

Drug Policy: An Examination of Canada and Ukraine

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Introduction

The use of drugs is not a new phenomena to human society. Drugs have been a staple in human culture for centuries. So, why has drug use been such a controversial topic in the 21st century? A fundamental change is the increased use of psychoactive or mind-altering drugs (Boyd, Carter & MacPherson 2016:1). This paper examines drug policy in two states, Canada and Ukraine, to better understand the role politics and culture play in developing drug policies. This examination explores the development of contradictory policies in both states to understand the underlying systemic factors in decision-making.

The topic of changing drug laws will be examined through a social constructionist lens. Social constructionism is a theory that focuses on how society constructs specific issues as social problems. As a theory, social constructionism aims to understand "that the world, the categories and the concepts we use are historically and culturally specific" (Burr 2015:4), which means that there are changing opinions on societal issues throughout history or the course of an individual's life. Social constructionism assumes that ideas shift with time and vary due to the social, political and cultural environment in which it is developed.

As Burr (2015:8) alludes, social constructionism creates a complex society as "truth" differs depending on who or where you are. For example, the rules and regulations surrounding alcohol are a social construct. Different countries and regions have different legal drinking and purchase ages depending on cultural, societal and religious factors. For example, the United States' legal age is 21, while in Canada, the drinking age differs in each province at 18 or 19 years old. In some European countries, such as Germany and

Austria, the legal age can be as low as 16 for low-percentage alcohol such as beer, ciders and wines (Hansen 1997). Other countries, such as Saudi Arabia, have banned alcohol, while in Pakistan, alcohol is prohibited for Muslims but not for the rest of the population (Hansen 1997). It is possible to see the changing construct of alcohol in policy development, as in the 18th and 19th-century temperance movements in Canada, the United States, and the United Kingdom led to the prohibition of the substance, although the policies were later overturned. Overturning prohibition came as the social construction around alcohol inherently changed from the individuals being seen as entirely responsible for their behaviour and deserving of imprisonment to being victims of a substance and in need of medical or psychological treatment (Burr 2015:5).

Drug use being labelled a social problem points our attention to institutional powers creating and reinforcing the public's understanding of specific problems. Drug policy is an example of the power and showcases how "power was exercised in unequal ways, by police officers, social workers, doctors, government bureaucrats... 'Moral agents' with different priorities" (Carstairs 2000:4). As Carstairs notes, drug policy "raises serious questions about inequality, how and why it is reified and perpetuated and how it can be corrected (2000:4).

These institutional powers or claims-makers play an essential role in constructing and maintaining social problems. These experts help define the nature of social issues and offer solutions that align with their respective institutions' policies and goals (Best 1999; 67-68; Boyd et al. 2016: 6). Best (2018:54) highlights the shift in studying social problems as a problem of

claims-making rather than as a condition. Therefore, it did not matter if (x) condition existed, only that individuals had mobilized to make claims about (x) being a social problem.

By examining a shift in ideology, combined with various national and international agreements regarding equality and human rights, there has been a change in drug policy. This review examines the role of claims-making in developing policy as ideas about substances and the people who use them change. This review aims to understand better why drug policy has changed in Canada and Ukraine and address how and if each country's history has adverse effects on people who use drugs today. By answering how ideas about substances and people who use them shape policy, this paper argues that despite advancements, there is still a medical and criminal drug policy model in both countries. These models contradict each other and increase the harm placed on people who use drugs and minority groups due to systemic discrimination in policy making.

Literature Review

A critical starting point for this research is understanding drug policy. This work uses a critical and sociological understanding of drug policy, as it encompasses different laws and policies which guide decisions about how to allocate "public monies, the types and levels of services to offer and the laws and criminal justice activities to be taken by police, courts and correctional systems" (Boyd et al. 2016:2). Drug policy is not restricted to one institutional agency; instead, drug policy includes decisions from medical realms, policing, law, advocacy groups, and government officials (Boyd et al. 2016:2). Drug policy, therefore, is a multifaceted approach to drug use which can be shaped by both internal and external/international pressures.

Drug policy affects more than just the criminal/legal realm; it also affects the availability of treatment and services for people dependent on drugs. Ill-advised drug policy can increase the harm to users, done by increasing human rights violations, increased surveillance, hyper-criminalization, unlawful search and seizure, and contributing to the increase of preventable, transmissible diseases such as HIV,

Hepatitis C virus and rising overdose rates (Khenti 2014; Kiriazova and Dvoriak 2015).

There have been two models which have affected drug policy. The moral model emerged as individuals and governments understood drug use as a result of poor decision-making and as atypical compared to the rest of society (Boyd et al. 2016: 11). The 1930s and the rise of studying addiction led to the belief that individuals were morally flawed, therefore shaping both society's responses and in policymaking increasing punitive policy, rather than supportive. The moral model resulted in increased stigmatization, discrimination and marginalization of individuals who use drugs and therefore increased risky consumption due to fears of ostracization (Boyd et al. 2016:11-12). Studies in addiction sciences have been essential to the treatment of drug users in both Ukraine and Canada. The disease model of drug policy came into force during the second half of the twentieth century as individuals began to recognize addiction as a "chronic, relapsing brain disorder" (Leshner 1997: 45). Therefore, there was a distinct shift in opinions from drug dependency being a failure of individuals to a biological disease.

Unfortunately, as Leshner points out, the idea that users are inherently evil, immoral people is still prevalent in public, political and medical realms (1997: 45-46).

The development of the disease model of policy came with many fears that safe consumption would increase or enable drug use, especially for young people, and increase the crime rate. Despite the rise of the disease model, drugs and crime were intrinsically linked, disproportionately affecting minority groups by increasing police presence in the low-income communities where these groups make up the majority of inhabitants (Khenti 2014:191). Therefore, moralistic beliefs in society and policy are reinforced.

Therefore, increased arrest and crime rates in these areas are due to increased surveillance as police actively search out illegal behaviours. Harm Reduction International (2021) reported that 1 in 5 individuals are imprisoned for drug offences (2). An immediate consequence of the WOD in the United States saw the "prison population soared from about 300,000 to 1.6 million inmates and the incarceration rate from 100 per 100,000 to over 500 per 100,000" (Pfaff 2015: 173). While overdoses and the spread of HIV/AIDs increased in people who used drugs as they increased risky

behaviour to avoid being caught by the police (Strathdee, Beletsky and Kerr 2015).

There have been advancements to encourage equality of individuals in all spheres of life. This work references three specific pieces of work dedicated to ensuring human rights. This work mentions human rights defined by the Universal Declaration of Human Rights (UNHR) of 1948. The United Nations General Assembly adopted this work after the end of the Second World War. While this legislation is not legally binding, it created the framework for different countries' constitutional frameworks, as countries work to achieve "the promotion of universal respect for and observance of human rights and fundamental freedoms" ("Universal Declaration of Human Rights"). Human rights and a pledge to equality were observed in Canada's *Charter of Rights and Freedoms (Charter)* and Ukraine's Constitution of 1996.

Case Study: Canada

Canadian drug history has an underlying theme; rather than based on scientific fact, policy changes have allowed agents of social control the ability to achieve specific goals. As Marquis (2005: 62) describes, the debate on the proper way to handle drug use "hinged on cultural or moral values, not science." *The Canadian Charter of Rights and Freedoms* (1982) explicitly references in section 15(1) that "every individual is equal before and under the law and has the right to the equal protection and equal benefit of the law without discrimination and, in particular, without discrimination based on race, national or ethnic origin, colour, religion, sex, age or mental or physical disability." The Canadian Charter makes no explicit references to discrimination in health care. Under Canadian Health Act, a piece of federal legislation makes the responsibility of health care fall to provinces while upholding the Charter in its operation.

Canada's punitive drug laws and violations follow a history of ill-treatment of sub-groups. Before the adoption of the Canadian *Charter*, Canada's first drug laws, *The Opium Act* (1908) and *The Opium and Narcotic Act* (1911), was in place to target Asian Canadian communities, limiting "Asian immigration and trade, labour-market imbalances and moral upheaval" (Fischer et al. 2003:267). Parliament enacted the *Opium Act of 1908*, despite Prime Minister

Mackenzie King not having "a shred of hard evidence to support his claim that smoking opium equals harm and degradation" (Boyd 2017: 42-43). To strengthen his claims in the house of Commons in 1911, King cited a variety of media sources, including articles entitled "The Women is a Cocaine Fiend and Not Likely to Recover" (The Globe, October 20th, 1910, as cited in Boyd 2017: 45) and "Children Use Cocaine" (The Globe, April 8th, 1910, as cited in Boyd 2017: 45), showcasing the moral model of drug laws.

The 1960s were a period with several distinct shifts surrounding drug use and drug policy, including the increased recreational use of drugs among young adults. At the same time, adopting the *Narcotic Control Act* (1961) created the harshest drug laws of any western nation (Boyd et al. 2016: 21). The combination of the Narcotic Control Act and the War on Drugs (WOD) created an environment which targeted visible minority groups for drug use. Despite the emerging use of cannabis by white, middle-class, college-aged students, there was a different and contradictory treatment towards subgroups. While minority groups were hyper-surveilled, Boyd et al. (2016:21) explores how 1969 concerns about the "number of white middle-class citizens who could potentially receive prison sentences for possession" was partially responsible for an amendment in the *Narcotic Control Act*, "creating an alternative summary conviction and lesser maximum penalty".

The moral model also highlights the logic used by the United States under President Richard Nixon, who started the 'War on Drugs', which had adverse Canadian spill-over effects under Prime Minister Brian Mulroney. Mulroney's claims of a drug epidemic were the reason for starting the War on Drugs in Canada, despite cannabis, heroin and cocaine peaking in 1979 and declining in use and popularity to their lowest rates in a generation in 1991 (Adlaf, Smart and Canalde 1991). Under Mulroney, there was a surge of neo-liberalist policy in government and towards drug policy. An essential feature of neoliberalism as a political ideology is "the notion that individuals freely make choices in their lives" (Hardhill 2019: 21). By placing every individual on the same, "equal" level, neo-liberal policy assumes that individuals are responsible for their choices, creating the notion that drug use is just a choice, with the ability to be made or

un-made (Hardhill 2019: 21). The era was marked by the WOD, with strict attitudes of deterrence and criminalization of substance use, selling and possession.

Outcomes of WOD policies include adverse effects on minority groups. Sapers (2013) recognizes that Black Canadians are one of the fastest growing sub-groups in federal prisons, making up 9.5% of the total prison population, despite only representing 2.9% of the general population. With the number of Black inmates increasing by 90% and the Aboriginal [sic.] population increased by 46.4% between 2003-2013 (Sapers 2013). The increased level of minority groups in prison populations can be contributed to racial profiling and increased police presence due to the adoption of WOD policy. In the 1990's police officers were "trained explicitly profile certain ethnic and/or racial groups for law enforcement purposes" (Kenti 2014; Bobo and Thompsen, 2006)

Early decisions by agents of social control, influenced by the WOD, led to the hyper-criminalization and surveillance of minority groups. Black Canadians have been the target of the WOD, as the increased institutional powers under the 1995 *Controlled Drugs and Substances* allowed for increased police power, unlawful search and seizure, increased surveillance and new maximum sentences for drug use (Erickson and Hysha 2010). Single et al. (1996) found that because of the WOD, law enforcement received \$400 million in funding at the provincial and federal levels; on the other hand, funding for treatment received less than one-quarter of that, around \$88 million. There is no denying that services in Canada for drug users are underfunded by provincial and federal governments in favour of increased law enforcement.

Public health services for drug users developed in Canada in the late 1980s as the HIV/AIDS epidemic grew. Some of the first facilities opened in Vancouver, Montreal and Toronto were informal services that provided syringe distribution and received federal funding for two years in five provinces; many programs ran with provincial support afterwards (Hyshka et al. 2017: 2). The Canadian Federal government supported these services and recognized it as a critical pillar of its drug policy. They continued until 2007, with the election of a "tough on drugs" conservative government (Hyshka et al. 2017: 2). The new *National Anti-Drug*

Strategy transferred responsibility from the health sector back to the justice department. The new government made a step to close Insite, North America's first supervised injection facility. An action which Insite's staff and clients challenged in court as a violation of their "rights to life, liberty, and security of the person under the Canadian Charter of Rights and Freedoms," which resulted in the 2011 Supreme Court of Canada ruling, which ordered the minister of health to renew Insite's exemptions (Hyska et al. 2017: 2).

Case Study: Ukraine

Drug policy before the independence of Ukraine in 1991 fell under the Soviet Union's criminal code. Drug addiction was not seen as a social problem but rather as the individual fact of deviant behaviour, "non-typical" of a socialist society. Under the criminal code, drug use, production, storage, transportation and sale (outside medical institutions) were considered serious offences (Kiriazova and Dvoriak 2018: 7). Despite government attention, the use of drugs was widely ignored by the public, as the USSR insisted that there was "no social bases for drug addiction in the Soviet Union" (Kiriazova and Dvoriak 2018: 8). Since the fall of the USSR there has been a distinct shift in drug policy due to a rapid increase in drug use and the high transmission rate of diseases such as HIV/AIDS in Ukraine.

Drug use and policy are not only specific to the governing of neo-liberal societies. As mentioned, there are differing ideas of "truth" depending on where and when you are. Communism, as a form of political ideology, like neo-liberalism, governs and creates laws based on political, cultural and social norms. Criticisms of communism include totalitarian power, lack of freedom and free speech, censorship of ideas, and denial of 'negative' phenomena (such as drug use) that could only survive in capitalist economies (Kramer 1990: 21). Therefore, drug addiction was seen as deviant from the social norm and not a social problem reflective of socialist society. The USSR denied drug abuse claims until the mid-1980s and then claimed there was no severe addiction and no involvement of young people (Kramer 1990:23). Once the USSR accepted that some people use drugs within its territory, drug users needed to become registered. In 1988, there were 52,000 individuals registered as drug addicts in the Soviet Union, although the number is suspected of

having been much higher (Kramer 1990:23). Soviet denial of drug use made it incredibly difficult to receive treatment and support for addiction, as facilities were non-existent or inadequate; in the USSR in 1986, 25% of registered addicts had received any medical treatment (Kramer 1990:28)

Since Ukrainian sovereignty and the adoption of the Ukrainian constitution in 1996, set declarations that validated human rights and equality. Including Article 24, that "Citizens have equal constitutional rights and freedoms and are equal before the law. There shall be no privileges or restrictions based on race, colour of skin, political, religious and other beliefs, sex, ethnic and social origin, property status, place of residence, linguistic or other characteristics": Article 27, "... The duty of the State is to protect human life" and Article 49, "Everyone has the right to health protection, medical care and medical insurance" (Constitution of Ukraine 1996).

Since the adoption of the Ukrainian Constitution, there was a shift from denial and the moral model of drug policy to recognizing the rapidly increasing drug use within the country as an epidemic as HIV rates grew. Social movements such as "Faith, Hope, Love" were started by individuals in 1996 who recognized the growing epidemic and consisted of "health care specialists, lawyers, militia officials, scientists, and volunteers, who fought to implement strategies to prevent HIV/AIDS among people who inject drugs in Ukraine's city Odesa" ("Ukraine" 2022). Ukraine quickly recognized the growing epidemic and fought for its rights to life and health care services.

Ukraine's location has been integral for the trafficking of drugs from southwest Asia into Europe. It has been a side effect of the termination of Soviet border control, rapid political change and corruption. (Layne et al. 2002:11). The availability of services in Ukraine is in place to target the increasing trend of preventable disease transmission and overdose prevention. Despite the growing trend in infections, Ukraine has also passed legislation to decrease the legal limit for quantities of drugs called Resolution 634., which "focuses the efforts of law-enforcement agencies and judicial bodies on people who use drugs rather than drug dealers", side effects of this include people avoiding health services due to the risk of being caught, increasing infections and increasing the number of people in prisons (Layne

et al. 2002:11). By lacking conformity with international law and Ukraine's Constitution, Resolution 634 heightens the individual risk of using drugs, decreasing the quality of life for people who use drugs.

Comparison of Cases

Both countries have seen distinct changes in their drug policy as it has adopted new national and international legislation. Despite these changes favouring equality and a medical treatment model, neither country's policy has been without fault. These changes make it more difficult for equality if certain groups of people are being unjustly arrested, surveilled and detained for minor possession. Laws which are in place in Canada and Ukraine offer support for health and safe use but are criminalizing the ability to possess drugs.

While Ukraine has seen radical political changes, from a member of a communist regime entering the world of democratic and free thought, Canada has had a consistent form of government. Political changes are a central theme of this work as it follows a series of significant policy changes and government structure. In addition, membership in international organizations, such as the UN, and a commitment to human rights change how governments deal with a public health crisis, like the spread of HIV/AIDS and overdose rates. When there was federal pushback in Canada about Insite's exemption status, the court decision denying individuals access to this medical facility violated their rights. Despite this, there is still embedded discrimination in Canada's policy that has followed the moral model of drug use and a history of anti-Asian discrimination, shifting onto minority communities, such as Black Canadians during the WOD.

The influx of drugs transported through Ukraine has had a unique disadvantage as a transport country. Despite this disadvantage, Resolution 634 targets users, not dealers, of these substances. Ukraine's Resolution 634 sparked international debate about the ability of individuals to receive medical services once criminalization was increased. It increased risky behaviour and consumption due to fears of being caught and imprisoned. While Canada wanted to close Insite and remove its legal exemption, Ukraine did not want to deny the ability to use drugs safely- only to criminalize the ability to carry drugs. This created a

double-edged sword as contradictory policy affected users, not transporters. Despite advancements and understanding of addiction, this policy places blame on the individuals, following the moral model of drug addiction. This showcases the differences in punitive policy development in both countries and the underlying factors for why policy has developed.

Discussion

To evaluate the effect of drug policy, it is necessary to recognize three levels involved: the micro/ individual, meso/institutional and macro/societal. Drug policy and harm reduction reflect societal and institutional systemic discrimination, social control policy and its effect on individuals, their lives and their health. By having a harm-based, human rights-infused drug policy, people who use drugs are first and foremost people, regardless of race, ethnicity, or mental, physical or medical health. Without these approaches, it reinforces structural inequality and denies minority groups and people who use drugs the chance at life without discrimination.

While both countries have seen shifts to support for people suffering from the adverse physical and medical side effects of drug use, recent developments have denied fair access to services and increased incarceration rates against minority groups. With this shift, there is a disregard for equality based on human rights principles, affecting individuals and their communities.

In Canada, embedded discrimination in policy is seen from a history of targeting minority groups for drug use and has continued in today's policy. Minority groups whose rights are violated because of increased police presence include suffering from higher mental health issues due to increased fear, such as increased anxiety and depression (Khenti 2014: 193). Individual effects of ill-advised drug policy include higher rates of overdose and the spread of diseases. The prevalence of HIV for people who inject drugs in Ukraine is 22.6%, and Canadian statistics showcase a 14% prevalence ("Ukraine" 2022; "People living with HIV in Canada" 2020).

As Khenti (2014: 195) describes, targeting individuals for minor possession charges also increases the prison population and the number of individuals with criminal

records, reinforcing structural inequality and excluding minority groups from society. This showcases the effects on individuals but reflects institutional and societal inequalities. At the meso level, there are institutional implications due to punitive drug policy. Increased incarceration rates for minority groups have significant effects on families. Parental incarceration can reinforce poverty, disturb family life, force children into foster homes and create difficulties such as deepening socio-economic and health problems for parents once they are out of prison (Paynter et al. 2022: 2128). A lack of support, including monetary and housing, once parents are out of prison also reinforces risky behaviour and affects their ability to parent (Paynter et al. 2022: 2128). A 2016 survey conducted in Ontario found that 82% of women who responded had been pregnant at some point in their life (Liauw et al. 2016). There were detrimental effects for those with families, and similar findings were found in the European Union. Children who had a parent incarcerated report poor mental health, stigma, social isolation and an adverse change in family dynamic both during and after the incarceration of a parent (Manby et al. 2013: 230).

As demonstrated, individuals who are a visible minority are more likely to be imprisoned for drug possession in Canada due to over-policing in low-income areas. Then when these individuals are out of prison, they are denied social support, are forced back into low-income neighbourhoods and have little means to provide for themselves and their families. Therefore, it reinforces a circle of inequality in Canada as social control increases and is integrated into the prison and policing systems. In Ukraine, targeting users for possession, rather than transporters, is reflective of societal issues and corruption. This form of social control is indicative of societal implications as harsher forms of social control reinforce inequality. Policy is not shifting the social order away from the police and onto other systems by viewing drug laws as a medical concern.

Discussion

Social constructionism and claims-making have played an integral theme throughout this work. Canadian Prime Minister Brian Mulroney claimed drug use was a rising issue in Canada, despite reports showcasing that drug use was steadily declining in Canada. The Soviet

government claimed drug use was not a problem in socialist societies. Ukrainian laws also avoid claiming drug transportation as a problem; instead claim that minor possession is. Claiming who, why, when etc., allows for government and institutions to play a more significant role in the lives of their citizens and plays into social control. By claiming that specific subgroups cause drug use, we have seen the hyper-criminalization of minority groups and hyper-surveillance of their neighbourhoods. This has allowed governments to control groups more efficiently in correctional facilities or by police.

The reason institutions make claims, then align their institutional policy and practices towards social control is due to embedded discrimination and political ideology in both countries. Canadian history has been built at the expense of minority groups, and by hyper-criminalizing them, it is easier to control these groups for fear of imprisonment. While it violates their charter rights, the claims that low-income neighbourhoods where many minority groups reside are responsible for drug use allow for increased police presence. While not targeting specific ethnic or racial groups, Ukraine targets individuals who use drugs or carry small possessions, increasing prison populations and increasing risky use and consumption. Placing the onus of responsibility on individuals increases social control while ignoring illegal transportation.

As this essay showcases, social, cultural and political factors are at the forefront of explaining why political leaders decide on drugs and the people who use them. Despite scientific changes, there is push back in Canada and Ukraine's institutions due to cultural and social discriminatory norms. Changes have been made to support human rights in the medical realm but still criminalize people for carrying drugs, reinforcing risky behaviour and consumption. It is necessary for a shift in institutional power. The "burden of responsibility" can no longer be governed by lawmakers and bureaucrats who do not reflect drug users' needs and wants and their friends and families directly affected by the policy. In this, laws must be governed by a combination of people, such as politicians, medical experts, and the people directly affected by drug use, including users, former users and their support systems as drug use shifts from a criminal/legal realm into a medical one.

The result of this essay showcases that drug policy is governed by societal and institutional decisions, with adverse effects on the individuals they are in place for.

Despite agreements and ratifications in different legislation at the national and international levels, institutions are still encouraging discriminatory policies. Medical services and drug policy issues reflect more significant, systemic problems in Canada and Ukraine's societies. Despite changing attitudes and advancements in addiction studies, many people, including lawmakers, still intrinsically follow the moral model of drug use. As we have seen, this has incredibly unequal tones to scapegoat minority groups and reinforce inequality. Increasing individuals' quality of life and encouraging equality will not be seen if larger institutional structures are governed by institutions embedded with discrimination while creating policy.

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