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Research Paper

Problematizing the DSM-5 criteria for opioid use disorder: A qualitative analysis

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ABSTRACT

Background: This paper includes the voices of people who are members of a peer-led drug user group (SNAP) in Canada who are receiving heroin-assisted treatment (HAT) outside of a clinical trial. Drawing from critical drug studies, we problematize the criteria for severe opioid use disorder (OUD) from the fifth edition of the Diagnostic and Statistical Manual of Mental Disorders, by exploring SNAP members' experiences in relation to heroin-assisted treatment, and examining how SNAP participants' narratives challenge conventional notions of what constitutes severe opioid use disorder.

Method: Drawing on critical analysis and research guidelines developed by drug user unions and organizations, and critical methodological frameworks on ethical community-based-and-responsive research for social justice, in this paper we focus on semi-structured interviews conducted with 36 SNAP members at the Vancouver Area Network of Drug Users site in the Downtown Eastside of Vancouver, Canada. We included opened ended questions about experiences prior to receiving HAT, experiences while receiving HAT, experiences of drug use and cessation, and future hopes.

Results: Although SNAP participants were diagnosed as suffering from OUD, the DSM-5 criteria for OUD fails to encompass their diverse experiences of opioid use. Nor does the DSM diagnosis capture the complexities of their lived experience. The DSM OUD constructs an idea of addiction and the addicted person based on a list of symptoms thought to be associated with extended use of opioids. The problem with this is that many of these "symptoms" of drug use are, in the case of SNAP participants, tied to contextual issues of living in the DTES, experiencing structural vulnerability, and being the target of punitive drug policies and laws.

Conclusion: To label someone as having a severe disorder shifts the focus from political and social issues, including the lived experiences of people who use heroin. The DSM-5 de-contextualizes drug use. How addiction and heroin are constituted has political implications that will determine what types of services and programs will be set up. Treating a disorder, or a person with a disorder, requires a much different approach than understanding heroin use as a habit. SNAP, and their allies, are rupturing conventional ideas about heroin and taken for granted assumptions about people who use heroin.

This paper includes the voices of people who are members of a peer-led drug user group in Canada who are receiving heroin-assisted treatment (HAT) *outside* of a clinical trial – in the Injectable Opioid Agonist Treatment (iOAT) program in the Downtown Eastside of Vancouver (DTES), British Columbia. The iOAT program at Crosstown Clinic is the first program in Canadian (and North American) history to provide HAT outside of a clinical trial. The interviewees are members of the SALOME/NAOMI Association of Patients (SNAP), an independent peer-led drug user organization that meets weekly at the Vancouver Area Network of Drug Users (VANDU) site in the DTES of Vancouver. SNAP advocates for diverse and flexible HAT programs, the human rights of people who use criminalized drugs, and an end to drug prohibition.

Our assumptions about heroin, HAT, and the people who use heroin during particular historical periods are shaped by shifting socio-cultural morals and norms (including ideas about heroin, "addiction," and "problematic" drug use) and have significant political and legal implications for the adoption or rejection of social, health, and justice policies. Thus, our commitment to collaborate with SNAP and to include the voices of those most directly affected by drug policies and

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diagnostic tools: people receiving HAT. In this paper, drawing from critical drug studies, we problematize the criteria for severe opioid use disorder (OUD) from the fifth edition of the Diagnostic and Statistical Manual of Mental Disorders (APA, 2013), by exploring SNAP members' experiences in relation to HAT and examining how SNAP participants' narratives challenge conventional notions of what constitutes severe opioid use disorder. SNAP, and their allies, are rupturing conventional ideas about heroin and taken for granted assumptions about people who use heroin.

Background

In Canada, following the *Opium Act* of 1908, nonmedical use of opiates was criminalized in 1911; however, the brand name "heroin" (diacetylmorphine) was not added to the drug schedule until 1923. Canadian doctors were also prohibited from prescribing opioids for maintenance purposes to people identified as "addicts" and could be charged with a criminal offence if they did so (Boyd, 2017; Giffen, Endicott, & Lambert, 1991). However, Canadian physicians retained the right to prescribe heroin for medical purposes. From the mid-1920s on, U.S. and national pressure to ban the manufacture and medical use of heroin grew. By the 1950s, a ban on approving licences for heroin importation was put in place by the Canadian federal government (Giffen et al., 1991). That ban was not lifted in Canada until 1984. However, negative discourses about heroin, and security criteria, protocols, and other bureaucratic obstacles made it difficult for doctors to prescribe the drug; consequently, suppliers stopped providing it in Canada (Walker, 1991).

Outside of Canada, heroin continued to be prescribed in Britain to treat medical conditions and to manage pain. In addition, although limited and regulated, heroin was prescribed for the treatment of those identified as being "addicted" to illegal heroin (Blanken et al., 2010; Strang, Groshkova, & Metrebian, 2012). Abstinence-based drug treatment was, and continues to be, the primary form of treatment available in Canada (Boyd, Carter, & MacPherson, 2016). However, following a change in the Narcotic Control Act in 1961, which allowed for the legal provision of methadone maintenance treatment (under strict regulation), methadone became the treatment of choice for opioid substitution programs in Canada. Research has made it abundantly clear, though, that methadone maintenance treatment does not work for everyone (Luce & Strike, 2011). More recently, buprenorphine and methadone (and methadose), and to a lesser degree, slow release oral morphine, along with oral and injection hydromorphone are being prescribed for those labeled with "opioid use disorder" in some regions of Canada (Ahamad et al., 2017).

Legal access to heroin-assisted therapy is fairly new in Canada. The Canadian Institutes of Health Research approved and funded Canada's first HAT clinical trial, the North American Opiate Medication Initiative (NAOMI) study, which ran in the DTES and Montreal from 2005 to 2008 (Gartry, Oviedo-Joekes, Laliberté, & Schechter, 2009). Although the study found (similar to other studies outside of Canada) that injectable HAT proved to be a safe and highly effective treatment for the participants, continued treatment post-trial (an exit strategy) was not set up (Boyd & NAOMI Patients Association, 2013; Small & Drucker, 2006). At the end of the NAOMI trial, participants had the option to return to conventional treatments such as methadone or abstinence-based treatment that had previously failed them, or to buy heroin once again from the illegal market.

SNAP was founded in 2008 by former NAOMI research subjects. At that time they called their peer-led group the NAOMI Patients Association. As the only Canadians to have received HAT, they came together to support one another, to advocate for the establishment of permanent HAT programs, and to tell their own story in order to effect change (Boyd & NAOMI Patients Association, 2013; Boyd, Murray, & NAOMI Patients Association, 2017a; Boyd, Murray, SNAP, & MacPherson, 2017b). Canada's second clinical trial began recruiting in the DTES at the end of 2011, the Study to Assess Longer-term Opiate Medication Effectiveness (SALOME). Like the NAOMI trial, it did not have a formal post-trial or exit strategy for participants – whereby a permanent HAT program would be established (Boyd et al., 2017a). However, this time around, due to extensive advocacy efforts by SNAP, Pivot Legal Society, Providence Health Care Society (PHCS), some SALOME staff, and others, an alternative post-trial strategy was developed as the first SALOME trial participants began to exit the study. The lead author and SNAP have written elsewhere about the social and legal battle (including a constitutional challenge) to provide HAT outside of a clinical trial in Canada; thus, we will not discuss this in depth here (Boyd & Norton, 2019; Boyd et al., 2017b). Suffice to say that advocacy is ongoing, although new regulations introduced in 2017 by the federal government make it easier now to provide HAT during a public health crisis (Government of Canada, 2017). Since November 2014, more than 100 people receive HAT through the iOAT program at Crosstown Clinic in the DTES. SNAP and their allies argue that the prohibition of drugs, criminalization, and health policies continue to shape HAT and the illegal overdose crisis in Canada.

Canada is experiencing its worst illegal drug overdose death crisis since prohibition. The crisis stems from prohibitionist policies, a poisoned illegal drug supply (partially due to fentanyl and related analogues), and limited drug substitution programs. Between January 2016 and June 2019, more than 13,900 Canadians died from a preventable illegal drug overdose (Government of Canada, 2019). The province of British Columbia continues to be the epicenter of the crisis and a public health emergency was declared in BC in 2016. One response to the illegal drug overdose death crisis in British Columbia and the rest of Canada has been, rather than HAT, as noted above, the establishment and expansion of injectable and oral hydromorphone treatment. Given the illegal drug overdose death and poisoned drug supply crisis in Canada, discussion about illegal opioid use and substitution programs has increased as politicians, physicians, researchers, drug user groups, and families search for solutions to the crisis.

Contesting "addiction"

Critical drug researchers explore assumptions about the label "addiction" and the instability of addiction models (Campbell, 2007; Fraser, 2017; Fraser, Moore, & Keane, 2014; Hart, 2017; Keane, 2002; Levine, 2015; Pienaar & Dilkes-Frayne, 2017; Reinarman, 2005; Reinarman & Granfield, 2015). Early on, Harry Levine's research on alcohol consumption in the late 1700s and early 1800s contributed to our understanding of the invention of the concept of addiction (Levine, 2015). Levine asserts that rather than a medical or scientific discovery, the concept of addiction stemmed from changes in social thought and social life (Levine, 2015, p. 37). Reinarman affirms that the disease concept of addiction "was not a scientific discovery"; rather, the concept is "continuously redefined" (Reinarman, 2005, p. 307). Reinarman and Granfield explain that a contemporary concept such as "addiction-as-disease has a history, a genealogy" (Reinarman and Granfield, 2015, p. 2), and Campbell's examination of addiction research in the US concludes that scientists have not been able to discover a fixed answer to the "nature of addiction" (Campbell, 2007). Nor has recent neuroscientific research (Campbell, 2007; Hart, 2017).

Following drug prohibition, people who used illegal heroin were demonized (and continue to be) and constructed as criminal. However, in the late 1940s and early 1950s, psychiatry emerged as a new knowledge producer in the field of addiction in and outside of Canada (Acker, 2002; Boyd, 2013; Campbell, 2007). Rather than abandon the category of criminal, psychiatrists in Canada worked with law enforcement, and people who used illegal heroin were constructed as 'criminal addicts' who were doubly deviant, criminal and pathological, thus justifying mandatory treatment in prison (Boyd, 2014). In the twenty-first century, people who are labeled addicted or dependent on illegal opioids continue to be constituted as deviant, criminal, and/or

pathological. It has been assumed that framing continued illegal opioid use as a disease or pathology, rather than as criminal and deviant behavior, reduces stigmatization. However, that has not been the case (Fraser, 2017; Fraser et al., 2017; Pienaar & Dilkes-Frayne, 2017; Reinarman & Granfield, 2015). In fact, it is argued that "addiction operates as a powerful therapeutic and political discourse which classifies, normalises and disciplines subjects" (Fraser et al., 2014, p. 5; Valverde, 1998; Fraser & valentine, 2008; Keane, 2009). As Fraser et al. note, "the reality of addiction is brought into being in research labs, clinical encounters, health policy meetings, legal schedules and texts such as the *DSM*. Addiction is produced in these contexts through the assemblage of certain elements and the exclusion of others" (Fraser, 2014, p. 26). Conventional narratives of illegal drug use and those identified as "dependent" or "addicted" to heroin include experiences of increased use, loss of control, immoral and criminal activity, drug treatment failure, and – for some – control through abstinence or participation in a drug substitution program such as methadone maintenance treatment (Fraser & valentine, 2008a; Boyd, 2008b; Pienaar & Dilkes-Frayne, 2017).

Redefining concepts of addiction and dependence are evident in the different classifications and list of criteria in the American Psychiatric Association's (APA, 2013) *Diagnostic and Statistical Manual of Mental Disorders* (*DSM*) since its inception in 1952. The *DSM* is regarded as the primary mental health diagnosis manual in western nations (Blashfield, Keeley, Flanagan, & Miles, 2014; Fraser et al., 2014; Robinson & Adinoff, 2016). In the 1980s, the *DSM-III* classified substance use disorder as a primary mental health disorder rather than as "underlying a primary psychopathology" (Robinson & Adinoff, 2016, p.1). The *DSM-5* (the most recent edition, revised in 2013) includes a number of specific substance use disorders (SUD), such as Alcohol Use Disorder, Cannabis Use Disorder, and Opioid Use Disorder (OUD). The shifting and narrow depiction of illegal drug use and drug users the criteria advances in the *DSM* over time contributes to what Pienaar and Dilkes-Frayne refer to as "stigmatizing ontological politics" (Pienaar and Dilkes-Frayne, 2017, p. 153). In Canada, regular opioid users are constituted as criminal and as having a disorder.

In this paper, we focus on the *DSM-5* diagnostic criteria for OUD. Debates about concepts and diagnostic categories are important because the *DSM*, including its most recent edition, the *DSM-5*, along with conventional ideas about addiction, inform policies and treatment options, as well as how people themselves define or understand their own use of drugs in a specific era and cultural and social setting (see Fraser, 2017, p. 130; Pienaar & Dilkes-Frayne, 2017; Reinarman & Granfield, 2015). In our findings section, SNAP participants also rupture some ideas about regular heroin use and fixed pathological identities.

SALOME researchers describe the participants in the SALOME trials as meeting the *DSM* criteria for severe OUD (Oviedo-Joekes et al., 2016). Individuals receiving HAT in the permanent iOAT program at Crosstown Clinic are also described as meeting the *DSM* criteria of OUD. In May 2019, Health Canada announced a Notice of Compliance change that supervised injectable hydromorphone can be prescribed for adults with severe opioid use disorder who have repeatedly failed opioid agnostic therapy (Health Canada, 2019). Therefore, in Canada, individuals must meet the *DSM-5* criteria for severe OUD in order to receive HAT and/or injectable hydromorphone treatment (Health Canada, 2019).

However, Fraser et al. (2014) assert that heavy and regular drug use does not need to be understood as a fixed pathological identity, or a "neurobiological condition"; rather, it could be understood as a "habit" (Fraser et al., 2014; Keane, 2002). Drawing from the 2012 online Oxford Dictionary, Fraser et al. (2014, p. 22) define habit as:

> "a settled or regular tendency or practice, especially one that is hard to give up:
>
> - *he has an annoying habit of interrupting me*
> - *good eating habits*"

Thus, the authors argue, "habit is neither good nor bad" (Ibid.).

For over a century, heroin has been constructed as highly addictive, compelling, and destructive. In Canada, until recently, heroin has also been constructed as having no therapeutic value (Boyd, 2017). Lurid representations of 'junkies' and 'addicts' are transmitted through language, texts, and visual media (Acker, 2002; Boyd, 2008b), producing a constellation of discrimination and stigmatization.

In her 2018 article on drug problematizations and politics, Carol Bacchi includes an excerpt by Michel Foucault recounting "how 'madness' was produced as 'real,' as an object of thought" (p. 9). Below we insert 'heroin addict' rather than 'madmen' in the excerpt, to illustrate how the heroin addict (or person labeled with severe opioid use disorder) is produced, just as the madman is produced:

> How … [heroin addicts] were recognized, set aside, excluded from society, interned, and treated; what authorities decided on their … [heroin addiction], and in accordance with what criteria; what methods were set in place to constrain them, punish them, or cure them; in short, what was the network of institutions and practices in which the … [heroin addict] was simultaneously caught and defined. (Foucault, in Bacchi, 2018, p. 9).

Madness, or in our case, the heroin addict, is not' real' "*until it is produced through the practices*" (italics in original, Bacchi, 2018, p. 2018), such as the *DSM-5* criteria for OUD, and specific HAT enrollment criteria that patients must meet. Of course, there are multiple representations of the heroin addict; however, as Stuart Hall notes, stereotyping reduces people to a few essentialist characteristics and this is accomplished partially through representation and discourse and occurs most often when there are "*gross inequalities of power*" (italics in original, Hall, 1997, p. 258). People who use illegal heroin are Othered.

Canada's first drug user union, VANDU, emerged partially in response to the failure of all levels of government to take action to save lives during the first overdose death crisis in the DTES of Vancouver in the 1990s. VANDU ruptured conventional stereotypes about people who use criminalized drugs such as heroin. Until the emergence of drug user unions in Canada, including SNAP, the voices of people who used heroin regularly (who did not fit conventional discourses) were mostly ignored by politicians and policy makers (including criminal justice and medical professions) (Boyd, MacPherson, & VANDU, 2019; Boyd, Murray, SNAP, & MacPherson, 2017; Boyd, Osborn, & MacPherson, 2009). Drug user unions and their allies are again at the forefront of activism to stem the current illegal overdose death epidemic in Canada – setting up alternative services (such as the first unsanctioned overdose prevention sites) and proposing alternative drug policies (BCYADWS, 2019; Tompson, 2019).

Methods and participant characteristics

This paper builds on earlier collaborative, community-based qualitative research with SNAP that has resulted in three separate research projects (Boyd & NAOMI Patients Association, 2013; Boyd et al., 2017b, 2017a).[1] To date, SALOME and NAOMI researchers have not published interviews from their studies; thus, this paper fills an important gap. In this paper we focus on semi-structured interviews conducted with 36 SNAP members at the VANDU site in the DTES of Vancouver, British Columbia. Interviews were scheduled at different times throughout the

[1] This study is a component of a larger Social Science and Humanities Research Council-funded grant awarded to Susan Boyd, Heroin: Social 'problem' and emerging drug treatment in Canada. The multi-method Heroin Study investigates three sites of knowledge production: a Charter challenge, news reportage, and the experiences of SNAP members who are/were recipients of HAT.

week. As noted by the City of Vancouver, the DTES is one of Canada's poorest urban neighborhoods (City of Vancouver, 2012), and the epicenter of a public health crisis stemming from prohibitionist drug policies fuelling illegal drug overdose deaths. Despite the public health emergency declared by the province of British Columbia in 2017, preventable deaths continue in 2019. The causes are a poisoned drug supply where the drug fentanyl and its analogues are contributing to the crisis, alongside a lack of legal access to flexible opioid substitution programs and unadulterated opioids (BC Coroners, 2019).

Since 2011, SNAP members have been at the forefront of advocacy to establish permanent flexible HAT programs in Canada. In January 2020, SNAP entered its ninth year. The members activism and participation in SNAP may distinguish them from other individuals receiving HAT who are not advocating for drug policy reform. In February 2011 the lead author was invited to collaborate with SNAP and to attend their weekly meetings in order to better understand the peer-led group's concerns, advocacy, and research goals. She did so regularly over the nine years. Ongoing collaboration with SNAP draws from research guidelines developed by drug user unions and organizations, including VANDU and SNAP, and critical methodological frameworks on ethical community-based and responsive research for social justice (Boilevin et al., 2019; Boyd, 2008a; Boyd et al., 2017a; Canadian HIV/AIDS Legal Network, 2005; Carroll, 2004; Culhane, 2011; Neufeld et al., 2019; Smith, 1999; VANDU, 2019). Central to these qualitative perspectives is acknowledging that research (and the research process) is political, collaboration is essential, the voices of those most affected are central, the organization and/or community must benefit, and that research findings contribute to advocacy and social change (Ibid.). For SNAP, access to HAT, an end to suffering, and an end to drug prohibition are paramount.

In keeping with the approach outlined above, at SNAP's weekly meetings the qualitative interview schedule for the study was developed, including research questions that reflected the interests of SNAP members and the lead author. In developing our questions we also drew broadly from the interview schedule developed by researchers at the Social Studies of Addiction Concepts Research Program, Curtin University, Australia, included in their report, “Experiences of alcohol and other drug addiction, dependence or habit in Australia: Findings and recommendations from a national qualitative study” (Pienaar et al., 2017). However, given that our research focus is on HAT and the personal experiences of SNAP participants, we included open-ended questions about experiences prior to receiving HAT, experiences while receiving HAT, experiences of drug use and cessation, and future hopes.

Following ethics approval from University of Victoria, interviews were conducted from October 2016 to November 2018. Interviews lasted up to 50 min (average about 35 min). The lead author, second coauthor, and one RA who worked for a short period of time at the beginning of the project conducted the interviews. All interviews were tape-recorded and transcribed.

Participants

The average age of SNAP participants was 52 (range: 40–68). Sixteen participants identified as female (20 male), and 13 identified as Indigenous (22 white, one mixed race). The majority of the participants lived in the DTES area; five reported living outside the DTES and having a significant commute to the Crosstown Clinic where they received HAT. While not all participants discussed their housing situation in detail, most reported living in SROs (single room occupancy) or social housing (i.e., BC Housing). The majority of participants relied on income assistance (i.e. disability benefits or welfare assistance) as their main source of income. References to “work” in the following quotes refer to volunteer work and paid work while receiving benefits. For example, at the time of the interviews, individuals receiving income assistance in BC were allowed to earn up to CA$200 a month.

Of the 36 SNAP members interviewed, 26 were currently receiving HAT and five participants were receiving hydromorphone at Crosstown; 31 had been participants in the SALOME trial, and 15 had been in the earlier NAOMI trial. Most SNAP members had extensive experience with opiate use (average 23 years of using opiates), with 25 reporting having used opiates for 20–40 years, five having used opiates for approximately 10 years, and two participants having used opiates five years or less.

Analysis

After five interviews the interview schedule was revised slightly to make some questions more understandable and coding was undertaken using Nvivo. Discourses were identified using a critical analytic approach (Bacchi, 2009, 2018; Carroll, 2004). We did not include questions about the *DSM-5* diagnostic criteria for OUD in our interview schedule. However, in our second reading and analysis, we considered, but did not fully apply, Carol Bacchi's analytical approach, ‘What's the problem represented to be?’ (WPR) to analyze SNAP participants’ narratives about heroin consumption in and outside of the iOAT program and the *DSM-5* diagnostic criteria for OUD (Bacchi, 2009; Bacchi, 2017).

Bacchi's guidelines facilitate the critical interrogation of problematizations in drug and alcohol research and a number of critical scholars have applied the WPR approach to their diverse studies (i.e., Boyd, 2014; Boyd & Norton, 2019; Boyd, Boyd, & Kerr, 2015; Fraser & Moore, 2011; Lancaster, 2014; Lancaster & Ritter, 2014; Moore & Fraser, 2013; Seear & Fraser, 2014). Bacchi also notes that the WPR approach can be applied to nongovernmental and governmental technologies, including the *DSM* (Bacchi, 2009, p. 235). In this paper, we problematize taken for granted assumptions in the *DSM-5*.

Several scholars have explored the problematics of the research interview in relation to poststructural methodology (Bacchi & Bonham, 2016; Bastalich, 2009). Yet, given SNAP participants’ particular subject position, the group's advocacy goals, the collaborative framework of the study, and its focus on a specific policy, time and place – HAT and the *DSM-5* criteria for OUD in the DTES of Vancouver – SNAP members and the authors found Bacchi's approach useful in their analysis in relation to contesting taken for granted assumptions about heroin, people who use the drug, identity, addiction, and treatment. Thus, in this paper, we focus on experiences of opioid use and HAT in relation to the diagnostic criteria set out in the *DSM-5* for OUD. The quotes below are representative of our findings.

Our paper is the product of a lengthy back and forth process, feedback, and editing between SNAP and the authors. Drawing from this particular set of interviews, a report (Boyd, Ivsins, Murray, & SNAP, 2019) and a draft article were completed. In January 2020, once again, the lead author and SNAP members discussed specific revisions for the final article. In collaboration with SNAP and VANDU members (and the VANDU board of directors), the report and article findings were presented by the lead author and Dave Murray (SNAP's founder and facilitator) to VANDU and SNAP members. Copies of the report were also made available to VANDU and SNAP members.

Findings

Eligibility criteria for NAOMI and SALOME and the DSM

To be eligible to participate in the NAOMI and SALOME trials, participants were required to have at least five years of self-reported opioid dependence and regular injection of street-acquired opioids. Further inclusion criteria included diagnosed opioid dependence (from the *DSM-4*), or severe opioid use disorder (from the *DSM-5*), as well as two previous attempts with treatment, one of which had to be a substitution therapy (e.g., methadone). In the final screening process for SALOME “a study physician performed a full medical exam to verify Diagnostic and Statistical Manual of Mental Disorders (*DSM*), fourth

edition, criteria for opioid dependence (severe opioid use disorder in the *DSM-5*)…" (Oviedo-Joekes et al., 2016). The *DSM-5* Criteria for Opioid Use Disorder lists 11 specific criteria which, when met, determine a person's severity of OUD (mild: 2–3 criteria met; moderate: 4–5 criteria met; severe: 6 or more criteria met) (APA, 2013, pp. 484 and 541). The American Psychological Association *DSM -5* criteria is summarized below:

1 Taking larger amounts or taking opioids over a longer period than intended.
2 Persistent desire or unsuccessful efforts to cut down or control opioid use.
3 Spending a great deal of time obtaining or using the opioid or recovering from its effects.
4 Craving, or a strong desire or urge to use opioids.
5 Problems fulfilling obligations at work, school or home.
6 Continued opioid use despite having recurring social or interpersonal problems.
7 Giving up or reducing activities because of opioid use.
8 Using opioids in physically hazardous situations.
9 Continued opioid use despite ongoing physical or psychological problem likely to have been caused or worsened by opioids.
10 Tolerance (i.e., need for increased amounts or diminished effect with continued use of the same amount).
11 Experiencing withdrawal (opioid withdrawal syndrome) or taking opioids (or a closely related substance) to relieve or avoid withdrawal symptoms (APA, 2013, p. 541).

In the following, we present SNAP participant narratives to problematize the *DSM-5* OUD criteria. Having to meet 6 or more of the criteria in order to be eligible for SALOME is not necessarily difficult for someone using heroin regularly, who also might live in poverty and have unstable/no housing, which leads us to question the usefulness of the *DSM-5* OUD criteria.

Problematizing the DSM

Most SNAP participants had a long history of opioid use. Thirty-five participants reported having used opioids for more than 10 years; 25 of these had been using opioids for over 20 years. Their histories of opioid use are varied, some stemming from teenage experimentation with drugs, others from accidents or injuries requiring extensive pain management. What was common among the participant narratives was that opioid use over time led them to feel sick when the drug was not available to consume. SNAP participants discussed being drawn into what for many became a lifetime of opioid use. As one participant described:

> *The minute I tried to pull away and I was sick. I realized I'm – I need something, got take care of this and the only thing that would take care of it was more – at the time I was using morphine so I had to use morphine – I was using three times a day but I had to. I had to have that in my system in order to operate as a – you know – I – without getting sick.* (Participant 2, 45/M/I)[2]

We can reliably suggest that for many of the SNAP participants this was not an intended outcome – to feel sick. Yet at the same time, there were distinct positive, beneficial, or useful aspects of opioid use for SNAP participants. Opioids provided enjoyment, pleasure, pain relief, or brief respite from stress, depression, or anxiety. Recurring opioid use not only staved off feeling sick, but helped participants feel "normal." Discussing how opioids made them feel, one participant stated, "Now I don't even notice it. Now I just want to stay normal, be able to function as a person. You can't function if you're sick all the time" (Participant 5, 60/F/W). Similarly, when another participant was asked what heroin did for them they replied, "Nothing, it just makes me feel normal (laughing). I don't get high off it. Nothing, it just – so I am not sick" (Participant 22, 48/F/W). This idea of opioids helping them feel normal was common among SNAP participants:

> *I feel more normal after I do a fix than I do when I am normal (laughs). I don't know if that sounded – made any sense … like I am not getting sick. I can cope with the day. I can handle what happens that day.* (Participant 11, 58/F/I)

For SNAP members, rather than having a disorder, using opioids regularly was experienced as beneficial because it helped them to regulate their pain, to be able to function, and to feel normal (not sick). Rather than a fixed or stable effect, such as heroin being destructive, SNAP participants articulated diverse effects using heroin regularly.

Ineffective treatment

SNAP participants had extensive experience with conventional abstinence-based treatments. Indeed, one of the eligibility criteria for the NAOMI and SALOME trials is two previous unsuccessful attempts at treatment. What the participant narratives demonstrate however, is that treatments were ineffective not because of participants' *unsuccessful efforts*, but because conventional treatment options historically available to SNAP participants did not appropriately address their needs and therefore failed them. As the quotes below demonstrate, cutting down, quitting, or controlling opiate use is not as simple as choosing to do so, or simply putting in the effort, but is shaped by prohibitionist discourses, policies, and practices that produce treatment options that fail to meet the needs of many individuals.

> *P: No, I've been to quite a few treatments. I was always trying to fix myself, better myself…. I've been to quite a few….Nothing worked. They have a very poor success rate.* (Participant 18, 68/M/W)

> *P: Oh, I couldn't tell you the first time I went to treatment. I've been so many times. I've been to every detox in the Lower Mainland and outside of the Lower Mainland. I've been to treatment… I was there six months. I've been to detox probably 100 times.*
>
> *I: Why do you think they don't work or why did they not work for you?*
>
> *P: Because I was always trying to quit and then the reality of it is, I have chronic pain and I'm never going to be drug free completely if I want to do any kind of stuff.* (Participant 20, 46/F/W)
>
> *P: I went to the … treatment center. They put me through that. I went to this lake out here. I went to – I can't remember the name of it. There's a 30 day thing there. I went to that. I've done so many programs.*
>
> *I: So many.*
>
> *P: Yeah, so many, yeah. It just didn't work.*
>
> *I: Why do you think they didn't work?*
>
> *P: I wasn't ready for it, I guess. I wasn't ready to accept the fact that I quit or I don't. I wasn't ready to quit. I'm still not ready to quit now.* (Participant 8, 63/M/W)

These accounts contradict normative conceptions of addiction and disorder that are based on notions of "out of control" or "loss of control." A common narrative in addiction discourse is that the person labeled addicted is seeking redemption through treatment and recovery. In taking on the "addict" role, people who use drugs are expected to take control of their use, to regain control of their "out of control" lives by successfully engaging with the treatment and recovery system. The participants above disrupt this narrative. For some SNAP participants, abstinence from heroin was not understood as a solution; rather, conventional abstinence-based treatments were ineffective or

[2] Self-identifying information = (Participant number, age/gender/ethnicity [W = White, I = Indigenous])

inappropriate for their needs, especially when participants did not want to stop using opioids altogether or wished to use opioids to manage pain.

It takes time

Prior to enrolling in iOAT, SNAP participants spent significant amounts of time, energy, and money on activities related to obtaining and using opioids. What is important to recognize is that these conditions are produced by drug laws and policies that criminalize specific drugs such as heroin and limit access to legal sources of the drug, including the failure of conventional treatment options to adequately address casual and long-term opioid use. Due to negative discourses about heroin that shape drug prohibition policies, legal sources of heroin in Canada were not available outside of clinical trials until the newly established iOAT program at Crosstown Clinic in Vancouver, B.C. was implemented. Therefore, outside of the 100 or so individuals receiving legal heroin at Crosstown (and more recently, a clinic outside of Vancouver), people who use heroin must purchase it on the illegal market. Whereas upper and middle class opioid users can afford to purchase large amounts of an illegal drug at one time, oftentimes in the privacy of a home, prior to participating in the HAT clinical trials in Vancouver, SNAP participants purchased drugs from the illegal street market (in which the price of opioids is massively inflated). Combined with a lack of adequate income, SNAP participants became entangled in a recurring and extremely time consuming cycle of having first to find/make money, and then find opiates. Buying on the street daily also exposed them to police encounters, violence, and associated drug trade rip offs.

> *P: That was – it was a lot of hustling to get money daily, three times a day at least just to stay better and endless – that's all it is. And that's all you think about. That's it – just trying to get through.*
>
> *Interviewer: A cycle.*
>
> *P: Yeah, it's terrible. Because your whole life revolves around it and that's it.* (Participant 5, 60/F/W)
>
> *…just buying off the street that seems to consume so much of your time. First you got to chase up the money. Then you got to chase down your dealer, that type [of] thing.* (Participant 16, 58/M/W)

These narratives illustrate how continued opioid use, in the context of prohibitionist policies coupled with structural vulnerability, involves a significant amount of time, energy, and money. Applying the *DSM-5* OUD criteria to individuals pathologizes both the individual and their lived experience. On the contrary, an individual not entangled with poverty and homelessness, with for example the means to purchase larger amounts of opiates, can oftentimes avoid stigmatizing labels of addiction and disorder and repeated criminal justice encounters.

Treatment schedules and lack of time

Just as buying heroin on the illegal market was time consuming for SNAP participants, so too was receiving HAT in Vancouver. Speaking about some of the negative aspects of the iOAT program at Crosstown Clinic, the most common complaint was about the schedule and routine involved, and being tied to the clinic. Initially, most participants receiving iOAT at Crosstown were going three times a day to receive their dose. This was often described as burdensome, even for those participants who lived very near the clinic. Having to attend the clinic two or three times a day impacted peoples' lives by preventing them from straying too far out of the neighborhood, greatly impeding and restricting their free time. A number of participants discussed wanting to go back to school or work but being hindered by the routine at Crosstown. This was especially difficult for individuals on higher doses who had no choice but to attend the clinic three times a day.

> *Well, we have to get our dose, right. If we don't get our dose, we're sick. So it's frustrating. That part sucks because I want to go to school and how can I go to school if I have to be at the program three times a day?* (Participant 3, 46/F/I)
>
> *Like I said I'm trying to cut the middle one out. I'd like to go back to school so I am going twice a day now. I still haven't cut the middle one right out. I still can go there at 1 o'clock if I have to. But I'm trying really hard to just go twice a day. It gives me more time because you have to wait there so long for the process to go through there, right.* (Participant 11, 58/F/I)

For SNAP participants receiving iOAT at Crosstown Clinic, the rules and regulations restrict their time for other activities, such as prohibiting them from potentially fulfilling work or school obligations (e.g., being able to commit to traditional work schedules). Yet, as noted earlier, prior to receiving iOAT at Crosstown Clinic, due to their social and economic marginalization, SNAP participants described buying heroin on the illegal market; a lot of their time was taken up by the daily hustle. Thus, practices stemming from both criminalization and health policies (i.e., HAT) constructed everyday life for SNAP participants.

Prohibition and criminalization

Reflecting on life prior to starting iOAT, SNAP participants shared a common narrative about the negative impact of drug prohibition and the criminalization of heroin and other opioids. For many, this involved engaging in criminalized and stigmatized activities for income generation and/or procurement of opiates – a perpetually revolving door of "hustling" (chasing down money and drugs), frequent police encounters, often then time spent in jail, emergency room visits, and homelessness/unstable housing. What is particularly problematic about the *DSM* criteria 6 is ascribing a diagnosis of OUD based on common experiences related to structural vulnerability and drug prohibition and the policies and practices that stem from them. Many SNAP participants were caught in this recurring cycle produced by drug policies in Canada.

> *I was continually going to court for drugs – selling drugs, for crime – petty crime, things like that, theft, you know, just getting in trouble all the time, right, you know. A lot of the time I would miss court. Then I would have warrants for that. It would just – yeah, it would just be a vicious cycle, yeah. It was really bad.* (Participant 2, 45/M/I)
>
> *But, yeah, so at times it came to breaking the law to get money. It wasn't fun. I tried panhandling but eight hours panhandling at a hospital I'd get 20 bucks and that wasn't enough to get two people un-sick so I had to do what I had to do, I guess. But it wasn't fun breaking the law and going to jail.* (Participant 9, 40/M/I)
>
> *I used to shoplift and I got caught a number of times for that. But I couldn't stop because every time I get out of jail I got back to using drugs again. And so it was like a revolving door. I was sort of – the only way I could figure out how to get money was to do petty crime. So I just kept doing it.* (Participant 16, 58/M/W)

For SNAP participants, drug prohibition (laws, and policies and practices stemming from them) and lack of access to a legal opioid source exacerbated the impact of their drug use. Rather than pathological hardened or violent "criminals," SNAP participants were involved in petty crime – shoplifting, panhandling, theft – to support their habit. Yet many SNAP participants spent years in and out of jail and prison and were constituted as addicted and criminal. Abstinence, enforced through imprisonment or drug treatment, was constructed as the solution to the 'problem' of heroin use.

Family time

SNAP participants explained that prior to receiving HAT at Crosstown Clinic, some of their time was spent "hustling to get money" to purchase heroin on the illegal market. However, SNAP members also noted that once receiving HAT at Crosstown Clinic, the daily schedule at Crosstown Clinic, combined with legal restrictions prohibiting the transportation/use of the prescribed drug outside of the clinic, also negatively impacted some SNAP participants' family relations. A number of SNAP participants described how being on iOAT had helped renew and strengthen relations with family members. However, some participants spoke about the negative impact that having to attend the clinic daily for their medication had on their relations with family. Participants are not allowed HAT carries (to receive HAT outside of the clinic). One participant recounted a troubling experience:

> *That is a problem because every year I go to my family's for Christmas and every year it's the same thing. I get so sick I end up having to come back early. I can't go for more than a day. Like, last Christmas my doctor gave me 1000 mg of morphine [Kadian]. He told me to take it all at once. Okay, he said I'd be good for the whole day, right. Well, I took 'em. By 1 o'clock my mother was sending me home from Maple Ridge in a taxi because I was so sick and I didn't even last a whole day. So something has got to change around that because my mom is 70. She's not getting any younger. That's the only day of the year that I want to go out there and be with her and I should be able to do that.* (Participant 20, 46/F/W)

The *DSM-5* criteria for OUD includes: "problems fulfilling obligations at work, school or home" and "giving up or reducing activities because of opioid use." The DSM criteria "assumes that drug use is external to and destructive to the everyday life of friends, family, work and leisure" (Keane, Moore, & Fraser, 2011, p. 876). Yet, numerous studies challenge these negative assumptions (Boyd & NAOMI Patients Association 2013; Fraser et al., 2014; Pienaar et al., 2017). Once SNAP participants were eligible to receive legal opioids, daily attendance requirements (from one to three times a day) at the iOAT program at Crosstown, ironically, "produce" iOAT patients as "dependent and inflexible subjects who struggle to manage work and family responsibilities" (see Fraser & valentine, 2008; Fraser et al., 2014, p. 6). Furthermore, "these effects of treatment are interpreted as symptoms" of dependence "and a drug-using lifestyle" in both the *DSM-5* OUD criteria and the *DSM-IV* substance dependence criteria (Fraser & valentine, 2008, p. 140).

Hazards of heroin use

The *DSM-5* criteria 8 includes "recurrent opioid use in situations in which it is physically hazardous." However, drug laws and policies shape where and how individuals can consume opioids, including heroin. Thus, potentially hazardous practices and spaces are produced by drug policy. As noted earlier, in Canada, until recently, legal heroin was not available for consumption. Outside of medical and scientific use, opioid possession, sale, and production are constituted as criminalized in Canada. Consequently, an illegal drug market has emerged in Canada. Drugs sold on the illegal market are of unknown quality and dosage. The current illegal opioid overdose epidemic in Canada stems from drug prohibitionist policies, which causes a lack of access to legal sources of opioids and a poisoned drug supply on the illegal market. Therefore, illegal drug consumption can be physically hazardous due to drug prohibitionist policies. SNAP participants made clear that at Crosstown Clinic, having access to safe legal opioids reduced overdose deaths and provided a space of safety (no one has died from an overdose at Crosstown or any of the other supervised injection and overdose prevention sites in BC (BC Coroners, 2019).

> *Like, say you overdose or something, they're there to call an ambulance for you if need be. So it's safe. Nobody's died. There's been a few cases of overdose but they've been – they were able to revive them so nobody's been hurt from the program. That's one of the benefits of it because if you're just fixing drugs on your own and you overdose there's nobody there to take care of you whereas here that's available. So that's a big difference for me. I feel a lot safer going there than using drugs on the street.* (Participant 16, 58/M/W)

The experiences of some SNAP participants were also shaped by gendered expectations, gendered violence, and negative colonial stereotypes about women who use illegal opioids that stem from ongoing colonial policies and practices in Canada. One woman stated:

> *Well, women are always victimized to say the least, most of the time whether it be sex or oppression; because we are the fairer sex we tend to be targeted more that way. Just in the way we get money to purchase drugs, you know. So there's that end of it and – yeah. I just think that women are more victimized than men are.* (Participant 7, F/46/W)

An Indigenous woman went on to explain, "men don't have to worry about getting raped and attacked, not normally whereas women, you get robbed. You get violated" (Participant 28, F/45/I). Furthermore, women described how imprisonment for drug related offences impacted their relationships with and custody of their children. One woman noted:

> *I ended up going to jail but their dad took them. I – we had arranged. Their dad took them and that was from the time they were about seven until they were 12. And then they came back to me.* (Participant 32, F/64/W)

One Métis woman also noted that she experienced stigma due to her illegal heroin use and, "being Native down here. Oh, yeah" (Participant 13, F/51/I). The impact of gendered discourses, stigmatization, colonization, child apprehension policies, drug policy, and its intersection with race, class, and sexuality are absent from *DSM* OUD criteria. Rather than recognizing the diverse lived experiences of women who use heroin (Boyd, 1999; 2015; Campbell & Ettorre, 2011; Campbell & Herzberg, 2017; Fraser & valentine, 2008), heroin use by a woman is constructed as deviant and as a disorder.

Benefits of heroin use

Rather than a negative outcome, participation in the iOAT program also provided benefits for SNAP participants. The following quote speaks to the hardship of living on the street, which is exacerbated by homelessness and the context of opioid use in the DTES.

> *I have arthritis now. I don't know how old you are but I'm going on 52. I've been on the street for three years; it sucked the life out of me. I was suffering from malnutrition. I barely slept because people would always try to rob me or hurt me. One guy tried to light me on fire one time. I slept with a big fucking axe. So you go through so many years like that then when I do my down I'd be like ooohhh. I'd just relax, you know.* (Participant 14, 52/M/I)

Participation in a HAT clinical trial and the iOAT program facilitate continued (i.e., daily) opioid use, as all opioid substitution programs do. We question whether or not people who enter an iOAT or other substitution programs should be labeled pathological when there are so few alternatives in Canada. Basically, one can either abstain from criminalized drugs or participate in iOAT programs that require that you attend the clinic daily or you will eventually be expelled. In that sense, iOAT produces a particular addicted subject and priviledges daily use because there are no programs or access to legal opioids for occasional use or other patterns of use. Both abstinence-based programs and, to a lesser extent, drug substitution programs are provided in Canada. Socially constructed binary classifications (i.e., self-control/addicted) influence the type of services set up and how the heroin user will be managed (Fraser et al., 2014; Moore & Fraser, 2006). This is not to say

that HAT programs should not exist, as it is clear from our collaborative study with SNAP that participants benefited from HAT and also understood it as life saving, especially during an illegal drug overdose death epidemic. It is just to point out how drug programs and the addicted subject are constituted in Canada and how the *DSM-5* fails to capture diverse forms and contexts of drug use. Nor does the establishment of iOAT programs disrupt or challenge dominant assumptions about 'addiction' as a disease or pathology; in fact, it reproduces the individualized pathological addicted subject.

Medical supervision

The *DSM-5* states under criteria 10 and 11 for OUD that tolerance and withdrawal should not be considered:

> "This criterion is not considered to be met for those taking opioids solely under appropriate medical supervision." (APA, 2013, p. 541).

Given the caveat above, it would appear that SNAP participants receiving iOAT under medical supervision would be exempt from Criteria 10 and 11. Yet participants in both HAT trials in Canada and those now receiving HAT or injectable hydromorphone continue to be labeled with severe OUD even though the *DSM-5* makes clear that Criteria 10 and 11 should not be applied to individuals taking a prescribed agonist medication such as methadone. Thus, if this caveat is applied to prescribed heroin and hydromorphone, we must assume that six or more other criteria were met.

Heroin as medicine

A number of SNAP participants interviewed discussed opioids as a medication, as something to manage their pain, or generally make them feel better. This idea of opiates as medication may also stem from involvement in a program that constitutes participants' use of legal heroin as "treatment." For some SNAP participants, after receiving HAT, their identity transitioned from a "criminal" drug user to a person taking medicine.

> *I don't consider it drug use. I consider it medication to help with my pain that I have.*
>
> (Participant 1, 54/M/W)

> *No, it's just a medication, basically. I don't do it no more, no less. So it's basically just like a script, just like someone getting pills, I guess. It's just my medicine…Half way through SALOME, I guess, kind of switched my thought rather than as a drug addict.* (Participant 9, 40/M/I)

> *Well, when I was – before SALOME, I was out there to get high and to get better, right. But I – my mentality has changed now, right. I just do it just for medication.* (Participant 2, 45/M/I)

For some SNAP participants, their new identity was co-produced through treatment, from 'criminal' to a 'patient' receiving a legal medication. However, whether we understand illegal heroin use as criminal, or as a disorder, in both approaches the heroin user, the drug, and addiction continue to be constituted "as *the problem*" (italics in the original, Fraser, 2017, p. 133). Fraser questions what is left unexamined when we "consistently constitute drug use and addiction as *the problem?*" …. [including] complex, multifaceted issues (poverty, marginalization)—or sometimes rather simple, but practically or politically awkward ones (such as different ideas about what makes a good life)?" (italics in the original, Fraser, 2017, p. 133). SNAP participant experiences and subjectivity are multifaceted and complex. Drug laws and policies, including the criminalization of heroin and access to HAT, are also experienced through a myraid of subject positions: i.e., class, gender, race, and sexuality. The heroin user is not fixed, nor are drug treatments static, including HAT; identity is produced and disrupted and challenged in any specific era (see Bacchi & Goodwin, 2016, p. 49; Bacchi & Bonham, 2016, p. 115). In our discussion below we highlight how people who use heroin (and other illegal drugs) in B.C., including SNAP members, are rejecting both criminalization and pathologization by advocating for and producing alternative knowledges and services to manage their own drug use. Thus they disrupt conventional assumptions about addiction, criminality, and heroin – identity.

Discussion: problematizing the *DSM-5*

Drawing from critical drug studies and community-based qualitative research approaches, in this study we problematize *DSM*-5 criteria for severe opioid use disorder, by examining SNAP members' experiences. SNAP are members of an independent peer-led drug user group in the DTES of Vancouver who are receiving HAT in the first program established in Canada (and North America). Our analysis was also partially informed by Bacchi's critical analytical approach, "What's the problem represented to be?" (Bacchi, 2009). As Fraser et al. (2014) note, the problem with labeling people as "addict," or in this case as meeting the criteria for OUD, is that it "produces an identity, a type of person – the addict – who is defined in terms of pathological desires" (p. 28). In the *DSM,* the problem of regular heroin use is represented as a disorder to be treated. People who enter treatments (including iOAT) that base their eligibility criteria on the *DSM-5* become defined as people with severe OUD, a stigmatizing label in itself. The effect of this label is that programs that utilize the *DSM-5* for eligibility criteria thus construct participants as people with a disorder rather than as people made up of everyday experiences and practices far beyond the narrow confines of *DSM-5* criteria for OUD. The difference is important, because how people who use heroin or other opioids are constituted determines actions taken and pursued, and self identity.

The *DSM-5* Criteria for Opioid Use Disorder lists 11 specific criteria which, when met, determine a person's severity of OUD. As demonstrated above, some of these criteria are closely tied with socio-structural issues like being homeless, having to engage in illegal activities to make money (e.g., shoplifting, drug dealing/middling), having experience with unsuitable (i.e., abstinence-based) treatment options, and often a lifetime of exposure to gendered/racialized/structural violence and colonialism. This becomes problematic when the *DSM* conflates drug effects with political and socio-structural drivers of drug related harm. To label someone as having a *severe disorder* shifts the focus from cultural and political discourses about heroin and addiction and broader policies that constitute heroin use in a particular era. The *DSM-5* decontextualizes drug use, rather than acknowledging how it "is bound up with other social and political issues, such as marginalization, poverty, violence, isolation, stigma and institutional neglect" (Pienaar & Dilkes-Frayne, 2017, p. 151). These issues are left unproblematized in the *DSM-5*.

The *DSM* OUD diagnosis does not capture the complexities of the lived experiences of SNAP participants. For example, criteria 3 in the *DSM-5* (similar to *DSM-IV* criteria 4) states, "a great deal of time is spent in activities necessary to obtain the opioid, use the opioid, or recover from its effects," yet as Fraser et al. note, "this is not a single symptom but a cluster of experiences related to time and its use" (Fraser et al., 2014, pp. 31–32). The *DSM* criteria discounts the fact that when drugs are criminalized, and a safe and affordable legal source does not exist, it can take a great deal of time to obtain an opioid on the illegal market or to visit a doctor in hope of a legal source. It can also take time to earn enough money to pay for illegal drugs that are sold at inflated prices on the illegal market.

Similar to the findings of Fraser and valentine on MMT, SNAP participants receiving iOAT are seemingly constructed as no longer heroin addicts or 'straight'; rather, they are located somewhere in between as patients (see Fraser & valentine, 2008, p. 140). HAT participants are not yet constituted as fully rational "humans." Yet SNAP participants' diverse everyday experiences and practices rupture the narrow diagnostic label offered in the *DSM* model. As other critical scholars have noted, the *DSM*, including the criteria for OUD, is

unstable and cannot be universally applied. Rather than experiencing regular heroin use as solely destructive or harmful, SNAP members' heroin consumption was multifaceted, providing enjoyment, pleasure, and pain relief. However, the *DSM,* and the criteria for OUD, does not acknowledge pleasureable heroin use as legitimate (see Fraser & valentine, 2008). SNAP members' political advocacy for an end to drug prohibition also disrupts conventional notions about 'out of control,' 'disordered addicts' whose desire for heroin supposedly surpasses all other activities.

In our study, the *DSM* OUD criteria does not fit the context of HAT and SNAP participants at this particular site in Vancouver, B.C. SNAP participants' narratives challenge fixed assumptions about heroin, addiction, and identity. Keane et al. (2011, p. 876) argue that "recognizing the *DSM* as active in constituting addiction and those called 'addicts,' rather than merely describing them, opens up complex political and ethical issues". We agree with the author's further assertion that these issues should be central to future research. How addiction and heroin are constituted has political implications that will not only determine laws and policies, but what types of services and programs will be set up, especially during a public health emergency, such as the illegal drug overdose epidemic Canada is experiencing today. People's lives are at stake. Ideas about heroin and addiction and intersecting constellations – political, social, and cultural – construct contemporary heroin use, treatment, and identity (see Treichler, 1999). Treating a disorder, or a person with a disorder, requires a much different approach than does understanding illegal heroin use as a habit.

In response to the illegal overdose death epidemic in B.C., clinical guidelines are recommended for low-barrier injectable hydromorphone programs for people with severe OUD (Fairbairn et al., 2019). However, a "heroin compassion club" or cooperative model was also put forth by people with lived expertise, allies, and the British Columbia Centre on Substance Use (Thomson et al., 2019). The compassion club or heroin buyer club model could potentially provide prescription heroin (or hydromorphone) for regular users without applying *DSM* OUD criteria to its members. In late August 2019, in recognition of International Overdose Awareness Day on August 31, 2019, the BC/Yukon Association of Drug War Survivors (BCYADWS) followed up by requesting that the B.C. government and the B.C. Minister of Mental Health and Addictions immediately implement heroin buyer clubs. The BCYADWS argued that a new Ministerial Order to establish heroin buyer clubs would fall under the public health emergency declared in B.C. April 2016, which also facilitated the rapid expansion of overdose prevention sites in the province (BCYADWS, 2019). If the compassion or buyer club model is implemented in British Columbia, will their members' understanding of prescribed heroin (or hydromorphone) use, and their identity, differ from those people in formal iOAT programs where severe OUD criteria is applied?

We argue that the *DSM* criteria for OUD is unstable. It makes invisible the diverse experiences of SNAP participants at this one particular HAT site in Vancouver, B.C. The majority of SNAP participants we interviewed had suffered a lifetime of marginalization. Conventional discourses about heroin and addiction, drug prohibitionist laws and policies, economic and social marginalization, gendered violence, and colonialism shaped their lives in myriad ways. Framing regular and prolonged heroin use as a disorder makes these factors invisible. If currently criminalized drugs such as heroin were legally regulated, if the labels criminal, disordered, and/or diseased were absent, and if the social and legal discrimination and stigmatization that accompanies them were peeled away, what might be the life of someone who regularly uses heroin? It is difficult to know, although could it be worse than what we have produced over the last century? It is impossible to return to the past, pre-prohibition. Yet, we can examine more closely how addiction discourses and practices intersect with structural violence and constitute the lives of people who use heroin and other criminalized drugs. Drug user unions, including SNAP, allies, and critical drug researchers are contesting conventional ideas about heroin (and opioids) and taken for granted assumptions about people who use heroin. These advocates are providing alternative ways of imagining and understanding heroin use (habit versus invidualized pathology), and are advocating alternative policies (ending prohibition) and practices (e.g., heroin buyer clubs). Given the ongoing illegal drug overdose death epidemic in Canada and other countries, and the need for immediate action, questioning and challenging prohibition and the *DSM-5* criteria for OUD and conventional assumptions and theories about people who use heroin, 'addiction,' and drugs themselves, is imperative.

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