

Social Problems and Moral Panic: Primary, secondary, and oppositional definers in the social construction of Canada's opioid crisis in select corporate print media

by

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Abstract

This thesis seeks to explore the viability of a composite model of social problems using Canada's current "opioid crisis" as a case study. Drawing on and modifying Joel Best's (2017) and Herbert Blumer's (1971) social problems models, I develop a four-stage composite model that aims to explain how primary, secondary, and oppositional definers construct competing claims over the discovery of a variously labeled opioid crisis. Relying on a materialist theoretical formulation of social constructionism and a critical assessment of the news media as both source and interlocutor for primary, secondary, and oppositional definers, I contend that in the making of the opioid crisis primary and elite secondary definers have a resource advantage in laying claims of expertise and "definitional dominance" over the construction of social problems. As an epistemological inquiry into the making of social problems, this study relies on the print news media as the locus for the articulation of competing claims in the construction of social problems. Respecting the social construction of the latest drug scare, I use the *Toronto Star* and the *Globe and Mail* as my primary data sources. This study uses a range of theoretical perspectives—symbolic interactionism, labelling theory, and a Marxian perspective on conflict and inequality—to operationalize processes of representation at each stage of my composite model of social problems. Since the composite model seeks to make sense of "text and talk" in the making and experience of reality, this study employs critical discourse analysis (CDA) to analyze how primary, secondary, and oppositional definers engage in exclusionary and usurpationary closure while in the process of mobilizing and resisting discourses, narratives, and constructions of folk devils, as these relate to meanings of a perceived opioid crisis in Canada.

Key Words: social problems; moral campaigns/panics; social constructionism; opioids; social closure

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Introduction

This thesis is a case study of the current discourse of the “opioid crisis”, which is evident in the increasing numbers of Canadians dying from prescribed, self-medicated, and recreational overdoses. With pharmaceutical opioids as its focus, this thesis seeks to provide an account of the relationship between the social construction of the “opioid crisis” and moral panics. Moral panics are a dramaturgical articulation of the claims-making process in which primary and secondary definers mobilize resources of opinion-making and appropriate the definition and solution to a problem. According to Stanley Cohen and colleagues, a moral panic can be defined as:

[when] a condition, episode, person or group of persons emerges to become defined as a threat to societal values and interests; its nature is presented in a stylized and stereotypical fashion by the mass media; the moral barricades are manned by editors, bishops, politicians and other right-thinking people; socially accredited experts pronounce their diagnoses and solutions; ways of coping are evolved or...resorted to; the condition then disappears, submerges or deteriorates and becomes more visible. Sometimes the subject of the panic is quite novel and at other times it is something which has been in existence long enough, but suddenly appears in the limelight (1972:1).

Informed by a Marxian perspective on conflict and social inequality, this thesis draws on the sociological literature on the making of social problems, claims-making, and moral panics.

Through this body of scholarship and following Stuart Hall et al., (1979) I want to understand how primary definers (e.g., the Prime Minister, a premier, the Health Minister, the Ministry of Health, and/or the Medical Officer of Health), secondary definers (e.g., moral entrepreneurs, pressure groups, social service agencies, tax payers, and/or the corporate news media), and oppositional definers (e.g., critical scholars and safe-injection/opioid-prevention site coordinators

and/or volunteers)¹ are represented in the news media as contributing to the construction of the “opioid crisis.”

Most notably, this thesis is functionally a “test” of the career of a social problem and the specific ways that various definers seek to effect “exclusionary” or “usurpatory closure” over the meaning of opioid dependency² and overdoses in Canada. I seek to understand the ways opioid mis/use and overdoses come to be framed as the result of personal and moral failings rather than a result of the dynamic interaction between agency and social “structure” as workers and others cope, increasingly, with the routinization of pain and suffering in their lives that can be attributed to capitalism and neoliberalism. The thesis does not deny the existence of suffering from opioid mis/use, instead my aim is to understand how the process of social problems and hegemonic discourses of appropriate moral norms are implicated in framing opioid mis/use and overuse as a “crisis” over other possible explanations. Essential to the argument of this thesis is that opioid fatalities are not inherently evidence of a crisis, but that “crises” are socially constructed phenomena. Other than insurgent critiques, which are marginalized, we do not in general speak of pollution and wars as crises although these could easily qualify as such. By this logic, “crises” and other social problems are constructed, even if there are real effects for real

¹ Ontario currently has two types of harm-reduction sites: supervised consumption sites, which are approved by Health Canada after a long and tedious application process; and overdose-prevention sites, which were created as temporary centres for addressing the so-called opioid crisis.

² The terms “‘overuse’ and ‘dependence’, as they are used throughout this thesis, conform to the Diagnostic and Statistical Manual of Mental Disorders 4th Edition (DSM-IV-TR) and International Statistical Manual of Mental Disorders 4th Edition (DSM-IV-TR) and International Statistical Classification of Diseases and Related Health Problems (ICD-10) definitions of substance abuse and dependence” (Hart, Marvin, Silver and Smith 2012:586). DSM-IV-TR and ICD-10 terminology “are used to avoid the use of pejorative words and terminology that have multiple meanings” (Hart et al. 2012:586). It is this reason throughout this thesis I refer to ‘dependency’ rather than ‘addiction’.

people, non-human animals, and the planet. I suggest that opioids have become an instrument of moral panic that allows the state and other primary and secondary definers to demonstrate compassion on one hand for particular citizen-subjects who “matter” (e.g., white middle and working-class persons) and simultaneously exercise repressive control over social constituents who are constructed as “dangerous” and “threatening”, and thereby do not “matter” (e.g., negatively racialized groups, the uneducated, the unemployed and poor, women, etc.)

Drug “addiction” is not any more of a health problem in Canada than alcohol. According to statistical incidence taken in 1962, approximately 2% of Canada’s population experienced “addiction” (Whitaker 1969a). To put it another way, “the number of persons addicted to opiates appears to have been more or less stable over the past few years, with a slight upward trend in keeping with the general population increase” (Whitaker 1969b:37). In the latest 2012 Canadian Alcohol and Drugs Monitoring Survey, it was estimated that 21.6% of Canada’s population or approximately 8 million people met the criteria for substance use disorder (i.e., craving, loss of control of amount or frequency use, compulsion to use, and continued substance use despite physical and psychological consequences) (Smith 2019). People have been using drugs for millennia, sometimes with little pharmacological knowledge of the substance(s) they consume, ingest, snort or inject; as a result, there has always been a potential for misuse and overuse (Blackwell and Erickson 1978; Miller 1996). Canada’s “opioid crisis” emerged as a “social problem” just over a decade ago, according to medical professionals and healthcare providers. The “crisis”, however, has only gained national recognition within the past five years and received little media and political attention until recently (Sherman 2017).

Media coverage of opioids became aggressive and pervasive between 2015 and the first quarter of 2018 as opioid-related deaths seemingly increased and further affected white middle

and working-class persons and their families (BC Coroners Service; Government of Canada 2013, 2018b; King 2014; Sherman 2017). In response to the “opioid crisis”, the general public, moral entrepreneurs, and physicians have requested stronger preventative measures to reduce opioid-related deaths and enforce stricter prescribing practices within the field of medicine. In 2017, for example, the College of Physicians and Surgeons of Ontario (i.e., the regulatory body for the province’s physicians) created new opioid prescribing guidelines in 2017. These guidelines require physicians to lower the dosages of opioid prescriptions, provide alternative measures to pain management, or wean their patients off opioids entirely. Purdue Pharma also created a tamper-resistant drug called OxyNeo to replace their expired patent in 2012, for OxyContin. OxyNeo is harder to crush and inhale or inject for a quick high and the pill turns into a gel-like substance once it comes into contact with water. Police officers and emergency personnel (e.g., paramedics and firefighters) have been urged by medical professionals, healthcare providers, community outreach workers, and political leaders to carry naloxone on them at all times (The National Drug Institute 2017). Naloxone (i.e., Narcan[®]) is a safe and legal “opioid antagonist” that is used to quickly reverse the effects of an opioid overdose, specifically morphine, fentanyl, and heroin overdoses (The National Drug Institute 2017).

Pop-up safe-injection sites have also been established throughout Canada, whereby oppositional definers, health practitioners, and emergency personnel assist drug using populations to carefully consume or inject opioids and other “street-marketed” narcotics (Tremonti 2019). Safe-injection sites are an example of a harm-reduction initiative which opposes abstinence-based approaches to drug use (Boyd, Carter, and MacPherson 2016). Harm-reduction programs include a number of secondary benefits that are not exclusive to drug treatment such as increased access to health care, house referrals, counselling, and more (Boyd et

al. 2016:104). The so-called drug war demonstrates that harm-reduction programs are often ineffective because they are grossly underfunded, uncoordinated, and receive minimal support from all three levels of government, medical professionals, and community groups (Boyd et al. 2016). In saying that, however, numerous pop-up safe-injection sites are prominent across Canada and have received public funding to ensure the safety of opioid using populations and preventing overdoses. Finally, the media's overwhelming representation of opioid mis/use as a "crisis" across Canada, and the way the "crisis" is used to mobilize moral and political rhetoric, has generated anxiety and hysteria among the public about opioid dependency and overdoses.

In this thesis, I explain how the social problems literature keeps open the possibility for critical skepticism and a critical relativist position in examining the emergence and evolution of social problems. Instead of producing claims that identify law-abiding or deviant actors, social problems scholars attempt to show *how* some social issues versus others draw the attention of governments, legislative committees, and other powerful individuals and groups who benefit from the "discovery" and subsequent control of social problems. Scholars also show how the hierarchical configuration of claims discredit and downplay some behaviours that are actually harmful to a given social formation but are accepted as routine outcomes of organized life and living. Considering the stages or phases involved in the political nature of claims-making, some claims are viewed as more credible than others; therefore, exemplifying how a whole symbolic universe of discourse, narrative, and representation are mobilized in the dramaturgy of moral panics is essential to understand how social problems come into being (Kitossa Personal Communication 2019b).

While the social problems literature is predominantly concerned with semiotics and the social-psychology of symbolic interactionism, I draw on theorists in the Marxist tradition to

move beyond the inherent pluralism of symbolic interactionism toward a more concrete materialist approach that emphasizes the importance of dialectics in claims-making activities and the dramatization of moral panics. In simple terms, pluralism represents the co-existence of diverse and varied groups in the social order, presupposing there are no superordinate groups with the power and resources to exercise control and/or influence other less powerful groups (Parenti 1970). As a theory for understanding the power dynamics in policymaking decisions, pluralists argue that “participation in political decision making is enjoyed by a variety of competing groups operating in specific issue-areas often in response to the initiatives of democratically elected officials” (Parenti 1970:501-502). Pluralists contend that there is no evidence to support the claim that a group of powerful corporate elites “rule over an inarticulate mass” to secure its own latent interests (Parenti 1970:502). The empirical claims of pluralists have received serious criticism by scholars working within the Marxist tradition, for example (see G. W. Domhoff 1967). Marxist scholars argue that more visible exercises of power may disguise the fact that some groups exercise power in less obvious ways, and, that economic and political interests are not necessarily equal to objective or “real” interests of the public (Parenti 1970). Critics, therefore, argue that a major limitation of pluralism is that the political theory does not address *how* lower-ranked groups “exercise ‘indirect’ or subtle influence” throughout the policymaking process (Parenti 1970:504). It is worth mentioning that in chapter 3, I will return to a discussion of pluralism in the context of labelling theory. Particularly in developing my four-stage composite model for the making of social problems, I demonstrate how access to and control over a range of social resources—not least the news media itself—is vital in allowing some groups to resist usurpation of their credibility over social problems.

I intend to address how social problems are manufactured, since the fundamental argument of this study is that the “opioid crisis” is discursively constructed in ways which foreclose other interpretive possibilities. As an example of how primary definers, such as the state have a “hierarchy of credibility” over the making of social problems, Stuart Hall and his companions (1978) examined the increase in media reporting of British muggings in the 1970s. Hall et al. showed that in order to understand how primary and secondary definers constructed crime in the corporate print media to advance and preserve their interests, it is critical to understand how they use and are used by the news media. Hall (1978) further analyzed how the state criminalized youth, negatively racialized groups, and the unemployed as a means of dealing with the then capitalist crisis, rather than attempting economic reorganization to reduce the economic and political dislocation of these groups.

Similar to Hall, I investigate the dramatic spike in media coverage on opioid dependency and overdoses in the *Toronto Star* and the *Globe and Mail* to examine how primary, secondary, and oppositional definers represent the “opioid crisis” in Canadian corporate print media between October 1st, 2008-October 1st, 2018. I am interested in analyzing how social problems and moral panics emerge out of the economic and political interests of these various definers. Social problems and moral panics focus closely on claims-making activities and the media while ignoring the larger political economy. But whereas Hall et al., exposed the process of elite construction of social problems, I aim to elaborate the stages by which primary, secondary, and oppositional definers engage in processes of competition, negotiation, and sometimes collaboration to make claims over a social problem. Relying on how the media, which is itself a secondary definer, represents the narratives of the three definers, I aim to “test” the viability of a composite model of social problems to account for the making of the opioid crisis. Borrowing

certain stages from both Joel Best's (2017) and Herbert Blumer's (1971) models of social problems, I create a composite model of social problems that explains how primary, secondary, and oppositional definers construct Canada's current "opioid crisis" in the *Toronto Star* and *Globe and Mail* through claims-making activities, negotiation, and social closure. The composite model of social problems includes four stages: 1) the claims-making process and the emergence of social problems, 2) legitimation of social problems, 3) policymaking and the formation of an official plan of action, and 4) the implementation of an official plan.

Personal Positionality

C. Wright Mills asserted "no social study that does not come back to the problems of biography, of history and of their intersections within a society has completed its intellectual journey" (2000:6). With this admonition, I turn to how my biography has influenced this study. In 2014, I was "diagnosed" with chronic depression and generalized anxiety disorder (GAD). I was asked questions by a "credentialed" psychiatrist about my sleeping patterns, eating habits, occupational status, self-esteem/self-perception, and my relationships with co-workers, family members, friends, and professors. Each of the questions I answered would likely yield similar responses across multiple human groups. Symptoms and their severity levels, however, often vary across age, class, gender, sexuality, "race", and (dis)ability. After answering each question, the psychiatrist wrote a prescription for the anti-depressant, CipraleX (i.e., Escitalopram/Lexapro). During this time, I was oblivious to the unwelcomed side effects of CipraleX such as low-sodium blood levels (e.g., headache, weakness, difficulty concentrating, and remembering), angle closure glaucoma (e.g., eye pain, changes in visions, etc.), and serotonin syndrome (e.g., shivering, diarrhea, confusion, severe muscle tightness, fever, seizures, and death) (Rexall 2018). I also did not expect to experience debilitating withdrawal symptoms

(e.g., vomiting, sleeplessness, shivers, loss of appetite and motivation, etc.) once I stopped taking the prescription drug. I assumed that the psychiatrist's "expertise" in mental disorders and his decision to prescribe Cipralelex would "cure" my sadness/anxious tendencies and ultimately aid in my overall psychological health, and in turn, my physical well-being.

Although I was prescribed a small dosage of 10mg, the prescription drug did more harm than good. Within the first two weeks of taking Cipralelex, I endured six panic attacks, missed one full week of my undergraduate courses, and I could not leave my bed for three consecutive days. In the Fall of 2017, I sought an alternative approach to the mainstream strategy of prescribing drugs for "mental disorders": marijuana. As a "social marijuana smoker" throughout high school, I was familiar with the benefits of this highly stigmatized drug (e.g., pain relief, calmness/relaxation, happiness, etc.). I had experienced more panic attacks and depressive episodes from orally consuming Cipralelex on a regular basis than prior to my "diagnosis" and consistent engagement with marijuana. It has been almost two years since my liberation from Cipralelex and regular engagement with marijuana. During this time, I have only experienced a handful of anxiety/panic attacks and I am able to adequately cope with my "depression."

Through the careful study of the social construction of social problems, moral panics, and claims-making activities, I want to understand how licit drugs and/or substances (e.g., prescription narcotics, caffeine, alcohol, etc.) become identified as "good" and beneficial to one's overall well-being, while an illicit substance such as "street-marketed" cocaine becomes recognized as "evil" and is considered a gateway drug to much harsher narcotics (e.g., heroin, "street-marketed" fentanyl, etc.) (Best 1989; Goode and Ben-Yehuda 1994). Considering the duality between illicit versus licit substances and the positive narrative of prescription opioids, I want to understand how opioid mis/use and overuse has been accepted as a social problem across

Canada. I am less interested in the “opioid crisis” as an objectively real phenomenon, although real people are dying and being killed (i.e., by their physicians and Big Pharma), than I am concerned with *how* opioids have become accepted as a social problem. In short, I am concerned with an epistemic problem—how we know what we know and come to accept what we know as true.

My social identity or location is that of a cisgender, heterosexual, white female. I was born in Canada and have resided here my entire life. I classify myself as coming from a middle-class family in a small rural town in Northern Ontario. My social identity is one of privilege, privilege that I must take into account during my everyday lived experiences, but especially in the context of discussing and analyzing social phenomena. As a white woman, I am privileged from the criminalization and stereotypes of drugs and drug use; however, I am also victimized by the commodification of white middle and working-class people who have insurance and disproportionately medicated because I am a woman. I, for example, have not experienced prejudice, felt stigmatized, been labelled “morally defective” or feared incarceration for the recreational use of marijuana or breaching certain sections of Canada’s Cannabis Act. My whiteness is thus reaffirmed through these privileges, and this awareness makes me more critical of the content I encounter and the topics I discuss throughout this thesis.

Furthermore, this thesis contributes a composite model of social problems that aims to explain how primary, secondary, and oppositional definers construct competing claims over the discovery of a variously labeled opioid crisis. As an epistemological inquiry into the making of social problems, this study relies on the print news media as the locus for the articulation of competing claims toward the construction of social problems.

Chapter Summaries

I now turn to the organization of chapters to follow. Chapter 1 provides the rationale and justification for employing a critical discourse analysis, as both a method and mode of analysis, to examine how primary, secondary, and oppositional definers represent the “opioid crisis” in Canadian corporate print media. I also discuss my data sources and engage in a detailed explanation of social closure. Chapter 2 provides an overview of the social problems literature from its development in the early 1940s to the present. In this chapter I discuss the construction of social problems and the professional ideology of the “news”, in large measure because the two are inexorably linked. I also explain Joel Best’s and Herbert Blumer’s social problems models and provide a rationale for each stage of the composite model of social problems. I complete chapter 2 with a definition of social closure and discuss how exclusionary and usurpatory closure function in this thesis. I cite this literature in which Frank Parkin develops a neo-Weberian approach to examine how social and professional groups seek to extend and deepen their control over specialized areas of expertise, especially as this relates to the construction of social problems. Chapter 3 details the theoretical approaches and perspectives employed in this thesis. This chapter employs a Marxian perspective of conflict and social inequality, Gramsci’s theory of hegemony, symbolic interactionism, and labelling theory to examine *why* the recent upsurge in opioid dependency and overdoses have become identified as a “social problem”, and *who* benefits from the “discovery” of a social problem.

Chapter 4 engages the reader in a social history of narcotics prohibition in North America to demonstrate that drug scares are often used as an instrument for the powerful to advance and/or maintain their superior positions in the social order. As well, I illustrate that the social construction of drug use is motivated by a particular bias, one that is informed by racist

ideologies and monetary incentives instead of drug-using behaviour itself (Szasz 1974). Lastly, chapter 5 “tests” the viability of a composite model of social problems using Canada’s current “opioid crisis” as a case study. Drawing on and borrowing certain stages from both Best’s (2017) and Blumer’s (1971) social problem models, I develop a four-stage composite model of social problems to operationalize the processes of representation at each stage of the model for the “discovery” of what is variously described as either an opioid crisis or epidemic. In addition, I demonstrate how primary, secondary, and oppositional definers engage in exclusionary and usurpationary closure through claims-making and negotiation to either maintain or wrest control of the dominant narrative(s) and representation(s) of opioid dependency and overdoses in Canada.

Chapter 1

Methods and Analytical Approach

The main purpose of this research is to gain a better understanding of *how* the recent upsurge in opioid dependency and overdoses have become identified as a “social problem” and *who* benefits from the “discovery”, which is to say construction, of Canada’s “opioid crisis”. This study is designed to be critical of the role of language and meaning in constructing social reality and experience relative to Canada’s “opioid crisis.” In this chapter I outline my research question, discuss the importance of qualitative research for this thesis topic, and explain my rationale for choosing critical discourse analysis (CDA) as both a method and mode of analysis. I also describe the sources from which my data is gathered, discuss sampling selections, and outline my data analysis methods.

Statement of Research Question

Toward fulfilling the aims of this study, which is to understand how primary, secondary, and oppositional definers contribute to the social construction of the “opioid crisis”, the following question will be addressed:

As represented in the *Toronto Star* and the *Globe and Mail*, how are the claims of primary, secondary, and oppositional definers consistent with each stage of my composite model of social problems?

Method and analytical Approach

i. Qualitative Research

This thesis is an epistemological inquiry into how social problems are made with the “opioid crisis” as a case study. Case studies are useful for analyzing a research area in which detailed consideration is given to the development and representation of the “opioid crisis”, for

example, in Canadian corporate print media between October 1st, 2008-October 1st, 2018. Using critical discourse analysis as both a qualitative method and mode of analysis, I investigate the *Toronto Star* and the *Globe and Mail* to examine the representation of discursive strategies by primary, secondary, and oppositional definers in a struggle over the dominant narrative and meaning of the “drastic” increase in opioid mis/use and overuse in Canada. The *Toronto Star* and the *Globe and Mail* are two of Canada’s oldest and highest circulated newspapers. Narrowing my research to these two English newspapers is a feasibility measure that allows me to explore the discourses, representations, and symbolisms used by primary, secondary, and oppositional definers to construct the “opioid crisis” across Canada. Qualitative research seeks to explore, interpret, explain, and/or evaluate social phenomena, often in the form of words, patterns, themes, and observations (Symbaluk 2014). Qualitative research is used to investigate certain aspects of the social world, and, it provides methods for analyzing and understanding participants’ personal experiences and subjective realities.

ii. *Applying Critical Discourse Analysis to the “Opioid Crisis”*

A variety of legal and criminology scholars have also successfully employed critical discourse analysis as their methodological framework to examine drug use. Susan Boyd’s (2004) work, for example, addresses the impact of drug laws and policies on women in the United States, Britain, and Canada. Boyd (2004) uses critical discourse analysis to analyze how mainstream media, political leaders, and non-government organizations construct drug problems that inform national and international drug policies. She concludes that the highly racialized, misogynist, and stigmatized portrayals of drug users in the media can have different consequences for men and women regarding drug use.

Philip Bean (1993) uses critical discourse analysis to critically assess the promotion of Britain's so-called crack cocaine epidemic in the press throughout the late 1980s to 1990. Bean finds that discourses and misinformation about drugs led to an increased fear among the public about crack cocaine and influenced extreme punitive and oppressive measures such as the creation and operation of the National Task Force. This task force was a joint unit of police, military personnel, and other tactical units dedicated to controlling crack and disproportionately incarcerating Black people in the UK for their so-called "constant use" of the drug (Bean 1993). Both Bean (1993) and Boyd (2004) emphasize how discourses, in the context of drugs and drug use, are important tools for distinguishing between law-abiding and deviant classes and "races." As evidenced by Bean's (1993) and Boyd's (2004) works, the principles of critical discourse analysis provide useful analytic tools to examine how raced, gendered, and classed strategies of dominance are used to construct knowledge about opioids and opioid users.

iii. Mode of Analysis: Critical Discourse Analysis (CDA)

This thesis uses Teun van Dijk's (1993) principles of critical discourse analysis to examine how the discursive practices, linguistic features, and representations of primary, secondary, and oppositional definers correspond to each stage of my composite model of social problems with Canada's "opioid crisis" as a case study. Critical discourse analysis is a widely used mode of analysis in sociopolitical research. It intends to "analyze the structural relationships of dominance, discrimination, power and control through textual study" (Blommaert and Bulcaen 2000:448). Van Dijk defines dominance as "the exercise of social power by elites, institutions or groups, that results in social inequality, including political, cultural, class, ethnic, racial and gender inequality" (1993: 249-50). Blommaert and Bulcaen (2000) suggest that critical discourse analysis has a social responsibility to correct particular discourses for "change, empowerment,

and practice-orientedness” (p.449). Critical discourse analysis, accordingly, produces knowledge about the role of power, social cognition, and ideology in the formation of discourses, and the reproduction and opposition of dominance through discourse. The reproduction of dominance may involve different modes of discourse-power relations; therefore, critical discourse analysts want to know how “structures”, strategies, or other properties of text, talk, verbal interaction, or communicative events function toward the reproduction of dominance and opens possibilities for resistance (Van Dijk 1993). McGregor (2010:2) also argues that critical discourse analysis challenges us to move from seeing language as abstract to seeing our words as having meaning in particular historical, social, and political contexts.

Critical discourse analysis does not have a monolithic definition; instead, it “has become the general label for a special approach to the study of text and talk, emerging from critical linguistics, critical semiotics, and in general, from a socio-politically conscious and oppositional way of investigating language, discourse and communication” (Van Dijk 1995:18). Critical discourse analysis is the “oppositional study of structures and strategies of elite discourse and their cognitive and social conditions and consequences, as well as with the discourses of resistance against such domination” (Van Dijk 1995:18). With respect to critical discourse analysis’s oppositional framework, it does not use conventional methodological principles typically used in mainstream literature (e.g., observational, descriptive, explanatory, etc.). Critical discourse analysis is different from other forms of discourse analysis because of its “critical” component. The focus on dominance and inequality implies that unlike other areas or approaches in discourse analysis, critical discourse analysis does not contribute to a particular research field, perspective, or theory. In fact, critical discourse analysis is mainly interested in analyzing and exposing persistent hegemonic discursive formations about social problems (e.g.,

im/migration, racial discrimination, gender inequality, etc.) and how the powerful use discursive strategies to describe and represent these social issues (Van Dijk 1995). Critical discourse analysis thus focuses on the discourse dimensions of power and the injustices and inequalities that result from it (Blommaet and Bulcaen 2000). On the whole, the use of language does not function nor occur in isolation but in a set of cultural, social, and psychological frameworks that provide meaning on and in the making of experience (Van Dijk 1993). Critical discourse analysis acknowledges this social context and studies the connections between textual “structures” and their functioning and interaction within social formations. Equally important, Critical discourse analysis explores the:

- (a) discursive practices, events and texts, and (b) wider social and cultural structures, relations and processes; to investigate how such practices, events and texts arise out of and are ideologically shaped by relations of power and struggles over power; and to explore how the opacity of these relationships between discourse and society is itself a factor securing power and hegemony (Fairclough 1993:135).

My rationale for employing Van Dijk’s model of critical discourse analysis is threefold. First, the advantage of conducting a critical discourse analysis for the constitution of the “opioid crisis” rests on an in-depth inquiry into discourse and forms of representation used to mobilize public anxieties, fears, and eventually, to manufacture consent to elite discourses about opioid and narcotic use in Canada (Best 1989; Goode and Ben-Yehuda 1994; Miller 1996; Van Dijk 1995). Second, critical discourse analysis coupled with a materialist social construction framework reveals the powerful role of authority figures in “discovering” the “opioid crisis” and constructing social meanings through specific discourses in news media. More specifically, I use critical discourse analysis to analyze the struggle and conflict between primary, secondary, and oppositional definers over the social meanings of opioid dependency and overdoses as constitutive of a “crisis.” I also use critical discourse analysis to examine how power,

dominance, and inequality are reproduced or resisted through text and talk about the “opioid crisis.” Finally, when studying the role of discourse in constructing Canada’s “opioid crisis”, critical discourse analysis draws attention to the discursive strategies that are employed by primary and secondary definers in print media. Unveiling these discursive strategies in a composite model of social problems provides a greater understanding of how inequality is justified by the positive representation(s) of political leaders, medical professionals, healthcare providers, and law enforcement officials as advocates for “tackling” opioid dependency and overdoes, and the negative representation(s) of “street addicts” and recreation users.

iv. *Sources of Data and Methods of Data Analysis*

My data sources are the *Toronto Star* and the *Globe and Mail*. These data sources provide a rich volume of material to examine the discourses and representations used by powerful groups (e.g., physicians, the Prime Minister, Premier(s), Health Minister, Medical Officer of Health, etc.) to control a narrative of the problem and expropriate resources through “definitional dominance” (Kitossa Personal Communication 2019). My justifications for surveying these English-language newspapers are that the *Toronto Star* and the *Globe and Mail* provide different ideological views about the “opioid crisis” to various audiences, they are the oldest and most reputable newspapers in Canada, and these newspapers are from the most populous cultural capital of Canada, Toronto. The *Toronto Star*, for example, is a Toronto-based newspaper with the largest circulation in Canada (Wortley 2002). The *Star* was established in 1892 by a group of unemployed printers who had lost their jobs to a labour disagreement (Bothwell 2009). Joseph E. Atkinson, however, took over the paper in 1899 and his immense efforts contributed to the *Star*’s growth. The *Star* is presumed to demonstrate a sense of community and considers itself to be liberal in nature. The *Globe and Mail*, on the other hand, is explicit in its conservative credentials

and generally promotes a law-and-order agenda (Doyle, Potter, and Yusufali 2009). The *Globe and Mail* was founded in 1936 by George McCullagh who combined two influential and historically significant newspapers: The *Globe* and the *Mail and Empire* (Doyle et al. 2009). It is important to note that while each newspaper may represent a specific ideological position when covering a news story, the corporate print media can at times either take on a moral entrepreneurial role or tacitly align with oppositional definers (Kitossa Personal Communication 2019d). The content in both newspapers includes stories at the local and national levels. Despite the ideological differences between the two newspapers, they are: a) capitalistic, b) the nature of their content is defined, however subtle, by the preferences of the publishers, and c) both their journalists construct reality through journalistic standards and devices which constitute the professional ideology of journalism. Thus despite the differences in political ideology between the *Toronto Star* and the *Globe and Mail*, this is less my concern than the ways both are a medium through which social problems are constructed.

v. *Sampling*

I employ a purposive sampling technique for the selection of newspaper articles covering the “opioid crisis” between October 1st, 2008 and October 1st, 2018. I chose this ten-year time period to examine the transition from seldom and scant media coverage on opioids in 2008 to a dramatic increase in media coverage between 2015-2018. Purposive sampling is a non-probability method that is commonly used in field studies by researchers who are constrained by time, budget, and workforce (Wolfer 2007). Considering these limitations, it is impossible for researchers to randomly sample an entire population for their studies; therefore, non-probability samples are typically selected in terms of their accessibility or by the researcher’s personal judgement (Wolfer 2007). Wolfer (2007) notes that purposive sampling is appropriate “when

researchers want to focus on specific cases for further in-depth examination” (p. 209). Seale explains that when using purposive sampling, “items are selected on the basis of having a significant relation to the research topic” (2012:237). My research study thus coincides with Seale’s and Wolfer’s criteria for using a purposive sampling technique.

After selecting the *Toronto Star* and the *Globe and Mail*, I sampled articles from these newspapers using specific time periods and key search terms. I collected data from Brock University’s online library using ProQuest Canadian Newsstand Database to systematically choose news stories from each newspaper. I then chose key terms that would likely yield the most results and are representative of my thesis: “opioid crisis” and “opioid overdose.” I did not search for the key phrase “opioid epidemic” as most politicians, public health officials, pharmacists, physicians, harm-reduction/community outreach workers, and journalists label the recent upsurge in opioid dependency and fatal overdoses across Canada as an “opioid crisis.” I searched each key phrase within one four-year interval (2008-2012) and two three-year intervals (2012-2015 and 2015-2018). Once I eliminated duplicate articles that appeared under more than one key phrase and in different editions of the *Toronto Star* and the *Globe and Mail*, I selected the first three news articles for “opioid crisis” and the first three news articles for “opioid overdose” to equal a total of six news articles for each time interval. I chose the first three news articles for each key phrase, because according to ProQuest Canadian Newsstand’s Database, the first three news articles are considered the most relevant to the key phrase I searched. It is worth mentioning that I chose eight (8) news articles from the *Toronto Star* for the time interval 2015-2018 and key phrase “opioid crisis.” I made this decision because after screening duplicate news articles, the database showed only one (1) result for the key phrase “opioid crisis” between 2008 and 2012 and zero (0) results between 2012 and 2015. I also selected four (4)

news articles from the *Globe and Mail* for the key phrase “opioid crisis” between 2015 and 2018 as there were only two (2) results for the same key phrase between 2012 and 2015. In sum, I selected 18 articles from each newspaper for a total amount of 36 news articles. I then tracked quantitatively the growth in news stories which is suggestive of the emergence of the opioid crisis as a social construction. The results are recorded in two tables below:

The Changes and Transition in Reporting of the “Opioid Crisis” in Canadian Corporate Print Media Between October 1st, 2008-October 1st, 2018

Table 1.

The Toronto Star		
	"Opioid Crisis"	"Opioid Overdose"
2008-2012	1	6
2012-2015	0	14
2015-2018	65	49

Table 2.

The Globe and Mail		
	"Opioid Crisis"	"Opioid Overdose"
2008-2012	4	12
2012-2015	2	24
2015-2018	256	300

As evidenced by the tables above, the Canadian corporate print media took particular interest in reporting on the increase of opioid dependency and overdoses between 2015 to 2018, but the scale of coverage in the *Globe and Mail* is extraordinary. Each table demonstrates the insignificant media coverage of Canada’s “opioid crisis” between 2008 and 2015 to a “spontaneous” upsurge in reporting between 2015 and 2018. I cannot confidently determine the reason(s) for this pattern, but considering moral panics and social problems seem to arise during economic downturns, political elections, and a generalized sense of anomie (Cohen 1972; Hall et

al. 1978; Goode and Ben-Yehuda 1994), it is fair to assume that politicians' platforms in the 2018 Ontario election, for example, focused on the "opioid crisis" and emphasized Canada's dire need for solutions to curb opioid dependency and prevent overdoses. As well, the news media, never failing to exploit a good crisis of its own making, amplifies the perception of problems through the dictum "if it bleeds it leads." All of this influences public opinion in a spiraling feedback loop that emboldens politicians to be public saviors and spurs the news media into "social responsibility" to increase its coverage.

To facilitate my understanding of the ways that primary, secondary, and oppositional definers seek to mobilize the particular constructions of opioid use and deaths, I sought to verify the frequency of opioid-related deaths and harms prior to 2015 by contacting the Centre for Addiction and Mental Health (CAMH), InSite, Health Canada, the Government of British Columbia, and Nova Scotia Archives³. Using my student email account, I contacted these government agencies and non-profit organizations because their websites do not provide any statistical data for opioid-related deaths and harms preceding 2015. Health Canada, the Government of British Columbia, and Nova Scotia Archives' responses included a link to the online databases I already accessed prior to contacting these sources, and CAMH and InSite were unable to provide any statistical information concerning opioid-related deaths and harms.

If primary and secondary definers are to claim that opioid dependency and overdoses have been "plaguing" Canadian society for over ten years, complete and updated statistics should be made available to the general public. Complete data for opioid-related deaths and harms, however, were first available in 2015. These statistics came after Health Canada "granted the Canadian Institute for Health Information \$4.3 million to develop a coordinated national

³ See Appendix A-F.

approach for monitoring and surveillance of prescription drug abuse” (Smolina, Persaud, and Morgan 2016:252). It is worth noting that in 2013 the British Columbia Coroners Service provided statistics for opioid-related deaths between 2005 and 2010. In the summary statement of their report, however, the chief coroner stated “the data are considered preliminary until all investigations have been completed. Data are subject to change, and are not directly comparable to published counts from previous years” (BC Coroners Service 2013).

Respecting the news stories I analyzed to determine the operability of the composite model of social problems, my sample consists of “hard” news stories. Hard news refers to “ground-breaking” or “up-to-the-minute” news and events that require immediate coverage and reporting (Iyengar and Kinder 1987). Topics, stories, or events relating to politics, economics, war, and crime are often considered hard news. From these news stories, I selected 36 news articles based on systematic criteria:

1. News stories are published in the national news, “news”, medicine, Globe Life, Greater Toronto and British Columbia news sections of each newspaper. These sections are relevant to the news stories published on the “opioid crisis”, opioid overdoses, and narcotic use generally and show how the “opioid crisis” dominates various sections of each newspaper. Since the focus of this thesis is to examine the narratives of primary, secondary, and oppositional definers in Canadian corporate print media relative to claims-making, usurpation and closure, commentary, editorial, and opinion pieces were eliminated from my analysis as they do not conform to standard journalistic practices.
2. News stories that cover Canada’s “opioid crisis”, illicit versus licit opioid mis/use and overuse, the policies implemented in response to the Canadian “crisis”, and the actors involved in “dealing” with the “opioid crisis” (e.g., government officials, emergency

personnel, medical authorities, healthcare providers, pharmaceutical industries, harm-reduction and community outreach workers, and families who endured the loss of a loved one to opioid mis/use/overuse) between October 1st, 2008-October 1st, 2018.

3. Based on these criteria, I selected 18 news articles from the *Toronto Star* and 18 news articles from the *Globe and Mail*. This means I selected (36) news stories to examine the qualitative data aimed at exploring the viability of my composite model of social problems within the specific time period. These criteria were used to choose the purposive sample and identify the news stories.

I numbered each article chronologically from 1-36 and read the *Toronto Star* first, followed by the *Globe and Mail*. I chose this order to examine how the claims of primary, secondary, and oppositional definers have identified and framed Canada's "opioid crisis" as a social problem over ten years. Then I coded for themes as per the Marxian and symbolic interactionist perspective on the claims-making of social problems and the social construction of reality. I used codes such as "addicts", "class", "manipulation", "material interests", "persuasion", and "power." I also searched for primary definers (e.g., physicians, the Prime Minister, Premier(s), Health Minister, Ministry of Health, and the Medical Officer of Health), secondary definers (e.g., moral entrepreneurs, pressure groups, social service agencies, and tax payers), and oppositional definers (e.g., critical scholars, harm reduction/community outreach workers) within the samples for each time interval.

Chapter Summary

This chapter has provided the rationale and justification for employing a critical discourse analysis (CDA), as both a qualitative method and mode of analysis, to examine how primary, secondary, and oppositional definers construct the "opioid crisis" in Canadian corporate print

media. I also discuss my sample choice and outline the different data sources I examined. In the next chapter, I undertake a detailed presentation of Best's (2017) and Blumer's (1971) social problems models to explain that "problems" arise from the claims-making activities and definitional processes of primary, secondary, and oppositional definers engaged in social closure. Furthermore, I connect the theory of social problems to the concept of claims-making to signal that various definers are invested in laying claims to definitions of Canada's "opioid problem."

Chapter 2

Claims-making and moral panics: A symbolic interactionist review of the making of “social problems” literature

This chapter provides an overview of social problems literature from its inception in the early 1940s to the present. The objective is to establish two essential criteria governing the ontology of social problems and moral panics: first, social constructedness, and second, the social dynamics and processes of claims-making. From the establishment of these facts I aim to develop a composite model of social problems that is synergistic with Critical Discourse Analysis (CDA). Moving from a review of the theoretical literature, I analyze the social history of illicit drug use and “addiction”, thus enabling me to identify how the essential dimensions of the ontology of social problems are mobilized by groups engaged in hegemony, negotiation, and social closure.

The Social Construction of Problems

The social construction of problems is fundamental to understanding how and why a particular behaviour, series of events, and/or group(s) is defined and comes to be understood as a “social issue.” A group or category typically competes for control of the definition of a social problem. When one group is successful in achieving a hegemonic definition, its terminology may be accepted, internalized, and institutionalized compared to the definitions and concepts of opposing groups (Spector and Kitsuse 1987). If vocabularies change, original terms are created, or existing terms receive new meanings, these actions suggest that something significant has ensued regarding the history of a social problem. According to Blumer, the definition of a social problem derives from a process of moral and value judgements, not “independently as a set of objective social arrangements” (1971:298). Spector and Kitsuse, therefore, argue that social problems should be recognized “as the activities of individuals or groups making assertions of

grievances and claims with respect to some putative conditions” they seek to control (1987:75). Spector and Kitsuse’s (1987) definition of social problems demonstrate that “the emergence of a social problem is contingent upon the organization of activities asserting the need for eradicating, ameliorating, or otherwise changing some condition” (Spector and Kitsuse 1987:75). Their definition also emphasizes the importance of power and “expertise” in claims-making activities and that definitions of social problems are political.

The forthcoming section discusses the media’s prominent role in shaping public opinion(s) about social problems. The news media is relevant for the making of social problems because claims-makers often rely on media coverage to bring their claims about a “harmful” condition or behaviour to the attention of a wider audience. All forms of media coverage tend to modify how social problems are constructed as well (Best 2017). The following sections also discuss the professional practices of the news media to describe the techniques that journalists and editors employ to achieve newsworthiness, perpetuate the dominant ideology of the ruling class, and to elicit feelings of anxiety and fear. These “techniques” include the “myths” of objectivity and balance, publisher and journalist self-censorship, framing, priming, and agenda-setting.

The Media’s Role in Shaping Public Opinion(s) about Social Problems

Many people do not perceive a social issue as “harmful” or “troublesome” until it receives media exposure (Parenti 1992). The public’s understanding of an event or issue is greatly influenced by their engagement with the media’s selective portrayal of the issue/event, which is largely determined by primary and secondary definers. The corporate media presents itself as impartial, objective, and value-free; however, the media is guided by an established ideology of the powerful and privileged (Hall et al. 1978; Parenti 1992). Through elite media

discourse, the public have been indoctrinated, socialized, and forcefully instilled with conservative values and specific information about social reality (Parenti 1992, 1996). The public, however, are not waiting to be filled up with capitalist propaganda—the very conditions of life in a capitalist social order generates an inherent conservative bias, although capitalists generate ideology as a guarantee against ideological “break out” (Kitossa Personal Communication 2019).

The common myth regarding news media in the United States, and more broadly North America, is that it perpetuates a liberal bias (Parenti 1996). Political leaders, news anchors, radio talk-show hosts, and other media personnel help propagate this belief. Critics who attempt to challenge the “liberal-bias” claim by revealing the media’s conservative composition receive minimal, if any, exposure in the “liberal media” (Parenti 1996). Regarding the United States, Michael Parenti (1996) asserts that ownership of the mass media can be traced to “Hearst, Luce, Murdoch, Sulzberger, Annenberg and the like, personages of markedly conservative hue who regularly leave their ideological imprint on both news and editorial content” (p.99). He discusses that many news media organizations include representatives from “Ford, General Motors, General Electric, Alcoa, Coca-Cola, Philip Morris, ITT, IBM and other corporations [are] in a system of interlocking directorates that resembles the boards of any other corporations” (Parenti 1996:99). Similar to the large and successful corporations that own the media in the United States, media in Canada are predominantly owned by Bell, Corus, Rogers, Newcap, the Quebecor, and the government-owned Canadian Broadcasting Corporation (CBC) (Shade and Lithgow 2014). It is worth mentioning that unlike most broadcasting companies that rely on advertisers to earn revenue, CBC does not. Instead, the Canadian Broadcasting Corporation receives most of its operating funds from parliament (Government of Canada 2019).

These examples highlight that the “mainstream” news media, as corporate enterprises, are financially and ideologically supported by capitalists. The corporate news media, accordingly, promotes the political and economic definitions of the powerful (Hall et al. 1978). Corporate elites determine what content is shown or not shown, what to omit, and how to deceive the public through claims-making activities. Corporate elites also use specific vocabularies to narrate, overemphasize, and underemphasize⁴ the enormity of an issue or event, and they cancel any news stories that may reflect a poor self-image of themselves (Parenti 1992, 1996). The media, however, must occasionally acknowledge and provide images, statistical data, and information about white-collar or corporate crimes (e.g., money laundering, insider trading, embezzlement, racketeering, etc.), poverty, and global warming to maintain their credibility, “neutrality”, and “dedication” to collective public interests (Hall et al. 1978). The news media frequently employs techniques such as obscuration, selection, and fearmongering to enhance newsworthiness. Newsworthiness refers to an event, fact, or person that is considered interesting enough to be reported in newspapers and/or on the television or radio. The number of fatalities involved in a story, for example, make it newsworthy. An item may become even more newsworthy if the police or tactical units were involved (Iyengar and Kinder 1987; Parenti 1992).

The intended goal of enhancing newsworthiness is to attract extensive reader/viewership to a story. Attaining mass reader/viewership to be packaged as a commodity and sold to advertisers generates profit for the newspapers/networks broadcasting the story and the

⁴ Democracy Now (2019). *Climate Change Is Impacting Every Aspect of Modern Life, But the Press Fails to “Connect the Dots.”* [video] Available at: https://www.democracynow.org/2019/7/24/michael_mann_climate_crisis_media_coverage [Accessed 25 Jul. 2019].

corporations who have a stake in the news media business. Mass reader/viewership also means that state-oriented definitions of social problems gain recognition quickly. As a result, these definitions can invoke fear among the lay public about a social issue and help establish policies to ameliorate the issue. The media, therefore, shows what they think the public wants to know about the world to accomplish the intended goal of newsworthiness. Overall, corporate news media reproduces the cultural and moral attitudes of the powerful and is financially backed by multi-billion dollar companies (e.g., Disney, Westinghouse, Time Warner, etc.) to create an atmosphere that is regulated and controlled by capitalist elites (Hall et al. 1978; Parenti 1992, 1996).

Professional Practices of the News Media

In order to connect conversations about social problems and the news media, this section discusses the ways in which journalists deploy standard news practices to construct and represent a particular form of the social world. These news practices include the myths of objectivity and balance, self-censorship, framing, priming, and agenda-setting. At any given moment, numerous events take place around the world, all which have the potential to be considered “news”: but how does it come to be that so many events are filtered into discrete stories that become represented as “news”? Hall et al., further explain that “the media do not simply and transparently report events which are ‘naturally’ newsworthy in themselves. “News” is the end-product of a complex process which begins with a systematic setting and selecting of events and topics according to a socially constructed set of categories (1978:53). These events, however, do not develop as such until some purveyor of news provides an account of them (Hall et al. 1978; Parenti 1993).

Journalists and editors are responsible for locating and presenting news to the mass public (Best 2017). They “are expected to work under stressful time constraints, make quick decisions, and position themselves so that they have access to institutions that generate reportable activity on a regular basis” (Hall et al. 1978:58). Considering journalists are expected to meet specific timelines within a short duration, they are unable to focus on the specific details of a story. Journalist, therefore, select certain segments of the story to make it *newsworthy*. Journalists must also ensure that their reports are *objective* and that they include “authoritative statements from ‘accredited’ sources” to reinforce the legitimacy of the information delivered to the public (Hall et al. 1978:58). Hall et al. demonstrate that “these two aspects of news production—the practical pressures of constantly working against the clock and the professional demands of impartiality and objectivity—combine to produce a systematically structured over-accessing to the media of those in powerful and privileged institutional positions” (1978:58).

Hall et al. (1978) use the term “professional ideology” to describe that there is a selection process that determines what constitutes “good news” (i.e., newsworthiness). The selection process often involves “grouping” items that are abnormal, unexpected, and spontaneous as they breach conventional expectations of social reality (Hall et al. 1978). This is sometimes called the “primary” or “cardinal” news value. Events that involve elite persons, groups and/or nations, personalized events, dramatic and heart-wrenching stories, tragedies, and sporting tournaments are among the many news values that achieve “newsworthiness” (Galtung and Ruge 1978; Hall et al. 1978). Events and/or stories that are ranked high on a scale of these news values have a greater probability of being included in the news and may interrupt programs so that these items or values can be communicated to the public immediately (Hall et al. 1978).

i. *The Myths of Objectivity and Balance*

Journalists often claim that their own biases and the pressures from advertisers and media owners do not influence their work because of their professional standard of “objectivity” (Parenti 1996). The routinization of news selection and production, however, demonstrate otherwise. For Johan Galtung and Mari Ruge (1965), the representation of any story will include: frequency, threshold, unambiguity, meaningfulness, consonance, unexpectedness, continuity, composition, reference to elite nations and reference to elite people, personification, and negativization. To briefly summarize each factor, frequency addresses the time-span required for a specific event to develop itself and obtain meaning. The threshold factor refers to how intense and dramatic a particular event is—absolute intensity suggests that an event will receive bigger headlines (e.g., if mass groups are dying from opioid-related overdoses, there is an increased chance of its inauguration being reported) (Galtung and Ruge 1965).

The third factor, unambiguity, signifies the clarity of a story and how well it can be interpreted by the public. Limited ambiguity of a story allows the interpreter to understand it without inconsistencies and/or misrepresentations. The fourth factor, meaningfulness, encompasses cultural proximity and relevance; that is, “the event-scanner will pay particular attention to the familiar, to the culturally similar, and the culturally distant will be passed by more easily and not be noticed” (Galtung and Ruge 1965:66). Consonance, the fifth factor, refers to associating “a selected mental pre-image, where the word ‘expects’ can and should be given both its cognitive interpretation as ‘predicts’ and its normative interpretation as ‘wants’” (Galtung and Ruge 1965:67). In other words, if a person predicts something will happen or wants something to happen, they become receptive and prepared if the event actually takes place.

The sixth factor, unexpectedness, suggests that if an event is unexpected and abrupt, there is a higher chance of it being considered “news” compared to an event or story that has been recycled throughout various news outlets (Galtung and Ruge 1965). Continuity, the seventh factor, is the idea that once a story is recognized as “news” and receives widespread attention, any subsequent stories related to it will be recognized as news as well. In the eighth factor, composition, Galtung and Ruge (1965) discuss the importance of news content, how the content is articulated and presented, and the implications of the event. In the reference to elite nations and reference to elite people, otherwise known as the ninth and tenth factors, explain how events that include elite nations and elite people are often considered news items compared to events that include lay people or developing nations. The news is elite-centred; therefore, the actions of the elite are generally more consequential and important than the activities of lay people.

The last two factors, reference to persons and reference to something negative, suggest that the more personal a story is, the more interesting and newsworthy it becomes (Galtung and Ruge 1965). Again, this idea typically applies to the actions of specific groups, particularly elite persons. This is because they represent objects of general identification within an elite-centred news communication system (Galtung and Ruge 1965). With reference to something negative, if an event is inherently negative in its consequences, there is an increased probability that it will become a news item (Galtung and Ruge 1965). Positive news is difficult to interpret and requires a lengthy development period, whereas negative news is much easier to produce and solidify as it satisfies the frequency factor. Based on Galtung and Ruge’s (1965) research and knowledge about news factors, events and narratives become news if they satisfy the twelve conditions.

When journalists cover a particular subject that provokes disagreement and opposition from different groups, journalists often feel “obliged to *balance* their coverage by reporting the

views of “both sides” (Best 2017:135). This expression suggests that most social issues only have two sides—liberal or conservative, pro-intervention or anti-intervention, pro-life or pro-choice and so forth (Best 2017:135). The news media often resist reporting complex stories in which there are more than two competing positions; they prefer to construct the issues as a straight-forward, two-party disagreement (Best 2017: 135). Journalists, however, do not feel compelled to “balance” coverage when they perceive a general consensus of opinion or wish to imagine such a consensus exists.

ii. Journalist and Publisher Self-Censorship

Although journalists claim that they enjoy editorial autonomy, freedom, and independence, “journalists and publishers often operate in a state of self-censorship and anticipatory response” (Parenti 1996: 104). Our “free” and “independent” news media are actually controlled by publishers and network bosses who see to it that their own preferred views prevail (Parenti 1996: 146). Network authorities and publishers will refuse to “run letters, guest columns, and occasionally even their regularly syndicated features and comic strips if the material does not suit their political proclivities” (Parenti 1996:146). Network authorities punish journalists and editors by denying them promotions, transferring them to isolated posts, and even firing them if they do not re-shape their narrative to ideologically fit to print or broadcast media (Parenti 1996). Michael de Adder, for example, is a Canadian cartoonist who lost his contract with several New Brunswick newspapers, just 24 hours after an unpublished illustration of US president Donald Trump playing golf over the bodies of two drowned migrants went viral. The cartoonist’s illustration captured the real-life viral image of a father and daughter from El Salvador who drowned trying to cross the Rio Grande in late June 2019. Advertisers, media owners, and publishers expect journalists to generously report on conservative politics and

pronouncements (Parenti 1996). Media suppression, then, works to preserve the dominant conservative ideology of the ruling class. Journalists may put themselves in professional jeopardy if they give the appearance of publicizing particular viewpoints such as a “left wing” approach.

iii. Framing, Priming, and Agenda-Setting

The previous section exemplifies that the myths of balance and objectivity and the practical reality of self-censorship are pervasive and all-encompassing news practices that inform the ways that journalists construct social reality and perpetuate the dominant ideology of the ruling class. Framing, priming, and agenda-setting, however, are subtle procedures that journalists deploy to condition the cognitive and mental functioning of the reader/viewer about the social world and those who live in it. Framing and priming are two prominent news media procedures that contribute to individuals’ understanding of a social problem and moral panic (Best 2017; Iyengar and Kinder 1987; Scheufele and Tewksbury 2007). The news media uses the process of framing to present an issue to the public in a strategic way (Hall et al. 1978; Scheufele and Tewksbury 2007; Spector and Kitsuse 1987). Frames situate a social problem and moral crusade within a larger context and draw attention to the main behaviour(s) and folk devil(s) (Hall et al. 1978). Frames often overemphasize specific components of a social problem and moral crusade while obscuring or overlooking other elements. Most importantly framing assigns meaning to the social problem and moral crusade against folk devil(s) (Iyengar and Kinder 1987). Iyengar and Kinder (1987) aptly note that the news media relies heavily on “news frames” to decide which events or stories to cover and how to present them to the public. Previous news frames influence the selection of frame, the authority and power of news sources, history, and even ideology (Iyengar and Kinder 1987; Scheufele and Tewksbury 2007). News frames about a social problem

or moral crusade are presented differently to elicit powerful emotions (e.g., anger, fear, outrage, etc.) which seek to create public consensus toward the cause (Best 2017). News frames, therefore, are constantly contested or negotiated and do not reflect objective events (Iyengar and Kinder 1987).

In contrast to framing, priming refers to a psychological process whereby the news media places emphasis on a specific issue to increase the importance of it on the public agenda (Iyengar and Kinder 1987; Scheufele and Tewksbury 2007). The priming method operates in accordance with news frames to “trigger” a person’s established attitudes, beliefs, and prejudices concerning an issue (Iyengar and Kinder 1987). Iyengar and Kinder (1987) assert that priming also influences new impressions and perspectives about particular groups or events. With respect to the impressions people form about drug users, for example, themes such as their drug using and/or selling behaviour, the type of drug they are engaged with, and the psychological and/or physical effects of the drug may be examined (Iyengar and Kinder 1987; Scheufele and Tewksbury 2007).

Agenda-setting includes both framing and priming practices. Agenda-setting is concerned with the ability of the news media to emphasize the importance of an issue or event (McCombs and Reynolds 2002). Iyengar and Kinder (1987) developed an agenda-setting hypothesis which states that “those problems that receive prominent attention on the national news become the problems the viewing public regards as the nation’s most important” (p.16). Agenda-setting attempts to provoke anxiety about salient issues presented by the news media (McCombs and Shaw 1972). The media’s intended goal is not to reflect social reality, but to regulate and shape it through the use of discursive strategies, specific vocabularies, and dramatized images. The agenda-setting function of the media is used to communicate political ideas, opinions, and

thoughts that influence the public's way of looking at and interpreting a story or event (McCombs and Shaw 1972; Iyengar and Kinder 1987).

iv. Mobilizing Anxieties and Fears throughout the News Media

This section looks at how anxieties and fears are exacerbated throughout the news to enhance a story's newsworthiness and maintain the discourses surrounding a social problem and moral panic. Media forms and frames are responsible for controlling the selection and presentation of events or stories emphasizing anxiety and fear (e.g., crime, sexual violence and drugs) (Altheide 1997). A "problem frame" is appropriate for forming the entertainment requirements used by the news media as a material version of a morality play (Altheide 1997). Problem frames play a critical part in promoting images and messages that stress widespread fear and danger in modern-day capitalist societies (Altheide 1997; Best 2016). The focus and content of fear changes over time and "moves" throughout various media as the interests of primary and secondary definers shift toward different economic and political opportunities (Altheide 1997; Parenti 1992).

The media and in particular, the news media, is dominated by tragic stories and gruesome images of crime, violence, sexual assault, and drug use (Altheide 1997). Reinerman and Levine (1997) use the term "routinization of caricature" to explain that the media often portrays the worse-case scenario of an event or story as the typical scenario; and episodic behaviour(s) becomes represented as an "epidemic." In turn, audience members perceive social reality much differently than it actually is; they view the social order as fundamentally violent and criminogenic, that tragedy can happen at any time without warning (Altheide 1997).

Perceptions of safety, security, and relative “ease” of everyday circumstances are neither uniform throughout North American society nor are they similarly perceived (Altheide 1997:664). Private life and personal troubles are closer to public concerns, as images conveyed throughout the media about the world’s uncertainties and its problematic composition generate substantial fears and anxieties among the public (Altheide 1997). The public is then left to internalize and make assumptions about these images and messages which are convoluted, exaggerated, and inaccurate in nature. Having cited literature that accounts for the role of the news media as the preeminent site that funnels, sifts, and squeezes knowledge of events to fit with its news values and profits, which is relevant to the way definers are represented and able to make a case for their claims, I now turn to literature that specifically makes a case for the social construction of reality. The next section will draw on a number of theorists (e.g., Joel Best, C. Wright Mills, Antonio Gramsci, and Peter L. Berger and Thomas Luckmann) to explain the epistemic approaches to social problems: subjectivism, objectivism, and constructionism. These varying perspectives demonstrate how a certain behaviour or condition becomes identified and understood as a social problem.

Epistemic Approaches to Social Problems

i. The Objectivist Approach

Objectivists perceive and define social problems as conditions that are inherently harmful to a social formation and its members (Best 1989, 2017). Macionis (2013) uses the objectivist approach to define a social problem as “a condition that undermines the well-being of some or all members of a society and is usually a matter of public controversy” (p. 5). This definition suggests that some conditions are capable of threatening the overall well-being of individuals in

a given society; thus, characterizing them as social problems. Although a behaviour or condition may be considered harmful, it might not be identified as a social problem (Best 2017).

C. Wright Mills (1959) makes the distinction between personal troubles and social issues as “this distinction is an essential tool of the sociological imagination and a feature of all class work in social science” (p.8). He asserts, personal troubles “occur within the character of the individual and within the range of his immediate relations with others; they have to do with his self and those limited areas of social life of which he is directly and personally aware” (Mills 1959:8). Mills (1959) emphasizes that:

the statement and the resolution of troubles properly lie within the individual as a biographical entity and within the scope of his immediate milieu—the social setting that is directly open to his personal experience and to some extent his willful activity. A trouble is a private matter: values cherished by an individual are felt by him to be threatened (p.8).

Social issues, on the other hand:

have to do with matters that transcend these local environments of the individual and the range of his inner Me. They have to do with the organization of many such milieux into the institutions of an historical society as a whole, with the ways in which various milieux overlap and interpenetrate to form the larger structure of social and historical life. An issue is a public matter: some value cherished by publics is felt to be threatened. Often there is a debate about what that value really is and about what it is that really threatens it. This debate is often without focus if only because it is the very nature of an issue, unlike even widespread trouble, that it cannot very well be defined in terms of the immediate and everyday environments of ordinary men. An issue, in fact, often involves a crisis in institutional arrangements, and often too it involves what Marxists call 'contradictions' or 'antagonisms' (pp.8-9).

Following Mills’s (1959) example, if an individual is unemployed or laid off, this is a personal trouble. If six thousand people are laid off, however, then working-class individuals must work together to demonstrate that unemployment is a social issue and gain the government’s attention. If, and once, workers attain the government’s attention, the government(s) will negotiate the nature, consequences, and implications of the problem under

investigation (Blumer 1971). The working class's demands about unemployment may not be fully met, however. Instead their demands may be modified to manufacture a different social problem from the initial one presented. The government, for example, may frame unemployment as a gateway to heightened criminality and suggest that more prisons, tougher laws, and law enforcement officials are needed to rectify this "issue" (Blumer 1971). This example demonstrates that while unemployment may cause financial and psychological stress to an individual in capitalist and liberal democratic formations, unless an entire social formation is burdened with unemployment and the ruling class can no longer exploit workers as a result, unemployment is not considered a social issue.

In regard to social problems, the objectivist approach has been criticized by subjectivist and constructionist scholars for not providing the same degree of recognition across all "harmful" conditions (Best 2017). Sexism, racism, and sex inequality, for example, are typically viewed as social problems, yet they do not receive the same degree of claims-making, media attention, or policy changes as the so-called drug war, the "opioid crisis", and blue-collar crimes (e.g., petty theft, sexual assault, burglary, murder, etc.) (Best 1989, 2017; Miller 1994; Spector and Kitsuse 1987). Another critique of the objectivist approach is that there is not "an impartial objective standard for recognizing what is or is not a social problem" (Best 2017:5). A condition may be recognized as a social problem for a variety of reasons; that is, people might disagree and have opposing views as to why a particular condition is detrimental to broader society. A third critique of the objectivist approach is that it uses vague descriptions and fails to adequately define what constitutes harm (Best 2017). As a result, the concept of "harm" becomes ambiguous and relies on meanings created by the ruling class to "protect" their latent interests over the lay public's. In short, the objectivist position is tautological; meaning, the approach accepts as a given what

should be explained. It is for all these reasons that objectively distinguishing what people consider or do not consider a social problem becomes difficult to analyze and explain.

ii. The Subjectivist Approach

Subjectivists argue that our own mental activity and interpretations of the social world determine our experience, and that external or objective truths do not exist independent of perception (Best 2017). According to the subjectivist approach, social problems are defined based on people's subjective understandings, interpretations, and value judgements of a particular behaviour, series of events, and/or group(s) (Best 2017; Spector and Kitsuse 1987). The meanings inherent in the discourses, narratives and representations of morality versus immorality are manipulated by powerful groups to manufacture consent over the definition of a social problem (Blumer 1971; Goode and Ben-Yehuda 1994). The subjectivist approach also explains how social problems emerge out of the various reactions of individuals toward a specific behaviour or condition (Best 2017). With this in mind, social problems should not be perceived as social conditions, "but as a process of responding to social conditions" (Best 2017:9-10). Social problems, therefore, should be defined as efforts to produce consent about particular meanings of behaviours, events, and things within the social order. In other words, to effectively analyze social problems, one must not solely focus on conditions but rather focus on who creates and preserves the claims about conditions (Best 2017; Blumer 1971; Spector and Kitsuse 1987). For subjectivists, studying a social problem demands an analysis of how the social issue emerged within and is advanced throughout a given social formation.

iii. The Constructionist Approach

Antonio Gramsci (1971) explains the concept of "common sense" in relation to ideology. He argues that people's "common knowledge" about the world, those who live in it, and the rules,

norms, and values that govern a given social formation derive from the political ideology of the ruling class. Although political leaders, criminal justice personnel, and other representatives of the social order use physical violence and economic and political coercion to maintain social order, they also assert their dominance and power through ideology (Gramsci 1971). The bourgeoisie seek to establish a hegemonic culture and to reproduce their sentiments, rules, and beliefs throughout various “institutions” (e.g., media, churches, schools, the criminal justice “system”, etc.). Ruling class values have become the “common sense” values of the proletariat and the general public (Gramsci 1971).

Professional groups present themselves as highly knowledgeable and specialized representatives of different areas in medicine (e.g., diagnostic radiology, dermatology, internal medicine, etc.), academia (e.g., health sciences, sociology, psychology, economics, etc.), and law (e.g., criminal, family, employment, etc.), for example (Gramsci 1971; Krancberg 1986). The lay public views physicians, scholars, and lawyers as possessing esoteric and complex philosophies that are not typically understood by the ordinary person. These “experts” differ from laypeople because of their roles in an atmosphere of complicated tasks and critical and detailed thinking (e.g., hospitals, colleges, universities, and law firms). Gramsci (1971), however, challenges this belief or “prejudice” and proves that every human being is a philosopher in their own nature (i.e., spontaneous philosophy).

For Gramsci (1971:323), this philosophy is

contained in: 1. Language itself, which is a totality of determined notions and concepts and not just words grammatically devoid of content; 2. ‘Common sense’ and ‘good sense’; 3. Popular religion and, therefore, also in the entire system of beliefs, superstitions, opinions, ways of seeing things and of acting, which are collectively bundled together under the name of folklore.

Gramsci does not suggest “that the vital and functional role of ‘spontaneous philosophy’ possessed by ‘everyman’ will necessarily herald the demise of the professional” (Kranenberg 1986:167). Instead Gramsci was interested in the class dynamic of this “spontaneous philosophy” and how “spontaneous philosophy” is rooted in common-sense truths about social reality.

Gramsci (1971) argues that our conception of reality is grounded in language. Through language we come to understand the experience with and the making of the social world, which is largely determined by the many social groups (e.g., cultural, ethnic, political, religious, etc.) we associate and identify with “from the moment of entry into the conscious world” (Gramsci 1971: 323). Gramsci further states that “we are all conformists of some conformisms or other, always man-in-the mass or collective man” (Gramsci 1971: 324). Given the intimate relationship between language and thought, Gramsci “regards language as the most conspicuous manifestation of intellectual activity in every man” (Kranenberg 1986: 167). Since groups use language to communicate their thoughts, emotions, desires, fears, and ambitions, the totality of these ideas manifests in perceptions, beliefs, sentiments, or actions (Gramsci 1971; Kranenberg 1986). As a result, the aggregate of all these ideas is embedded in one’s understanding of the social world, which is, according to Gramsci “a response to certain specific problems posed by reality which are quite specific and ‘original’ in their immediate relevance” (1971: 324).

Social constructionism, therefore, is an alternative approach to understanding social problems and the various ways people give meaning to the world; it views reality and knowledge as created by the dynamics of social interaction (Berger and Luckmann 1966). In regard to social problems, the constructionist approach stresses the importance of claims-making and the role of claims-makers in using specific vocabularies to define a social issue (Best 2017; Spector and

Kitsuse 1987). Claims are created and articulated in a way that reflect the perceptions and opinions of those formulating them (Woolgar and Pawluch 1985). It is imperative for the constructionist framework to conceptualize how social problems emerge, by whom social problems are discovered, and whose interests are being advanced in this definitional process (Goode and Ben-Yehuda 1994).

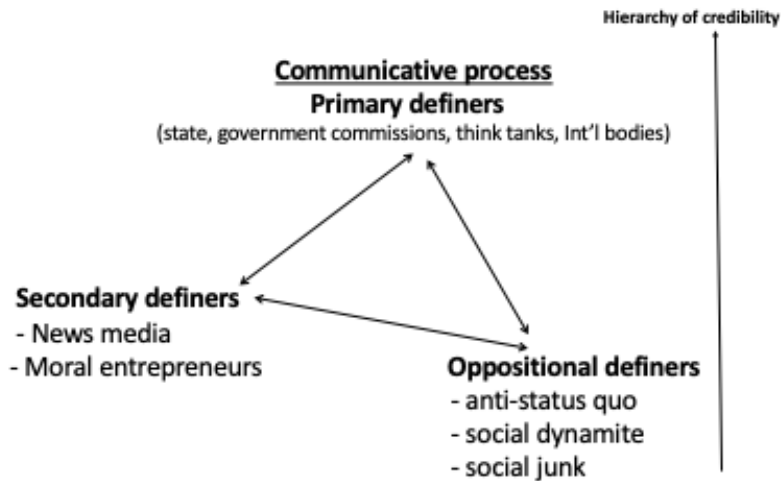
Social Closure and Social Usurpation

While the news media is the milieu in and through which social problems are constituted, and clearly social problems cannot be made, contested, and unmade without it, of equal importance is to account, theoretically, for the ways that primary, secondary, and oppositional definers mobilize to maintain or to change the status quo. Here it is vital to account for the neo-Weberian understanding of group conflict through the theory of closure: social and usurpatory closure. What this literature indicates is that in order to make sense of and to develop a model of social problems, one must account for credibility and the right to make a claim over the control of a problem.

Social closure is the phenomenon whereby credentialed and powerful groups exclude “outside” members in order to maintain their privilege and economic and political resources (Parkin 1979). Authorities exclude subordinate groups from obtaining similar economic privileges and rewards based on varied criteria, such as physical and social characteristics (e.g., “race”, gender, language, religion, and social origin) and education. Becker’s (1967) concept of the hierarchy of credibility is used to describe the social inequality between classes and the moral hierarchical “structure” of the social order. Individuals or groups positioned at the top of a given social order or organization (e.g., political leaders, criminal justice personnel, physicians, psychiatrist, scholars and military leaders) are perceived by the public as more credible and

knowledgeable than individuals or groups at the bottom of a given social order or organization (e.g., negatively racialized groups, the working-class, vulnerable populations, the lay public, etc.). The social location of primary, secondary, and oppositional definers in the hierarchy of credibility, therefore, can influence the public to either accept or reject the various definers' claims about Canada's current "opioid crisis."

Figure 1. The Communicative Process of Primary, Secondary and Oppositional Definers in Producing Knowledge about Social Reality.



Permission granted by Kitossa, Tamari. 2015. Symbolic Interactionism, Definers and Other Key Concepts [PowerPoint slide].

This model represents the hierarchical structure of knowledge and power in capitalist social formations. It can be used to explain the roles of primary, secondary, and oppositional definers in the communicative process of the opioid crisis. Primary definers are “accredited sources” who play a predominant role in establishing the initial framing of an event, story or topic in the media (Hall et al. 1978). Positioned at the top of the hierarchy of credibility, primary definers include political leaders, criminal justice personnel, and medical professionals, to name a few. These individuals are granted media access to produce definitions about a topic within their area of “expertise.” The primary definition sets the tone about a topic and places it within a

larger social, political, and cultural context. Attempts made by subordinate groups to change the initial definition are rarely successful, unless through massive social movements (Hall et al. 1978). Secondary definers are the media, moral entrepreneurs, and “addiction” service providers credentialed and legitimated by the therapeutic state. Secondary definers are also positioned above oppositional definers; however, they stand in a position of subordination to primary definers (Hall et al. 1978). Their main goal is to take on a moral entrepreneurial role and to reproduce the definitions and meanings created by primary definers about an event, story or topic in the news media.

Primary and secondary definers are key actors in shaping public consciousness toward a social problem. They are able to persuade the general public through claims-making activities and can influence policies to remedy a social problem (Spector and Kitsuse 1987; Best 2017). Negatively racialized populations (e.g., Indigenous persons, African and Latino/X Canadians, im/migrants, etc.), the working-class, women, and the lay public generally lack resources and political coordination to effectively challenge dominant definitions of social problems. Those who oppose primary definitions are identified as “oppositional definers” or “social dynamite” (Spitzer 1975). Oppositional definers are perceived as violent, threatening, failing to socially integrate (e.g., forming relationships, pursuing education, obeying the law, securing employment and producing labour, etc.), and resistant to powerful groups’ narratives about social issues, policymaking decisions, and political action generally (1951; Spitzer 1975). Positioned at the bottom of the hierarchy of credibility, their inferior status as “oppositional definers” have little, if any, impact during the claims-making process, unless they have access to lobby groups (Hall, Critcher, Jefferson, Clarke, and Roberts 1978; Spector and Kitsuse 1987). In saying that, however, those who are subordinate are also the audience from whom consent is sought.

Finally, “it is the structured relationship between the media and its ‘powerful sources’ which begins to open up the neglected questions of the ideological role of the media” (Hall et al. 1978:59). Frank Parkin (1979) extends Max Weber’s original theory of social closure and identifies two major types of social closure: exclusionary and usurpatory closure. Parkin’s concepts are useful for explaining how oppositional definers compete with the powerful for the definitions, narratives, meanings, and discourses of opioid mis/use and overuse. The distinctive feature of exclusionary closure is that a group attempts to preserve their privileged position in a given social formation by subordinating and excluding another group (Parkin 1979). Parkin (1979) refers to this process in metaphorical terms as the use of power downwards. Usurpation, however, is the type of social closure arranged by a group “in response to its outsider status and the collective experiences of exclusion” (Parkin 1979:74). Where usurpatory actions are concerned, these subordinate groups are aimed at obtaining a greater share of resources and social and economic opportunities that are often enjoyed by dominant groups in a social formation (Parkin 1979). The metaphor Parkin (1979) uses to describe usurpation is the use of power upwards.

Usurpation encourages negatively racialized groups, women, the poor, and other vulnerable groups to use collective efforts in attaining civil and social rights. The public mobilization of members and supporters in the form of strikes, symbolic vigils, academic journal publications, demonstrations, and other forms of resistance are common practices in usurpatory closure (Parkin 1979). Usurpatory activities are not always legal and sanctions are often employed by the powerful to ensure that such activities or practices are unsustainable. Usurpatory efforts challenge the “state’s claims to the legal monopoly of physical coercion” (Parkin 1979:75), and as usurpatory approaches become more effective, they begin to

threaten the allocation of goods (i.e., distributive justice) which are communicated in the legal authorization of exclusionary rules and organizations (Parkin 1979). Exclusionary and usurpatory closure, for example, is exemplified in the “opioid crisis” as primary, secondary, and oppositional definers compete for the dominant discourses and representations of opioid mis/use and overuse in Canadian corporate print media.

Physicians, for example, engage in exclusionary closure by employing the methods of “expert” opinion, credentialism, and in-group membership. They, along with the Medical Officer of Health and government commissions, define acute and chronic non-cancer pain, determine the type of treatment(s) that moderate and control these forms of pain, and it is physicians who decide which patients can/not work, can/not drive, and the type of lifestyle regimen they are required to follow as a result of their acute and chronic non-cancer pain (Illich 1976). With respect to the “opioid crisis”, the medical establishment becomes expanded through the definitional process as well. Physicians, the Medical Officer of Health, and government commissions have membership within the medical establishment. This authority and power allows medical professionals to close out the lay public, community outreach workers, and others from making claims and judgments about how physicians should treat the “opioid crisis” as a problem.

In the case of usurpatory closure and the “opioid crisis”, academic scholars, interest groups, and safe-injection/overdose-prevention site coordinators and volunteers challenge dominant vocabularies, representations, and discourses of drug use through ideological resistance. Some of the usurpatory actions employed by these individuals or groups include claims-making activities, the creation and use of safe-injection sites, and producing empirical or theoretical studies that disrupt mainstream conceptions about opioids and the non-medical use of

psychotropic drugs. These oppositional definers also promote marijuana as a form of non-pharmaceutical therapy for acute and chronic non-cancer pain, and protest the solutions or strategies proposed by political leaders, legislative committees, and other powerful groups to ameliorate opioid mis/use and overuse across Canada (Best 2017; Blackwell and Erickson 1988; Cohen et al. 1972; Hall et al. 1978; Hart 2012; Spector and Kitsuse 1987; Tremonti 2018).

Primary, secondary, and oppositional definers all have a relationship to hegemonic discourse, but as noted by Parenti (1970), oppositional definers in getting their claims recognized or not, need allies from both primary and secondary definer groups (Kitossa Personal Communication 2019). Furthermore, the data analysis chapter of this thesis uses my four-stage composite model of social problems to show how the *Toronto Star* and the *Globe and Mail* represent primary, secondary, and oppositional definers as engaging in social closure over the dominant narrative of and solutions to curbing opioid dependency and preventing overdoses across Canada.

Having accounted the role of the news media and charting varying epistemological approaches to conceiving social problems, I now turn to the literature on the modelling process by which social problems are constituted in the context of group conflict and varying claims of expert knowledge. The next section, therefore, explains Joel Best's (2017) and Herbert Blumer's (1971) social problems models to demonstrate that social problems have "careers" in which there are definite stages of claims-making, opposition, policymaking, and others. Leading to a composite model of social problems, I provide a rationale for the stages I find suitable for my composite model.

The Career of Social Problems and Claims-making

This thesis uses symbolic interactionism, labelling theory, and a Marxian perspective of conflict and social inequality to analyze how the "opioid crisis" is constructed and framed as a

social problem in two Canadian corporate print media outlets – the *Globe and Mail* and the *Toronto Star*. Any social issue, whether it be sex inequality, climate change, homelessness, kidnapping, or drug abuse can be examined with the career model. “Career” is extensively used in the academic field of labour and occupations as well as in the academic field of deviance. The term is frequently used to specify both the development of a person’s biography and the general order associated with people who hold the same job position (Spector and Kitsuse 1987). The former refers to a person’s history or biography, the latter necessitates an examination of many biographies and coincides with the various stages involved in the development of a social problem. Social problems do not emerge fully formed, demanding community attention and policies for their amelioration (Fuller and Myers 1941). Social problems must undergo a course of development in which they encounter different stages. A social problem is thus conceived as always being in a dynamic state of “becoming” (Fuller and Myers 1941:321).

In regard to the emergence and evolution of a social problem, Best’s (1989, 2017) “natural history” model and Blumer’s (1971) “career model” examine the many stages a social problem encounters before it becomes legitimized politically and publically. Although not ideal because it lends itself to confusion, Best’s conception of “natural history” does not suggest that there is anything natural about social problems and their evolution; instead, “natural history” “refers to a sequence of stages that tends to appear in a lot of different cases” (Best 2017:17). I discuss both Best’s and Blumer’s models as they are two principal scholars in the social problems literature and have tested their models empirically.

Blumer’s Career Model of Social Problems

Herbert Blumer argues that “social problems are fundamentally products of a process of collective definition and behaviour instead of existing independently as a set of objective social

arrangements with an intrinsic makeup” (1971:298). He challenges the positivist approach used by sociologists to examine social problems and believes current sociological theory and knowledge are unable to identify and predict social problems – assuming that social problems, as yet to be determined, are not objectively real but are the consequence of a meaning-making process. According to Blumer (1971) positivism does not consider the reasons why social problems emerge or how they become defined as “problems.” Instead “sociologists and other social ‘scientists’ objectify their research of what ‘common sense’ or ‘prior public concern’ defines as a problem for study and remedial action” (Kitossa Personal Communication 2015). Blumer argues that the analyst of social problems should “study the process by which a society comes to see, to define, and to handle their social problems” (1971:301), as there is nothing inherently objective about a social problem. Blumer, therefore, developed a five-stage process to offer an improved understanding of the development, evolution, and outcome(s) of social problems: “the emergence of a social problem, the legitimation of the problem, the mobilization of action with regard to the problem, the formation of an official plan of action, and the transformation of the official plan in its empirical implementation” (1971:301-305).

i. The Emergence of Social Problems

Social problems arise from a process of definition whereby a particular condition is characterized as harmful and problematic (Blumer 1971). Social awareness about a given problem is not only pivotal to its development and existence, but social awareness enables discussions and solutions toward rectifying the social problem as well. In authoritarian and economically stratified social formations, social problems are borne out of interest groups and class antagonisms. Power and control of “legitimate” knowledge determines what issues are defined as “problems” (Blumer 1971). In short, someone, for example, Ralph Nader who

popularized consumer advocacy, the African American civil rights movement which demanded racial and class equality, the LGBTQ movement which exposed the oppression of gays, lesbians, and trans and the privileges of heteronormativity, and many other individuals and movements asserted claims against the status quo. Whether and how these individuals and groups were able to gain recognition, force legal and social changes, and usurp claims, required in the first instance drawing attention to a cause demonstrates the issue of problem-making. To understand social problems in their simplest and complex forms, Blumer (1971) suggests that an analysis of how they emerge is critical to understanding the career of social problems.

ii. Legitimation of Social Problems

Once a social problem receives widespread recognition, the validity of the social problem rests on testimonials provided by activist or expert claims-makers to effectively advance its career (Blumer 1971). Drawing public attention to a social problem requires a degree of respectability which grants it consideration in economic, educational, cultural, legal, and political domains (e.g., legislative chambers, schools, news and print media and collective organizations) (Blumer 1971). Failure to achieve respectability or legitimacy in portraying a given social problem may result in the problem being considered insignificant. Although a variety of groups define social conditions as “harmful” and “threatening”, achieving legitimacy is somewhat limited. The selection process of determining what constitutes a social problem and what does not demonstrate how numerous social problems are overlooked and ignored while others are quickly legitimized and safeguarded by influential and powerful persons, groups, or organizations (Blumer 1971).

iii. Mobilization of Action

If a social problem achieves societal recognition and legitimation, it enters a stage of opposition and claims-making (Blumer 1971). To put it another way, a social problem may be approached with disagreement and debate, varying portrayals, and erroneous claims. Individuals who wish to modify the problem often face opposition or resistance from those who attempt to defend dominant interests (Blumer 1971). Secondary definers employ scare tactics and deception to support dominant interests, and empirical evidence is typically presented to and in official establishments such as city hall, congressional hearings, and senate. Blumer states that:

All of this constitutes the mobilization of the society for action on the social problem. How the problem comes to be defined, how it is bent in response to awakened sentiment, how it is depicted to protect vested interests, and how it reflects the play of strategic position and power—all are appropriate questions that suggest the importance of the process of mobilization for action (1971:303-304).

iv. Formation of an Official Plan of Action

In analyzing the emergence of social problems, this stage reflects the decision of political leaders, legislative committees, medical professionals, and other powerful groups to determine what actions must be taken to address a social problem (Blumer 1971). Once formal institutions accept that a particular condition constitutes a social problem, action plans are formulated to address and rectify it. Formulating a plan of action generally involves bargaining and compromise, in which wide-ranging perspectives are entertained (Blumer 1971). Definitions of a given social problem are thus modified and (re)constructed, so that what emerges may be different from how the problem was perceived at the start of its career. The official plan that is enacted constitutes, in itself, the official definition of the problem; it represents how the society through its official apparatus perceives the problem and intends to act toward the problem (Blumer 1971:304).

v. *Implementation of the Official Plan*

The final stage in studying the career of a social problem is the implementation of the official plan. According to Blumer (1971), the official plan is constantly updated, restructured, and improved throughout the social problems process. This stage also establishes the boundaries between individuals in charge of the definition of a social problem and those impacted by the plan. Both primary and secondary definers who are in fear of losing their powerful and privileged positions in developing and implementing an official plan of action attempt to manipulate, restrict, and/or sabotage the plan in new directions (Blumer 1971). Those whose interests are clearly outlined in the plan (e.g., political leaders, medical professionals, law enforcement officials, etc.) may use it to reinforce their authority and knowledge over the lay public and to enhance their reputation for future elections or promotions.

Best's (2017) "Natural History" Model of Social Problems

Best (2017) provides a six-stage natural history model to demonstrate how a "harmful" behaviour or condition becomes constructed as a social problem through claims-making activities. Best's six-stage social problems model includes: "the claims-making process, media coverage, public reaction, policy-making, social problems work, and policy outcomes" (2017:18-23).

i. *The Claims-making Process*

The first stage of constructing a social problem is the claims-making process (Best 2017). Throughout this stage, claims-makers attempt to draw the public's attention to some behaviour or condition that they find "harmful" and debilitating to the social order. Claim-makers, then, argue that something must be done to ameliorate and control the aberrant behaviour(s) and harmful condition(s). Rhetoric is heavily emphasized in claims-making activities and assists in the

development of a social problem (Best 2017). Claims-makers use rhetoric to elicit emotional responses, such as empathy or disgust, and to generate a public discussion about people's anxieties regarding the social threat (Best 2017). Best (2017) also explains how defining a problem is central to claims-making. Identifying a problem sets boundaries as to what can be said. A definition determines which issues are relevant and which serve no function in developing the problem. Defining phenomena influences which actions should be taken to ameliorate the issue, and how political actions should be deployed as well.

ii. Media Coverage

The second stage of constructing a social problem is media coverage. Best (2017) stresses the importance of media coverage in gaining the public's attention about a particular claim. Editors and journalists reconstruct the claims made by activists or "experts" into secondary claims, ensuring that they are newsworthy and/or meet the requirements suitable for entertainment. Since there are many claims-makers and the media can cover only a limited number of events or stories, claims-makers are often competing for media attention. Claims-makers often articulate and present their claims in novel ways to draw the interest of the media (Best 2017). This was seen recently with Extinction Rebellion protestors who glued themselves to government buildings in the UK and USA to protest the lack of political action on climate change. Once the media selects and represents successful claims, the lay public is made aware of the "social problem" and becomes concerned with its severity and the steps necessary to ameliorate the problem.

iii. Public Reaction

The general public, then, learns about claims either directly from claims-makers or indirectly through media reports (Best 2017: 21). Best's stage of public reaction describes how

members of a given social formation respond to claims in various and unpredictable ways. They may be motivated and “moved to action by some claims, deciding to contribute to a social movement organization, participate in demonstrations, write their legislators, or relay the claims to others they know” (Best 2017:163). Some may find a claim interesting and engage in conversation or debate about it with acquaintances, family members, or friends. Others may be apathetic toward or uninterested in a claim because it appears boring, while “others may react negatively, disagreeing with the claim and opposing its conclusions” (Best 2017:166). All claims, however, generally elicit one, if not all, of “these possible reactions in different people” (Best 2017:166). Since the lay public typically keeps their opinions about claims to themselves, claims-makers are unsure of how they interpret or respond to claims. Claims-makers, therefore, often use public opinion polls, focus groups, and social media to measure and better understand the public’s response(s) toward specific claims (Best 2017).

iv. Policymaking

The fourth stage of constructing a social problem is policymaking. Social policies are created to address “harmful” behaviours and/or conditions “so that the problem can be, if not eliminated, at least made better” (Best 2017:199). Toward this end, claims-makers are interested in changing social policies, to alter how a social formation deals with a harmful behaviour or condition; and this means that their claims must influence assemblies and legislators (Best 2017:199). Legislative bodies and their representatives have the power to negotiate and ratify laws, allocate funds, and establish guidelines to official organizations that administer those laws. They often operate under constraints and are urged by the lay public to take immediate action against a troubling condition and/or behaviour. Overall policymakers recognize the significance of claims, media exposure, and public reaction in creating and enacting policies; however, their

own perspectives and interests play an essential role in the policies they develop as well (Best 2017).

v. *Social Problems Work*

The claims-making process, media coverage, and policymaking stages tend to focus on the wide-ranging implications of the “troubling” behaviour or condition for the social order as a whole. In social problems work, however, the focus narrows (Best 2017:232). Social problems work consists of applying constructions of social problems or social policies to their immediate, practical solutions (Best 2017:232). This stage, therefore, focuses on the diverse roles of social problems workers (e.g., physicians, police, social workers, teachers, etc.) “in carrying out the formal policies enacted to address claims-making about” harmful behaviours and/or conditions (Best 2017:256). Social problems work also focuses on the dynamics of interactions between social problems workers and the people who in some way embody a constructed social problem (e.g., “addicts”, clients, patients, perpetrators, students, etc.).

vi. *Policy Outcomes*

Policy outcomes is the final stage in Best’s (2017) model. This stage examines the critical reactions to the way governments and legislative committees have implemented policies. According to Best, the general public and various actors involved in the claims-making process often criticize social policies if they do not “solve” a social problem entirely. Critics may disagree with newly-developed policies by arguing that they are ineffective in addressing a “harmful” behaviour or condition, or that the policies will cause additional problems that are arguably worse than the initial “problem” (Best 2017). These outcomes or reactions can be viewed as new claims that “construct interpretations of a social policy’s shortcomings and make recommendations regarding what ought to be done differently” (Best 2017:265).

Rationale for the Composite Model of Social Problems

Both Best's and Blumer's social problems models can be used to identify how primary, secondary, and oppositional definers make claims about opioid dependency and overdoses in Canadian corporate print media. I borrowed and combined specific stages from Best's and Blumer's models to create my own composite model of social problems: the claims-making process and the emergence of social problems, legitimation of social problems, policymaking and the formation of an official plan of action, and the implementation of an official plan. I now provide a rationale for each stage of the composite model of social problems. I combined Best's first stage (i.e., the claims-making process) and Blumer's first stage (i.e., the emergence of social problems) to analyze how primary, secondary, and oppositional definers construct opioid dependency and overdoses in the press through claims-making activities, hegemony, and social closure. Best and Blumer mutually discuss how the claims and definitions of a "harmful" behaviour or condition are constructed and reconstructed throughout each stage of the social problems process to make them more appealing, credible, and persuasive to governments, legislative committees, and the general public. I will examine how the claims-making activities and definitions of the various definers aid in the emergence of Canada's "opioid crisis" and either foreclose or usurp control over the management of opioid dependency and overdoses.

Blumer's second stage, the legitimation of social problems, is used to examine how the social location or status of claims-makers determines whether a "harmful" behaviour or condition becomes identified as a "problem." This stage is useful for examining how the problem is articulated in the press and by whom to ensure the validity of claims and influence policymaking decisions. I excluded Blumer's "mobilization of action" stage from the composite model for two reasons: first, the stage is similar to and overlaps with Blumer's fourth stage, "the

formation of an official plan of action”, and second, there is a flaw in Blumer’s logic or sequencing of the third stage in the social problems process. I argue that the “formation of an official plan of action” stage should come before describing the actions of various actors in Blumer’s third stage. The rationale for combining Best’s fourth stage (i.e., policymaking) and Blumer’s fourth stage (i.e., formation of an official plan of action) is to analyze how political leaders, legislative committees, medical professionals, and other powerful groups employ bargaining, compromise, and negotiation to create policies aimed at curbing opioid dependency and preventing overdoses across Canada.

Best’s fifth stage (i.e., social problems work) and Blumer’s fifth stage (i.e., implementation of an official plan) recognize that economic and political interests shape or modify claims and policies throughout the social problems process. I, however, use Blumer’s fifth stage instead of Best’s. I cannot empirically analyze the interactions between social problem workers and their subjects (e.g., “addicts”, clients, perpetrators, etc.), which is a central component of Best’s fifth stage, and such analysis does not coincide with the focus of this thesis. I use Blumer’s fifth stage to identify the hegemonic definition of opioid dependency and overdoses across Canada. The definition of a problem, which is outlined in the official plan, determines who has control over the definition, the approach that should be taken (e.g., criminal justice or public health), the policies that are created to ameliorate or “solve” Canada’s “opioid problem”, and who is involved in carrying out the newly-enacted policies. I will also demonstrate how social closure is employed by the various definers to determine who benefits from the official definition of Canada’s “opioid crisis” and who is impacted by the official plan.

There are three distinct stages in Best’s social problems model that do not coincide with any of Blumer’s stages: media coverage, public reaction, and policy outcomes. I did not include

Best's "media coverage", "public reaction", and "policy outcomes" stages in my composite model of social problems. Each stage of the composite model analyzes print media coverage of the "opioid crisis" to see how primary, secondary, and oppositional definers lay claim over opioid dependency and overdoses across Canada; therefore, I did not include Best's "media coverage" stage. I excluded Best's third stage, "public reaction", as I cannot empirically measure public opinion through opinion polls or other methods for assessing public opinion. Best's "public reaction" stage, moreover, does not meet the focus of this study: to analyze primary, secondary, and oppositional discourse of the "opioid crisis" in Canadian corporate print media. This thesis is interested in how the discourses and claims-making activities of primary, secondary, and oppositional definers have come to signal an "opioid crisis" across Canada. This thesis is also interested in the interlocking struggle between the various definers over the dominant definition of opioid dependency and overdoses in Canadian corporate print media. Best's "policy outcomes" stage would require an analysis of the public's responses, among others, to the newly-enacted policies aimed at curbing opioid mis/use and overuse which does not meet the aims of this study.

Furthermore, this four-stage composite model of social problems analyzes how primary, secondary, and oppositional definers engage in hegemony, negotiation, and social closure over the dominant definition of Canada's "opioid problem" in the *Toronto Star* and the *Globe and Mail*. In this section, I explained both Best's and Blumer's social problems models, provided a rationale for the stages I find suitable for the composite model of social problems, and I briefly mentioned the similarities and distinctions between the scholars' models. The following section will engage the reader in a discussion about the theoretical influences that have guided my

research: a Marxian perspective of class conflict and social inequality, symbolic interactionism, labelling theory, Gramsci's concept of hegemony, and "materializing" symbolic interactionism.

Chapter Summary

In this chapter I reviewed literature on social problems research, the professional ideology of the news media, and the subjectivist, objectivist, and constructionist approaches to understanding social problems. I also explained both Best's and Blumer's social problems models and provided a rationale for the stages I find appropriate for the composite model of social problems. Finally, I explained exclusionary and usurpationary closure and how they will function in this thesis. Primary and secondary definers "discover" social problems and create moral panics to maintain dominant ideologies of the ruling class and to instill anxieties and irrational fears among the lay public about a particular issue (Cohen et al. 1972; Goode and Ben-Yehuda 1994; Hall et al. 1978; Parenti 1992). In general, media portrayals of the "opioid crisis" often adhere to specific definitions of morality, which are manufactured by economic and political elites (Cohen et al. 1972; Good and Ben-Yehuda 1994; Kitossa Personal Communication 2019; Parenti 1996).

Chapter 3

Theoretical Foundations

Karl Marx asserted that “There is no royal road to science, and only those who do not dread the fatiguing climb of its steep paths have a chance of gaining its luminous summits” (Marx, 1872). Science, nevertheless, is not morality. Although science may be guided by morality, the scientist who manipulates and studies the phenomena of nature is not explicitly making a moral judgment about nature. The social “scientist” is unable to remove emotion and sentiment from the object of their investigations. Simply put, no social theory is neutral; since the social theorist is always implicated in their theory of the social. While this thesis concerns the epistemic project of identifying how primary, secondary, and oppositional definers are locked in a struggle of closure and usurpation over the meaning of and solutions to opioid mis/use and overuse across Canada, a theory of social conflict is automatically implied. This theory of social conflict, however, is sympathetic to the viewpoint that the ethical uses of power must be in favour of values that ensure justice (see Becker 1968). The subsequent sections are less concerned with describing a theoretical framework that is followed mechanically throughout this thesis; instead, I provide an account of the theoretical perspectives that constitute an ethical guide by critical skepticism and critical relativism to social problems. In short critical relativism does not mean “anything goes”, but that one takes a position on social theory that is consistent with an ethical and normative stance in a social order where rhetorics of justice and fairness must be made real for the majority (Kitossa Personal Communication 2019).

Given the foregoing meta-theoretical statement, I now provide what for me is a compelling and persuasive perspective of conflict and social inequality to examine: a Marxian account of social reality. I am interested in understanding why the recent upsurge in opioid

dependency and overdoses has become identified as a “social problem.” I am keen to understand who benefits from the “discovery” of Canada’s “opioid problem” in particular and other social problems more generally. I am interested in the specific ways that groups contest the meaning of reality, taken as a given by the status quo, through the social dynamics of claims-making, labelling, and social closure. Chapter 3 describes the significance of the theoretical influences that have guided my research and their relevance to my study: symbolic interactionism, labelling theory, and Gramsci’s concept of hegemony. I also borrow the concept of “ideology” from the Marxist tradition and examine Stuart Hall’s discussion of “discourse” to explain how they will function in this thesis. After I provide a brief outline of both concepts and discuss each theory, I “materialize” symbolic interactionism.

Theoretical Concepts

“Ideology” and “discourse” are vital concepts to the Marxian theory of knowledge that have guided my interests. The concept of ideology has become closely associated with the Marxist tradition to explain how a social formation and its members are guided by a set of normative beliefs, sentiments, and values of the ruling class (Purvis and Alan 1993). In other words, “the Marxist concept of ideology describes how the dominant ideas within a given society reflect the interests of a ruling economic class” (Stoodart 2007:191). Stoodart explains how “ideological systems work to integrate people into social networks of oppression and subordination” (2007:200). Ideology, accordingly, is a cultural, economic, and political tool for reaffirming the authoritative positioning of the ruling class over the subordinate classes (Purvis and Alan 1993). Ideologies are intended to deceive and conceal the inequalities that exist in capitalist formations. These legitimating ideologies often explain that equality is manifested in various social institutions (e.g., education, labour, the law, etc.), therefore, diverting attention from other areas

of social life where inequality is widespread. Furthermore, the concept of ideology is used in this thesis to explain how certain behaviours or conditions become legitimized as “social problems” depending on whose interests they protect and serve.

The theory of discourse refers to ways of speaking and narrating truths and facts that are combined in systems of discourses which shape how people think, behave, and speak about a specific issue, event, and/or group of people. To be clear, discourses are not in and of themselves concerned with truth, but rather ways to narrate what *is* true. Donald Trump, for example, asserts that there is such a thing as “alternative facts” and that there is “fake news.” This discourse speaks a particular truth, although it is not true or is only true within definable limits. When a topic is described within a specific discourse, therefore as I showed in chapter two with Antonio Gramsci, language is used to construct the topic in a particular way (Hall 2007). Discourse is produced and represented by a practice known as ‘discursive practice’, which simply means “the practice of producing meaning” (Hall 2007:56). Meaning is inherent in all recurring episodes of social interaction; thus, face-to-face exchanges are shaped by discourse (Hall 2007). Discourse and power have a symbiotic relationship. Discourse is concerned with how language produces knowledge about the world, and “the knowledge which a discourse produces constitutes a kind of power, exercised over those who are ‘known’” (Hall 2007:57-58). When knowledge is employed in practice, “those who are ‘known’ in a particular way will be subject (i.e., subjected) to it” (Hall 2007:58). Individuals who create the discourse have the authority and power to make it true by reinforcing its legitimacy and “scientific” status (i.e., “Regime of Truth”) (Hall 2007). Although discourses cannot be reduced to class interests, they constantly operate in relation to power and play a key role in distributing and opposing power as well (Hall 2007). In this thesis, I

explore how discourse, meaning, and representation become sites of mediated conflict at which oppositional definers attempt to contest hegemonic ideas in the claims-making process.

Marxian Perspective of Conflict and Social Inequality

The Marxist tradition draws on the works of Friedrich Engels and Karl Marx to explain how capitalism oppresses the working class through labour relations and the perpetuation of class interests, which are expressed and maintained through ideological domination. Marx examines class conflict and social inequality by employing a materialist interpretation of historical development and adopting a dialectical perspective (Eagleton 2011). The forces of production are central to the complex arguments posited in Marxism and determine a unified reality. Marx's base/superstructure model suggests that human social formations are comprised of two parts: the base (or substructure) and superstructure (Williams 1973). The "base" refers to the economic and material foundation of social formations, and represents the forces of production (e.g., factories, land, tools and machinery, raw materials) and the relations of production (e.g., dominant social institutions that shape public consciousness and influence human relationships between labourers and owners) (Williams 1973). Following Marx's observations, in order to exploit the forces of production owners and labourers must work together, even at the most basic level (Williams 1973). Marx believed that social development would transform the dynamics of the base and would eventually produce changes in the superstructure (Williams 1973). Marx's theoretical approach, however, does not explain why the working class has failed to achieve a "worker's revolution" and overthrow capitalism despite having the necessary conditions to revolt.

Capitalism and its inherently racist ideologies, exploitive strategies, and profit-driven incentives have created social formations dependent on the production of commodities, and the accumulation and expansion of capital (Eagleton 2011). Capitalism is a "system" of wage-labour

and commodity production for sale, exchange, and profit, rather than the immediate need of the producers. This economic, political, and social “system” has brought intensified competition, whereby the powerless attempt to obtain the lifestyle of the rich and wealthy from a working-class perspective. Marx was aware of the manipulative and persuasive techniques used by the rich and powerful to advance their economic interests, while ensuring the powerless remained below them in hierarchical formations. According to Marx, a social class is a group of people who are categorized by their similar relationship to labour and the modes of production (Stoodart 2007). Class conflict occurs when the interests of classes are antagonistic or are in opposition with one another. Marx identified two principal classes, the proletariat (i.e., those compelled to sell their labour-power) and the bourgeoisie (i.e., owners of the means of production). He demonstrates that these classes compete for control over resources and economic and political opportunities (Williams 1973). Labour and more specifically, wage labour, determines worker’s material and moral standing in the capitalist social order (Gordon 2006). Gordon states that “an important measure of a person’s moral standing in our society, for instance, is their industry and their ability to hold down a job. Failure to do this often suggests, to the state and police, a person’s potential for criminality” (2006:60).

Marxism is important for analyzing the discourses that are used by primary and secondary definers to describe, represent, and ameliorate opioid mis/use and overuse across Canada (e.g., lawmaking, stricter guidelines for physicians, harm-reduction initiatives, etc.). Based on state narratives, drugs “threatened” and continue to “threaten” labour and industry which are essential to capitalism’s economic and exploitive functions. As illustrated by North America’s current drug war, discriminatory and punitive laws have been established to maintain labour discipline, social order, and whiteness (Gordon 2006). Marxism is useful for examining

how the “emergence” of social problems, such as the “opioid crisis”, justifies strengthening social control apparatuses through lawmaking and/or other “effective” measures (e.g., prescription (PMPs), “stricter” prescribing guidelines, lack of access to drugs, etc.). Marxism is also important for analyzing who has the power to identify and label a “harmful” behaviour or condition as a social problem and who is impacted or targeted by the “discovery” of a problem.

Symbolic Interactionism

Symbolic interactionism is a sociological perspective that examines how communication and meaning are represented through signs and symbols (Blumer 1969; Carter and Fuller 2015). The framework was established in the mid-twentieth century by a variety of scholars, “including the Scottish Moralists and American Pragmatist philosophers—its greatest influence being American philosopher George Herbert Mead and his theory about the relationship between self and society” (Carter and Fuller 2015:1). In 1937, however, Herbert Blumer coined the term “symbolic interactionism” and was the first scholar to develop Mead’s ideas into a unified theory with specific methodological implications for the study of social behaviourism (Carter and Fuller 2015). Similar to Mead, Blumer (1969) viewed individuals as engaged in “mind action.” That is, humans are constantly involved in thoughtful action where they control and manipulate symbols and negotiate the meaning in a given context (Mead 1934). Blumer’s (1969) symbolic interactionism focuses on processes used by actors to continually construct and reconstruct experiences from one interaction to another. From his perspective, social institutions only exist because of human interaction and individuals’ meaningful face-to-face encounters with each other. It is important to note that society is not a structure, but an ongoing process in which agency and indeterminacy of actions are prioritized (Blumer 1969; Carter and Fuller 2015; Collins 1994). It is a reification to consider a culture as organized, patterned, or unchanging

because cultures are inherently unpredictable, just like the interactions and experiences of individual people.

Echoing Mead, Blumer's symbolic interactionism recognizes institutions and social structures as "social habits", which are shared among those involved in the interaction (Carter and Fuller 2015). Meanings are not inherent in objects or people; in fact, individuals attribute meanings to their unique encounters as they perceive them (House 1977). Blumer's (1969) theoretical argument is that patterns of human behaviour should be examined in terms of action, and that group activity should be examined in terms of what members do collectively. His perspective toward social phenomena focuses on the concept of independent action, which contends that human cultures are distinguished by each member's ability to act autonomously (Carter and Fuller 2015; House 1977). Symbolic interactionism does not address the conflict or disagreement among or between group interactions; therefore, I will offer critiques and qualifications later in this chapter that are relevant to "materializing" symbolic interactionism.

Symbolic interactionism will be used in this thesis to demonstrate how primary and secondary definers achieve control and mobilize power over others (e.g., laypersons, negatively racialized groups, vulnerable populations and oppositional definers) through dominant discourses and ideology about Canada's "opioid crisis." Definitions, representations, and symbols about narcotics and opioids are developed, maintained, and reproduced by social interactions between a potential deviant and agents of control (Becker 1963). Another justification for using symbolic interactionism in my thesis is that it enables a critical discussion about how oppositional definers understand the "opioid crisis" and their role or lack thereof in providing adequate solutions to curb opioid dependency and prevent overdoses. Oppositional definers, then, challenge and resist

the ideological control and social influence of primary and secondary definers through alternative discourses about opioid dependency and overdoses.

Labelling theory

Grounded in the social construction of reality, labelling theory was a driving force of the revolution in the sociology of deviance and social problems throughout the 1950s and 1960s (Manders 1975; Wellford 1975). The development of mainstream criminology following the post-war period, both in Britain and the US, considered criminal and deviant behaviour as explicit occurrences that could be readily identified and explained by individual psychology or genealogy (Manders 1975; Wellford 1975). The idea that crime was committed by people who suffered from psychological disorders or were a part of particular socio-cultural groups became widely recognized and accepted by western cultures (Wellford 1975). Critics of orthodox criminology not only challenged this perspective, but they also argued that the discipline reproduced authoritative definitions of deviance and was overly inclusive in its view of what caused deviant behaviour, assuming deviance has causes that are not a priori, socially constructed (Davis 1972; Manders 1975; Wellford 1975).

Labelling theory emerged out of symbolic interactionist thought and has thus “provided a theoretical model by which criminologists could reassert their interests in the study of the criminal justice system and those who operate within it, after decades of focusing on the characteristics of the offender” (Wellford 1975:332). The labelling perspective is usually viewed as an extension of Edwin Lermert’s (1951) distinction between primary and secondary deviance. Primary deviance refers to the episodic nature of norm-violation and secondary deviance is the symbolic reorganization of self and social roles that may result from the public’s response toward any violation of dominant norms (Lermert 1951). Labelling theorists examine how the

behaviour and self-identity of certain individuals may be influenced or shaped by the terms used to define or categorize them (Becker 1963). Howard Becker's (1963) work *Outsiders* explores this idea further and suggests that deviance is created by cultures. For Becker "social groups create deviance by making the rules whose infraction constitutes deviance, and by applying those rules to particular people and labelling them as outsiders" (1963:9). To put it another way, criminality is defined by the state, while deviance is a function of a wider dynamic involving the definitions of both primary and secondary definers.

Deviance is defined by authorities and moral regulators to control negatively racialized groups, the poor, women, youth, and the lay public through regulatory surveillance, discriminatory and harsh laws, discourses, and ideologies of normalization (Becker 1963). Crime is defined by authorities to subordinate and confine "evildoers" to spaces of denunciation (e.g., the courts) and exclusion (e.g., prison) (Becker 1963; see Garfinkel 1956). Deviance, therefore, does not represent a set of characteristics of individuals or groups; instead, it is an interactive process between deviants and non-deviants, and the context in which criminality is conceived (Becker 1963; Wellford 1975). In applying negative labels to people, categories of deviance become established to reinforce power, "race", class, and gender relations within capitalist social formations (Becker 1963; Manders 1975).

Concepts such as "stigma" and "self-fulfilling prophecy" are associated with labelling theory and are useful in explaining the outcome of negatively applied labels (Becker 1953; Merton 1938). Goffman (1959) explains that negative labels produce "spoiled identities" (e.g., those with physical impairments, drug "addicts", prostitutes, etc.) which make it difficult for people to negotiate their social environment. Once a person is labelled as a "criminal" or "deviant", for example, it is nearly impossible to remove that label. Undesirable social reactions (label or

stigma) to individual drug use, for example, facilitate even more, not less, drug-using behaviour because groups would presumably internalize their applied label and engage in deviant activities. Their identities, therefore, undergo a transformative process to complement the negatively applied label and its expectations (Merton 1938).

The rationale for using Becker's (1963) theoretical insight on deviance and labelling is that his explanations are relevant to how primary and secondary definers construct or modify the identities of opioid "users" in the news media. By drawing attention to the role of labeling in identifying social problems, individuals are able to see the importance of language in shaping how they define, understand, and respond to social problems. The perspective of labelling, however, does not address why some behaviours or conditions become identified as problems, and why particular social constructions are widely used throughout a given social formation. One of the ways in which the labelling perspective has been developed is through connecting social construction to issues of social interests, power, and ideologies. Through this view, social formations are characterized by patterns of inequality and class antagonisms between different social groups and classes. Primary and secondary definers use the process of labelling to impose their definitions of opioid dependency and overdoses on the general public. (Becker 1963; Merton 1938). Labelling theory, therefore, provides insight into how a social problem moves throughout its definite stages and how opioid-using populations navigate and negotiate their social worlds after being labelled an "opioid user" or "opioid addict."

Gramsci's Concept of Hegemony

Gramsci's (1971) concept of hegemony provides a reinterpretation of Marx's base/superstructure model (Stoodart 2007). Although Gramsci accepted Marx's analysis of the conflict and struggle between the ruling class (i.e., the bourgeoisie) and the subordinate working

class (i.e., proletariat), he was critical of Marx's deterministic and unitary model of ideology (Buckel and Fischer-Lescano 2009). Missing from Marx's analysis, according to Gramsci, was that the ruling class could not rule by coercive force alone (Burke 2005). The notion of "hegemony" is rooted in Gramsci's articulation of the relationship between coercion and consent (1992:137) to achieve ideological domination. Coercion refers to "the State's capacity for violence, which it can use against those who refuse to participate in capitalist relations of production" (Stoodart 2007:200-201). Consent (persuasion), on the other hand, embodies the non-violent inculcation of the general public into adhering to the interests of the ruling class and deferring to authority.

Persuasion is achieved through the media and the organization of social "structures" in ways that appear natural or ordinary (Stoodart 2007). Hegemonic power persuades individuals and social classes to subscribe to the dominant norms and values of an intrinsically repressive system. This form of social power relies heavily on the participation and voluntarism of the underclass, instead of enforcing punishment for disobedience, unless absolutely essential (Stoodart 2007). Gramsci argues that Marx's superstructure does not merely represent the economic base; instead, there is a significant degree of autonomy between the spheres (Stoodart 2007). Gramsci (1971) viewed the capitalist state as being comprised of two overlapping spheres: a "political society" (e.g., asserts power through force—police, military, government, etc.) and a "civil society" (e.g., asserts power through consent—schools, media, churches, trade unions, law, etc.). He predominantly focused on the role of civil society in establishing hegemony and reproducing the philosophy, sentiments, and values of the ruling class (Stoodart 2007). Through the use of corporate-owned media and ideological state apparatuses (e.g.,

churches, schools, the media, etc.), the public have been conditioned to accept the ruling class's ideas and cultural forms as "common sense" (Burke 2005).

In capitalist social formations, for example, a "common sense" view is that individuals who are unemployed are "lazy", "unproductive", and ultimately "deviant." An example of a contemporary hegemonic ideology, then, is the notion that diligence and hard work are rewarded with economic success; therefore, the wealthy are hard workers. This example and other similar hegemonic ideologies come together to produce a "common sense" worldview whereby inequalities are obfuscated. The division of labour, in fact, means that hard work does not necessarily guarantee financial rewards. As evidenced by many scholars and government documents, there has been a decline of wages coupled with longer work days since the inception of neoliberalism in the 1970s (Gordon 2006). The dominant worldview of labour encourages people to work so that the ruling class can alienate and exploit the productive power of the subordinate classes. Having workers consent to their rule and the illusion that hard work is equated with reward, elites reduce the costs and harms associated with controlling populations through physical force and violence (Burke 2005). This ideology also asserts that the oppressed must take personal responsibility for their inferior social positioning; therefore, individualizing inequality and diverting attention away from the dysfunctional and illogical nature of social relations brought forth by capitalism (Parenti 1996).

Gramsci's theoretical work informs my project as moral panics complement the concept of "hegemony." Though not coined by Italian theorist Antonio Gramsci but as used by him, the term explains how the state and ruling class (i.e., the bourgeoisie) maintain power through a balance of persuasion and force. In the Prison Notebooks Gramsci demonstrates that the state and ruling class use discourse to persuade with the force of ideas, but coercive force (e.g., police)

is a latent resource looming in the background. Unless used routinely on socially disfavoured individuals and groups to demonstrate that social order is being maintained for the “collective good”, the order maintaining function of ideology reveals the “true” coercive nature of the state (Kitossa personal communication 2018k). Hegemony, however, is never total as it is a process that undergoes constant negotiation and re-negotiation.

Political elites and the capitalist class generally have acquired substantial power and wealth due to ideology, historical inertia, and force. These social groups are considered extremely credible, influential, and knowledgeable; therefore, individuals often adhere to and internalize the ideologies of the capitalist elites (Best 1989). Marx, thus, noted that ‘the ruling ideas of any age are the ideas of the ruling class’. Consistent with the theory of hegemony, there are powerful systemic imperatives to create and maintain moral panics: an increase in the power and dominance of the ruling class, and an increase in the control and subordination of the working class (Cohen 1972; Smith 2014). Herman and Chomsky (1988) propose that social reality is constructed through media frames and framing generally. The mass media are effective and powerful ideological institutions that systematically perpetuate propaganda. This is achieved by its reliance of ideologues on market forces, internalized assumptions and self-censorship, without overt coercion (Herman and Chomsky 1988). The propaganda role of the media thus mobilizes biases, public fears and anxieties to ensure the maintenance of state-manufactured definitions about social problems and more specifically, the so-called opioid crisis (Herman and Chomsky 1988).

Materializing Symbolic Interactionism

Although symbolic interactionism is used to examine how humans interact with one another, the meanings people attribute to and acquire through symbols and social contexts, and the

processes of constructing/reconstructing and interpreting/reinterpreting social realities, interactionism received criticism in the 1970s for its neglect of class interests, power, and history (Manders 1975; Wellford 1975). Consistent with this view is Coser's (1976) argument that symbolic interactionism "prevents the understanding of social structures and their constraining characteristics or of patterns of human organization such as class hierarchies or power constellations" (p.157). Conflict theorists contend that symbolic interactionism does not acknowledge how difficult it is to change established social arrangements (Coser 1976).

For Manders (1975) symbolic interactionism promotes the most ideologically meaningful assumption of liberal sociology – pluralism. As I noted in the literature review, the pluralist perspective asserts that social formations are democratic in nature and do not represent or reinforce the political power of any economic class (Manders 1975). Manders further argues that symbolic interactionism reflects the current bourgeois ideology of capitalist social formations, rather than provide a critical examination of it (Manders 1975). Symbolic interactionism assumes that everyone has equal power and privilege to create and construct their own social realities; however, it is only a small group of powerful people who can construct, define, and impose a universally dominant worldview on others whereby it becomes internalized as "natural." Symbolic interactionism fails to address the raced, classed and gendered relations upheld by capitalist social relations of production and the inequalities that emerge out of unequal wealth and resource distribution (Manders 1975).

Relative to chapter 2's discussion about the role of the news media in shaping public opinion(s) about social problems and "materializing" symbolic interactionism, Edward S. Herman and Noam Chomsky (1988) use the propaganda model to demonstrate that economic variables such as capital and power enable control over the selective process and the sorting of

news. In bureaucratic and class-based social formations, economic and political elites use the print news media as a means for furthering their private interests as well as dramatizing and manipulating specific events to divert attention away from other matters (Herman and Chomsky 1988). The media acts as a system for conveying messages and symbols to the general public (Herman and Chomsky 1988). As the most influential form of information about the world, the media's purpose is to "amuse, entertain, inform, and to inculcate individuals with the values, beliefs and codes of behaviour that will integrate them into institutional structures of the larger society" (Herman and Chomsky 1988:1).

Herman and Chomsky (1988) propose that social reality is constructed through media frames and framing generally. As effective and powerful ideological institutions, the media actively creates content that appears to be "accurate" and "genuine" but is instead intentional manipulation to systematically promote and maintain a bourgeois worldview. This is achieved by its reliance of ideologues on market forces, internalized assumptions, and self-censorship, without overt coercion (Herman and Chomsky 1988). The propaganda role of the media thus mobilizes anxieties, biases, and public fears to ensure the maintenance of state-manufactured definitions about social problems and more specifically, the so-called opioid crisis (Herman and Chomsky 1988). Furthermore, the way in which news is structured creates an inherent conflict of interest that operates as propaganda for undemocratic authorities.

Instead of analyzing group dynamics and individual autonomy in creating unique social realities, "materializing" symbolic interactionism articulates the ways that social reality is shaped by the ruling class to achieve material ends. Materializing symbolic interactionism, moreover, moves beyond a pluralist and consensus view to reveal the latent interests of the ruling class in discovering social problems and constructing the so-called opioid crisis. This theoretical

framework demonstrates that “the ruling class uses property and academic credentials or qualifications that reflect either the qualities or attributes necessary for social ascent or the occupancy of elite roles” (Khalanyane 2010:227). Primary and secondary definers use such strategies of social closure to exclude the opposing narratives of and solutions to opioid mis/use and overuse that may threaten the “expertise” and knowledge of primary and secondary definers. “Materializing” symbolic interactionism, therefore, enables a critical examination of how primary, secondary, and oppositional definers represent opioid dependency and overdoses in Canadian corporate print media through competing claims. Finally, this theoretical perspective will show how social groups and classes use the media to mobilize their material interests in “discovering” and manufacturing the “opioid crisis” and social problems generally.

Chapter Summary

This chapter provided justification for the theoretical frameworks through which I will employ Critical Discourse Analysis. Through a Marxist perspective, I highlighted the importance of theories that examine the social construction of reality to expose how the discovery and construction of the “opioid crisis” is motivated by the material interests of primary and secondary definers at the expense of oppositional definers. I discussed how these theories contribute important insights and provide guiding principles for my research as well. I also discussed the concepts of “ideology” and “discourse” and how they inform this thesis. “Materializing” symbolic interactionism, moreover, is required to move beyond the inherent pluralism of symbolic interactionism and to analyze how power relations are implicated in discourses about the so-called opioid crisis. In the next chapter I will discuss the social construction of illicit and licit substances, as well as present a social history of prohibition and “addiction.” My aim in doing so is to explicitly mobilize an account of social problems and

claims-making related to the ways primary, secondary, and oppositional definers have been in both strategic alliance and contention over the use of intoxicants. This social history will also operationalize a materialist and symbolic account of the competing interests of the various definers. The ultimate objective of this social history is to prepare the ground for the determination of a composite model for social problems. The composite model articulates the ways that through media representation, primary, secondary, and oppositional definers mobilize discourse and resources in the construction of opioid mis/use and overuse as a crisis.

Chapter 4

Licit and Illicit drugs: A brief social history of ‘addiction’ and prohibition

In the previous chapter I explain how a Marxian perspective of conflict and social inequality, symbolic interactionism, labelling theory, Gramsci’s concept of hegemony, and “materializing” symbolic interactionism has informed my research and guided my understanding of *why* the recent upsurge in opioid dependency and overdoses has become identified as a social problem, and *who* benefits from the “discovery” of a social problem. Here I move to a discussion about the social history of narcotics prohibition in North America. I intend to illustrate that drug scares are often used as an instrument for the powerful to advance and/or maintain their superior positions in the social order. Power, therefore, is not only pertinent to decision making and resource allocation but to the social construction and proliferation of ideology and morality. The social construction of drug use is motivated by a particular bias, one that is informed by racist ideologies and monetary incentives instead of drug-using behaviour itself (Szasz 1974). This chapter is relevant to determining the viability of my composite model of social problems because I aim to explain that material and metaphysical interests are the driving force behind the “discovery” of a social problem, and that when groups with less social power are constructed as the main source of “social problems” or moral campaigns, solutions are often more punitive. The current construction of opioid users (e.g., *respectable*, white middle and working-class men), however, has influenced a different type of approach, one that is more compassionate and empathetic toward opioid mis/use and overuse.

The Social Construction of Drug Use

Drugs have played a critical and diverse role in almost every social formation since the beginning of documented history. They have played a vital role in both ancient and modern

medicine, in developing cures for diseases and in symptomatic relief from pain (Fehr 1988a). Drugs have been and continue to be used as important components of rituals and ceremonies, for religious and spiritual transcendence, enhancers of mood, to achieve insight and personal growth, lubricants to social interaction, and for recreation and pleasure (Fehr 1988a). This brief commentary on drugs is other than the therapeutic view which assumes that drugs are only to be used within a controlled and confined environment, often supervised by a physician, or an “expert” in medicine and its varied practices. Non-medical drug use, other than alcohol and tobacco, is intensively scrutinized and stigmatized by a range of primary and secondary definers: the mass media, political leaders, medical professionals, criminal justice personnel, law enforcement officials, and non-using populations (Blackwell and Erickson 1988; Miller 1996). This chapter, therefore, demonstrates that primary and secondary definers employ discursive strategies to construct meaning about illicit versus licit substances and “addiction.”

Illicit Substances

Illicit substances are forbidden by law and considered “illegal”; a criminal-justice approach is typically enforced for the sale, use, and distribution of illicit substances (Blackwell and Erickson 1988; Center for Addiction 2018; Goode and Ben-Yehuda 1994). Primary and secondary definers claim that illicit substances are highly dangerous, susceptible to misuse, and threaten the stability of a given social formation (Best 1989; Goode and Ben-Yehuda 1994; Miller 1996; Spector and Kitsuse 1987). Some illicit substances include marijuana, heroin, opium, cocaine, methamphetamine, ketamine, and lysergic acid diethylamide (LSD) (Blackwell and Erickson 1988; Center on Addiction 2018). Anecdotes about the horrors of drugs existing in the social order and drug users developing super-human strength and unique cognitive effects have been recycled across generations (Hart 2012). The media is awash with panic and distorted

images surrounding illicit drugs and drug use to reproduce hegemonic ideas about moral versus immoral behaviour and stereotypical drug users (e.g., negatively racialized groups) (Blackwell and Erickson 1998; Hart 2012; Miller 1996).

Historically, religious and medical authorities worked closely with government officials to establish the moral boundaries of a given social order. In modern-day capitalist social formations, however, governments and legislative committees manufacture and control the legal and political definitions of morality (Chambliss 1979). These definitions became legitimated through the implementation and enforcement of formal legislation regarding “appropriate”, law-abiding behaviour (Chambliss 1979; Hepburn 1977). Some laws are manifestly accepted and passed for the financial and/or status advancement of powerful individuals; others may develop as a result of “lobbying groups representing substantial portions of the populations; yet others, perhaps the majority, are no more than an expression of the views and interests of legislative committees” (Chambliss 1979:149).

Primary and secondary definers use specific discourses, narratives, and representations to maintain hegemonic definitions of illicit versus licit substances. Discourses surrounding psychotropic drugs or substances, for example, depend on the cultural and moral attitudes of authorities and who is engaged in drug-using behaviour. Hall (1993: 507) asserts that “messages have a ‘complex structure of dominance’ because at each stage they are ‘imprinted’ by institutional power-relations.” Hall’s (1993) concepts of “connotation” and “denotation” are useful here, as they explain how meanings about the world, behaviour, and people reflect the established ideologies of the corporate elite. Connotation and denotation are two principal elements of a sign, and the connotative meanings of a word co-exist with the denotative meanings (Hall 1993). According to Hall, the term “connotation”

is employed simply to refer to less fixed and therefore more conventionalized and changeable, associative meanings, which clearly vary from instance to instance and therefore must depend on the intervention of codes (1993:512).

“Denotation”, on the other hand:

is widely equated with the literal meaning of a sign: because this literal meaning is almost universally recognized, especially when visual discourse is being employed, ‘denotation’ has often been confused with a literal transcription of ‘reality’ in language—and thus with a ‘natural sign’, one produced without the intervention of a code (Hall 1993:512).

Primary and secondary definers employ connotative and denotative meanings to drugs to establish their role in the social order. With respect to the denotative meanings of drugs, the term has two meanings: 1) a medical, lawful, and positive (meliorative) meaning (e.g., a substance prescribed by healthcare providers or other “professionals” with a license to prescribe); and 2) a negative (pejorative), immoral, and unlawful meaning in which habitual use often leads to dependency and stigmatization (Peele 1989). Connotation represents the emotional and imaginative associations attached to a word (Hall 1993). There are many negative connotations associated with illicit drugs or substances. Illicit drugs or substances have come to connote criminality, deviance, evil, and moral failings. Illicit drug or substance user, moreover, denotes the demonic, immoral, and degenerate character of the person engaged in such behaviour (Szasz 1974).

The social location of various actors on the hierarchy of credibility and human meaning largely determine how some drugs or substances are identified as illicit, while others are not (Peele 1989). Definitions of illicit versus licit drugs or substances appeal to traditions of ethical, moral, and religious beliefs. There is often consensus and shared meaning among primary and secondary definers in creating definitions and perpetuating claims about illicit substances.

Primary and secondary definers, for example, define the meaning of drugs and the meaning of

the drug experience. These definitions, however, vary among different cultures and among subgroups within the same culture (Illich 1978; Szasz 1974). Governments and legislative committees define what kind of drug-using behaviour is appropriate and which is dangerous and unlawful. Primary definers (e.g., physicians, health minister, ministry of health, etc.) determine who takes drugs and why and what amounts of each drug are “safe” and socially acceptable.

Primary and secondary definers concoct erroneous claims and spread rumours about the “dangers” of drugs (e.g., drug fallacies), which end up in the press and become established as legitimate knowledge (Reinarman 1994). Drugs, however, are not considered “dangerous” unless they are used by specific users; therefore, primary and secondary definers link drugs to users already perceived as “dangerous”, “disreputable”, and “threatening” (e.g., African, Latino/X and Indigenous Canadians) (Levine and Reinarman 1997). Drug fallacies continue to circulate in the media as politicians attempt to be the “toughest” on drugs and request assistance from the general public in ratifying new laws to prohibit illicit drug use (Blackwell and Erickson 1988; Hart 2016). Cocaine providing African Canadians with superhuman strength, for example, is a common myth regarding illicit drug use. This myth has influenced law enforcement officials to increase the calibre size of weapons to protect themselves and the public against the “uncontrollable” conduct of “cocaine-using” African Canadians. Primary and secondary definers also claim that cocaine and other “harmful” drugs (e.g., heroin, methamphetamine, and marijuana) make African Canadian men rape white women (Reinarman 1994). These narratives and misconceptions, among many others, have formed and continue to form the basis for racist and problematic drug policies (Hart 2016).

Illogical claims about and representations of illicit narcotics and drug users are so widely distributed throughout North America and learned from a young age that the general public does

view the previously mentioned drug fallacies as constructed ideas; instead, they become normalized and interpreted as “common knowledge” (Hall 1993). Existing scientific literature (Blackwell and Erickson 1988; Hart et al. 2012; Whitaker 1969a), however, challenges the common-sense understanding(s) of “dangerous drugs” by examining the effects of cocaine, heroin, and other seemingly addictive drugs. Results have shown that consuming “one illicit drug does not necessarily lead to taking others, and the use of dependence-producing substances does not necessarily lead to dependence” (Blackwell and Erikson 1988:134). Carl Hart, a respected neuropsychopharmacologist, and his colleagues disrupt mainstream notions about drugs and drug use. Hart, Marvin, Silver, and Smith (2012) use empirical data to challenge the erroneous claims made by primary and secondary definers about the “causal relationship” between methamphetamine and unique cognitive disruptions. Hart et al. (2012) discovered that the chemical structures of amphetamine and methamphetamine are almost identical, except for the “metha” group on the methamphetamine structure. Results also demonstrate that amphetamine and methamphetamine produce identical effects on the human body; therefore, the unique cognitive effects produced by methamphetamine are not empirically supported (Hart et al. 2012). Even when scientific literature contests hegemonic discourses and ideas about cocaine and heroin, their negative connotations have become so normalized within the hierarchy of discourse and meaning, that any other perspective or meaning would seem anomalous (Hall 1993).

Primary and secondary definers work together to stigmatize “street-marketed” drugs and drug using populations through claims-making activities. Primary and secondary definers are not concerned with drawing public attention to a specific psychotropic drug, they are more concerned with identifying and stigmatizing the drug user through a process of ostracism and ritual destruction (Hall et al. 1978; Miller 1996). Drug using and selling populations are

constructed as “addicts”, “criminals”, “delinquents”, “deviants”, “rebels”, mentally insane and incompetent; and most importantly, drug using and selling populations are labelled as “social scum” (Miller 1996). Hart et al. (2012) are among many other scholars (Blackwell and Erickson 1988; Boyd et al. 2016; Miller 1996; Szasz 1974) who are interested in reevaluating how drugs are constructed and represented by political elites, criminal justice personnel, medical professionals, and the media. Hart et al. (2012) argued that 1.5 million people were arrested for drug-related offences in the USA; however, more than 80% are for simple possession. Decriminalizing drugs and exposing scientific literature which discredits traditional drug fallacies are some of the approaches that can be taken to address and usurp state-manufactured definitions of illicit drug use. The temperance movement, along with other prohibitions demonstrate how some narcotics and substances were once socially accepted and legal to use, only later to be criminalized. The social reality, meaning, and public reaction of narcotics and substances, therefore, have changed over time.

i. The Temperance Movement

Although some substances are considered “legal” in capitalist social formations today, they were not always viewed or considered legal. Alcohol, cocoa, coffee, and tea are primary examples of substances that are “licit” today, but were prohibited throughout the sixteenth to twentieth centuries (Hall 2010). The Temperance Movement was organized to encourage the moderate use and consumption of intoxicating liquors; however, Canada’s federal government introduced nationwide alcohol prohibition in 1918. This movement mainly developed in response to white middle and working-class women’s concerns about the uncontrolled drinking behaviour(s) of their menfolk and immigrant men (Gusfield 1963). The political and social campaign against alcohol claimed that the substance “was responsible for most of North

America's poverty, crime, violence, mental illness, moral degeneracy, 'broken' families and individual and business failure" (Levine and Reinerman 1997:26). These claims generated widespread panic around the "issue" of excessive alcohol consumption.

The Temperance Movement and other prohibitions were and are implemented as a method for "solving" social problems and instilling social order when it is seemingly lacking (Gusfield 1963). In regard to claims-making and moral panics, the Temperance Movement perceived alcohol as a dangerous substance that disturbed the moral fabric of the nation (Gusfield 1963). Primary (e.g., government officials) and secondary definers (e.g., temperance organizations: Women's Christian Temperance, Anti-Saloon Leagues, American Temperance Society, etc.) represented immigrant men and men in general as folk devils⁵ in the moral panic around alcohol (Levine 1978). Many Canadians came to believe "that alcohol was a demonic, destructive substance, and made it the scapegoat for many problems whose sources lay in larger political and economic forces and patterns" (Levine and Reinerman 1997:26; also see Gusfield 1963; Levine 1984). The Temperance Movement also entered the political arena of symbolic action in which "conflicts in the social order are institutionalized as political issues. Groups form around such issues, symbols are given specific meaning and opposing forces have come to test their power and bring about compromise and accommodation if possible" (Gusfield 1963:183).

Similar to the moral panic around alcohol and immigrant men during North America's temperance period, Canada's decision to prohibit opium during the twentieth century created

⁵ Stanley Cohen (1972) introduced the concept of a folk devil to describe an individual or group of people who are portrayed in the media or folklore as deviants and "social scum." They are often blamed for engaging in criminal behaviour and threatening the social order. Unlike some deviants, folk devils are entirely negative. They are the embodiment of evil and the adversary in a moral panic drama; in fact, it is not possible to construct moral panics without folk devils.

heightened fears and hysteria among the public about drug use, the Chinese, and other drug using populations.

ii. Canada's Opium Prohibition

Prior to 1908, Canada witnessed few restrictions in terms of the distribution and consumption practices of opium users, whether for medical or recreational purposes (Solomon and Green 1988). Canada participated in the annual importation of raw opium and large amounts of processed opiates. During this time, low-cost opium supplies were easily distributed by physicians, patent medicine companies, pharmacies, and Chinese opium shops (Solomon and Green 1988). If people developed a dependency on opium, it was generally viewed as an individual or personal trouble; stigma(s) surrounding opium did not exist at the time. There was graver concern about cigarette smoking and alcohol consumption, and how these substances negatively affected an individual's health and moral status. Canada's decision to prohibit opium was not influenced by the "addictive properties" of the drug; instead, Canada's decision to prohibit opium derived from the cultural and moral attitudes about opium smoking which were codes for anti-Chinese sentiments (Solomon and Green 1988; Szasz 1974).

Opiates became viewed as the embodiment of evil and the destroyer of Christian values, "thus exposing a man's natural tendency to depravity" (Solomon and Green 1988:88). Although similar moral and symbolic campaigns such as alcohol, tobacco, and other "bad habits" occurred, they had relatively little impact. The anti-opium crusade greatly influenced public opinion and the criminal law about substance use altogether because the focus was on the "alien" Chinese other (Solomon and Green 1988; Szasz 1974). The crusade was successful because it targeted Chinese opium smokers and Chinese opium factories, but it did not pose any threat to middle-class white persons who became reliant on the products developed by the pharmaceutical

industry (Blackwell and Erickson 1988; Solomon and Green 1988). After the first criminal drug law in 1908, the public began to fear drug use and users. The prohibition produced a thriving illicit trade, increased the costs of opium, and created a new category of criminals (Solomon and Green 1988). In Canada, primary and secondary definers identified drug users as non-Christian and non-white populations, who deserved the discriminatory, harsh, and punitive sanctions that were enforced during this time (Solomon and Green 1988). The strict Canadian prohibition laws of the early 1920s were created by government-funded drug agencies and enforced by police who associated themselves with “the moral reformers and anti-Asiatic forces in calling for stricter laws” (Solomon and Green 1988:89). Chinese opium smoking did not pose any harmful effects to the smoker or cause social degeneration; however, political leaders, medical professionals, priests, law enforcement officials, and other criminal justice personnel were strongly against whites smoking opium because it encouraged “racial mixing” (Solomon and Green 1988). “Racial mixing” was viewed as causing greater harm than the drug’s chemical properties.

During the middle of the nineteenth century, there was an intensified focus on human labour and productivity across North America (Gordon 2006; Szasz 1974). The emergence and prevalence of free-market economies, longer work hours, and welfare assistance created increased competition among and between social classes for resources, economic opportunities, and access to upward mobility (Gordon 2006). In regard to labour and capital advancement, colonialism, imperialism, slavery, and genocide prevented immigrants and Indigenous Canadians from competing with white Canadians (Solomon and Green 1988). As a result, African and Indigenous persons were burdened with labels such as “degenerate”, “feebleminded”, “inferior”,

and “lazy” (Szasz 1974). Prohibition against opium reflected the economic competition Chinese immigrants posed for white workers.

The Chinese were regarded as disciplined, hard-working, and industrious which was perceived by white American and Canadian working classes as a threat (Solomon and Green 1988; Szasz 1974). The Chinese also smoked opium, similar to how Americans and Canadians smoke tobacco. Many of the Chinese claimed that opium enhanced their ability to work. If smoking opium hindered the productivity of Chinese workers, white American and Canadian workers would have encouraged them to continue smoking, just like they had done with Indigenous persons and alcohol (Szasz 1974). Since opium did not affect the hard-working and industrious qualities of the Chinese, white American and Canadian workers attempted to exclude Chinese migrant workers from immigration in hopes of eliminating competition with them. They also attempted to deprive the Chinese of opium, which many of them were using to deal with the hardships of being a minority in predominantly white middle and working-class countries (Solomon and Green 1988; Szasz 1974). Simply put, racial discrimination prompted Canada’s initial drug regulation and prohibition, not the pharmacology of drugs.

The Opium Act and Narcotic Drug Act guided Canadian drug policy for the next 40 years (Solomon and Green 1988). Global drug prohibition and strict regulation through the *Single Convention on Narcotic Drugs* (1961) and the *Convention on Psychotropic Substances* (1971), which Canada signed, reinforced the constructed and manufactured division between illicit versus licit drugs and substances (Solomon and Green 1988). Throughout the 1960s and 1970s there was an upsurge in illicit drug use (e.g., cannabis, LSD, methamphetamine, etc.) across Canada, which was addressed with increased criminalization and the associated social costs. Despite the implementation of mandatory minimums for drug possession, high incarceration

rates, and the excessive pressure and “strain” on criminal justice personnel, there was seldom deterrent effects on cannabis use in Canada (Solomon and Green 1988). The failure to deter and ultimately inhibit illicit drug use created pressures for the liberalization of Canada’s drug laws. As a result, Canadian policymakers enacted *The Commission of Inquiry into the Non-Medical Use of Drugs* in 1969, which later became known as *The Le Dain Commission*, to address this concern (Solomon and Green 1988).

iii. *The Le Dain Commission*

The *Le Dain Commission* was named after its chairperson Gerald Le Dain, a well-known academic in the field of legal studies. Le Dain attempted to educate the Canadian public about illicit drugs and move toward a decriminalization approach. Commissioners, however, were undecided and did not achieve a unanimous decision regarding the non-medical use of drugs (Blackwell and Erickson 1988). Canadians have long argued that the punitive measures for marijuana possession and use exceeds the “severity” of the drug; therefore, in 1969 Pierre Trudeau’s Liberal government decided to review Canada’s current drug laws (Fehr 1988b). In June 1970, the Commission of Inquiry into the Non-Medical Use of Drugs developed a tentative document suggesting that all drugs become decriminalized (Blackwell and Erickson 1988; Fehr 1988b). The Order in Council, then, set out a list of terms of reference for the Commission. This list suggested that Canadian policymakers examine the social factors that have contributed to the use of non-medical drugs (e.g., education, socioeconomic status, ideology, etc.); collect numerical data and substantive information from medical authorities and researchers about stimulants, tranquillizers, hallucinogens, sedatives, and other psychotropic drugs or substances; describe and make public the scientific and medical knowledge about the effects of non-medical drugs and substances; and Canadian policymakers must decide whether the Canadian

government can rectify this issue on its own or if it needs assistance from other governments (The Le Dain Commission 1973). The Commission was interested in the examination of a wide range of psychotropic drugs; therefore, the Commission was not solely concerned with “soft drugs” such as marijuana and other hallucinogens, but with “harsh” drugs such as opiate narcotics as well (The Le Dain Commission 1973). Alcohol and tobacco, two of the most frequently and widely used substances by Canadians, were also analyzed.

The Commission (1973) acquired knowledge from physicians, psychiatrists, hospital reports of treatment services, and other useful documents to demonstrate Canada’s “issue” of the non-medical use of drugs. In claims-making research, these actors are recognized as credible and reliable sources because of their “expert” roles in the field of medicine. They also have privileged access to scientific data and information about the non-medical use of drugs and the consequences of non-medical drug use (Best 2017). The report highlights that youth were more engaged in the non-medical use of psychotropic drugs than any other age group; therefore, youth were considered the predominant folk devils in the case of the non-medical use of drugs in Canada during the 1960s (Le Dain Commission 1973). In the report’s section on “The Use of the Criminal Law Against Non-Medical Drug Use” the Commission claims that youth were viewed as violating Canada’s dominant norms and values which led to their ritualized moral destruction. Therefore, re-defining morality, specifying its role in shaping drug legislation, and restoring moral boundaries with respect to the non-medical use of psychotropic drugs was pivotal to the *Le Dain Commission* (Blackwell and Erickson 1988; Fehr 1988b).

Overall, the *Le Dain Commission* argued that because drug use is widespread in Canada, the government strategy should move toward drug education, not prohibition. In addition, the Commission stressed that although Canada has a legal responsibility to enforce the criminal law

to protect the interests of its citizens, “the law should not be used without regard for its own potential for harm to the individual or society” (Blackwell and Erickson 1988; Fehr 1988b). Unfortunately, the *Le Dain Commission*’s recommendations for reconsidering Canadian drug laws and conducting further research on cannabis use were rejected (Blackwell and Erickson 1988; Fehr 1988b). And while marijuana was legalized in 2018, federal, provincial, and municipal governments have largely ignored the bulk of recommendations to treat dependency as a medical matter than a criminal problem.

Licit Substances

Licit substances are by right of licence considered lawful and/or “within the law”; it is legal to purchase, distribute and use licit substances (Center on Addiction 2018). Some licit substances include alcohol, caffeine, tobacco, and prescription opioids, with the latter used according to a medical professional’s instruction (Goode and Ben-Yehuda 1994; Spector and Kitsuse 1987). These substances are generally legalized because corporations can maximize profit from products such as caffeine, liquor, tobacco, and prescription drugs. Caffeine, prescription drugs, and tobacco are often used on a regular basis and are perceived as stimulants for combating stress, hunger pains, and other unwelcomed conditions (Sherman 2017). Habitual use of alcohol, caffeine, and tobacco are often seen as signs of adulthood and maturity; they have come to determine and signify the competency of individuals in “handling” the stressors associated with everyday life (Szasz 1974).

Prohibitions aimed at alcohol, cocoa, drugs, and tea were unsustainable over long periods of time because they remove a meaningful source of tax revenue and increase government spending, which contradict corporate elite values (Gusfield 1963). Alcohol sales in Canada, for example, generated \$20.5 billion dollars between April 2013 and March 2014 (Government of

Canada 2015). This amount of revenue is more beneficial and useful to the material and metaphysical goals of elites than prohibiting the substance. A moral campaign is sometimes framed and presented to the public to seemingly represent and symbolize one meaning (e.g., uncontrolled drinking behaviour); meanwhile, the moral campaign has more than one function (e.g., increased law enforcement, stricter laws, strengthening social control apparatuses) (Gusfield 1963). Most importantly moral and political campaigns are racially motivated. Moral and political campaigns are manufactured by authorities to exclude negatively racialized populations through legal sanctioning (e.g., the Chinese Immigration Act/Chinese Exclusion Act of 1923, the Indian Act in 1867, segregation/Jim Crow laws in the late 1800s, etc.) (Gordon 2006; Solomon and Green 1988; Szasz 1974). With this information in mind, discriminatory and exclusionary “moral” and political campaigns are still employed against negatively racialized groups today (e.g., North America’s “drug war”) (Gordon 2006).

Additionally, prohibitions are designed by the state to intensify “the internal psychic repression that is part of industrial capitalism—the subordination of desires for recreation, drink, festivity, sex, and social celebration to employers’ demands for a sober, industrious, and disciplined workforce” (McNally 2002:122). To put it another way, in order for the interests of the capital class to be fulfilled, capitalists require a “healthy” and reliable workforce (Gordon 2006). Throughout the period of industrialization, therefore, indolence and insobriety became identified as “social problems” because these behaviours threatened to disrupt patterns of labour and the bourgeois norm of a sober and industrious worker (Gordon 2006). Equally important, scholars argue that British industrialists came to take a growing interest in the “health of the nation” toward the end of the nineteenth century. Such industrialists became concerned that poor health and malnutrition made the working class less strong and less competitive compared to

other industrializing nations (Gordon 2006). The emergence and evolution of moral and political campaigns (e.g., prohibitions) are thus the result of interests being threatened.

Claims-making activities are fundamental to the emergence and success of moral campaigns against “dangerous” drugs or substances. In the case of licit drugs or substances, however, primary and secondary definers engage in claims-making activities to promote the manufacture, distribution, sale, and use of caffeine, prescription opioids, tobacco, and tea. Over the past 30 years, the public have become reliant on prescription opioids for “curing” their illness(es), treating chronic pain, and relieving their anxieties and depression (King 2014; Sherman 2017; Smolina et al. 2016). Medical professionals with a license to prescribe and administer opioids have been both generous and lenient in their prescribing practices (Belzak and Halverson 2018). Licit substances are viewed as harmless, tolerable, and unthreatening if consumed/ingested/smoked in small amounts (e.g., alcohol, cigarettes, and opioids); however, there are many false assumptions associated with licit substances and their chemical structures (Blackwell and Erickson 1988; Miller 1996). These false assumptions are borne out of the claims-making activities of primary and secondary definers. Purdue Pharma and the Sackler family, for example, made claims about OxyContin that fabricated the “benefits” and “uniqueness” of the prescription opioid.

Arthur, Mortimer, and Raymond Sackler, all psychiatrists, purchased Purdue Pharma in 1952 (King 2014). The Sackler family exploited their economic and political resources as well as their membership within the academic, medical, and scientific communities to convince physicians that OxyContin was a benign drug with low-abuse potential. They used health monographs and medical journals to foreclose on the definition of OxyContin; in fact, Purdue Pharma relied on advertisements of OxyContin in medical journals to reshape the narrative

around opioids, downplay dependency concerns, and perpetuate the claim that OxyContin is a harmless substitute for Advil or Tylenol (King 2014). The pharmaceutical company also funded textbooks for medical students at the University of Toronto which falsified the “benefits and “effectiveness” of OxyContin, how and when the drug should be taken, and what the potential risks are if patients misuse or overuse OxyContin (King 2014). Purdue Pharma held conventions throughout Canada to “educate” physicians about the “exclusive” and “ground-breaking” features of OxyContin as well (King 2014). These conventions encouraged physicians to engage in more liberal prescribing of opioids and OxyContin in particular. Primary and secondary definers, therefore, use knowledge as a form of deception to further promote erroneous beliefs about drugs and drug use by discussing the “dangerousness” of “street-marketed” drugs and avoiding conversations about the detrimental and fatal effects of prescription drugs, until recently (Booth 2007; Mohamed and Fritsvold 2012).

In his documentary *American Drug War: The Last White Hope*, Kevin Booth (2007) addresses America’s drug scheduling system. Illicit and licit drugs are categorized and placed within a scheduling scheme to identify their medical use or properties and the potential for abuse and dependence (Booth 2007). “Schedule I Drugs” are described by the federal government as the most potent and dangerous drugs with no medical value. “Schedule V Drugs”, however, are labelled as the least dangerous of drugs and have medical value (Booth 2007). What is particularly interesting about schedule I drugs is they consist of drugs that the state and the pharmaceutical and medical authorities have failed to monopolize (e.g., cocaine, heroin, LSD, and marijuana). Government officials and medical authorities, therefore, are unable to control, regulate, tax, and maximize profit from these drugs. Schedule V drugs, on the other hand, include cough and epilepsy medicines, to name a few. State-owned pharmaceutical companies

are responsible for manufacturing and distributing these drugs to physicians. Pharmaceutical corporations and the state, therefore, profit considerably from the sale of these drugs because of their economic, legal, and political relationship (e.g., patent protection, the price of medications, regulation of clinical trials, the drug approval system, etc.) (Booth 2007).

The public has been taught that schedule I drugs are dangerous and highly addictive compared to schedule V drugs. This information is illogical, which leaves the public misinformed and uneducated about drug use altogether. In fact, Booth (2007) explains that the withdrawal symptoms for prescription drugs are worse than cocaine and heroin, and states that North America has experienced 100,000 deaths from the use of prescription drugs, while 10,000 deaths have been documented for cocaine and heroin use (Booth 2007). Although marijuana is portrayed as a gateway drug to other harmful substances and is perceived as influencing criminal and deviant behaviour(s), there has not been any reported deaths from marijuana consumption to date (Blackwell and Erickson 1988; Miller 1996).

Unsurprisingly the public places their trust in those positioned at the top of the hierarchy of credibility, especially those who practice and prescribe medicine (Best 1989; Goode and Ben-Yehuda 1987; Miller 1996). Physicians' white coats have come to symbolize altruism, authority, compassion, and extensive knowledge in a specific field of medicine; therefore, the public are unlikely to dismiss or challenge the advice instructed by their healthcare providers. The general public expects medical professionals to prescribe adequate dosages for a specific "illness", explain the side-effects of the drugs prescribed, and to provide protection from any potential harms or risks associated with their patients' prescriptions (Blackwell and Erickson 1988; Boyd et al. 2016; Miller 1996). Next, I move to demonstrate that Canada's latest drug scare emerged in

part from the Sackler family, Big Pharma, and physicians falsifying claims about the effectiveness and low-abuse potential of opioids and OxyContin in particular.

i. Opioids

Opium “first arrived in Europe during the Renaissance and by the sixteenth century alcoholic extracts of the drug were being prepared for use in the treatment of both mental and physical ailments” (Fehr 1988b:34). The human body has a panoply of endorphins that closely match the chemical structure of opium; opioids attach to opioid receptors in the brain. Normally these opioids are the endogenous variety that are created naturally in the human body (The National Drug Institute on Drug Abuse 2016). Once attached to receptors, opioids send signals to the brain, creating an “opioid effect” which inhibits pain, decelerates breathing, and has a general calming and anti-depressant effect (The National Alliance of Advocates for Buprenorphine 2008). After vigorous exercise, the “runner’s high” as it is sometimes called, is a common opioid effect. The human body, however, is unable to produce enough natural opioids to prevent severe and/or chronic pain, nor can it produce enough to initiate an overdose (The National Alliance of Advocates for Buprenorphine Treatment 2008). Opioids are a category of drugs that include the illicit drug heroin, synthetic opioids such as fentanyl, and pain relievers (e.g., oxycodone (OxyContin[®]), hydrocodone (Vicodin[®]), codeine, morphine, etc.) which are prescribed legally by a physician (National Institute on Drug Abuse 2016). Synthetic opioids are classed as highly potent, manufactured drugs (e.g., methadone, meperidine) that mimic naturally occurring opioids such as codeine and morphine (Fehr 1988b).

ii. The Opioid Crisis

The “opioid crisis” emerged as a widespread “social problem” in the early 1990s as physicians, psychiatrists, pharmacists, and advocacy organizations in North America claimed

there was a prescription opioid epidemic. This was also a time when Purdue Pharma, one of Canada's main pharmaceutical companies, received legal protection for a new pain killer, OxyContin (Borwein et al. 2013). Purdue's representative claimed that OxyContin significantly improves the efficiency and quality of pain management without many side effects (Borwein et al. 2013; The Canadian Bar Association 2018). OxyContin was viewed as revolutionary because it had a controlled time-release oxycodone feature. This feature meant that the medication would be released in the body over a ten-hour period compared to other painkillers which only have a four-hour dosage cycle (Borwein, et al. 2013; The Canadian Bar Association 2018). Purdue Pharma claimed that a reduced daily intake of OxyContin would make it more effective and prevent patients from experiencing the addictive high typically associated with other painkillers. In 1996 Health Canada approved OxyContin and allowed Purdue Pharma to advertise and sell the painkiller on the opioid market (The Canadian Bar Association 2018).

Researchers, however, discovered that when OxyContin is “crushed or chewed and inhaled, injected, or swallowed, the oxycodone is released and absorbed rapidly, producing a heroin-like euphoria” (Borwein, et al. 2013:1686). This evidence was shocking to medical authorities across the Atlantic provinces as well as parts of the United States. After much consideration, the Canadian government decided to prohibit OxyContin and referred to oxycodone as a “street drug” (Borwein, et al. 2013). The media used political propaganda to display powerful images of opioids and emphasized their fatal effects, especially for respectable, (white) working and middle-class people (Borwein, et al. 2013; King 2014).

On a global scale Canada is the second-highest consumer of prescription opioids, after the United States (Government of Canada 2017; Ubelacker 2016). In April 2019 the Public Health Agency of Canada (PHAC), on behalf of the federal, provincial, and territorial *Special Advisory*

Committee on the Epidemic Opioid Overdoses, released data on apparent opioid-related deaths in Canada. These statistics have been provided by government organizations and medical researchers to describe the increase in opioid-related fatalities across Canada and the magnitude of the “crisis.” The “National Report: Apparent Opioid-Related Deaths” shows that more than 11, 500 Canadians died between January 2016 and December 2018 as a result of opioid-related overdoses (Government of Canada 2019). According to the report, 3,017 opioid-related deaths occurred in 2016 and in 2017 there was a total of 4,034 opioid-related deaths (Government of Canada 2019). The “National Report: Apparent Opioid-Related Deaths” also demonstrates that 4,460 deaths occurred across Canada in 2018, meaning that “1 life was lost every 2 hours related to opioids” (Government of Canada 2019:1).

iii. Fentanyl

Addressing opioid mis/use and overuse has become a priority in Canada. Driven by both illicit and licit prescription opioids, Canada’s “opioid crisis” has created widespread concern, fear, and hysteria among the public (King 2014; Sherman 2017). Although every region of Canada seems to be impacted by opioid mis/use and overuse, there are some jurisdictions that have been impacted more than others (Belzak and Halverson 2018). The western provinces such as British Columbia and Alberta as well as the Yukon and Northwest Territories have experienced a heavy increase in opioid-related deaths and hospitalizations since 2016 (Belzak and Halverson 2018; Government of Canada 2018c). In 2016 Canada encountered 2,861 apparent opioid-related deaths and the amount of opioid-related deaths surpassed 4,000 in 2017 (Belzak and Halverson 2018; Government of Canada 2018c). On average, eight people die from opioid mis/use and overuse each day in Canada, and according to The Public Health Agency of

Canada (PHAC) (2017), three-quarters of opioid-related deaths occurred among white males, with the highest proportion (28%) clustered among Canadians aged 30 to 39.

With the “opioid crisis” at the forefront of media coverage and government and public health officials’ agendas, drugs such as alcohol and tobacco get overshadowed. Interestingly, the opioid statistics provided above do not surpass the death toll from alcohol and tobacco. Between 2015 and 2016, there were approximately 77,000 hospitalizations directly caused by alcohol in Canada, with an average of 217 hospitalizations per day (Government of Canada 2016). For opioid poisoning in 2017, there was an average of 17 hospitalizations each day, with a total of 6,025 hospitalizations annually (Government of Canada 2017). In 2016 there was an average of 16 hospitalizations each day for opioid poisoning, with a total of 5,840 hospitalizations annually (Government of Canada 2018b). The statistics for opioid poisoning are substantially lower than the statistics for alcohol poisoning, yet Canada’s governments are more concerned with opioid mis/use and overuse than alcohol-related poisoning and deaths. In 2008 impaired driving was the leading cause of criminal homicide in Canada, and in 2002 there was a total of 4,258 alcohol-related deaths (Government of Canada 2016)⁶. Even more striking, 100 Canadians die each day from smoking-related illnesses compared to the eight Canadians who die each day from opioid mis/use and overuse (Government of Canada 2015). In 2002, for example, there was a total of 831 deaths related to second-hand smoke. These statistics reinforce the idea that state-oriented definitions and discourses, as well as excessive media exposure surrounding “opioid crisis”, have created panic among the public about opioid use and misuse.

⁶ On a global scale, alcohol-related deaths account for three million people annually (The World Health Organization 2018).

On a national scale opioid-related harms and deaths have increased since 1999 (Belzak and Halverson 2018). Based on approximations in 2007, synthetic opioids are “the fourth most prevalent form of substance use (after alcohol, tobacco, and cannabis), making it more likely to misuse a prescription opioid than to use heroin or cocaine” (Belzak and Halverson 2018:225). There were more than 8,000 opioid-related deaths across Canada between January 2016 and 2018 (Government of Canada 2018d). In 2016 there were 3,005 fatal opioid overdoses across Canada and in 2017, the total number of deaths increased to 3,996 Canadians (Government of Canada September 2018d). In the first quarter of 2018, approximately 1,036 opioid-related deaths took place across Canada, with 94% of them being accidental (Government of Canada 2018d). Empirical evidence demonstrates, however, that the province of British Columbia (BC) is the epicentre of the opioid deaths. With a population of approximately four million, British Columbia is one of few North American jurisdictions with extensive knowledge about population-level opioid distribution and has verifiable evidence of opioid-related deaths and injuries over the past decade (British Columbia Coroners Service 2013, 2018; Smolina, Gladstone, and Morgan 2016).

In August 2018, the B.C. Coroner’s Office estimated 106 illicit drug overdose deaths containing fentanyl (BC Coroners Service 2018). Fentanyl or its analogues were discovered in an estimated 84% of illicit drug overdose deaths in 2018 and 84% of illicit drug overdose deaths in 2017 (BC Coroners Service 2018). British Columbia’s Coroner’s Office (2013) also released empirical data, suggesting that 61% of deaths were accidental overdoses and 33.6% were suicide deaths. Opioid-related overdose deaths occurred among 51.1% of males and 48.9% among females (British Columbia Coroners Service 2013). The age range of decedents were between 40 and 59 years of age and accounted for 58.4% of opioid-related overdose deaths (British

Columbia Coroners Service 2013). The Interior region appears to have the highest rate of prescription opiate-related overdose deaths for 2005-2010, with 2.8 deaths per 100,000. The death rate was 1.9 for both the Island and Northern regions, and 1.3 for both the Fraser and Metro regions (British Columbia Coroners Service 2013:1). Although empirical evidence has shown the harsh realities of opioid mis/use and overuse, it is relatively limited in many provinces throughout Canada, including Ontario. The public does not have access to readily available data of opioid-related deaths in many jurisdictions throughout Canada.

Nationally there has been an intensified focus on fentanyl and fentanyl detection in other illicit substances (e.g., cocaine and heroin). Over the past five years, fentanyl-related deaths continue to dominate other opioid-related deaths. Fentanyl is a powerful synthetic opioid painkiller that is similar to morphine but is 50 to 100 times more potent (The National Drug Institute on Drug Abuse 2016). Fentanyl is classified as a Schedule II drug, which means that there is heightened potential for abuse. An individual may develop severe physical and psychological dependencies on the drug if it is orally consumed, inhaled, ingested, or makes contact with an individual's skin on a regular basis (The National Drug Institute on Drug Abuse 2016). Fentanyl is used to treat patients with severe pain or to manage pain after surgery; it is sometimes used to treat patients with chronic pain who are physically and psychologically tolerant of other opioids (Schwaner 2009). When fentanyl is used for medical purposes it is usually administered by a physician through an "intravenous (IV), intramuscular (IM), or a skin patch (transdermally)" (Ohio Nurses Association 2016).

Illicit fentanyl is often created by combining cocaine or heroin to the synthetic compound. According to statistics provided by the Government of Canada and Health Canada (2018b), 53 percent of all opioid-related deaths in 2016 were caused by the illicit use of fentanyl and in 2017,

75 percent of all opioid-related deaths were caused by the illicit and medicinal use of fentanyl. The majority of accidental opioid-related deaths in the first quarter of 2018 (i.e., 1,036) were caused by fentanyl or fentanyl analogues (Government of Canada 2018b). More specifically nearly three-quarters of accidental deaths involved illegally manufactured fentanyl or fentanyl analogues, which is a slight increase from 2017 (Government of Canada 2018b).

People's fascination with illicit fentanyl can be traced to Canada's removal of OxyContin in 2012. Oxycodone dependents, for example, sought an alternative painkiller with similar potent effects. Fentanyl also drew the attention of heroin users during this time as it contains heroin-like properties. There are many other possibilities for why people misuse or overuse fentanyl analogues, synthetic fentanyl, and opioids generally: lenient and overprescribing; physicians' failure to provide adequate education and warnings about the possible consequences of misusing and overusing opioids; physicians' greed and Big Pharma's profit-driven agenda; the physical aches and pains of workers attempting to meet the demands associated with hard and extensive labour; and the curiosity of combining illicit substances with synthetic opioids (Belzak and Halverson 2018; Fischer, Vojtilla, and Rehm 2018; Sherman 2017).

The purpose of the following section is to analyze "addiction" as a culturally situated concept, rather than a "disease" (Room 2003). In order to explain how "addiction" is socially constructed through discourse and meaning, I begin the following section with Stanton Peele's (1987) first, second, and third generation diseases to discuss the hegemonic definition of "addiction" versus dependency.

Addiction versus Drug Dependency

Peele outlines three generations of diseases to distinguish between “addiction” and other diseases: physical ailments (i.e., first generation diseases), mental disorders (i.e., second generation diseases), and addictions (i.e., third generation diseases) (1987:5).

i. First Generation Diseases

First generation diseases are a category of disorders that have measurable physiological characteristics and effects such as malaria, cancer and HIV/AIDS (Peele 1989). First generation diseases “are clearly connected to the functioning of the body and...with the damage the disease does to the body” (Peele 1989:5).

ii. Second Generation Diseases

Second-generation diseases refer to “mental illnesses” which are now identified as emotional disorders (Peele 1989). Emotional disorders are apparent to us not because of what we measure in people’s bodies but because of the feelings, thoughts, and behaviours that they produce in people, which we can only know from what the sufferers say and do (Peele 1989:5). Second-generation diseases are incurable, they are manageable through a regimen of chemical treatment that mimic endocrine chemicals and other bodily hormones (Kitossa Personal Communication 2015). Primary definers, moreover, use the *Diagnostic and Statistical Manual of Mental Disorders* (DSM) to diagnose “mental illnesses” or “emotional disorders.”

iii. Third Generation Diseases

Third-generation diseases or “addictions” are characterized by “craving or compulsion: the idea that there is something in the mind of the user that compels use, overriding apprehensions of the adverse consequences, the self-control of the user, and often even the user’s will” (Room 2003: 228). Medical “experts” claim that “addiction” is “progressive and irreversible, so that the

addiction inevitably worsens unless the person seeks medical treatment or joins an AA-type support group” (Peele 1989:5). The term “addiction” derived from the habitual drinking activities of certain groups (e.g., immigrant men and menfolk) in Jacksonian, United States (Room 2003). Beginning in the 1950s, the American and Canadian judicial “systems” accepted the psychiatric definition of chemical dependency as a disease. As a result of this definition, courts began to either institutionalize (e.g., mental facilities) “addicts” for treatment or refer them to programs such as Alcoholics Anonymous (i.e., AA).

Peele (1987) contests the above definition of “addiction.” He argues that there is nothing inherent in one’s biology that makes them “addicted” to a particular activity, food, or substance. In fact, there is “no medical treatment that will ever be created to excise addiction from people’s lives, and support groups that convince people that they are helpless and will forever be incapable of controlling an activity are better examples of self-fulfilling prophecies than of therapy” (Peele 1989:4). The term “addiction” does not have a universal definition; however, it is often described by medical professionals and political figures as a prevailing issue in modern-day capitalist social formations (Hart 2016; Room 2003). For Szasz (1974), “addiction” refers not to an individual suffering from an illness or disease but of a detested kind of deviance. The public often imagines an “addict” to be a patient in a hospital gown; however, Szasz (1974) asserts that an “addict” is a stigmatized identity which is usually applied to a person against their personal choice. Dependence, on the other hand, refers to the physical and psychological dependence on a drug or substance which impairs psycho-social functioning. Dependence represents the symptoms of tolerance and withdrawal, that is, an individual experiences physical and psychological discomforts (e.g., diarrhea, vomiting, headaches, etc.) when the use of a drug

is ceased abruptly or an individual is slowly weaning themselves off a particular drug (Room 2003).

In short, the public has been misinformed about “addiction.” Addiction and medical “experts” claim that if a person consumes an illicit or licit substance regularly, whether it be alcohol, drugs, or food, they are engaging in addictive behaviour (Hart 2012). Someone who is *required* to orally consume a pharmaceutical drug on a regular basis for their cardiovascular health, however, is not perceived as an “addict.” After the first year of the Narcotic Control Act of 1961, “the Department of National Health and Welfare in Ottawa estimated that the total number of addicts in Canada was 3,576. In 1967 the estimate was 3,715” (Blackwell and Erickson 1988:37). By contrast, in 1924 there were an estimated 9,000 addicts out of a total population of 9,200,000 (Blackwell and Erickson 1988:37). According to these estimates and the publishing year of Blackwell and Erickson’s (1988) work, addiction decreased entirely. Drug “addiction” seems to be concentrated in one province or territory during a specific point in time (Blackwell and Erickson 1988). In the early 1930s, for example, Montreal was considered a focal point for addiction. As of the late 1930s, however, Toronto became the center of attention for addiction and drug dependency (Blackwell and Erickson 1988). Recent research indicates that approximately 80-90% of people who consume, inject, or smoke heroin do not develop a dependency on the drug; in fact, the scientific community has known for 40 years that only 15-20% of people become dependent on cocaine or heroin (Hart 2012). This statistic is similar to the 10-15% of people who become dependent on alcohol (Hart 2016). Hart (2016) thus defines “addictive behaviour” as the inability of a person to complete daily tasks such as grocery shopping, eating, working, or going to school due to the illicit or licit substance(s) consumed.

Chapter Summary

Through the use of discourse, political propaganda, distorted images, and symbolisms, chapter three illustrates how illicit versus licit substances are socially constructed by primary and secondary definers to reinforce what constitutes moral righteousness versus moral indignation in capitalist social formations (Best 1989, 2016; Blackwell and Erickson 1988; Gusfield 1966; Miller 1996). This chapter also outlines the social history of prohibition (e.g., “dangerous” drugs alcohol, and opium) to show that moral campaigns are borne out of racist ideologies and the material interests of the white ruling and working classes. Finally, I discussed first, second, and third-generation diseases to demonstrate that “addiction” is a culturally situated concept/socially constructed term. In the next chapter I undertake a Critical Discourse Analysis to explore the viability of a composite model of social problems with Canada’s current “opioid crisis” as the case study. The composite model includes stages from both Joel Best’s (2017) and Herbert Blumer’s (1971) social problems models to analyze how primary, secondary, and oppositional definers engage in claims-making activities over the “opioid crisis” in the *Toronto Star* and the *Globe and Mail*. I also demonstrate that primary, secondary, and oppositional definers are locked in a struggle of “closure” and “usurpation” over the meaning of opioid dependency and overdoses across Canada. The four-stage model is as follows: the claims-making process and the emergence of social problems, legitimation of social problems, policymaking and the formation of an official plan of action, and the implementation of an official plan.

Chapter 5

The press, prohibition and making-up the opioid crisis: A Canadian survey

The present chapter examines (18) news articles from the *Toronto Star* and (18) news articles from the *Globe and Mail*—between October 1st, 2008 and October 1st, 2018—to determine the viability of my composite model of social problems using Canada’s current “opioid crisis” as a case study. My composite model borrows specific and viable stages from Joel Best’s (2017) and Herbert Blumer’s (1971) social problems models to explain how primary, secondary, and oppositional definers construct competing claims over the dramatic rise in opioid dependency and overdoses across Canada. These four stages include: 1) the claims-making process and the emergence of social problems, 2) legitimation of social problems, 3) policymaking and the formation of an official plan of action, and 4) the implementation of an official plan. Using symbolic interactionism, labelling theory, and a Marxian perspective on conflict and inequality I operationalize processes of representation at each stage of my composite model of social problems as these occur in journalists’ representations of the various definers. Since the composite model seeks to make sense of “text and talk” in the making and experience of reality, this chapter employs critical discourse analysis (CDA) to analyze how primary, secondary, and oppositional definers engage in exclusionary and usurpatory closure while in the process of mobilizing and resisting discourses, narratives, and constructions of folk devils as these relate to meanings of a perceived opioid crisis in Canada.

In times of public health issues and social problems generally, Canadians often turn to the media to educate themselves about the problem, the level of impact it has on their communities, and the policies or solutions implemented by governments to ameliorate the problem (Best 2017). Toward the end of 2017, Canada’s “opioid problem” had achieved extraordinary visibility

throughout the print news media. The tables I produced in chapter 1 and reproduce below indicate that news media coverage of Canada’s current so-called opioid crisis has increased considerably since October 1st, 2008. The ways in which the print news media constructs opioid dependency and overdoses in Canada is significant because for many individuals, the media is their only source of information concerning this “social problem.” As mentioned in chapter 2, the media plays a key role in shaping public consciousness about what social problems are considered important which I intend to show below.

The Changes and Transition in Reporting of the “Opioid Crisis” in Canadian Corporate Print Media Between October 1st, 2008-October 1st, 2018

Table 1.

The Toronto Star		
	"Opioid Crisis"	"Opioid Overdose"
2008-2012	1	6
2012-2015	0	14
2015-2018	65	49

Table 2.

The Globe and Mail		
	"Opioid Crisis"	"Opioid Overdose"
2008-2012	4	12
2012-2015	2	24
2015-2018	256	300

An Application of the Composite Model of Social Problems to the Issue of Opioid Dependency and Overdoses across Canada

This section is driven by my research question: as represented in the *Toronto Star* and the *Globe and Mail*, how are the claims of primary, secondary, and oppositional definers consistent with each stage of my composite model of social problems? I anticipate that opioids have

become an instrument of moral panic that allows the state and other primary and secondary definers to demonstrate compassion on one hand for particular citizen-subjects who “matter” (e.g., white middle and working-class persons) and simultaneously exercise repressive control over social constituents who are constructed as “dangerous” and “threatening”, and thereby do not “matter” (e.g., negatively racialized groups, the uneducated, the unemployed and poor, women, etc.). This is not to say that oppositional definers are not themselves above seeking to construct opioid use and misuse in terms of a panic, especially if it enables them to usurp the definitional dominance of the status quo of primary and secondary definers. In order to examine the emergence, career, and fate of the “opioid crisis” as a social problem in Canada, my composite model of social problems illustrates the evolving struggle between primary, secondary, and oppositional definers over the definition of opioid dependency and overdoses as it moves through the four stages. Should the reader wish to be refreshed on Best’s and Blumer’s social problems models from which I borrowed and modified for my own composite model, please refer to chapter 2. I now return to these modified stages in consideration of the data.

i. The Claims-making Process and the Emergence of Social Problems

The first stage of my composite model of social problems follows Best’s and Blumer’s description of how a social problem comes into being. Best describes this stage as “claims-makers making claims; that is, they argue that a particular troubling condition ought to be recognized as a social problem, and that someone ought to do something about that problem” (2017:18). Best also states that “claims are social products; they do not exist independently of people. People assemble—construct—claims in hopes of persuading others” (2017:61). Blumer asserts that “social problems are not the result of an intrinsic malfunctioning of a society but are the result of a process of definition in which a given condition is picked out and identified as a

social problem” (1971:301). In any case, this first stage explains how primary, secondary, and oppositional definers are reported in the press as understanding and labelling the “issue” of opioid mis/use and overuse.

Throughout the articles I examined in the *Toronto Star* and the *Globe and Mail*, each definer participates in claims-making activities to convince and persuade government officials, legislative committees, and the general public that the sudden increase in opioid dependency and overdoses has become a major problem across Canada. Although the various definers share a similar view regarding the overall magnitude and scope of the “crisis”, their perspectives vary in terms of how each definer identifies the “crisis”, pop-up/safe-injection/overdose-prevention sites, treatment options, and adequate solutions to ameliorate the “opioid problem.” This stage focuses on the claims-making function and definitional processes of social problems; therefore, the definers’ varying perspectives in terms of pop-up/safe-injection/overdose-prevention sites, treatment options, and adequate solutions to ameliorate the “opioid problem” will be addressed throughout the different stages. It is worth mentioning that primary, secondary, and oppositional definers did not engage in conflict or debate over whether opioid mis/use and overuse is in fact a “crisis” across the country because of a priori agreement. It can be inferred that since white working- and middle-class persons, especially men, are the demographic predominantly dying from opioid-related overdoses, compassion and empathy were essential to the solutions or strategies aimed at curbing dependency and preventing overdoses from the beginning of the “crisis.” Hence the empathetic discourse of “death by despair” (see Case and Deaton 2015) which undergirds the public health approach to opioid-induced deaths and overdoses. Despite conflict, which is often a key component of the social problems process, there are times when

consent about a definition of a social problem is not in dispute as is the case with Canada's "opioid crisis."

Throughout the sample of Canadian newspapers, primary definers (e.g., former and current Health Ministers, provincial premiers, representatives from the College of Physicians, and Surgeons of Ontario and other medical authorities) identify the inappropriate use, overuse, and diversion of prescription opioids and controlled substances as a "public health crisis." For example, in an article published by the *Globe and Mail* Dr. Jane Philpott, Canada's 2016 Federal Health Minister, is reported as saying that the increase in opioid mis/use and fatal overdoses "...is a national public health crisis. It is an emergency. It's absolutely essential that we put all tools on the table to address it" (Howlette 2016:A9). Dr. Eric Hoskins, Ontario's former Health Minister, is reported as maintaining a similar discourse. He states that "...measures are desperately needed to tackle a public health crisis that is claiming more and more lives each month. We're dealing with a grave situation" (Benzie 2017:A1). As seen in the claims-making activities of Philpott and Hoskins, terms such as "crisis" and "emergency" convey to the public a sense of direness and urgency in dealing with the problem before it becomes uncontrollable and spirals out of control.

In the newspaper articles under study, primary definers are reported as claiming that physicians' liberal and inappropriate prescribing practices of opioids—and OxyContin in particular—have played a key role in the genesis of the crisis and the crisis's continued existence. Canada's "opioid crisis" would not be considered a "drug scare" unless a specific group (i.e., folk devils) is participating in some form of "evil" or "sinful" behaviour (Cohen et al. 1972). Although a specific population is typically perceived as "threatening" in the moral panics process, in this case, it is white middle and working-class persons who are the object of concern.

Here we do not see white middle and working-class persons being stigmatized and criminalized like their negatively racialized counterparts who are often the targets of moral and political campaigns (see chapter 3). In the articles under examination, the news media, along with primary definers, construct physicians and pharmacists as the main folk devils in the moral crusade against prescription and illicit opioids.

In the *Toronto Sun* and the *Globe and Mail*, primary definers such as representatives from the College of Surgeons and Physicians of Ontario (CPSO) and Canada's 2014 Federal Health Minister, Rona Ambrose, use the press to reconstruct the image of physicians and pharmacists as folk devils by moving that status onto the abstraction of the "training process" (Hall 2010; Weeks 2014). The *Globe and Mail* draws on an interview with the Chair of the working group, Dr. Stephen Wetmore, to relay his view of the inadequacy of training for physicians in medical school regarding pain management and "addiction." Dr. Wetmore is reported as arguing "pain management training in its present format in undergraduate education, particularly for physicians is insufficient. Physicians receive less pain management training than virtually any other healthcare provider" (Hall 2010:A6). Wetmore contends that this lack of medical training leads to inappropriate and lenient narcotics prescribing among physicians, with some prescribing too many, and others too few, to their patients. In an article published by the *Globe and Mail*, the College of Physicians and Surgeons of Alberta reveal that "in Alberta, more than 3,000 doctors prescribe more than the equivalent of 200 milligrams of morphine a day, which is four times the dose recently recommended by the Centre for Disease Control and Prevention in the United States" (Howlett 2016:A9). This information, moreover, maintains the construction of physicians as folk devils as well.

Physicians have also acknowledged the role overprescribing has played in fueling the “opioid crisis.” Dr. Irfan Dhalla, for example, is a medical researcher at St. Michael’s hospital in Toronto. He is reported as claiming that “governments around the world should better control the availability of painkillers because of the rising number of deaths and ignorance among physicians who prescribe them” (Boyle 2011:GT4). Dr. Dhalla contests the hegemonic idea that prescription opioids are highly effective and have long-term benefits for relieving acute and chronic non-cancer pain. He is reported as arguing that “so many physicians out there believe opioids are very effective for chronic, non-cancer pain when in fact the evidence doesn’t support that assertion and many physicians believe that the risk of addictive and overdose death is very low, and again, the evidence doesn’t support that position” (Boyle 2011:GT4). Not only does this secondary definer draw attention to the prescribing practices of physicians, Dr. Dhalla is also reported as arguing that empirical evidence does not support the many claims made by medical regulatory bodies, physicians, and other medical “experts” regarding the benefits and effectiveness of opioids over a long period of time.

As mentioned in chapter 2, the media must occasionally present news stories that expose the immoral and corrupt behaviour(s) of a politician or respectable figure, for example, to maintain their credibility, “neutrality”, and “dedication” to collective public interests (Hall et al. 1978). Journalists of a *Toronto Star* article comply with the professional practices of the news media by publishing a story with the headline “Drug Dealing Pharmacists Feed Opioid Crisis” (Chown, Cribb, Jarvis, Lecce, and Bailey 2018:A1). The story covers Waseem Shaheen, an Ottawa pharmacist who staged a robbery of 5,000 fentanyl patches to cover up an illicit drug-dealing operation of opioids in Ontario. Throughout the article journalists from the *Star*, along with other media personnel, compiled and analyzed disciplinary records from the Ontario College of

Pharmacists between 2013 and 2017. The investigation found that 241 Ontario pharmacists "...put massive amounts of deadly opioids onto the street; defrauded the provincial drug benefit plan for millions of dollars; sexually harassed and assaulted their patients and employees; and committed fatal dispensing errors" (Marco et al. 2018:A1) This narrative exposes the fraudulent behaviour and inappropriate dispensing practices of several healthcare providers registered with the Ontario College of Pharmacists. As well, this narrative supports the initial framing of physicians and pharmacists as the "folk devils" in the moral panic around opioids, but the focus is on individual "errant" and "corrupt" health practitioners.

The media is not removed from the process of social closure. Through news values, the media plays a part in their own understanding of how Canada's so-called opioid crisis should be represented to the public. The professional misconduct of physicians and pharmacists in fueling Canada's "opioid crisis" is newsworthy, because it involves elite persons (e.g., physicians and pharmacists) and this behaviour is typically "unexpected" from healthcare providers given their "altruistic" and "reputable" status in the social order. The events that transpired between pharmacists, their patients, and communities (e.g., defrauded the provincial drug benefit plan for millions of dollars) are considered "abnormal" and "unconventional" healthcare practices, therefore, categorizing such stories as "newsworthy" (see chapter 2). What is particularly interesting about the above discourses and narratives is that a professional class (e.g., healthcare providers—physicians and pharmacists) is constructed as inflicting harm and jeopardizing the well-being of their patients and the general populous. Such a discursive framing constructs Canada's "opioid problem" as a unique drug "crisis."

Dr. Dhalla attempts to correct the image of physicians by displacing some of the blame onto pharmaceutical companies for their misbranding of opioids, specifically Purdue Pharma. Dhalla

is reported as charging that drug companies have "misled" the average physician about the risk of addiction and overdose death, and have overstated the case for effectiveness. Indeed, Purdue Pharma, maker of OxyContin, was ordered to pay out more than \$600 million in fines in 2007 when a U.S. court found it had made false claims about the drug (Boyle 2011:GT4). There is very seldom discussion, however, throughout the *Toronto Star* and the *Globe and Mail* about the vital role that Purdue Pharma played in enabling the "opioid crisis" through their deceptive marketing of OxyContin nor substantive criticism of the research and vetting procedures of Health Canada which authorized the drug for sale in Canada. It is worth mentioning that Health Canada is situated at the top of the hierarchy of credibility and positions themselves in the press as a reliable and "trustworthy" organization that plays a central role in shaping public opinion(s) about opioid mis/use and overuse across the country. Health Canada is also represented in the press as a key decision-maker in approving or disapproving the installment of overdose-prevention and safe-injection sites throughout Canada, enacting or endorsing legislation concerning narcotics, and the government organization is reported as working closely with the pharmaceutical industry in terms of drafting drug monographs and developing and implementing drug regulations (Edwards 2017; Howlett and Weeks 2015; Warren 2015). There are approximately three articles that address Purdue's role in misbranding OxyContin to monopolize the painkiller, which is only mentioned in conjunction with the development of their new tamper-resistant drug, OxyNeo.

The little reporting on Purdue's manipulative marketing techniques of OxyContin, which ultimately influenced the careless prescribing practices of physicians, is an example of news journalists employing the professional news practice of self-censorship. As previously stated in this thesis, Purdue Pharma and the government have an economic, legal, and political

relationship. If journalists publish several news articles revealing Purdue's corrupt and immoral conduct, the Canadian government will receive extreme backlash from pressure groups regarding discrepancies in drug regulation and families who lost someone to OxyContin or other opioids, if they have not already. Most importantly, the "for the people" image that the news media and several other "institutions" maintain of the government would become tainted. Additionally, this information reveals that the state's economic or monetary success is more important than individuals' physical well-being.

Elite secondary definers such as former Ward 20 Councilor, Joe Cressy, who is chair of the Toronto Drug Strategy Implementation Panel, labels Canada's "opioid crisis" as a "serious almost plague-like" problem (Warren 2015:GT1). Cressy is reported as arguing that "the increase in deaths [in Toronto] is related to a rise in the use of opioids, including heroin and fentanyl, a deadly potent painkiller that can be abused in its patch form or ingested through an illegal pill or powder" (Warren 2015:GT1). Cressy contributes to the construction of the "opioid crisis" by perpetuating the seemingly catastrophic and fatal effects of fentanyl. The media, then, draws on statistics provided by Toronto Public Health to evoke panic over the increasing number of opioid-related deaths in Toronto. According to Toronto Public health (e.g., secondary definers) and the *Star*, there has been a dramatic increase in the reported number of fatal opioid-related overdoses from 2004 to 2013 (Warren 2015). In a report published by Toronto Public Health⁷, which was presented to Toronto's Board of Health in September 2013, overdose deaths in the city have increased by 41 per cent in that period, from 146 in 2004 to 206 in 2013.

⁷ De Villa, Eileen. 2015. "Overdose in Toronto: Trends, Prevention and Response." Retrieved July 4, 2019 (<https://www.toronto.ca/legdocs/mmis/2015/hl/bgrd/backgroundfile-83429.pdf>).

Natalie Kallio, the harm-reduction program lead at Parkdale Community Health Centre, is reported as calling overdoses an “epidemic” in the neighbourhood (Warren 2015). Kallio, an oppositional definer, is reported as saying that “there is variety of reasons that people think an increase in overdoses is happening. One is that since OxyContin was taken off the market, people are replacing it with what they can get” (Warren 2015:GT1). These discourses are compelling, persuasive, powerful, and call attention to the seemingly high rise of opioid-related deaths; however, Joe Cressy and Natalie Kallio stand in a position of subordination to primary definers. Their counter-definitions of the crisis are overlooked by public health and government officials as authorities have defined opioid mis/use and overuse as a “public health crisis.” Public health and government officials employ credentialism (e.g., their medical experience and expertise) and in-group membership to foreclose on the normative understanding of Canada’s opioid crisis.

While primary definers label the drastic rise in opioid dependency and overdoses as a “public health crisis”, and secondary definers label the crisis an “epidemic”, the *Toronto Star* and the *Globe and Mail* report that more than 700 healthcare workers including physicians, nurses, and harm-reduction workers urged Canada’s provincial government to declare the opioid crisis an “emergency.” Overwhelmed by the increasing number of dying patients and little resources, the group of physicians, nurses, and front-line workers are reported as stating that “labelling the crisis an ‘emergency’ would allow the government to release additional funding for more front-line workers from 55 programs to help those suffering from ‘addictions’” (McIntosh 2017:A7).

These oppositional definers went to the front steps of Queen’s Park with an open letter to then-Premier, Kathleen Wynne, and then-Ontario Health Minister, Eric Hoskins, demanding they declare a national “emergency” over the rising number of overdoses, as British Columbia did last

year (Ferguson 2017a). Dr. Alexandra Caudarella, an addictions and family physician in Toronto who helped draft the request, is reported in the press as saying “the letter really comes out of this place of total frustration, exhaustion and just feeling abandoned” (McIntosh 2017:A7). Dr. Caudarella adds, “this is not a Toronto problem. This is not an exclusively inner-city problem either. Opioids—alone or combined with other drugs—were to blame for a third of all accidental substance use deaths in Toronto in 2015” (McIntosh 2017:A7). Caudarella’s discourse constructs the increase in opioid dependency and overdoses as a prevalent problem across Canada and the recent surge in opioid-related fatalities as primarily accidental and not confined solely to one municipality or demographic. Again, this discourse constructs Canada’s “opioid crisis” as a different type of drug scare from alcohol and tobacco.

It should be noted that the terms “substance use deaths” and “drug overdoses” are often used by the media, physicians, government officials, public health authorities, and health organizations (e.g., Health Canada) to mislead the general public about the correct number of opioid fatalities in a given year. The “correct number” of opioid fatalities, however, is relatively ambiguous and unknown as the statistics for legitimately prescribed opioid deaths has yet to be reported by government agencies or medical organizations. In fact, the Government of Canada (2018c, 2019) labels the current investigations into opioid-related deaths and harms as “ongoing.” In an article published by the *Globe and Mail*, the media states that the province of Ontario “grappled with an opioid epidemic that saw more than 1,200 overdose deaths in 2017” (Giovanetti 2018:A4). “Substance use deaths” or “drug overdoses” are standard jargon that characterizes fatalities from all narcotics, including anti-coagulants (i.e., “blood thinners”), anti-depressants, aspirin, cocaine, heroin, alcohol, etc. Most people, however, will read the statistics and arrive at the conclusion that a significant number of individuals died by prescription pain

medication. “Apparent opioid-related deaths and harms” is another deceptive term used by government officials and medical authorities to heighten public anxieties and produce consent about the meanings of opioid mis/use and overuse. Empirical data on fatal and non-fatal opioid overdoses, for example, does not identify what type of opioid caused an overdose; instead, “opioid-related deaths and harms” often mean that a specific opioid, such as heroin, was combined with another drug or substance (e.g., fentanyl, alcohol, etc.). The Government of Canada, for example, states that “in 2018, 73% of accidental apparent opioid-related deaths involved fentanyl or fentanyl analogues” (2019:1).

As a secondary definer Dr. Caudarella, along with the many other physicians that participated in the usurpatory movement, express sentiments about the government’s lack of action in addressing the increase in opioid dependency and overdoses. These oppositional definers engage in usurpatory closure by collectively demanding that the spike in opioid mis/use and overuse be labelled as a “national emergency.” In doing so, Dr. Caudarella and other front-line workers attempt to extend the domain of their control over the “problem” and obtain increased funding to pay for harm-reduction staff, more supervised injection sites, more treatment beds, and testing street drugs before users take them (McIntosh 2017). The *Toronto Star* reported that Toronto’s health board unanimously asked for the emergency designation as well. Dr. Eileen de Villa, the city’s medical officer of health, said that, in B.C., such a designation or label improved access to overdose data and helped “create (new) overdose-prevention” in that province (Rider 2017:GT6). Eric Hoskins, however, engages in exclusionary

closure by rejecting the front-line workers' and public health board members' declaration sought under the Emergency Management and Civil Protection Act⁸.

Hoskins's is reported as stating that "Ontario wasn't hit as hard (compared to British Columbia), but the province is working to prevent the problem from worsening" (Rider 2017:GT6). Hoskins adds,

declaring a state of emergency is unnecessary because it would not provide me with opportunities or powers that I don't already have. I feel confident in my current ability to work, in collaboration with partners, to address the public health crisis that is the opioid crisis (Rider 2017:GT6).

Hoskins' narrative appears to downplay the scope and severity of Ontario's "opioid problem" compared to British Columbia, therefore, maintaining the construction that British Columbia is the epicenter of the Canadian "crisis" (see chapter 3). Hoskins also suggests that if declaring the "opioid crisis" an "emergency" enhanced his already existing powers and status as a public health official, he might entertain the idea. Hoskins' narrative implies that declaring the "opioid crisis" an "emergency" may jeopardize his current authority over the career of the "crisis"; and in turn, his material and metaphysical interests. If the "opioid crisis" were to be declared an "emergency", a range of bureaucratic actors (e.g., provincial public health and government officials, pressure groups, etc.) would be responsible for drafting and implementing such legislation; therefore, potentially minimizing his now-active role in defining the crisis and providing solutions. By giving primacy to Hoskins, both the media and

⁸ "Emergency" means a situation or an impending situation that constitutes a danger of major proportions that could result in serious harm to persons or substantial damage to property and that is caused by the forces of nature, a disease or other health risk, an accident or an act whether intentional or otherwise (see Emergency Management and Civil Protection Act R.S.O. 1990, Chapter E.9).

Hoskins are able to create and maintain the dominant position of defining the crisis in Ontario.

Despite Hoskins decision, primary definer, Kathleen Wynne, is reported as acknowledging the “devastating impacts and consequences of opioid mis/use and overuse” (Ferguson 2017a:A2). The *Toronto Star* draws on a meeting between Wynne and the several front-line workers that appeared at Queen’s Park about the decision to declare Canada’s “opioid crisis” a national emergency. Wynne is reported as saying “I agree with physicians and harm-reduction workers that Ontario is experiencing a public health crisis” (Ferguson 2017a:A2). Wynne continues “that’s why I strongly reaffirmed our government’s commitment to combat this crisis with additional resources...Our government will work more closely with people living with addictions, their family members, front-line workers and volunteers” (Ferguson 2017a:A2). Wynne’s discourse also stresses the idea of deploying a collaborative approach to ameliorate opioid mis/use and overuse in Ontario, which will be discussed in the “implementation of an official plan” stage.

In the group’s struggle to usurp the government’s primary framing and labelling of the crisis, the oppositional definers were able to negotiate and compromise with then provincial premier, Wynne, to acquire more economic resources. It is important to note that in June 2018, the media reports that the provincial government gave local health agencies \$15 million to hire staff and hand out naloxone kits, which are used to reverse the effects of an overdose (Ferguson 2017a). The group is reported as looking for an improved regulatory environment, “where sites can open up exactly where people need them, so overdoses can be prevented”, said Dr. Caudarella. The secondary definer who adopted an oppositional stance is reported as stating, “the one thing that

the premier did make explicit was that any funding announcement would make the funds clearly available faster and that they would go where they need to go, quickly” (Ferguson 2017a:A2).

Physicians and nurses mainly participated in this usurpatory movement; therefore, their social location within the medical establishment and their credentialed and professional status in the social order, therefore, make their claims about declaring Ontario’s “opioid crisis” an “emergency” more appealing and more likely to be heard than the claims of oppositional definers alone. Ownership of a social problem is established when particular claims become generally recognized as the best way to understand a specific problem. The media predominantly focuses on the claims of primary definers in constructing opioid mis/use and overuse as a “public health crisis.” Those who own the means of production are the same groups who control and have ownership over the hegemonic definition of opioid mis/use and overuse.

Public health officials and politicians are represented in the news media as guiding the discourse of Canada’s “opioid crisis” as a medical matter. There is not a clear distinction between primary, secondary, and oppositional definers throughout the *Toronto Star* and the *Globe and Mail*; in fact, some primary and secondary definers align themselves with oppositional definers, and there are rarely any claims made by secondary definers (e.g., pressure groups, social service agencies, taxpayers, etc.). Primary definers identify the “harmful” conduct (e.g., opioid mis/use and overuse), describe the main folk devils (e.g., pharmacists and physicians), and propose preliminary solutions. The three definers attempt to foster public support by publicizing and stigmatizing the conduct, along with convincing the general public that there are not enough resources being allocated toward resolving the problem, therefore, becoming a political issue.

In determining whether the evidence I produced for the first stage of my composite model of social problems is consistent with Best's (i.e., the claims-making process) and Blumer's (i.e., the emergence of social problems) first stages, I noticed that the various definers unanimously agree that the recent increase in opioid dependency and overdoses across Canada signifies a "crisis." The only difference between the definers and their descriptions of the "crisis" is who gets a) the blame and therefore the right to be excluded from definitional control, and b) the resources at the expense of one group or another. The general consensus that emerged among primary, secondary, and oppositional definers contradicts Best's first stage. Competing claims are pivotal to the social problems process. The three definers, however, do not offer competing claims or definitions of opioid mis/use and overuse across Canada, therefore this particular consensus does not coincide with Joel Best's first stage.

Consistent with Best's first stage, and a key component of Blumer's first stage, is that primary, secondary, and oppositional definers draw the reader's attention to the dramatic rise in opioid mis/use and overuse across Canada. Medical authorities, physicians and nurses, and harm-reduction/community outreach workers use terms such as "crisis", "emergency", and "epidemic" to convey to readers that all three levels of government must take political action against opioid mis/use, malpractice, production, and distribution, and implement effective and long-term solutions to curb opioid dependency and prevent overdoses. As well, rhetoric is used by the various definers to convince and persuade readers that an increasing number of Canadians are dying from prescribed, self-medicated, and recreational overdoses. Primary and some elite secondary definers, as well as the corporate print media, often provided statistics to convince their audience of the increasing number of opioid-related fatalities and overdoses across the country. Rhetoric is also used by the definers to elicit emotional responses from readers such as

anxiety, compassion, empathy, fear, and sympathy. It is worth noting that primary (e.g., medical authorities) and secondary definers (e.g., physicians) construct the rise in opioid dependency and overdoses as a medical matter and support a public health approach toward ameliorating the “issue” of opioids across Canada. A public health approach promotes rehabilitation and treatment, rather than confinement and punishment. As discussed in Blumer’s first stage, those with power (e.g., public health authorities) and control of “legitimate knowledge” (e.g., medical “experts”, physicians, medical regulatory bodies, and government officials) determined that opioid mis/use and overuse constitutes a “social problem” across Canada. The second stage in my composite model of social problems, legitimation, examines how the social location or status of claims-makers determines whether a “harmful” behaviour or condition becomes identified and legitimated as a “problem” in the political and public domains.

ii. Legitimation of Social Problems

After gaining initial recognition, a social problem must acquire social endorsement if it is to be taken seriously and move forward on its career. It must acquire a necessary degree of respectability which entitles it to consideration in the recognized arenas of public discussion (Blumer 1971: 303).

Not all social conditions or behaviours become identified as a “social problem.”

Legitimation or respectability is an essential condition, but crucially only those with the hierarchy of credibility can grant the new condition that status. Opioid mis/use and overuse is on the public agenda and has received considerable media attention because white middle- and working-class people are “accidentally” developing an opioid dependency after being prescribed painkillers for a “debilitating” illness or injury. Over- and self-medicating, therefore, has come to signal a “crisis” in Canada because these practices deviate from cultural norms and values of appealing to professional opinion in the diagnosis and treatment of health conditions. When a “harmful” condition or behaviour begins to affect the white middle- and working-classes,

specifically those who are able to influence government policy or have access to the media, the chances of the “harmful” condition or behaviour being identified as a “social problem” increases substantially. Canadian public health officials and politicians, for example, identified a new “social problem” when medical “experts” “discovered” that white middle- and working-class persons, specifically men, are dying as a result of prescription and illicit opioids.

The news media typically uses framing techniques to elicit negative emotions and perceptions of drug users, and the claims-making activities of “addicts” often dramatize the prevalence of public injection drug use and their unwavering appetite for drugs, despite possible health consequences (Peele 1989). A sympathetic portrayal of opioid-dependent persons, however, is prominent throughout the sample. In regard to the increasing number of opioid dependency and overdoses, the media frames opioid “addiction” as “different.” The “changing face of addiction” is a common narrative used by journalists, as well as primary and secondary definers throughout the *Toronto Star* and the *Globe and Mail*. This discourse is, in part, used to explain *why* the increase in opioid dependency and overdoses has been established and legitimated as a “social problem.” In an article published by the *Toronto Star*, pharmacology and toxicology professor Michelle Arnot, of the University of Toronto, is reported as saying “there is now way more diversity in the profile of who struggles with addiction (referring to the recent increase in opioid dependency and overdose). It could be our cousin, our neighbour or our friend. Today, people (who) have addiction issues span the breadth of the socio-economic and political background” (Hennessy 2013:A8). Toronto Mayor John Tory similarly explains that “each person who dies from an overdose is someone’s son, daughter, friend or loved one. They are human beings and they should not be abandoned by society due to a particular addiction” (Hennessy 2013:A8).

Primary definer, Mayor John Tory, is also reported as stating that “opioid ‘addicts’ are not thugs or gangsters” (Hennessy 2013: A8), which Tamari Kitossa argues is a racial code, especially for young African Canadian men (2018). Mayor Tory further argues that a community approach must be taken to “provide the best help possible to those in the grips of addiction” (Hennessy 2013: A8). Tory uses the method of priming to “trigger” existing constructed ideas that “dangerous drugs” are used by a “dangerous” demographic or social group. The discourse that arose from these quotes suggest that criminal justice personnel, medical authorities, and the general public need to alter their understanding of “addiction” to accommodate the latest drug epidemic of opioids. In fact, Arnot is reported as arguing that “the remaining stigmas surrounding drug addiction and drug addicts needs to go. We believe anyone who uses a drug, by extension, is bad, which isn’t true. Drug addiction affects every type of individual” (Hennessy 2013: A8).

According to the normative definition of a “drug user” African, Latino/X, and Indigenous Canadians, the “uneducated”, and the poor are generally the accepted faces of “addiction.” These groups are often represented by the media as “enemies of order” for engaging in illicit drug-using behaviour; therefore, their “addiction” is collectivized and is seen to warrant criminal sanctions (Miller 1996). There seems to be less stigma around opioid “addiction” and opioid use, however, because opioids are considered legal, they are not traditionally viewed as bad or “evil”, and they are prescribed by a licensed dentist, physician, or psychiatrist. Considering the legal and medical status of opioids, “addiction” of this nature is framed by the media as a “disease” that transforms people into addicts against their own will (Szasz 1974). The mis/use and overuse of legal drugs, therefore, achieves the news value of “extraordinariness” as most cases of drug

“abuse” are constructed as involving “dangerous” narcotics such as cocaine and “street-marketed” heroin.

The news media, as a secondary definer, uses their own discourse to help propagate the meaning of opioid “addiction” as well. A *Toronto Sun* article reports that the “‘jobless man on the street’ stigma no longer exists” (Hunter 2009:A4), and that drug users now include “your average man and woman dressed in business attire, working 9-5p.m. every day” (Hunter 2009:A4). The article uses the opioid-related death (e.g., codeine, morphine, and heroin) of Cory Monteith, a white Canadian actor who was known for his lead role as Finn Hudson on the television series *Glee*, to illustrate that “faces associated with methadone and ‘addiction’ alone continue to change” (Hunter 2009:A4). Betty-Lou Kristy, a mother who lost her 25-year-old (white) son to an opioid-related overdose and who manages a peer group for parents who also lost their offspring to overdose, is reported as saying “the public has this particular perception of the ‘addict’, but opioid use is every demographic, everywhere” (Gallant 2013:A1). A racialized code, indicating that the poor and people of colour engage in “addictive” drug-using behaviour is implied. These discourses are used throughout the Canadian corporate press to reproduce the idea that opioid “addiction” is relatively “rare” and “unique”, and to convince the reader that the “problem” of opioids is different from previous drug issues. As discussed in chapter 4, “addiction” typically connotes both a morally stigmatized and undesirable outcome of some repetitive behaviour, which is usually described as “evil” or “sinful”, and the term is often used in conjunction with negatively racialized groups. The priming method, therefore, is used to help the reader develop a new impression or understanding of the term “addiction” in the context of opioid mis/use.

Dr. Dirk Huyer, the Provincial Chief Coroner, released opioid-related death statistics to former Health Minister, Dr. Eric Hoskins, for 2017. The *Toronto Star* reproduced these statistics to persuade the public that opioid-related fatalities are on the rise and continue to worsen over time. These statistics show that between July and September, there were 2,449 emergency-department visits related to opioid overdoses in Ontario. Dr. Huyer is reported as stating, “that’s a 29-per-cent increase from the 1,896 such visits in the previous three months and a staggering 115-per-cent hike from the same time period earlier” (Benzie 2017:A1). Dr. Huyer is also reported as saying “it’s unfortunate that we’re here to say that the news is not good. This is incredibly significant and an incredibly large number. This is a phenomenally big issue” (Benzie 2017:A1). Dr. Huyer revealed that the mean age of the deaths was 41, and 61 percent of the deaths occurred in those between ages of 25 and 44. He is reported as making a statement about this statistic, claiming “it’s a terrible tragedy from that perspective” (Benzie 2017:A1). Dr. Huyer also specifies that an increasing amount of fentanyl was found in most overdose “victims.” According to statistics in 2015, fentanyl detection accounted for “19 per cent of overdoses; 2016, it was 41 per cent; and in three months...of our snapshot (for 2017), it was 67 per cent of the time fentanyl was detected” (Benzie 2017:A1).

The statistics presented by primary definer, Dr. Huyer, help legitimate opioid mis/use and overuse as “social problem” in Canada. While the *Toronto Star* does not specify how Huyer determined the numerical data nor is there comparison to deaths from “legitimately” prescribed opioids or from other substances such as alcohol and tobacco, his role as “Provincial Chief Coroner” ensures the reader that Huyer conducts “high quality” death investigations. His social location in the government sector and high moral standing in the social order also means that readers are more likely to perceive his statistics as credible, factual, and reliable than someone of

lesser authority. In fact, after Huyer's statistics became publicly available Ontario earmarked \$222 million over three years to curb opioid dependency and prevent overdoses. Hoskins is reported as saying that this money is going toward funding more safe injection sites, "rapid access" clinics, and hiring more harm-reduction workers (Ferguson 2017b), but he did not verify how much of that money would go to law enforcement. Huyer's contribution of statics also influenced secondary definer and Community Safety and Correctional Services Minister, Marie-France Lalonde, to provide emergency personnel (e.g., police and fire services) with naloxone kits. Waterloo Regional Police Service, Chief Bryan Larkin, is reported as saying that "police personnel will be better equipped to save lives and protect themselves" (Benzie 2017:A1). Lalonde is reported as mentioning that "adopting the kits would be 'voluntary' for emergency services" (Benzie 2017:A1).

In terms of legitimation and respectability, oppositional definers are clearly represented as not having the resources to grant credibility to their claims. Coordinators and volunteers of the previously operating overdose-prevention site, Moss Park, revealed that they oversaw 9,062 injections and intervened in 251 overdoses from mid-August 2017 to end of June 2018. Zoe Dodd, a lead organizer of the Toronto Harm-reduction Alliance who helped staff the increasingly busy pop-up safe-injection site in Moss Park with other volunteers, is reported in the press as frustratingly stating "it's not slowing down. People are ODing every day and we are burnt out and burdened with what is happening" (Mathieu 2018b:GT1). Dodd is also reported as stating that "delaying the opening of these sites will contribute to unnecessary illness and death. The government's lack of urgency in dealing with the crisis is negligent and inhumane" (Mathieu 2018b:GT3). Instead of the government supporting these volunteers and their efforts, the provincial government decided to shut down Moss Park. Since oppositional definers do not come

from a place of authority or power, their claims are often discredited and overlooked in attempting to achieve legitimacy and establish opioid mis/use and overuse as a “social problem.”

Overall, based on the media’s representation of primary and some elite secondary definers, there appears to be three reasons as to why opioid mis/use and overuse is identified as a “social problem.” First, there appears to be an increasing number of white middle- and working-class persons dying from the self-medicated and recreational use of prescription and illicit opioids. Second, physicians and pharmacists are constructed as the main folk devils in the moral panic around opioids; that is, primary definers blame physicians and pharmacists for the genesis of Canada’s opioid “crisis.” Finally, opioid mis/use and overuse violate the cultural norms and values of the given social order.

The data presented in the second stage of my composite model of social problems is consistent with Blumer’s second stage, legitimation of social problems. As evidenced by the *Toronto Star’s* and the *Globe and Mail’s* disproportionate coverage of Canada’s “opioid crisis” between October 1st, 2008 and October 1st, 2018, opioid mis/use and overuse has received widespread recognition by various primary, secondary, and oppositional definers. It is clear throughout this stage of my composite model that “credible” and “reliable” sources (e.g., government officials, medical authorities, addiction “experts”, etc.) have the power to advance their claims throughout the press and legitimate social problems (resource advantage). The validity of Canada’s “opioid problem” relies on the testimonials of “expert” claims-makers such as the province’s Chief Coroner, Dirk Huyer, to disseminate facts and information about opioid-related deaths and harms. The spike in opioid dependency and fatal overdoses has become identified by primary and some elite secondary definers as a socially acceptable “problem” and achieves legitimacy based on several factors which are outlined above.

iii. *Policymaking and the Formation of an Official Plan of Action*

Best uses his fourth stage of policymaking to describe that “most claims-makers hope to do more than simply draw attention to a troubling condition; they also want to change things, to improve social arrangements so that the problem can be, if not eliminated, at least made better” (2017:199). Toward this end, claims-makers seek to change social policies, to alter how the society deals with the troubling condition; and this means that their claims must reach those who have the power to make policy changes—the policymakers (Best 2017:199). Like Best (2017), Blumer describes his fourth stage, the formation of an official plan of action, as:

This stage in the career of social problems represents the decision of a society as to how it will act with regard to the given problem. It consists of the hammering together of an official plan of action, such as takes place in legislative committees, legislative chambers, and executive boards. The official plan is almost always a product of bargaining, in which diverse views and interests are accommodated. Compromises, concessions, tradeoffs, deference to influence, response to power, and judgments of what may be workable—all play a part in the final formulation. This is a defining and redefining process in a concentrated form—the forming, the reworking and the recasting of a collective picture of the social problem, so that what emerges may be a far cry from how the problem was viewed in the earlier stage of its career. The official plan that is enacted constitutes, in itself, the official definition of the problem; it represents how the society through its official apparatus perceives the problem and intends to act toward the problem (Blumer 1971:304).

Leaving aside the implicit pluralism in the notion that a “society decides” anything at all, the fourth stage of my composite model of social problems, therefore, analyzes how political leaders, legislative committees, medical professionals, and other powerful groups employ bargaining, compromise, and negotiation to create policies aimed at curbing opioid dependency and preventing overdoses across Canada. The definitions of a given social problem are modified and (re)constructed to form policies that are consistent with the material and metaphysical interests of the powerful.

The media constructs the “problem” of opioid mis/use and overuse as highly complex due to opioids’ legal status and thus frames Canada’s “opioid issue” as requiring solutions from all levels of government. As reported by the press, primary definers (e.g., medical authorities, physicians/medical “experts” and policymakers) have proposed public health strategies that emphasize the importance of enhanced prescription monitoring systems and making prescription medication harder for physicians, patients, and the general public to access. Primary and some elite secondary definers also propose tamper-resistant oxycodone, re-training physicians, and educating the general public about the dangers and risks of opioid narcotics. Oppositional definers (e.g., harm-reduction/community outreach workers and some public health officials), however, propose greater accessibility to and availability of naloxone for the general public and emergency personnel. Oppositional definers, moreover, suggest installing more safe-injection and opioid-prevention sites and propose decriminalizing the simple possession of all narcotics (Ferguson 2017c; Paperny 2011, 2012; Ubelacker 2017; Weeks 2010, 2013; Woo 2017).

In regard to making prescription medication harder for physicians, patients, and the general public to access, the province is reported as attempting to tighten the rules on painkillers covered by Canadians’ health plans (Paperny 2012). The media’s discourse suggests that government officials and public health authorities seek to establish stricter laws and improve surveillance and regulatory systems to monitor the prescription practices of physicians and dispensing habits of pharmacists (Paperny 2011). Achieving stricter legislation and improving drug surveillance regimes enables authorities “to get a better handle on who’s getting what pills and where” (Paperny 2012:A5). Such political actions enhance the psycho-social control of the corporate elite over the general public.

The press reports that the provincial government first implemented prescription monitoring systems in 2011 to supervise and collect information on who is prescribing how many prescription medications to whom, and where those prescriptions are getting filled (Paperny 2011). Secondary definer and *Globe and Mail* journalist, Anna Paperny, reports that the “new and comprehensive drug information systems are technologically enhanced databases that will include records of every prescription dispensed for every patient in a distinct jurisdiction” (Paperny 2011:A5). Paperny uses the narratives of the Ontario Ministry of Health and Long-Term Care to complement the above information. The Ontario Ministry of Health and Long-Term Care is reported as saying that “these information systems collect data at the point of prescribing, dispensing, or both. As a primary definer, the Ontario Ministry of Health and Long-Term Care is perceived by readers as a “reliable” government organization and therefore, their claims are more likely to be accepted. The newly-developed surveillance technology enables storage, retrieval, and sharing of patient medication profiles in real time” (Paperny 2011:A5). The objective of prescription monitoring systems is to deter physicians from over-prescribing, discourage pharmacists from corrupt dispensing, and to prevent patients from “physician shopping” (i.e., visiting several physicians to obtain multiple prescriptions for either the same medication or different narcotics) (Paperny 2011).

A similar attempt to control the distribution and sale of opioids, as well as to lower the risk of “addiction”, was made in 2012 when the Ministry of Health decided to remove OxyContin and its successor, OxyNeo, from Ontario’s Drug Benefit Program (Ogilvie 2012). The media frames this decision as “the province’s first time delisting a drug on the grounds of its addictive properties” (Ogilvie 2012:A1). This discourse conveys to readers that government officials and public health authorities acknowledge the criticalness and level of seriousness that

needs to be taken in “dealing” with opioid mis/use and overuse across the province. The Ministry of Health notified physicians that OxyNeo will be available only through the province’s Exceptional Access Program. The program permits physicians, on behalf of their patients, to request access to drugs not registered in the Ontario formulary (Ogilvie 2012). Primary definers (e.g., physicians, addictions specialists and those who treat chronic pain) are reported as saying that “removing OxyContin and its successor from the Ontario Drug Benefit program will help prevent people from abusing the drug while still helping those who depend on it for pain management, including patients in palliative care and those with spinal cord injuries” (Paperny 2011:A5).

Additionally, the Ontario government is represented throughout the *Globe and Mail* as “strongly urging” the federal government not to let the generic brands of OxyContin into Canada once Purdue Pharmaceuticals’ patent expires in November 2012. Primary definer and former Ontario Health Minister, Christine Matthews, is represented in the press as asking former federal Health Minister, Leona Aglukkaq, to withhold approval of any applications seeking to get generic versions of the drug on the market (Paperny 2012). Ms. Matthews is reported as stating that “approving the generic versions of OxyContin would further exacerbate the incidence of addiction and death in Canada and contribute to a growing public health crisis” (Paperny 2012:A5). The media uses Matthews’ primary discourse to perpetuate the “common-sense” belief that opioid mis/use and overuse has led to a drastic increase in “addiction” and death. In doing so, Matthews has a stake in defining the problem and enhancing her role and status in ameliorating the crisis. In a letter to the federal Health Minister, Matthews writes:

I understand the generic manufacturers may have submitted their products for approval on the market in Canada, but I urge you to direct your officials to consider the broader

public health perspective...the costs to society of the reintroduction of the more-easily abused version far outweigh the financial benefits (Paperney 2012:A5).

In response to Matthews' letter, Health Canada uses the media to inform the public of its decision to disapprove Matthews's request. In fact, the media reports that in 2012, the same year that Purdue's OxyContin patent expired and replaced it with OxyNeo, a tamper-resistant drug, the federal government approved six generic versions of OxyContin (Howlett and Weeks 2015).

Health Canada's decision to approve the generic brands of OxyContin allows pharmaceutical companies to manufacture cheaper versions of oxycodone, thus making the painkiller more affordable and increasing the sales of generic OxyContin. If Health Canada were to withhold approval of the generic brand of OxyContin, state and public health officials would lose revenue of oxycodone sales and potentially threaten their economic, legal, and political relationship with the pharmaceutical industry. Referring to chapter 4, OxyContin is viewed as a highly "addictive" painkiller and its increased use in the late 1990s to early 2000s ultimately led to the emergence of an "opioid crisis"; therefore, Health Canada's decision to approve the generic brand of OxyContin on the pharmaceutical market communicates to readers that federal authorities are more concerned with economic success than the physical well-being of the general public.

While primary, secondary, and oppositional definers do not overtly criticize Health Canada's decision to approve the generic brand of OxyContin, Dr. David Juurlink a drug-safety specialist at Sunnybrook Health Science Centre in Toronto, is reported as saying that the generic versions of the controlled-release oxycodone "will be in pharmacies across Canada—20, 40, 80 milligrams of easily crushed oxycodone that people can go back to snorting or injecting...the streets will readily fill up again with the tablets" (Paperney 2012:A5). This narrative, therefore, implies that the secondary definer disagrees with Health Canada's decision to approve the

generic brand of OxyContin and maintains the idea that oxycodone is a “street drug” (see chapter 4).

On the subject of tamper-resistant oxycodone, the media reports that in June 2015 Health Canada disclosed draft rules that would require slow-release oxycodone to be tamper-resistant, making it more difficult to crush, snort, or inject for a quick high (Howlett and Weeks 2015). Former Health Minister, Rona Ambrose, introduced a three-year phase for tamper-resistant oxycodone. Ambrose’s decision, as reported by the *Globe and Mail*, would forbid Purdue Pharma’s competitors from marketing equivalent tamper-resistant oxycodone until 2027, when the last of the company’s patents on its abuse-deterrent technology expires (Howlett and Weeks 2015). Jim Keon, president of the Canadian Generic Pharmaceutical Association is reported as saying that “generic drug manufacturers would have to stop selling oxycodone, forcing consumers to buy the more expensive brand-name version and creating a monopoly for Purdue” (Howlett and Weeks 2015:A1). The elite secondary definer claims that, “for a generic drug to receive approval, a comparison by Health Canada must verify that it is equivalent to the brand-name version in every way” (Howlett and Weeks 2015:A1). Health Canada seems to give primacy to Purdue in advancing their tamper-resistant version of oxycodone over any other pharmaceutical company; therefore, Health Canada prevents other pharmaceutical corporations from reformulating tamper-resistant OxyContin. As a result, Health Canada and Purdue Pharma work together to exclude major pharmaceutical corporations, such as Ranbaxy Pharmaceuticals Canada, from obtaining similar economic rewards as Purdue.

Craig Landau, chief executive officer of Purdue Pharma Canadian operation, contests Keon’s narrative and is reported as arguing that “other drug manufacturers could create their own tamper-resistant technologies” (Howlett and Weeks 2015:A1). In an interview with the *Globe*

and Mail, Dr. Landau, an anesthesiologist and pain doctor, maintains that “our protection is of our own invention” (Howlett and Weeks 2015:A1). The elite secondary definer goes on to say, “to suggest that with a single product we’re cornering the market because of intellectual property is just false” (Howlett and Weeks 2015:A1). Landau’s narrative attempts to reinforce and protect the reputation of Purdue Pharma and connotes a positive image of the pharmaceutical company. The media, however, reports that “since Landau took over as president of Purdue Pharma Canada in September 2013, he has been pushing the federal government to remove generic oxycodone from the market” (Howlett and Weeks 2015:A1). The media’s discourse suggests that Landau’s eagerness to remove generic oxycodone is materially-driven, as Purdue would monopolize the market of tamper-resistant oxycodone.

Addiction “expert”, Meldon Khan, is represented in the press as disagreeing with tamper-resistant oxycodone because “Health Canada does not address a major public health problem: the overprescribing of opioids that has led to an epidemic of drug abuse and overdose deaths” (Howlett and Weeks 2015:A1). The secondary definer argues that “the government’s proposal to require oxycodone to be tamper-resistant would give Purdue exclusive control over one class of opioids while doing little to address the crisis” (Howlett and Weeks 2015:A1). Khan is also represented as questioning why Health Canada would not apply the proposed rules to all opioids. Ms. Ambrose, nonetheless, is reported as providing a rationale for focusing solely on oxycodone and states that “the government is targeting controlled-release oxycodone –long-lasting versions of the painkiller—because it has a well-established history of abuse. The long-term goal is to apply the rules to other opioids, she said, but there is no timeline” (Howlett and Weeks 2015:A1).

The press also reports that in June 2014, Ambrose announced the plan to require oxycodone products sold in Canada to be tamper-resistant, which contradicts an earlier policy decision in November 2012 (Howlett and Weeks 2015). The *Globe and Mail* article reveals that in 2012, Health Canada was of the view that evidence concerning tamper-resistant formulations and their alleged low-abuse potential was insufficient (Howlett and Weeks 2015). In fact, as reported by the media, Health Canada “noted in a news release that the product monograph for OxyNeo contains no claims that the product is harder to abuse” (Howlett and Weeks 2015). The media asserts that the news release on Health Canada’s website, which has since been deleted, indicates that “there is no scientific evidence to date that would allow OxyNeo to claim that it is ‘tamper-resistant’” (Howlett and Weeks 2015). Given the active and dominant role of Health Canada in managing the representation of the “crisis” and how to ameliorate opioid mis/use and overuse across the country, this government organization determines what type of opioid-related information is made available to the public and what type of information is not worth knowing.

Throughout the sample of Canadian news articles, medical authorities and public health officials promote education and health promotion as a viable, long-term solution to curbing opioid dependency and preventing fatal overdoses. The media represents the College of Surgeons and Physicians of Ontario, Eric Hoskins, and other federal and provincial health officials as stressing the need to re-educate physicians through additional pain-management and “addiction” courses. As well, the media reports that educating the general public about the dangers and risks of opioids has been a priority for Hoskins since early 2017 (Ferguson 2017c). Hoskins is represented in the press as advocating for the widespread dissemination of “facts” concerning the potential harms of opioid mis/use and overuse throughout various public domains. In a news conference about opioids that the *Toronto Star* covered, for example:

Hoskins reveals plans for “robust and targeted” public education materials on the dangers of opioids for distribution in schools, campuses, coffee shops, and night clubs, as well as pamphlets to be handed out at pharmacies for people picking up opioids painkiller prescriptions (Ferguson 2017c:A13).

The media represents elite secondary definer and Progressive Conservative MPP, Lisa MacLeod, as having urged “speedier action” on education materials, saying that “the educational materials she called for in 2016 could have been quicker, but that’s not the point now. People are dying on the streets of Ontario... We’re going to see, hopefully, real action” (Ferguson 2017c:A13). MacLeod’s statement suggests that current efforts to rectify the “opioid crisis” do not reflect “real action” against opioid mis/use and overuse, and that those who can influence and administer “real action” are individuals with authority and power (e.g., political leaders and public health officials).

A prominent solution that emerged from the data is the expansion of harm-reduction services (Edwards 2017). In August 2017, Health Canada is represented in the press as having approved the immediate opening of a downtown Toronto supervised injection site to “combat” the opioid crisis in Toronto (Edwards 2017:A2). Here the media employs military language such as “combat” to illustrate to the reader the enormity and pervasiveness of the “crisis.” Oppositional definer, Leigh Chapman, is a Registered Nurse and one of the founders of an unsanctioned pop-up site at Moss Park. Chapman, however, believes that Health Canada’s decision to approve the immediate opening of a downtown supervised safe-injection site is not enough to “deal” with opioid mis/use and overuse. In an interview with the *Toronto Star*, she is reported as saying “this is not a crisis response” (Edwards 2017:A2). While Chapman appreciates Health Canada’s effort to provide solutions to Canada’s “opioid crisis”, she is reported as stating that “it would be useful if they could have extended hours compared to the hours Moss Park has” (Edwards 2017:A2). Chapman adds, “there are no plans to shut down Moss Park. We are building trust and allowing

them the opportunity to feel safe with volunteers who care about their well-being. The city should care too” (Edwards 2017:A2).

In a *Globe and Mail* news article, the media reports that Canada has approved a total of 18 federally sanctioned overdose prevention sites, a dozen of which are functioning (Woo 2017). The media also reports that “Toronto has an overdose action plan and safe injection sites are operating out of a Toronto Public Health building housing the Works needle exchange program and the South Riverdale centre” (Mathieu 2018a:GT1). A third site opened on February 28, 2018 at Fred Victor Centre (Mathieu 2018a). Elite secondary definer, Councillor Joe Cressy, is reported as saying that “a fourth Queen St. site will open within weeks, 1,700 members of front-line city staff have been trained in overdose prevention and the city has received federal approval to implement drug testing at safe injection sites” (Mathieu 2018a:GT1).

The *Toronto Star* and *Globe and Mail* frame the “opioid crisis” as an “addiction epidemic” in Canada. The media uses this discourse to communicate to the reader that in the case of opioid mis/use and overuse, measures or solutions that would not normally be proposed and/or implemented have been. The Global Commission on Drug Policy, for example, is represented in the press as calling for de facto decriminalization and the immediate expansion of harm-reduction services (Woo 2017). “De facto decriminalization” means that states or cities can sometimes make decisions for which they do not need federal approval (Woo 2017). The media reports that the Global Commission is now recommending a “sanctuary city” initiative under which cities that wish to do so can de facto decriminalize petty drug use (Woo 2017:A3). Secondary definer and a physician and professor of medicine, Dr. Michel Kazatchkie, is reported in the *Globe and Mail* as stating “repression is harmful. Wherever repressive policies are in place, people will not be in the best condition to access services” (Woo 2017:A3). The media

reports that Vancouver's former mayor, Gregor Robertson, is the latest person to advocate for this shift in drug policy after new statistics showed his city had already surpassed 2016's overdose death toll of 231 people (Hager 2017:S1).

In addition, a select number of public health officials and oppositional definers continue to urge the Canadian government to decriminalize all narcotics for simple possession and personal use. Although Toronto Medical Officer of Health Dr. Eileen de Villa is an elite secondary definer, she maintains a similar narrative as oppositional definers in terms of decriminalizing all narcotics. De Villa criticizes Canada's current drug laws that prohibit the simple possession of drugs for personal use (Mathieu 2018b). In an article published by the *Toronto Star*, De Villa is reported as claiming that "the lack of affordable housing and mental health and addiction services have contributed to the rise in opioid-related overdoses and deaths. Her narrative calls attention to the "structural issues" of Canadian society, particularly poor government spending and politicians' careless allocation of funds. De Villa is represented in the Canadian press as urging the city's board of health to call on the federal government to decriminalize possession of drugs for personal use, while "scaling up prevention, harm reduction and treatment services" (Mathieu 2018b:GT1). She is also reported as concerned, arguing that "there is an opioid overdose epidemic that is happening in our city and too many people are dying" (Mathieu 2018b:GT1). De Villa continues, "I believe we have scientific evidence and evidence from other jurisdictions that would suggest this different approach, a more public health approach to drug policy, is at the very least worth trying."

The media expands on De Villa's assertions by reporting that "the basic principle is to move away from treating individual drug use as a crime and viewing it more as a symptom of broader social failures" (Mathieu 2018b:GT1). De Villa uses the news media as a platform to

promote her definition of the “crisis” as an “epidemic.” Her social location and status as Toronto’s Medical Officer of Health grants her privileged access to the news media. By defining the “crisis” as an “epidemic”, de Villa is able to grab the attention of government officials and garner support from the public in her proposition to decriminalize all narcotics. Justin Trudeau’s government, nonetheless, rejected the idea of decriminalization, even as delegates to the federal liberal party convention backed the idea in April 2018 (Wood 2018). Maryse Durette, a spokesperson for Health Canada and the Public Health Agency of Canada, is reported as saying that “the federal government is not looking at decriminalizing or legalizing all drugs at this time and while there has been some success with decriminalization in countries such as Portugal, Canada’s criminal justice system is different and more study is required” (Mathieu 2018b: G1). Federal Health Minister, Ginette Petitpas Taylor definer, is reported as stating that her “government is unwilling to take other measures that health-care specialists and harm reduction workers agree would help to bring the crisis under control” (Mathieu 2018b:G1).

Here, Ginette Petitpas Taylor uses media coverage as a tool to change her initial framing of the “crisis” from the increase in opioid dependency and overdoses being identified as “national public health crisis” to a “national public-health emergency.” As a primary definer, she also uses the media as tool to engage in social closure. Canada’s health minister rejects the opinions of “outside sources” (e.g., those who are not a healthcare specialist or harm-reduction worker) regarding policymaking decisions and the solutions needed to deal with Canada’s current opioid “crisis.” The Minister of Health’s narrative conveys to readers that the main objective of the public health approach is to curb opioid dependency and reduce overdoses. For Ginette Petitpas Taylor, the decriminalization of “dangerous drugs” does not coincide with the public health objective; therefore, she uses the press to assert, without much explanation, that

decriminalization is not an effective or viable strategy to rectify opioid mis/use and overuse. The federal government, however, compromised with public health officials and oppositional definers' in their attempt to decriminalize all narcotics for simple possession by legalizing marijuana in Canada in October 2018. The discourses surrounding decriminalization, moreover, signals to the reader that alternative drug laws are needed to ameliorate the existing “opioid crisis” and provides the reader with a new impression of drug policy reform.

In the fourth stage of my composite model of social problems, policymaking and the formation of an official plan of action, the various definers can be seen as working toward ameliorating opioid mis/use and overuse by focusing intensively on re-training physicians and educating individuals about the potential risks of opioids, expanding harm-reduction services, improving prescription surveillance systems, and more. Although primary, secondary, and oppositional definers present varying claims concerning solutions or strategies to curb opioid dependency and prevent overdoses, and wide-ranging perspectives are entertained, government officials and legislative committees have the authority and power to enact legislation and endorse solutions either proposed by public health officials, harm-reduction/community outreach workers, and others, often in congressional hearings, or developed by the Canadian governments and its diverse organizations. As discussed above, for example, Justin Trudeau's government rejected Eileen de Villa's request to decriminalize the simple possession of all narcotics (Mathieu 2018b).

As discussed in chapter 2, Blumer states that the definition of a given social problem is modified and (re)constructed, so that what emerges may be different from how the problem was perceived at the start of its career. Public health officials and politicians initially identified opioid mis/use and overuse as a “public health crisis”; however, the initial definition of opioid mis/use

and overuse changed throughout the sample as the various definers expressed their reasoning behind certain viewpoints and provided justifications for their solutions or strategies to curb opioid dependency and prevent overdoses. “Crisis”, “emergency”, and “epidemic” were often used throughout the *Toronto Star* and *Globe and Mail* to define opioid mis/use and overuse, thus coinciding with Blumer’s fourth stage, the formation of an official plan of action. The development of policies and proposed solutions adhere to the material and metaphysical interests of the individuals promoting certain strategies to rectify opioid mis/use across Canada, therefore conforming to the discussion of underlying economic and political interests that shape policymaking decisions laid out in Best’s and Blumer’s fourth stages. Throughout the sample, there was only one mention of an action plan that has been developed to ameliorate the “opioid crisis”, *Toronto’s Drug Strategy Plan*. The action plan was mentioned in passing and the press did not elaborate on what this plan entails, nor did the various definers. The final stage of my composite model of social problems examines the hegemonic definition of opioid dependency and overdoses, as outlined in the official plan, to determine *who* has ownership over the problem and what measures will be used to ameliorate Canada’s “opioid problem.”

iv. Implementation of an Official Plan of Action

The final stage of Blumer’s social problems process, implementation of the official plan, explains that “an official plan and its implementation in practice” are not the same (1971:304). Blumer maintains that,

invariably to some degree, frequently to a large degree, the plan as put into practice is modified, twisted and reshaped, and takes on unforeseen accretions. . . . The implementation of the new plan ushers in a new process of collective definition. It sets the stage for the formation of new lines of action on the part of those involved in the social problem and those touched by the plan. The people who are in danger of losing advantages strive to restrict the plan or bend its operation to new directions. Those who stand to benefit from the plan may seek to exploit new opportunities. Or both groups may work out new accommodative relationships unforeseen in the plan. The

administration and the operating personnel are prone to substitute their policies for the official policy underlying the plan. Frequently, various kinds of subterranean adjustments are developed which leave intact central areas of the social problem or transform other of its areas in ways that were never officially intended (1971:304-305).

The definition of a problem, which is outlined in the official plan, determines who has control over the definition, the approach that should be taken (e.g., criminal justice or public health), the policies that are created to ameliorate or “solve” Canada’s “opioid problem”, and who is involved in carrying out the newly-enacted policies. The fourth stage of my composite model of social problems analyzes how social closure is employed by the various definers to determine who benefits from the official definition of Canada’s “opioid crisis” and who is impacted by the official plan. This stage takes into account the policymaking process and the formation of an official plan of action to identify what solutions or strategies have actually been implemented in the context of surveillance (e.g., Narcotics Monitoring Systems), harm-reduction services (e.g., Naloxone and Consumption and Treatment Sites), education (e.g., alternatives to pain medication), lack of access to opioids (e.g., new prescribing guidelines), and other solutions or strategies that have been deployed to ameliorate opioid mis/use and overuse across Canada.

As mentioned in stage four, the media reports that the Ontario Ministry of Health and Long-Term Care were in the process of improving surveillance and drug monitoring systems to better locate and supervise the dispensing and prescription of medications and to whom. Indeed, in 2012, the Ontario Ministry of Health and Long-Term Care implemented the Narcotics Monitoring System (NMS) to “identify and reduce the abuse, misuse and diversion of monitored drugs” (Oved et al. 2018:A1). Secondary definer, Dr. David Juurlink, is reported as saying that “the new system is poorly designed and doesn’t update in real time”, which contradicts a previous statement made by the Ontario Ministry of Health and Long-Term Care regarding

enhanced real-time technology (see above). Juurlink also draws attention to the flaws of the newly-implemented system by comparing the database to videogames:

it's kind of crazy in 2018 that a child can go online and play a video game in real time with somebody thousands of miles away, but a pharmacist in downtown Toronto doesn't have real-time access to all of the prescription information for the patient in front of him or her from the pharmacy across the street" (Oved et al. 2018:A1).

The media asserts that the system will “flag when a pharmacist is asked to fill a prescription that has been filled elsewhere” (Oved et al. 2018:A1). But, according to Juurlink’s narrative, “the set of things that has to happen to trigger a flag is a little bit of too high a bar in my view” (Oved et al. 2018:A1). The press, then, represents Haley Chazan, the Health Ministry spokesperson, as defending the new surveillance system. Chazan is reported as charging that “the Narcotics Monitoring System does not monitor pharmacy inventory, and was not established to proactively detect diversion or criminal activity.” In response to Chazan’s statement, Dr. Juurlink uses the press to expose the information laid out in the Narcotics Monitoring System handbook. Juurlink reveals that according to the Narcotics Monitoring System handbook, “the collected data will be reviewed and analyzed by the Ministry of Health and Long-Term Care for a variety of purposes including, ... reporting possible criminal conduct to law enforcement agencies” (Oved et al. 2018:A1); therefore, disproving secondary definer Chazan’s articulation of the Narcotics Monitoring System.

Chazan, moreover, is reported as saying that “while the Narcotics Safety and Awareness Act specifies \$50,000 fines to pharmacists and \$200,000 fines to pharmacies that input ‘false or misleading information,’ not a single charge has ever been laid” (Oved et al. 2018:A1). The secondary definer’s narrative signals two messages to the reader as to why physicians and pharmacists have yet to be fined: 1) the system is ineffective in detecting the unethical

prescribing practices of physicians and dispensing habits of pharmacists, or 2): the system *is* effective in deterring physicians from overprescribing and preventing pharmacists from engaging in corrupt dispensing. Either way, Chazan's narratives are consistent with Blumer's fifth stage. The Health Ministry representative is represented in the press as protecting the interests of a government organization from Dr. Juurlink, who mobilizes discourse to threaten the image of the Narcotics Monitoring System by unveiling its weaknesses.

A major theme that appears throughout the sample is the province's limited availability of naloxone. To get naloxone, people must be a known opioid drug user and go through the program. Between April 2012 and April 2013, Kathleen Wynne's government, introduced the Ontario Harm-reduction Distribution Program (Gallant 2013). The Ministry funded the distribution of overdose take-home kits, which included two doses of naloxone, syringes, alcohol swabs, and gloves. Secondary definer, Michael Parkinson, is a community engagement coordinator at the Waterloo Region Crime Prevention Council, which has worked to establish a naloxone distribution strategy in the area. Parkinson is represented in the press as expressing disappointment over the Ministry's decision to put the remaining naloxone kits on hold, pending the restart of the program. Parkinson, a secondary definer, is reported as saying that "they essentially have this important drug, paid for by taxpayers, sitting in a warehouse" (Gallant 2013:A1).

According to the *Globe and Mail*, approximately 1,800 vials of naloxone have yet to be distributed after the program was suddenly suspended because of "regulatory and other challenges", according to the Ministry's spokesperson Joanne Woodward Fraser (Gallant 2013). The article, however, does not explain what is meant by Fraser's comment, which can be viewed as a form of social closure. Fraser uses the media as a tool to engage in social closure by

excluding journalists, provincial and federal public health officials, and the general public from “insider knowledge” about the suspension of the naloxone program. The article goes on to say that “fewer than 500 of the vials had been sent to harm-reduction programs across the province” (Gallant 2013:A1). Secondary definer and family physician at the Guelph Community Health Centre, Lori Hasulo, is reported as commenting on Ontario’s unproductive approach with naloxone as well, “Ontario has been slow on this. It’s frustrating because there is such good evidence of how naloxone can help prevent death, and it’s not like it’s an expensive program, so I don’t understand the holdup” (Gallant 2013:A1).

As evidenced by the primary and secondary discourse used throughout this news article, the media frames naloxone as a feasible, short-term solution to preventing overdoses until more stable, long-term solutions are formed. The *Globe and Mail* also presents opioid-related death statistics to support the definers’ narratives about the province’s need for greater availability of and accessibility to naloxone. In 2011, about 550 Ontarians reportedly died from opioid-related overdose, making such overdoses one of the leading causes of accidental death in the province (Gallant 2013:A1). The media’s narrative indicates that several overdoses could have been prevented had Ontario’s Naloxone Distribution Program still been in place. Nevertheless, public health officials from a few Ontario cities, specifically Toronto and Ottawa, mobilized action in 2011 by developing distribution programs and purchasing their own naloxone. Public health officials, however, are reported as saying that they “would gladly take naloxone from the ministry should it ever come with a new distribution model” (Gallant 2013:A1).

Taking on the status of a secondary definer the media portrays other public health units as having adopted a similar form of resistance against Wynne’s government, despite the then-premier’s vague assurance that the medication will be delivered eventually. Although some

jurisdictions are able to distribute naloxone to opioid users, Guelph, Ontario does not have the budget to fund naloxone kits. The media's coverage of Guelph's inability to supply opioid users with naloxone demonstrates that Wynne's government excludes less powerful groups from obtaining similar economic resources and mobilizing action without the approval of and funding from all three levels of government.

This stage also shows that secondary definers (e.g., Michael Parkinson and physicians) opposed Wynne's decision to suspend the naloxone program. These definers use the term "life-saving" throughout the article to explain the significance of naloxone in reversing overdoses and to possibly obtain funding from other jurisdictions or government agencies for the continued supply of the drug. Elite secondary definer, Joe Cressy, however, is reported as stating that "naloxone should be easier to access and made available over the counter" (Warren 2015:GT1). The discourse around naloxone and the "dire need" to make the drug more available and accessible to the general public is primary, secondary, and oppositional definers' way of confirming that the recent upsurge in fatal opioid overdoses is a "problem" across Canada.

In January 2017, the federal government implemented new prescribing guidelines to help Canadian pain specialists and family physicians prescribe opioid narcotics for chronic non-cancer pain more safely. Representatives from the College of Physicians and Surgeons of Ontario created Canada's first prescribing guidelines in 2010, which set the foundation for the newly-implemented guidelines in 2017⁹. The first Canadian Guidelines for opioids were developed to deter physicians from prescribing at high rates; however, the media and many

⁹ In 2017 the Michael D. DeGroote National Pain Centre at McMaster University developed the new "Canadian Guidelines for Opioids for Chronic Non-Cancer Pain" to help Canadian physicians prescribe opioids for chronic non-cancer pain more safely and effectively (Ubelacker 2017).

physicians claim that even with the guidelines, physicians continued to prescribe high doses for medications. The *Globe and Mail* use the first opioid guidelines to distinguish between potential “opioid abusers” and patients who *require* them for acute and chronic non-cancer pain.

The *Globe and Mail*, for example, reports that “the first Canadian guidelines were created to keep powerful opioid painkillers out of the reach of potential abusers and put them back into the hands of patients who need them” (Weeks 2010:L1). This dichotomy proposes that there are some opioid users who, as a result of “moral failings”, engage in inappropriate opioid use, and then there are some opioid users who “need” medication(s) to alleviate their pain. Such dichotomy is present in the new prescribing guidelines, which encourage physicians to use “their best judgement” in deciding which patients display “addictive tendencies” and therefore require other treatments or an extremely low dose of pain medication (Ubelacker 2017).

The new “Canadian Guidelines for Opioids for Chronic Non-Cancer Pain” also recommends that physicians use non-opioids pharmacotherapy (e.g., non-steroidal anti-inflammatory drugs) and non-pharmacological therapy over the use of opioids for patients with chronic non-cancer pain (Ubelacker 2017). The “message” behind these guidelines is that opioids are useful for controlling and mediating pain, if the medication is taken at a proper dose. The regulatory body of physicians, therefore, is not trying to deter or inhibit individuals from using opioids, they are trying to make the public more aware and cautious of opioids and their potential harms. The new guidelines thus adhere to the material interests of the College of Physicians and Surgeons of Ontario. Informing individuals about the dangers of opioids and how to use them “properly” allows a continued market for these drugs, and these guidelines are used as a form of social closure. Representatives from the CPOS use their credentials and knowledge of pain medication and the human body to determine which doses are “effective” and safe for use/which are not,

how and when to take them (e.g., with food, water, in the morning, before bed, etc.), and what other substances to avoid if using prescription painkillers (e.g., alcohol). Furthermore, the implementation of such guidelines institutionalizes the problem of opioid mis/use and overuse across Canada.

The Premier of Ontario and primary definer, Doug Ford, introduced Consumption and Treatment Services (CTS) as another strategy to prevent fatal and non-fatal overdoses (Weeks and Stone 2018). Throughout the sample of Canadian newspapers, primary, secondary, and oppositional definers are represented as claiming that safe-injection and opioid-prevention sites play a critical role in preventing overdoses and saving lives. Doug Ford's government, however, made the decision in August 2018 to suspend funding to these sites (Giovannetti 2018).

Provincial Health Minister Christine Elliot use the news media to announce that Consumption and Treatment Services (CTS) will replace the former Supervised Consumption Services and Overdose Prevention site models (Weeks and Stone 2018). Existing centres are now required to reapply and meet a new set of requirements and guidelines, while moving to strictly limit the number of new sites that are allowed to open. In 2018, Elliot is reported in the press as announcing that “after a three-month review, the provincial government will only fund 21 sites as it meets the needs of communities across the province” (Weeks and Stone 2018:A3). Elite secondary definer and Toronto's Mayor, John Tory, is reported as arguing that “the overdose-prevention and the supervised injection sites are saving lives. The city has a ‘responsibility’ to offer any services that are proven to save lives” (Mathieu 2018c:GT3).

Elite secondary definer Eileen de Villa, Toronto's medical officer of health, is reported as making a similar comment to Tory's, “the scientific literature, along with the experiences from other jurisdictions and our own local ones have shown that supervised injection services and

overdose-prevention provide many health benefits, including reversing overdoses and saving lives” (Giovannetti 2018:A4). David Juurlink, the head of clinical pharmacology and toxicology at the University of Toronto, is also reported as maintaining Tory’s and de Villa’s narratives:

no government serious about addressing Ontario's opioid crisis would turn away from the overdose-prevention sites. It's crazy to halt new overdose-prevention, these places save lives, connect people to addiction care, reduce the spread of HIV and hepatitis C, and save the health system money. We need more of these sites, not fewer (Giovannetti 2018:A4).

Juurlink’s narrative constructs Doug Ford and his colleagues as irresponsible and counterproductive in deciding to suspend funding. This discourse questions whether the “opioid crisis” is at the forefront of Ford’s public agenda, as several public health officials and front-line workers struggle to develop long-term solutions without the support and financial backing of the government.

Premier Doug Ford is reported as saying that he is “dead against” supervised drug use and overdose-prevention sites during the 2018 election campaign in the Spring (Giovannetti 2018:A4). Ford uses the news media as a tool to engage in social closure over safe-injection and overdose-prevention sites. Using the term “dead against” signals to readers cum-the-electorate that his decision to suspend funding to overdose-prevention sites is non-negotiable. Ford asserts, however, that the province should focus on drug rehabilitation instead of harm-reduction. What is interesting about Ford’s decision to concentrate on rehabilitation is that it involves methadone and buprenorphine treatments, which are drugs that are manufactured and distributed by major pharmaceutical companies. The costs of rehabilitation and paid-treatment programs vary depending on the level of “care” needed, whereas safe injection and overdose-prevention sites are free to use. The new supervised consumption site models require a fee to use as well.

Primary (e.g., political figures and public health officials), secondary, and oppositional definers continue to criticize the Canadian governments for not allocating enough resources toward “resolving” the “opioid problem.” In fact, oppositional definer Zoe Dodd uses the news media to expose the federal and provincial governments’ near-absent role in ameliorating the issue of opioid use, misuse, and overuse (Ferguson 2017b). Dodd’s discourse suggests that Justin Trudeau’s government played a part in the 865 opioid-related fatalities that took place in Ontario in 2016 (Ferguson 2017b). Dodd’s discourse can be viewed as tool for influencing public outcry against authorities. Dodd is reported in the *Toronto Star* as arguing, “if they had acted sooner (referring to the Canadian government) and listened to us on the front lines, yeah, maybe we could have stopped some of the deaths. We could have got a handle on this” (Ferguson 2017b:A3). Doug Ford’s decision, therefore, may come from a place of trying to restore his control over the crisis through the implementation of safe-consumption services. This decision enables Ford’s government to enforce their own rules and regulations regarding the new services, have control over the funds allocated to and the revenue made from the new services, and by implementing the new consumption services, Ford contests the various definers’ claims and demonstrates to readers that the provincial government *is* addressing the crisis through rehabilitative measures.

The media reports that in another letter sent to the provincial government, primary (e.g., public health officials) and oppositional (e.g., harm-reduction workers) definers request Ford’s government to revoke the suspension on existing overdose-prevention sites and approve the opening of new ones. The request, however, was denied and the restriction on new overdose-prevention sites remain. Heather Watt, Ms. Elliott’s chief of staff, is reported in the *Globe and Mail* as saying, “the minister has been clear that she is undertaking an evidence-based review of

the overdose prevention and supervised consumption site models to ensure that any continuation of these services introduce people into rehabilitation” (Giovannetti 2018:A4). John Tory’s efforts to expedite the new application process, which requires a lengthy review before the new sites are approved, is his way of confirming that Canada is experiencing an “opioid crisis.”

Despite Ford’s decision to suspend funding to overdose-prevention sites and waiting on “evidence-based research” for feasible and effective solutions, the Toronto Overdose Prevention Society (TOPS) defied Ford and started operating out of a tent in Parkdale-High Park in August 2018. Similar to the Moss Park pop-up site, volunteers from TOPS did not wait for the approval of provincial health minister Christine Elliot to house their tent in the park. Guided by the belief that active drug users play a critical role in harm-reduction services and solutions, these oppositional definers took action when the government is seemingly not. In addition, as part of a “National Day of Action”, a group of oppositional definers rallied at King and York Street South in response to the pharmaceutical and illicit “opioid crisis” (Mathieu 2018a). Speakers and supporters from oppositional organizations such as the Toronto Overdose Prevention Society (TOPS), Prisoners HIV/AIDS Support Action Network, Black Lives Matter, the Toronto Harm-reduction Alliance and the South Riverdale Community Health Centre came together to call for the decriminalization of all drugs. These oppositional definers use the news media as a tool to engage in usurpationary closure by constructing the government’s intended plan of action – a strategy for rehabilitation and treatment – as a needlessly long, difficult, and misdirected process (Mathieu 2018a). By constructing rehabilitation in such a way, these oppositional groups sought to convince readers and primary definers to see their proposed method of decriminalization as an effective “solution” to opioid dependency and overdoses.

The media reports that Canada’s decision to implement the *Good Samaritan Drug Overdose Act* and Ontario’s decision to implement an emergency “task force” are among the other policies or strategies that were introduced to reduce the increasing number of fatal overdoses across the country. In 2017 then-federal Minister of Health, Jane Philpott, is reported as announcing that the *Good Samaritan Drug Overdose Act* received Royal Assent and became law (Mathieu 2018a). Primary definer Jane Philpott is reported as stating that this newly-implemented legislation is designed to offer “some legal protection”, although the extent of protection is not defined, “against charges for possession if people call in a suspected overdose” (Mathieu 2018a:GT1). While the media reports that the *Good Samaritan Drug Overdose Act* was developed and implemented in the wake of 4,034 apparent opioid-related deaths across Canada in 2017, the legislation is not confined solely to opioid overdoses. In fact, the *Good Samaritan Drug Overdose Act* is applied to all drug overdoses, including illicit substances and “street-marketed” narcotics (Mathieu 2018a).

Guided by then-provincial Health Minister, Eric Hoskins, Ontario implemented an “emergency” task force, although the province does not declare opioid mis/use and overuse an emergency. The task force is comprised of bureaucratic actors (e.g., public health and government officials), physicians, “addiction” experts, harm-reduction/community outreach works, emergency personnel (e.g., police and fire services), former and current drug users, and families who have endured an opioid-related death. Hoskins’s task force will work together to explore options for curbing opioid dependency and preventing overdoses across Canada, which coincides with Blumer’s (1971) discussion that although solutions and strategies have been implemented, they are constantly modified, revised, and updated. Overall, political action at each

stage will continue to inform and shape action in subsequent stages, and the process will likely operate in a cyclical fashion until an “adequate” solution is achieved.

In regard to the implementation of solutions or strategies aimed at curbing opioid dependency and preventing overdoses, the claims-making activities of the various definers are consistent with the fifth stage of my composite model of social problems. Similar to the fourth stage of the composite model, the media provides the title of one “drug strategy plan” but does not discuss it in detail; therefore, I relied on the discourses and claims-making activities of primary, secondary, and oppositional definers in explaining or contesting current solutions that have been implemented by Canadian governments, major health organizations (e.g., Health Canada), and legislative bodies. It is obvious that those who stand to benefit from the “discovery” of Canada’s “opioid crisis” and its proposed and implemented solutions are primary and some elite secondary definers (e.g., Premier Doug Ford, former provincial Health Minister Eric Hoskins, former federal Health Minister Jane Philpott, etc.). Their economic and political resources and social location within the social order provides government officials, medical authorities, and health organizations immediate access to the news media. To this end, primary claims circulate the media more rapidly and mold public opinion(s) about Canada’s recent spike in opioid dependency and overdoses.

Physicians, pharmacists, and harm reduction workers are impacted by the solutions or strategies that have been implemented to ameliorate opioid mis/use and overuse. Stricter prescribing guidelines and prescription monitoring systems, for example, may restrict physicians’ and pharmacists’ authority in making decisions about prescribing/dispensing medications, as they will be highly monitored through surveillance systems and regulatory bodies. Also, stricter legislation in regard to the new supervised consumption services may limit

the role of harm reduction workers in providing adequate and self-less services for drug users across the country. The news media frequently used the discourses of Dr. Eric Hoskins to contribute to the construction of the “opioid crisis” in Canada. Hoskins’s voice was most active in news articles between 2016 and 2017, where discussions about developing solutions to curb opioid dependency and prevent overdoses were prominent. It is worth noting that Hoskins was seeking re-election for his role as Ontario Health Minister in 2018. Using the “opioid crisis” as an election platform enables him to present a “humanitarian” image of himself, while advancing his prestige and enhancing his status as a politician. Hoskins, therefore, uses the media to communicate his plan to help curb opioid dependency and prevent overdoses. This is relevant to implementation because the general public will view Hoskins as an ideal candidate for playing a dominant role in creating solutions or strategies to reduce the risk of fatal and non-fatal opioid overdoses, and taking action against opioid mis/use and overuse. The implementation of Hoskins’s task force communicates to readers that the “opioid crisis” is a priority for Hoskins and that he is capable of taking political action to ameliorate opioid mis/use and overuse in Ontario.

Chapter Summary

To conclude, in attempting to operationalize processes of representation at each stage of the composite model of social problems, Best’s and Blumer’s descriptions generally conform to the data from the news articles. As I anticipated, primary definers represent themselves and are usually represented by the press as more compassionate and sympathetic toward prescription and illicit opioid users than illicit drug-using populations. What is crucial to the emergence of illicit opioid use as a crisis is that the demographic predominantly dying from opioid mis/use and overuse is respectable white working- and middle-class men. Instead of addressing the crisis with

punitive measures, a public health approach is employed to ameliorate the issue of opioid mis/use and overuse in Canada. The various definers appear to create a moral panic around the prevalence of opioid dependency and overdoses across Canada. For the most part, other than the College of Physicians and Surgeons of Ontario's (CPOS's) recommendations for physicians to try non-opioid treatments for chronic non-cancer pain, primary definers (e.g., government and public health officials) do not attempt to deter individuals from using prescription opioids or narcotics. Public health officials call on the federal and provincial governments to take action, whereas in other moral and political campaigns, the government is more active in addressing the "problem." Finally, the print news media coverage of Canada's "opioid crisis" increased disproportionately between October 1st, 2008 and October 1st, 2018 to the incidence of opioid dependency and overdoses. Primary, secondary, and oppositional definers frame Canada's "opioid crisis" as a widespread social problem which requires urgent measures to curb opioid dependency and prevent overdoses.

Conclusion

In conclusion, this thesis borrowed and modified certain stages from Joel Best's and Herbert Blumer's social problems models to determine the viability of my own composite model of social problems with Canada's "opioid crisis" as a case study. The four-stage composite model includes: 1) the claims-making process and the emergence of social problems, 2) legitimation, 3) policymaking and the formation of an official plan of action, and 4) implementation of an official plan of action. Relying on a materialist theoretical formation of social constructionism and a critical assessment of the news media as both source and interlocutor for primary, secondary, and oppositional definers, I demonstrated that in the making of the "opioid crisis", primary and elite secondary definers have a resource advantage in laying claims of expertise and "definitional dominance" over the construction of social problems.

Returning to the research aim I set out in the introduction, the focus of this thesis has been to explore how the process of social problems and hegemonic discourses of appropriate moral norms are implicated in framing opioid mis/use and overuse as a "crisis" over other possible explanations. Through critical discourse analysis supplemented by the *Toronto Star* and the *Globe and Mail*, I have investigated the socio-political and economic context through which social problems emerge and explored how primary, secondary, and oppositional definers are engaged in exclusionary and usurpatory closure while in the process of mobilizing and resisting discourses, narratives, and constructions of folk devils, as these relate to meanings of a perceived opioid crisis in Canada.

In the first chapter I posed the question that would drive this research. My question was concerned with how the *Toronto Star* and the *Globe and Mail* represent the claims of primary, secondary, and oppositional definers in contributing to the construction of opioid mis/use and

overuse across Canada between October 1st, 2008 and October 1st, 2018. My question was also interested in determining if I could operationalize processes of representation at each stage of my composite model of social problems. Generally speaking, the data from the news articles conform to the stages I borrowed and modified from Dr. Joel Best's and Herbert Blumer's models of social problems. In short, this study demonstrated how discourse, linguistic codes, and rhetorical devices in the print media carry ideological meaning(s) (Van Dijk 1993). Concerning the representation of opioid mis/use and overuse in the *Toronto Star* and the *Globe and Mail*, each definer unanimously agrees that the recent increase in opioid-related deaths and harms have come to signal a "crisis" in Canada. Primary definers (e.g., the Prime Minister, premier(s), Health Minister, Ministry of Health, and the Medical Officer of Health), however, are responsible for establishing policies and determining the roles of various actors involved in curbing opioid dependency and preventing overdoses. After examining the sample, it is clear that primary and some elite secondary definers have control over the dominant definition of opioid dependency and overdoses across Canada.

The linguistic tools and representational processes present no major or substantial differences between the liberal newspaper (i.e., the *Toronto Star*) and the conservative newspaper (i.e., the *Globe and Mail*). The two Canadian newspapers demonstrate significant consistency in focusing on elite discourse to construct opioid mis/use and overuse. This discourse focuses on reducing the number of fatal opioid overdoses through a collaborative and compassionate public health approach. Medical authorities, physicians/medical "experts", policymakers, and harm-reduction/community outreach workers have proposed strategies that emphasize the importance of enhanced prescription monitoring systems, making prescription medication, specifically opioids, harder for physicians, patients, and the general public to access,

tamper-resistant oxycodone, re-training physicians and educating the general public about the dangers and risks of opioid narcotics, expanding harm-reduction services (e.g., safe injection sites and greater availability of naloxone), and the decriminalization of simple possession of all narcotics.

Prior drug panics, such as the crack cocaine “epidemic” in the 1980s and alcohol temperance, prohibited the manufacturer, distribution, possession, sale, and use of these “dangerous” drugs/substances. In the event of the “opioid crisis”, however, government officials and legislative committees develop and implement solutions geared toward treatment and rehabilitation. It can be inferred that a more compassionate and empathetic approach is used to curb opioid dependency and reduce the number of opioid-related harms and overdoses, because prohibiting the manufacture, sale, and use of opioids would “threaten” a reliable source of revenue for pharmaceutical corporations and the state. In discovering opioid mis/use and overuse as a social problem across Canada, primary and secondary definers avoid more practical and pressing issues (e.g., unemployment, poverty/homelessness, racism, gender inequality, etc.) that never become identified as social problems. Indeed, this is a strategy used by primary and secondary definers to maintain and advance their latent interests toward social control and regulation throughout the social order. By defining certain behaviours (e.g., child abduction, the prevalence of cocaine in the 1980s, rebellious youth, etc.), conditions, and/or groups (e.g., negatively racialized groups, the uneducated, the poor, etc.) as “social problems”, political leaders can justify implicit and explicit discriminatory and racially-motivated legislation and divert the public’s attention from other political matters.

In this thesis I have demonstrated some of the ways that primary, secondary, and oppositional definers construct opioid mis/use and overuse as a “social problem” in Canadian

corporate print media. Social problems and their broad implications are not objectively “given” realities whose existence may be taken for granted. Instead, social problems should be perceived independently of objective behaviours and conditions (Blumer 1971). Social problems are the activities or “efforts” of various definers who assert the existence of issues and identify them as “problems.” For Blumer (1971), social problems must be analyzed within a socio-political context where issues develop a “career” over time. In order for a social problem to transition into a public issue, a complicated socio-political process develops around the claims-making activities of major bureaucratic actors, the media, “experts”, and private interest groups. Conflicts often arise over not only what is considered a “public issue”, but also over how the “problem” is defined and what solutions are most effective in ameliorating the social problem. Competing claims and debates will occur between, on the one hand, government officials, medical authorities, and legislative committees and, on the other hand, advocacy and oppositional groups, as well as the target population involved in the social problem. If a “harmful” behaviour or condition is to achieve legitimacy and respectability as a “social problem” and remain as such, it must be incorporated within the existing socio-political arrangements (Best 2017; Blumer 1971).

Although this analytical and wide-ranging project is inconclusive and leaves many questions unanswered, the goal was to present original ideas to scholars who wish to examine this research topic more extensively in the future (Symbaluk 2014). This theoretical account of how discourse and knowledge are mobilized to secure social closure and usurpation open the opportunity to undertake empirical study that could more rigorously ascertain the utility of the various stages of my social problems model to explain how various definers mobilize resources to frame reality.

The problem with using mediated knowledge, pressed and compressed through the filtering process of news values to determine what the various definers are actually saying is that I never truly knew if what I read was factual information or constructed to adhere to a certain ideology and advance or maintain the interests of a particular group of people. As a result, this study does not claim to have tackled all the linguistic structures of news media discourse about Canada's "opioid crisis." This study is confined to the representations of primary, secondary, and oppositional definers in contributing to the constructing and representation of opioid mis/use and overuse through various discourses. Within this limitation, my research is not interested in determining or highlighting who is right or wrong in their ideological perspectives; instead, my research explained how social meanings are reproduced and focused on the ideological, communicative, and construction processes of Canada's "opioid crisis" in the *Toronto Star* and the *Globe and Mail*. A "limitation" of the composite model of social problems is that it does not examine how opioid mis/use and overuse affected Canadian society once the "harmful" conduct became identified as a "social problem" and institutionalized into the social "structure." Future studies, therefore, should focus their research attention on the end of the life cycle of a social problem's "career", to what has been referred to as the "fragmentation" or "demise" of social problems (Mauss 1975). What is necessary to ask in future research is what happens to social problems and claims-making activities once the issue has been institutionalized into the political and public domains? Specific attention should be given to the economic and political sources that mold social policy and the development of social problems.

In final consideration, this thesis contributed a composite model of social problems that explained how primary, secondary, and oppositional definers construct competing claims over the discovery of a variously labeled opioid crisis. I found that primary, secondary, and

oppositional definers did not engage in conflict or debate over whether opioid mis/use and overuse is in fact a “crisis” across the country because of a priori agreement. It can be inferred that since white working- and middle-class persons, especially men, are the demographic predominantly dying from opioid-related overdoses, compassion and empathy were essential to the solutions or strategies aimed at curbing dependency and preventing overdoses from the beginning of the “crisis.” Hence the empathetic discourse of “death by despair” (see Case and Deaton 2015) which undergirds the public health approach to opioid-induced deaths and overdoses. Despite conflict, which is often a key component of the social problems process, there are times when consent about a definition of a social problem is not in dispute as is the case with Canada’s “opioid crisis.” As an epistemological inquiry into the making of social problems, this study relied on the print news media as the locus for the articulation of competing claims toward the construction of social problems. It is worth noting that the theoretical model I created, however partial and incomplete, gestures toward just one possible way of thinking about how social reality is made and experienced in an ongoing way.

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Appendix A – Email of Inquiry about Opioid-related Deaths and Harms Preceding 2015

To Whom It May Concern,

My name is Julia Kenny and I am a second-year Master's student in Critical Sociology at Brock University (located in St. Catharines, Ontario). I am writing my thesis on the representation of the current opioid crisis in the *Toronto Star* and the *Globe and Mail*. I am contacting Health Canada (I modified this part depending on who I was contacting at the time) to inquire about statistics for opioid-related deaths and harms preceding 2015 or within the time frame of 2008-2015, because this information is not readily accessible on Health Canada's website (again I modified this part depending on who I was contacting at the time). I was wondering if one of your representatives could email me back with this information, as these statistics would be extremely useful for my thesis topic. These statistics would allow me to gain a better understanding of the magnitude and pervasiveness of the opioid crisis in Canada.

Thank you for your time, I look forward to hearing back from one of your representatives.

Best,

Julia Kenny

Appendix B: Email Response – Health Canada



Gillespie, Darcy (HC/SC) <darcy.gillespie@canada.ca> on behalf of opioidresponse / interventionopioides (HC/SC)



Wed 5/29, 1:27 PM

Julia Kenny ✉

Good Afternoon Julia,

Thank you for reaching out regarding collecting statistical information for your thesis.

Beginning in 2016, the Public Health Agency of Canada (PHAC) started working with the provinces and territories to collect and share accurate information about the opioid crisis in order to provide a national picture of the public health impact of opioids in Canada and to help guide efforts to reduce opioid-related harms and deaths.

Health Canada does not have the data you requested available with respect to opioid-related harms and deaths in Canada prior to 2016.

If you require additional information as part of your project, please visit: <https://www.canada.ca/en/health-canada/services/substance-use/problematic-prescription-drug-use/opioids/data-surveillance-research/harms-deaths.html>. This site provides information about opioid data, surveillance and research.

Good luck with your thesis.

Darcy Gillespie
Opioid Response Team / Équipe d'intervention en matière d'opioïdes
Health Canada / Santé Canada
Government of Canada / Gouvernement du Canada

Appendix C: Email Response– The Government of British Columbia



servicebc@gov.bc.ca
Wed 10/3/2018 5:38 PM
Julia Kenny ✓



Hello Julia

Please visit the link below for Statistical Reports for the Province of BC. There is an email provided to the Coroners office for further details.

<https://www2.gov.bc.ca/gov/content?id=26C257C597784B5A8A0C96226DA390C2>

Thank you

MaryF

Customer Service Representative
Service BC

Ministry of Citizens' Services

Phone Toll Free: 1-800-663-7867

Website: <http://www2.gov.bc.ca/gov/content/home/services-a-z>

"Access to government services made easy"

Appendix D: Email Response – Nova Scotia Archives



Nova Scotia Archives <archives@novascotia.ca>

Thu 10/4/2018 7:54 AM

Julia Kenny ✓



> Hello Julia,

>

> As Nova Scotia's Archives, we store very old historical records here, none of which include information on opioids. You might try contacting the Department of Health & Wellness. Their website is <https://novascotia.ca/dhw/primaryhealthcare/midwifery.asp>. Another avenue would be Statistics Canada. Their website is <https://www.statcan.gc.ca/>.

>

> Good luck with your thesis.

>

> Regards,

> Lois Pyke

> Reference Team

> Nova Scotia Archives

> 6016 University Avenue

> Halifax, NS B3H 1W4

> 902-424-6060

> archives@novascotia.ca

Appendix E: Email Response – The Centre for Addiction and Mental Health (CAMH)



Sarah Bonato <Sarah.Bonato@camh.ca>

Thu 2018-09-27 12:40 PM

You ▾



Hi Julia,

My apologies for the delay. As an organization, CAMH does not collection statistics on opiate related overdose. However, the Public Health Agency of Canada has recently published a report and you can access it at <https://www.canada.ca/en/public-health/services/publications/healthy-living/national-report-apparent-opioid-related-deaths-released-june-2018.html>. Health Quality Ontario also has information on opiate related morbidity and mortality at <https://www.publichealthontario.ca/en/dataandanalytics/pages/opioid.aspx>

Good luck with your research!

Cheers,

Sarah Bonato, MIS
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Appendix F: Email Response – InSite



Bell, Erika [VC] <Erika.Bell@vch.ca> on behalf of InSite Tour Requests <InSiteTourRequests@vch.ca>



Wed 10/24/2018, 6:31 PM

Julia Kenny ✉

Hello Julia,

Thank you for your request.

Insite only has data available having to do with Insite and there have been no deaths within Insite since conception. It has been suggested that you could search the coroner's report which can be found online as well as different stats live online through Vancouver Coastal Health.

<http://www.vch.ca/Documents/overdose-surveillance-week-20.pdf>

I apologise we do not have exactly what you are looking for but hopes this helps!
Thank you and have a great day.

Erika Bell

Administrative Assistant to
Caitlin Etherington, Interim Director, Regional Prevention

Vancouver Coastal Health

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