SOWK2050 Assignment #4 - Developing your anti-discriminatory approach

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People who use drugs, particularly injection drugs, face numerous forms of discrimination and structural oppression. Discrimination against substance users has been rooted in socioeconomic status, homelessness, unemployment, disability, criminality, and other factors, each intricately traversing the others at various intersections. In a system which has been largely influenced by biomedical discourse and neoliberal agendas, people who use substances are commonly referred to as addicts; addicts are frequently marginalized by both treatment modalities and by society at large. Substance use services are often medicalized and subjugate clients instead of recognizing them as lived experts who inform treatment. Participants in methadone maintenance treatment, for example, must endure intrusive and restrictive measures in order to receive services (Smye, Browne, Varcoe, and Josewski, 2011). Users have faced and continue to face various forms of discrimination as their lifestyles and choices are not widely accepted thus rarely openly shared. This population is forced to remain in society's shadows in order to avoid incarceration or societal persecution. In Toronto, there are many treatment options for injection drug users which have been proven effective in significant research throughout the years (Strike et al., 2006; Strike et al., 2009) and yet advocates like me are still fighting to improve and increase access to those services.

Intravenous drug users in Toronto encounter forms of oppression on every level of society - micro, mezzo, and macro. A neoliberal society views a substance user as one having an individual problem with only one solution: abstinence. While biomedical discourse would consider the substance user as an addict with a disease (Healy, 2014), it still heaps blame and responsibility upon said addict to get help and get 'cured'. Failure to do so would result in consideration of that individual as responsible for their own ensuing suffering (Capponi,1997) such as physical

illness and poverty which in turn become additional sources of discrimination and oppression. The individual suffering which commonly accompanied substance using lifestyles often engage the users in a repetitious cycle. Because opiate use by injection or any other method is illegal, users frequently carry with them records of criminality. Criminal records can be barriers to employment, housing, and even some substance abuse treatment programs. Additionally, due to the controversy in dominant discourse regarding injection drug use (Hyshka et al., 2012; Tempalski et al., 2007), users often find it difficult to gain regular access to clean equipment or safe places to use. Failure to use clean injection equipment poses extremely serious risks to individual and public health (Strike et al., 2006).

It is difficult but not impossible to access services for substance use when impoverished and ill however, often inherent in treatment modalities is yet another layer of oppression. With particular regard to methadone maintenance treatment (MMT), the structure and delivery model of the service has been described as oppressive, restrictive, and often inaccessible (Smye, et al., 2011). While Baines (2011) would suggest that an anti-oppressive model be designed around the needs and wants of program participants, MMTs are antithetically governed by the College of Physicians and Surgeons. MMT clinics are run by appointed physicians who are not required to have any lived experience with using opiates and participant requirements include regular and observed urination screening and inability to leave the geographical area (CPSO, 2011). It is an abstinence-based treatment model and positive drug tests can result in ejection from the program (CAMH, 2011). Programs which are not abstinence based are known as harm reduction models and they are also widely known as cause for controversy.

It is important to unpack the controversy surrounding harm reduction models so that we can understand and disrupt the perpetuating discourse. Services like needle exchange programs and safe injection sites have been proven to effectively, positively, and significantly impact individual and public health and yet both common citizens and the politicians who represent them are often vehemently opposed to the programs. The dynamics which help to fuel arguments against services for injection drug users are cyclical and structural. It has been argued that the presence of safe injection sites, for example, would bring crime to the neighbourhood (Campbell, March 14, 2016; Dehaas, March 14, 2016; Yuen, March 13, 2016). There are two things to examine in consideration of this complaint. Firstly, it has been demonstrated that safe injection sites do not increase criminal activity (Small, 2012). Secondly, we must consider why criminalization and heroin use are intertwined. I argue that decriminalization of heroin would produce only positive outcomes for societal fiscal, forensic, and health matters. Policy makers have the power to make these changes and yet they chose not to do so. Moral governance is so ingrained that to even suggest decriminalizing heroin is usually cause for uproar even though the fiscal outcomes would be positive (Collin, 2006). It seems to be in direct contradiction to neoliberalism which values dollars above all else (Wharf and McKenzie, 2009). The relief of finical strain on correctional services, health care services, policing and enforcement services, and social services could be felt almost immediately by a change in policy which is overwhelmingly supported by researched based evidence. With so much evidence to support harm reduction models there is cause to wonder why policy makers would even hesitate to make the simple changes.

It seems clear that social justice transformation is necessary to impact governmental policy development. Ideally a shift in macro-level policy would provoke a trickle-down effect resulting

in less oppressive treatment modality structures. Removal of the criminalization label forces a new way to regard injection drug users. When the act is no longer a crime, then the actor is no longer a criminal. An injection drug user who is not criminalized no longer faces barriers to accessing health care and wellness treatment options. Improved health increases ability to advocate against ableism. Removal of ableism opens wide the door of opportunity for many people to many things. Deconstruction of ableism can impact the medicalized architecture of methadone maintenance programs. The domino effect goes on, but how do we go about attaining this anti-oppression utopia? Baines (2011), Barnoff (2011), Fay (1997), Profitt (2011), and Webhi (2011) are going to help us get started.

Developing an overarching anti-discriminatory approach to working with injection drug users will require modifying the view of the population that the dominant group currently holds. Social workers we must lead by example in this endeavour as Baines (2011) reminds that, "The responsibility to make social changes becomes one of the lenses through which we view the world" (p.79). Shifting from an individual, neoliberal viewpoint to an acknowledgement of socially constructed problems in society is a challenging but achievable task demonstrated by students of social work year after year. If social workers regularly engage in critical conscious raising then they can effect change in their work environments. For example, in my work, I can attend mental health grand rounds and generate consciousness-raising discussions through asking questions. I can also engage clients in discussions. Harm reduction work relies heavily on the premise that lived experience informs expertise and worker-client relationships are reciprocal in nature. It is likely, then, that by engaging intravenous drug-using clients in discussions there is much to be learned about their substance use and what programs and policies are effective, nec-

essary, and where they identify the gaps in service. In this regard it is important for both workers and clients to remember that, "the system was not made for us or by us and we do not have to prop it up" (Baines, 2011, p.92). Together worker and client may empower and learn from each other, each able to take that knowledge and power away to be reapplied in various settings in order to effect change.

Effecting change such as normalizing harm reduction and injection drug use in an environment dominated by medicalization is not an easy task. In today's neoliberal society people seem to effortlessly and unconsciously tend toward individuation. The concept of medicalization, however, can be easily unpacked and explained in a manner supportive of the social model described by Webhi (as cited in Baines, 2011). When applied to substance use, the dominant discourse upholds medicalization such that substance using behaviour is considered to be always problematic and that abstinence from illicit drugs is normal, unproblematic, and the ideal state. In Webhi's (ibid) discussion of the social model, injection substance use is not problematic behaviour that needs changing, but the framework of consideration used to evaluate the situation is problematic. In simple terms, injection drug use is wrong only because dominant discourse says it is wrong. The injected substances have been criminalized so the act becomes criminal. Consider this example: someone uses a needle to inject vodka into their vein - is the act problematic and, if so, how? Vodka is a lawfully sanctioned substance and there is no law prohibiting a person from injecting themselves with legal drugs; many people with diabetes do this multiple times per day. Through this example we can begin to recognize the way injecting heroin has been socially constructed as a problem. If advocates of social justice continue their work for harm reduction and decriminalization of substances then perhaps injection drug users may eventually

move out of the shadows, away from the margins, and into mainstream society where we all belong.

When working with marginalized populations such as injection drug users, systems theory may offer useful insights into how best to consider current problematic situations. Unlike the social model, systems theory suggests that an individual modify their own interactions with various social constructs and groups so that relationships may be improved (Fay, 1997 as cited in Baines, 2011). Despite the blame and individuation inherent to systems theory, I believe it can, on occasion, be beneficial to workers. While Barnoff (2011 as cited in Baines, 2011) offers helpful information about organizational change and anti-oppressive practice, the ideas are more suitable for a workplace environment willing to embrace change. As an employee in a predominantly white, upper middle class suburb, understanding the nuances of the various systems involved in day to day operations appears to be a much better fit for insertion of anti-oppression work. Familiarizing oneself with and understanding the hierarchical structure of the organization and various stakeholders creates a well-informed position for introduction of the subtle changes possible within the current medicalized structure. It can be a daunting and threatening environment where rabble-rousing is not generally applauded, thus one must tread carefully if attempting to effect change. In a medicalized structure which places extremely high value on professional standing, anti-oppressive practice is not naturally occurring nor seemingly openly welcomed by this system. My workplace often promotes its multi-disciplinary team approaches however as a member of one of those teams I clearly know my place and it is well below where the power lies.

Structural perspective is a useful way to explore not only my workplace but also the experiences felt by the clients I work with and hope to work with in the future. Fay (1997 as cited in

Baines, 2011) suggests that, "Critical analysis can help examine the unequal power relations inherent" in our various institutions. This suggestion is invaluable when working with injection drug users. Unequal power relations are largely the driving force behind the oppressive structure which is still so resistant to harm reduction approaches. Harm reduction is an anti-oppressive approach, aligning well with the practice model table illustrated by Fay (ibid). The power imbalance which impacts harm reduction actually strikes twice due to the modality's anti-oppressive nature. The dominant group asserts power over injection drug-users through structural oppression such as criminalization, impoverishment, and ableism. Harm reduction workers act with clients, not for clients, and are commonly peers, thus workers are also subjected to power imbalances of similar origin. Harm reduction agencies generally receive less funding than non-harm reduction agencies, have lower remuneration for staff, and are often afforded less credibility and recognition than more mainstream service providers despite voluminous evidence of efficacy (Cavalieri and Riley, 2012). From a structural perspective it appears that harm reduction workers must engage in significant and effective self care.

The importance and occurrence of self-care is directly correlated with success in social work. In the case of harm reduction workers who are working with injection drug users, self-care is extremely valuable to workers for whom resilience is essential. According to Profitt (2009 as cited in Baines 2011), there are many ways in which self-care can, and should be, political. It is suggested that social workers have an ethical obligation to care for themselves so that they can best perform their roles. Profitt (ibid) also discusses Friere's concept of conscientization, a key piece of which, "Involves understanding how we are implicated in relations of domination and oppression and using such insight to make change" (as cited in Baines, 2011, p. 281). This concept is

of significant importance if social workers are to use anti-discriminatory, anti-oppressive practice. Awareness and understanding are necessary components of the reflection and reflexion processes which are key to self-care in social work. Profitt (2009 as cited in Baines, 2011) highlights the importance of self awareness in discussing subjectivity. Knowing and naming our social locations and our relationship to the world around us are key components of the subjectivity described by Profitt (ibid) and the outcomes of this process will impact the services we provide. Working with injection drug users in a harm reduction capacity without a fully developed understanding of one's social location and relationship to structural dominance and oppression could impair working relationships with clients. Genuineness is a well accepted component necessary for establishing rapport in working relationships and harm reduction worker to injection drug user relationships are no exception. Given the anti-oppressive nature of harm reduction work, lacking genuineness is likely to result in service delivery failure. On the other hand, harm reduction work done right means great gains for society, such as decreased crime rates and incarceration, increased individual and public health, and freer, happier, citizens. For the neoliberal agenda the outcomes will be fiscally pleasing; for injection drug users and harm reduction workers working along side them, a more equitable society is within reach. It may not be an anti-oppression utopia but it is at least movement in the right direction.

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