates. The Toronto DTC has sought to address its difficulties in attracting and retaining women by forming a Women and Children's Sub-Committee of its Community Advisory Committee, leading the Toronto DTC to offer programming specifically for women. However, many of these DTCs "struggle with being able to provide this type of support due to limited staff" (Department of Justice Canada 2009: iii). Thus far, no evaluations of the very few gender-sensitive or culturally appropriate programs have been conducted to determine their effectiveness.

These low rates of enrolment and graduation among women participants undoubtedly require addressing. In the Winnipeg DTC, Gorkoff, Weinrath, and Appel found that graduation standards are biased against participants who are marginalized. They state:

> The phase completion standards are better suited to those who are less

> marginalized and have more privileged backgrounds and family support. There is a concern that the court's standards for achievement and graduation may be biased toward better advantaged clients who are of the majority (i.e. white, socio-economically advantaged, male) (2007: 50-1).

Evidence of these findings is reflected in Aboriginal rates of graduation. For example, Aboriginal participants are less likely to succeed in the Regina DTC, despite Aboriginal people comprising 67% of participants in the Regina court. In Winnipeg, Aboriginal participants are also less likely to graduate and "being Caucasian was strongly associated with graduation" (Department of Justice 2009: 49).[17] Aboriginal women and men, individuals living in poverty, and street-involved drug users are already overrepresented in Canadian jails and prisons. For example, Aboriginal people make up only approximately 4% of Canada's population, yet "Aboriginal women make up 45% of the overall prison population and are estimated to account for 90-99% of the population in some provincial jails in Canada" (Canadian Association of Elizabeth Fry Societies n.d.). Given these figures, the current DTC model may be exacerbating the inequalities already inherent in the criminal and justice systems. These trends are also reflected south of the border. In examining American DTCs, O'Hear argues that because research has demonstrated that participants in DTCs who are white are more likely to be successful than participants who are black, "DTCs are apt to exacerbate, not ameliorate, overall racial disparities" (2009: 477).

Cost-Effectiveness and Recidivism

The claim that DTCs cost less than the regular court system is based on the assumption that DTCs reduce drug use and recidivism. However, existing evaluations in Canada and

[17] Ottawa and Toronto DTCs do not collect data pertaining to Aboriginal ancestry. In Toronto the two categories are "Caucasian" or "Other" (Department of Justice 2009).

the United States do not demonstrate that DTCs decrease rates of recidivism over the long term (Anderson 2001; Department of Justice 2009; Fischer 2003). Despite there being over 2100 drug courts in the United States, there has not been a reduction in recidivism amongst participants (Drug Policy Alliance 2001).

However, notwithstanding this lack of evidence, DTC proponents often argue that DTCs are successful at curbing recidivism. For example, despite the fact that only some DTCs provide data on rates of recidivism (Department of Justice 2009: v), the Department of Justice summative report on Canadian DTCs claims that "most key informants, survey respondents, and case study participants believe the program is reducing recidivism." This is a prime example of how beliefs and assumptions, rather than evidence and data, are used to support the continued existence of drug treatment courts. The evaluation of the Winnipeg DTC includes data on recidivism and short follow-up data but notes that "detail in documenting recidivism [was] lacking," and that data on recidivism was "highly preliminary" (Gorkoff, Weinrath & Appel 2007: 6, 8). Furthermore, the process and outcome evaluations of the DTCs that do include information on recidivism do not include any kind of longitudinal data (data on recidivism once participants leave the DTCs).

Evaluations often compare the costs of one year in the DTC to one year of incarceration. However, this is a problematic comparison because most DTC participants would serve a much shorter sentence than one year if they were convicted in court (Department of Justice 2009; Fischer 2003). Furthermore, low program completion significantly elevates the overall cost to treat a single individual. For example, it cost $4,058,819 to operate the Vancouver Drug Treatment Court for approximately 5 years.

During this time only 42 people graduated, with a cost per graduate of $96,639 (Werb et al. 2007). As the Department of Justice summative evaluation concludes:

> Assuming a DTC participant graduates from the program and does not reoffend, the costs of the DTC are 70 percent lower compared to two years of incarceration. However, if an offender is sentenced to one year of probation, the cost of DTC is 365 percent higher than the traditional system (2009: vi).

Given that the vast majority of participants do not graduate from DTCs, and that there is no data on whether those who do graduate re-offend and at which rate, it is not possible to conclude that DTCs are more cost-effective than the traditional justice system.

Furthermore, graduation rates do not support claims that DTCs are effective in their aim of producing non-criminal, non-drug using citizens, particularly regarding marginalized communities and women. However, there are financial benefits accrued by the non-legal professions associated with DTCs: "The economic payoffs are staggering for those who are successful in diverting federal funds earmarked for the criminal justice system to drug court treatment personnel" (Chriss 2002: 197). The data from the Ottawa DTC supports this argument. The treatment provider agencies receive funding for their role in the court, while this type of funding is otherwise very difficult to obtain. These benefits make it very profitable for the continuation of DTCs for treatment professions, calling into question their capacity to offer honest assessments of DTC program success.

Research Quality of Evaluations

The quality of science in DTC research varies, with the majority of studies produced suffering from serious methodological flaws. In the case of Canadian DTCs, the evaluations are conducted by those parties who profit from the program, which raises concern about possible bias in the evaluations. The ODTC staff, like staff in other DTCs,

"produce the client and organizational outcomes that become measures of their agencies" (Mackinem & Higgins 2007: 245). For example, the Toronto and Ottawa DTC evaluations are conducted by treatment providers who run the treatment programs, and who therefore have a vested interest in the reporting of positive outcomes.

The majority of evaluations are methodologically problematic because: (1) appropriate comparison groups are often not used, if at all; (2) the studies do not account for people who drop out of DTCs; and (3) long-term data is absent (Belenko 2002; Fischer 2003; Gutierrez & Bourgon 2009; Miethe, Lu & Reese 2000; Stevens et al. 2005). Furthermore, the Department of Justice summative evaluation is itself based upon the flawed evaluations of Canadian drug treatment courts, produced by the DTCs themselves, along with key informant interviews, a survey of stakeholders, and case studies of people participating in DTCs (Department of Justice 2009). The summative evaluation does not explain how key informants, stakeholders or case studies were sampled, and as the quote above demonstrates, key informant and stakeholders' opinions and beliefs are often taken as evidence of the program's success.

Inadequate Comparison and Control Groups

DTC evaluations often use a quasi-experimental research design, which does not randomly assign participants to control groups (Anderson 2001; Gutierrez & Bourgon 2009; Belenko 2002; Fischer 2003; Weekes et al. 2007). In the Toronto DTC evaluation, the comparison group was composed of people who had applied to the DTC and were deemed eligible but did not end up enrolled in the Toronto DTC (Anderson 2001; La Prairie et al. 2002). The control group has been judged inappropriate because it was mismatched with the treatment group:

> Some of the preliminary Toronto findings reveal that the Experimental and Comparison groups are poorly matched along a number of demographic, drug use, and criminal history variables, and the comparison group members are at greater risk for re-offending. The program attracts more males than females, and many more Black than Aboriginal clients, although Caucasians comprise the largest single group (La Prairie et al. 2002: 1589).

The comparison group used in the Vancouver DTC evaluation was also inappropriate in its demographic makeup, with more men, more Caucasian people and older people than in the experimental group comprised of DTC participants (Werb et al. 2007). The proper matching of treatment and control groups is a vital aspect of any appropriate research design since mismatching, as evidenced in the Toronto and Vancouver DTC evaluations, results in selection bias and inaccurate data (Fischer 2003). Researchers have indicated that "the process of random assignment is essential in creating a control group that can be fairly compared with a treatment group. Without the use of random assignment, there is a chance that the results are reflective of individual differences and not of the effectiveness of the program" (Gorkoff, Weinrath & Appel 2007: xv). Furthermore, self-selection of participants to DTCs results in a selection bias since participants in the DTC group may be more motivated to engage with DTC programming than those in comparison groups (Belenko 2002; Fischer 2003; Gutierrez & Bourgon 2009; Werb et al. 2007). This may result in biased findings that overestimate the effectiveness of DTCs compared to control programs, as DTC participants may be more likely to engage with drug treatment compared with participants in the control program. Such a scenario would therefore falsely attribute participant-specific outcomes (i.e., improved retention in treatment) to enrolment in a DTC program. While the bias resulting from the lack of appropriate comparison groups can be addressed by a research design that uses random sampling techniques, the Canadian DTC evaluations have not employed these sampling designs

(Fischer 2003).

In DTC evaluative reports, comparisons are often made between DTC participants and other populations in the criminal system. For example, the Winnipeg DTC evaluation compares DTC participants to people who are on conditional sentence and those on provincial probation in Manitoba (Gorkoff & Weinrath 2009). A more appropriate comparison would be between DTC program cohorts and cohorts in voluntary treatment programs to determine whether the element of coercion embedded in the DTC system makes it more effective (Anderson 2001).

The Toronto DTC evaluators took such an approach, including a treatment comparison group. The treatment comparison group consisted of individuals in the Centre for Addiction and Mental Health cocaine program who did not participate in the Toronto DTC program. The goal was to have 200 individuals as part of the comparison group; however, in the end, only 26 individuals (23 men and 3 women) constituted the group. The treatment comparison group was deemed inappropriate for comparison to the group of individuals participating in the DTC because of this low number and because of significant differences in age, housing, employment and history of criminal involvement (Gliksman et al. 2004).

Low Rates of Retention

Low rates of retention and high rates of attrition affect the validity of the DTC evaluations (Belenko 2002; Gutierrez & Bourgon 2009; Weekes et al. 2007). For example, in 2006 only 6 out of 31 participants, or 19%, made it to the six-month mark in the Ottawa DTC (Rideauwood Addiction and Family Services 2009). Of the 365 people admitted to the Toronto DTC from 1998 to 2004, 308 people (84%) were expelled, with

close to half (46.8%) of expulsions occurring within the first two months (Gliksman et al. 2004). With such low rates of retention it is difficult not only to claim that DTCs are effective, but even to claim that the evaluations are valid and reliable. Further, while in some cases indicators of recidivism and drug use during program participation demonstrate effectiveness among individuals who subsequently graduate from DTCs, the small number of DTC graduates—which remains consistently low across the DTC evaluations—strongly suggests that these programs are limited in their level of effectiveness across drug-dependent subpopulations.

Lack of Long Term Impact Assessment

Claims that DTCs are effective and appropriate abound. Yet these claims are undermined by the failure to examine the long term impacts of DTCs. While many DTC evaluations have been undertaken, there is a serious dearth of data regarding follow-up outcomes (Belenko 2002). Indeed, while many DTC evaluations assess outcomes for drug use, recidivism, and other drug-related outcomes during DTC participation, few DTC evaluations in Canada include post-program data on these indicators of effectiveness. The Toronto DTC evaluation notes that "while in the short term there may appear to be positive outcomes, the true test of drug court programs may be whether clients are able to sustain the changes made while in the program for an extended period of time" (Gliksman et al. 2004: 32). Assessing the long-term effectiveness of DTC programs in this context is absolutely necessary.

The Toronto DTC evaluation did include post-program data on recidivism, which demonstrated a similar drop in levels of recidivism among both DTC clients and participants in the judicial comparison group. However, indicators of post-program drug

use were not assessed, which seriously hampers an assessment of the effectiveness of this program in addressing a primary aim of inculcating long-term abstinence in participants.

Inconclusive Evaluations

Given that current evaluations of the Canadian drug treatment programs emerge from unreliable data, it is impossible to conclude at this stage that DTCs result in decreasing drug use and/or recidivism (Drug Policy Alliance 2011; Gutierrez & Bourgon 2009; Stevens et al. 2005). In assessing the quality of DTC evaluations Gutierrez and Bourgon concluded that:

> study quality and treatment quality greatly influenced the results of the drug court evaluations. Issues surrounding quasi-experimental study designs, comparison groups, management of high attrition rates, as well as inadequate searches and controls for group differences are methodological problems that often bias evaluations in favour of treatment (2009: 12).

The available evaluations of Canadian DTCs thus do not allow us to conclude that they are superior to other forms of interventions (such as voluntary treatment) or that DTCs are more cost-effective than standard judicial interventions. Furthermore, the Canadian evaluations do not address questions of how DTCs fit into larger policy questions such as whether offering health services outside of the judicial system would be more effective and whether DTCs are better than other current options, including probation and conditional sentencing.

In the following chapter, I turn to an analysis of the discourses of addiction in the Ottawa DTC. I engage with the concept of addiction-as-disease, outlining both its historical emergence as well as its deployment within the ODTC. I then discuss the implications of such a model as well as how the ODTC constructs and furthers a particular understanding of the *addicted subject.*

Chapter 6: Discourses of Addiction in the Ottawa Drug Treatment Court

6.1 Introduction

This chapter outlines the discourse of addiction that is produced and reproduced in the Ottawa Drug Treatment Court and addresses some of the key implications of the ODTC's approach to addiction. I begin by defining the disease model of addiction and outlining the historical considerations of the emergence of this concept, as well as its articulations in contemporary brain science. Here I also provide a brief overview of how the ODTC currently makes use of the disease model of addiction. I then turn to a discussion of the ramifications of the ODTC's use of the addiction-as-disease discourse. Specifically, I outline how beliefs and policies about abstinence, relapse, and drug use as a *choice* reveal a deep contradiction at the heart of the ODTC's approach to addiction. I also address the implications of the ODTC's approach to drugs as inherently dangerous and addictive as well as the deployment of a clean/dirty binary within its treatment strategy. I then discuss how the ODTC constructs and maintains an understanding of the *addicted subject* by outlining what I deem to be its four key characteristics: universality, treatability, criminality and dishonesty.

6.2 The Disease Model Approach to Addiction

The disease model of addiction assumes that: (1) addiction is life-long and permanent, with individuals either being addicted or not (Hammersley & Reid 2002); (2) that addiction is chronic and progressive, meaning that it will get worse unless one undergoes treatment and engages in abstinence (Brown & Stewart 2007; Peele, Bufe & Bodsky 2000); and (3) that the disease of addiction resides within individuals (Boshears, Boeri & Harbry 2011; Graham et al. 2008; Levine 1978). This conception of addiction as a

chronic, progressive, life-long disease is central to the Ottawa DTC and other DTCs (Mackinem & Higgins 2007; Miller 2009; Nolan 2001; Reinarman 2000) and figures prominently in popular culture (Peele 1989), films (Boyd 2008), television (e.g. A&E's popular series *Intervention*), media, drug prevention policies—including the government of Canada's Drugs not4me Drug Prevention Campaign (Government of Canada, n.d.)—as well as academic research into addiction (Kalant 2008; Kuhar 2010; Larkin, Wood & Griffiths 2006; McLellan 2000; Wong et al. 2011).

It is important to clarify that the disease model of addiction does not necessarily hold that drug users have a medical condition. The assumption that drug-dependent individuals have a medical illness goes beyond the disease model and is often an unexamined assumption that pervades popular culture and research on addiction. Assuming that drug-dependent individuals have a medical condition does not necessitate a particular treatment, unlike the disease model of addiction which requires life-long abstinence. In other words, one could oppose the analytics of the disease model of addiction while still maintaining that drug-dependent individuals are afflicted by a medical illness.

A Brief History

Early conceptions of addictive behaviours were constituted as moral failings and diseases of the will (Valverde 1998). While historically there have been those who contended that addiction should be classified as a medical issue, the shift towards the disease model does not have a clearly attributable starting point. Some argue that the concept of alcohol addiction originated early in the 17th Century (Warner 1994), while others point to Benjamin Rush, an 18th century American as the first "physician to propose that the

chronically intemperate were diseased and should be medically treated" (White 1998: 21). Others situate the shift from understanding alcoholism as a moral failing to understanding alcoholism as a medical issue as beginning at the start of the 19th Century (Levine 1978; May 2001). Levine argues that a shift during this time "defined addiction as a central problem in drug use and diagnosed it as a disease" (1978: 143). He argues that prior to this shift, people did not use alcohol "because they 'had' to" but "because they wanted to" (Levine 1978: 144). Berridge and Edward (1981) also locate the emergence of the disease model in 19th Century Britain alongside the medicalization of addiction and treatment. They state:

> The nineteenth century was a period during which the basis was laid for a disease theory of addiction. The social consequences were seen in the addict being defined as patient, the design of treatment methods and treatment facilities which would now deal with this illness, and the medical specialists who had the continuing right to define the realities (Berridge & Edwards 1981: 242).

Many point to Jellinek's (1962) disease model of alcoholism as key in establishing of the notion of addiction-as-disease within psychological and medical professions in North America. Room argues that early conceptions of alcoholism as a disease intended to "remove the responsibility from the drinker, on the promise that a disease formulation would replace a moral framing" (2000: 147). Beginning in the 20th century, the construction of addiction-as-disease called for specific social and political responses. For example, Dyck argues that "acknowledging alcoholism as a medical disorder rather than a moral failing facilitated the expansion of state-funded treatment centres, identifying the condition as a primarily political dilemma" (2006: 314). Thus the construction of addiction-as-disease has complicated roots in the historical constructions

of alcohol and alcoholism, with a variety of responses to manage what were perceived to be addictive substances and behaviours.

However, there still remains no clear distinction between disease model understandings of addiction and moralistic understandings. Stigma and morality continue to be deeply embedded in understandings of addiction-as-disease (May 2001). As I outline below, the discourse and practice of the ODTC constructs addiction not only as a disease residing in the individual, thereby erasing social factors, but also by placing the responsibility for treatment solely on the shoulders of participants.

Addiction as a Psychiatric Disorder

Addiction has been listed in the Diagnostic and Statistical Manual of Mental Disorders (DSM) as a psychiatric disorder since 1968 (Foddy 2010). The clinical term for addiction in this highly influential diagnostic tool produced by the American Psychiatric Association is currently *substance dependence,* which is characterized by tolerance, withdrawal and compulsion. Lart argues that the 1970s saw the concept of addiction re-emerge as an individual disease, but unlike earlier times and constructions of addiction, this conception was "psychiatrised" (1998: 55). In this sense, the DSM-IV moves away from physical symptoms to diagnosis and relies on "subjective feelings of compulsion" (Keane 2004: 192). It was not until the 1990s that addiction became understood to be more of a biological or brain disease, as I discuss in the next section (Foddy 2010). However addiction is still construed as a "psychiatric disorder" (Wong et al. 2011). Furthermore, addiction is not defined only in terms of consumption of substances; rather, a proliferation of behavioural addictions have been identified, such as gambling, food or video game addiction, which has worked to broaden definitions of addiction (Bancroft

2009; Keane 2004; Rapping 1996; Reith 2004; Vrecko 2010). Currently, the DSM-V is revamping and expanding the category of addictions with gambling and tobacco use disorder, for example, being considered for official addiction classification (American Psychiatric Association, n.d.; Potenza 2011).[18]

Addiction as a Brain Disease

The current dominant conception of addiction in North American is that of a chronic psychiatric and physical disease of the brain (Anderson, Swan & Lane 2010; Detar 2011; The Lancet 2011). The idea that addiction resides in the brain and is a chronic, relapsing *brain* disorder became solidified in the 1990s in the US (Foddy 2010) within the context of the War on Drugs. Within the influential US-based National Institute on Drug Abuse's tremendous amount of research and funding lies the central assumption that addiction is a disease, in particular a brain disease. In their publication "Drugs, Brain, and Behavior: The Science of Addiction," they state that

> Addiction is defined as a *chronic, relapsing brain disease* that is characterized by compulsive drug seeking and use, despite harmful consequences. It is considered a brain disease because drugs change the brain—they change its structure and how it works. These brain changes can be long lasting, and can lead to the harmful behaviors seen in people who abuse drugs (National Institute on Drug Abuse 2008: 5).

Foddy (2010) argues that there is no evidence to support the claim that addiction is a brain disease; nonetheless, the National Institute of Drug Abuse (NIDA) and the World Health Organization, supported by neuroscientists, (cf. Volkow et al. 2011) claim that addiction is a brain disease (see also Courtwright 2010). NIDA's stance is that "addiction is a brain disease because addicts exhibit a behavioral disorder that can be

[18] The DSM is currently being revised to produce the DSM-V scheduled for release in May 2013, and the term *substance dependence* is being removed in order to broaden the diagnoses of addictions. www.dsm5.org/ProposedRevisions/Pages/Substance-RelatedDisorders.aspx

linked to observable pathological changes in their brains" (Courtwright 2010: 137-8). Kushner (2010) argues that conceiving of addiction as a brain disease was propagated by NIDA, particularly Alan Leshner (NIDA director, 1994-2001). From a poststructural and foucauldian perspective, the establishment of addiction as brain disease as truth raises important questions of who benefits from this construction.

A consequence of this conception of addiction as residing in the brain is the power given to neuroscience in drug research (Campbell 2007; Keane 2004).[19] "New therapeutic strategies" emerged in conjunction with a growing understanding of addiction as rooted in neurobiology, including the development of pharmaceutical medications "targeting the brain's 'reward' system" (Vrecko 2010: 42). For example, Vrecko argues that these "brain-targeting anti-craving medications make it possible to *act* upon oneself as such a subject" (2010: 43). Bourgois (2000) argues that methadone maintenance treatment acts in a similar way, blocking pleasure by interfering with mechanisms in the brain.

This research and the effort to disseminate it have produced certain truths: drug addiction and use result in permanent negative changes in the brain (NIDA presented this as a fact in the above quote), and drugs take over users' brains (Acker 2010; Campbell 2007). For example, Volkow et al. write that "Addiction coopts the brain's neural circuits" (2011: 599). Potenza et al. also provide a recent example of current understandings of addiction as a brain disease, requiring abstinence, but treatable with pharmaceutical interventions that act on neural circuits:

> The development of neuroscience methodologies for assessing brain structure and function provides an exciting opportunity for applying these tools to understand and improve treatments. Additional research efforts should define

[19] The political contexts of the 1990s and the involvement of neuroscience did not invent the idea of addiction as a chronic, relapsing disease/disorder; however, the idea of addiction being a chronic, relapsing *brain* disease was established during this time.

> novel targets for treatment (e.g. cognitive function, control of craving, impulsivity, compulsivity, and/or self-control) (2011: 705).

Campbell (2007) warns that this conception of addiction precludes consideration of other parts of the body, apart from the brain, when examining addiction and drug use, as well as ignoring the role that social factors play in substance use. She also argues that despite claims that this conception of addiction reduces stigma towards drug users, "a neuroscience of difference is likely to simply become a way to render social and economic distinctions scientific" (Campbell 2007: 207). Hammersley and Reid argue that a central assumption of the disease model is that "things that have powerful effects on people must be caused by clear changes in their brains" (2002: 24). Like Campbell, they argue that this approach undermines social factors involved in substance use. Similarly Graham et al. (2008) argue that conceiving of addiction as an individual brain disease obscures gender.

It is important to note that addiction, addictive behaviours and addicted subjects are socially constructed and that these concepts emerge from specific sociopolitical contexts and power relations. In other words "addiction is a contested state" (May 2001: 386). Severns (2004: 149) argues that not only are the concepts of *drugs* and *addicts* socially constructed, but that these concepts function to maintain certain cultural ideals. The concept of addiction is used to describe behaviours that are deemed problematic and that violate certain cultural norms and ideals, such as productivity and individual responsibility. Keane argues that "discourses of addiction appear, in part, as a response to anxieties about the regulation and containment of intimate attachments within socially acceptable boundaries" (2004: 191). Hughes connects social discourses to social practices surrounding addiction, enabling us to think of addiction as a "discursive practice" where

"discourses and practices of addiction can be understood as both productive of and constrained by corporeal experience" (Hughes 2007: 689). Therefore discourses, practices and performances of addiction and recovery are embedded with each other—and in this work.

Addiction-as-Disease in the Ottawa Drug Treatment Court

As witnessed in documents, court proceedings and treatment practices, the Ottawa DTC is explicit in its reliance on the disease model of addiction. To this effect, the section "The Disease Concept Model" of the *Ottawa Drug Treatment Court Program Case Management Practice Guidelines* states that:

> The disease concept model introduces participants to the *concept* of understanding addiction as a disease. As a result of this understanding, participants view their addiction as similar to other diseases, with a biological cause, a specific set of signs and symptoms and a clinical course. This understanding can help participants to follow treatment recommendations, and can reduce shame and guilt commonly associated with chemical dependency (Rideauwood Addiction and Family Services 2008: 5).

From this perspective, conceptualizing addiction as analogous to other diseases like diabetes is seen as reducing shame among those who are drug addicted and receiving treatment.

However, even given this intention of the disease model, Darbro argues that "substance abuse remains one of the most stigmatized of the chronic, relapsing medical conditions" (2009: 16). Another strange inconsistency of the disease model of addiction is that "we do not normally hold people morally or legally responsible for symptoms of a disease," including when the symptoms are behaviours (Foddy 2010: 26). Quite the contrary, the symptoms of addiction-as-disease (consuming substances) and the people

who engage in these behaviours face stigmatization, legal punishments and removal of rights (such as not receiving disability benefits) (ibid).

The approach to addiction-as-disease in ODTC policy and treatment was also evident in the courtroom and in conversations and interviews. Participants in the Ottawa DTC were explicitly taught that they had a disease. During our interview, Chad told me that despite asserting that he did not have a disease of addiction, his treatment counsellors taught him that addiction was a disease in both his individual and group therapy sessions:

> **Tara**: Do you think you have a disease of addiction?
>
> **Chad**: No I don't think so.
>
> **Tara**: And did you feel that was something that Rideauwood taught you?
>
> **Chad**: Yeah, oh yeah.
>
> **Tara**: In like individual and in group [therapy sessions]?
>
> **Chad**: Yeah for sure.

Another participant and I had the following discussion about being taught that he had a disease of addiction:

> **Tara**: Were you taught you had a disease? Was that part of the programming?
>
> **Frank**: Partly yes.
>
> **Tara**: And so that came in the form of what, how did they teach you that? In the papers they handed out to you?
>
> **Frank**: Sure, and their little, their view finders and their little films and stuff and so forth they had. They tried to tell you that it wasn't your fault that it was disease orientated in some ways.

Therefore, the dominant discourse of addiction in the ODTC is that addiction is a disease, which is not surprising given that addiction-as-disease discourses have also been found to be central in other DTCs (Mackinem & Higgins 2007; Nolan 2001; Reinarman 2000).

In the ODTC addiction is presented as a progressive, life-long and chronic disease that affects people from all walks of life; there are important consequences to this approach. For example, participants in the Ottawa DTC are instructed that addiction is a disease characterized by compulsion and relapse. Because of this, individuals must remain abstinent from all substances and abide by the rules and suggestions of treatment providers in order to "arrest" their disease, as there is no cure (Peele 1989; Peele, Bufe & Brodsky 2000).

It is important to acknowledge that *how* addiction is constructed has significant consequences. The Ottawa DTC and DTCs in general are, in part, a result of how addiction is currently conceptualized in the broader society; however, maintaining such discourses and practices also brings with it important social implications. As stated above, this work is based on a feminist foucauldian approach that conceives of knowledge and discourse as inseparable from relations of power. In the following section, I will address the implications of adopting the disease model approach to addiction in the ODTC including: (1) strict abstinence requirements; (2) the perpetual fear of relapse; (3) conceiving of drugs as inherently dangerous and addictive; (4) a binary of *clean* and *dirty*; and (5) drug use as a choice.

6.3 Implications of the Addiction-as-Disease Discourse in the Ottawa DTC

Abstinence

Perhaps one of the most obvious implications of the addiction-as-disease discourse is that individuals considered to have the disease must abstain from all mood-altering substances as a part of their addiction treatment (Brown & Stewart 2007; Keane 2002; Peele 1989).

The National Institute on Drug Abuse publication "Principles of Drug Addiction Treatment" states that "Addiction treatment must help the individual stop using drugs, maintain a drug-free lifestyle, and achieve productive functioning in the family, at work, and in society" (2009: v). Within this construction of addiction as disease, abstinence is understood to be the only cure for addiction since drug use is a symptom of the disease of addiction (Brook & Stringer 2008; Keane 2002; Peele 1989). The differing ways in which participants and the ODTC negotiated the meaning of abstinence highlights the limitations of the disease model approach, as well as the complex ways in which participants managed their substance use, or non-use.

Abstinence is a central principle for the ODTC and its treatment practices. The ODTC makes a clear link between the disease model of addiction and abstinence in the *Ottawa Drug Treatment Court Program Case Management Practice Guidelines*: "The disease model is particularly useful in promoting abstinence from all mood-altering substances and emphasizing chronicity and progression" (Rideauwood Addiction and Family Services 2008: 5). The document entitled *Ottawa Drug Treatment Court Program: The Rules—Your Duties and Obligations*, which participants must sign along with waivers to be accepted into the ODTC, makes it clear that abstinence is expected: "You are to consistently remain drug free as evidenced by repeated negative lab results demonstrating you are not using drugs" (Ottawa Drug Treatment Court, n.d.b).

The Ottawa DTC is not alone in favouring an abstinence-based approach, which remains the focus of most alcohol and drug treatment programs in Canada (Boyd, MacPherson & Osborne 2009; Brown & Stewart 2007). Even though the literature reveals that long periods of abstinence after addiction treatment is rare (Laudet, Stanick

& Sands 2007; O'Brien & McLellan 1996), "miraculous (long-term continuous abstinence) cures are still an expected standard for people entering addiction treatment, not only by many of the public but by pockets of professionals working in the field as well" (Sellman 2009: 8). The ODTC is one such site where this miraculous and instantaneous abstinence is expected. If individuals participating in the ODTC program cannot abstain from "mood-altering substances" immediately upon entry into the program, they face serious consequences including admonishments, sanctions and threats of removal from the program.

As mentioned earlier, participants are released from custody into the Ottawa DTC with a long list of bail conditions. The conditions include not using any drugs or alcohol and not entering any place where alcohol is served. When a person is accepted into the ODTC, the judge emphasizes the requirement of abstinence from all mood-altering substances, stating that "the main objective of the program is to stop using." For example, a judge explained to Dominic:

> You understand that an expectation of the DTC is that you'll stop using drugs. It's a main expectation of the program...We want to you to stop using from the moment you come in.

The Crown counsel also reiterates to participants that abstinence is required in the Ottawa DTC. In one instance where Dominic reported his drug use, the Crown said, "I want to remind Dominic that he's in the program and one of the expectations is no use." When drug use is reported by participants, the legal and treatment staff members reiterate that abstinence is required for continued participation in the ODTC. In referring to one ODTC participant, the treatment staff said, "There is consistent use of marijuana...This is definitely an abstinence-based program and we hope all of our clients maintain that."

The abstinence requirement in the Ottawa DTC is very strict and includes alcohol and certain medications. However as indicated by many of the examples discussed below, the manner in which the Ottawa DTC determines what substances can be consumed or not as well as what is considered situational "contact with" banned substances is fuzzy at best, and points to some of the limitations of the abstinence model. For one, there is a requirement of complete abstinence from alcohol in the Ottawa DTC, regardless of whether individuals have a history of drinking alcohol or whether they identify alcohol as a problem substance for them.

> Louis reported to the court that he had a good, sober weekend with his family. They had a poker game and he won. He said "there was alcohol there but I've never been one to drink so it's not a problem." The treatment liaison stated "treatment would see the poker game as high risk. It [Alcohol] may not be a drug of choice, but it's still a mood-altering substance."

Requiring that individuals with addictions stay physically away from all mood-altering substances, without regard to whether they pose a problem for the individual, is fundamental to disease model understandings of addiction and treatment.

How policies of strict abstinence play out in the ODTC often leads to situations where participants seem to be set up to breach their bail conditions. As stated above, bail conditions in the ODTC forbid participants from consuming alcohol and drugs, and this includes forbidding individuals from going to places or establishments where alcohol is served, including restaurants. Here is a passage from my field notes on this point:

> Allan tells me that he had a nice Easter dinner with his family at Red Lobster, but he's not telling the court or his treatment counsellor about it because he's not supposed to be in restaurants that serve alcohol.

Although participants are encouraged at times to take psychiatric medications (i.e., Seroquel[20]), they are prohibited from taking medications that are considered mind or mood-altering for fear of invoking a *relapse*—i.e. a resumption of drug use. For instance, the treatment liaison advised the Court

> There is concern with his prescriptions. Inform the pharmacist you're a recovering person and can't have anything mind altering...Call your case manager before you take anything. We wouldn't want a relapse on medication. It's quite common.

In fact, the requirement of abstinence is so strict that participants are not permitted to ingest common cold medications. Participants have to report use of any and all medications to their counsellors as one of the conditions of the ODTC. As the treatment liaison once warned a participant: "A cautionary note. Tylenol 3 contains codeine which is mood-altering. You need to report the use of any cold medication to your case manager." During an interview, Phyllis explained how she was not allowed to take Neo Citran, a common over-the-counter cold medication in Canada:

> **Phyllis**: Remember me getting sanctioned for taking cough syrup and Neo Citran. Neo Citran! I have a sinus infection. I have a cold for three weeks...and I take half a cup of Neo Citran and you wanna sanction me.
>
> **Tara**: And that was after the clinic gave you some sort of cold medication...?
>
> **Phyllis**: Yeah! I called [Rideauwood] from the clinic, I said they gave me Advil cold and sinus. No, you're not allowed to take it. But it's from the clinic... [and their response is] No, you're not allowed to take it. So I come home, I take half a cup of Neo Citran 'cos I'm allergic to lemon, but just to give my sinuses some relief so I can go to bed and I'm gonna get sanctioned for it.

The above example illustrates a central assumption of the addiction-as-disease discourse: one taste, one toke, or close association will result in immediate relapse. Participants are taught that they have a disease of addiction and that therefore no

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20 Seroquel (Generic name: Quetiapine) is a prescribed antipsychotic pharmaceutical medication. More information is available at www.seroquelxr.com

substance is safe for them, for the duration of their lives. The idea that the disease of addiction is progressive and chronic is also related to this concept. The Ottawa DTC teaches participants that just one slip—even if it were accidental such as in the case of medication—will undo all the work that the individual has made towards recovery. The ODTC teaches participants that any such slip will result in using drugs at an increased rate and with worse consequences than before, because of the progressive and chronic character of the disease of addiction. Strict abstinence is therefore required to prevent the addicted subject, who is defined by the disease of addiction, from going back to using drugs.

If a participant were to use other mood-altering substances—marijuana, alcohol or other substances—without harmful repurcussions, the addiction-as-disease discourse would be threatened. Not only is the disease model approach threatened by non-abstinence, but the disease model in fact reinforces the *necessity of abstinence*. For example, as Brown and Stewart argue, the belief that "abstinence is the only treatment choice is exacerbated by the dominant disease-based model, which emphasizes the necessity of abstinence and closes the door to alternatives" (2007: 436).

However, this ideology suffers from a deep contradiction because not only are ODTC participants allowed to smoke tobacco cigarettes and drink caffeine, but they are in fact encouraged to do so. The ODTC gives participants Tim Horton's gift cards (commonly referred to as "coffee cards") as rewards for remaining abstinent (Rideauwood Addiction and Family Services 2009). Smoking cigarettes is also encouraged if smoking prevents a relapse, as demonstrated in this exchange when the treatment liaison is reporting to the judge:

Treatment liaison: There are some withdrawal issues with regard to nicotine.

Jesse: I cracked and bought a pack this morning.

Treatment liaison: Do what you gotta do.

In another example Alex reported the smell of marijuana as a high-risk situation:

Judge: Any high-risk situations to report?

Alex: Yes, in my building I can smell marijuana.

Judge: How do you deal with that?

Alex: I have a cigarette.

Judge: That's good. That's a week clean.

Another way that cigarette smoking was encouraged by the Ottawa DTC treatment team was by the selling of contraband cigarettes[21] to participants, an illegal practice. When I was conducing my fieldwork, there were some concerns over participants selling other participants contraband cigarettes, particularly "Native" cigarettes, which are "designated for sale on Native reserves (and thus exempt from federal and provincial excise taxes)" but which are often sold off-reserve in bags of 200 (Gabler & Katz 2010: 5). This was a practice that I observed during my fieldwork, and some ODTC participants and treatment team members expressed concern over its illegality, which breached ODTC bail conditions of not engaging in illegal activities. The following is an extract from my field notes about what one participant said on the topic:

> Roy talked to ODTC manager about Native cigarettes and Roy said the manager is trying to work on a solution. They don't want [one of the participants] selling cigarettes because he said then people in group are less likely to call her on shit because she's giving them a deal on cigarettes. Roy says people get kicked out of treatment centres for dealing these cigarettes.
>
> The ODTC manager is trying to come up with a solution because people want cigarettes when they first get out of jail and go to detox. So Roy tells me the

[21] "Contraband tobacco is defined as any product that violates federal and provincial regulatory statutes pertaining to taxes and cigarette manufacturing and distribution" (Gabler & Katz 2010: 5).

> ODTC manager knows a native person who is going to donate cigarettes to ODTC. I ask how this is different and he says because they're donated. And then he says that in return DTC will donate money to a native fund of some sort.

In an interview, Rebecca told me that members of the DTC treatment team were selling participants these contraband cigarettes:

> **Rebecca**: What is was, they were selling us cigarettes. Illegal cigarettes.
>
> **Tara**: Rideauwood was?....Who was selling them to you? Like your counsellors?
>
> **Rebecca**: Yeah they basically had them. They were giving them away but also you could buy through...
>
> **Tara**: ...Through a counsellor?
>
> **Rebecca**: Yeah...I know it's like totally fucked up. So like I can come buy a pill here at anytime too? [laughing].

This policy highlights contradictions in not only the ODTC's abstinence policy, but also in its policy on illegal activity. Rebecca notes this contradiction when she says, "So like I can come buy a pill here at anytime too?" Beyond strict consequences for straying from total abstinence, the ODTC also has harsh sanctions for engaging in illegal conduct while in the program, often expelling participants from the program for illegal activity. The contraband cigarette policy, however, is in direct conflict with both of these policies.

These examples illustrate how the ODTC defines certain substances as harmful and inappropriate for addicted subjects and others as acceptable. Importantly, these definitions do not account for the actual harms that substances may cause, or Phyllis would have likely been granted permission to take cold medication, while Jesse would have likely been encouraged to abstain from cigarette smoking. As such, distinctions between banned and non-banned substances in the ODTC are based on both the legal status of the substances and seemingly arbitrary decisions by the treatment team. In his

ethnography of methadone maintenance programs, Bourgois discussed similar contradictions in approaches to heroin and methadone; while both substances are narcotics with similar effects, one is an illegal drug and one is a prescribed drug treatment. He argues that "the state and medical authorities have created distinctions between heroin and methadone that revolve primarily around moral categories concerned with controlling pleasure and productivity: legal versus illegal; medicine versus drug" (2000: 167). In the ODTC there is an added dimension to this in that certain medications are acceptable for some participants (e.g. antipsychotics) while others, such as cold medication, are forbidden.

Relapse as Part of the Disease

The disease model of addiction posits that addiction is a chronic disease that involves episodes of drug use after a period of abstinence, called relapses (Garcia 2008). Relapses occur within the context of recovery and treatment; these episodes of drug use are often referred to as *slips* in the Ottawa DTC, and they are understood to be a part of the disease of addiction. For example, my field notes detail how a judge reassured Robert, who had had a relapse:

> "It's positive that you feel badly about the relapse, but relapse is part of the road to recovery, you know that." He encourages Robert to focus on "getting back on track" and tells him, "don't beat yourself up over it."

At the same time, drug use is a violation of bail conditions, meaning that relapses—while admittedly part of the road to recovery—are technically forbidden in the ODTC. As the Crown warned Connor, "I'd like to see some commitment to non-use...Even though we don't sanction for use, it's a court order." In this example, the Crown reiterates that the ODTC does not sanction for drug use but points out that using drugs or alcohol is a

breach of bail conditions. Thus accepting relapse as part of the disease of addiction runs contrary to the requirement of strict abstinence in the ODTC. Another example of this conflictual policy came when the treatment liaison explained that drug use is a decision but that relapse (drug use) is a part of recovery. After Brian reported smoking cannabis, the treatment liaison asked how many 12-step meetings Brian had attended, and then told the court:

> [Drug] use is always a very conscious decision and normally there are signs, thinking, behaviours that happen just before...It's his first use [since being in ODTC] and we hope it's the last. We understand relapse is a part of it.

In another instance, the treatment liaison stated that

> It's always concerning when we hear of clients relapsing...Before his THC [cannabis] use was consistent and it was very hard to get him off that drug. There is a strong suggestion he increase his 12-step meetings right now, twice a day if he can...Relapse is a process that clients learn about. Hopefully he takes this occasion and learns from it. We hope to move forward with Carlos.

In the above examples, the ODTC staff and treatment providers acknowledged that relapses are a part of the recovery process, and it was stated repeatedly in court that the ODTC's policy is not to punish participants for drug use relapses. Yet there were tensions in the court around the strict requirement of abstinence, which become most apparent over sanctions for drug use. In one case the judge warned a participant, "We don't punish people for use but it's an abstinence-based program...You're running out of time." In conversations with participants, many talked about how they were sanctioned for drug use despite this going against ODTC policy. During my fieldwork, ODTC participants were indeed sanctioned for using drugs. They received verbal reprimands from the legal and treatment teams, reminders that they could not remain in the ODTC if they continued

using drugs, bail revocation, and were even removed from the ODTC and sent for sentencing[22] if they did not engage in and maintain abstinence.

Mackinen and Higgins' (2007) study of three drug courts in the United States reveals similar findings, with treatment staff expecting relapse in the early stages of entry into the program, but complete abstinence with no relapses expected after a period of time. My observations in the Ottawa DTC mirrored these findings. Relapses were more likely to be tolerated if they occurred shortly after participants entered the ODTC, or if they rarely occurred. On the other hand, when participants reported repeated relapses they were admonished and at times expelled from the program. Fischer argues that despite DTCs accepting relapse as part of addiction and recovery, "it is strongly implied that the 'chronic disorder' can successfully be overcome by sufficient moral and personal strength, discipline and willpower" (2003: 235-6). Relapses, as I will discuss further in the next chapter, are used by the ODTC as evidence of a lack of motivation or willingness to engage in treatment.

Drugs as Inherently Addictive and Dangerous

Discourses of addiction are also intimately tied to the construction of truths about substances (Keane 2002; Hammersley & Reid 2002). The notion that certain substances have inherently addictive properties that can turn a *recovering* person back into an active drug user with one ingestion is closely associated with the disease model perspective. Keane argues that "this view of an illicit drug as an inherently destructive agent of physical disease and moral decline is a staple of addiction discourse" (2002: 13). This

[22] As discussed earlier, by the time that participants entered the ODTC, they had already pled and been found guilty for their charges.

construction of certain substances as powerfully addictive agents permeates drug policy, popular culture and academic literature on illicit drugs. For example, Kuhar states as fact that "One of the reasons for the 'success' of drugs is that they are very powerful in changing the brain and gaining control over much of our behavior" (2010: 32). In the mainstream discourse on addiction, drugs are thus given agency and conceptualized as powerful, dangerous substances that take over people's lives (Reith 2004); this discourse completely ignores the context and setting for drug use and its actual potential harms. For example, the treatment liaison reported to the court that he/she

> met with Kurt and he was talking about that slippery drug marijuana...He's keeping his case manager very aware of what's happening. Unfortunately because of marijuana use he has to stabilize and re-apply for housing because of the use.

It was not only the ODTC legal and treatment team members who engaged in this discourse, but also some participants. For example, Billy discussed the power of crack cocaine to transform people:

> Good people, Tara, in a blink turn into a piece of shit, a blink...When crack first came around...it got a whole lot of people real quick and from all walks of life. You'd be surprised. I'm sure you've dealt with a lot of it, but it's like, I was like holy smokes, these are people who are doctors or lawyers, whatever, are in the midst of ruining their lives, and seniors, 65 and 70 doing big bowls.

In this example, crack cocaine is ascribed the power to destroy lives instantly, a power from which no one is immune. This construction serves to reinforce the requirement of abstinence. Keane argues that "the demonisation of drugs is also, in large part, fuelled by their presumed ability to destroy an individual's autonomy and instead reduce them to an inhuman state of dependence" (2003: 230-1). Thus, according to the disease model of addiction, substances have the power to turn a non-user into a drug addict (Alexander 2008; Hammersley & Reid 2002; Heyman 2009; Larkin, Wood & Griffiths 2006).

The discourse of dangerous, addictive drugs has tremendous resonance despite the fact that the majority of people who use mood-altering substances, including tobacco, alcohol, illicit drugs and prescription medications do not become addicted and "'addictiveness' is not a property of any particular behaviour or drug" (Larkin & Griffiths 1998: 81). In fact, the majority of those people who do develop problematic use stop using without going through a treatment program (Heyman 2009; Mohatt et al. 2007). This is because substance use is a complex social, cultural experience (Alexander 2008; Cohen 2000; Room 2003). Fraser, valentine & Roberts argue that culture and drugs cannot be separated since "culture... [is] built into drugs" (2009: 127), with social norms and values embedded in drugs and drug use. Yet too often addiction and its treatment practices (overwhelmingly taking the form of abstinence) are overly simplistic, as we see in the case of the ODTC. The discourse that substances are inherently addictive is fundamental to the construction of addicted and recovering subjects, which I will discuss in depth later in this chapter.

The Clean/Dirty Binary

The binary discourse of *clean* versus *dirty* is prevalent in the ODTC. Of course, this discourse is not unique to the ODTC; rather, getting and staying *clean* from drugs is pervasive in discourses of addiction and recovery (Weinberg 2000). In the ODTC, to be clean is to be completely abstinent from drugs, as demonstrated by producing *clean* urine screens, free from evidence of drug or alcohol use. Treatment providers instructed participants to *stay clean* to demonstrate that they were serious about their recovery. Participants received praise from the judge and treatment providers when their urine results came back as *clean*; for instance, "Treatment are very satisfied with continued

clean results." Judges and treatment providers instructed participants "to do whatever it takes to stay clean."

Participants also referred to their abstinence from drugs and alcohol as their *clean time*. When drug use was detected in the urine samples the tests were referred to as *dirty*. This discourse of clean and dirty corresponds to that found in Weinberg's (2000) ethnography of drug treatment programs. In the example below, the treatment liaison initially used clinical language to refer to a urine test, then corrected her language to correspond to the preferred clean/dirty discourse of the ODTC:

> It was a point of collection sample and the results is that it was positive for cocaine. I mean, the test is dirty for cocaine.

While getting and staying clean is ostensibly about not using substances, this discourse also relates to the physical transformation of participants from addicted subjects to recovering subjects. Participants and ODTC staff referred to *cleaning up*, which involves more than just not using drugs. Shaving, having dental work done and changing one's hair were all positively reinforced in the ODTC.[23] This relates directly to the construction of addicted subjects as *dirty*, *unkempt*, even *uncivilized*, and to the larger goal of transforming addicted subjects into recovering, *clean* subjects. As such, subjects that are designated as addicted are considered *dirty*, threatening *clean*, *normal* citizens (Weimer 2003). Radcliffe and Stevens argue that the discourse of clean versus dirty functions to categorize "a certain group of drug users as social dirt; a source of both contamination and danger to other members of society" (2008: 1071). While *normal* subjects are perceived as able to control themselves and their bodies, addicted subjects are seen to be *dirty* in their incapacity to control their use of drugs (Ettore 2004). In the

[23] Weinberg's ethnography of treatment programs (2000) also found similar references to *cleaning up*.

next chapter, I argue that *cleaning up* by improving one's appearance is a technique of the self deployed in the Ottawa DTC.

Drug Use as a Choice

The treatment team and judges in the ODTC refer to drug use, or more specifically not using drugs, as a choice that participants must make. Participants in the Ottawa DTC are expected to choose not to use any mood-altering substances and to avoid *high-risk* situations, such as places where drugs and/or alcohol are consumed and by avoiding physical locations where they used drugs in the past. Every bi-weekly court appearance began with the judge asking each participant, "Have you used any substances?" and, "Have you had any high-risk situations?" Judges even went so far as to ask participants to promise not to use drugs:

> "Do you think we can try for not using two days in a row?" Phil says he has promised his partner that he'd try hard to make more effort. The judge goes through the days counting them out for Phil, "Today is day one, tomorrow is day two and then Thursday [the next court date]." The judge finishes with asking Phil to promise to not use drugs: "I want you to really make an effort and *promise me* that you'll try not to use until Thursday." Phil promises the judge.

Not only does the above example demonstrate how the ODTC frames drug use as a choice, but it also lays bare the paternalistic character of the court, in particular the paternalistic attitude of the judge. This characteristic of DTCs has been noted elsewhere in the literature (Nolan 2001). When Justice Bentley, the Toronto DTC judge, and other Toronto DTC team members went to the Cayman Islands to train other DTC practitioners, he assumed this paternalism in his keynote address: "I've seen people who actually enjoy coming to Drug Court, and don't want to leave, for it becomes like family

to them, with the judges involved seen as a father or mother figure" (Cayman Islands Government, n.d.).

In another example of the discourse of choice, the judge admonished a participant for not abstaining:

> The judge says to Alex, "If your motivation is there the court expects to see some better results....I'm gonna expect to see a series of clean tests [in two weeks]." Two weeks later, the urinalysis results are not to the judge's liking and he responds, "Two weeks ago, I tell you I expect to hear clean urine results and you've been using. I'd like to have a letter provided to treatment by Monday about your intentions."

Here again, the judge conveyed that it is Alex's choice not to use drugs, becoming angry with him when the expectation of abstinence was not met.

In their study of three DTCs, Mackinem and Higgins (2007) also found that abstaining from drug use was understood as a decision for the client to make. Under this framework, participants who use drugs against the orders of the judge are deemed to lack the willingness or motivation to become and remain abstinent. The following exchange shows how the court equates any drug use with a lack of motivation or effort, which Stanley contested:

> **Stanley**: I've been using quite a bit.
>
> [The judge asks about the circumstances of his use.]
>
> **Stanley**: I don't know. I wanted to.
>
> **Judge**: I'm sorry to hear that.
>
> **Stanley**: I'm a drug addict. I'm using that's it. No one pushed it on me.
>
> **Judge**: You're also in a program and there are some expectations.
>
> **Stanley**: Just because I'm using doesn't mean I'm not making an effort.

If individuals participating in the ODTC do not stop all forms of drug use, it quickly becomes a question of their motivation to recover, and they are threatened with expulsion

from the ODTC. The Crown emphasizes that participants only have to make a choice and a decision to stay abstinent from all substances. For example, while arguing to revoke Carlos' bail to prevent him from consuming drugs before going into residential treatment, the Crown counsel said that, "He was asked last week to stay clean and sober." On other occasions the Crown threatened to move to expel individuals from the ODTC if they did not stop using drugs; for example, "If he's not clean next week I'll make submissions to remove you from the program." In another instance, in ordering Lenora to immediately attend detoxification, the judge said, "Lenora you need to find some way to break the cycle so treatment can work with you. By breaking the cycle I mean not using." Hence participants are expected to make the choice not to use substances in order to arrest their disease of addiction.

This *choice* to abstain is accompanied by the expectation for participants to make the *choice* to change their lives and themselves. In Beck's (2006) study of women in a treatment centre, she found a similar discourse of choice around treatment and recovery. Women in the treatment centre were continuously reminded by treatment staff that it was their choice to use drugs and to change their lives and selves. She argues that this discourse of choice assumes a neoliberal subject completely free of history, culture and context, which "can be deeply problematic for drug-using women, who internalize notions of choice in ways that suggest they are responsible for their social conditions" (Beck 2006: 254). The discourse of choice in the ODTC works to make participants wholly responsible for their lives, thereby concealing broad structural factors and the reality of constrained choices. Beck argues that the "focus on choice implies blame" and "further create[s] deep, often irreconcilable, tensions for women" (2006: 253-4). It is

important to understand that, contrary to the discourse of choice, choice is never unconstrained: "choice, including choice in relation to drug use, is not equally shared by all those within and on the margins of consumer society" (Measham 2002: 345).

These examples illustrate a core contradiction evident in ODTC policy and practice: if addiction is a disease, and if relapse is integral to the disease, then why is drug use framed as a choice and why are participants punished for relapsing? This tension is also found in studies of other DTCs (Christie & Anderson 2003; Weinberg 2000) as well as in methadone maintenance treatment programs (Bourgois 2000; Fraser & valentine 2009; Fraser, valentine & Roberts 2009). Garcia (2008: 727) attributes this tension to the existence of two different perspectives acting alongside each other: *biomedical* and *juridical* approaches to addiction. Relapse is accepted as part of a biomedical approach to addiction while "from a juridical perspective the relapsed addict is ultimately assigned the blame for relapse and is seen as lacking the will to recover" (Garcia 2008: 727). This dilemma is also noted in May's work: "Although addiction might arise out of inheritance, organic disease or psychological stress, it could only be 'cured' by attempts to motivate the patient" (2001: 388). Christie and Anderson argue that because of this contradiction between framing addiction-as-disease and drug use as a choice, DTCs "may be in the grasp of a fundamental misunderstanding of the nature of addiction that ultimately produces anti-therapeutic consequences" (2003: 74). This is one area where moral judgments persist in being fundamental to drug policy and treatment.

While the discourse of drug use (or non-use) as choice seems contradictory to the discourse of addiction-as-disease, they are in fact related in their focus on the individual. The disease model views abstinence as the way to manage addiction, and because it

locates addiction within the individual, it is assumed that individuals are responsible for making the choice to not use drugs. Furthermore, this individualistic notion of addiction forms the basis for coerced treatment as practiced in the ODTC. What this and the related discourse of addiction-as-disease overlook is that choices are always constrained (Brook & Stringer 2008; Measham 2002; Pauly 2008; Weinberg 2000). In the next section, I examine one of the products of the discourse of addiction-as-disease, that is, the construction of an *addicted subject*.

6.4 The Addicted Subject in ODTC: Key Characteristics

The disease model of addiction used in the Ottawa DTC requires participants to undertake steps to transform themselves from *addicts* into individuals who do not use drugs or commit crimes. However, the choice not to use substances must come from the individual participant (whether coerced or not). Because the court and its treatment program are premised upon the disease model of addiction and its attendant cultural values, the ODTC in fact *requires* the production of an addicted subject in order to carry out its function. This section outlines four characteristics of the addicted subject in the Ottawa DTC: (1) a universal subject who is genderless and dislocated from any context; (2) a treatable subject who requires therapeutic interventions and who is motivated, grateful and *positive* in attitude; (3) a criminal subject who has already pled guilty to charges and who may face criminal sanctions for non-criminal behaviour; and (4) a dishonest subject whose honesty must be proven at the outset.

A Universal Subject

Under the disease model of addiction, individuals become responsible for the outcomes and effects of their disease. Hence addicted subjects are held responsible for their health and must engage in appropriate prevention (e.g. abstinence) (Greco 1993). Within the disease model, individuals are compelled to be entrepreneurial in the approach to their lives and bodies. Health, happiness and recovery become projects to be undertaken (Nettleton 1997). Recovery is the process through which addicted subjects (re)achieve values of productivity and individual responsibility. Addiction and recovery are positioned as individual matters and are thus aligned with neoliberal ideology. As Room explains:

> The ideas that good behavior is a matter of individual self-control and that the individual is responsible for control of his or her life, are very much embedded in a particular cultural matrix. They make sense in a culture where individuation and individualism are taken for granted (2003: 225-6).

As a consequence of its acute focus on the individual, the disease model of addiction overlooks social factors in explaining and treating drug use (Boshears, Boeri & Harbry 2011; Lyons 2010). As Radcliffe & Stevens argue, the "failure to consume appropriately is seen as resulting from individual weakness, and not from social problems" (2008: 1071). This individual approach is deeply rooted in the disease model of addiction and 12-step programs (Makela 1996; Rafalovich 1999) and is based on the neoliberal values of personal entrepreneurship, freedom, autonomy and individual responsibility (Acker 2010; Garcia 2008; Moore & Fraser 2006; Reith 2004). As Fraser explains,

> Contemporary liberal democratic society produces the subject as an autonomous, self-governing, enterprising individual who exercises rational thought and choice in managing life. This approach benefits government as it devolves responsibility for maintaining health and wellbeing to the individual subject, rather than to the welfare system or other government structures (2004: 200).

Thus the Ottawa DTC homogenizes participants under a single rubric, while differences within and between communities of drug users, and different types of drug use, are overlooked. In short, in the ODTC there is a conception of a universal subject whose identity can be reduced to the *addict-with-a-disease-of-addiction*. In his ethnography of Narcotics Anonymous, Rafalovich (1999) found that establishing "homogenization" was the first stage in forming the recovering subject, a process he calls "leveling." Participants are taught that their disease of addiction makes them all the same, while "variables such as race, class, sexuality, and gender become less significant than the more basic principle of the disease of addiction" (ibid: 141). Keane also concluded that addiction-as-disease discourses "emphasize the commonalities of addictive desire and addictive conduct across their different manifestations" (2004: 191). In other words, this conception of addiction does not acknowledge differences between experiences of drug use.

This notion of the universal addicted subject embedded within the disease model of addiction is also pervasive in popular culture, media and treatment programs. However, as Reinarman argues "Whether in news or film, the media tend to frame their addiction stories as if it is a disease that 'can happen to anyone.' This is true enough as far as it goes, but it ignores all the sociological variables that make such an outcome far less likely for such a privileged person" (Reinarman 2000: 314).

The homogenization inherent in the ODTC's conception of addicted subjects also involves understanding women and men to have the same disease of addiction requiring the same treatment and interventions (Rafavolich 1999). This approach is closely related to 12-step programs, which teach participants that their identity of *addict* or *alcoholic* is

primary and far more significant than gender or cultural identities (Makela 1996). The disease of addiction is thus put forth as the common fact that unites all addicted subjects. Not only are individuals seen to be addicts first, but they are also taught that differences between them, including gender, do not matter. The lack of attention paid to gender is reflected in the absence of gender-specific programming in the ODTC, despite lower rates of enrolment and successful completion for women in DTC programs. As mentioned earlier, the Ottawa DTC outcome and process evaluations do not report on the number of women who participate in the program. The ODTC's ignoring of gender as a factor in treatment outcomes is an indication of the program's construction of a universal subject whose only relevant marker is addiction.

The ODTC's adoption of a universal, diseased subject is problematic, particularly when we consider research on gender. Following from Ettore, I hold that "Gender is embedded in our drug using cultures and treatment systems" (2004: 329). Measham argues that "women 'do drugs' differently than men within the wider cultural context of gendered drug use" (2002: 349). As Ettore explains, "Access to drugs, knowledge of drugs, use of drugs and help for misuse of drugs—all involve hidden and sometimes not so hidden gendered processes" (2007: 21). Women and men use substances differently, and this use has differential impacts. For example, women use substances at lower rates than men, yet they face greater stigma and face more barriers to entering treatment, particularly around mothering and pregnancy (Boyd 2007; Greaves et al. 2002; Health Canada 2008; Poole & Dell 2005; Poole & Issac 2001). In other words, drug use experiences are gendered, as are experiences in treatment.

Part of the stigma that women experience is related to whether they embrace the disease model of addiction. In Brown and Stewart's study of women in alcohol treatment, they found that the majority of women internalized discourses of addiction-as-disease, arguing that there are negative impacts to this internalization, specifically "disempowering effects, including individualistic, often self-blaming, and socially decontextualized understandings of alcohol problems" (2007: 437). Consequences of drug use are also gendered. For example, women experience guilt and shame related to the consequences of substance use, whereas men often term these consequences (e.g. physical illness, depression) in positive ways or in ways that Measham (2002) argues perform masculinity. In Palm's study of women in treatment programs, more than 80% of the treatment staff "agree that women are more ashamed of their misuse than are men" (2007: 24). I discuss the role of shame in more detail in Chapter 8.

A Treatable Subject

The Ottawa DTC also constructs the addicted subject as a subject in need of the therapeutic interventions provided by legal and treatment teams. From the application process to exit of the program, participants are judged upon whether they are treatable and worthy of receiving treatment in the ODTC. Individuals evaluated as having high needs or as unwilling to change are not accepted into the program, while those who are accepted are evaluated continuously to determine whether they remain treatable. Through this process, "The 'treatable' are categorised as distinct from the 'dangerous' or 'untreatable'" (Malloch 2000: 147). Treatable subjects who are accepted into the ODTC are rewarded if they display gratitude and a positive attitude towards the court and the treatment program. This relates to the Ottawa DTC's overall goal of not only creating

drug-free subjects, but also *better*, healthier, productive citizens. Furthermore, the ODTC and its staff "expect the worthy addict to progress towards recovery," reflecting what Mackinem and Higgins also concluded in their ethnographic study of DTCs in the US (2007: 238).

As previously mentioned, when participants do not engage in treatment to the extent demanded by their counsellors or the court, they are punished with sanctions. This distinguishes the addicted subject from other medicalized subjects in that non-compliance with treatment is punished with criminal sanctions. For example, Lucinda was removed from the ODTC program because she denied using drugs despite a positive result from urinalysis. The court and treatment deemed her to be worthy and in need of treatment; however, since she continued to deny drug use in the face of positive urine screens, she was expelled from the ODTC and sentenced. The following transpired:

> **Crown**: With considerable regret I cannot support Lucinda continuing in the drug treatment program...It's not because of the use...This program is designed to help people, and Lucinda needs help, but one of the pillars is honesty...I understand that part of addiction is denial....It's with great regret that I cannot support Lucinda anymore. I'd like to help her. [The Crown turns to Lucinda.] Lucinda, I have respect for you, it's taken a special person to come this far. It's with regret.
>
> **The treatment liaison**: Treatment are really really feeling very strongly that you need to continue. You're in great need of help. We'll do our best, whatever it takes.
>
> [...]
>
> **Judge**: The court has an application to remove one of our longstanding clients from the program. One of the key components of the court is honesty...The drug treatment court doesn't sanction people for admitted use or relapse....Unfortunately it's become apparent, and I don't know why, that you're unwilling or unable to comply with one of the conditions, that of honesty. The behaviour is incompatible. If the DTC is to be of assistance to others, the court has to be consistent with regard to its requirements. I hope you continue with treatment but very sadly I've come to the conclusion that this isn't the venue. You're removed from the program immediately.

The Crown counsel, treatment liaison and judge stated that Lucinda was in need of therapeutic assistance in order to stop using drugs and change her life. The ODTC actors also stated that they wished they could help her but could not because they perceived Lucinda to be lying about her drug use, thereby flouting two central rules of the ODTC: abstinence and honesty. The requirement of honesty in treatment also relates to the assumption in the ODTC that addicted subjects do not know what is best for them; rather the treatment and legal teams are deemed to be experts in the best way to treat addicted subjects. Because "drug users are to be understood as people who do not—and in fact by definition cannot—know their own best interests" (Brook & Stringer 2005: 319), the requirement of honesty, which I discuss in more detail below, becomes particularly salient.

In the Ottawa DTC, the judge, Crown counsels and treatment liaisons often reminded participants not meeting program expectations that they should be grateful for the opportunity to participate in treatment since they had access to scarce resources. A *treatable* subject could thus often mean having a grateful, motivated or *positive* attitude. In an example from the ODTC, treatment expressed concerns about Clint not taking the drug treatment program and his own recovery seriously.

> **Judge**: Are there concerns about attitude?
>
> **Treatment liaison**: It's an opportunity he has in the DTC program; an opportunity to work on himself and he needs to take this seriously.
>
> [The Crown reminds Clint that the Crown's position is to sentence him to over 12 months of incarceration and says that these are "*valuable resources* given to him and the others. Valuable in terms of money" and valuable because he is "being *fast tracked for resources he'd have to otherwise wait for*."]
>
> **Judge**: Motivation is very important. You need to listen to what [the Crown] says. You need to approach recovery with the appropriate attitude and seriousness.

The Crown emphasized that Clint should be grateful for obtaining access to scarce resources and confirms that ODTC participants *jump the line* for services, including treatment programs and housing beds. Those seeking treatment and housing services voluntarily are, in contrast, bumped off the list in order to make room for participants in the Ottawa DTC. In this exchange, the Crown also used a common technique of reminding participants who have used drugs, or who are not progressing in the program, of how much jail or prison time they would have to serve if they were to be expelled from the ODTC. Because participants in the ODTC have already pled guilty to any charges they faced when they entered the program, upon expulsion from the ODTC, they are immediately sentenced.

Participants in the ODTC also get priority access to health and dental services and housing. Here is how Billy described it:

> **Billy**: The good thing about it [the ODTC], the only, I mean the positive about it was that it had the power to open some doors up for people that were having problems, right away. You didn't get in line, there was no line up, no waiting period. I mean, which is unfortunate why these individuals should have, you know...
>
> **Tara**: Priority?
>
> **Billy**: Priority over those, you know...but then again it's, I guess it's a government program....It was almost automatic.

When I asked Billy how the Ottawa DTC compared to the other treatment programs he had participated in, he came back to how the ODTC was able to get participants into programs or housing that would have been otherwise unavailable to him:

> This [ODTC] one had its benefit because if there was a problem you, you were given that bed initially over anybody else. You were given things. They worked quickly, they had some sort of power to get you into um a half way house or a dry out two or three day one or a longer term one. Right away there was no waiting period.

In another example, the treatment liaison reported that Chad had missed urine screens,

treatment sessions, and that he had been evicted from John Howard housing.

> **Crown**: I'm having problems with this one...I don't see him working the program...*This program is resource intensive*...I need to see some action, not just words...There needs to be a sanction if Chad is to continue in the program to make him think about what are his priorities and his commitment to the program...When he was accepted into the program he also accepted sanctions in the program. I recommend he spend the night in custody thinking about his motivation.

As in the above examples, the Crown demanded that Chad show "commitment to the program" and recommended that Chad have his bail revoked for one day in order to reflect on his priorities to the court and treatment and to "think about his motivation." The Crown also underscored the fact that the ODTC program is "resource intensive," implying that Chad should not only be demonstrating gratitude for being accepted into the program, but that he should also abstain from substance use and follow all of the rules as a result of acceptance into the program.

The ODTC's capacity to bypass the waiting list for treatment and housing is one of the reasons that the ODTC team insists on participants demonstrating gratitude towards the program. In positive treatment reports, it was often noted when participants were displaying gratitude and appreciation; for example, "He's appreciative of being in the program." In another exchange, treatment told William that "you're appreciative of the services being offered" and the judge responds "That's wonderful."

Beyond the problematic way that the ODTC siphons resources from an already overburdened system, these examples also demonstrate how DTCs set up a system whereby individuals must be criminalized in order to access drug treatment and other services. Christie and Anderson argue that DTCs criminalize addiction, producing circumstances where "suffering from a medical condition becomes illegal and mandated abstinence is the only acceptable solution" (2003: 75). In addition, they argue that the

criminalization of addiction is also problematic because with DTCs "it will no longer matter whether the crime was committed because of substance dependence or not; so long as the offender is substance dependent, he or she would be coerced into treatment" (2003: 75). Furthermore, putting ODTC participants ahead of people who are voluntarily seeking treatment or who need housing pushes individuals who are seeking treatment into the margins, forcing them to wait longer. This makes for a slippery slope where ultimately DTCs may come to monopolize funding for treatment, and where drug users may become forced into criminal activity in order to access treatment services.

A Criminal Subject

As previously discussed, DTCs and their treatment interventions are only accessible to individuals who have proven that they have an addiction and who have been charged with, and pled guilty to, specific criminal activity. But as I discuss here, DTCs also have a very broad mandate that enables them to impose criminal sanctions on non-criminal behaviour, a capacity that stems largely from the blurring of therapeutic and legal approaches to treatment and that serves to further criminalize drug use.

The construction of addicted subjects as criminals can be sociopolitically located in Canadian history. As discussed in Chapter 4, the 1955 Special Committee on the Traffic of Narcotic Drugs in Canada was an important moment in the history of conceptions of *addicts* and of corresponding responses to addiction. There was, among other things, a heated debate over what made someone an addict. One understanding that vied for dominance at the time was that of the *criminal addict.* According to this notion, addicts were thought to be criminals first and foremost, and thus addiction was thought to be a preexisting *personality defect* that predisposed individuals to use drugs and engage

in criminal activity. This conception was mobilized by the law enforcement lobby to contradict claims that addiction was a disease and that the legalization of drugs would stop crime (Giffen, Endicott & Lambert 1991). Constructing subjects as *criminal addicts* in turn demanded specific techniques of government to manage this population, specifically institutionalization and imprisonment. With this understanding there was little hope that addiction could be treated. Treatment advocates disagreed and argued that the relationship between criminality and addiction should be inverted. They held that drug addiction resulted in criminal behaviour, and that therefore *addicts* should be treated within a medical model (Giffen, Endicott & Lambert 1991). Thus the debates over the appropriate response to addicted subjects are rooted in the construction of addicted subjects themselves. Constructing addicted subjects as criminals or criminal addicts demands a punitive response, whereas the construction of addicted subjects as ill and in need of therapeutic assistance requires a therapeutic response.

What is novel about the Ottawa DTC's construction of the addicted subject is that it views addicts as both treatable *and* punishable. These two subject positions do not typically inhabit the same individual. Rather, criminal subjects are managed in the criminal justice system using a juridical approach, and therapeutic subjects are managed in the health system using a biomedical approach (Garcia 2008). But such dual subjects are also constructed in other institutional milieus, such as in methadone maintenance programs (Bourgois 2000). Nolan (2002) argues that unlike court-ordered treatment sentences where treatment and criminal systems, although linked, remain distinct, in DTC programs treatment is at the core of the process, rendering the two systems indistinguishable. According to Nolan, "A defining feature of this new arrangement is the

legal reinterpretation of drug use as a disease rather than simply a criminal offense deserving a specified legal sanction" (2002: 1726). In the case of the ODTC, treatment of the addicted subject as both treatable and punishable also results in a wider range of punishments and interventions in individuals' lives and behaviours (more on this in Chapter 8).

At times participants were confused by the dual goals of punishment and treatment in the ODTC. In the following example, a participant had his bail revoked for missing an appointment regarding schooling with the John Howard Society:

> [Carlos reports using a couple of puffs of crack cocaine.]
>
> **Treatment liaison**: A very concerning report. He missed an appointment at John Howard and he hadn't called John Howard with an explanation...He missed a UDT [urinalysis] Friday...Carlos was asked to provide a note for illness for missed court Thursday. Carlos has had some very solid recovery. Lots of support groups and 12-step groups...There's real concern about where Carlos is going.
>
> [The judge asks if he has a note.]
>
> **Carlos**: I slept all day Friday, that's why I missed my UDT [urinalysis]...It costs $10 for documentation and I don't have that.
>
> **Crown**: He lost his housing at John Howard...Now we're moving from the occasional marijuana back to crack use. Carlos tells us he was sick and slept all day and that's the same day he was using crack and marijuana. [She asks for bail revocation.] Perhaps Carlos has to reflect a little on drug treatment court and his commitment to it...the priorities aren't there.
>
> **Carlos**: I'm still an addict, I'll always be an addict. I don't think being put in will help...I wanna graduate this program.
>
> **Duty counsel**: He missed school at John Howard. He was ill, he didn't have to come to court. It's his school. I don't think we sanction people from missing school. It's not a treatment related thing. Other people work and go to school and we don't sanction people for missing work. I don't know if he has an obligation to contact them and give them an explanation....By hearing him he sounds sick, one doesn't always go to the doctor when one has a common cold....Drug use isn't a sanctionable issue either.
>
> **Judge**: If you have money to buy crack it would've been better spent on a doctor's note.

Carlos: I didn't buy crack.

[The judge revokes his bail for two days.]

The above exchange is full of complex factors: it demonstrates how treatment is used as punishment, how bail revocation is used as treatment, how the ODTC does in fact sanction for drug use, and how some participants react to this combination of punishment and treatment. When the Crown suggested bail revocation for Carlos so that he may reflect on his commitment to the program, Carlos responded, "I'm still an addict, I'll always be an addict. I don't think being put in [jail] will help." In identifying himself as an addict, Carlos claimed that incarceration would not help him with his addiction. This example also demonstrates how drug use and/or breach of bail conditions were met with suspension of treatment services. The treatment liaison conveyed "concern about where Carlos is going" and fear that his recovery was backsliding. Further, the ODTC punished Carlos for missing an appointment not related to his treatment. This demonstrates the broad mandate with which ODTC may punish participants. The duty counsel argued that the ODTC should not punish participants for missing school or a shift at work, but the judge rejected her submission, revoking Carlos' bail. Thus, one consequence of the at once punishable and treatable *criminal* subject is that ODTC participants can receive criminal punishments for non-criminal behaviour (such as missing an appointment).

A Dishonest Subject

In the ODTC, participants are constructed as criminals who are dishonest and who cannot be trusted. A central premise of the court is honesty, yet staff members do not expect participants to tell the truth (Mackinem & Higgins 2007). As the judge instructed Johnny,

"if you do slip, and we're hoping you won't, you have to be honest. You have to be honest not just with Justice Wright and myself, but also your care providers as well."

During my fieldwork, treatment providers and ODTC staff frequently accused participants of lying about their drug use, both in court and outside of court. For example, the Crown counsel once told me outside of the courtroom that he was happy that Chad had used and that it was time he revealed himself because Chad's abstinence had been "too good to be true." This reflects the belief "that addicts lie as part of the addiction disease" (Mackinem & Higgins 2007: 238). As a consequence of this inherent mistrust, participants in the ODTC are subject to random urinalysis tests, to constant checks on their whereabouts by counsellors and to video surveillance in some of their housing. What's more, participants are required to hand in copies of paystubs as proof that they are working and must provide proof of attendance at 12-step meetings.

Because participants in the ODTC are constructed as criminal addicts who cannot be trusted to tell the truth, urinalysis tests are an integral part of the ODTC. Each participant is assigned a colour for the urinalysis. From Monday to Friday, participants are required to call into Rideauwood to see if their colour has been called that day. If it has, they must then report to a designated health centre and produce a urine sample under observation from a nurse practitioner (Rideauwood Addiction and Family Services 2009). The tests are meant to ensure that participants are not lying about drug use, and the observation by a nurse practitioner is to ensure they are producing their own urine for testing. For instance, concerned that a participant had missed a urine test, the Crown counsel told the court: "The purpose of the UDT is to monitor compliance...I'm gonna ask that he provide a urine sample as soon as possible."

According to the ODTC treatment and legal teams, urine drug tests cannot be refused by participants. If a urinalysis test comes back as positive for substance use, the court considers the participant to have relapsed, even if drug use is denied by the participant or if there exists an alternate explanation (such as second hand smoke, or sexual contact with someone who was using drugs). As with Mackinem and Higgins' study of DTCs in the US (2007), such explanations are rarely believed by the court. As is evident, not all of the explanations of positive urine tests were true; however, urine drug tests are also known to produce errors (Burns & Peyrot 2003). In the example below, a discrepancy was found to exist between two urinalysis tests taken on the same day. The treatment liaison and the Crown attempted to persuade the judge to validate the positive (*dirty*) test and dismiss the test that came back negative for drug use (*clean*):

> The ODTC manager required Natasha to give a urine sample at the courthouse, which is different than the usual procedure. The following court session treatment reported: "[At the last court session] Natasha provided a urine sample. It was a point of collection sample and the results indicate that it was positive for cocaine. I mean, the test is dirty for cocaine. She denied using and was directed to Somerset West for laboratory testing [where the urinalysis tests are usually done]. The results have come back as clean...The point of collection test are much more sensitive than those at Somerset West."
>
> **Crown**: There's a test that indicates cocaine is present...Her last reported use was in April, something doesn't jive...the point of collection test doesn't lie...Natasha isn't fooling anyone here. The failure to not tell the truth only hurts you. People here want to help you. [He asks for the judge to sanction Natasha for failing to tell the truth about drug use.]
>
> **Duty counsel**: The lab tests are the ones we have relied upon in this court. Why send her to Somerset West then. We've relied on these tests in drug court. This is the standard we held everyone to.
>
> **Judge**: I don't see how I can sanction her for the original test. Which isn't to say the original test was wrong but there's a standard. I've been told there's other evidence.
>
> **Natasha** interrupts: I know I haven't used.

Despite the fact that Natasha had one urinalysis test come back negative and that she stated having not used drugs, legal and treatment teams maintained that she was lying about her drug use. The judge did not sanction Natasha in this case but did support the treatment team's position that Natasha had lied about her drug use. The point of collection method used in this case was unusual and resulted in some participants voicing concern. Later that day, when Arthur was called before the judge, he questioned the on-the-spot demand of a urine sample.

> **Arthur**: I've now been informed of this new form of urine testing. Are they legal? Can we refuse them?...I'm upset this hasn't been brought forward.
>
> **Judge**: I'm gonna let [the ODTC manager] explain it to you...Occasionally they've used the point of collection system for people who can't make it to the lab.
>
> **Arthur**: In the case of Natasha you said you can't sanction her...Can I gather from that that the ones at the lab are crucial?
>
> **Judge**: It's a question we're looking at right now.
>
> **Arthur**: I'd like to make a request that this be put in writing and handed out to people in drug court.
>
> **Judge**: That's fair.
>
> **Arthur**: It's important that if there's guidelines we be informed of them.
>
> **Crown**: It's in the conditions that [Arthur] signed. It's just a new technique.
>
> **Arthur**: It's not just a new technique. I think it needs to be in writing and clarified. Our lives are subject to this and I find it frustrating.

During my fieldwork, the guidelines that Arthur requested were never distributed, and it is important to note that any changes to the treatment program or to the procedures in court were regularly justified as being "in the bail conditions," as in the example above. Since one bail condition required participants to follow any and all demands made by the treatment and legal teams, changes in procedure, graduation criteria and treatment requirements could be, and were, made at any time without informing participants. A

fundamental requirement in the ODTC is for participants to be completely and continuously honest with the court and their treatment providers. At the same time, participants are presumed to be dishonest until proven honest by urinalysis tests, surprise visits to their home by treatment counsellors and through providing documentation (letters, note, etc.). In sum, these processes work to construct a dishonest subject in the Ottawa DTC.

6.5 Conclusion

The discourse of addiction-as-disease is evident in ODTC documents, in the courtroom and in their treatment practices. The rigid requirement of abstinence stems directly from the ODTC's adoption of this approach to addiction, as does the construction of certain substances as dangerous and inherently addictive. Despite its ostensible understanding of addiction as a life-long disease involving repeated relapses, the discourse of choice over drug use pervades the ODTC. These discourses reveal that a contradiction exists at the very heart of ODTC policy and practice: while addiction is a chronic disease and relapse is integral to the disease, drug use is framed as a choice with participants being punished for relapsing. Hammersley and Reid argue that "there is nothing wrong with converting people to temperance and abstinence, but this is not a sufficient solution to the drug problem, nor one based on a purely empirical description of addiction" (2002: 16). The ODTC's treatment team and treatment practices are active actors in the reproduction of addiction-as-disease discourse and practices. As Reinarman states,

> The disease concept was invented under historically and culturally specific conditions, promulgated by particular actors and institutions, and internalized and reproduced by means of certain discursive practices (2000: 308).

These discursive practices include the promulgation of addiction as a brain disease by neuroscientists, despite a general lack of evidence to support such claims.

Under the rubric of the addiction-as-disease discourse, the ODTC constructs participants as addicted subjects. The addict is thus simultaneously understood to be *universal* (genderless, decontextualized), *treatable* (in need of therapeutic intervention and expressing gratitude), *criminal* (already having pled guilty to a crime and thus liable to more broader punishment by the court than is the norm), and dishonest (participants are assumed to be dishonest until they are proven honest).

Underlying the discourse of addiction in the Ottawa DTC is the assumption that addiction is a negative occurrence that individuals must overcome. Of course, the understanding of addiction as negative is prevalent outside of the ODTC as well. As a society, we are bombarded with images of addiction as unhealthy and harmful to individuals, to their families and to the larger society. That substances can have positive, pleasurable and beneficial effects is most often overlooked (Agar 2002; Bancroft 2009). At no time during my observations was drug use or addiction put in positive terms by the ODTC legal or treatment teams. Addiction is seen as a problem that needs to be dealt with (Mahmud 2008), with the ODTC being manufactured as one of the ways in which to address this problem.

Within the ODTC, the belief that drugs cause addiction results in simplistic responses to a fundamentally complex social phenomenon (Hammersley & Reid 2002). The imperative for drug users to make the choice to stop using drugs is ultimately a moral response to substance abuse and ultimately contradicts conceiving of addiction-as-disease (ibid). Furthermore, the addiction-as-disease discourse locates addiction within

individuals (Boshears, Boeri & Harbry 2011; Graham et al. 2008; Levine 1978), thereby obscuring structural considerations such as poverty (Boshears, Boeri & Harbry 2011; The Lancet 2011). Considering complete life-long abstinence as the only appropriate action to address addiction "restricts a whole range of questions about drinking behaviour, and its meaning and purpose which are critical to finding less harmful alternatives" (Brown et al. 2005: 107). As such, the onus to stop using drugs and make substantial life changes resides solely with the individual. As I demonstrate in the next chapter, this individualistic approach to addiction results in an understanding of treatment and recovery as *self-transformation*.

Chapter 7: Self-Transformation in the Ottawa Drug Treatment Court: Practices and Implications for Treatment and Resistance

7.1 Introduction

Discourses of recovery differ from discourses of addiction in that addiction is the *problem* and recovery is the *solution.* Like addiction, there is no standard accepted definition of recovery (Dodge, Krantz & Kenny 2010; White 2007). And while recovery most often requires abstinence (Laudet 2007), it also encompasses broader life changes. Recovery requires a person to make "substantial changes to their 'whole pattern of living'" (Sellman 2009: 10). In the ODTC recovery was referred to as "difficult" and as "a struggle" that brings with it a tremendous amount of "hard work," "willingness," "effort," "motivation," and "commitment to the ODTC and one's recovery."

In the Ottawa DTC, and in the 12-step programs heavily relied upon by the ODTC, recovery involves participants making substantial changes through techniques of the self: they must change how they think, how they behave, and even what they look like, based on treatment and court orders. In this chapter, I examine treatment and recovery in light of the ODTC's imperative of self-transformation. I then move on to discuss the impacts of this approach, in particular the requirement that participants prioritize their recovery above all else and its consequences for their employment, housing, and relationships with family. Finally, I discuss some of the ways in which many participants actively contested and resisted the ODTC's discourses on treatment and recovery.

7.2 Treatment and Recovery as Self-Transformation

"You have come a long way Arthur. You were a total different person then. You've grown and achieved and become the real Arthur over the last 13 months."

Treatment practices are part of the process of moving towards recovery (Mackinem & Higgins 2007); in the Ottawa DTC, they are explicitly designed to help individuals achieve recovery through a process of self-transformation. As such, judges prompt participants in the ODTC to make the *right decisions* in order to re-make themselves through techniques of the self, such as *working the program* and managing high-risk situations. As Garcia argues, this understanding of recovery as an individual choice is based on the 12-step model and on "the ever-expanding punitive approach to addiction, which emphasizes the addict's capacity to reason and, therefore, control her drug-using behavior" (2008: 727). Drug users deemed in need of treatment are thus impelled to be active in their own recovery and engage in appropriate behaviours in order to transform themselves into better citizens.

In this section, I outline what this process of self-transformation entails within the ODTC. I begin by (1) briefly discussing the ODTC's goal of identity transformation as well as how this discourse typically manifested itself; I then outline (2) how internalizing the *story of addiction* constitutes the first step towards treatment for ODTC participants; followed closely by (3) the need to perform the identity of the addict both in court and in group sessions; and (4) the need for women in particular to perform gendered roles in court. I then move to an examination of the various techniques of the self as taught by the ODTC, including (5) *using the tools* of treatment in order to stay on track in their progress; (6) self-managing high-risk places, people and situations; and (7) working

towards improving one's appearance as proof of sobriety. I conclude this section with (8) a brief discussion of what is meant by *progress* in recovery.

The Goal of Transformation

The goal of the ODTC is to transform addicted and criminal subjects into subjects who do not use certain substances and who do not commit crimes. The main mechanisms through which individuals engage in this transformation in the ODTC are techniques of the self, where participants are compelled to act upon themselves and their bodies. Some studies reinforce the use of techniques of the self in treatment and recovery by emphasizing identity transformation as a necessary aspect (McIntosh & McKeganey 2000; Radcliffe & Stevens 2008). Others, however, disagree that identity transformation is the single most important aspect of recovery; Nettleton, Neale and Pickering (2011) argue for an embodied analysis of recovery, and Hughes (2007) argues that there is much more than identity work going on in the process of recovery.

When ODTC participants followed the rules of the court and refrained from using drugs, the judge often commented on how she or he had become a different, better person than upon entry into the program. For example, "You're certainly a different person than the person you were when you came in here." The discourse of transformation was most obvious at graduations or when participants who were doing well decided to leave the program (versus being expelled from the ODTC). In one example, the Crown said:

> The Randy we see today is different from the Randy we saw [when he entered the DTC]. He's been able to work and gather assets, stuff, you've been able to curb your anger. He recognizes the role of Rideauwood [treatment] in his life.

In another example, when Luke was leaving the program, duty counsel spoke about how well he had "improved himself as an individual [and] he's taken steps to turn his life

around." She finished by saying, "the Luke who we see now is not the same person who came before you in April [when he came into the ODTC program]...He's come a long way to deal with his addiction issues." Then the Judge initiated the following exchange:

Judge: You're a changed person.

Luke: I feel like a changed person.

This goal of transforming subjects is also present in other DTCs in Canada. For example, a presentation I attended by Justice Darlene Wong of the Edmonton Drug Treatment and Community Restoration Court at a conference in 2007 included a graphic describing the process of entry into and exit out of the DTC. The first box was labeled "Arrest" and the last box, after graduation, was labeled "A Renewed Life."[24] Transformations of participants' lives, identities, behaviours and appearances are required in the Ottawa DTC. In the next section I detail how these transformations require participants to both internalize and perform the role of the addicted subject and engage in techniques of the self as prompted by the legal and treatment teams.

Internalizing the Story of Addiction

Reinarman (2005) argues that a person *becomes* an *addict*—one who suffers from the disease of addiction—through a *pedagogical process*, learning and internalizing the language of disease and recovery from service and treatment providers (who are often *recovering addicts* themselves), as well as from peer groups of other *addicts* in treatment. *Addicts* in treatment are required to learn and use the vocabulary of the 12-steps during which "recovery becomes a story-telling process involving socialization into the language

[24] This presentation was given at the "Issues of Substance: Canadian Centre on Substance Abuse National Conference" in Edmonton, Alberta November 28, 2007.

and lore of A.A." (Denzin 1987: 197). Through this pedagogical process, individuals "are taught to retrospectively reinterpret their lives and behavior in terms of addiction-as-disease" (Reinarman 2005: 315).

Just as individuals learn to become drug users through interacting with people who use drugs (Becker 1953), individuals come to understand themselves as having the disease of addiction and learn how to engage in techniques of the self to achieve recovery through interactions with other subjects in treatment programs. Denzin argues that "Central to the recovery of the self is learning how to become a storyteller about one's life, before and after A.A. membership" (1987: 193). Rafalovich (1999) had similar findings in his ethnography of Narcotics Anonymous, where after the process of *leveling* (erasing differences between subjects and establishing the disease of addiction as the single most important aspect held in common by individuals in the program), participants are compelled to *reflect* in order to shape themselves into recovering addict subjects. Reflecting is "where individuals maintain their identity as recovery addicts through seeing this same identity in others" (Rafalovich 1999: 142). In Denzin's ethnography of recovering selves in Alcoholic Anonymous, he states that "In order for the alcoholic self to recover it must come out of itself. It must find a place for itself in a network of selves who are undergoing the same process" (1987: 22).

In the ODTC, participants learn what recovery means, and how to practice their own treatment from other participants in the ODTC, the treatment team, and 12-step involvement. In court, participants sometimes referred to their disease of addiction and what they were learning in treatment. For example, Anthony once told the Judge, "there's

no cure, only arrest. I've been learning a lot in 10 months [of ODTC]". In another example from an interview, I asked

Tara: Did you feel in drug court they were telling you were an addict?

Chad: Yeah for sure.

Tara: Would that come through in groups, in the court?

Chad: Mostly on the one on ones [individual therapy sessions]

[...]

Tara: Telling you that you should identify?

Chad: Yeah, exactly yeah and I'd always skate around the subject.

Through court proceedings and interactions with treatment counsellors, the ODTC (re)produces and (re)enforces knowledge about moral and responsible self conduct. ODTC participants are taught that they suffer from the disease of addiction by their treatment counsellors. In Russell et al.'s study of treatment providers' understandings of addiction, they found that "treatment providers who have had a personal problem with addiction in the past were significantly more likely to believe addiction is a disease the longer they attend a 12-step-based group and if they are presently abstinent" (2011: 150). McIntosh and McKeganey's (2000) study of recovery narratives found that individuals' construction of their recovery and addiction was significantly influenced by drug treatment workers. In Brown, Stewart and Larson's (2005) study of alcohol treatment programs for women, they found that participants who internalized the addicted subject identity ("I'm an alcoholic") were more likely to believe abstinence was required for treatment. They argue this belief stems from the discourse of addiction-as-disease, which posits addiction as a life-long, chronic illness that "by definition, requires abstinence" (Brown et al. 2005: 101).

Performing the Story of Addiction

Above I outlined Reinarman's (2005) *pedagogical process*, by which an individual internalizes or *becomes* someone who suffers from the disease of addiction. The second process that he introduces is *performative*. In the performative process,

> addicts tell and retell their newly reconstituted life stories according to the grammatical and syntactical rules of disease discourse that they have come to learn. In so doing they not only spread the word (e.g., "carry this message to other" addicts) but also help "save" themselves from relapsing back "into" their "disease" (Reinarman 2005: 315).

Similarly, in Burns and Peyrot's study of DTCs they found that "defendants often mirror the court's own re-socializing discourse of rehabilitative change and individual responsibility, and do so through collaborative 'co-tellings' with the judge" (2003: 432). For example, Fred appeared before court and said to the judge, "I'm talking a lot with my case coordinator...She told me 'Fred, don't worry the only thing you have to change is everything.'" Some participants adopted and used the therapeutic language of the ODTC (Moore & Lyons 2007). For example, Kendra told the judge how she had placed herself in a high-risk situation that had led to a relapse: "I put myself at risk by smoking in front of the building where I live." The judge and Crown commended her for her insight and her identification of the high-risk situation that led to her drug use. In another example, the judge asked Lucinda what she was doing in order to avoid using drugs. She said that she was going to 12-step meetings and staying at JF Norwood House. When the judge asked if she liked the residence she said, "Yeah, [pause] it's not my home, but it keeps me safe," to which the Crown responded, "I'm sitting here listening to Lucinda and...the degree of insight and intelligence, boy, there must be a tremendous upside to this person."

When I asked participants whether their experience in the ODTC and with the treatment provider, Rideauwood Addiction and Family Services, changed how they thought about themselves, some mentioned that treatment uncovered their true or different selves:

> **Tara**: Did going through the drug court or Rideauwood change how you thought about yourself?
>
> **Jesse**: I think it made me realize more who I am, like the person I am now and that I wasn't the person when I was like heavy into drugs for sure. You kinda go back years and years and years and realize you know, that I am energetic I am motivated, I am ah, you know I can do right. It made me realize really who I am you know without, 'cause whenever I was on drugs or when I was out for years and years being friggin' maniac, you know that wasn't really me so it made me come to terms with who I really am. The person I am right now and I came to realize that I was two different people when I was using drugs and when I was not using drugs.

In another interview, Billy told me that when a person is using drugs they do not exist anymore and are replaced by a different personality.

> I try to tell them, say to my mother or friend or somebody's who's using I try to tell 'em, it's really not that person, you're not dealing with that person, that person doesn't exist anymore, really doesn't. You know, and, so don't try to compare, well, 'cause that person is no longer there, that person is lost, you know. They aren't there, that's a different personality, it really is. It's true you just become something else for your drive to use.

As the examples above serve to illustrate, the courtroom can be seen as a stage of sorts, upon which participants perform their addicted selves. During my time at the ODTC, one key role in this performance was that of the *recovering addict.* By presenting themselves as recovering addicts mindful of their disease, participants earned praise in treatment and in court. In other words, some participants knew what they had to say in order to get through the ODTC and their court appearances. On this point, Chriss argues that DTC participants "easily come to understand the prevailing protocols and definitions of 'sickness' and 'recovery' employed by members of the treatment team" (2002: 200).

In Butler's (2001; 1990) work on performativity, she challenges the stability of identity categories by arguing that these categories are constituted by repeated performances and by the exclusion of other identity categories. Butler frames this instability as the multiple performances of the *I*, arguing that there is no essential identity underlying these performances. Instead, the repetition of performances both results in and challenges identity itself. For example, there are many different ways to perform the identity of *addict* (relapsing addict, recovering addict, sober addict) which change over time and in different contexts (e.g. in court or outside of court). The concept of performativity, and its capacity to challenge identity even while it produces it, links to how some participants engaged in resistance in the ODTC, which I discuss at length in section 7.4 of this chapter.

Performing Gender

Some women in ODTC also performed the normative femininity of the *good woman* (Moore & Lyons 2007; Naffine 1990; Smart 1995). This performance often involved supporting, comforting and looking out for other participants. For example, one woman ensured that other DTC participants had food at their house by bringing them groceries. One woman who performs the *good woman* was told that she was a positive presence in the courtroom and in the DTC program in general. She also initiated the practice of clapping for every person who appeared before the court. When this *good woman* missed a treatment session and a urine screen the Crown asked for a sanction of community service hours. He qualified this sanction with:

> We can't deny that she's a very enthusiastic and positive contribution to the courtroom and the drug treatment program ... She supports others. She's cheering people on, clapping. We don't want to lose you.

Women also performed the good woman role by showing interest in regaining custody of their children. An exchange in a DTC illustrates this:

> **Judge**: I hear also that you're actively participating in programming...and that you had a visit with your children. How was it?
>
> **Georgette**: It was awesome, I needed to see them.
>
> **Judge**: How old are they?
>
> [Georgette tells the judge their ages.]
>
> **Judge**: This calls for a coffee.
>
> [Georgette is handed a coffee card.]

In another example, Lucinda had relapsed and knew that the court was likely going to revoke her bail. Before court, Lucinda flirted with a police officer working at the courthouse. Here is an excerpt from my field notes:

> Lucinda tells me that she's in shit today because she relapsed. She is making plans for people to take care of her stuff in case her bail is revoked. Lucinda flirts with a cop and says he's the one that is going to put her in handcuffs later so she needs to be nice to him.

Lucinda knew that she was facing a sanction for her relapse and used traditional gender roles and power relations to engage with the police officer who worked at the courthouse. In another instance, Lucinda verbalized that she is a "good girl" when appearing before the court and reporting that she had not used drugs or had any high-risk situations:

> **Judge**: Do you have anything to report?
>
> **Lucinda**: Nothing. I've been a good girl.

Conversely, when women did not conform to traditional gender roles they faced derogatory comments from the judge. For instance, it was common practice for the judges to comment on sports jerseys that the men wore to court, or to ask if they were

going to watch the hockey game. Natasha was a vocal sports fan and the judge, also a woman, found this to be anathema to traditional gender roles:

> [The judge asks Natasha about her weekend plans.]
>
> **Natasha**: NFL Sunday.
>
> **Judge**: What's that mean?
>
> **Natasha**: All day football.
>
> **Judge**: I guess you're a football fan. That's so unusual to hear that coming from a woman.

This interaction was very different to how the judges responded to men and sports. For example, when men told the court they were playing sports, they were encouraged to continue doing so with the judges often inquiring about what position they played. In this exchange, the judge asked for more details about Roy playing rugby:

> [Judge asks about the game.]
>
> **Roy**: It was good. It was brief. I didn't play the whole game.
>
> **Judge**: How often do you practice? Once a week?
>
> **Roy**: Once a week.
>
> [Judge asks what position he plays.]

As these examples demonstrate, women participants in the ODTC who engaged in traditional gender roles, such as the *good woman*, were rewarded while those who did not were criticised in the courtroom by the judge for engaging in masculine activities, such as watching football.

"Using the Tools" of Treatment

Once the identity of the addict is taught to participants in the ODTC there is an expectation that they then begin their transformation into *better* subjects. A key means of

this process of self-transformation is *using the tools* of treatment to achieve recovery. These tools are taught to participants during treatment programs and sessions with their treatment counsellors. For example, the treatment provider describes one of the treatment groups, the *Conflict Resolution Program*, as a group where "Participants learn to self-monitor and self-regulate their behaviour" (Rideauwood Addiction and Family Services 2008: 17). Another treatment group, called the *Basic Program* of treatment, is described as a group or individual treatment session that "provides basic skills in communication, as well as self-monitoring and relaxation" (ibid: 16). It is important to note that there are pre-requisites to the *Treatment Program* in the ODTC. These are listed as "Stable housing, stabilized affect and motivated to abstain" (ibid: 17). The actual treatment group is therefore not accessible to the majority of participants in the ODTC. The group is described as providing "in-depth coverage of a number of key concepts, including, the disease model, signs of relapse, self-defeating thinking patterns and cognitive distortions and introduces participants to daily mood logs" (ibid). In other words, participants are encouraged to follow treatment orders, work on themselves and use skills they have learned in treatment, such as self-monitoring, relaxation and daily mood logs, in order to *stay on track*. As the treatment liaison reported to the court:

> He's going away for the weekend...We're concerned about his decisions lately and we're hoping he uses the tools he's gained in recovery and stays straight during the next couple of days.

As such, participants are instructed to continually practice techniques of the self, including monitoring their feelings, changing their thinking and reflecting internally. For example, Brian was sent to a detoxification centre for six days in a town outside of Ottawa. When the judge inquired about his time in the detoxification centre, Brian said, "I did a lot of work on me." The judge rewarded and praised Brian, and the treatment

team encouraged him to "live and breathe recovery" over the weekend. Living and breathing recovery includes continuing to work on oneself and remaining abstinent from all substances.

In another example, Sophie received praise from the treatment liaison for "monitoring what she can and can't handle." Participants were encouraged to use the *tools* that treatment had given them to prevent relapse and work towards recovery. For example, the treatment liaison reported, "It's good to hear how he's using his tools and changing his thinking and his behaviour changes as a result." Similarly, in Beck's study of women in court-ordered treatment, she found the treatment program "demands self-reinvention through intensive focus on oneself and one's behavior" (2006: 250).

These exchanges demonstrate the goal of the ODTC, and the disease model approach to treatment, of transforming *addicts* into *better*, healthier people through techniques of the self. As Burns and Peyrot state: "Success in drug court requires more than complying with the letter of the law. It is about demonstrating the recovering self" (2003: 430). Participants who demonstrated a transformation of themselves and of their lives were held up as models to which others were instructed to aspire. In Beck's ethnography of court-mandated women in a therapeutic-community drug treatment program, she also found that working on one's self, or what she calls *self-work*, occupied a central role in the treatment program:

> The imperative of working on oneself is the heart of treatment in the TC [therapeutic community]. "Doing the work," or "working your program" to use treatment lingo, connotes "building" in the sense of building moral character (2006: 246).

Using the tools and *working the program* are phrases that refer to a participant's engagement in recovery; they imply that a participant is continually working on him- or

herself and towards recovery (Gubrium 2008). The *tools* refer to the techniques of the self, or self-work, which require "self-modification" (Rimke 2000: 62). The treatment programs and treatment providers teach and require participants to engage in techniques of the self, or tools of treatment. For example, attending the *Conflict Resolution Program* is compulsory for participants; as mentioned, in this group they "learn to self-monitor and self-regulate their behaviour" (Rideauwood Addiction and Family Services 2008: 17). Self-regulation, self-monitoring and self-transformation are explicitly described as treatment tools required to progress in recovery.

Self-Managing High-Risk Situations

Another technique of the self that participants in the ODTC are expected to mobilize is avoiding and/or managing high-risk situations. Because there is a constant fear that recovering subjects will transform back into addicted subjects and return to their life of crime and drug use, participants are told that they must be ever vigilant in order to prevent slips back into drug use. Another treatment group is the weekly *Living Clean and Sober Program* which is "intended to teach participants to recognize, avoid and/or cope with a wide variety of situations that put them at risk of relapse to substance use or criminal activity" (Rideauwood Addiction and Family Services 2008: 17-18). As such, they are taught that they must monitor their feelings and behaviours, be aware of whom they associate with, and avoid people, places and things that are considered high risk. For example, the treatment liaison once advised the judge about the treatment providers' concerns about a participant socializing with people who smoked cannabis:

> There are concerns with peers he spent time with over the weekend. They used cannabis while with him but he didn't use...It's of grave concern because it's a matter of time before he slides back.

Friends, partners and family members can also be considered high-risk by the ODTC. Randy was required to leave his partner as part of his treatment in the program. In this court exchange, the judge asked Randy about the situation with his partner:

> [Randy says he is talking with her on the phone.]
>
> **Judge**: In terms of your recovery is it better to be in contact with her?
>
> [Randy says he'd rather not cheat the court about talking with her.]

Therefore, in order for participants to leave behind an old *addict* self for a transformed, *better* self, they were often instructed to reinvent themselves and leave their family, friends and entire life behind. For instance, when Dominic used drugs after a friend came over to his house, the following exchange took place:

> **Treatment liaison**: The [ODTC] manager wants him to share name of individual he used with and more particulars.
>
> **Crown counsel**: [We ask for a] reprimand in the form of a letter from Dominic to the court. A page where he reflects on what he hopes to get out of the DTC. He needs to make life changes like walking away from old friends [and] the letter can help him to gain an understanding of what temptation is.

When ODTC participants demonstrated that they were leaving their *old life* behind, they were rewarded, whereas when they associated with people or places from their *old life*, as in the case of Dominic above, they were reprimanded. The ODTC also required participants to provide detailed and potentially incriminating information on their friends. Below is another exchange in court in which Dominic reported that he used. The judge asked about the circumstances of use, and Dominic told the judge that he was with his old roommate:

> **Judge**: You know the objective here is that we move you from an addict to a non-user. How can we do this?
>
> **Dominic**: By staying away from old friends, not calling them, keeping busy with other things.

Judge: Based on this, is it a good idea to see them?

Dominic: No it is not.

Once the knowledge of how to avoid high-risk situations and relapse is conveyed, participants are expected to use this knowledge to govern their conduct accordingly (McKim 2008). For example, one of the treatment groups that participants are required to attend is the *Healthy Living Program*, which "educates participants about the connection between high-risk behaviours and health risks" (Rideauwood Addiction and Family Services 2008: 16). In the following exchange, Adrian outlined a high-risk situation:

> **Adrian**: I had a high-risk situation. I was cleaning out my truck and I found some drugs and I threw it down the manhole.
>
> **Judge**: It shows strength on your part to resist the temptation.
>
> **Treatment liaison**: The quick decision is crucial...good judgment and insight. He's using the tools already.

In the following example, the treatment team gave specific instructions to participants in order to avoid relapse over the Canada Day long weekend:

> [The judge asks about Arthur's plans for Canada Day.]
>
> **Arthur**: I may be seeing a friend out of town...not sure yet.
>
> **Judge**: I wanna be sure you have plans in place for Canada Day.
>
> **Arthur**: I'm pretty good about keeping busy of weekends.
>
> **Treatment**: Because Canada Day weekend is coming up and is a difficult weekend for our clients, the most difficult weekend of the year for some of our clients. Treatment really hopes clients put in extra [12-step] meetings, extra phone calls and avoid high-risk areas...We hope they're setting up relapse prevention plans.

These instructions to engage in techniques of the self to avoid drug use relate back to the discourses of addiction-as-disease, which, as previously discussed, "constructs everyday substances and experiences as potentially dangerous, and sees risk, dysfunction and disorder everywhere" (Keane 2002: 11). The ODTC also considers certain family

members as high-risk (more on this in section 7.3). As a result, subjects in the ODTC were instructed to be vigilant and avoid at all costs *high-risk situations* that could lead to relapse.

Improving Appearance

The ODTC's use of a clean/dirty binary, as discussed in the previous chapter, is also tied to another technique of the self: improving one's personal appearance. ODTC participants were encouraged to visit the dentist, lose or gain weight, and generally improve their appearance as part of their transformation towards a *better* self. As such, judges made positive comments when individuals changed their hairstyle, dressed in clothes deemed *nice*, and when they appeared to be healthy. By way of example, a judge once told Arthur, "You're looking well, very healthy." In general, participants were rewarded with praise and encouragement when they addressed their health and went to dental appointments. For instance, after a woman had had dental surgery the judge commented, "'You look different. A great smile. You look wonderful," and the treatment liaison remarked "I'd like to say how great the smile is." In another instance, the judge said, "You look so much better than you did when you came in [to the ODTC]."

Weinberg's (2000) study of drug treatment also found a connection between the recovery discourse of clean and dirty and participants being compelled to improve their appearance. Likewise, Young's (1994) study found that women in treatment were encouraged to change their behaviours, dress and mannerisms with the goal of being *good* mothers and women. In the Ottawa DTC, links can also be made between being

healthy and being engaged in treatment. Below is an interaction with Carlos after he began following court and treatment orders:

> **Treatment liaison**: I'm pleased to give a very positive report. He's looking, sounding so much better. He's been to five 12-step meetings. He's at John Howard currently on house arrest. He's done some good reflection in the last little while.
>
> **Crown**: Congratulations. What a change.
>
> **Judge**: You look really healthy.

Conversely, participants were also derided by the ODTC staff if progress was not deemed to have been made on their appearances. For example, the judge often pointed out instances when individual participants did not look well or had not shaved, once saying to Kendra, "You don't look too well." How individuals appear in the ODTC is thus perceived as a reflection of whether they are maintaining sobriety (clean) or have the potential to relapse (dirty).

What Constitutes Progress?

Progress in recovery was not explicitly defined by the Ottawa DTC during my fieldwork, or in its policy documents. However, when pieced together, the ODTC's discourse of recovery reveals that progress in treatment involves, as discussed above and in the previous chapter, not using any substances, being honest with the court and treatment providers, accepting/performing one's identity as an addict, continually using the tools of treatment to self-govern one's conduct, avoiding situations, people and places that are deemed high-risk, improving one's appearance, and overall becoming a *better* person.

During pre-court meetings and at scheduled court appearances, participants were judged as to whether they are *on track* and *making progress* in their recovery. For example, in a typical exchange, the judge asked Tyler what he had been up to as of late.

Tyler: Wednesday I worked all day. This morning I did my community service hours…I had a one-on-one with [a treatment liaison] before court.

Judge: Are you back on track?

Tyler: I'd like to say I'm back on track, one day at a time.

Though vague benchmarks for measuring *progress*, phrases like "being on track" generally served to construct participants as *out of control* and as requiring treatment practices and techniques in order to regain control over their lives.

Personal progress in recovery is also understood as a long process in the ODTC; as the Crown counsel told the court, "the road to recovery is a long road". In Burns and Peyrot's (2003) study of DTCs in the United States, they found that recovery was constructed as a life-long process with no finish line. Thus, even if a participant reaches total abstinence for a long period of time they are still considered to be recovering. Participants in the ODTC were also told that "recovery is one day at a time...It really is a daily program that people have to work." The concept of recovery as mobilized by the ODTC has its roots in 12-step models and programs (Ronel 1997). In Narcotics Anonymous, for instance, addiction is conceptualized as an incurable disease that needs to be combated each and every day, for the remainder of one's life: "We cannot afford to become complacent, because our disease is with us twenty-four hours a day" (Narcotics Anonymous Basic Text 1988: 97). In this sense individuals never graduate from Narcotics Anonymous or fully recover from their disease of addiction: "We can never fully recover, no matter how long we stay clean" (Narcotics Anonymous Basic Text 1988: 80).

7.3 Implications of Treatment and Recovery as Self-Transformation

Participants in the Ottawa DTC are repeatedly taught that their recovery must become a *priority above all else*, including their families, spouses, friends and work. This prioritization of one's recovery works in concert with the emphasis placed on self-work as the primary course of treatment, and ultimately, on the fact that participants are held as individually responsible for their recovery. To this effect, judges and treatment staff often instructed participants on the importance of prioritizing recovery. By way of example, one judge said,

> Of concern are recent use of drugs...The priority has to be seen as your recovery. Recovery comes first and employment is gravy...Recovery has to be first. I'm of the view that it's far too early [to work].

This discourse of prioritizing recovery is directly tied to the ODTC's construction of a universal (genderless) subject rooted in neoliberal rationalities as well as to the disease model of addiction, which work to erase social factors and contexts from approaches to addiction and treatment. By ordering participants to focus on recovery, the ODTC pushes participants to detach from their social connections. In this section, I discuss the impacts of this discourse on relationships, particularly family ties in the case of women participants, and on employment, schooling pursuits and housing arrangements.

Impact on Family Relationships

Participants are ordered by the court to do work on themselves in order to enhance their well-being and improve themselves. Focusing all energy on themselves often has seriously adverse impacts on relationships with family members. McKim's (2008) ethnography at a mandatory criminal treatment centre for women revealed that staff encouraged the women to "focus on themselves" and less on their obligations to their

children, since these obligations were seen to interfere with treatment and recovery. This was also evident in the Ottawa ODTC; in one instance, Lucinda was working with her treatment counsellor to make plans to see her children, who live out of town. When Lucinda appeared before court, the Crown expressed concern about Lucinda seeing her children and perhaps developing a relationship with them:

> On the face of it I think it's a good thing that Lucinda reconnects with the kids. I'm wondering if that's feasible...How are the kids going to handle the in and out of Lucinda. The Crown would certainly want to hear of a more comprehensive plan...The idea here is to be a part of a program. I'm glad she wants to see [names Lucinda's children], but I want everyone to know that this is a serious program and it requires serious commitment.

In response, the judge addressed Lucinda and said,

> The reason we're all sitting here is that we don't want you to be placed in a situation where you relapse...We want to make sure that it's the best thing for you and your children. [The judge tells Lucinda to keep discussing this with her counsellor.] Hopefully you'll get to see your children with a plan everyone can live with.

The Crown and judge also expressed concern that her visit could potentially harm the children: "How are the kids going to handle the in and out of Lucinda?".

Male parents face no such scrutiny, underscoring the gendered nature and masculine ideal of recovery in the ODTC. The court is aware that certain men have children since this information is included on their intake forms. Male participants also talked about their children in court, and some even brought their children to court. However, the court showed more interest in women's children and in particular, in exerting control over the relationships women participants had with their children. ODTC team members typically asked the names and ages of a woman's children, inquired about the last time she saw them, and followed up by asking how visits went. In contrast, men's visits with their children did not face the same scrutiny because these relationships and visits were not generally considered risk factors that could lead men to relapse. When a

man reported having visited with his children, he was typically given approval by the court. There was rarely a discussion of whether or not the man would regain custody of the children (or even whether he wanted to). For example, the judge inquired about Ben's weekend plans:

> **Judge**: You're going to see your kids this weekend?
>
> **Ben**: Yes.
>
> **Judge**: Good, well have fun with them.

Unlike in the example of Lucinda above, Ben's involvement in his children's lives is not seen as a risk for relapse or as interfering with his recovery.

Impact on Employment and Schooling

The requirement to prioritize recovery above all else has implications for participants' involvement in work and school. For instance, attending school or work is prohibited during the first three to four months of participation in the Ottawa DTC because these activities are seen as interfering with recovery. The employment rate of participants varies among Canadian DTCs. For example, 45% of participants in Regina and 31% of participants in Toronto held an employment position upon entry into the program (Department of Justice 2009). Furthermore, employment or attendance in school is one of the requirements for graduation in the Toronto, Vancouver, Winnipeg and Ottawa DTCs.[25] Paradoxically, work, school, and in some cases stable housing are perceived as a threat to recovery despite being required for graduation (Rideauwood Addiction and Family Services 2008). One reason Seamus dropped out of the Ottawa DTC within the

[25] Edmonton DTC requires participants to have "contributed to the community through service work," and the Regina DTC requires participants to "have acted on their return to community plan" both of which could include a requirement to be employed or in school depending on specific conditions (Department of Justice 2009: 33).

30-day trial period was this policy of not being able to work during the first months of the program. In an interview, he explained why this policy did not work for him:

> I needed to work basically to put a roof over my head and food in my belly...Work is important to me. I've always worked, you know what I mean. It gives me a sense of purpose.

When Kathy reported relapsing on the weekend, the court and treatment team encouraged her to quit school. The judge asked her about when she used, and the following exchange took place:

> **Kathy**: Thursday, Friday, Saturday and Sunday...I left school to concentrate more on recovery. I'm gonna be at group sessions every day.
>
> **Judge**: I hope this is an opportunity for you to turn it around. I'm glad you're still working with E. Fry.
>
> **Treatment liaison**: The decision to leave school to focus on recovery is a good one...Kathy maintains contact with Rideauwood and does the work.

In McKim's (2008) ethnography of a court mandated women's addiction treatment centre, this same contradiction was highlighted. Just as with participants in the ODTC, women in her study were required to have a job or be enrolled in school in order to graduate from the program; however, both the ODTC and McKim's treatment centre "viewed employment, like motherhood, as something clients were not ready for until they had built up a therapeutic self-understanding" (2008: 319). Furthermore, the Department of Justice's own summative evaluation of Canadian DTCs found that "some DTC team members acknowledged that the requirements of the treatment program can make it difficult for participants to achieve other outcomes during the program, such as education and training or employment" (2009: 33). Yet prioritizing recovery above all else remains central to the discourse of recovery and shapes the ODTC's policy and treatment practices.

During my fieldwork, I also noted gendered conceptions of the kind of work or school that women participants were encouraged to pursue by the ODTC. In one instance, the judge asked Natasha whether she was working or in school:

> **Natasha**: I'm working with [John Howard] about going to school in January.
>
> [The judge asks what she's taking.]
>
> **Natasha**: Chemical engineering.
>
> **Judge**: What made you think of that?
>
> [Natasha says she did testing at John Howard and it kept coming up that she was suited for engineering.]

A few weeks later, when the same judge asked Natasha if she was working, she replied:

> **Natasha**: No, just doing testing for back to school.
>
> **Judge**: I understand your testing shows you'd be good for [laughing] engineering.

The judge's disrespectful response implies that Natasha should not be pursuing engineering, which is a traditionally masculine profession. This corresponds to findings in the literature that argue that women in the judicial system are expected to abide by traditional gender norms, and that the education and employment training available in prisons are highly gendered (Bertrand 1999; Maidment 2006). For example, Bosworth's (1999) focus on women's experiences in prison reveals the ways in which women are subjected to gendered programming such as sewing and cooking, which is designed to *rehabilitate* by teaching them to embrace traditional notions of femininity. Natasha's foray into a traditionally masculine industry is laughed at by the judge in open court, signalling that the court would prefer that she pursue a job considered more appropriate for women.

Impact on Housing

If participants had housing upon entry into the ODTC (most did not), they were often forced to move out because they would no longer have the financial means with which to pay rent after quitting their jobs, or because they were living with people or in areas that were deemed high-risk by the ODTC. Often, such measures resulted in participants going from a situation of stable housing to one that was much more precarious. Angelica detailed such tensions around her housing:

> My youngest had a restraining order on me when I went into drug court. She kicked me out of the house. I wasn't allowed to live there. I had nothing, nothing. I finally got back on my feet got an apartment and [the ODTC Manager] says "No you're quitting your job and you have to give up your apartment." I just came from the streets you idiots. Like, you don't know nothing.

Even in ordering participants to self-manage high-risk situations and to avoid people and places deemed dangerous to their recovery, the ODTC would often place participants in high-risk situations such as ordering them to live at shelters, which have high rates of drug use and violence. When I interviewed Rebecca, she discussed the difficulties in being required to stay in a shelter while in the DTC program, which requires maintaining abstinence:

> But major problems with housing. Like you can't put somebody that's...you might as well just gimme a pipe and a rig, you know what I mean, when I walked out the door.

In the following example, ODTC actors discussed whether to allow Drew, who was in custody at the time, to continue in the program. The court emphasized that Drew must make "some dramatic life changes":

> **Crown**: The assessment phase should be extended another 30 days and quite frankly that's to protect Drew because what's needed is some dramatic life changes.
>
> **Duty counsel**: I spoke to him about his desire to stay in the drug treatment

> court and he recognizes some changes will have to be made in terms of his living arrangement...There's a bed available at the Salvation Army.
>
> **Treatment liaison**: Major changes need to be made.
>
> **Judge**: You've had a few days to think about it [in jail]. This is going to take some work, changes have to be made and the first change is your living arrangement and who you hang around with...See if you can stay away from all the negative things [at the shelter tonight].

The judge acknowledged that the shelter was not a safe space for Drew to live while simultaneously demanding that he change his life and his friends. However, it is important to recall here that the onus always rests with the individual participant not to use drugs or violate their bail conditions, such as if Drew had stayed at a friend's house instead of at the homeless shelter. If a violation occurs, even if exacerbated by an order from the treatment team or judge, it is the participant who is punished. Here, the tangible negative impacts of the disease model of addiction and of treatment as self-transformation on the lives of participants is laid bare. In the next section, I discuss how some participants expressed resistance toward these approaches.

7.4 Resistance to Treatment Practices and Discourses of Addiction

I now turn to a discussion of the ways in which some of the participants in the ODTC actively contested the discourses and practices of recovery and treatment. In particular, I explore how some participants viewed their addiction in more complex ways than the understanding put forth by the ODTC, and how others refused to identify as, and perform the role of, *addicts*. I also discuss how some participants effectively put into practice harm reduction techniques in order to self-manage their addictions. I then conclude this

section by highlighting an instance of resistance where a participant refused the imposition of a new *clean date.*

Contesting Discourses of Addiction and Recovery

Even given the unrelenting pressure to self-identify as victims of a chronic, progressive disease, some participants understood their addiction in more complex ways. In one example, Tyler explained how his understanding of addiction was different than that of the Ottawa DTC:

> **Tyler**: See I have a hard time with the disease concept. I think it's, that's the way the manipulation is at this point in time, but ultimately it comes back down to the addicts that have, ah there's fears, pains and crap that's bottled up that has to come out somehow and that's where the counsellors come in and that's what my definition of addiction is, you know is dealing with the coping skills.
>
> **Tara**: So addiction is coping?
>
> **Tyler**: Yeah, that's what I think it is.

When I asked Graydon if his experience in the ODTC changed how he thought about his addiction, he responded by saying,

> I always kinda thought of this theory that if I admitted it [that I have a disease of addiction] and kinda given myself stage [steps one and two of the 12-steps] maybe that's almost like my justification for, for letting myself just go crazy because I've almost got like an out. Well, I'm an addict so I might as well just go for broke, you know what I mean?

Here, Graydon challenged steps one and two[26] of 12-step programs specifically, and the disease-model basis for 12-step programs in general, by explaining that admitting to a disease and giving oneself over to a higher power provides an excuse to use drugs. This is similar to how Ben spoke about his *recovery* in non-recovery terms:

> I looked at it different you know, everybody was saying stop, you know, you

[26] Steps 1 and 2 of the 12-steps of Narcotics Anonymous are: "(1) We admitted that we were powerless over our addiction, that our lives had become unmanageable and (2) We came to believe that a Power greater than ourselves could restore us to sanity" (Narcotics Anonymous Basic Text 1988).

> have to stop [using drugs], and nah nah nah. I said, I just told 'em psychologically stopping allows you to start [using again]. It's just something that, you know, you can start because you know that you're working on stopping...I said me, I just put my foot down and I just said I'm not going to start. I had to draw that line there. I couldn't deal with stopping because I said, you know...stopping allows you to start you know, it really really does you know. It does and you think well, *if you got a program that's fixated on stopping ah, it really opens up one's thought process to, oh I can use because I'm trying to stop. You know, you can use again because you can stop*. I looked at it like that, I think more than anything so, it worked (emphasis added).

Embedded within the discourses of addiction-as-disease, and touched on in the examples above, is the concept of control: control over one's self and control over substances. In Brown and Stewart's (2007) work on harm reduction alcohol treatment programs for women, they found that many participants had internalized the belief that they have no control over alcohol. The conception of the addicted subject as totally lacking in control over substances themselves is central to addiction-as-disease discourse and its associated treatment practices. Brown, Stewart and Larson argue that this approach "encourages binge drinking: if having one drink is perceived as failure, it makes no difference whether one has one drink or many" (2005: 102). Graydon comments that the 12-step and disease models of addiction are a justification for drug use and binges supports such findings.

The disease model of addiction continues to prevail in part because it resonates with the idea that addicted subjects are not in control of themselves and therefore require therapeutic interventions (Hammersley & Reid 2002; Weinberg 2000). As such, another manner in which participants contested the discourse of addiction-as-disease was by denying that they had an addiction and by therefore asserting that they did not need treatment. For example when I asked Chad if going through the ODTC or Rideauwood changed how he thought about himself, he responded:

> **Chad**: I don't know, I don't think so 'cause I, I never really considered myself an addict in the beginning.

Tara: Okay and you still don't?

Chad: No

When I asked him what kind of using would result in him considering himself an addict, Chad responded, "My thinking also is that if you're using every day, obsessively and I never did use every day, anytime, so I, that's why I don't consider myself an addict." Chad had never participated in addiction treatment before, had little exposure to 12-step meetings, and did not believe himself to be an addict. Nor did he believe abstinence to be the most appropriate treatment for him, which led him to inquire about harm reduction treatment programs with other service providers in Ottawa. Similarly, in Culhane's long-term ethnography of women in Vancouver's Downtown Eastside, women in the study consistently rejected addiction-as-disease and its attendant notion of recovery. Instead, "Women stressed the importance of building strong support networks, of access to safe housing, of protection from interpersonal violence, and of opportunities for education" (Culhane 2009: 174).

In my conversations with participants, some discussed their ability to stop using drugs if they so chose. One participant told me he could stop using drugs altogether since he had previously stopped using crack. Another told his case manager that he would not stop using drugs forever. When participants suggested that they could quit using drugs without treatment, they were ridiculed by ODTC staff and even other participants, and/or considered to be in denial. Here is one exchange that took place when Carly decided not to enter the ODTC:

> Carly said, "I was speaking with [the treatment liaison] this morning and he told me it'd take up to two years [to finish ODTC]. I've quit drugs before on my own and I'm sure I can do it again." A ODTC team member looks back at me and rolls their eyes. The participants in the front row also dismiss what Carly says and laugh.

When individuals stop using drugs without the assistance of treatment, or gradually come to use substances moderately (i.e. do not engage in abstinence), the discourses of addiction and recovery which underpin not only the Ottawa DTC, but also Canadian drug policy and popular conceptions of addiction, are challenged.

The concept of denial is central to the discourse of addiction and recovery in both the ODTC and Canadian society in general (Peele, Bufe & Bodsky 2000). Keane argues that this concept "justifies, even requires, overriding the addict's expressed wishes and ignoring his version of reality, in the name of his genuine needs and desires" (2002: 76-7). In the ODTC the concept of denial was used to justify the imposition of instructions and orders of the court and treatment teams. In this way, the ODTC constructs addicted subjects as being incapable of understanding what is best for them and as therefore requiring the intervention of experts—treatment providers and judges—to come to this understanding. When participants tried to speak about what worked best for them, for example requesting a change of their treatment counsellor, they were deemed to be lacking motivation or to be in denial. In Whetstone and Gowan's study of a drug court, they found that "self-advocacy that departed significantly from standard recovery mantras was invariably taken as proof that the 'disease' was speaking" (2011: 318). However, my findings indicate that many participants in the Ottawa DTC did in fact know what strategies of drug use management and treatment practices were most effective for them.

Harm Reduction as Drug Use Management

As outlined in the previous chapter, with the disease model of addiction underpinning treatment practices in the ODTC, recovery must involve complete abstinence. Some participants in the ODTC, however, adopted different understandings of their own drug

use and, as a result, adopted different techniques to manage their drug use or non-drug use. For some, this meant that not all drug use caused the same degree of harm and that their experience of *progress* was different than that of complete life-long abstinence as required by the ODTC program. For example, Jeremy was reducing his drug use significantly and considered this an accomplishment, telling the judge after reporting drug use, "I did use less." On another occasion, Jeremy talked about reducing the amount of drugs he used:

> **Jeremy**: I slipped on Sunday but I was 6 days straight...It was very little I used that night.
>
> **Judge**: It doesn't seem like it was worth it, was it?
>
> **Jeremy**: No.

Another participant, Randy, articulated how his process of recovery was happening more slowly than what is required by the court. He spoke about how he was using less and also doing less crime:

> **Randy**: I was going to lie, but Tuesday I went to the [homeless shelter] and smoked a couple of joints with cocaine.
>
> **Judge**: We need to start thinking about something that's going to work for you.
>
> **Randy**: It's working a bit, I'm using a bit, I'm not using every day...I'm not out hustling at night.

In another case, Graydon explained how he managed alcohol and drug use with harm reduction techniques:

> **Graydon**: When I start, like if I were to start using drugs, yeah it's tough for me to stop and yeah I'll go crazy.
>
> **Tara**: But you can drink [alcohol]?
>
> **Graydon**: I can drink wine beer...My big thing now is I stay away from hard liquor because hard liquor leads to...

Tara: Wanting to use?

Graydon: Exactly so I can, you know on a number of occasions my girlfriend and I share bottles of wine, we go out, we have a couple of drinks...If maybe she's not around and I start drinking vodka or Jagermeister then it could get ugly.

Graydon was not alone among ODTC participants in his use of harm reduction strategies. Some participants avoided situations that they felt would lead them to using drugs, while others avoided specific substances. Certain participants felt they could not take any of their drug of choice without harm ensuing, but, like Graydon, they felt they could use other substances without negative repercussions for them. In the same discussion, Graydon told me that he used marijuana as a way to prevent a drug-using binge. When I asked Graydon if a harm reduction program would work better for him than an abstinence-based approach, he responded:

> I don't know. I don't know about that. I'll still smoke weed. I think you know, in a lot of instances, like I'll finish work you know, I can sit at the bar and have four beers or you know I'll smoke a joint and have one [beer] and go home...If I didn't smoke a joint I'd sit at the bar and drink three beer and what's next?

In the above passages, it is clear that Graydon engaged in harm reduction practices, even though he was not comfortable in labeling these practices as harm reduction. For instance, he used marijuana to prevent himself from using other substances that would have led to self-defined trouble. He also said that being with his girlfriend kept him safe from using certain drugs.

Often participants would discuss having a sense of what substances would allow them to get through the day, make them feel better, and reduce harm. For example, Kurt reported to the judge, "On Saturday I slipped up and smoked a joint of weed but I didn't do crack...I passed on that." After reporting marijuana use on the weekend, Samuel explained, "I was coming down and it was maintenance for me to stay off the crack and I

didn't use crack". Unfortunately, treatment programs and policies too often disregard drug users experience and knowledge (Fischer et al. 2007). In the ODTC, treatment providers and judges are considered the experts, not the drug users themselves. Denying drug users the opportunity to define for themselves what works in terms of treatment is perhaps one of the greatest failings of the ODTC's approach to treatment and recovery. This practice also contravenes findings that stress the importance of including drug users in treatment decisions (Fischer et al. 2007; Pearshouse 2009). In the next example, Alex was using marijuana and not reporting this drug use to the treatment team or to the court. However, at this particular court appearance, he admitted that he had been in fact smoking marijuana.

> **Alex**: I was unhonest about [drug] use the last time I reported it.
>
> [The judge asks when.]
>
> **Alex**: There was a couple of times.
>
> **Judge**: With treatment or court?
>
> **Alex**: I didn't report as many times as I used.
>
> **Judge**: I'm glad you're coming clean and admitting the dishonesty but I'm concerned about where you're going with the continued use.
>
> **Treatment liaison**: Alex is struggling to remain alcohol and drug-free, especially cannabis free.
>
> **Crown**: Alex has reported his use and told us he wasn't honest about his full disclosure of his use. The problem I'm having is that, we don't sanction for use, but...at this point I don't know if Alex is committed to this program. I ask Alex to take the weekend to really think about and reflect on where he's going.
>
> **Judge**: [Two weeks ago] I tell you I expect to hear clean urine results and you've been using. I'd like to have a letter provided to treatment by Monday about your intentions.
>
> **Alex**: I have an appointment next month with mental health...*I use marijuana, it's wrong. I can't deal with life sober, it's just too fast. I can't write a letter sober. I'm paying rent, paying my bills, not smoking crack, that's the first time in my life.*

> **Judge**: We don't punish people for use but it's an abstinence-based program...You're running out of time. [He orders the letter written by Monday.]

Here the judge makes it clear that unless Alex can stop using all forms of drugs, including cannabis, he will be expelled from drug court and sentenced for the charges he has already pled guilty to. I spoke with Alex after court; here is an excerpt from my field notes:

> Alex says that was the first time he has opened up in court and the judge shut him down. He says he smokes a joint and by the fifth day he starts to go nuts. He says he's doing good and when people see him they're like, "Wow you look great" and his response is that he is not smoking crack and only smokes pot on weekends. He says he needs to smoke cannabis to calm down or he goes nuts. He says look at this and hands me a piece of notebook paper from a Royal Ottawa Mental Health outreach person. He said she spent ten minutes with this person and was prescribed Seroquel.

Alex saw himself as improving his life by not smoking crack and only smoking cannabis on the weekends. Alex explained how smoking marijuana, for him, results in less harm in his life. He gave measures of his progress (e.g., paying the bills), but these were not considered relevant to the ODTC because he has been consuming cannabis. The ODTC admonished him continually about his marijuana use and instructed him to take Seroquel instead of marijuana, since marijuana is illegal, but Seroquel is not. Alex did as instructed by the ODTC, and two weeks later, he talked to me about his experiences with Seroquel and cannabis before attending court. Here is another excerpt from my field notes:

> Alex is on Seroquel now and it's making him "trip." He's having fits of anger. Smoking a joint doesn't make him flip out he says. They [treatment] tell him to keep taking it. Two other women are sitting nearby and they ask how much he's taking. They say they are taking 300 milligrams a day.[27]

[27] Research has demonstrated that Seroquel is readily dispensed to women in Canadian jails and prisons (Kilty 2008). Kilty argues this "Over-prescription effectively subdues this population of women, who are often characterized as misbehaving or rowdy" (2008: page number not given).

Seroquel does produce *mood-altering* effects, and like all substances has different effects on different people and in different contexts. In this case, the Ottawa DTC pushed prescribed medications while admonishing the use of cannabis, a substance with medical properties[28] that Alex found helpful.

When participants did disclose to the court and treatment providers that they were using cannabis, the news was never well received. Individuals who did not produce *clean* results, including Alex, were removed from or quit the program and sent to sentencing. Other participants quit the ODTC because they understood that they would be required to stop using cannabis. Seamus, in discussing why he quit the Ottawa DTC within the 30 day trial period, said:

> Not being able to...smoke marijuana there was no way I would be successful at it because marijuana is a tool that I use to much benefit to stop doing needles and stop doing morphine, you know to get on with my life. It was an essential part. I know some may say it's a crutch but it's an alternative but ah it's a much safer alternative.

These examples demonstrate how participants often had different understandings of success and recovery than the ODTC. Some participants did not adhere to the strict abstinence requirement and did not see all drug use as harmful. Some participants used cannabis to mitigate their mental health issues, for pain management, or to help avoid their drug of choice. Not all of this use was reported to the ODTC; some of this information comes from my conversations with participants. These examples not only challenge the ODTC's discourses of addiction and treatment practices, but they also illustrate why addiction and recovery cannot be separated from social contexts and social relationships. The ODTC's approach effectively erases social contexts and factors

[28] Medical marijuana is legal in Canada, and its medicinal qualities are recognized outside the drug court. See an overview of Health Canada's medical marijuana program (Health Canada n.d.).

whereas participants' understandings of their own addictions were often more nuanced, incorporating the role of housing, past trauma, personal relationships and other factors into their drug use or non-use patterns.

Resisting the Imposition of Clean Dates

One final example of resistance points to the contradictions within the drug treatment court system and how some participants contested and resisted the ODTC's approach to addiction and recovery, particularly over the imposition of *clean dates.* At the previous court date, Jesse's urine drug test came back positive; however, Jesse denied having used drugs. The treatment team informed him that he was to have a new clean date (first day of abstinence) because of the positive urine test, which he contested. I wrote in my field notes that:

> He said they took away his clean date which was shit so he decided if they were going to take away his clean date he might as well use and change it for real; change it for himself.

A new clean date meant that Jesse would not be eligible for early leave or for graduation from the program because of the requirement for a specified amount of days *clean* (free from any drug use) in order to apply for graduation. As an act of resistance against the imposition of this new clean date, Jesse decided that he would use and make a new clean date on his own terms. When Jesse next appeared before the judge, he explained his motive for using to the court.

> [The judge asks if he used.]
>
> **Jesse**: Yes, yesterday I did a line of coke and smoked a joint. They changed my clean date so I decided to change it myself. I thought about it lots and it was something I had to do.
>
> **Judge**: You understand that when you have a positive test...

Jesse: I know, it's all been explained to me.

Judge: The court doesn't change your clean date, you do. How'd you feel after you used?

Jesse: How did I feel the day before, how do I feel like, like garbage...Can't change what's done.

Judge: I encourage you to get back to doing 12-step programs. Your short term goal is to get your early leave back. You don't need to be involved with drugs. You can beat this.

Jesse: I know.

Treatment liaison: Our concern as always is to stabilize clients, to get them back on track...Our concern is when a client decides to use it can awaken a cycle...He's been a high functioning client and there's no reason he can't get back to that.

Jesse: Next week is a new week, today is a new day.

Judge: That's right.

Jesse decided to use drugs in an effort to define a clean date on his own terms. The judge replied by saying that the ODTC does not take or set clean dates for participants in the ODTC, yet this is what happened to Jesse. This is one of the strongest examples of resistance I witnessed, in part because Jesse was close to graduation and because he was considered one of the *successes* of the program. Jesse also understood that the ODTC needed and wanted him to graduate because the program was desperate for graduates. When I interviewed him and asked about this incident, he said:

Jesse: I super felt cheated on that because, and I think that was the breaking point when I decided that I just wanted to move on and...maybe try to exit the [ODTC] program because I think in order to graduate you needed to have, I forget what the time was but I think I was close [to that clean time to graduate] and I was like...if they're gonna take my clean date I might as well make it worth it...I might as well go on a friggin lil' bender.

Tara: And then you came in and told them I used because they took my clean date?

Jesse: Exactly I took control because they, that's what they tell you, you know, that this is yours, it's your recovery. This is your program, you work it the way

> you want. But then all of a sudden they kinda go back on the other angle and say uh uh uh, no maybe that's not right. You know, maybe we really control everything the be-all-end-all you know, what we say stands...You know I disagree, it's still my program, still my recovery, I can do what I want.

This example demonstrates Jesse's resistance to the ODTC's determination of abstinence and the consequences of positive urinalysis results. Jesse resisted in that he *took back* his clean date by using drugs after the court changed the date of his last drug use against his consent. Jesse had felt a sense of ownership over the recovery process, which the ODTC attempted to take away towards the very end of Jesse's participation in the program; he fought back by asserting control over the situation in the only way that he saw available to him.

7.5 Conclusion

The ODTC's discourse of treatment and recovery is one of self-transformation. Through being taught to assume an addicted identity, and being rewarded for performing that identity in court, participants themselves come to reproduce the disease model of addiction. One important implication of this adoption of an addict identity is that participants often come to feel personally responsible for events in their lives that may contribute to their drug use. As mentioned above, however, structural factors are by definition ignored in the ODTC's disease-based approach.

In helping participants to transform their identities into those of *better* citizens, the ODTC compels them to adopt techniques of the self including working on oneself through *using the tools* of treatment, self-managing high-risk situations and improving one's appearance. Progress in recovery does not appear to be measured in any precise and consistent manner; however, what is clear is that participants are expected to not only

stop using substances, but to transform their behaviours and thinking through techniques of the self. This prescribed treatment of focus on the self before all else—termed prioritizing one's treatment—often has dire impacts on participants' lives outside of the program. Contact with family was subject to particularly onerous examination, particularly when it came to their children as the court claimed that such contact may result in high-risk relapse situations. Participants are also prohibited from holding employment or going to school for the first three to four months of the program, resulting in many having to quit their jobs, and others having to give up their current living arrangements in order to live in shelters instead because they cannot continue with their rent

Even in the face of unrelenting pressure to do otherwise, many participants refused to internalize the identity of the addict, instead opting for more nuanced understandings of their drug use. Others initiated harm reduction techniques in order to help manage their drug use, though they did not always use the harm reduction label. Others still actively contested instances where the ODTC sought to take control over their recovery process.

In many ways, addiction and recovery are about so much more than just the use of drugs in the drug treatment court; DTCs and therapeutic jurisprudence constitute the addicted subject as requiring personal and individual transformation (Miller 2009). The Ottawa DTC is set up to control behaviours deemed unacceptable, particularly those that threaten neoliberal principles, such as individual responsibility. According to Tiger, "Drug courts are interested...in affecting a constellation of behaviors believed to contribute to drug use and its outgrowth, criminal activity" (2011: 174). Controlling

participants' drug use ultimately becomes a matter of control over the participant's entire life and way of being. In the following chapter, I examine in detail the blurring of the boundaries between treatment and punishment, and between legal and treatment actors, in the ODTC. I detail a number of negative implications of this blurring, as well as means through which ODTC participants pushed back.

Chapter 8: Punishment and Treatment in the ODTC: The Implications of Blurring Boundaries

8.1 Introduction

As I outlined in the previous chapter, the goal of the ODTC is to compel participants to transform their lives, and particularly to cease drug use and criminal activity. Participants are taught that they suffer from the disease of addiction, but that through following a treatment program and engaging with the process of *recovery,* they can gain happiness and freedom (Nolan 2001). And although addicted subjects are not considered to have *chosen* their disease per se, participation in treatment and ceasing to use drugs are viewed as choices that addicts must make. In order to compel participants to choose recovery, the ODTC mobilizes a system of rewards and sanctions that blurs the boundaries of the judicial and biomedical fields.

The following chapter explores the implications of blurring punishment and therapy in the ODTC. Specifically I outline six practices where the boundaries of treatment and punishment are blurred, framing the courtroom as a therapeutic site where judges attempt to engage in therapy with defendants, while treatment counsellors are given legal powers. First, I discuss how the courtroom has become a therapeutic space where public appearances and the use of shaming are part of the therapeutic process. Second, I show how legal actors, in particular judges, have taken on the role of dispensing therapeutic advice, effectively compromising their traditional role as neutral arbiter. Third, I explore how treatment providers are given powers of enforcement and judgment despite having no training in those areas. Fourth, I outline how participants are subject to intensive surveillance as well as punitive measures through their housing arrangements with the ODTC. Fifth, I examine how therapeutic sanctions operate within the ODTC, that is, when judges and treatment providers order sanctions as a way to

motivate participants to work towards their treatment goals. Finally, I turn to a discussion of the use of incarceration and forced detoxification as therapeutic treatments within the ODTC. Ultimately, I argue that the blurring of legal and therapeutic roles and boundaries results in serious negative consequences for ODTC participants and undermines the stated goals of the process itself: to help participants achieve recovery from addiction.

8.2 The Courtroom as Therapeutic Space

In the ODTC, courtroom appearances are considered to be part of the therapeutic process. During the twice-weekly appearances, participants are questioned about their progress and setbacks. As detailed in Chapter 5, ODTC staff hold private meetings prior to court sessions. During these meetings, ODTC staff decide the order in which participants will be called before the judge. Those who are *progressing* appropriately in the ODTC are called first, while those who will be receiving sanctions at that court appearance are called later. After appearing before the judge, participants are required to stay in the courtroom until all participants have appeared. The stated rationale for this policy is that participants who are *doing well* in the program will set good examples for participants who are *struggling*. The ODTC outcome evaluation states that "the judge will sometimes recognize participant success by asking them to share their experience with the court and for the benefit of other participants" (Rideauwood Addiction and Family Services 2009: 17). Here is one such exchange:

> [Aaron reports no drug use.]
>
> **Judge**: Has that been hard?
>
> **Aaron**: No
>
> **Judge**: Can you tell everyone else why this is.

> **Aaron**: I think about how I feel after getting high. I'll end up in jail or want to kill myself.

In a conversation with one of the treatment counsellors, I asked why participants were required to stay in court for the duration and noted her response in my field notes:

> She says, of course I wouldn't understand because I do sociology, but they have to stay to create or force insight; things like, "I remember when I used to do that" and to see how other people are progressing.

This policy also ensures that participants not following treatment orders are punished in public; thus, not only do participants who are progressing well become role models, but those who are disobedient are made an example of by the court. This policy resulted in anxiety for some participants, particularly those who did not believe that they had a reason to be sanctioned. On one occasion, Lucinda was in trouble with the court but was not given notice that she would be called later than usual. Here is an excerpt from my field notes on this issue:

> They are leaving Lucinda until last because she is in trouble and they do this as a form of punishment. Lucinda is getting more anxious and more upset with every person who is called before her.

Those participants who were progressing well through the program—i.e. had a period of abstinence and had complied with their bail conditions and treatment orders—were often accorded *early leave* (Rideauwood Addiction & Family Services 2009). Those with early leave are called to appear before the judge first and are allowed to leave immediately after their appearance. Early leave is revoked if the participant uses drugs or breaches any bail conditions. If those without early leave exit the courtroom before court is adjourned, the clerk makes an announcement calling them back into the courtroom and/or the treatment staff brings them back into the courtroom. Like sanctions, early leave was inconsistently given and taken away. Kathy had her early leave revoked as a sanction, and three weeks later Kathy asked about getting it back:

Kathy: It was [revoked] for two weeks, now I've been told it's 30 days.

Judge: The policy of the program is that early leave and coming to court once a week are an earned privilege, not a sanction...We've had a 30 day window now as long as things are going okay.

Kathy: It was used in this situation as a sanction for what I did when I used.

Judge: It may've seemed like that but it was a removal of a privilege.

Treatment liaison: It is a policy we're working on...We look for 30 days of abstinence...*Those reappearances in court are about stabilizing and help[ing] support the client.* Hopefully they see them that way.

While Kathy was initially told that her early leave would be revoked for two weeks, she was later informed her early leave would be revoked for 30 days. When she questioned this change, the judge responded that the removal of her early leave wasn't a sanction but a withholding of a privilege. Therefore, privileges and the revoking of privileges are also used as sanctions in the ODTC.

Public Shaming

Using public courtroom appearances as therapeutic exercises in the ODTC explicitly works to shame participants. Miethe, Lu and Resse (2000) hypothesized that drug court participants would have lower recidivism rates compared to individuals in the regular court system because drug courts utilized the principles of reintegrative shaming. *Reintegrative shaming* is one of two types of shaming in Braithwaite's theory. It is characterized by disapproving of actions rather than individuals, and presents the opportunity for reintegration into the community. According to Braithwaite's theory, reintegrative shaming has a positive social impact, allowing individuals to distance themselves from criminal behaviour. *Stigmatizing shaming*, on the other hand, imposes a deviant label on individuals and is not deemed to have a positive social impact. Miethe,

Lu and Resse found "that drug court was far more stigmatizing than reintegrative" characterized by a public shaming in open court, including "a clear preponderance of stigmatizing rather than reintegrative comments" from judges to DTC participants (Miethe, Lu & Reese 2000: 536-7).[29] They found that those in the mainstream criminal justice system faced less stigmatizing comments and practice. Likewise, Chriss argues that "the personal, intimate approach of the drug court may actually be exacerbating rather than reducing stigmatizing shaming, thereby promoting secondary deviance among drug court defendants" (2002: 199). Boldt argues that moral judgments embedded with our cultural understandings of drugs make it difficult to foster a therapeutic, non-judgmental environment "within the context of the criminal blaming system" (2010: 67).

8.3 Legal Actors as Treatment Providers

As discussed in Chapter 5, legal and treatment actors occupy significantly different roles in DTCs. A central aspect to the courtroom as therapeutic space is that judges act as team leaders rather than as neutral arbiters (Wiener et al. 2010), and Crown counsels give therapeutic orders and attempt to engage participants in therapy. As Wiener et al. state, in DTCs "Judges...lead community treatment teams and play an important role motivating participants and directing treatment" (2010: 424). Mackinem and Higgins argue that the therapeutic role of judges poses problems: "Judges have great power to punish but are only amateur therapists, opening the opportunity for naïve abuses of power. Judges are

[29] It is important to note that the Miethe, Lu and Resse (2000) study included three months of fieldwork observations in the Las Vegas drug court. These observations shaped the research conclusions and demonstrate the importance of courtroom observations. The research design included a control group of cases from non-drug courts and found that DTC participants had higher recidivism rates. The court observations allowed for an explanation for this surprising finding which is further evidence of the importance of incorporating ethnographic methods into future research on DTCs.

not independent but act in concert with others, including private therapy providers who profit by the judge's decisions" (2008: 32).

In Bourgon and Price's evaluation of the Ottawa DTC, they note that the relationship between judges and participants is "similar to a therapeutic alliance" and is more successful if there is good rapport (2007: 35). The judges often ask therapeutic questions, such as "How did that make you feel?" in their exchanges with participants. When Brian admitted using drugs, the judge prompted him to discuss treatment strategies:

> [Brian reports drug use and the judge asks about the circumstances around the drug use.]
>
> **Brian**: I had my head at the wrong place...I'm going to a relapse prevention group.
>
> **Judge**: Are there plans or strategies you can use to not fall into the trap?
>
> **Brian**: Go to my meetings. Every Thursday I go to that group. Follow the direction [of treatment].

Judges also often asked participants who had reported drug use about how it made them feel:

> **Douglas**: I took five Valium. The trigger was I was going through a rough time. [He explains an issue with his son.]
>
> **Judge**: It probably didn't make you feel any better the next day.
>
> **Douglas**: No, worse.
>
> **Judge**: It's important you develop skills and tools to deal with stress.

In other cases judges asked participants who were doing well questions such as "Are you using any particular strategies to help you not use?" or "What techniques have you taken to avoid taking drugs?"

Below are two more examples of some of the therapeutic techniques used by judges to prompt participants to engage in *reflection*:

[Dominic reports drug use yesterday. He says his bible study was cancelled.]

Judge: If there had been a Wednesday night bible study would you have been there?

Dominic: Yes.

Judge: Could you have made better use of your church? Could you have called someone?

Dominic: Yes.

When the judge revoked Archie's bail for leaving the detoxification centre early, Archie repeatedly asked the judge why he had done so, which led to the following exchange:

Archie: I got you pissed off at me is that why?....I haven't done nothing.

Judge: I want you to think about your attitude towards the court....The next step is expulsion. Your attitude is such that I'm wondering whether you should be in the program. If your attitude continues I'll remove you from the program.

Archie: You're putting me in jail because you're pissed off at me?

Judge: No, because it's my job.

The judge told Archie that it is his job to revoke his bail and punish him for not complying with bail conditions and treatment orders. Archie, however, was confused and interpreted his bail revocation as a result of the judge being angry at him for leaving the detoxification centre early. This confusion may be in part because judges act as counsellors in their interactions with participants. In the criminal justice system, judges have clear roles and relationships with defendants; however, in the ODTC these boundaries are blurred, with the judge both punishing participants (revoking bail) and acting as therapist (asking how they felt after a relapse). One judge outlined some of the tensions that arose from this dual role. In sentencing a long-time participant in the ODTC, he discussed the problem of familiarity:

> This creates certain advantages and great difficulty personally for the judges to impose sentence on any participants in drug treatment court because we get to see a side of the person we're sentencing. We're able to watch

> progress...We're someone who cheers the successes and mourns the losses. We see very good people like William who do bad things. Very unique human beings who have so much to offer.

The role of judges in DTCs is drastically different than the role of judges in regular courtrooms. Notably, judges in the ODTC continued to work in regular courts when they were not overseeing the ODTC. Thus they had to transition between the regular and DTC court systems and roles a number of times per week. In the above exchange, the judge noted his challenge in sentencing ODTC participants who he had come to know, unlike participants he sentences in the regular court system. In the ODTC, judges see participants twice per week, and they learn intimate knowledge about participants' lives and histories, including sexual and physical trauma, relationships with their partners and families, medical information and other topics discussed with treatment counsellors. This familiarity is noted as a challenge when judges in the ODTC are required to sentence participants who have been expelled or have quit the program.

Gender Implications

Women in particular resisted therapeutic interventions by judges. When asked by the judge about the circumstances surrounding her relapse, Natasha said, "I don't wish to discuss it if you don't mind." In another example, the judge seemed angry that Lenora did not want to divulge her reasons for using in open court:

> **Judge**: Do you have gum in your mouth?
>
> **Lenora**: No, I don't have anything in my mouth.
>
> [The judge asks if she has used.]
>
> **Lenora**: Yes, crack and percs.
>
> **Judge**: How do you feel about that?

Lenora: Not too good.

[The judge asks her why she used.]

Lenora: Because of the things I'm going through.

Judge: What are those things?

Lenora: A whole bunch of things.

Lenora resisted the therapeutic interventions of the judge by refusing to give details on why she used drugs. Women commonly resisted these questions about why they used and the circumstances around their use. For example,

Judge: Anything you would like to tell us?

Kathy: Nope.

Judge: Okay, if you want to be that way.

In another instance, the judge asked Kathy why she relapsed:

Kathy: If I don't have to discuss it, I'd rather not.

Judge: It's helpful for me if you do.

Kathy [who is crying]: I'm very emotional right now.

Women's resistance to therapeutic inventions by the judge may relate to how some women felt that they received harsher punishment and sanctions because of their gender. Despite the ODTC's embrace of the universal, genderless addicted subject, some of the women in the court relayed experiences of gendered punishment. During the interview, Jody said,

> I've said this to [her treatment counsellor], I've said this to [the ODTC program manager], you guys are really rough on me 'cos I'm a girl if I had a dick between my legs I'd be sure that I'd get away with anything.

Jody continues:

> **Jody**: If you talk to [Probation Officer] or you talk to [Duty Counsel], they will tell you the same thing, the program, they seem to be a lot harder on women than they are on men.

> **Tara**: You get more sanctions?
>
> **Jody**: We get more sanctions, they expect more from us, and they treat us a whole lot different.

While gender is not explicitly addressed in policy documents or the courtroom, gendered power relations pervade the ODTC. These quotes highlight how some women felt that they were treated differently than men in the ODTC. Furthermore, there was a marked difference between how men and women discussed gender in the interviews. In my interview notes I wrote:

> Interviewing women has been different than interviewing men. The women started talking about gendered experiences before I had time to start the tape. The men let me guide the interview by answering my questions and waiting for the next and when I ask about gender they don't perceive any differences.

It is important to note that both court sessions and treatment groups were mixed-gender. Alcohol and drug treatment programs were historically designed by men, for men, the result being that women, youth and racial and ethnic minorities have been overlooked (Ettore 2004; Litzke 2004; Lutze & van Wormer 2007; Measham 2002; Peralta & Jauk 2011). Because treatment has traditionally been male-centered, there have been calls for women-centered treatment and gender specific research on drug use (Carter 2002; Grella 2008; Greaves & Poole 2008; Poole & Dell 2005). Research has demonstrated the importance of gender-specific treatment groups and treatment programs tailored to women (Greenfield & Pirard 2009; Simpson & McNulty 2008; Vaillancourt & Keith 2007); however, the Ottawa DTC does not have separate gender treatment groups. When I asked Justice Wong of the Edmonton DTC whether they had separate treatment groups for women, she not only said no, but informed me that men were "supportive" of women in the program (Personal communication, November 28, 2007). However, Rebecca had this to say about mixed gender treatment groups in the Ottawa DTC:

> Myself telling somebody, sitting around with a bunch of guys telling them that I had to work in the sex trade. I didn't want no part of that. I did not want to sit there with guys 'cos some of them had no clue. Most of them had no clue. I tried to hide it very well.

Rebecca's views invalidate Justice Wong's claim of men's putative support of women. The point, rather, is that women-only treatment in this context may very well be more appropriate than mixed treatment groups, primarily because of gendered power relations.

8.4 Treatment Providers and Punitive Measures

"There are serious concerns raised regarding the therapeutic potential of the ODTC" (Dowden 2007: 15).

Just as judges become therapeutic actors in the ODTC without the appropriate training, treatment counsellors in the court are given powers of enforcement and judgment despite having no training in those areas. For example, when Archie resisted the order to go to a detoxification centre, the judge reminded him that treatment orders are non-negotiable:

> **Judge**: The main focus of why we're here is for treatment. The team, including the judge, put a great deal of weight on the experience and knowledge of the treatment providers. One of the conditions you've agreed to is that you comply with treatment. If treatment decides they want you to report to detox then you're required to do that.
>
> [Archie says he's not stupid so he doesn't have to talk to him like he is.]
>
> **Judge**: When treatment decides you need to go somewhere you're required. It's not up for debate.

Treatment counsellors discussed revoking clients' bail in order to get them to comply. For example, the ODTC held a memorial service for a participant who passed away unexpectedly. At this memorial service, which was held in the courtroom and as a part of the ODTC session, his treatment counsellor said, "I had to revoke, I had to ask to have his bail revoked three times in the beginning to get him to comply." Thus treatment counsellors recommend that their clients be criminally sanctioned if they do not follow

treatment suggestions. As one interviewee put it, "they're almost like officers of the court."

Lack of Confidentiality

Another important implication of the blurring of boundaries between treatment and punishment in the Ottawa DTC is a lack of confidentiality between participants and their treatment providers. Participants are required to sign release of confidentiality forms upon entry into the ODTC. *The Ottawa Drug Treatment Court Consent and Waiver* form instructs participants that "any statements made during the counselling sessions may be reported to the Court, which monitors my progress in the Program" (Ottawa Drug Treatment Court n.d.a: 6). As a result, individual and group counselling sessions and any conversations with their treatment providers can be discussed in pre-court meetings with the entire team as well as in open court. In most treatment settings, the goal is to decrease the power differential between counsellors and clients, and to assure confidentiality (Ackerman & Hilsenrot 2003; Sellman 2009). As Dowden states "the primary goal of building the therapeutic relationship is trust" (2007: 7). However, there is no confidentiality between participants and their counsellors in the DCTO. When I asked Ben whether he trusted his treatment counsellor, he responded:

> **Ben**: Did I trust her? No, I didn't trust any of them to tell you the truth.
>
> **Tara**: Is there a particular reason?
>
> **Ben**: She's working for the court first of all.
>
> **Tara**: Did you have to sign the waiver that the things you guys talked about weren't confidential?
>
> **Ben**: Yes, but I know that [what I shared] was shared with staff...the courts, the cops if need be. I was very careful in what I answered because of my

> distrust....I was always concerned about it, I was always concerned about what I said and how I said it.

In another example, Roy was frustrated with the treatment team after being sanctioned for being dishonest with his treatment counsellor. Here is an excerpt from my field notes:

> Roy says he's not going to tell her anything now, only do what he has to do—jump through hoops. He says it's no longer treatment for him. How is he supposed to do treatment when he can't trust his counsellor?

A number of the participants told me that they were very careful about what to divulge and not to divulge to their treatment counsellors because it could be used against them. ODTC participants are expected to engage in a therapeutic relationship with treatment and the court; however their right to confidentiality is withheld, and their treatment providers act as agents for the court.

This approach is inconsistent with research on treatment that finds trust and positive interactions as fundamental to success (Ackerman & Hilsenrot 2003). For example Sellman states:

> Demonstrating the qualities of being a good friend such as being flexible, honest and trustworthy and being interested and warm, as well as having therapeutic skills including exploration, reflection, making accurate interpretations, facilitating expression of affect and being affirming, are the basis for developing strong therapeutic alliances (2009: 9).

Similarly, Ostertag et al. (2006) concluded that injection drug users who trust their physicians are significantly more likely to access health care services. Power is pervasive in all treatment relationships (Young 1994); however, in the ODTC this is exacerbated by the fact that treatment counsellors are given, and use, punitive powers granted to them by the legal system.

This blurring of boundaries by treatment counsellors may be in violation of the Canadian Code of Ethics for Psychologists. Mugford and Weekes point out that

> There may also be issues of professional ethics for treatment providers who

> deliver assessment and treatment services to clients who are mandated to attend treatment. For example, the Canadian Code of Ethics for Psychologists requires psychologists to recognize the self-determination and personal liberty of the clients whom they serve. Treating clients on an involuntary basis may place licensed psychologists and other professionals in violation of this code (2006: 2).

However, it should be noted that the treatment counsellors in the Ottawa DTC are not actually registered psychologists. This is one way in which professional standards, such as confidentiality between therapists and clients, are bypassed in the case of the Ottawa DTC.

Questioning the Qualifications of Treatment Providers

While there is limited information available on the qualifications of Rideauwood Addiction and Family Services and its treatment providers, one key evaluation conducted by Dowden (2007) provides some insight into the backgrounds of these treatment providers. As part of the first year evaluation of the ODTC, Public Safety and Emergency Preparedness Canada commissioned a Correctional Program Assessment Inventory-2000 (CPAI-2000).[30] The evaluation found that "the treatment services are likely inadequate to promote positive behavioural change within this population" (Dowden 2007: 19). Furthermore, the evaluation determined that what Rideauwood considers treatment is problematic. The majority of the treatment hours not spent at 12-step meetings were divided between meeting clients at coffee shops, speaking to clients on the phone, returning messages, and other such unstructured contact. This corresponds to my own observation of the ODTC and conversations with participants, as well studies of DTCs in

[30] It is important to note that feminist criminologists have critiqued the use of risk assessment tools, like the CPAI-2000, for being biased and part of a "neo-liberal agenda of responsibilizing individuals" (Maidment 2008: 41).

other jurisdictions. For instance, in a study of treatment services in drug treatment courts, Taxman and Bouffard (2002) found that treatment was not appropriately integrated into DTCs. Lutze and van Wormer argue that "effective treatment may be hindered by the drug court team because of the complexity of managing the drug court environment, or a lack of expertise or understanding of the causes of drug addiction" (2007: 236).

The ODTC evaluation concluded that treatment counsellors and the ODTC Manager who deliver treatment services lack the necessary skills and qualifications. The ODTC hires treatment counsellors based on factors including "honesty" and "being non-judgmental" (Dowden 2007: 12). However, none have experience in clinical supervision or training above an undergraduate degree, which Dowden (2007) found to be problematic. Research demonstrates "that clinicians with higher education and/or attainment of national certification have a more favorable outlook regarding evidence-based practices" (Kubiak & Arfken 2008: 93). Furthermore, it is significant that the majority of treatment counsellors in the ODTC, and in Ontario (Ogborne, Braun & Schmidt 2001), identify as *recovering addicts* but lack professional training. Treatment counsellors who are recovering addicts therefore facilitate the pedagogical process identified by Reinarman (2005), inculcating the language of addiction-as-disease and the necessity of recovery in the minds of ODTC participants.

Treatment and treatment providers thus play a powerful role within DTCs, one that focuses far more on punishment than in non-DTC treatment programs. Furthermore, "The language of therapy and rehabilitation/medication conceals the fact that those who fail to conform are punished" (Malloch 2000: 147). In DTCs, as in other forced treatment programs, "both the treatment objective (abstinence) and the means to achieve it (long

term in-patient therapy) are predefined; there are almost no individual choices—the only alternative is serving a sentence of imprisonment" (Kemmesies 2002: 697). Returning to Foucault's concepts of power/knowledge and governmentality, we can identify a number of ways that power operates in the ODTC. Surveillance, monitoring, and sanctions—particularly incarceration—are overt, punitive expressions of power. A second central manner in which power is carried out in the ODTC is through techniques of the self that prompt participants to engage in self-regulation and act upon themselves. O'Brien's study of juvenile justice centres found similar results. She argues that workers in these settings play "a mediating role between broader social goals (to change one's drug use) and the individual, through the worker's status as a drug and alcohol expert" (2002: 636).

8.5 Housing: Increased Surveillance and Punishment

The Ottawa DTC has housing arrangements with two residences, the Tom Lamothe Residence run by the John Howard Society of Ottawa (for men) and the J.F. Norwood House run by the Elizabeth Fry Society of Ottawa (for women). The ODTC currently has four apartments at Tom Lamothe, while the ODTC and the Elizabeth Fry Society of Ottawa "have an arrangement that allows female ODTC participants to have priority access to beds at J.F. Norwood House" (Rideauwood Addiction and Family Services 2009: 10). Therefore, individuals who are on waitlists for voluntary access to treatment and housing services are bumped off the list by participants in the Ottawa DTC, an issue that I discussed in the previous chapter.

The housing support staff in these residences act as agents for the Ottawa DTC. Individuals staying at the residences are subject to video and staff surveillance, and if

they violate a house rule (such as missing a house meeting or curfew), they are punished by both the ODTC and the residence. The Elizabeth Fry Society of Ottawa also provided court escorts for some of the women in the ODTC. These escorts (usually students) accompanied women to and from court and to other appointments. It is important to note that men did not have escorts assigned by their housing provider or the court. In one case, Sophie was staying at J.F. Norwood House; after a drug use relapse, the ODTC threatened to kick her out of the program and her housing. Her treatment counsellor and the manager of the residence met with Sophie. The result was a demand for Sophie to sign a contract in order to keep her housing and to prevent her from being expelled from the ODTC. Her two-week contract included: (1) urine drug tests three times a week; (2) house arrest at the J.F. Norwood House; (3) daily attendance at 12-step meetings accompanied by an escort; and (4) participation at a weekly relapse prevention group. In court, the treatment liaison referred to this meeting as "a very up front intervention meeting." This example demonstrates how housing staff also acted as punitive players in the ODTC, and how violation of a rule in the housing residence could also result in a sanction by the DTC. This also demonstrates how housing staff worked closely with the Ottawa DTC.

While the ODTC requires complete honesty and confessions of drug use, the residences have a strict abstinence policy. This means that admitting drug use in the ODTC while staying in one of the residences can result in eviction. In one instance, the duty counsel raised a concern about tensions between the residences and the ODTC over drug use policy:

> I'd like to say that when people are in the residence there are consequences...Although the court doesn't sanction for use and expects honesty they're in a difficult position when they report use because there are

consequences and their housing is put at risk.

Furthermore, the surveillance at the housing residences for the ODTC is so onerous that duty counsel once argued that the time spent living there should count towards time served at sentencing:

> The bail conditions are very onerous...not only stringent but they're monitored by the court, similar to those of a conditional sentence. The monitoring is greater if one is at a residence such as John Howard, where he's been most of the time, with 24-hour staff supervision and a video camera that monitors his coming and goings. This adds to the stringency of the bail conditions. He was placed under house arrest....Given the stringency of the bail conditions, given to where he was living, the monitoring...certainly it's worth 2 months.

Thus, participants are subject to intensive surveillance and punishment through housing arrangements within the ODTC. Participants are required to be honest about any drug or alcohol use, yet the housing residences have abstinence policies, thereby forcing participants to choose between facing possible sanctions in the ODTC or admitting losing their housing.

8.6 Therapeutic Sanctions

Perhaps the best example of the blurring, or erasure of boundaries between therapeutic and criminal boundaries is that of therapeutic sanctions. The ODTC works on a basis of sanctions for non-compliance and rewards for progress, which are meant to function as incentives for participants (Bourgon & Price 2007; Department of Justice 2009). Judges and treatment providers order sanctions as a way to motivate participants to work towards their treatment goals (Burns & Peyrot 2003). Participants are rewarded when they do not use drugs or alcohol, when their counsellors confirm that they are participating in treatment, when they do not violate any of their bail conditions, and when they are not charged with criminal offences (Bourgon & Price 2007). Rewards in the ODTC include

verbal praise, Tim Hortons gift cards ("coffee cards"), and privileges such as leaving court early, or coming to court less often (i.e. only once per week). These rewards are similar to those offered in other DTCs in Canada (Fischer 2003). Sanctions include community services hours, bail revocation, verbal reprimands, and therapeutic sanctions (Bourgon & Price 2007; Department of Justice 2007; Rideauwood Addiction and Family Services 2009). Therapeutic sanctions involve a therapeutic punishment of some sort, and they make up 14% of sanctions according to the second evaluation of the ODTC (Rideauwood Addiction and Family Services 2009). These include "mandatory attendance at 12-step meetings, preparing a letter for the court, a period of reduced curfew/house arrest, or developing a specific plan to avoid high-risk situations and/or substance use" (Rideauwood Addiction and Family Services 2009: 20). These therapeutic sanctions underscore the argument that the ODTC blurs the boundaries between punishment and treatment, producing negative consequences for participants.

The following example perfectly demonstrates how the courtroom acts as a therapeutic setting, how the judges and crowns act as therapists, and how therapeutic sanctions are ordered. In this instance there was a discrepancy over the time Archie was supposed to have stayed at the detoxification centre. He believed that he was meant to leave the detoxification centre on Saturday, while his treatment counsellor insisted that she told him to stay until Tuesday. The judge was in the process of sanctioning Archie for leaving the detoxification centre early when duty counsel intervened:

> I'm concerned Your Honour. I don't normally like to bring this up in court but treatment's reports in court and treatment's report in pre-court are substantially different. In pre-court we discussed the fact that Archie had left detox on Saturday. One treatment person says one thing; another treatment person says another. Treatment didn't feel like it was something he did totally by his own choice...and now it's being put to the court that it was...Now the Crown is also using the negative [version] to revoke his bail. The fact that he'd left detox

> wasn't being held against him as sanctionable because it wasn't known by treatment what happened...now [his leaving] is being used as a reason to revoke his bail when it wasn't looked at that way before. I have to ask Your Honour to give him the benefit of the doubt because of this conflicting information.

The judge dismissed the duty counsel's concerns. Then, in an unusual move the judge called for the treatment counsellor to come before the court:

> [The treatment counsellor stands up beside Archie, with her hand on his arm, looks at him and starts speaking in a patronizing tone.]
>
> **Treatment counsellor**: You were supposed to stay there until Tuesday. We talked about this.
>
> **Archie**: We did?
>
> **Treatment counsellor**: Yes.
>
> [Archie says he thought it was Saturday.]
>
> **Treatment counsellor**: No, it was very clear that it was Tuesday.
>
> [Archie asks the reasons why he was supposed to stay until Tuesday.]
>
> **Treatment counsellor**: Because we were moving you to [a neighbourhood in Ottawa], remember? I think you are mixing up the two situations, right Archie?
>
> **Duty counsel** [interrupts]: I don't think this is the appropriate way to deal with the situation. I'm uncomfortable with this.
>
> **Judge**: Do you have a better solution?
>
> **Duty counsel**: No I don't, but to stand the case manager there and tell him what happened and adopting it as is in front of the court... [She suggests that it could be stood down.]
>
> [The judge asks the case manager to call the detoxification centre for some clarification.]

This exemplifies some of the problematic implications of combining therapeutic and enforcement interventions in the ODTC. The duty counsel intervened twice, first voicing her concern over inconsistent treatment reports and that one version of the report was adopted as justification for a sanction despite an agreement in the pre-court meeting that the discrepancy would not result in a sanction. In her second intervention, the duty

counsel highlighted the inappropriateness of the exchange between the treatment counsellor and her client, suggesting that it not be adopted as evidence. The example also demonstrates the role that treatment providers play in the delivery of sanctions, which corroborates Nolan's finding that while judges adopt the role of therapist, "regularly engaging 'clients' in counseling-like exchanges....'expert' treatment providers play a central role in the adjudication process" (2010: 67).

Letters

As a therapeutic sanction, participants were sometimes ordered to write letters to the court outlining their commitment to the program, why they should be allowed to stay in the ODTC (after a relapse or other breach of bail conditions), and/or how they were going to change for the better. In considering a sanction in the early weeks of the ODTC's operation, the judge asked the treatment liaison "Is a letter sometimes employed as a treatment tool?" The treatment liaison responded, "Certainly, it gives further thought...Rideauwood is receptive, open and supportive of a letter [as a sanction]." Thereafter letters were used as one type of therapeutic sanction. In one example, the treatment liaison reported to the court:

> There is a request for him to attend two NA [Narcotics Anonymous] meetings a week and to write a 2-page letter on how his behaviours and attitude have gotten in the way of his recovery.

These letters were not usually read out loud in the courtroom; however, in one instance Lucas was upset that the judge read his letter in court. At the next court appearance, Lucas and the judge had the following exchange:

> **Lucas**: I'd like to point out that the letter was addressed to you and the Crown, not the entire courtroom. [Lucas says he was not comfortable and that he thinks he should have been asked if it was okay to read the letter out loud first].

> **Judge**: If you write a letter to the court it's a public letter. We don't receive things in secret.

This demonstrates further the lack of confidentiality in the Ottawa DTC not only between therapists and clients, but also between legal team members and defendants. Therapeutic orders, like any treatment session or program, are shared not only among the ODTC team members but also in open court adding to potential harms of shaming. As outlined in Chapter 6, in order to function the notion of therapeutic sanctions depends on a subject that is simultaneously treatable and punishable.

12-Step Meetings

As part of the ODTC treatment program, participants are required to attend 12-step meetings and become active in Alcoholic Anonymous (AA) and/or Narcotic Anonymous (NA) programs. NA is a twelve-step based program of recovery that is derived from the twelve-step group AA, which originated with Bill Wilson and Dr. Bob, who met in Akron, Ohio in 1935 (Gellman 1964). The first meeting of NA was held in July 1953 in Southern California (Narcotics Anonymous Basic Text 1988). The 12 steps of NA require individuals to admit that they are powerless over their addiction and that their "lives had become unmanageable" (Narcotics Anonymous Basic Text 1988: 19). 12-step meetings are a central part of AA and NA and are places where individuals meet to practice the 12 steps. The meetings are known for the practice of individuals stating "My name is ___ and I am an addict" prior to speaking at every meeting. As of May 2010, there are NA meetings in 131 countries and over 58, 000 meetings each week (Narcotics Anonymous 2010).

The first year evaluation of the Ottawa DTC found that participants received 31.5 treatment hours per month, nearly half of which were dedicated to 12-step meetings of AA and/or NA. Attendance at 12-step meetings is also the most common therapeutic sanction ordered. Participants can be ordered to attend meetings by their treatment counsellors or, more publicly, by judges. For instance the treatment liaison once reported to the court that Connor had "a new condition of attending AA meetings." Thus, both treatment counsellors and the judge ordered participants to attend 12-step meetings; participants not abiding by such orders received sanctions.

The discourse of recovery in the ODTC parallels the discourse of recovery in Alcoholics Anonymous and Narcotics Anonymous because: (1) both are based on the disease model of addiction (Gubrium 2008; May 2001; Rafalovich 1999; Ronel 2000; Yalisove 1998); and (2) individuals in the ODTC are required to attend 12-step meetings of AA and NA as part of the program. For example, slogans from the 12-step treatment programs, such as "one day at a time," are used in court and in treatment. Narcotics Anonymous and the disease model of addiction share principles including the requirement of abstinence and teaching others about the disease of addiction (Reinarman 2005; Yalisove 1998). Yalisove (1998) argues that the evolution of the disease model of addiction can actually be traced through the development and spread of Alcoholics Anonymous. The similarities between the 12-step programs and DTCs have been noted elsewhere in the literature (Burns & Peyrot 2003). It is also important to note that the majority of treatment programs rely on the 12-step programs of AA and/or NA (Boyd et al. 2009; Peele, Bufe & Brodsky 2000; Yalisove 1998).

12-step programs have been criticized for being rooted in masculine principles, relying on the concept of powerlessness, and for overlooking structural factors including gender, trauma and stigma (Berenson 1991; Greaves & Poole 2008; Kasl 2007; Matheson & McCollum 2008; Travis 2009). Greaves and Poole argue that 12-step programs are male-centreed and are often "unresponsive to the particularities of women's experiences and roles" (2008: 1271). Denzin (1987) asserts that Alcoholics Anonymous is male-dominated, and Berenson argues that "While the experience of powerlessness may be liberating for some women in some respects, it does nothing to address the very real social, political, and economic power inequalities that exist" (1991: 78). For example, in Whitehead's (2007) study of feminist prison activism, 12-step meetings are criticized for their individualistic approach, for blaming women themselves for their drug convictions, and for overlooking policies stemming from the War on Drugs that imprison women. Matheson and McCollum's (2008) study found that powerlessness was more often embraced by women who believed that they had no control over their lives, whereas for women who "felt their lives were successful except for a few areas where drugs and alcohol were problematic, the concept of powerlessness was more difficult to accept" (Matheson & McCollum 2008: 1039).

In one example of the ODTC using 12-step meetings as therapeutic sanctions, Carlos was about to have his bail revoked. However, the duty counsel advocated for 12-step meetings to be ordered as a therapeutic sanction in lieu of incarceration:

> When he was doing well, what he was doing right was attending 12-step meetings. He hasn't attended a meeting since Saturday. [She asks that he be ordered to 12-step meetings.] *It is a sanction, it'll be therapeutic and it'll be good for Carlos*...It's beneficial from a therapeutic point of view for Carlos to start attending 12-steps again.

In another example, the treatment liaison asks the court for "some encouragement" for Claude to attend 12-step meetings:

> **Treatment liaison**: Some encouragement for Claude to get to some 12-step meetings. It's been an ongoing discussion. We'd like a bit more experience.
>
> **Judge**: I think it's a really good suggestion... Millions of people can't be wrong. [She orders that Claude attend at least one 12-step meeting by the next court appearance in two days.]

Judges in the ODTC regularly ordered 12-step meetings, sometimes as sanctions, sometimes as orders. The judge's comment that participants should attend 12-step meetings because "millions of people can't be wrong" demonstrates the hold that the purported success of 12-step programs has on the ODTC.

In another example, Alex had relapsed after a period of abstinence and had breached his curfew as a result of his drug use. The Crown asked for four hours of community service and increased the number of required attendance at 12-step meetings to one per day for the next week. The judge asked the treatment liaison about the proposed meetings, specifically whether increasing the meetings would be good thing. The liaison replied that, "Rideauwood does strongly endorse the 12-step meetings."

When individuals are engaged in the 12-step program (i.e. remaining abstinent, working the 12 steps, attending meetings regularly, having a sponsor and sponsoring others) they are praised in the ODTC for taking active steps in their recovery:

> **Treatment liaison**: It's always great news when a client steps forward and says they have a sponsor...Care was taken in choosing someone with clean time. It's sure to further her recovery.

In non-punitive settings, a treatment counsellor can recommend attendance at 12-step meetings to a client; however, in the ODTC if a participant does not attend meetings as instructed, they are sanctioned by the court. In the example below, a judge encouraged

Louis to go to a 12-step meeting. What is unique about this exchange is that the judge gave a personal example of his desire to attend a 12-step meeting as well as his nervousness in making the decision:

> [The judge asks if Louis going to 12-step meetings.]
>
> **Louis**: Not since Tuesday.
>
> **Judge**: Do you think that might be helpful?
>
> **Louis**: Wise, yeah, personally no, but at the advice of the court...I'd feel more comfortable if I went with someone I know...I have one meeting where I do know a few people...It's hard for me to go to these places knowing I don't know anyone.
>
> **Judge**: I understand what you're saying. I've never been to a meeting. I've seen movies about them and read academic articles, but it's not the same. So I asked treatment for some information and they gave me a list of places...and quite frankly I'm trying to get over the hurdle of walking through the door. I haven't gone and I have the information right on my desk...I plan to go...I think it's really really important to get over that.
>
> **Treatment liaison**: It's a support system we require for all clients. A lot of clients have anxiety when they first start going...It was expected by the case manager for Louis to have gone to this meeting.
>
> **Crown**: This was a therapeutic assignment given by his case manager that he was to attend the meeting today. It's been explained to him how important these meetings are for his recovery. [She asks the judge to order that Louis attend two 12-step meetings before Tuesday.]
>
> [Louis says he'll go to the meetings.]
>
> **Judge**: When treatment directs you to go you must follow that.

This is yet another example of how the traditional boundaries between judges and defendants are blurred in the Ottawa DTC. Not only did the judge address Louis on a first name basis, but he also discussed his own personal challenge in attending a 12-step meeting. After the Crown pointed out that Louis had not complied with treatment's requirement that he attend 12-step meetings, the judge reminded Louis that non-compliance with treatment orders would result in sanctions.

Not all actors in the ODTC rigidly adhered to 12-step ideology. In a conversation, one of the ODTC team members voiced concern to me over ordering participants to attend 12-step meetings. He said that they were taught to work with clients rather than forcing treatment options on clients that aren't going to work. He also admitted that the court is relying on 12-step meetings and not improving their own treatment services. However, no other such concerns were raised by ODTC staff to myself or in the court when I was in attendance.

Resistance to 12-Step Meetings

Some participants resisted attending 12-step meetings and participating in 12-step programs. Participants were required to attend a weekly check-in group at the treatment centre called the *Monday Morning Check-In Program.* It is described as "Delivered by a Case Manager, this program helps participants deal with any issues that emerged over the weekend, including relapses" (Rideauwood Addiction and Family Services 2008: 16). At this group participants reported the number of 12-step meetings they had attended since the last court date. A number of participants told me that they falsely reported their 12-step attendance at these meetings and to the court. One ODTC participant, Brock, regularly resisted attending 12-step meetings. In this example, the judge admonishes Brock for not calling his treatment counsellor, who reported the act of not calling her as a missed treatment appointment:

> **Brock**: It wasn't a missed appointment. I didn't know I was supposed to call until she told me on Monday.
>
> **Judge**: My understanding is that she told you to call...We expect you to put in 100 percent.

> **Brock**: I spend 6 to 8 hours a day reading. I train 4 or 5 hours, I walk...I've only been a month in this program. I'm not using.
>
> **Judge**: We expect you to put in 100 percent...like attend NA meetings. We've had this conversation before. I think you should be going to more of them. NA meetings are very very good. You're with people who understand what you're going through. They're very good.
>
> [A participant sitting beside me in court whispers to me: "They're boring."]

Unlike some other participants who didn't attend meetings, Brock was perfectly honest in telling the court and his treatment counsellor that he had no intention of attending. When asked by the judge how many 12-step meetings he had attended, Brock would always reply that he had attended none. After one particular court date, I noted the following in my field notes:

> Roy congratulated Brock for being honest about not going to meetings. Brock says he told them [treatment] a while ago that they were putting him in the position of lying because they kept asking him about meetings after he told them he doesn't and won't go.

This is not to say that participants who resisted attending 12-step meetings or other conditions of the ODTC were all successful in their resistance. There are numerous examples in my data of individuals receiving sanctions for not attending 12-step meetings. Brock may have avoided sanctions because he maintained a lengthy period of abstinence, did not violate bail conditions and was on track to become a graduate of the ODTC at a time when the ODTC desperately needed graduates to demonstrate the program's effectiveness.

Another participant in the ODTC resisted going to 12-step meetings because someone involved in the Ottawa program had sexually assaulted his girlfriend when she was young, and they had had altercations in the past. When the judge asked him about whether he had been attending 12-step meetings, the following exchange took place:

> **Aaron**: I don't know if you know, but I have an issue with some people in 12-

step meetings, that's why I don't go.

Judge: Well find one you're comfortable with.

Aaron: It's a personal situation.

Judge: Your case manager can help you with that. Most people there are very supportive.

Aaron told me that he was concerned about being charged with assault if he attended a meeting with his girlfriend's abuser, which would effectively jeopardize his standing in the ODTC. Regardless, the judge insisted that he attend 12-step meetings as part of his treatment. The Winnipeg DTC evaluation also found resistance to 12-step "treatment" groups as part of the drug treatment court: "Clients felt the DTC pushed these programs on them and would have preferred to be allowed to join other more positive programs" (Gorkoff & Weinrath 2009: 53).

Certain women also resisted attending 12-step meetings. In an interview with a young woman who did not stay in the Ottawa DTC, she explained to me why she and others resisted going to 12-step meetings and other mixed-gender treatment groups:

> A lot of people I know, girls especially, say it's really hard for them because they'll see people there, they'll see dealers who have ripped them off, they'll see dealers they've slept with for dope. Stuff like that and it triggers it all over again or it makes them feel really bad about other things. It basically upsets them.

Academic literature has also found there to be gender dynamics in 12-step meetings and groups that can undermine their treatment purpose (Sanders 2011; Makela et al. 1996). Sander's (2011) study of women in Alcoholics Anonymous and Narcotics Anonymous found one reason women chose to attend women-only 12-step meetings was that they felt uncomfortable discussing certain topics, such as child apprehensions, with men present. Furthermore, in their study of 12-step groups in eight countries, Makela et al. (1996)

found that one reason behind the founding of women-only groups was because men make sexual advances at women in mixed meetings.

8.7 Incarceration and Forced Detoxification as Treatment

Another important implication of the blurring of therapeutic and criminal boundaries and the constitution of treatable and punishable addicted subjects in the ODTC is the use of incarceration and forced detoxification as therapeutic treatments. As part of treatment in the ODTC, participants are forced to attend residential detoxification programs and residential treatment programs, which are usually located outside of the City of Ottawa (Rideauwood Addiction and Family Services 2009). Incarceration and forced attendance at detoxification centres are presented as therapeutic orders that give clients the opportunity to reflect on their drug use and how they can achieve abstinence and recovery. For instance, the judge was explicit in her reasoning for revoking Stanley's bail for two days: "It'll give you a chance to dry out and think about whether you want to stay in the program...I want to arrest this [drug use]." The judge ordered incarceration as: (1) detoxification; (2) as a therapeutic time to reflect; and (3) a way to "arrest" Stanley's drug use. In another example, the treatment team stated, "I'm happy Brian didn't entirely enjoy his stay at detox, it's not the Holiday Inn...It is to stabilize and reassess and make some commitments to oneself." In another case the judge was in the process of releasing Lucas from custody:

> **Judge**: I won't ask about high-risk situations [because he knows that drug use and high-risk situations are rampant in the jail]. Did you have time to reflect on our issues?
>
> **Lucas**: There's a lot of time to do that.

The second ODTC evaluation—carried out by the treatment provider itself—explicitly states that forced stays at detoxification centres are used "as a 'preventative' measure for participants who have only used a small amount of drugs, but are at high risk for relapse or on methadone" (Rideauwood Addiction and Family Services 2009: 13). Similarly, in Burns and Peyrot's (2003) study of California drug courts, participants were presented with a *choice* to either enter out-of-town residential treatment programs or detoxification centres, or be put in jail or removed from the drug court program.

In another example, there was a conflict between William and the treatment team and judge over when he was meant to go to the detoxification centre. William was ordered to call the detox centre every hour until a bed became available after court on Thursday:

> [William explains the detoxification centre would not take him Thursday]
>
> **William**: No, he told me they wouldn't take me because if it's not the same day you used.
>
> [The treatment liaison reports that William did not call detox every hour Thursday as he was ordered to do by the court.]
>
> **William**: I went with [the treatment liaison] and I was with her when she called [detox after court]...She said *de matin*, so no bed until morning.
>
> **Judge**: Well, she's shaking her head.
>
> **William**: I know, she and I had a disagreement about this.
>
> **Judge**: Maybe your French needs some dusting.
>
> [William, whose first language is French, speaks to the judge in French. The judge does not understand what he says. The judge says she's not going to sanction him.]

The Crown also often argued for bail revocation or forced attendance at detoxification in order for participants to reflect on their commitment to the drug court program and their recovery. For instance, before the judge revoked Lucinda's bail, the Crown counsel and

duty counsel made submissions—despite the sanction already being agreed upon in the pre-court meeting. The Crown stated:

> This is very concerning...I'm asking for bail revocation. There's been a pattern here of stretching the rules. There's been considerable slippage. The Court's tolerance of Lucinda's behaviour is getting to the point where there has to be some severe sanction. I'm concerned about the high-risk situation which is very concerning, especially when there was no admission of this...One of the pillars of this program is honesty. Lucinda really has to stop and think about what she's doing. There needs to be a sanction where she can sit and think about it. I'm proposing bail be revoked, Lucinda be taken into custody. *I'm asking she take the time to think about whether she can comply with the program.* If this continues it'll be a short time before I argue strongly for her removal from the program.

In another instance Carlos was ordered to enter residential treatment at Camilla House, which requires 48 hours of sobriety before entry. Carlos reported using drugs, and the Crown suggested that Carlos be sent to jail to ensure that he does not use before leaving for the treatment centre. I noted the Crown's following remarks in my field notes:

> "If he's gonna go off to Camilla Centre *we could revoke his bail to ensure he's clean and sober."* He follows up saying "He's got to demonstrate willingness to be clean and sober... He was asked last week to stay clean and sober", which contradicts his previous statement that Carlos cannot control his drug use and he needs to be incarcerated to prevent drug use.

This example relates to the discussion in Chapter 6 regarding the contradictions in the discourses of addiction-as-disease and drug use as a choice. This also constitutes another example of how incarceration is used not only as punishment but also for prevention. In this example, Sophie reported drug use, and there was tension over whether she should go to jail because there were no beds available at the detoxification centre over the weekend:

> [Treatment outlines her missed appointments.]
>
> **Treatment liaison**: She's back in her old lifestyle. We've been suggesting detox over the weekend but there's no beds available.
>
> **Crown**: She says she needs help. I understand plans are in the works for a residence...Detox beds aren't available. I'm more concerned about the

> breaches. Sophie has been using quite heavily. [He asks for bail revocation.] Hopefully treatment can line up the residence to get her back on track...She says she needs help and wants help so that's what I'm recommending [bail revocation].
>
> **Duty counsel**: *I don't think that we'd be considering bail revocation if detox beds were available.* A number of other people have been in this situation and went to detox and not had their bail revoked...We may say we don't place people in detox as a sanction but we place people in detox and defer sanction...There's no other place for her to stay...She's prepared to contact detox on an hourly basis. She normally wouldn't be subject to bail revocation...We don't sanction use. *We can't justify putting someone in jail because there's no resources for them in the community.*

Thus in this instance, the duty counsel made important connections that other team members continually overlooked or ignored. She recognized that the ODTC does in fact sanction participants by sending them to residential detoxification as punishment and acknowledged that the court uses detoxification centres (and jail) as housing. This use of jails as housing is prevalent in other Canadian DTCs, and the larger Canadian judicial system. For example, jails and prisons are used to warehouse individuals with addictions and mental health issues (Pollack 2008). Likewise, Maidment found that incarceration is used as a "last resort for dealing with the mentally ill" in Canada (2006: 88). Importantly, she notes, "Prisons are the only places that cannot turn women (and men) away" and therefore people who have not obtained appropriate care in the health care system often end up incarcerated (Maidment 2006: 88). In Carlen and Tombs' study of women prisoners, the judges "sent women with addiction problems to prison because there were no suitable resources in the community" (2006: 346).

Another ODTC participant, Eric, was in a similar position that same day. Rather than being sent to jail because beds at the detoxification centre were not available, the treatment team recommended that he attend 12-step meetings:

> In circumstances like this, after three days of use, we'd be imposing some set of intervention like detox. Unfortunately there are no beds available at detox. The

> suggestion from treatment is that he goes to more 12-step meetings to serve like an intervention.

This occurred before Sophie's appearance in court and is an example of how inconsistent sanctioning occurs in the Ottawa DTC. In another instance, Lenora became angry while court was in session because she was sent to jail for missing group therapy, while another participant did not have his bail revoked for missing a group. Lenora said loudly: *"They're hypocrites here. They're two-faced."* She was swearing, and the ODTC manager told her to stop it. When Lenora continued, the ODTC manager told her to come with him outside of court. She continued swearing and was shouting at the ODTC manager as she left the courtroom.

Resistance to Forced Detoxification and Residential Programs

While it may be argued that the ODTC does not technically force its participants into detoxification centres and residential treatment programs, non-compliance with these court orders resulted in revocation of bail, or even removal from the ODTC for sentencing. This is not to suggest that participants did not resist being forced into residential treatment and detoxification. Consider the following example.

> **Treatment liaison**: There's been a few last minute changes that were not discussed in pre-court. The most important is recent use…I'd like to give Kathy the opportunity to say what she can.
>
> **Kathy**: I used on Sunday.
>
> [The judge asks what she used.]
>
> **Kathy**: Crack.
>
> **Judge**: How much?
>
> **Kathy**: A 20 piece.
>
> [The judge asks what the circumstances were.]

Kathy: I'd rather discuss that with my counsellor if I can.

Treatment liaison: Kathy approached me with a real concern that if she's honest about her use she'll lose her residence because it's the third time...We're not clear what the ramifications are at that this point. [He recommends that Kathy go to detox today.]

Kathy: Can I say something? I will attend detox if everyone else here who used attends detox because that's not right.

Judge: We deal with cases individually.

Kathy: Why do I have to go if no one else has to go?

Judge: I'm not going to debate with you.

Treatment liaison [interrupts]: Can I contribute? We don't want to see her on the streets. We want to stabilize her, engage her in program...Following court we'll meet with her and make calls [to detox].

Judge: I'll leave that in treatment's hands.

Kathy: I refuse to go to detox.

Judge: Your bail conditions require that you abide by treatment's direction.

This example illustrates: (1) how participation in the ODTC can result in a loss of housing; (2) the uneven application of sanctions such as forced detoxification; and (3) how refusing treatment orders results in sanctions and potentially serious consequences such as homelessness. Furthermore, Kathy had used on the Sunday and this court date was Tuesday, two days later, but detoxification centres only admit individuals who have used in the last 24 hours. When I asked Angelica in an interview whether the threat of jail was useful in a treatment sense, she responded:

Angelica: No, no. It actually just kind of, it kind of I don't know how you say it. All the threatening and stuff like that made me just wanna, just throw in.

Tara: Just leave?

Angelica: Yeah

In a final example, Brian contests the legal and treatment teams' decision to incarcerate him as a therapeutic method.

Treatment liaison: I met with Brian this morning...Treatment would like to continue with Brian in the program. He has good motivation.

Judge: I hope you'll be better able to comply with the rules of the program [now that you've had your bail revoked].

Brian: I'm still not happy about being sent to jail for missing something [an appointment]. I think [you should be] putting me up to a positive place [but] you're sending me to a negative place. I don't understand that.

Judge: That was a decision that was recommended by the team. We didn't seem to be getting your attention in other ways.

Brian: So sending me to jail, you think it's the best way?

[The judge says it's not necessarily the best way.]

Brian: That's what I wanted to hear.

Brian challenged the decision of the legal and treatment teams to revoke his bail for missing an appointment, pointing out to the judge that incarceration is a "negative place" whereas the ODTC is meant to be putting him in "positive places." The judge justified the decision as a way to get Brian's attention, implying that the goal of his bail revocation was to get him to follow the rules of the treatment team and court more closely. The judge eventually agreed with Brian that incarceration is not necessarily the best method; however, this was not the last time that Brian had his bail revoked for not complying with treatment and court orders.

The above examples demonstrate the problematic consequences of the blurring of boundaries between treatment and punishment in the ODTC. The ODTC relies on incarceration and forced detoxification as therapeutic tools, expecting participants to use the time in detention to reflect, become more motivated, and recommit to the ODTC programs. The above examples also demonstrate how participants resisted and were sometimes confused by the ODTC casting punishment, including incarceration, as treatment.

8.8 Conclusion

The threat of incarceration is understood as an incentive for DTC participants to stop using substances and engage with, and complete, treatment (Hepburn & Harvey 2007). DTCs view participants who cannot achieve permanent abstinence as failures. However, this contradicts one of the DTCs' underlying assumptions: that drug dependent individuals have a disease of addiction that involves chronic relapse. The failure of participants incapable of achieving permanent abstinence is attributed to the individual and is not perceived as a consequence of environmental circumstances (e.g. lack of housing) or of inappropriate or ineffective treatment.

An example of this individualistic approach comes from the Toronto DTC program evaluation team (Newton-Taylor, Patra & Gliksman 2009), who were based out of the Centre for Addiction and Mental Health—the treatment provider for the Toronto DTC. They examined characteristics of participants in the Toronto DTC to determine which were associated with graduation and which were associated with expulsion. Successful participants, they argue, "were serious about changing their lives, and were eager to take advantage of opportunities, and the legal and treatment supports provided by the TDTC program" (Newton-Taylor, Patra & Gliksman 2009: 980). This firmly locates success and failure in the individual, just as does the Ottawa DTC. It is important to note that although Newton-Taylor, Patra and Gliksman do mention age and socioeconomic status as factors that may impede a potentially successful candidate from graduating, there is no mention of gender. In Whiteacre's (2007) study of a juvenile DTC in the United States, he also concluded that staff attributed failure of the DTC to the

participants' characteristics, such as having a bad attitude and not being motivated enough. In other words, "struggling drug court participants are often blamed for the inadequacies of the treatment system" (Drug Policy Alliance 2011: 13).

The central premise underlying the discourses of addiction and recovery in the ODTC, treatment practices and therapeutic jurisprudence philosophy is that program failures, breaches and relapses are attributed to the failure of its participants and never to flaws in the drug treatment court or to structural inequalities. For example, one of the Crown counsels spoke to me outside of court about how women were not successful in the ODTC. Rather than attributing this lack of success to the drug treatment court or to treatment programs, he said, "Young women don't stand a chance. The trauma of their youth and they're a commodity and they're worth more on the street." Here, the Crown counsel remarked on a difference between the women and men in the ODTC. However, he then proceeded to reduce women to trauma-victims and sex workers, refusing to even consider whether the DTC itself or the treatment program may in part explain why women were struggling in the program.

In these last three chapters, I have demonstrated that the addiction-as-disease discourse central to the Ottawa DTC determines which treatment services are offered, which therapeutic sanctions are ordered, and how addicted subjects are constituted by the court. In other words, the disease model of addiction relied upon by the ODTC requires particular discourses and practices of recovery and treatment. The adoption of a philosophy of therapeutic jurisprudence by DTCs, and the embrace of the disease model of addiction, result in the traditional courtroom being transformed into a therapeutic space where judges attempt to engage in therapy and give therapeutic orders to

participants (such as mandatory attendance at 12-step meetings), while treatment counsellors are given legal powers. In this chapter, I have shown how the roles of judges and treatment providers in the ODTC are blurred and have argued that this blurring gives rise to a number of negative consequences. For example, participants in the ODTC are incarcerated when housing is not available and/or when the treatment and legal team decides that participants need time to *reflect*. Not only do participants in the ODTC lose access to treatment services because of therapeutic sanctions such as forced detoxification and incarceration, but these sanctions also often result in the loss of employment and housing.

One of the central premises of DTCs is that drug addicted offenders will receive addiction treatment; DTCs therefore position themselves as a humane step away from criminalization of drug users. However, one of the main consequences of drug treatment courts is that they establish a wider, more insidious net of punishment and control over marginalized drug users. Prisons and DTCs in Canada are framed as therapeutic spaces where women and men can heal from addictions, trauma and be rehabilitated (Hayman 2006; Maidment 2006). However, as has been documented in research on women in prison, "Few, if any, women would elect to undertake 'healing' in a prison if a community option should be available" (Hayman 2006: 244). Furthermore, Pollack highlights how this blurring of boundaries has implications for the funding of treatment outside of the criminal system: "At the same time that publicly funded addiction, counselling and mental health services are being eviscerated in the community the federal women's prison system appears to hold the promise of therapeutic support for criminalized women" (2008: 14). Mold argues that it is difficult to disconnect treatment

and enforcement in drug policy in part because "the combination of medical and social 'danger' expressed in public health rhetoric necessitated both the treatment and control of drug addiction" (2004: 508). DTCs are a perfect example of intervention based on contradictory medical and public health approaches coupled with the belief that addiction is dangerous and needs to be controlled. DTC treatment providers embody this contradiction by fulfilling not only a treatment role but also a punishing, sanctioning role rooted in an enforcement and control approach.

Chapter 9: Moving away from Addiction-as-Disease: Theoretical Summary, Findings and Policy Considerations

Drug addiction continues to be understood as an individual problem, where addicted subjects make a choice to arrest their disease of addiction. Based on this understanding of addiction, treatment is understood to be a life-long, ongoing process involving abstinence from all mood-altering substances. These same views also frame Canadian drug policy, as the treatment industry's practices are enmeshed with drug policy and discourses of addiction (Lart 1998). As shown in this thesis, drug treatment courts work to establish and further promote problematic social and drug policies—such as drug policies that result in harms and inadequate housing—by propagating an individualistic approach to addiction, thereby validating policies that actually create harm and constrain choices (Miller 2009). In other words, "a strategy focused on individual responsibility and self-esteem cannot engage with the wider perspective of governmental and social failure that is the backdrop against which many drug addicts live their lives" (ibid: 427).

In this thesis, data from a 25-month critical ethnography has exposed how the Ottawa DTC is a site that reproduces and maintains truths of addiction, addicted subjects and recovery as well as how it engages in treatment practices that support punitive, criminal justice responses to drugs and drug users. However, as Moore argues "...seeing any form of service provision as merely a technology of the self sidesteps the ethical responsibility to produce forms of governmentality that arguably produce less social suffering" (2009: 1167). Therefore, by way of concluding this thesis, I turn to a discussion of possible reforms at both the policy level and within the institutions currently in operation. I consider two types of recommendations: (1) broader drug policy and treatment reform recommendations, and (2) specific recommendations to improve drug treatment courts in Canada. First, however, I summarize the principle theoretical

findings of the thesis by directly engaging with the research questions with which I approached this project.

9.1 Theoretical Summary of Findings

Research Question #1: What Are the Discourses of Addiction in the Ottawa DTC?

The central discourse of addiction in the Ottawa DTC is that addiction is a life-long, chronic disease. The discourse of addiction-as-disease emerges through ODTC documents, exchanges in the courtroom, and treatment practices. I have highlighted five consequences of this approach: (1) the rigid requirement of abstinence; (2) the construction of certain substances as dangerous; (3) a discourse of *clean* versus *dirty*; (4) perpetual fear of relapse; and (5) drug use as a choice. Despite the notion that addiction is a life-long disease involving repeated relapses, a second prominent component of the discourse of addiction produced by the ODTC is that participants are seen as having a *choice* not to use drugs. The result of the ODTC simultaneously conceiving of addiction-as-disease and as a choice is that participants who relapse are punished by the court.

The observations and interviews undertaken for this study have also revealed the ways in which participants negotiated and resisted the discourses of addiction in the Ottawa DTC. Examples have demonstrated how some participants in the court challenged the ODTC discourses of addiction and related treatment and court requirements. Specifically I outlined how some participants did not internalize the addiction-as-disease pedagogy of the ODTC, instead engaging in harm reduction practices that contested the assumptions that all drug use is harmful and a threat to addicted subjects. The ODTC's mobilization of the addiction-as-disease discourse inevitably erases social, cultural and

historical factors, including gender, whereas participants demonstrated a more nuanced approach by incorporating issues such as the role of housing, past trauma, and relationships in their drug use or non-use.

Research Question #2: How Do the Discourses of Addiction in the Ottawa DTC Relate to its Treatment Practices?

A crucial implication of the ODTC's discourse of addiction is the requirement of abstinence in treatment practices. Participants in the ODTC are required to abstain from all mood-altering substances as a part of their treatment; this abstention is also required to remain in the program. The abstinence requirement is strict and includes not only alcohol, but also over-the-counter pharmaceuticals such as cold medication.

I have also demonstrated how the discourses of addiction and related strict abstinence-based treatment requirements are contradictory and inconsistent. While participants were forbidden from taking certain cold medications because they were deemed mood-altering, they were encouraged to take anti-psychotic medications. Furthermore, the ODTC sanctioned participants for consuming cannabis at the same time as treatment staff distributed and sold them contraband cigarettes. Thus, the ODTC categorizes substances as acceptable or not based on morality, the current legal status of the substance, and treatment's seemingly arbitrary decisions on which participants could take certain substances or not.

The discourse of addiction-as-disease is closely related to discourses of recovery in the ODTC. Recovery involves engaging in techniques of the self, such as working on one's self through therapeutic practices (particularly the 12-steps). Participants were prompted to be active in recovery and engage in appropriate behaviours in order to

transform themselves into better citizens. Two central discourses of recovery in the court are making progress in one's recovery and prioritizing recovery. I have argued that these discourses have implications on participants' relationships, employment, schooling and housing.

A key finding of this study is the blurring of the boundaries between punishment and therapy by the Ottawa DTC. The discourse of addiction in the court results in increased punitive treatment practices and widening of the judge's and treatment provider's roles in ordering treatment. Judges and treatment providers order participants to attend 12-step meetings and participate in the 12-step program (i.e. get a sponsor, work the steps). If they do not, participants receive sanctions such as admonishment from the judge, bail revocation and/or expulsion from the ODTC. Paradoxically, incarceration (punishment) is ordered as a treatment practice, while participants are sent to residential detoxification as punishment. Furthermore, the ODTC uses detoxification centres and the Ottawa Carleton Detention Centre (the Ottawa jail) as housing. The discourses of addiction-as-disease and the notion that individuals can stop using drugs as a choice results in punitive treatment practices designed to motivate participants to engage in recovery and treatment practices.

Research Question #3: How Are Addicted Subjects Constituted in the Ottawa DTC?

In Chapter 6, I examined how the ODTC constructs addicted subjects and gave examples of how techniques of the self are deployed to encourage participants to transform their addicted subjectivities. Addicted subjects have four principal characteristics: (1) they are universal and genderless; (2) they are treatable; (3) they are criminal; and (4) they are dishonest. In this work I have highlighted the following implications of the ODTC's

construction of the addicted subject: (1) the blurring of traditional boundaries of punishment and therapy; (2) the re-definition of roles of judicial and treatment providers, resulting in a widening net of criminalization; and (3) the implementation of a system whereby individuals must be criminalized to access voluntary treatment programs and housing services.

Furthermore, the data reveals that addicted subjects are required to transform into *recovering* subjects in order to be considered successful in the ODTC. Stories of how addicted subjects have transformed their lives into responsible, non-drug using, law-abiding citizens are used by the Ottawa DTC outcome evaluations as evidence that drug treatment courts work, and that they should continue to be granted funding. For example, the ODTC outcome evaluation includes a *Profile of a Graduate* that outlines the drug using and criminal history of Bill prior to entering the drug treatment court, then illustrates his transformation into a recovering subject: "Bill became determined to not only stop using drugs but to better his life" (Rideauwood Addiction and Family Services 2009: 27). The ODTC's success stories make up an exceedingly small percentage of overall participants. The majority, therefore, who do not graduate "face a very different set of outcomes" (Boldt 2010: 69). In order to become eligible for the ODTC, participants must plead guilty to their charges; therefore, not only do they face sentencing for these charges, but participants who do not meet the lengthy and arduous standards of the ODTC are also publicly deemed failures, with this failure being firmly placed on the individual. In sum, I have argued that the Ottawa DTC produces and requires both a treatable and a criminal subject and that there are tensions and contradictions between

such a construction of addicted subjects as well as negative implications for their treatment.

Research Question #4: How Are Discourses of Addiction and Treatment Practices Gendered in the ODTC?

The ODTC's approach results in issues of gender being disregarded in both policy and treatment practices. This is evidenced by the lack of gender-specific programming despite there being lower rates of enrolment and successful completion for women in DTCs. For example, the Ottawa DTC outcome and process evaluations do not identify the number of women in the program. This erasure of gender by the Ottawa DTC is informed by the disease model of addiction and its universal, genderless *addicted* subject. Furthermore, in court observations and in interviews, some women participants found punishment in the Ottawa DTC to be gendered. Some women felt that they were treated differently than men and were given harsher sanctions because they were women. As Jody stated, "they seem a lot harder on women than they are on men" and "they expect more from us, and they treat us a whole lot different."

The universal, genderless subject produced by the Ottawa DTC has implications for treatment practices. Women are required to attend and participate in mixed gender treatment groups despite the evidence that gender-specific groups improve women's success in treatment (Health Canada 2001). The ODTC reduces participants of all genders to their putative disease of addiction and therefore imposes a uniform treatment modality. As such, the particular needs of women and a consideration of social contexts and histories of trauma are overlooked. Thus, the ODTC's reliance upon a universal, genderless subject who is reducible to a disease has particularly egregious implications for women in the ODTC.

Additionally, the requirement for participants to remake themselves through techniques of the self into recovering subjects is especially problematic for women and ignores social and structural considerations. As Beck argues,

> Becoming a reformed drug user through successfully reinventing oneself...is deeply problematic for women in light of social structural inequality and the weight of state authority in their lives. For it is but another manifestation of social control, albeit in the form of good citizenship (2006: 257).

Participants are required to leave behind "people, places and things" (a 12-step slogan also used in the ODTC) from their former lives for fear that association with them will result in relapse and slippage instead of progressing in recovery. Motherhood itself was conceived of as a risk; the court expressed concerns that visits with children could potentially harm women's progress in recovery and result in relapse. Furthermore, women and men were ordered to leave their partners and move out of their housing, which disregards childcare responsibilities and women participants' input into how these orders resulted in harms. Recall Angelica's comments on how she was ordered to move out of her apartment and into a less secure residence:

> I had nothing, nothing. I finally got back on my feet got an apartment and [the ODTC Manager] says "No you're quitting your job and you have to give up your apartment." I just came from the streets you idiots. Like, you don't know nothing.

Research Question #5: What Are the Implications of these Conceptions of Addiction, Addicted Subjects and Corresponding Treatment Practices?

Two main implications stem from the ODTC's discourse of addiction, its construction of addicted and recovering subjects, and the treatment practices it mobilizes. First, the boundaries between punishment and treatment are blurred, with incarceration being prescribed as treatment (i.e. participants are ordered to use their jail time to reflect on how they can engage in the ODTC and treatment practices in ways prescribed by the

court and treatment provider), and treatment such as detoxification being used as punishment. Second, in giving their participants priority access to scarce resources of treatment and housing, the ODTC, and DTCs in general, promulgate a system whereby criminalization becomes the most efficient if not the only route for some to treatment.

A central finding of this work is that the blurring of boundaries between punishment and therapy and between legal and treatment actors results in harm to participants in the Ottawa DTC. Participants in the court faced punishments for drug use, for missing appointments and for not participating in treatment to the satisfaction of their treatment counsellors. Treatment counsellors were given powers of enforcement while judges engaged in therapy in the courtroom resulting in confusion, lack of confidentiality and increased punishments. This finding is supported by other research on DTCs; for example, Mackinem and Higgins argue that the therapeutic roles played by judges poses numerous problems:

> Judges have great power to punish but are only amateur therapists, opening the opportunity for naïve abuses of power. The judges are not independent but act in concert with others, including private therapy providers who profit by the judge's decisions (2008: 32).

DTCs thus allow courts, judges and treatment providers to exert increased control, surveillance and power over their participants (Nolan 2001). Furthermore, while individuals with diseases are usually treated in medical systems, here the contradictions inherent to the concept of therapeutic jurisprudence become apparent. As Reinarman points out:

> No smoker was ever kicked out of treatment for not wearing her nicotine patch. No one was ever arrested or spent a night in jail to deter their smoking. But when a drug offender on probation or parole [or in the Ottawa DTC] cuts his intake of illicit drugs in half, he is said to be in "relapse" and/or "denial" and is sent back to jail (2007: 59).

Therefore, I argue that the blurring of the boundaries separating therapeutic and punitive approaches results in harms to participants in the Ottawa DTC. For example, Kerr argues that "the blurring of criminal justice and health systems responses to drug use seem to continuously present new harms, as custody and control repeatedly trump efforts to protect and promote individual health" (2006: 2). This claim is supported by my observations that the Ottawa DTC creates harms in forcing some participants to give up their permanent housing in order to live in shelters and by not allowing participants to engage in harm reduction practices. Incarcerating those ostensibly seeking treatment, using treatment as a punishment, and relying on treatment practices that are problematic results in new or further harms being inflicted on those participating in the Ottawa DTC.

The ODTC's contradictory approach to addicted subjects as both criminal and treatable and its confounding of punishment and treatment links to broader social constructions of addiction as well as to current policy decisions about the best way to manage drug addiction. On the one hand, addiction is presented as a disease with no cure, which would logically put addicted subjects into health care. On the other hand, addicted subjects are seen as criminal and therefore best managed through criminal justice measures. This project, however, has highlighted a number of serious implications that the disease model approach to addiction and the construction of addicted subjects has for treatment practices and policies. Importantly, the ODTC does not stand alone in its approach; rather, the ODTC exemplifies the Canadian government's current approach to drugs and drug users. The Harper Conservative government promises to help the victims of addiction and punish drug dealers, which further perpetuates false distinctions between users and dealers.

In addition, this thesis demonstrates how DTCs are currently initiating a system whereby criminalization is the route to treatment and housing resources, which effectively widens the net of criminalization and decreases access to voluntary treatment programs. As Ogborne, Smart and Rush argue, in Canada, "all treatment takes place against a backdrop of a strong prohibitionist, law-and-order approach to nonmedical drug use, and many users in treatment are involved with the criminal justice system" (1997: 23). The discourses and practices produced by the ODTC, and other DTCs, maintain and strengthen current prohibitionist drug policies, which in turn require the construction of addicted and recovering subjectivities. As Tiger argues, "Drug courts, then, present an alternative to incarceration that keeps the War on Drugs firmly intact and does little to address the biases that this war perpetuates" (2011: 181). These specialized courts only make sense in light of the current climate of prohibition-based drug policies, which are based upon the belief that certain individuals who use drugs deserve to be punished and are best managed in the criminal system. By further criminalizing drug users, DTCs support and perpetuate these beliefs and their corresponding punitive responses. Furthermore, as I outlined in Chapter 4, DTCs are used as a means to justify mandatory minimum sentencing for certain drug offences in current legislation and thus continue to perpetuate prohibitionist drug policies that result in harm to drug users and communities.

9.2 Policy Considerations and Recommendations

In this section I propose a series of general policy and treatment reform recommendations based on the findings in this thesis. First, I propose a move away from individual responses to addiction through close consideration of the social dislocation theory of

addiction. Second, I suggest offering and supporting genuine harm reduction options. Third, using the Canadian Nurses Association as a concrete example, I recommend a redefinition of treatment provider roles. Fourth, I discuss the re-regulation of drug policy as a way to initiate a conversation about alternatives to our current drug policy regime. Here I propose a review of Canada's drug classification scheme as one way in which to improve drug policy. The final two recommendations in this section focus on treatment. Specifically, I recommend the exploration of alternative, non-abstinence based treatment and increased funding of appropriate, voluntary treatment programs.

Moving Beyond Individual Responses

The disease model of addiction presumes that responsibility for addiction and recovery lies with the individual addict; this results in social dislocation and exclusion. The strength of the addiction-as-disease discourse is witnessed in Pollack's study of incarcerated women in Canada's federal penitentiaries, in which the vast majority (66 of 68 participants) self-identified as having an addiction. The women she interviewed gave insight into what women require beyond abstinence and treatment programs based on punishment:

> Women identified many barriers to feeling and being included into communities, such as the virtual impossibility of gaining employment after a lengthy incarceration period, negative judgments from banks, parole officers, social assistance workers, halfway house staff, government bureaucracies (such as department of motor vehicles) and potential employers (Pollack 2008: 27).

Pollack's examples further exemplify Alexander's (2008) social dislocation theory of addiction. Rather than individualizing addiction and reducing it to choice or brain chemistry, Alexander argues that addiction must be considered alongside social and economic systems and contexts. Combining Alexander's social dislocation theory of

addiction with a feminist approach allows for the examination of the gendered social conditions that contribute to gendered social dislocation. In other words, this combined approach helps to cast light on structural issues such as poverty, child apprehensions and marginalization as factors that contribute to social dislocation, factors which require addressing in order to discuss and formulate alternatives to the current treatment model that is rooted in criminalization.

In considering social dislocation theory and feminist theories, it is important to address stigma and shame, particularly around mothering, when proposing means of (re)integration. Shantz, Kilty and Frigon demonstrate how criminalized women face stigma and dislocation, arguing that "Experiencing dislocation and a lack of resources directly affects these women's ability to renegotiate their identities and lives upon release" (2009: 102). Furthermore, in Pollack's study, women identified "Stresses related to re-establishing relationships with children, particularly in relation to feelings of shame" as factors that hindered their experiences after release from imprisonment (2008: 22). The women in Pollack's study also identified "difficulties finding childcare and employment" as factors contributing to relapse after their release (ibid: 22). Therefore, in combining Alexander's theory with feminist analysis, we can propose means for women, men and transgendered people to access resources as well as provide them with opportunities to negotiate their identities in ways that are not enmeshed in stigma.

Following Alexander's theory that addiction results from social dislocation, healing requires psychosocial (re)integration. Rather than forcing *addicts* into drug treatment courts and other forms of coerced treatment, psychosocial (re)integration would involve the development of approaches and programs that allow individuals to engage in

meaningful employment (if appropriate), establish community ties, live in safe housing, and create identities that are free from stigma. As Maidment argues "Safe and adequate housing and meaningful employment should be a guarantee for all women" in Canada (2006: 147). And in Schlesinger and Lawston's study of incarcerated women, they argue that "job creation, particularly of jobs that provide a living wage, is imperative to combat social vulnerability" (2011: 12). Thus, it is necessary to move away from viewing addiction as an individual problem that requires individual interventions to viewing addiction as a complex social phenomenon that is best addressed without criminalization.

Such an approach not only brings social factors into consideration, but it also enables non-individualistic responses. Furthermore, approaching addiction as embedded in social, cultural and historical phenomena, while also paying close attention to gender, also means actively and vocally denying that the criminal justice interventions are appropriate means for improving women's lives: "experience should teach us not to look to institutions of criminal law to improve the life of the female who is victimized" (Snider 2006: 340). In other words, we must be clear and emphatic in our assertion that DTCs and their underlying principles and practices are grossly inappropriate responses for women—and indeed all people—who use drugs. It is time to move beyond individual, disease-based discourses of addiction and treatment and towards policies that are based on human rights and that address poverty and stigma.

Offering and Supporting Genuine Harm Reduction Options

The disease model of addiction mobilized by the Ottawa DTC demands that its participants engage in complete abstinence. Participants are granted a small number of relapses when they first enter the program; however, ODTC actors continually emphasize

that the court is an abstinence-based program. Participants who do not stop substance use entirely are removed from the program. Abstinence may be an appropriate path for some individuals; nevertheless, as demonstrated through participants' negotiation of and resistance to treatment practices in the ODTC, prescribing the same exact treatment path to every drug user is both ineffective, and in some cases harmful. In response to such approaches to treatment, harm reduction programs have been used to mitigate certain harms related to substance use. Harm reduction is defined as

> a health-centred approach that seeks to reduce the health and social harms associated with alcohol and drug use, without necessarily requiring that users abstain. Harm reduction is a non-judgmental response that meets users "where they are" with regard to their substance use rather than imposing a moralistic judgment on their behaviour (Thomas 2005: 1).

Harm reduction is both a philosophy and a variety of practices currently used throughout the world in order to reduce substance-related harms. In Canada, there are a number of examples of harm reduction programs including moderate drinking programs (Brown and Stewart 2007), needle exchange programs which distribute supplies for sterile injection and safer inhalation kits (also known as crack pipe distribution) (Canadian HIV/AIDS Legal Network 2008; Canadian Nurses Association 2011; Dell & Lyons 2007; Hayashi, Wiebe & Kerr 2010; Strike et al. 2006).

In keeping with the theoretical and political orientation of this research, it is also important to acknowledge the limitations of current conceptions of harm reduction. This section is not meant to provide evidence against harm reduction programs, but to offer recommendations that will work to strengthen harm reduction practices. Harm reduction and drug policy reform are often placed in opposition to addiction-as-disease discourses. However, the harm reduction model and the disease model of addiction often share the same underlying principles with many advocates of drug policy reform and harm

reduction also positing addiction as a chronic brain disease (Brook & Stringer 2005). For example, critics of DTCs often argue that drug-dependent individuals have a disease or an illness and are therefore in need of health interventions rather than criminal justice interventions. The Justice Policy Institute begins its critical report on DTCs by stating that "As addiction is a disease, an appropriate approach to a public health issue of this magnitude would be to substantially increase funding for treatment in communities" (2011: 1). Drug policy reformers working to end the criminalization of drugs and to implement alternative regulation models also often make similar arguments.

The majority of harm reduction programs currently in practice focus on educating drug users to monitor their own drug use, including means of drug administration and disposal of drug using equipment. Thus harm reduction principles and practices also rely on a neoliberal subject who is rational, entrepreneurial, autonomous and who engages in techniques of the self. As in the disease model of addiction, this often results in the overlooking of structural inequalities (such as lack of access to economic and housing resources) and other factors (such as gender) (Moore & Fraser 2006; Pauly 2008). Therefore, the addicted subject in harm reduction is also constructed as an individualistic, neoliberal subject who is required to take responsibility for his or her drug use and to manage health risks appropriately (Keane 2003; Moore & Fraser 2006). For example, Simmonds and Coomber's (2009) study of needle exchanges provides an example of how when drug users did not share needles or dispose of needles using harm reduction techniques, this resulted in their being viewed by other drug users as irresponsible. As a consequence, individuals remain responsible for their health and harms stemming from lack of housing and violence: "drug users are positioned as individually responsible for

hepatitis C [and HIV] transmission (and by implication, for the high rate of transmission of hepatitis C in injecting drug users' circles)" (Fraser 2004: 205). Furthermore, as Moore argues, "The decontextualisation of drug use individualises 'drug problems' and ignores the well-established relationship between political economy and drug-related harm" (2009: 1164; see also Bourgois 2003).

Therefore, harm reduction programs and philosophies often rely on neoliberal conceptions of the subject, thereby raising no challenge to social structures that have a serious impact on many drug users' lives. Seddon argues that "harm reduction is, and has always been, a technology for social regulation" (2008: 104). Thus, just as the concept of drugs and practices of treatment are socially constituted and infused with power relations, harm reduction as a philosophy and as a set of practices cannot be viewed as neutral or as unequivocally beneficial. As Keane argues, "harm reduction is not so much value-neutral, but rather expresses and promotes values that are so widely accepted that they are not subject to debate" (2003: 228). Therefore, harm reduction programs and practices should be called upon to critically examine their reliance on neoliberalism's individualized subject and to work with drug users towards meaningful structural change in order to reduce harms.

Redefining Treatment Provider Roles

Treatment providers and harm reduction service providers who adopt a non-judgmental, apparently neutral approach can be seen as condoning harmful drug laws and policies because "a stance of neutrality is a moral stance with consequences" (Stafford 2007: 88). Therefore more political engagement from treatment and service providers, including

harm reduction workers, is required in order to advance structural changes such as poverty reduction and better access to viable, appropriate housing.

One way to avoid perpetuating problematic assumptions about drug users in a harm reduction approach is for treatment providers to undergo a redefinition their own roles. Alexander calls on treatment providers to be public educators and to "let the public know that the power of the treatment that they themselves do is often seriously exaggerated by governments and media as a way of distracting attention from the more costly interventions that are needed to overcome dislocation" (2008: 342). Furthermore, Young argues that treatment providers need to be "conscious of how social norms can enter their work and can actively undermine the processes of the reproduction of structures of privilege and oppression" or they will only replicate racism, sexism, classism and associated institutional practices (1994: 46). Below I outline an example of how treatment providers can move away from a purportedly value-neutral approach and advocate for concrete changes that can help to reduce harm to their clients.

The Canadian Nurses Association provides an example of how professionals and associations can work from a harm reduction perspective that includes reducing the harm related to drug laws and stigma in their discussion paper titled *Harm Reduction and Currently Illegal Drugs: Implications for Nursing Policy, Practice, Education and Research*. The report argues that

> Although harm reduction is a means of reducing the harms of illegal drugs, it is a partial approach to addressing the health inequities associated with illegal drug use. To fully address those health inequities, attention must be paid to current drug and policing policies as well as other social policies, such as housing and income, as part of a broader social justice commitment (Canadian Nurses Association 2011: 4).

The report argues that drug laws and the accompanying negative health and social implications must be considered as a part of harm reduction strategies. One example of this approach as translating into practice was the Canadian Nurses Association, the Registered Nurses' Association of Ontario and the Association of Registered Nurses of British Columbia acting as interveners at the Supreme Court of Canada in support of Insite, a supervised injection facility in Vancouver, British Columbia.

It is also important for harm reduction programs and treatment programs that involve harm reduction to offer genuine harm reduction options. It is important to note that even if women are able to access harm reduction treatment programs, abstinence is still required by the child welfare and criminal justice systems: "In such instances, women have very little actual choice, especially if they wish to regain or retain custody of their children" (Brown & Stewart 2007: 437). Furthermore, Brown and Stewart found that "women in alcohol-use treatment have deeply internalized the dominant social ideology on substance use and treatment (i.e. that abstinence is the only treatment goal)" (2007: 431). They argue that this internalization must be considered and addressed in harm reduction approaches and programs. Specifically it is not enough for a treatment program to offer a choice between abstinence and harm reduction (in this case moderate drinking). Education and training on how to engage in harm reduction treatments are necessary to "make harm reduction goals a real choice" (Brown & Stewart 2007: 431). Furthermore, as Colleen Dell and I have recommended elsewhere "There is also a specific need for increased education among addiction counsellors, health workers and community leaders on what harm reduction is" (Dell & Lyons 2007: 12). Therefore a starting point towards transforming the role of treatment providers may be the offering

and promoting of education on what harm reduction involves and on how genuine choices can be offered.

Re-regulating Drug Policy

The goal of personal abstinence advocated by the disease model of addiction links directly to contemporary policy goals of a *drug-free world.* The prohibition and enforcement that have been mobilized to create this drug-free world are abject policy failures (Alexander 2008; International Centre for Science in Drug Policy 2010; Kemmesies 2002; Transform Drug Policy Foundation 2009). However, the concept of a drug-free world has been successful in ensuring public, political and financial support for the criminalization of drugs and drug users, forced and coerced treatment programs (like DTCs), and the ineffective *Just Say No* drug prevention campaigns (Alexander 2008; Lyman et al. 1999).

Contemporary drug policies allow state governments to perform exceptional interventions, such as crop eradication and military engagement. Further, there is evidence that drug policies, prohibition and trafficking themselves result in harms such as increased violence in drug using communities (International Centre for Science in Drug Policy 2010; Kemmesies 2002; Stop the Violence BC Coalition 2011). As the Health Officers Council of British Columbia argues, "Drug control policies could be crafted to reduce harmful use of substances, minimize negative health effects to the individual, and limit secondary drug-related harms to society" (2005: 2). Drug decriminalization has been considered a success in Portugal after a decriminalization law was passed on July 1, 2001 (Domosławski 2011; Greenwald 2009). Therefore, serious consideration must be made to calls for drug policy reform, or re-regulation, which have been gathering steam

in recent years. For example, the recent Report of the Global Commission on Drug Policy (June 2011) comprised of influential world leaders released a report calling for the end of the War on Drugs and policies that criminalize drugs and drug users.

The majority of drug regulation regimes currently in place are based on prohibition and specific moral values. Re-regulation models (decriminalization, legalization) are highly contested and often misunderstood. Furthermore, there are many approaches to re-regulation, and it does not necessarily entail a supermarket model where all drugs would be available to anyone anywhere (Stop the Violence BC 2011; Transform Drug Policy Reform 2009). Just as there are specific controls on alcohol and tobacco (e.g. age of purchase, areas of consumption, limits on driving), re-regulation can also involve a variety of controls and does not necessarily mean a single model for all drugs. For example, cannabis controls would look different than methamphetamine controls. Haden (2008) proposes a regulated market system with numerous controls including the degree of control of quantities available, age restrictions, proof of dependence in some cases, graduated licensing and proof of residency. He also proposes corporate controls such as controls on advertising and controls over profit. Re-regulation would also recognize that some of the substances that are currently criminalized are medicines, and that this is a highly problematic situation. In other words, we must look to our flawed medical marijuana program for lessons on how to re-regulate drugs in ways that do not violate the right to access medicine and health care services.

Reviewing the Drug Classification System

Canada is in need of reviewing its drug classification system (including alcohol and prescription medications) in order to evaluate criminal scheduling of drugs and to gain a

better understanding of the harms related to substance misuse. David Nutt and his colleagues in the UK undertook such a study in which they measured the harms of 20 drugs on individuals and others (Nutt, King & Phillips 2010). They found that alcohol causes the greatest harm to society and had an overall harm score of 72 out of 100, whereas ecstasy—which Bill C-10 proposes to move to Schedule I—had an overall harm score of 9 out of 100, a score well behind tobacco and other drugs. The Canadian Addiction Survey found similar results. In Canada, alcohol results in far more social, health and economic costs than all other illicit drugs combined (Canadian Centre on Substance Abuse 2005). While there are limitations to this kind of ranking system (Caulkins, Reuter & Coulson 2011; Fischer & Kendall 2011), Nutt's harm classification system outlines how drug policies are not based on actual potential harms but on ideology. This demonstrates the necessity for a re-evaluation of how drugs are scheduled, particularly in the face of legislation like Bill C-10 which proposed to reschedule over 20 substances from Schedule III to Schedule I. This would result in a tremendous increase of young people incarcerated for lengthy periods of time for doing something as innocuous as passing one pill of ecstasy to a friend at a rave.

Alternatives to Abstinence Treatment

We often hear calls for treatment as a solution to drug-related problems. However this simplistic approach depoliticizes addiction treatment and ignores evidence that treatment is not necessarily an effective solution. Treatment "can only make modest reductions in the number of men and women who misuse drugs" (Reuter & Pollack 2006: 341). Reuter and Pollack argue that "We cannot treat, prevent, deter or incarcerate ourselves out of 'the drug problem,' although each measure is a valuable component of drug policy" (ibid:

345). Therefore, it is important to heed Chriss' cautionary words: "where drug courts and drug treatment professionals seek to replace criminalization with medicalization...I suggest that medicalization will not alleviate the problems associated with 'illicit' drug use, and in fact, could even make the situation worse" (2002: 204). With this warning in mind, I would like to propose realistic, tangible alternative treatment recommendations while at the same time acknowledging the philosophical and theoretical problems with some of the short-term solutions.

Treatment in Canada remains embedded within abstinence-dominated approaches and requirements (Boyd, MacPherson & Osborn 2009; Brochu 1990; Brown & Stewart 2007). Furthermore, much of the available treatment relies on 12-step programs and models (Boyd et al. 2009). However, abstinence-based treatment does not deliver high rates of success, indicating that it does not work for many individuals. Here I introduce two alternative treatments as a starting point for discussion; however, I recognize that this is by no means an exhaustive list of potential alternative treatment options.

Ibogaine is one alternative treatment that falls well outside of the traditional understanding of treatment (one-on-one and group counselling, life-long abstinence). Ibogaine is a naturally occurring substance found in the root bark of *Tabernanthe Iboga*, a plant that grows in West Africa (Alper, Lotsof & Kaplan 2008). It has been used both medicinally and ceremonially for many years by Indigenous peoples. It is a powerful psychedelic that can remove withdrawal symptoms and reduce cravings and is also used to heal physical ailments (Alper, Lotsof & Kaplan 2008; Brackenridge 2010). There are two ways in which ibogaine treatment differs from conventional treatment: first, it is a short-term treatment, and second, it does not require abstinence.

Ibogaine treatment is neither life-long nor even long term. Some individuals undergo treatment a single time, while others undergo treatment a small number of times, either over a short period or over a longer period. Secondly, ibogaine treatment does not require abstinence. Ibogaine treatment providers understand that those seeking treatment know what is best for them (much like a harm reduction approach of meeting people where they are at with dignity and respect). If someone seeking treatment with ibogaine is working towards complete abstinence, the ibogaine treatment providers work with them towards that goal (Alper, Lotsof & Kaplan 2008). It is important to note that using drugs or not using drugs is not the focus of ibogaine treatments. Rather, it is a much more comprehensive, holistic treatment approach that moves away from abstinence as a marker of success. "Ibogaine therapy is attractive because it redefines success not as abstinence but as a measureable improvement in an addict's quality of life, and this is because ibogaine is not about prohibition or substitution, it's about spiritual evolution" (Shaw 2010). In many ways ibogaine, like moderate drinking treatment programs (Brown & Stewart 2007), challenges the disease model understanding of addiction and treatment as a life-long struggle towards abstinence. However, ibogaine treatment persists in treating individuals as individuals, and although it challenges the disease model of addiction and abstinence-only approaches, it does not challenge structural factors in drug abuse, like racial and gender inequalities or poverty.

Heroin prescription is another effective and humane method of treatment that resulted in less crime, less drug use and better health outcomes in trials in Germany, the UK, Spain, and here in Canada (Kerr, Montaner & Wood 2010; Strang et al. 2010). For instance, the North American Opiate Medication Initiative (NAOMI) was a randomized

controlled clinical heroin prescription trial in Canada with 253 participants in Vancouver and Montreal beginning in 2005 and ending in 2008 (Oviedo-Joekes et al. 2009b). The NAOMI studies delivered positive results. For example, there were high retention rates with 87.8% of individuals prescribed heroin staying in the treatment program versus only 54.1% retention in the methadone comparison group (Ovideo-Joekes et al. 2009a). Participants who were prescribed heroin engaged in fewer illegal activities and less illicit substance use than those in the methadone comparison group (Ovideo-Joekes et al. 2009a). While there were criticisms regarding the strict recruitment criteria, some of the researchers involved in the study have responded that "Addiction-treatment research navigates between science and politics, and evidence-based medicine is many times confronted by moral beliefs" (Oviedo-Joekes et al. 2009b: 269). Given the positive results of NAOMI and other similar studies, prescription heroin treatment programs should be considered as an alternative to strictly abstinence-based treatment.

Funding and Providing Voluntary Treatment

The literature comparing the effectiveness of voluntary and coerced treatment programs is mixed. Despite the discrepancies, it is safe to say that voluntary treatment is as effective as coerced treatment programs. For example, in their international review of quasi-compulsory treatment (QCT) Stevens et al. found "that non-coerced drug-user treatment is generally effective in reducing crime and drug use" (2005: 271). The American research on coerced treatment generally finds that compared to no treatment, coerced treatment produces better results, but that these numbers are similar to voluntary treatment success numbers (Hough 2002). In Schaub et al.'s (2011) study comparing voluntary and quasi-compulsory addiction treatment, they concluded that retention in

addiction treatment was similar in voluntary treatment programs and in quasi-compulsory treatment programs. Therefore funding and policy priorities should be shifted in order to increase voluntary treatment options. As Beck argues, "drug treatment must be disentangled from the penal system and social-control settings" (2006: 257).

This enhancement and focus on voluntary treatment is especially important because, as I have demonstrated in this work, DTCs set up a system whereby access to treatment is incumbent upon criminalization. Our current voluntary treatment system is highly stressed and lacking, especially for youth and for those residing in non-urban areas (Dell & Lyons 2007). As Boyd argues "coerced treatment is problematic when voluntary treatment is unavailable for most women in the U.S. and in Canada" (2004: 196). As I explained in Chapter 6, DTC participants are granted priority to treatment and housing, bumping individuals who have voluntarily signed up for residential treatment off the list. If the underlying principle of DTCs is that drug dependent individuals are in need of treatment in order to address their addiction, why are we not offering treatment *before* they become criminalized? As Kirkby sums up, "additional resources should be spent on expanding access to voluntary treatment rather than on expanding systems that follow the coerced treatment approach" (2004: 64). Therefore priority should be placed on increasing voluntary treatment programs and services before further entrenching and enhancing the DTC model.

9.3 Drug Treatment Court Recommendations

In what follows, I provide recommendations that are specific to DTCs in Canada. First, I suggest setting up housing arrangements for participants that are independent from the DTC program and where participants are not subject to surveillance. Second, I

recommend increasing the flexibility of bail conditions using recent changes in the Vancouver DTC as an example. Third, I propose that DTCs provide appropriate treatment services, particularly ensuring that gender-specific and culturally-specific treatment programs become available. Finally, I emphasize the importance of conducting reliable and valid evaluations of DTCs in operation. It is important that this step be carried out prior to the renewal of funding of DTCs in operation as well as before new funding is allocated for establishing new DTCs in Canada.

Arranging for Independent, Non-Surveilled Housing

Many DTC participants do not have access to safe, appropriate housing. Forty percent of participants in the Toronto DTC, 27% of participants in the Edmonton DTC, and 72% of participants in the Ottawa DTC have no fixed address or are living at an emergency shelter upon entry into the program (Department of Justice 2009).[31] Viable housing remains scarce, which impacts DTC participants. The Department of Justice summative DTC evaluations notes that

> The lack of safe housing and treatment beds limits the DTCs' ability to accept participants and/or stabilize those in the program. DTC team members reported poor success with participants who remain in high-risk environments like shelters (Department of Justice 2009: iv).

Regardless, stable housing is a requirement for graduation in the Vancouver and Toronto DTCs despite the recognition that "the DTC program has additional obstacles due to lack of gender-specific programming and adequate housing for women" (Department of Justice 2009: 27). Therefore, participants should have access to independent housing.

Most importantly, abstinence should not be a requirement to obtain or keep

[31] The Winnipeg and Regina DTCs did not collect this data.

housing. Recall that housing staff also acted as punitive players in the Ottawa DTC; violations of a rule in the housing residence could result in a second sanction in the drug treatment court. Thus, housing support staff in these residences act as agents for the Ottawa DTC, and participants staying at the residences are subject to video and staff surveillance. Furthermore, because residences enforce abstinence-only policies, participation in the drug treatment court can result in individuals losing their housing if they report relapses to the court. Studies of *Housing First* models where abstinence and treatment program attendance are not required to obtain and keep housing have also demonstrated positive results: costs of health care and rates of incarceration significantly decreased, and participants reported drinking significantly less alcohol over a 12-month period in comparison to the control group (Larimer et al. 2009). Therefore, abstinence should not be a requirement for housing in DTC programs.

Increasing Flexibility with Bail Conditions

The Vancouver DTC recently eased bail conditions because participants were often breaching their bail conditions (i.e., missing curfews) and consequently were unable to engage in treatment due to incarceration. The Vancouver DTC reports that reducing bail conditions to "reporting to the treatment centre and abiding by its conditions" has helped treatment outcomes (Department of Justice 2009: 32). Similarly, unlike the Ottawa DTC, the Vancouver DTC only uses sanctions "to reengage the participant in treatment" (Department of Justice 2009: 32). As a result, if participants are understood to be participating in treatment they are not sanctioned for violations, including missed urinalysis or appointments, which the Ottawa DTC automatically sanctions. This partially addresses the concern that participants lose access to treatment services when they are

sanctioned in the Ottawa DTC. Therefore, based on my findings it is recommended that if DTCs continue to be funded in Canada, increased flexibility with regard to bail conditions should be considered.

Ensuring Availability of Appropriate Treatment Services

The Government of Canada's DTC Funding Program has mandated that DTCs target individuals from high-needs groups, including "Aboriginal men and women, and sex trade workers, as well as women in general" (Department of Justice 2009: iii). As discussed in the "Effectiveness of DTCs" section in Chapter 5, while DTCs have tended to successfully attract and retain men and older adults (Department of Justice 2009), attracting young people, sex workers and women, including Aboriginal women, as well as retaining Aboriginal men in DTC programs has proven extremely difficult. Some DTCs have sought to provide more culturally-appropriate and gender-sensitive services "by either directly offering or referring Aboriginal participants to Aboriginal-specific programming" (Department of Justice 2009: 26). The Toronto DTC has sought to address its difficulties in attracting and retaining women by forming a Women and Children's Sub-Committee of its Community Advisory Committee, ultimately leading the Toronto DTC to offer separate programming for women. Yet, many of these DTCs "struggle with being able to provide this type of support due to limited staff" (Department of Justice 2009: xii). Lutze and van Wormer argue that it is imperative that drug treatment courts "assure that the process and programs that offenders participate in are accessible, relevant, and of quality—if not, then both the court and the defendant are likely to fail" (2007: 230).

Women, people of colour, Aboriginal people, and those who are not interested in 12-step, disease model-based treatment services are, nonetheless, required to participate in the treatment programs assigned by the courts. Women, youth, Aboriginal people and people of colour should thus be included in the development of programming in order to not only identify appropriate support services but also to develop appropriate frameworks for DTCs to use. Therefore, it is crucial that appropriate and effective treatment services for target populations be earmarked within funding schemes.

Conducting Appropriate, Reliable and Valid Evaluations of Canadian DTCs in Operation

DTCs are a politicized intervention. The Minister of Justice declared DTCs a success and expanded the pilot program before any data was available and two years before the first evaluation of the Toronto DTC was completed (Fischer 2003). Therefore it is vital that the DTCs in operation be properly evaluated by non-partisan researchers with methodological integrity and rigour. This is particularly important because of the methodological problems associated with the DTC evaluations as outlined in Chapter 5.

One of the DTC Funding Program's objectives is to "collect information and data on the effectiveness of DTCs in order to promote best practices and the continuing refinement of approaches" (Department of Justice, 2009: 3). Yet, the information and data collected continues to be methodologically flawed. It is thus imperative that evaluations be conducted appropriately and by unbiased third parties. Furthermore, it is vital that the treatment programs and services offered in DTCs be evaluated by appropriate outside observers to ensure that the treatment that is offered complies with the Charter of Rights and Freedoms and Canada's international human rights obligations.

As part of the first year evaluation of the Ottawa DTC, Public Safety and Emergency Preparedness Canada had a Correctional Program Assessment Inventory-2000 (CPAI-2000) completed (Dowden 2007). The report concluded that the treatment counsellors and the ODTC manager who deliver treatment services lacked the necessary skills and qualifications to perform their work. However, no changes were instituted based on this report. What is more, the second evaluation of the ODTC was undertaken by the treatment provider itself, posing serious questions as to the commitment of the federal government, and the Ottawa DTC, to evidence-based best practices.

9.4 Conclusion

Part of the reason that punitive, prohibitionist drug policies continue to be crafted and supported despite evidence that they are ineffective and unjust is that they are rooted in pervasive and problematic assumptions about addiction and treatment. The belief that drug dependent individuals have a disease and lack the willingness and motivation to abstain from drugs and alcohol has created space for the development of drug treatment courts that blend punishment and therapy in highly problematic ways. DTCs are based on the assumption that threatening participants with incarceration is an appropriate and effective means of cultivating willingness and motivation to live drug-free and to transform into *better* citizens. However, rather than placing the sole onus of responsibility of addiction onto drug users, the scope of reference must be widened. Poverty, lack of social housing and social and economic marginalization are primary factors in substance use; nevertheless, these factors continue to be entirely overlooked by DTCs and other approaches informed by the disease model of addiction and by the neoliberal values of

individualism and autonomy. As a result, alienation, isolation and social dislocation of drug users are currently the norm. In order to recognize the human rights of drug users, to mobilize evidence-based strategies rooted in harm reduction, and to prevent the advent of a system where the only route to treatment is through criminalization, it is imperative to look past the ideology of punishment and responsibility that informs not only DTCs but the entire prohibition and enforcement based drug policy regime. Real progress in drug treatment can only come from real progress in social justice: providing opportunities for safe and adequate housing and employment, as well as countering racial and gender-based marginalization.

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