*Article*

Contemporary Drug Problems
1-17

DOI: 10.1177/0091450919856635
journals.sagepub.com/home/cdx
SAGE

# Addiction and Heroin-Assisted Treatment: Legal Discourse and Drug Reform

**Susan Boyd**[1] **and Alexa Norton**[1]

## Abstract

This paper analyzes the arguments put forth over a 3-day period at an injunction hearing, *Providence Health Care Society v. Canada*, held March 13–15, 2014 in Vancouver, British Columbia. The plaintiffs sought broad interlocutory relief from the Court for the provision of prescription heroin if requested by their physicians. This paper fills an identified gap in scholarship by analyzing the civil *Charter* challenge, including the notice of civil claim, injunction court transcripts, judgment, and individual plaintiffs' affidavits. We draw from Canada's unique history of drug prohibition and critical drug research to contextualize our analysis and findings. We argue that the lives of people using criminalized drugs, such as heroin, are affected by legal realms that produce ideas about heroin, addiction, and criminality that ultimately impact public health policies and treatment initiatives.

## Keywords

heroin-assisted treatment, addiction, legal discourse, constitutional challenge, Canada, Carol Bacchi

In order to understand discourse and policy decisions about addiction, heroin, and heroin-assisted treatment (HAT) in Canada, this paper analyzes the arguments put forth over a 3-day period at an injunction hearing, *Providence Health Care Society v. Canada*, held in Vancouver, British Columbia, March 13–15, 2014. The plaintiffs sought broad interlocutory relief from the court for the provision of prescription heroin if requested by their physicians. The injunction actors included the judge, counsel for the plaintiffs, the provincial intervenor (Vancouver Coastal Health Authority [VCHA]), and the Government of Canada (Attorney General). In addition, Chief Justice Hinkson's May 2014 judgment and the individual plaintiffs' affidavits are analyzed. We draw from Canada's unique history of drug prohibition and critical drug research to contextualize our analysis and findings. We argue that the lives of people using criminalized drugs, such as heroin, are affected by legal realms that produce ideas

[1] Faculty of Human & Social Development, University of Victoria, Victoria, British Columbia, Canada

Received December 19, 2018. Accepted for publication May 22, 2019.

**Corresponding Author:**
Susan Boyd, Faculty of Human & Social Development, University of Victoria, PO Box 1700 STN CSC, Victoria, British Columbia, Canada V8W 2Y2.
Email: scboyd@uvic.ca

about heroin, addiction, and criminality that ultimately impact public health policies and treatment initiatives.

## Background

Narcotic prohibition first began in Canada in 1908 with the *Opium Act*, which criminalized the importation, manufacture, and sale of crude or powdered opium for nonmedical purposes. In 1911, the expanded *Opium and Drug Act* criminalized the possession and nonmedical use of opiates and cocaine, followed with cannabis in 1923 (Giffen, Endicott, & Lambert, 1991). Right up until the 1950s, the Canadian Division of Narcotic Control had primary control over drug and addiction discourse and policy and constructed heroin users as dangerous "criminal addicts," who even if offered drug treatment (abstinence-based or drug maintenance services) would remain criminal and a threat to law-abiding Canadians (S. Boyd, 2017; S. Boyd & NPA, 2013; Carstairs, 2006). From the 1920s on, the Narcotic Division, the media, and other moral reformers circulated misinformation and wild claims about newly criminalized drugs and the people who used them. The Narcotic Division pushed for total abstinence and prison time as the "cure" for illegal drug use; therefore, unlike other Western nations, publicly funded drug treatment was not set up until more than half a century later, following criminalization, nor was drug maintenance in any form (Acker, 2002; Giffen et al., 1991; Lart, 1998; Musto, 1987; Tallaksen, 2017; Waldorf, Orlick, & Reinarman, 1974).

Early on, Canada adopted a criminal justice approach to drug control rather than a public health or social approach. As a result, long prison sentences for drug offenses (overwhelmingly drug possession convictions) were common (S. Boyd, 2017). It was also illegal for Canadian physicians to prescribe drugs for maintenance purposes to people identified as "addicts," and as a result, many were arrested and convicted. By 1925, the maximum penalty for doctors who issued a prescription for nonmedical use was 5 years in prison (Giffen et al., 1991). The federal government's policy decision to solely embrace abstinence and reject drug maintenance had several negative long-term consequences. Legal sources of heroin and other opioids became less available; an illegal drug market emerged where drugs were sold at inflated prices with no quality controls; people who used newly criminalized drugs were criminalized, demonized, arrested, imprisoned, and deported; and doctors and pharmacists were threatened with arrest if they provided legal drugs for drug maintenance purposes.

In contrast to Canadian policy, British physicians retained the right to prescribe drugs, including heroin, to people identified as "addicts" (Stimson & Ogborne, 1970; Strang, Groshkova, & Metrebian, 2012). Doctors in the UK also retained the right to provide long-term drug maintenance treatment, including the prescription of heroin (Strang et al., 2012, p. 137). Even in the United States, the federal government allowed the establishment of over 40 narcotic clinics between 1919 and 1923 that provided drug maintenance and detox services to a wide socioeconomic range of people (Musto, 1987; Terry & Pellens, 1928/1970; Waldorf et al., 1974). In contrast, federal drug policy in Canada steadfastly advanced criminalization, and no drug treatment or drug maintenance options were publicly funded.

Up until the 1950s, the Narcotic Division and law enforcement officials in Canada were the primary knowledge producers about criminalized drugs such as heroin. They constructed heroin as dangerous and the people who used it as predators and inherently criminal. However, their hegemony was challenged in a number of ways: In the 1950s, new psychiatric knowledge emerged labeling "addicts" as both pathological and criminal (Giffen et al., 1991, p. 381); a vocal Member of the Legislative Assembly in British Columbia spoke against criminalization; a group of diverse professionals in Vancouver called for a shift in drug policy from a criminal to a health perspective; and in 1955, the province of British Columbia funded the Narcotic Addiction Foundation of British Columbia (NAFBC; S. Boyd, 2017; Stevenson, Lingley, Trasov, & Stansfield, 1956). In 1958, the NAFBC opened a small clinic in Vancouver for men identified as "addicted" to narcotics (S. Boyd, 2017).

Yet, it was not until recommendations were put forth by the Canadian Commission of Inquiry into the Non-Medical Use of Drugs (the Le Dain Commission) in the late 1960s and early 1970s, and increasing medicalization of addiction, that more publicly funded drug treatment services were established in Canada. The Commission also recommended that a heroin prescription trial be initiated in Canada for people who did not respond to conventional opioid addiction treatments, including methadone maintenance therapy (MMT) (Information Canada, 1973). However, at that time, a trial was not set up and abstinence-based programs remained the primary form of treatment. For those in need, MMT became available in many urban centers. However, punitive rules and policies have consistently led to poor retention rates (Luce & Strike, 2011; Reist, 2011). In 1974, the province of British Columbia considered establishing heroin maintenance; however, with the election of a conservative party in 1975, drug reform was abandoned (Waddell, 2018, p. 45). Punitive drug laws and policies, including resistance to HAT and more diverse drug services, led to a public health emergency in Vancouver in the 1990s.

In 1997, a steep rise in heroin overdose deaths and rising HIV/AIDS and hepatitis C rates, along with mounting pressure from activists in Vancouver's Downtown Eastside (DTES), caused a public health emergency to be declared. Community activist groups, such as the Portland Hotel Society and Vancouver Area Network of Drug Users (VANDU)—Canada's first drug user union—played a major role bringing the crisis to the attention of the public. They advocated for a change in drug policy and the establishment of more harm reduction services (rather than solely abstinence-based services), including supervised injection sites and HAT (S. Boyd, MacPherson, & Osborn, 2009; L. Campbell, Boyd, & Culbert, 2009). Canadian activists also looked to other countries that had practical and effective harm reduction and alternative initiatives, such as HAT, which was considered an effective and safe treatment option for chronic opioid users not responsive to conventional treatments such as MMT and abstinence-based treatments. After Switzerland's success with HAT in the 1990s, other European countries adopted similar models, providing a "rich data set on the feasibility, efficacy, safety and effectiveness of HAT" (Blanken et al., 2010, p. S151; Strang et al., 2012).

## Clinical Trials and Special Access Program

In 2005, the first Canadian HAT clinical trial, the North American Opiate Medication Initiative (NAOMI), opened in the DTES and Montreal (Gartry, Oviedo-Joekes, Laliberté, & Schechter, 2009). The DTES is Canada's poorest urban neighborhood, and research participants in the NAOMI site endured years of legal and social discrimination prior to participating in the trial. However, similar to international studies (Strang et al., 2012), NAOMI found that injectable HAT proved to be a safe and highly effective treatment for research participants in the trial. It was observed that NAOMI participants "decreased use of illicit 'street' heroin, decreased criminal activity, decreased money spent on drugs, and improved physical and psychological health" (NAOMI Study Team, 2008, p. 18). Despite HAT's proven effectiveness, in opposition to recommendations from the World Health Organization and UNAIDS report, *Ethical Engagement of People Who Inject Drugs in HIV Prevention Trials* (WHO & UNAIDS, 2011), and unlike every other nation that had conducted a HAT trial, NAOMI did not provide continued treatment posttrial (an exit strategy). Thus, at the end of the trial, NAOMI participants had the option to either return to conventional treatments that had previously failed them or to buy heroin from the illegal market.

In December 2011, another clinical trial, the Study to Assess Longer-term Opiate Medication Effectiveness (SALOME), opened in the DTES; it also lacked an exit strategy for participants (S. Boyd & NAOMI Patients Association, 2013; Small & Drucker, 2006). Led by extensive advocacy efforts on the part of the SALOME/NAOMI Association of Patients (SNAP), Pivot Legal Society, and others since late 2012, Providence Health Care Society (PHCS) and some of the SALOME team strove for a feasible exit strategy for research participants. PHCS physicians at Crosstown Clinic in the DTES

successfully submitted Special Access Programme (SAP) requests to Health Canada in order to continue prescribing heroin to eligible patients exiting the SALOME trial.

In Canada, all drugs included in Schedule I of the *Controlled Drugs and Substances Act* (CDSA; 1996), including heroin, are deemed the most dangerous of all controlled substances and given the most punitive of penalties. Until NAOMI, physicians in Canada could not legally prescribe heroin to patients for addiction treatment. In addition, Health Canada's permission was limited to this one specific clinical trial, and a special section 56 exemption to Canada's CDSA was necessary to allow NAOMI researchers and staff to import, receive, and administer heroin to research participants without being arrested. Similar approvals made the later SALOME clinical trial possible.

On September 20, 2013, for the first time since heroin was criminalized, Health Canada approved 21 SAP requests for research participants exiting SALOME to receive legally prescribed heroin as a substitution drug. SAP allows for physicians to submit a request on behalf of a patient for a drug not yet approved in Canada. However, before the research participants could celebrate their victory, then-Federal Minister of Health Rona Ambrose announced that her government would stop SAP requests for heroin and further announced immediate new regulations for Health Canada's SAP, eliminating diacetylmorphine (prescription heroin) for the treatment of addiction.[1] In response to these new regulations, five plaintiffs—Larry Love, Deborah Bartosch, Charles English, Douglas Lidstrom, and Dave Murray, all former SALOME participants—along with co-plaintiff PHCS filed a constitutional challenge in the Supreme Court of British Columbia to overturn the federal government's decision to prevent further SAP requests for HAT (*Providence Health Care Society v. Canada*, 2013). The notice of civil claim was submitted on behalf of the plaintiffs and "on behalf of all persons with *severe opioid addiction* [emphasis added] who have previously not responded to other available treatment and on whose behalf a SAP request for diacetylmorphine is made by a medical practitioner" (*Providence Health Care Society v. Canada*, 2013, p. 1). Pivot Legal Society initiated the constitutional challenge on behalf of the individual plaintiffs and PHCS retained Joseph Arvay as legal counsel.

The role of SNAP in the constitutional challenge stands out. Since 2011, SNAP, a unique independent peer-run group of people who were research participants in the NAOMI and/or SALOME HAT clinical trials in Vancouver, British Columbia, has met weekly in the DTES at VANDU's site. SNAP advocates for the human rights of people who use opioids, the establishment of permanent and less medicalized HAT programs in Canada, and an end to drug prohibition. They also provide support and education for their members at weekly meetings. SNAP pointed to the lack of a permanent HAT program as a component of the SALOME trial prior to the trial opening its doors in the DTES (S. Boyd & NAOMI Patients Association, 2013; S. Boyd, Murray, SNAP, & MacPherson, 2017). SNAP, now doing advocacy work for 8 years, continues to bring the issue of access to HAT to the public's attention. Four of the plaintiffs in the *Charter* challenge are SNAP members: one of the four, Dave Murray, is the founder and facilitates SNAP meetings. SNAP members argue that in the midst of a preventable public health illegal opioid overdose death crisis, having access to HAT saved their lives (S. Boyd et al., 2017). Under the restraints of drug prohibition, SNAP seeks to have more flexible HAT programs established in Canada so that lives can be saved.

When the plaintiffs' SAP applications were denied following the new regulations, they stated in their individual affidavits that, once again, they resorted to using illegal heroin and were vulnerable to all of the associated risks including infection, overdose death, and arrest. Because HAT was an effective treatment for the plaintiffs, they argued that the new federal regulations were unconstitutional and infringed on the rights of SALOME participants as set out in the *Canadian Charter of Rights and Freedoms*. Because the *Charter* case would not be heard for at least another year, in May 2014, BC Supreme Court Chief Justice Hinkson granted an injunction, in effect approving an exemption from the new federal regulations for the participants in SALOME (*Providence Health Care Society v. Canada, 2014* ). Therefore, former SALOME research participants could receive HAT if their physicians deemed it the best treatment option and SAP concurred. Hinkson's judgment was a victory for

SALOME patients exiting the SALOME trial. Since November 2014, more than 100 people receive HAT through the injectable opioid agonist treatment (iOAT) program at Crosstown Clinic in the DTES. The *Charter* case was never heard because, following a federal election in October 2015, the newly elected Liberal government reinstated the former SAP policy for diacetylmorphine only.

## Method

Critical drug scholars have recently begun to interrogate further how we understand the "problem" of drugs—their materiality, their agency, and effects (see Fraser, 2017, p. 130). Drawing in part on Bacchi's (2009) theoretical approach, "What's the problem represented to be [WPR]?" new questions are being asked about the ways in which drug use is understood. As Fraser notes, "we construct our problems according to our values, our unexamined assumptions and our political contingencies" (2017, p. 131). Following Fraser and Moore's (2011) application of Bacchi's theoretical and methodological WPR framework in their analysis of Australian drug policy on amphetamine-type stimulants, other critical drug scholars have extended this framework to their own studies of alcohol and other drug policy, case law, and representation (i.e., S. Boyd, 2014; J. Boyd, Boyd, & Kerr, 2015; Lancaster, 2014; Lancaster & Ritter, 2014; Moore & Fraser, 2013; Seear & Fraser, 2014b). Bacchi's guidelines facilitate the critical interrogation of policies (in this case, legal documents) by proposing to work backward from a perceived problem. Bacchi posits that implicit dominant assumptions inherent in "problems" can be uncovered by critically interrogating their representation. In this paper, we utilize Bacchi's guidelines to problematize the taken-for-granted assumptions about criminality, addiction, HAT, credibility, and human rights that emerged in the *Providence Health Care Society v. Canada,* 2014 *Charter* challenge. Specifically, we examine the notice of civil claim, injunction court transcripts, the judgment, and individual plaintiffs' affidavits.

Bacchi (2009) notes that implicit representations of problems lead to specific courses of action. This study asks the six questions she introduced in WPR: (a) What is the "problem" represented to be in the material analyzed? (b) What presuppositions or assumptions underlie this representation of the "problem"? (c) How has this representation of the "problem" come about? (d) What is left unproblematic in this problem representation? Where are the silences? How can the "problem" be thought about differently? (e) What effects are produced by this representation of the "problem"? and (f) How/where has this representation been produced, disseminated, and defended? How could it be questioned, disrupted, and replaced?

In their analysis of addiction in Australian case law, Kate Seear and Suzanne Fraser also draw from Bacchi (2009), arguing, "the law can be understood as a realm within which addiction is constituted rather than simply reflected or addressed" (2014a, p. 441). They also note that "how addiction is understood and managed" outside of criminal law is "sometimes overlooked in academic research," even though civil and case law play a significant role in the production, maintenance, and destabilization of the "stigmatization and marginalization" of people labeled "addicts" (2014a, p. 438–439). In Seear's analysis of Canadian lawyers' reflections about "addiction" in their legal practice, she concludes that lawyers make decisions about the "nature, origins and effects of addiction" (2017, p. 189). Seear notes that lawyers' strategic "reframing of client's narratives" as "addicts" may also have downsides (p. 190). In addition, "judicial formulations also have a tendency to become fixed via the legal doctrine of precedent" (Seear & Fraser, 2014b, p. 834). In keeping with these assertions, this paper fills an identified gap in scholarship by analyzing the civil *Charter* challenge.

### *Findings: Providence Health Care Society v. Canada, 2014 BCSC 936*

In Canada, drug policy reform is often the result of a constitutional challenge pursued by plaintiffs who are most affected, rather than an initiative of a particular political party or elected official. The

*Canadian Charter of Rights and Freedoms* came into force as part of the *Constitution Act* in 1982. The *Charter* guarantees specific rights and freedoms and states the powers of federal, provincial, and territorial governments in Canada. The *Charter* has become one avenue to advance drug policy reform in Canada. For example, sustained community activism for harm reduction services in the DTES resulted in Canada's first federally sanctioned supervised injection site, Insite, which opened in 2003 (S. Boyd et al., 2009; Lessard, 2011). The federal minister of health at that time granted Insite a section 56 exemption from the CDSA (which among other provisions, criminalizes possession of drugs) so that clients could legally possess and inject an illegal drug at the harm reduction site without fear of arrest. However, following a federal election in 2006, it was unclear whether or not the Conservative government's minister of health would continue to grant Insite's exemption. Therefore, a *Charter* challenge was launched by plaintiffs who argued that the closure of Insite would infringe on their rights guaranteed under the *Charter*. Upon appeal, the Supreme Court of Canada[2] agreed that revoking the section 56 exemption was unconstitutional and would prevent access to an important harm reduction health-care facility, violating the rights of clients and staff guaranteed under section 7 of the *Charter*, which states that, "Everyone has the right to life, liberty and security of the person and the right not to be deprived thereof except in accordance with the principle of fundamental justice." Insite, an essential harm reduction service, remained open (Bunn, 2019; Calder, 2011; Lessard, 2011; Small, 2012).

Plaintiffs turn to the *Charter* to initiate change, drawing on legal arguments put forth in earlier cases. However, *Charter* challenges are expensive, can take years, and often result in a narrow ruling (Calder, 2011; Lessard, 2011). Yet the arguments and decisions put forth in these constitutional cases shape public health initiatives and treatment policies in Canada, as did the injunction hearing that took place in March 2014 and the final judgment made by Chief Justice Hinkson in May 2014. On the first day of the injunction hearing, Justice Hinkson communicated to the plaintiffs' primary lawyer, Mr. Arvay, that he had read all of the material provided to him. However, he noted:

> I don't pretend to have completely understood the medical articles nor do I think you should expect me to completely understand them when I'm deciding your application. I expect doctors to tell me what the medical literature says. And I don't expect to have to wade my way through it and decide what's accurate and what's not. (*Providence Health Care Society v. Canada*, 2014, March 25, page 4, line 26)

Justice Hinkson made clear to counsel that he expected that the medical evidence highlighted in affidavits submitted by physicians would be central to the case.

## Addiction

In order to participate in the SALOME trial, research participants had to be deemed "dependent" and "long-term street opioid injectors." The SALOME researchers referred to the *Diagnostic and Statistical Manual of Mental Disorders* (*DSM*-IV and *DSM*-5) diagnostic criteria for "substance dependence" (i.e., opioid dependence) and severe "opioid use disorder" to describe the research participants admitted into the trial (Oviedo-Joekes et al., 2016; Oviedo-Joekes et al., 2018; Palis et al., 2017). The *DSM* has long provided "the standard definition of addiction used in medical, epidemiological and psychological research" (Fraser, Moore, & Keane, 2014, p. 29). Both the plaintiffs' counsel and the Attorney General (AG) refer to the *DSM* categories, opioid dependence, and opioid use disorder in their arguments, as does Chief Justice Hinkson in his judgment; however, their arguments are not confined to criteria included in the *DSM*. Rather, in the notice of civil claim submitted by the plaintiffs in the Supreme Court of British Columbia, drug addiction is defined as a "chronic disease and can be progressive, relapsing and fatal" (*Providence Health Care Society v. Canada*, Notice of Civil Claim, 2013, p. 4, line 18). Chief Justice Hinkson states in his judgment that

the plaintiffs provided evidence accepted in an earlier *Charter* case, *Canada v. PHS Community Services Society*, that "drug addiction is a chronic disease" (*Providence Health Care Society v. Canada*, 2014, p. 28, para 70; *Canada v. PHS Community Services Society*, 2011). Although it is argued that social factors that shape addiction were also highlighted in *Canada v. PHS Community Services Society* (Bunn, 2019), Chief Justice Hinkson placed considerable emphasis on addiction as a disease. This framing of addiction as a chronic disease or illness was also relied on by the plaintiffs' counsel and intervenor, VCHA, throughout the 3-day *Charter* challenge, albeit in different ways. The plaintiffs' primary lawyer, Arvay, used this framing to convey the injustice that people who use drugs face when compared to individuals suffering with other chronic illnesses such as HIV/AIDS:

> I ask you to imagine, what if the illness in question was HIV or AIDS and the government imposed a blanket prohibition on the only medication that seemed to be safe or effective? The cries of homophobia would be loud and clear. (*Providence Health Care Society v. Canada*, 2014, March 25, page 40, line 6)

The plaintiffs' primary lawyer also used the disease frame to paint plaintiffs' drug use as *out of their control* (in stark contrast to the familiar conception of addiction as choice), attributing plaintiffs' relapses to "the nature of this chronic relapsing disease" (*Providence Health Care Society v. Canada,* 2014, March 25, p. 26, line 4) By doing so, he enabled his later argument in favor of HAT: If addiction is akin to any other chronic disease, then heroin—an internationally renowned medicine supported by evidence and preferred by the plaintiffs—should be available to those diagnosed with severe opioid use disorder or "chronic refractory opioid dependence or addiction," as it is referred to in the transcripts. Similarly, counsel for VCHA connected "the disease aspect of illicit drug use" to "various other aspects [of drug use in the Downtown Eastside] that are injurious to public health" (*Providence Health Care Society v. Canada*, 2014, March 26, p. 39, line 36), enabling the argument that by withholding heroin as a medication, the Government of Canada enables unnecessary drug-related harms or social problems to proliferate in the DTES.

In the injunction transcripts we examined, this framing of addiction as a disease or disorder overlays much of the discussion. The plaintiffs' primary lawyer repeatedly refers to addiction as a "disease," "chronic relapsing disease," "illness," and "chronic illness." LaChance, the primary counsel for the defendant, the Attorney General of Canada, refers to addiction as an "illness." The VCHA refers to addiction as a "medical condition" and frames "addicts" as individuals who are "critically and seriously ill." All legal actors at the injunction relied on the medical model of addiction to advance their individual arguments, further lodging the idea of "addiction" as a "brain disease" (*Providence Health Care Society v. Canada,* 2014, March 27, p. 65, line 31). What *was* contested throughout was whether HAT or conventional treatments should be available.

Each individual plaintiff also included in their affidavit that they had been told by their physicians that they were "physically and psychologically addicted to heroin and other opioids," which they believed to be true (e.g., Bartosch, 2013, p. 2, para 5). Hearing this firm belief, substantiated by medical opinion, further drives the acceptance of regular or heavy heroin use as an "addiction," a physical and chronic condition or disease (see Moore, 2008). Despite accounts of homelessness, prison time, victimization, and poverty in the individual plaintiffs' affidavits, it is nevertheless, addiction and heroin use—rather than structural violence—that are framed as the "primary cause of suffering" by the legal actors (see Fraser et al., 2014, p. 41).

Critical drug researchers have brought to our attention assumptions about addiction and the instability of addiction models. Further, they make clear how ideas about addiction inform policy and treatment options and how people become labeled as "addicted" (N. Campbell, 2007; Fraser, 2017; Fraser et al., 2014; Hart, 2017; Keane, 2002; Reinarman, 2005; Reinarman & Granfield, 2015). Reinarman (2005) argues that the "disease concept of addiction obscures the fact that it did not emerge from the accretion of scientific discoveries" but is "continuously redefined" (p. 307); the disease model

of addiction is a "causal explanation rather than a list of symptoms" (Fraser et al., 2014, p. 30). For example, there are substantial differences between the *DSM*-IV and *DSM*-5: the *DSM*-5 no longer includes the term addiction "in favor of substance use disorder" (Reinarman & Granfield, 2015, p. 5). Suzanne Fraser, David Moore, and Helen Keane posit that addiction or substance use disorder does not need to be understood as a fixed pathological identity nor a "neurobiological condition"; rather, it could be understood as a "habit" (Fraser et al., 2014; Keane, 2002). Accounts of diverse experiences of drug use also contest conventional assumptions (i.e., Moore, Pienaar, Dilkes-Frayne, & Fraser, 2017; Pienaar & Dilkes-Frayne, 2017; Pienaar et al., 2017). Nevertheless, the medical model of addiction prevailed in *Providence Health Care Society v. Canada*, in the individual plaintiffs' affidavits, and in Justice Hinkson's decision.

However, while all legal actors within the transcripts rely on the dominant medical model of addiction, they also conceive of addiction in more social respects. LaChance, counsel for the Government of Canada and opponent of HAT, recognizes the complexity of addiction:

> My overview begins with the idea that there are multiple causes of drug addiction and they vary from individual to individual. I don't think that's in dispute. And there's quite extensive amount of detail about the causes including psychological issues, trauma, lifelong medical conditions, all of which remain in the underlying individuals. (*Providence Health Care Society v. Canada*, 2014, March 26, p. 42, line 24)

In this statement, LaChance recognizes that social determinants, or facilitators, may be factors in addiction. In another exchange, Arvay describes people who use heroin as disliking heroin use because of the negative social ramifications it has on their lives:

> But the evidence is, they don't like being heroin addicts, they hate being heroin addicts. They're ashamed of being heroin addicts. They can't face their family because they're heroin addicts. They want to quit, they've tried so many different ways. (*Providence Health Care Society v. Canada*, 2014, March 27, p. 90, line 45)

Arvay also pointed to "anti-social behavior" that can be the result of illicit drug use, as well as the inhumanity of withholding HAT from those who need it, the rights-based effect of which is to "deprive patients [people who use illicit drugs] of their life, their liberty and their security of person" (*Providence Health Care Society v. Canada*, 2014, March 25, p. 15, line 34). Although the notice of civil claim submitted on behalf of the plaintiffs claims that one aspect of the disease of addiction is the continuing "craving to consume" [opioids] (*Providence Health Care Society v. Canada*, 2013, p. 4, line 18), one of the striking details about the plaintiffs' affidavits is that each of the five plaintiffs stated they were able to use heroin for years, or on and off again, without becoming "addicted," and they also went for long periods of time not using heroin at all. This indicates that social and cultural factors were also at work in their drug use trajectories, in addition to the physical and psychological "dependence" repeatedly referred to (and depended on) by the legal actors.

There are multiple understandings, experiences, and "trajectories into, within, and out of" drug use (Reinarman & Granfield, 2015, p. 16). People's diverse experiences with heroin and other drugs cannot be divorced from historical, political, legal, social, cultural, and biological contexts (Fraser, 2017). The outcomes of illegal heroin use are shaped by one's social status, and how the "problem" of heroin use and addiction are understood, produced, and acted upon in a given historical era (Fraser, 2017). Since the early 1900s, in Canada, drug laws and policies have restricted access to legal sources of heroin. People who use illegal heroin have been subject to a host of discriminatory and punitive legal, social, and medical regulation. Poor and marginalized people are much more likely to be discriminated against, stigmatized, pathologized, and criminalized.

Although the injunction's legal actors rely on the "addiction as disease" frame, what is truly contested is whether HAT should be available to SALOME participants (including the plaintiffs)

exiting the trial or whether it should be refused. While the plaintiffs' counsel constructs addiction as a chronic disease in order to further their argument for the provision of HAT as treatment, the AG contends there are other more socially accepted treatments, like methadone, that should usurp HAT. Further, by framing addiction as a chronic disease out of the plaintiffs' control, the AG states:

> The addiction itself is going to lead [the plaintiffs] to seek out easy avenues for the drug [heroin] and Dr. Conway specifically talks about the risks of—of even the incentive being out there, destabilizing existing treatment. (*Providence Health Care Society v. Canada*, 2014, March 27, p. 32, line 20)

Here, the AG argues that by making HAT available, people who use drugs and who are characterized as helpless to their addiction will seek heroin out, destabilizing what the state views as other more conventional and suitable treatments.

## *Reliable and Unreliable Witnesses*

Throughout the injunction, the judge, AG, and plaintiffs' counsel deployed assumptions about people "addicted" to heroin. The reliability as witnesses of people who use heroin (including the plaintiffs) came into question repeatedly and was used by different legal actors to further their arguments. For the AG's lawyer, Mr. LaChance, discrepancies (or perceived discrepancies) in the plaintiffs' statements were construed as evidence that they could not be trusted to self-report:

> It's really hard to gauge what evidentiary value to give that without any specifics. How is that supposed to be taken. I don't know what normal sleep patterns are for somebody when they're using street heroin . . . I don't know what his [the plaintiff's] version of normal is. (*Providence Health Care Society v. Canada*, 2014, March 27, p. 29, line 22)

LaChance went further than casting doubt on the plaintiffs' reliability, characterizing their "lack of credibility" as a willingness to lie in order to receive HAT:

> So it's by far a stretch to suggest that the credibility of the information that was provided is not in doubt. It really is. It was being provided for the sole purpose of making sure they got in [to the HAT trial]. (*Providence Health Care Society v. Canada*, 2014, March 27, p. 18, line 46)

Justice Hinkson also cast doubt on the plaintiffs' reliability, connecting their perceived lack of credibility to their identities as "heroin addicts":

> Well, one of the difficulties that your friend has identified with the users themselves is that they aren't particularly reliable witnesses. They have said to doctors what they think they need to say to get what they'd like. (*Providence Health Care Society v. Canada*, 2014, March 25, p. 46, line 28)

Although the plaintiffs' primary lawyer defended the individual plaintiffs' reliability and integrity, arguing "the fact that they're heroin addicts doesn't mean they can't tell the truth" (*Providence Health Care Society v. Canada*, 2014, March 27), he also drew on the unreliable witness/addict trope. In one instance, he described a plaintiff's dishonest interaction with a physician as "not entirely surprising," later remarking "it's not unreasonable to suggest [the plaintiffs] would simply lie to the doctors to get [HAT]" (*Providence Health Care Society v. Canada*, 2014, March 27, p. 20, line 20). Dominant assumptions about addiction and people who use drugs were clearly relied on, even by those dedicated to defending them and supporting their claims. Claims about the plaintiffs' reliability also stem from long-held assumptions about the criminal and pathological nature of people who use heroin. The violence of drug prohibitionist policies is rendered invisible by a narrow focus on the individual. So

too are broader social and economic forces: colonialism, race, class, gender, and sexuality, which shape experiences of drug use, criminalization, and treatment.

The individual plaintiffs' affidavits outline their extensive legal employment histories and the criminal activity that plaintiffs undertook in order to support their heroin use prior to receiving legally prescribed HAT in the clinical trial. In fact, each affidavit is uniform in noting the reduction in criminal activity while in the SALOME trial. The criteria to be accepted into the SALOME trial were "long term street opioid injectors" (Oviedo-Joekes et al., 2016, p. E1), and one of the primary arguments and findings put forth by both Canadian HAT trials was the reduction of criminal activity, including use of illegal heroin (Oviedo-Joekes et al., 2016, p. E4). What might the lives of these plaintiffs have been if they had lived prior to criminalization and could purchase, without a prescription or on the illegal market, safe, legal, unadulterated opioids at the local pharmacy?

## *Doctors*

Medical evidence was a key driver of the injunction itself, with each counsel drawing on affidavits of medical practitioners and on the medical literature to construct and further their arguments. Also reliant on medical evidence was Justice Hinkson, who made clear he would ultimately make his decision based on medical evidence—however obtained—that was presented to him:

> I don't think it has to be the authors [of medical papers] necessarily, it just has to be a medical person whose evidence I'm prepared to accept—accepting the correctness of them. That's usually how medical reports gain evidentiary status. (*Providence Health Care Society v. Canada*, 2014, March 27, p. 20, line 20)

However, the doctors who provided affidavits must be given special attention, as those who supported the plaintiffs' claims and access to HAT were treated differently than those who refuted them. For example, Crosstown Clinic doctors were often framed by the AG as unreliable witnesses with similar status to the patient plaintiffs:

> It simply would be inappropriate to accept the affidavits from the doctors making wide-sweeping—asking the court to accept wide-sweeping conclusions as expert opinion. (*Providence Health Care Society v. Canada*, 2014, March 27, p. 21, line 14)

Mr. LaChance also aimed to sow doubt about the Crosstown Clinic doctors' medical and reporting practices (and therefore their reliability), referring to the doctors' acceptance of—in his view, unsubstantiated—reported patient symptoms in old medical records, which LaChance described as "vagaries" and "hearsay evidence" (*Providence Health Care Society v. Canada*, 2014, March 26, p. 48, line 24). In some cases, this tactic was made clear, with LaChance describing a Crosstown Clinic doctor's affidavit as "of extremely little value and seems to get the facts wrong" (*Providence Health Care Society v. Canada*, 2014, March 27, p. 33, line 27). Ultimately, what the AG hoped to achieve with this tactic was to exemplify that Crosstown Clinic doctors were too quick to resort to HAT and should have first made every effort to exhaust all other conventional avenues.

Following criminalization, health professionals who provide, or are suspected of providing, drug maintenance to people dependent on opioids have been constructed as unreliable and criminal by law enforcement agents and the courts (Fraser & valentine, 2008; Giffen et al., 1991; Musto, 1987; Waldorf et al., 1974). The criminal status of people who use heroin and opioids extends to those health professionals who provide care. Despite the construction of plaintiffs and their doctors as unreliable witnesses by the AG, the injunction led to a partial victory for the plaintiffs. Physicians who deemed HAT an effective treatment were again able to submit a SAP application to Health Canada on behalf of their SALOME patients. Thus, the status quo was restored. However, Justice

Hinkson rejected the application for a mandatory injunction; therefore, access to diacetylmorphine for non-SALOME patients remained limited at that time. The Supreme Court justice ruled that SALOME patients could receive heroin until the *Charter* challenge was heard. As noted above, a change in federal government in 2015 led to the former SAP policy being reinstated; therefore, the *Charter* challenge was dropped.

## Discussion: Human Rights, Disease, and Unreliability

In this article, we examine discourse and policy decisions about addiction, heroin, and HAT in Canada by analyzing the arguments put forth at an injunction hearing in Vancouver, BC, in 2014, *Providence Health Care Society v. Canada*. Canada's history of drug prohibition and drug treatment regimes, although influenced by international events—including treaties—is unique. Since the 1980s, *Charter* challenges and subsequent legal decisions have also influenced drug policy in Canada, including the injunction hearing in 2014.

The injunction decision by Justice Hinkson was an important partial victory for the plaintiffs in *Providence Health Care Society v. Canada* and for SALOME patients exiting the trial. For the brave individual plaintiffs, whose affidavits propelled the case into the Supreme Court of British Columbia and into the public realm, the injunction decision was significant. In that sense, the strategy of the plaintiffs' lawyers was quite effective. The lawyers successfully organized for the plaintiffs, and an array of expert physicians, health researchers, and government and health officials from across Canada submitted affidavits supporting the *Charter* challenge by providing evidence of HAT's efficacy. It was also a symbolic victory for the plaintiffs, the plaintiffs' counsel, and harm reduction advocates, as it directly challenged the ramped-up war-on-drugs mandate of Stephen Harper's ruling Conservative Party. The Conservative government's approach included a wholesale rejection of harm reduction, including the rejection of evidence supporting harm reduction programs and the framing of drug treatment as necessarily and solely abstinence-based, as well as framing people who use heroin as "junkies" and "criminals" (S. Boyd, 2017, p. 137). It is evident from the plaintiffs' personal affidavits (and scholarly research) that the provision of HAT was beneficial and effective for them. Given the plaintiffs' participation in the SALOME clinical trial, there was no doubt that they were using illegal opioids prior to entering the trial, and later, legal opioids when participating in the trial. We are not contesting the lived experience of these plaintiffs (whether negative or positive) nor their suffering. Nor are we contesting the benefits these plaintiffs experienced while being prescribed HAT. Rather, we are problematizing how their heroin use is constructed in the affidavits, notice of civil claim, hearings, and judgment. The manner in which the lawyers in the case presented their arguments is also problematized. We wonder whether there are other ways to frame heroin use that do not reaffirm conventional tropes.

Prior to the 1900s, people who used heroin were not constructed as criminal, addicted, or pathological. Rather, people were able to buy the drug legally and without issue. The transition from law-abiding citizen to "criminal addict" and "junkie" is a product of criminalization and prohibitionist discourses and policies (see Acker, 2002; S. Boyd, 2013, 2014, 2017; Carstairs, 2006; Fraser & valentine, 2008; Lart, 1998; Musto, 1987; Waldorf et al., 1974; Waldorf & Reinarman, 1975). In Canada, from the 1950s on, addiction and/or consumption of illegal heroin has also been constructed as a medical problem—and a problem that requires treatment. Shifting medical discourses and practices including those abstinence based—and later on, limited drug maintenance therapy—are imposed on those labeled addicted, especially when marginalized. For the poor and marginalized, treatment often reflects their social status. Surveillance and punishment are built into conventional treatment regimes, and people who cannot conform or who are unwilling to abide by treatment protocols are seen as resistant and eventually expelled, even when this results in prison time (i.e., drug treatment courts). People who are expelled or who drop out of treatment are constructed as the problem. Rarely are

addiction models and treatment itself, rather than the individual, seen as the problem; rarely is treatment constructed as failing the individual. Drug substitution programs, such as HAT, have long been restricted in Canada due to drug laws and policies. Due to criminalization and Health Canada restrictions, HAT in Canada today is highly medicalized; surveillance and monitoring of patients is excessive, and so, too, are security measures. Heroin use is not constructed as a social or cultural activity. Rather, assumptions about "addiction," the criminal status of heroin, and the people who use it influence and shape medical treatment in this setting.

In the injunction hearing, Justice Hinkson indicated that his judgment would be based on the medical evidence presented to him; thus, it is clear that medical discourse has a role in shaping legal judgments. However, the medical evidence was interpreted and framed by counsel, as were the submitted individual affidavits. Even when defending the plaintiffs' character and advocating for their access to HAT, dominant assumptions about addiction and reliability prevailed, with the plaintiffs constructed as afflicted with a disease, engaging in criminal acts, and as liars.

In relation to lawyers reframing clients (and in our case, individual plaintiffs' affidavits), Seear (2017) argues that "lawyers may erode clients' capacity for self-determination in legal settings" (p. 190). Thus, she questions whether or not these processes of reframing of clients' narratives about addiction are "stigmatising and/or disempowering for the people who experience them" (p. 190). Bacchi's (2009) first question, "What is the 'problem' represented to be?," provides guidance here: By pursuing their respective lines of defense, both counsels reduce the "problem" of addiction down to an individual level. However, social status and the level of punitive control shape experiences, outcomes, and the impact of heroin use (see N. Campbell & Herzberg, 2017; Reinarman & Granfield, 2015). When addiction is framed as a lifelong, progressive physical and psychological condition, people who use drugs are framed as powerless (to a degree) in the face of addiction, and structural violence (including drug prohibition) that contributes to discrimination and the marginalization of people who use illegal heroin is obscured. Conventional ideas about addiction, and prohibitionist policies and discourses, have the effect of producing stigma as well as creating a disincentive for cultural and structural reform that would support flexible HAT programs and other innovative options such as heroin compassion clubs (see Thomson et al., 2019). In our study, we also questioned whether the construction of the individual plaintiffs' affidavits challenged dominant ideas about "addicts" and addiction or whether they reaffirmed them. As we highlighted earlier, we conclude that the personal affidavits and arguments put forth by injunction lawyers reaffirmed the disease model of addiction and, to a certain extent, the characterization of criminality.

However, drug user unions (e.g., International Network of People who Use Drugs, VANDU, SNAP), harm reduction and drug reform activists and organizations (e.g., Canadian Drug Policy Coalition, Transform Drug Policy Foundation, Drug Policy Alliance), and critical drug researchers contest conventional assumptions about drug use and highlight alternative experiences, policies, and practices (e.g., J. Boyd & Boyd, 2014; S. Boyd, MacPherson, & Osborn, 2009; Kennedy et al., 2019; Moore et al., 2017; Pienaar & Dilkes-Frayne, 2017; Pienaar et al., 2017).

We acknowledge that there is a limit to what a judge or lawyer can accomplish in a *Charter* challenge. Legal discourse and truth claims can work to obscure structural violence and the complexities of people's lived experience, especially those who are systematically marginalized. Dominant assumptions about people who use heroin are deeply rooted, perpetuated, and defended in multiple and overlapping realms such as medicine and law. In utilizing Bacchi's (2009) methodological WPR guidelines, it became evident that legal discourse is shaped by dominant assumptions, discriminatory practices, stigma, and wider societal forces that frame the "problem" of addiction—and by extension the "addict"—as resting at the individual level in the body and through behavior. However, in asking Bacchi's second question of the data, "What presuppositions or assumptions underpin this representation of the 'problem'?," it also became evident that the "addict" label carries its own set of assumptions and stereotypes: criminal, deceitful, helpless, out of control, vilified. It became evident that in the

court transcripts, the judgment, and even in the plaintiffs' affidavits (all of which were aligned and unified in their presentation of the plaintiffs as helplessly addicted) that while the understanding of addiction is fixed, so too is the "heroin addict." These long-standing narratives are critical to the maintenance of the biomedical model (and medicalization) of addiction and the status quo regarding drug treatment: because while the plaintiffs' counsel did argue for an exception for the plaintiffs, by no means was there a recommendation for widely expanded access to HAT.

Bacchi's fifth question asks, "What effects are produced by this representation of the 'problem'?" The answer is that people who use heroin in Canada are not afforded the same human rights as other Canadians. Canada is currently experiencing a preventable illegal opioid overdose crisis, the worst overdose death crisis in its history. Since 2010, illegal opioid drug overdoses have increased due to a poisoned illegal drug supply, much of which includes fentanyl and its analogues, a class of highly potent opioid. Between January 2016 and September 2018, more than 10,300 preventable illegal opioid overdose deaths occurred across Canada (Government of Canada, 2019). In July 2017, in response to the deaths, Health Canada created a legal pathway to allow access to diacetylmorphine outside of SAP in jurisdictions in which a public health emergency has been declared (Government of Canada, 2017). Due to rapidly rising overdoses and overdose deaths in the province of British Columbia, such a public health emergency was declared in April 2016. However, in 2018, illegal opioid overdose deaths in BC and Canada continued unabated (British Columbia Coroners Service, 2019; Special Advisory Committee on the Epidemic of Opioid Overdoses, 2018). Further, little expansion of injection heroin treatment outside of Crosstown Clinic has occurred. Critics note that this is a missed opportunity, as many more people could have been receiving diacetylmorphine if the emergency option was implemented (MacDonald, 2018). In May 2018, Health Canada removed further regulatory barriers, allowing movement of diacetylmorphine (now reframed as an opioid that can be prescribed legally), and doctors and nurse practitioners are now able to prescribe both diacetylmorphine and hydromorphone for iOAT. Whereas availability of hydromorphone for iOAT has increased in some cities in BC and elsewhere, Crosstown Clinic in Vancouver continues to be the only provider of HAT in Canada. Rather than set up additional HAT services in order to save lives, across Canada, heroin possession offenses have been increasing since 2010 (Statistics Canada, 2019).

In the face of the preventable overdose crisis, we wonder: why have services not been *vigorously* rolled out? In Canada, not one overdose death has occurred at Crosstown Clinic's iOAT program or in federally sanctioned supervised consumption and provincial overdose prevention sites. These programs save lives. We can look to the injunction court transcripts and final judgment for some explanation for this inaction. People labeled as "addicted" to illegal heroin and other opioids continue to be constructed as criminal, pathological, and as suffering from a disease. The problem of drug prohibition and the broader social, legal, and cultural factors that shape the lives of people who use illegal and legal heroin continue to be obscured.

It is argued that "true equality before the law" for people labeled as addicted will only occur when drug use is conceptualized differently: socially, culturally, and politically (Bunn, 2019, p. 73). At the local and international levels, there is a growing movement doing just that—opposing punitive drug control and dominant assumptions about drug use and highlighting alternative experiences of drug use, drug policies, and practices. It is our hope that this diverse movement will continue to grow.

## Acknowledgments

The authors would like to thank CDP reviewers and Scott Bernstein for their insightful comments on an earlier draft of this manuscript. They would also like to thank Beth Abbott for editing the manuscript.

## Declaration of Conflicting Interests

The author(s) declared no potential conflicts of interest with respect to the research, authorship, and/or publication of this article.

## Funding

The author(s) disclosed receipt of the following financial support for the research, authorship, and/or publication of this article: This research was funded by the Canadian Social Science and Humanities Research Council through an Insight grant awarded to the lead author, Susan Boyd.

## ORCID iD

Susan Boyd https://orcid.org/0000-0001-7384-1378

## Notes

1. A number of other drugs, such as ecstasy and LSD, were also prohibited.
2. The plaintiffs put forth two legal arguments in the Insite case; however, their argument regarding interjurisdictional immunity was dismissed.

## References

Acker, C. (2002). *Creating the American junkie: Addiction research in the classic era of narcotic control*. Baltimore, MD: Johns Hopkins University Press.

Bacchi, C. (2009). *Analysing policy: What is the problem represented to be?* Sydney, Australia: Pearson.

Bartosch, D. (2013, December 3). Affidavit. Providence Health Care Society et al. v. Canada, 2014. Supreme Court of British Columbia.

Blanken, P., van den Brink, W., Hendriks, V. M., Huijsman, I. A., Klous, M. G., Rook, E. J., . . . van Ree, J. M. (2010). Heroin-assisted treatment in the Netherlands: History, findings, and international context. *European Neuropsychopharmacology*, *20*, S105–S158.

Boyd, J., & Boyd, S. (2014). Women's activism in a drug user union in the DTES. *Contemporary Justice Review*, *17*, 313–325.

Boyd, J., Boyd, S., & Kerr, T. (2015). Visual and narrative representations of mental health and addiction by law enforcement. *International Journal of Drug Policy*, *26*, 636–644.

Boyd, S. (2013). A Canadian perspective on documentary film: Drug addict. *International Journal of Drug Policy*, *24*, 589–596.

Boyd, S. (2014). The criminal addict: Canadian radio documentary discourse, 1957-1969. *Contemporary Drug Problems*, *41*, 201–232.

Boyd, S. (2017). *Busted: An illustrated history of drug prohibition in Canada*. Winnipeg, Canada: Fernwood.

Boyd, S., MacPherson, D., & Osborn, B. (2009). *Raise shit! Social action saving lives*. Halifax, Canada: Fernwood.

Boyd, S., & Murray, D., SALOME/NAOMI Association of Patients, & MacPherson, D. (2017). Telling our stories: Heroin-assisted treatment and SNAP activism in the Downtown Eastside of Vancouver. *Harm Reduction Journal*, *14*. doi:10.1186/s12954-017-0152-3

Boyd, S., & NAOMI Patients Association. (2013). Yet they failed to do so: Recommendations based on the experiences of NAOMI research survivors and a call for action. *Harm Reduction Journal*, *10*. doi:10.1186/1477-7517-10-6

British Columbia Coroners Service. (2019, February 7). Illicit drug overdose deaths in BC January 1, 2008–December 31, 2018. Victoria, Canada: BC Coroners Service. Retrieved from https://www2.gov.bc.ca/gov/content/life-events/death/coroners-service/statistical-reports

Bunn, R. (2019). Conceptualizing addiction as disability in discrimination law: A situated comparison. *Contemporary Drug Problems*, *46*, 58–77.

Calder, G. (2011). Insite: Right answer, wrong question. *Constitutional Forum*, *19*, 113–117.

Campbell, L., Boyd, N., & Culbert, L. (2009). *A thousand dreams: Vancouver's Downtown Eastside and the fight for its future*. Vancouver, Canada: Greystone Books.

Campbell, N. (2007). *Discovering addiction: The science and politics of substance abuse research*. Ann Arbor: The University of Michigan Press.

Campbell, N., & Herzberg, D. (2017). Gender and critical drug studies: An introduction and an invitation. *Contemporary Drug Problems*, *44*, 251–264.

Canada (Attorney General) v. PHS Community Services Society. 2011 SCC 44, [2011] 3 S.C.R. 134.

Carstairs, C. (2006). *Jailed for possession: Illegal drug use, regulation, and power in Canada, 1920–1961*. Toronto, Canada: University of Toronto Press.

Controlled Drugs and Substances Act, S.C. 1996, c.19.

Fraser, S. (2017). The future of "addiction": Critique and composition. *International Journal of Drug Policy*, *44*, 130–134.

Fraser, S., & Moore, D. (2011). Governing through problems: The formulation of policy on amphetamine-type stimulants (ATS) in Australia. *International Journal of Drug Policy*, *22*, 498–506.

Fraser, S., Moore, D., & Keane, H. (2014). *Habits: Remaking addiction*. New York, NY: Palgrave Macmillan.

Fraser, S., & valentine, K. (2008). *Substance and substitution: Methadone subjects in liberal societies*. New York, NY: Palgrave Macmillan.

Gartry, C., Oviedo-Joekes, E., Laliberté, N., & Schechter, M. (2009). NAOMI: The trials and tribulations of implementing a heroin assisted treatment study in North America. *Harm Reduction Journal*, *6*, 1–14.

Giffen, P., Endicott, S., & Lambert, S. (1991). *Panic and indifference: The politics of Canada's drug laws*. Ottawa, Canada: Canadian Centre on Substance Abuse.

Government of Canada. (2017, July 12). Regulations amending the Food and Drug Regulations (Importation of drugs for an urgent public health need). *Canada Gazette*, *151*. Retrieved from http://www.gazette.gc.ca/rp-pr/p2/2017/2017-07-12/html/sor-dors133-eng.html

Government of Canada. (2019, April). National report: Apparent opioid-related deaths in Canada. Retrieved from https://infobase.phac-aspc.gc.ca/datalab/national-surveillance-opioid-mortality.html

Hart, C. (2017). Viewing addiction as a brain disease promotes social injustice. *Nature Human Behaviour*, *1*, 0055.

Information Canada. (1973). Commission of inquiry into the non-medical use of drugs (Final Report, No. H21-5370/2). Ottawa, Canada: Author.

Keane, H. (2002). *What's wrong with addiction?* New York: New York University.

Kennedy, M., Boyd, J., Mayer, S., Collins, A., Kerr, T., & McNeil, R. (2019). Peer involvement in low threshold supervised consumption sites in the context of an overdose epidemic in Vancouver, Canada. *Social Science & Medicine*, *225*, 60–68.

Lancaster, K. (2014). Social construction and the evidence-based drug endeavor. *International Journal of Drug Policy*, *25*, 81–87.

Lancaster, K., & Ritter, A. (2014). Examining the construction and representation of drugs as a policy problem in Australia's National Drug Strategy documents 1985-2010. *International Journal of Drug Policy*, *25*, 81–87.

Lart, R. (1998). Medical power/knowledge: The treatment and control of drugs and drug users. In R. Coomber (Ed.), *The control of drugs and drug users: Reason or reaction?* (pp. 49–68). Amsterdam, the Netherlands: Harwood Academic.

Lessard, H. (2011). Jurisdictional justice, democracy, and the story of Insite. *Constitutional Forum*, *19*, 93–112.

Luce, J., & Strike, C. (2011). *A cross-Canada scan of methadone maintenance treatment policy developments*. Ottawa, Canada: Canadian Executive Council on Addictions. Retrieved from www.ccsa.ca/ceca/activities.asp

MacDonald, S. (2018, October 3). *Injectable treatment: Hydromorphone & heroin. Stimulus 2018, Drugs Policy and Practice in Canada*. Shaw Conference Centre, Edmonton, Canada.

Moore, D. (2008). Erasing pleasure from public discourse on illicit drugs: On the creation and reproduction of an absence. *International Journal of Drug Policy*, *19*, 353–358.

Moore, D., & Fraser, S. (2013). Producing the problem of addiction in drug treatment. *Qualitative Health Research*, *23*, 916–923.

Moore, D., Pienaar, K., Dilkes-Frayne, E., & Fraser, S. (2017). Challenging the addiction/health binary with assemblage thinking: An analysis of consumer accounts. *International Journal of Drug Policy*, *44*, 155–163.

Musto, D. (1987). *The American disease: Origins of narcotic control* (Expanded ed.). New York, NY: Oxford Press.

North American Opiate Medication Initiative Study Team. (2008, October 17). Reaching the hardest to reach—Treating the hardest-to-treat: Summary of the primary outcomes of the North American Opiate Medication Initiative (NAOMI). Retrieved from http://www.chumontreal.qc.ca/sites/default/files//documents/Media/PDF/081017-resume-resultats-etude.pdf

Oviedo-Joekes, E., Guh, D., Brissette, S., Marchand, K., MacDonald, S., Lock, K., . . . Schechter, M. (2016). Hydromorphone compared with diacetylmorphine for long-term opioid dependence: A randomized clinical trial. eAppenix 1. Screen Process. *JAMA Psychiatry*, *73*, e1–e9.

Oviedo-Joekes, E., Palis, H., Guh, D., Marchand, K., Brissette, S., Lock, K., . . . Schechter, M. T. (2018). Characteristics and response to treatment among Indigenous people receiving injectable diacetylmorphine or hydromorphone in a randomized controlled trial for the treatment of long-term dependence. *Drug and Alcohol Review*, *37*, 137–146.

Palis, H., Marchand, K., Guh, D., Brissette, S., Lock, K., MacDonald, S., . . . Oviedo-Joekes, E. (2017). Men's and women's response to treatment and perceptions of outcomes in a randomized controlled trial of injectable opioid assisted treatment for severe opioid use disorder. *Substance Abuse Treatment, Prevention, and Policy*, *12*, 1–12.

Pienaar, K., & Dilkes-Frayne, E. (2017). Telling different stories, making new realities: The ontological politics of "addiction" biographies. *International Journal of Drug Policy*, *44*, 145–154.

Pienaar, K., Dilkes-Frayne, E., Fraser, S., Kokanovic, R., Moore, D., Treloar, C., & Dunlop, A. (2017). *Experiences of alcohol and other drug addiction, dependence or habit in Australia: Findings and recommendations from a national qualitative study*. Melbourne, Australia: National Drug Research Institute, Curtin University.

Providence Health Care Society v. Canada (Attorney General), BCSC 936 (May 29, 2014).

Providence Health Care Society v. Canada (Attorney General), Notice of Civil Claim, BCSC S138411 (November 13, 2013).

Reinarman, C. (2005). Addiction as accomplishment: The discursive construction of disease. *Addiction Research & Theory*, *13*, 307–320.

Reinarman, C., & Granfield, R. (2015). Addiction is not just a brain disease: Critical studies of addiction. In R. Granfield & C. Reinarman (Eds.), *Expanding addiction: Critical essays* (pp. 1–20). New York, NY: Routledge.

Reist, D. (2011). *Methadone maintenance treatment in British Columbia, 1996–2008*. Victoria, Canada: Centre for Addictions Research of BC. Retrieved from http://www.health.gov.bc.ca/cdms/methadone.html

Seear, K. (2017). The emerging role of lawyers as addiction "quasi-experts." *International Journal of Drug Policy*, *44*, 183–191.

Seear, K., & Fraser, S. (2014a). Beyond criminal law: The multiple constitution of addiction in Australian legislation. *Addiction Research and Theory*, *22*, 438–450.

Seear, K., & Fraser, S. (2014b). The addict as victim: Producing the "problem" of addiction in Australian victims of crime compensation law. *International Journal of Drug Policy*, *25*, 826–835.

Small, D. (2012). Canada's highest court unchains injection drug users: Implications for harm reduction as standard of healthcare. *Harm Reduction Journal*, *9*, 34–45.

Small, D., & Drucker, E. (2006). Policy makers ignoring science and scientists ignoring policy: The medical ethical challenges of heroin treatment. *Harm Reduction Journal*, *3*, 1–14.

Special Advisory Committee on the Epidemic of Opioid Overdoses. (2018). *National report: Apparent opioid-related deaths in Canada* (January 2016 to June 2018). Web Based Report. Ottawa, ON: Public Health Agency of Canada. Retrieved from https://infobase.phac-aspc.gc.ca/datalab/national-surveillance-opioid-harms-mortality.html

Statistics Canada. (2019). Incident-based crime statistics by detailed violations, Canada, provinces, territories and Census Metropolitan Areas. Table: 35-10-0177-01. Retrieved from https://www150.statcan.gc.ca/t1/tbl1/en/cv.action?pid=3510017701#timeframe

Stevenson, G., Lingley, L., Trasov, G., & Stansfield, H. (1956). *Drug addiction in British Columbia: A research survey*. Unpublished manuscript, University of British Columbia, Vancouver, Canada.

Stimson, G., & Ogborne, A. (1970). Survey of addicts prescribed heroin at London clinics. *The Lancet*, *295*, 1163–1166.

Strang, J., Groshkova, T., & Metrebian, N. (2012). *New heroin-assisted treatment: Recent evidence and current supervised injectable heroin treatment in Europe and beyond*. Luxemburg: Insights, European Monitoring Centre for Drugs and Drug Addiction.

Tallaksen, A. (2017). The narcotic clinic in New Orleans, 1919–1921. *Society for the Study of Addiction*, *112*, 1680–1685.

Thomson, E., Wilson, D., Mullins, G., Livingston, A., Shaver, L, & McBain, L. (2019). *Heroin compassion clubs: A cooperative model to reduce opioid overdose deaths & disrupt organized crime's role in fentanyl, money laundering & housing unaffordability*. Vancouver, Canada: British Columbia Centre on Substance Use. Retrieved from http://www.bccsu.ca/wp-content/uploads/2019/02/Report-Heroin-Compassion-Clubs.pdf

Waddell, I. (2018). *Take the torch: A political memoir*. Gibsons, Canada: Nightwood Editions.

Waldorf, D., Orlick, M., & Reinarman, C. (1974). *Morphine maintenance: The Shreveport Clinic, 1919–1923*. Washington, DC: The Drug Abuse Council.

Waldorf, D., & Reinarman, C. (1975). Addicts—Everything but human beings. *Urban Life*, *4*, 30–53.

World Health Organization & UNAIDS. (2011). Ethical engagement of people who inject drugs in HIV prevention trials. Retrieved from http://www.unaids.org/sites/default/files/media_asset/20110429-Ethical-engagement-people-inject-drugs-HIV-prevention-trials_en_0.pdf

## Author Biographies

**Susan Boyd** is a distinguished professor in the Faculty of Human and Social Development, University of Victoria, Canada. She is also a long-time activist who works with national and community peer-run organizations that advocate for the end of drug prohibition and for the establishment of diverse harm reduction initiatives. She was a member of the federal Task Force on Cannabis Legalization and Regulation. She is the author of a number of articles and books on drug issues including *Busted: An illustrated history of drug prohibition in Canada*.

**Alexa Norton** is a research advisor at the First Nations Health Authority (FNHA) in British Columbia, Canada. At FNHA and with various community-based harm reduction and treatment initiatives, she advocates for programming that is culturally relevant, trauma-informed, and inclusive of Indigenized approaches.