Emancipations: A Journal of Critical Social Analysis

Volume 2 | Issue 3 Article 5

August 2023

Shaping a Crisis, Constructing Addiction: Discursive Depoliticization of British Columbia's Drug Policy

Hope Robinson
hoperobinson96@gmail.com

"The art of not being governed like that, and at that cost."
Michel Foucault's (1978:45) definition of critique

Introduction: "A crisis of incomprehensible scale" (Clarkson 2023)

Over the past decade, the Canadian province of British Columbia has faced an alarming surge in illicit opioid and stimulant-related fatalities – a situation known as the 'overdose crisis'. A public health emergency was declared in 2016.

This spurred significant political action: since 2017, two successive provincial New Democratic governments have expanded investments, enacted legislation, and launched a range of initiatives targeting the staggering levels of overdose – from supervised injection sites, and the decriminalization of drugs for personal use, to promoting opioid substitution therapy (Burton et al., 2021; KPMG, 2018; Conrad, 2022). This represents some of the most 'progressive' drug policies in the country, grounded in the province's proclamation of a shift towards a medical model that sees drug use as a health issue rather than strictly as a criminal one (PHO, 2019: 4).

Yet, the crisis has not abated; the number of overdose deaths has continued to rise dramatically, with 2022 marking the deadliest year of the crisis thus far (Gibbs et al.: 2023). Illicit drug toxicity has jumped to the leading cause of death in British Columbia for people between the ages of 10 to 59, surpassing the other top causes of unnatural and natural death combined (The Canadian Press, 2023).

This analysis sets out to inquire why the comprehensive public health response has not yielded the intended results, despite its forward-thinking policies grounded in a concern for health over criminalization (Govt of BC, 2016; Burton et al., 2021). I will claim that this purportedly progressive approach to public health has been ineffective because it fails to address the socio-political drivers of the overdose crisis. Relating the work of cultural anthropologist Philippe Bourgois on drug use as a coping mechanism and Carol Bacchi's ontopolitical approach to the issue, I will trace the discursive dynamics through which the opioid crisis has been constructed in a manner that obviates its structural roots in the political economy of capitalist democracies.

Cultural anthropologist Philippe Bourgois (2018) has observed that the crises of substance use and related harms that occur sporadically around the world can serve as 'canary-in-the-mine bellwethers' that help to reveal the fault lines of suffering within a society: exposing the stark disparities in power, social inequality, vulnerability, and resistance within communities, regions, and on a broader societal scale. Thus, he has directed attention to the social determinants of drug use, such as poverty, homelessness, social stigma, and discrimination (Galea & Vlahov, 2002; Spooner and Hetherington, 2005).

In both academic and policy circles, however, 'drug problems' tend to be considered exogenous to the policy process, which invites the search for 'evidence-based solutions' to these 'problems' (Fraser, 2020). Challenging this prevailing approach, Carol Bacchi has argued that health issues are interconnected with the policies through which they are addressed (Bacchi, 2018: 4). This perspective has been named ontopolitically oriented approach in critical drug studies: wherein problems are seen as "ontologically constituted in the interventions designed to solve them" (Farrugia, Seear, and Fraser, 2017: 4).

By asking "What's the problem represented to be?," Carol Bacchi directs attention to the way policy problems are constituted in the course of their treatment by public policy. For her, "representations of 'problems' play a central role in how we are governed": for, while we tend to assume that "policy solves social problems," she argues that "policies give shape to 'problems'" but "do not necessarily address them" (Bacchi, 2021e; Bacchi, 2009, xi in Boyd & Kerr, 2015: 421).

In other words, from an ontopolitical perspective, *policies* are discourses shaped by specific ontological assumptions about the nature of reality, agency, and social relations, and thus *realities* are in part produced by underlying social, political, and ideological mechanisms at work in policy discourses (Howarth et al., 2020: 1). The ontopolitical perspective directs attention to the heterogenous, complex, and multifarious 'strategic relations' – the *politics* – that shape lives, including what is assumed, what is emphasized, and what is concealed in those relations and problematizations, and their effects for the governed (Bacchi, 2021: 1).

Drawing on Bachi's work, I will explore the political construction of the overdose crisis in British Columbia's government's drug policy discourse. I will use as a primary corpus of analysis the main policy responses of British Columbia's government to the overdose crisis that were released between 2017 and 2021. I will argue that the failure of the purportedly progressive policy turn is due to the *depoliticization* of drug overuse through its discursive construction as a crisis of 'addiction', thereby directing attention away from the socio-structural roots of drug overuse.

In what follows, I will first theorize discursive depoliticization as a form of political strategy. I will then trace the discursive construction of the public health approach to drug use as a strategy that directs attention away from the social determinants of drug use and addiction. While mostly drawing on Carol Bacchi's engagement with the discursive articulation of health policy, I will also draw on anthropologist Didier Fassin's conceptualization of biolegitimacy, in order to argue that the depoliticization of drug use reflects a wider phenomenon – namely, the emergence of a humanitarian rationale in public policy that is narrowly remedial, and impervious to the social sources of the suffering that policies aim to alleviate. Ultimately, this will allow me to contend that the discursive production of public health problems forecloses radical systemic change. Harnessing conceptual logics of health, addiction, risk, and harm aligns with, and reproduces, the same register of rationality as that which it purports to replace -- that of a prohibitionist criminalized, 'eradicative' approach to drugs (Brown, 1998, 44, in Howarth et al. 2020: 1; Debbaut and Kammersgaard, 2022: 3). Thus, systematic discursive depoliticization perpetuates the crisis as it precludes more radical and emancipatory strategies of addressing the social determinants of drug use.

Discursive Depoliticization as a Political Strategy

Politicization is a process through which a phenomenon is problematized as a valid object of political contestation and requiring action by public authority (Azmanova, 2020: 45; Mazzuca and Santarelli, 2022). Rather than being the opposite of politicization, depoliticization is a form of politicizing a phenomenon in a way that obscures its political nature, that is, "the politically contested character of governing" (Burnham, 2001: 23). It

is a discursive process that obscures the availability of choice, thereby rendering "some options or circumstances natural, necessary, and/or inevitable" (Wood & Flinders, 2014: 161; Landwehr, 2017; Jenkins, 2011). This consists in discursively *presenting phenomena* to be removed from political accountability, generating inherently political effects that restrict autonomy while preserving specific strategies of power (Jenkins, 2011).

Bacchi's (1999, 2009) concept of problem-representations refers to specific problematizations: how issues are constructed in policy discourse purported to address them. Significantly, she posits that "we are governed, not through policies, but through their problematizations" (Bacchi, 2018, 6). Policies, in this light, can be seen as 'ontologically productive' discourses (Hjermann, 2020: 30), in the sense that policies do not *respond* to external issues, but *constitute* them in the first place, through discursive practices that link together elements, and obscure others (Remling, 2018).

Importantly, this claim does not amount to doubting the reality of individuals suffering in conditions deserving of amelioration, nor that the existence of problems such as poverty is acceptable or not problematic. In fact, this stance typically motivates the research (Bletsas, 2012). The 'reality' of drugs as physical substances is not denied. What *is* destabilized is the assumption of drug *use* as "defined by 'natural' distinctions stemming from the object itself", and drug 'problems', drugs, drug users, and drug experiences as objective starting points for researchers." (Herzog, 2016: 116). This leads us to consider how these "problems" are constituted by subjects, performances, and practices.

Depoliticization is one of the dynamics of selective problem-construction in the course of which only certain forms of action are rendered legitimate. This can serve to deny the contingency of politics by obscuring the power dynamics that generate these conditions in the first place.

In this way, the identification of problem-representations can serve to uncover discursive depoliticization, while also offering insights into how and why this may operate: as the relationship between problem-representations and depoliticization highlights the intricate ways in which power is exercised through the use of discourses-as-knowledges to influence the political landscape.

Identifying discursive depoliticization involves highlighting "whenever the acknowledgment or transparency of contingent political decision-making is undermined or obscured", as well as the involvement of and implications of associated decision-making (Landwehr, 2017: 53). This can appear, as Wood and Flinders (2014) assert, when policy discourse reflects "the promotion of an issue, but alongside a single interpretation and the denial of choice", rendering "some options or circumstances natural, necessary, and/or inevitable" (Wood & Flinders, 2014: 161; Bates, Jenkins, and Amery, 2014, in Vachon, 2020: 15).

As Brunila (2022) and Jessop (2014) posit, depoliticization is always "contingent and context-dependent": meaning its study requires establishing "specific reference points in past and present political spacetime against which to establish its occurrence" (207). Identifying depoliticization requires, thus, establishing how a given issue, resulting from prior political decisions, is constructed discursively in a way that impede or obscure 'the political': concealing "the possibility that society can be constituted differently," and thus denying the political character of phenomena within social reality (Sørensen and Torfing, 2017: 29). It can be seen to move an issue to the 'realm of necessity', or as Jenkins (2011: 163) posits, appears as "what is given to us as universal, necessary, obligatory": how the specification of limits of reason, or 'conditions of possibility', appears both "as though it cannot be traversed and is the only admissible way of seeing" – thus "concealing and reducing the inherent contingency of political processes" (Jenkins, 2011: 67; Foucault, 1984: 45).Thus: the crux of discursive depoliticization is to *produce* a phenomenon as something for which political authority cannot be held accountable, which is in itself a political act, with political effects: particularly, as Jenkins (2011: 160) asserts, the effect of "generat[ing] the restriction, removal or suppression of our capacities for autonomy, as well as the preservation of a particular strategy or force".

Let us turn to the specific dynamics of the discursive construction of the 'overdose crisis' as a medical problem.

Politicizing Drug Use: From Prohibition to Medicalization

The history of the regulation of drugs and drug-related policy includes many processes of politicization intertwined with the shifting and developing social and economic interests of the state, societal norms, and perceptions of risk. As Toby Seddon (2016) points out, prior to the late 19th and early 20th century, most drugs currently classed as illicit were not yet considered the danger to society and to health they are today. Comparatively, the use of substances that affect the brain and alter one's cognition, mood, and perception, has been a practice of human life and cultures for thousands of years – ranging from use in spiritual and religious ceremonies, as well as for medical treatment, social rituals, and recreational activities (Crocq, 2007).

As Derrida (1993) demonstrated, 'drugs' are not a pre-existing category in nature, and the meanings associated with drugs are not intrinsically related to the nature of the substances themselves. Rather, the 'drug label' is an "invented legal-regulatory construct" closely intertwined with the global drug prohibition system, encompassing a range of naturally occurring chemicals (categorized as stimulants, depressants, hallucinogens, and opioids) that have been declared licit or illicit depending on time, place, and culture (Seddon, 2016: 413). In other words, over the last several centuries, drug-related concerns have been discursively transformed into subjects of conflict and contention, with heightened politicization bringing them to the forefront of public and political agendas and processes of policy formulation.

Despite the veneer of respectability that is often associated with drug-related policy, the "deep history of the drug concept" is particularly racialized and colonial in its origins, shaped by cultural discourses of morality and racism in Canada, the United States, and the United Kingdom (Seddon, 2016: 414).

In Canada, from its origins as a colony of the British Empire, a strong Protestant Christian ethic influenced a view of opium as "inherently bad and an immoral, corrupting force" alongside racist notions about Chinese immigrants who consumed it (Boyd, 2017). By the mid-19th century, unlike alcohol and tobacco, which were already widely

consumed across social strata, opium use was exclusively linked to ‘deviant’ subcultures (Nadelmann, 1990; Debbaut and Kammersgard, 2022: 9). Industrialization and the emphasis on productivity and ‘labour discipline’ led to perceiving certain substances and addiction as threats to societal stability, prompting a focus on controlling opium's availability rather than its use (Debbaut and Kammersgaard, 2022; Reith, 2004). The roots of drug use as a medical issue date back to around this time, as the notion of drug addiction emerged primarily to justify the medical supervision of opium use despite its legality (Berridge, 1979; Debbaut and Kammersgaard, 2022; Spanjar, 2022).

This historical trajectory gives rise to a contemporary paradox: while regular alcohol drinking and opium smoking became medicalized via medical involvement with their treatment and supervision, avoiding addiction remained an individual responsibility, leading to stigma for those who failed (Debbaut and Kammersgaard, 2022). Justice and welfare systems were instrumental in normalizing and controlling perceived ‘unfit’ individuals or groups (Seddon, 2016).

Intertwined with these developments, the challenges presented to society by processes of industrialization, such as the spread of infectious diseases, gave rise to the emergence of public health: as a vital state-adjacent field for safeguarding the well-being of populations, characterized by regulation, prevention, and monitoring at the population level (Tulchinsky, 2014). Public health, as a state-adjacent field, emerged to safeguard population well-being with a focus on ‘social order’ and threats to productivity and social stability posed by 'addictions' (Tulchinsky, 2014; Reith, 2004).

These historical and disciplinary developments provided discursive resources to shape individuals into ‘governable subjects’ (Foucault, 1978, 1989). The emergence of public health and criminal justice resulted in disciplinary regimes, including asylums and prisons, designed to treat and cure this new category of disordered subjects (Reith, 2004 in QMJC, 2023).

The rise of moral and health-based arguments against opium use provided a convenient justification for the United States to exert control over the drug trade and position itself as moral leader on the international stage, by regulating opium (Seddon, 2016). Canada followed, adopting a prohibitionist approach with the 1908 *Opium Act*,

which sought to suppress immigrant populations' use of drugs for medicinal and spiritual purposes, despite data from that era showing 'greater harms' resulting from alcohol and tobacco use than from opium and its derivatives (TPH, 2018; Boyd, 2017).

Since the first *Opium Act* was enacted, Canada's drug framework across all jurisdictions has revolved near-exclusively around the prohibition of certain 'classes' of drugs and the criminalization of their use, manufacturing, possession, and sale, as a leading nation in the global prohibitionist regime throughout the 1900s (Boyd, 2017). In 1911, cocaine and morphine were added as prohibited substances, and policy authority was expanded to suppress drug use and trafficking, and by 1922, marijuana was prohibited as well – changes that coincided with increased social salience of these drugs as 'immoral' (Boyd, 2017).

The *Narcotic Control Act* of 1961 and the *Controlled Drugs & Substances Act* of 1996 both held the same focus on criminalizing drug use (TPH, 2018). Canada's drug regime was influenced heavily by the United States and their 'War on Drugs' seeking to stamp out drug consumption "as the origin of a range of serious social problems" (Fraser, Moore, and Keane, 2014). According to Bacchi (1999: 51), characterizing drug use as problems in this way is "indicative of the long tradition within Western democracies of designating and labeling certain activities 'social problems',
especially those linked to poverty and crime, marginalized communities, and perceived loss of self-discipline. This close association established powerful and persistent perceptions relating to criminality and morality that constitute stigma against drug use and people who use drugs (PWUD), even though the correlation between drug use and crime, poverty, and illness can alternatively, in another perspective, be seen as resulting *from* the effects of prohibition and criminalization, and their disproportionate impact on low-income and racialized populations (Cohen et al., 2022). This has been widely established: as Stevens (2010) posits, drug-related harms are "not naturally occurring, but products of social processes," and are "distributed unevenly across social cleavages that point to inequality as a causal factor in drug harms" (3).

This century of criminalization and regulation of certain drugs contributed to the creation, persistence and power of an illicit market characterized by uneven power dynamics between suppliers, distributors, and PWUD and the criminal justice system

(Bourgois, 2013). The widespread societal stigma and discrimination associated with substance use have simultaneously also contributed to the marginalisation and 'othering' of PWUD (Souleymanov & Allman, 2016 in Goodyear, 2021). Such processes of social exclusion have been "formalized into practice" and exacerbated by the domination of penal drug policies and laws, which promote and reinforce unfavorable public perceptions of the alleged moral worth of PWUD (Goodyear, 2021).

Drug use is a deeply intersectional phenomenon. In Canada, socioeconomic disparities and structural inequalities intersect with drug use patterns, often reflecting broader power imbalances in society, such as the effects of colonialism, systemic discrimination, poverty, and racism. Indigenous and racialized populations are over-represented in data on poverty, homelessness, and illicit substance use, as are people with disabilities (Boyd, 2017; Bourgois, 2013; Gehring et al., 2018). Lack of access to quality education, meaningful employment, and stable housing creates vulnerabilities that can lead to substance use to cope with mental and emotional suffering and stress (Boyd, 2017). Moreover, these communities often face barriers to accessing appropriate treatment and harm reduction services, perpetuating cycles of harm and marginalization. Hence, not only is the nature of the unregulated supply a product of power relations, but so too are the patterns and impacts of illicit drug use shaped by the structural disparities ingrained within Canadian society. Further, these harms often compound in the case of micro-local or regional drug 'crises', such as the situation in British Columbia, which disproportionately affects already-marginalized communities (Boyd, 2017). The state's response to drug epidemics is thus deeply influenced by power dynamics, as it often seeks to 'solve' the 'drug problem' of the day, at the junction of political, economic, and social forces that shape the prevalence, distribution, and impact of illicit drug use, through the silo of 'drug policy'.

As part of the complex interplay of forces contributing to the unequal social distribution of 'harmful' illicit drug use, the overdoses and deaths that characterize today's 'overdose crisis' can also be seen as resulting, in part, from the provincial and federal governments' decisions to curtail medical availability of opioids in the early 2010s. At that time, the 'overuse' and 'overprescribing' of medical opioids garnered widespread public and media attention in Canada (Clarke et al., 2019). Governmental

action to suppress these phenomena had the effects of triggering increased exposure to the unregulated market for individuals who could no longer source their opioids medically, the proliferation of powerful synthetic opioids such as fentanyl that made the market much more volatile and dangerous, and thus increased toxic drug exposure for those PWUD already relying on the illicit supply (Fischer et al., 2018). Ever since, the toxicity of the illicit supply has only been outmatched by its volatility and unpredictably, and PWUD are often unaware of the content and strength of their drugs, increasing the chances of toxicity leading to death (Tobias, 2023).

Producing the problem as one of criminality and deviance through prohibition and punitive measures and perpetuating a moral stigma against drug use led to the increasingly strong illicit market as well as the sustained strong pockets of marginalization and disadvantage in relation to drug use in Canada (Fischer et al., 2018). Thus, we can see why the shift towards a public health-oriented approach to the 'problem of drugs' in society is considered welcome to counter what Bourgois (2013) terms the 'dogmatic normativising intolerance' towards drugs that can be said to have characterized the 20th century. However, as the evolving formation of knowledge is ever-influenced by power dynamics, the contemporary policy configuration to drugs in British Columbia reflects the entanglement of power relations, discourses, and historical epistemologies and ontologies that have shaped prevailing ideas and practices concerning drug-related issues in the region – which the rest of the project will serve to interrogate.

The government of British Columbia declared a 'public health emergency' in 2016 under a Liberal government. Their response initially emphasized repression of use and supply, alongside some harm reduction and treatment initiatives (Kulkarni, 2022). By mid-2017, the New Democratic Party took provincial leadership, maintaining the state of public health emergency and shifting towards a more health-oriented response with expanded harm reduction and treatment initiatives (Kulkarni, 2022). Consequently, the analysis focuses on policy proposals, reports, and statements introduced by government Ministries during the successive mandates of the provincial NDP, who continue to govern as of 2023.

This provincial focus is justified by the provincial government's pressing need due to its significantly higher drug-related deaths and substance use impact compared to the rest of Canada, as well as British Columbia's reputation as a leader in 'overdose crisis management' and progressive drug policy – which underscores its potential influence on similar issues across different regions (KPMG, 2018).

Canada's federal structure and division of legislative powers also plays a role in this choice. Provinces hold significant autonomy in areas such as healthcare and social services. While the federal government structures drug laws, provincial governments play a crucial role in their enforcement, evidenced by B.C.'s decriminalization policy and ability to request exemptions under the *Controlled Drugs and Substances Ac*t (CDSA) (Majeed, 2006). Although the federal government contributes financially through healthcare funding, Canadian federalism dictates that the primary responsibility for addressing the overdose crisis lies with the provinces (Majeed, 2006). The province's overdose crisis discourse can thus be seen as 'central to', and as 'giv[ing] shape to', the 'crisis' itself (Johnson & Maclean, 2020: 377).

When the NDP government took power in 2017, it committed to considering the 'crisis' a 'public health emergency', in order to "prevent overdoses and deaths" (Govt of BC, 2016). That goal remains consistent throughout the corpus. While on the surface this could be interpreted as the dominant problem-representation that the policy proposals aim to solve, WPR acknowledges that representations 'nest' within each other: thus, considering the apparent lack of effectiveness of these interventions thus far, it is more fruitful to identify what the government aims to change to achieve that explicit goal – "and hence, what does it produce as the 'problem'?" (Bacchi, 2009: 4). Thus, the focus in this analysis is on the representations of what *leads* to these overdoses and deaths. It also necessitates considering how the notions of 'health crisis' and 'public health emergency' influence "the evolution of ongoing practices" over the course of the period under consideration in their linkage to health and particularly 'public health' – as Bacchi notes (2023b) that these can be considered 'governmental problematizations' in themselves (Tanesini 1994: 207 in Bacchi, 2023b).

In 2017, the government proposed a series of multi-sector 'comprehensive interventions' for the overdose crisis: aimed at "saving lives, connecting people to

treatment and recovery, and addressing some of the root cause issues connected to problematic substance use, such as stigma", retroactively described in the 2018 report under analysis (MMHA, 2018: 3). It distinctly states the problem as an issue of public health and care rather than of criminal justice (MMHA, 2018: 3). The core focus here is 'problematic substance use', and the interventions proposed can be seen to revolve around eliminating use as the key pathway to reducing harms, as well as directly mitigating the health consequences of said 'problematic use', mainly, overdoses.

In the aim of "connecting people to treatment and recovery", the government launched the Ministry of Mental Health and Addictions (MMHA): a new portfolio tasked with "leading the provincial government's response to the overdose emergency," and creating an 'integrated' system of "mental health and addictions services" (MMHA, 2019: 3). The MMHA is accordingly the author of all further policy responses. This action directly ties addiction to the 'comorbidity' of mental illness, and the two together as subject to stigma that prevents access to care. The other interventions launched in 2017-2018, as visible in the MMHA's 2018 Report, include the improved availability of methadone and suboxone therapy for 'opioid use disorder', the expansion of community-based naloxone distribution, and the establishment of Overdose Prevention Sites (OPS) and Safe Consumption Sites (SCS) (MMHRA, 2018). All three are distinctly 'harm reduction initiatives', reflecting attempts to mitigate the harm associated with drug use, particularly, chronic use. Methadone and suboxone are medications prescribed by physicians to treat 'opioid use disorders' and can ease withdrawals and help prevent relapse (referred to as 'Medication-Assisted Treatment' or 'Opioid Agonist Treatment') (MMHA, 2018: 3-6). These therapies thus aim at diminishing prolonged illicit substance use, understood as an 'addiction', and more specifically, as a specific type of addiction: 'opioid use disorders'. Overdose Prevention Sites and Safe Consumption Sites are facilities designed to provide a safe and supervised environment for individuals who use illicit drugs to use their substances, where aid will be provided in case of overdose, and PWUD can access information on addiction treatment - designed also to foster a closer proximity to the healthcare system (MMHA, 2018). Naloxone is a medication designed to rapidly reverse or reduce the effects of opioids, used in case of overdose by

bystanders – typically other PWUD, OPS personnel, or community workers (NIDA, 2022).

Within this first series of proposals, multiple problem-representations are identifiable. As noted above, the core 'problem' causing overdoses and death is represented to be 'problematic substance use': however, it prominently refers to 'addiction' as the main form of 'problematic substance use', also interchangeably referred to as 'substance use disorder', 'opioid use disorder' and 'opioid dependence', all representing states on the spectrum of 'addiction' (MMHA, 2018). Thus, although this policy discourse purports to address deaths and harms, it does not construct the problem solely *as* the deaths and harms. The proposal of increased addiction treatment programs implies the understanding of chronic substance use as a medical issue, requiring medical treatment: zeroing in on the vector of use disorder / addiction as leading to deaths. Although the texts acknowledge that 'the emergency is the result of an unpredictable, highly toxic drug supply', they do not construct the problem to be that drug supply, but individuals' exposure to it because of their addictions, compounded by mental illness and especially stigma (MMHA, 2019: 3).

Thus, the secondary, related problem-representation, tied to deaths and to the construction of addiction-as-disease, is that of stigma around illicit drug use: the 'shame and blame' associated with drug use and dependence as causing death by "preventing individuals from accessing health and social services", such as addiction treatment (MMHA, 2019: 10).

In early 2019, the B.C. Ministry of Mental Health and Addictions released an 'escalated' response plan, still centered on "saving lives, ending stigma, and building an evidence-based network of treatment and recovery services", now also aimed at "creating a supportive environment, advancing prevention [and] improving public safety" (MMHA, 2019: 4). Here, the notion of 'supportive environment' refers to "provid[ing] the social and economic supports that can help reduce problematic substance use and maintain recovery". The province constructs "investing in vital social supports such as housing and childcare, and other poverty reduction measures" as "essential to ensuring that people with a substance use disorder are engaged and retained in treatment and care" (MMHA, 2019, 5). There is recognition here of the influence of social determinants

on substance use disorders: however, those determinants – poverty, lack of healthcare and housing - are referenced as a *compounding* problem to the already existing 'problem' of addiction, primarily as a barrier to accessing and staying in treatment.

In its proposal of 'advance prevention', this idea is said to reflect "a core principle of public health": the idea that "prevention is better than treatment" (MMHA, 2019: 15). Within this idea, if "patients do not have to suffer from a disorder," then, the health care system "does not have to pay for treatment and recovery, and society does not have to shoulder social and economic costs" (MMHA, 2019:15). This proposal aims to "deliver the early intervention and education that can help keep childhood trauma and other mental health issues from driving substance use disorders" – reinforcing the problem as addiction-as-disease (MMHA, 2019: 15).

In 2020, the onset of the COVID-19 pandemic exacerbated the levels of overdose deaths as the drug supply became more unpredictable, and individuals faced reduced access to interventions and increased stress due to isolation and loss of mental health support (Burton et al., 2021). In response to the increased threat to PWUDs' lives, the government proposed a new intervention: a temporary prescribed safe supply program – allowing medical professionals to prescribe medication alternatives to substances, including opioids, stimulants, and benzodiazepines (MMHA, 2023). Here, the increased danger of exposure to a toxic drug supply, and thus to the lives of individuals with addictions, validates this step of introducing limited 'safe supply'. Thus the same knowledges are seen to be at work: as a health issue, addiction should be prevented from leading to death by intervening in a medical respect. The proposed safe supply project was, and today remains, managed by medical professionals within a healthcare framework (MMHA, 2023).

The concern with stigma persists into the last intervention proposed within the corpus: the decriminalization of PWUD. In 2021, the provincial government officially applied to the federal government for an exemption under Section 56(1) of the *Controlled Drugs and Substances Act*, to remove criminal penalties for people who possess small amounts of illicit drugs for personal use (BC Gov News, 2021). This was initially proposed in a 2019 report issued by the Provincial Health Officer, the senior non-elected public health official in the province (PHO, 2019). In the statement released

regarding decriminalization, the province suggests the exemption would directly reduce deaths by alleviating stigma: “reduc[ing] the fear and shame associated with substance use that prevents people from seeking care” (BC Gov News, 2021). Here, the role of drug laws as a stigmatizing structural factor is acknowledged, but stigma is constructed as the complex of attitudes and behaviors towards PWUD shared amongst the population, acting as a barrier to PWUD accessing treatment. This points away from the state, and towards the public and the need for PWUD to overcome stigma in their quest for recovery.

This proposal was represented as the next move of the government’s shift in focus from “punishment, which has resulted in social isolation, stigma and fear,” toward “a medical model that recognizes substance use as a health issue” (BC Gov News, 2021). This exemption was approved in 2022, enacted in 2023, and will last until 2026 as a “trial project”, marking the latest major development in the policy response to the overdose crisis (BC Gov News, 2021).

Thus, these problem-representations of addiction and stigma must be interrogated, not to deny the existence of experiences that can be identified by both concepts – but as they are made possible through presuppositions and assumptions that contribute to their reification. Fundamentally, these representations rely on the assumed existence of addiction / use disorders, the assumed presence of stigma regarding substance use as a process working against the creation of better health outcomes for PWUD by preventing access to support services, and of a relationship between the two: that treating substance use disorders (addictions) as a medical health issue contributes to the removal of stigma and opportunities for recovery for PWUD, thus better outcomes overall.

These problem-representations can be seen to emerge from and be situated within public health and harm reduction knowledges and the medical model of addiction-as-disease. The medical model of addiction assumes the presence of addiction as a chronic disorder of the brain, and thus that individuals do not want to use drugs but are controlled in effect by the pathways in the brain that compel them to do something that harms them, thus also assuming the need for treatment to achieve ‘recovery’ (Clark, 2018). Importantly, it also assumes that “medical language provides liberation” from the

moralized language and ideas historically associated with addiction (Frank and Nagel, 2017). The influence of public health knowledge here is the overarching framework within which addiction is constructed as a complex health issue, acknowledging the involvement of biological, psychological, and social factors in its development - but also recognizes addiction as a chronic disorder because it involves long-term patterns of behavior, relapse, and the need for ongoing management and treatment. This includes, in particular, the "evidence-based medical treatments", such as medication-assisted therapies, that aim to manage the chronic aspects of addiction, stemming from the medical model of addiction (MMHA, 2018: 16). Public health as a 'science' tends to focus on prevention through environmental factors, particularly using a language of risk - but in combination with a 'crisis' situation, tends to be presented as immediate mitigation tactics. Here is where harm reduction is subsumed to its logic: as consequentialist policy approach that encompasses strategies aimed at mitigating and reducing the negative consequences of 'risky behaviors' such as substance use, rather than requiring strict abstinence, as it also acknowledges 'the chronic nature of addiction' (HRI, 2016). The core assumption here is one of risk mitigation as preferable to repression, particularly in situations of crisis, seen to permeate the government's policy framework (HRI, 2016).

Further, the construction of 'stigma' as a secondary problem-representation assumes that stigma increases drug deaths through the barrier it represents to getting help and using safely. This is grounded in the assumption that the stigmatization of PWUD can lead to a range of interconnected challenges, including reduced access to healthcare services, social isolation, low self-esteem, engagement in riskier drug use practices, and avoidance of harm reduction services. Stigma's impact on these aspects can collectively contribute to increased vulnerability to drug-related harms, including overdose. Principally, however, the main assumption underlying this representation in the discourse is one that this barrier of stigma is preventing PWUD from accessing existing services.

Thus, throughout this policy-as-discourse, these knowledges work together to shape the implicit, core focus of the policies: reifying the concept of 'addiction' as the central driver of the crisis, which implies getting individuals 'off drugs' is the key to

protecting life: preventing overdoses and overdose deaths. In putting forth the building blocks of its approach to the 'public health emergency' of the overdose crisis, British Columbia's government has constructed a response built on the disease model of addiction that can thus be considered 'sanitorial' in its centralizing of health, with "care and cure as its primary responses" (Debbaut and Kammersgard, 2022).

Having identified the converging conceptual logics of the medical model of addiction, public health, and harm reduction within the policy discourse on the overdose crisis, this section embarks on a Foucauldian genealogy of these knowledges. This process involves tracing their multifaceted historical evolution, unmasking the power dynamics they emerge from, and thereby challenging the perception of the present as "natural and/or inevitable" (Bacchi, 2015). This examination elucidates how British Columbia's government can frame the core problem of the overdose crisis as "addiction" at the intersection of these intertwined knowledges (Bacchi, 2012: 56). It will also engage with several critical perspectives on the concepts of stigma and addiction in relation to the medical model, serving in a sense as a literature review and setting the stage for the final stage of the analysis.

The medical model of addiction, commonly referred to as the 'addiction as brain disease' model grounded in neuroscientific research, constitutes a central knowledge within this discourse (Lewis, 2018). It views prolonged substance use as a result of a 'pathologic neurologic pathway' causing 'chronic relapsing' (Lewis, 2018).

The first anti-opium laws in the West were introduced by the U.S. as it sought to pursue trade with China but also control the growing negative perception of opium on its home soil (Boyd, 2017). It thus became limited to medical uses only. As mentioned, it was at this time that in Canada, the state seized upon the racist and moralized ideas about the use of opium by Chinese immigrants to implement a prohibitionist regime in line with the U.S., and later the U.K. (Boyd, 2017).

Throughout the 19th and 20th century, the emergence of and advancements in new 'human sciences' of chemistry, physiology, and psychology further influenced ideas about opium and other drugs that were gradually rendered illicit for personal use over the first two decades of the 20th century (Debbaut and Kammersgaard, 2022). The confluence of socioeconomic and political shifts during the late 19th and early 20th

century, such as industrialization, class tensions, and increased immigration, converged with the rising legitimacy of medical experts, a combination which played a crucial role in the emergence of the concept of the 'addict' and the rise of public health (Reith, 2004). Here, the concerns of both the state and the medical profession converged around the "moral–religious notion of the diseased 'will'", producing a "medical-moral discourse" on drug use (Reith, 2004 in QMJC, 2023).

The 20th century witnessed a shift from predominantly moralistic explanations of addiction requiring medical management towards scientific understandings, which ultimately reinforced the need for medical involvement, influenced by the rise of positivist thought which sought objective explanations for human behavior (Reith, 2004). As medical practitioners sought to categorize and define addiction, they began to conceptualize it as a disease, a deviation from the normal state of health. This perspective framed addiction as a pathology with underlying causes rooted in biology, paving the way for the disease model.

The ascent of the psychological and psychiatric sciences prompted an increasing emphasis on medical and psychiatric interpretations of 'disordered identities' and 'addictions', highlighting the biological origins of conditions rather than attributing them solely to personal willpower, and emphasizing the presence of disease states (Reith, 2004). Within this terrain, the new discipline of 'psychobiology', later called neuroscience, gave rise to the predominant interpretation of addiction of recent times that focuses on the brain (Reith, 2004). While neuroscientific perspectives do occasionally recognize the impact of social and cultural factors on addiction (Fraser, 2013), their primary focus revolves around the 'brain's reward system' (Fraser et al., 2017: 4). According to researchers Volkow and Li (2004, 163), addiction is essentially described as the 'neurobiology of maladaptive behavior'. Research conducted on lab animals, the identification of the brain's reward pathways, and the possibility to treat addiction through pharmaceutical medications to ease withdrawal and prevent relapse are taken as evidence in support of this thesis of addiction (Frank and Nagel, 2017).

In the 1980s, a new discourse relating to drug use arose. In the context of the HIV/AIDs epidemic, activists identified the need for interventions to address the risks and 'pervasive drug-related public health problems' associated with injection drug use,

which was identified as a significant driver of HIV transmission (Erickson et al. 1997 in Allman et al., 2016). This led to the development of 'harm reduction', as a philosophy suggesting that the implementation of 'pragmatic and humane' policies, programs, and practices that "aim to minimize negative health, social and legal impacts associated with drug use, drug policies and drug laws," was the most important action to counter the harms prohibition had given rise to (HRI, 2016). Thus, harm reduction strategies were promoted as "alternatives to legal suppression of drug use that do not require the cessation of use" (HRI, 2016).

Initially, advocates of harm reduction promoted these alternative approaches often in direct defiance of strict prohibitive and punitive measures enforced by state and legal authorities, often with a distinctly oppositional perspective that considered harm reduction as a platform for broader and more structural change (Allman et al. 2016: 1442). It thus represented, for some, a "political and moral commitment" to changing the social and material conditions of PWUD, targeting the "deeper social, economic and racial inequality that the 'drug problem' masks" (Smith, 2012: 214; Roe, 2006: 447).

As many worked to politicize drugs as a health issue reflecting inequality, against the dominant representation of drugs as a criminal issue, these efforts did not go unnoticed for their efficacy in saving lives and reducing harms. Consequently, harm reduction began to receive "increasing yet variable levels of institutional support" across the world, including in Canada, as a recognized strategy for reducing harms (McLean, 2011: 71). Previously labeled as criminal 'subcultures,' clusters of individuals engaged in deviant drug use were reframed and depicted as communities possessing distinct 'medical requirements' that could not be disregarded or marginalized without incurring more significant societal harm (Smith, 2012: 213). In this sense, in its co-optation by institutions, harm reduction was drawn into alignment with the disease model of addiction (Keane, 2009a).

This model was taken up by public health discourses starting in the 1990s, promoted as a way of countering the persistence of moral stigma surrounding addiction. As Volkow (2015) argues, perceiving addiction as a chronic ailment, where drugs disrupt the fundamental circuits of the brain that enable us to execute decisions, can help to mitigate stigma by illustrating drug use is not a result of moral failing or

weakness, lack of willpower, or a character flaw (Volkow, 2015 in Fraser et al., 2017). This is purported to reduce the fear of judgment and social isolation that can often deter individuals from seeking assistance, increasing the likelihood of early intervention and access to appropriate treatment, and even encourage a shift in public perception towards empathy and compassion for those suffering with 'addiction'. Importantly, this model points to social factors in the development of this disease: but renders it resolvable through medical and psychological intervention.

In this context, we see how medical knowledges, from psychiatry to neuroscience, were implicated in the process of medicalizing drug use, as an expedient way to classify and treat a 'social problem'. This created a power dynamic where medical experts became the gatekeepers of defining and treating addiction, assisted by the practices of monitoring stemming from public health knowledge, and the focus on mitigation that harm reduction philosophy introduced. However, it also goes to show that addiction itself is merely a way of thinking about drug use – and its causal models often take for granted its existence as an objective reality. Addiction as a medical term is in fact "an innovation of the modern age", one that, despite the pretension of many of its advocates, remains embedded in ideas about "morality, purity, and prohibition" that it developed alongside (Herzog, 2016: 103; Zampini et al., 2021).

As Fraser et al. (2017) point out, this 'hierarchy of severity' between pathologizing and criminalizing 'addiction' is questionable. In particular, "the idea that labeling something a disease will alleviate stigma" is surprising when viewed from a sociological perspective on health and illness, as research in this field has shown that disease is routinely stigmatized (eg., Jutel, 2011; Fraser et al., 2017: 192). Furthermore, the nature of habitual substance use in fact remains a matter of debate. This model is contested, including by the demonstrated ability of many of those diagnosed as 'addicts' to refrain from 'engaging in addictive behavior' for periods of time (Levy, 2013; Lewis, 2018; Spanjar, 2022). Further, it has been widely noted that the addiction-as-disease model is both limited in scope and "ignores the wider context in which both substance use and substance use-related harms are situated", by oversimplifying the complex interplay of biological, psychological, social, and environmental factors involved in

'addiction' – including personal choice to use substances in response to difficult material conditions and the experience of suffering (Frank and Nagel, 2017 in Goodyear, 2021; Fraser et al., 2017).

This extends into a prominent problematization of how substance use came to be produced as a *medical problem*: the concept of medicalization. Medicalization is described as a "process by which medical definitions and practices are applied to behaviors, psychological phenomena, and somatic experiences not previously within the conceptual or therapeutic scope of medicine" (Davis, 2010: 211 in Degerman, 2020: 63). Foucault's genealogy of medicine led him to identify medicalization as a broad strategy of power (Simons, 1995: 8). He theorized the rise of medicine as a form of disciplinary power, within his notion of biopower and biopolitics, referring to the mechanisms through which societies manage and control populations' health and well-being (Foucault, 1978). Medicalization was for him a manifestation of biopower, as medical institutions and practices exerting authority over individuals' bodies, health choices, and access to healthcare. Campbell (2012) and others have argued that the 'diseasing of addiction' is a result of a process of medicalization occurring in the West in relation to drugs and drug use over the last few decades, suggesting the governance of drugs occurs along a continuum between criminalization and medicalization, between care and control (Michaud et al., 2023: 3).

However, Didier Fassin (2013) argues that there is no certainty about medicalization, and he suggests that it may not be the only process influencing the social response to addiction (2013: 85) According to Fassin, we cannot assume medicalization is a "linear process with a univocal meaning: the increasing hold of medicine over things and people" (2013: 89). Cautioning against treating any "configuration of reality as either an 'anthropological constant' or as a 'chronological variation'", he argues instead for the analysis of phenomena in their 'historically unique form' - hence, the analysis here focusing on the historically unique phenomenon of British Columbia's government's response to an unprecedented rise in drug-related deaths (2013: 90). The concept of medicalization is helpful, as it captures in a sense the journey taken by the construct of 'addiction' as traced in this section, but this

dissertation does not suggest the enduring loss of life of the overdose crisis can be attributed to the effects of the medicalization of addiction alone. As the genealogy showed, medical practitioners have been involved in the realm of drugs since the 18th century - thus, the association that is of more concern here is that with life itself.

Here, we have seen how public health, harm reduction, and medical understandings of drugs evolved in ways that are seen to converge in British Columbia's government's 'sanitorial' policy discourse, that foregrounds health as life and the threat 'addiction' as a disease or disorder presents to it. The following section will consider how this convergence constitutes depoliticization, and what implications that engenders - using Fassin's theoretical considerations to point to the paradox inherent in this new politics of drugs.

Obviating the Structural Drivers

I next interrogate what is left unproblematic in the policy discourse, and then consider the effects of these representations at the levels of discourse, subjectification, and lived experience (Bacchi, 2009: 16).

It would be disingenuous to suggest that structural factors in the development of illicit substance use and 'addiction' remain completely 'unproblematized' in the policy discourse under analysis. The proposals do suggest preventative measures, and emphasize the importance of the social and economic determinants of health (e.g. MHHA, 2018: 4; 2019: 10). However, these references serve to reinforce the 'center' of addiction, as these 'inequities' are identified as "what hinders the ability of individuals to live healthier lives," such as by recovering from addiction (Larocque and Foth, 2021, 8). This is particularly heightened during the period of the COVID-19 pandemic, when the first safe supply programs were enacted (Larocque and Foth, 2021).

Left unproblematic is the nature of inequities contributing to the development of patterns of substance use as politically determined through the "systematic process of structuring relationships, distributing resources, and administering power," at a sociostructural level (Dawes, 2020). Thus, the link is discursively obscured between these factors and the conditions they give rise to - such as material deprivation, unemployment, homelessness, discrimination, social exclusion - that are understood to

contribute to the chronic use of illicit drugs and are conceivably in the control of the state to ameliorate (Jalali et al., 2020; Fischer et al., 2018). By casting the problem to be individualized and medicalized 'addiction', it conceals alternate etiologies of the chronic use of substances - and declares sociostructural factors relevant essentially only to the prevention and treatment of addiction as a reified concept. This produces addiction as a reality to which PWUD must effectively subscribe in order to receive treatment and care, and the initiatives directed at 'getting people off drugs' are prioritized - and legitimized in their reference to saving lives in a crisis.

In a further respect, not only does it discursively obscure the political nature *of* the phenomenon of (illicit) substance use, it also can be seen to obscure the contingency of decision-making, by discursively forming "necessity, permanence, immobility, closure and fatalism," through the reliance on the concepts or 'objects' of addiction and stigma and the subjects they create (Jenkins, 2011, 160). This 'conceals/ negates contingency' in the sense that it establishes a "'necessity' of treatment and recovery: the construction of addiction as the problem makes the need for treatment self-evident" (Debbaut and Kammersgaard, 2022: 8).

While it would be false to say this goes as far as introducing a 'biological fatalism,' as it promotes the possibility of recovery, it can be seen to represent another fatalism regarding addiction: that its development, which alters the brain's pathways, prevents the individual's ability to choose. When chronic use is constructed as a disease/disorder, this implies that the individual does not choose to use, but is compelled to. This in turn deflects from and negates the idea that, as espoused by many PWUD, the decision to use illicit drugs is not a one-time decision that leads to addiction, but rather, a continual "decision-laden and goal-directed" process of coping with difficult realities and experiences (Clark, 2021: 220). The aim to counter these difficult realities and experiences, then, is put on the 'backburner' as efforts are directed at the notion of recovery. When you can theoretically rehabilitate anyone from a disease such as addiction, and institute measures aimed to keep them alive in the meantime, it introduces a "fatalism regarding the prospect of larger change" (Roe, 2006).

This 'closure' of the issue and the 'necessity' expressed, may indeed afford an approach to drug use that is ostensibly less oppressive and harmful than the strictly

prohibitionist approach - but as observed here, also sidelines alternative options for response to a surge in overdose deaths, as well as alternative tactics for prevention, that reckon with those aspects of the 'condition' of using substances that the state has the power to improve: thus concealing contingency (Jenkins, 2011).

Here, we see how the primacy given to 'health' corresponds discursively to the primacy of the medical model of addiction, and how untreated, in combination with a dangerous illicit market, places PWUD at risk of death. At this point, we consider how the 'crisis' / 'emergency' problematization influences and aids in this depoliticization: hinging on the way the government legitimizes their interventions by the call to "save lives". The suffering of PWUD with addiction, the loss of their lives, and the 'crisis'/ 'emergency' situation together are the foundation of British Columbia's government's political action (MMHA, 2019). Accordingly, underneath the focus on "health" and addiction, the focus is more concretely on biological *life* itself: producing a response aimed only at keeping people alive, rather than improving the conditions of their "lives-as-such", thereby supplanting the question of political struggle with managing a health crisis (Foth, 2020).

I have argued that the utilization of discourses within British Columbia's policy regarding the overdose crisis can be considered to constitute a process of depoliticization. This is due to the necessity, closure, and fatalism, it produces through its central construction of addiction as a disease within its 'health' focus, and denial of how this binds PWUD to accept the construct of addiction in order to receive supports, limiting their agency. However, attributing this solely to medicalization, falling under the regulation, administration, and surveillance of life processes as expounded by Foucault's concept of biopower, falls short of comprehensively addressing the underlying political dynamics. Such an explanation overlooks the way that governments legitimize their actions and policies through an essential value of life supported by medical knowledges, and the inequalities that this legitimization perpetuates (Fassin, 2013).

In the discourse being analyzed, addiction is linked to the peril it poses to biological life, as well as to the experience of suffering, the risk of death, and societal stigma experienced. Consequently, addiction is presented as the pivotal issue

demanding resolution to reduce the deaths characterizing the overdose crisis, driving the push for 'addiction treatment services' above all else.

For Fassin (2009) a specific form power characterizes contemporary societies: the 'sacredness of life', which he terms 'biolegitimacy'. This differs from the regulation of life, as it is the power of 'life itself' – and is the target of biopolitics. This power of life drives a humanitarian rationale, that reduces life down to its physical/biological form - and has "become a foundation of the moral economy of contemporary societies" (Fassin, 2009: 49 in Larocque and Foth, 202: 4).

The focus on biological life is not contradicted, but in fact reinforced, by the references to the larger determinants of health observed in the corpus - reflecting the acknowledgment, owed to the development of many converging discourses of drug use, that these factors play a role in 'addiction'. As noted, however, these determinants serve only to reinforce the center of 'addiction', constructed as preventing access to the care and treatment needed to recover from addiction, and being implicated in the development of addiction as disease or disorder. Thus, PWUD are granted rights - such as the ability to seek treatment and care, to use drugs without criminalization, to receive social support - through these determinants of health, which are fundamentally about "optimizing the biological and the physical" and reducing mortality. In this sense, it limits the conditions of possibility to "advocating in the name of life itself" (Larocque and Foth, 2021: 7).

Thus, the overdose crisis as it is discursively produced here, marked by mass fatalities attributed to addiction and its associated stigma, propels a definitive and 'incontestable' rationale of saving life to the forefront. As Larocque and Foth (2021) note, this approach is 'morally legitimated' by the association to the suffering body and the notion of emergency (4). By intertwining the constructs of addiction and crisis, the discourse validates reactive public health measures while excluding broader efforts to address the conditions contributing to 'harmful' drug use.

I suggest this is enabled by the division, as theorized by Fassin (2009, 2018), between life and 'life-as-such'. For him, 'life as such' is lived experience, "the course of events between birth and death as it is impacted by political or structural violence, health and social policies, cultural interpretations or moral decisions" (Larocque and

Foth, 2021: 3). British Columbia's 'progressive' drug policy has centered the value of life, purporting to aim to save lives through the medicalized construct of addiction. However, in doing so, by ostensibly treating all lives as 'equal' and worthy of saving, it neglects the 'life-as-such' of those individuals: establishing a 'politics of care' for biological life while overlooking the quality of life for PWUD. The rights granted to PWUD are centered around averting death due to addiction, undermining the consideration of measures such as a regulated safe drug supply, reducing poverty, or providing housing. By merging harm reduction, public health, and the medical model of addiction, the discourse renders PWUD as suffering individuals needing help to survive physically, rather than acknowledging the complexities of their lives (Foth, 2020). Thus, we see how, in this process of depoliticization, medical and scientific discourses-as-knowledges are employed to validate certain political actions while sidelining others, effectively centering the value of biological life over life-as-such.

As Jenkins (2011) noted, depoliticization "generat[es] the restriction, removal or suppression of our capacities for autonomy, as well as the preservation of a particular strategy or force". The depoliticization at work perpetuates here the state's disavowal of responsibility for the 'drug problem', that was also evidenced in more criminalizing and overtly moralizing discourses regarding drug use that proliferated through most of the 20th and early 21st centuries: denying drug use as a fundamentally political issue, that mirrors back the most troubling of social disparities. This appears as concealing, across time and space, how an individual 'gets' there: to status of addicted drug user, to the experience of harms, to death - neutralizing the political element of how and why individuals use illicit substances.

Cast aside are their 'lives as such': and paradoxically, they are only made worthy of state intervention by virtue of the need to save their (biological) lives. The separation between life and 'life-as-such,' as outlined by Fassin, contributes to this depoliticization, as the vehicle of 'life itself' and reliance on biomedical knowledge permits the government to emphasize life preservation for those with 'addiction', producing limited 'conditions of possibility' for the issue of the overdose crisis. Some might suggest that this PWUD a 'right to life' and a 'freedom to govern [themselves]' that could be considered a form of personal 'repoliticization'" (Fassin, 2013: 39). However, when that

'right to life' is in effect all they receive, by virtue of recognizing their condition as a disease, this potential for repoliticization is undermined by the way that policy discourse has depoliticized their conditions, their 'lives-as-such'.

I conclude by considering the 'subjectification effects' of problem-representations, referring to "subject positions that are made available within particular discourses/ knowledges", as well as their 'lived effects', meaning "the material impact of problem representations on people's embodied existence" (Bacchi, 2009: 70).

Depoliticizing the issue of illicit substance use and thus the 'lives-as-such' of PWUD, and what is recognized as relevant is constrained to actions to prevent deaths rather than to encourage a better quality of life for PWUD tends to situate PWUD as "socially disturbed, weak and lacking in assertiveness" which makes "the need for treatment self-evident" (Herzog, 2016, Lie et al., 2022 in Debbaut and Kammersgaard, 2022). Thus, two subject positions are made available for PWUD in the governing the 'conduct of conduct': the willing 'client' seeking treatment and abstinence, or the deviant addict evading responsibility. This perspective overlooks the complex paths to prolonged drug use, and death is the price one pays for not going to treatment – regardless of whether they do not want to receive treatment or cannot access it. Notably, this can be seen as a form of moral subjectification that also underpins strictly prohibitionist approaches to drugs. As Fassin (2013) notes, Foucault (1984: 56) never separates the questions of "how we are constituted as subjects who exercise or submit to power relations" and "how we are constituted as moral subjects of our own actions" – and accordingly, the subjectification of a person who uses drugs is inherently bound up with ideas of morality intertwined with 'risky' individual behaviors and choices. Just because they have been constructed as ill instead of criminal, as Fraser et al. (2017) noted, this does not erase the function of stigma underneath as 'politically productive', diminishing the agency and autonomy of individuals who use drugs to reinforce their behavior as abnormal. This facilitates the denial of alternative options for structural change to protect PWUD. For PWUD themselves, as Antoniou et al. (2019) find, when 'addict' is the dominant social identity ascribed to them in a medical model, this can have the effect of further isolating individuals from systems of support, as they may perceive themselves to be powerless.

At the level of lived experience, PWUD in British Columbia have recounted a feeling of being abandoned by the state and grappling with increasing social stigma for their use of drugs, compounded frequently by homelessness, mental illness, and disability, or a combination thereof (Kulkarni, 2022). I suggest these experiences are compounded and perpetuated by the problem-representation at work in the government's policy. Communities of PWUD, especially those concentrated in areas such as Vancouver's Downtown Eastside, are left to try and prevent each other from dying, while near unavoidably confronting the deaths of some in their communities with each passing week. Concurrently, those who live remotely or use in isolation do so without even the supports to prevent death.

Further, for those who wish to seek treatment, the "integrated system of mental health & addictions services" promised by British Columbia's government since 2017 has yet to materialize. Additionally, for those for whom abstinence is not the goal, but avoiding the dangerous illicit supply is, the medicalized nature of the existing safe supply program prevents many PWUD from accessing it (Tobias, 2022). Because the existing safe supply policy requires a diagnosis of addiction, and regular clinic visits, many PWUD who reject the notion or have not yet received such a diagnosis from a medical professional cannot access it. The unstable lives led by many PWUD also experiencing homelessness hinder those efforts further. A recent B.C. death review panel revealed an increasing percentage of overdose deaths in the province are of people who do not have a diagnosed substance use disorder – suggesting this barrier to service is a very present reality, an effect of the construction of addiction-as-disease and reliance on a medicalized approach (BC Coroners' Service, 2022). Lastly, outside of the limited 'safe supply' programs available, the drug supply remains unregulated: posing a risk to *any* person who uses an illicit substance, even if occasionally.

In many cases, these policies have saved lives, particularly through harm reduction measures (Fischer et al, 2018). However, the problem as produced by the government's policy – as addiction – means that these lives remain lived on the edge of society, within arm's reach of death, left to grapple with precarious lives for which the state appears to profess little to no accountability.

Conclusion

This analysis sought to illuminate a possible contributing factor in the continued elevated number of overdose deaths occurring in the province of British Columbia, as the province initiates ongoing investments and interventions into 'solving' the problem through a "comprehensive public health approach" to drugs (MMHA, 2018). It has argued that the policy discourse giving shape to the overdose crisis here can be seen to depoliticize the issue of illicit substance use, by harnessing medical, public health, and harm reduction knowledges and ontological assumptions in a way that constructs 'addiction' as the central problem driving the crisis, and produces a response aimed only at keeping people alive. This leaves basically untouched the sociostructural factors contributing to illicit drug use, and the power of the state to change them through contingent decision-making. Thus, the realities enacted by this discourse reproduce pre-existing social injustices faced by PWUD: and the tolls of harm caused may continue to mount, as the province's response forecloses reckoning systemically with substance use a response to living under conditions of material deprivation, social exclusion, and structural discrimination, the amelioration of which would likely go significantly further towards reducing harm and ultimately preventing death.

In producing PWUD to be suffering with illness, making the need for treatment self-evident, it may move beyond classifying PWUD as criminals or deviants – but the conditions PWUD live under remain unaddressed, considered only in terms of how they obstruct access to treatment, and thus cause death by addiction. This puts into sharp relief the paradox at the heart of this 'new politics of drugs': that valuing biological life, 'even of' an 'addict', does not equate to valuing and improving the conditions that shape one's lived experience.

As the work of Fassin (2009, 2018) and Larocque and Foth (2021) demonstrated, this is legitimized by the proclamation of a 'humanitarian rationale' (Fassin, 2009: 49) in the governing of populations such as PWUD, reinforced by the 'crisis' and 'emergency' frames: supplanting the need to "act in regard to the inequalities of the biographical life, the life as such, that reflects the larger social and political context," with an incontestable rationale of saving their lives, as they are unable to (Larocque and Foth,

2021, 8). This is evidenced in the support extended through harm reduction programs to prevent death, but the continual construction of addiction as the core problem to be solved in order to end the crisis: deflecting the blame, much like prohibitionist approaches do, to land squarely on the shoulders of PWUD and the 'addictive nature' of drugs.

This illuminates how such a 'crisis' can persist, and even worsen, not despite the funneling of resources towards its resolution – but because of how the policy discourse reproduces realities rife with injustice, inequalities, and precarity, precisely by considering these factors only in relation to the presumed reality of 'addiction' – through discursive depoliticization. Thus, it can be said that this policy aims to keep people who use drugs alive indefinitely but refuses to ameliorate their material conditions and limits the conditions of possibility for broader political action: leaving them in a condition of enduring precarity, as their lives are only valued because of this biological vulnerability. Drug use as a social and political phenomenon is moved "out of the political", with material and subjectification effects for PWUD, who are asked to fit to the systems in place to be deserving of the government's drug services, while remaining "socially and politically excluded" (Mclean, 2011, 71). Meanwhile, their deaths are attributed to the high cost of addiction – as opposed to a toxic unregulated supply and other conditions the state could improve (Kulkarni, 2022). It may be a step in the right direction, to value their lives – but critiqued here is how this paradoxically allows 'progressive policy' to content itself with caring about life, without addressing how drug use is experienced at a quagmire of power relations in contemporary society.

Some may suggest that addressing the political causes of the use of illicit drugs are simply "too large and too amorphous" for a government to tackle (Adams, 2010, 51). However, as we see a 'celebration' of the shift towards a focus on "health" in drug policy, it is all the more essential to engage with the historical context of the discourses surrounding these substances, their use, and the people who use them, because when policy discourses mirror and employ these knowledges, it is never without power – and never apolitical. Even in its life and health-focused rationale, the government's depoliticized construction of the overdose crisis reveals that improving the experience of life for PWUD is not and has never been the goal: it is enough to try and save lives,

rather than reckon with how they got to be lived this way. Ultimately, this reflects on a larger issue with drug policy as a whole: how it often casts the symptoms of social suffering from deprived communities as 'drug problems' in the first place.

As Jacques Rancière (2007: 11) suggests, "the art of suppressing the political" is one that can incur a high cost for vulnerable populations, in terms of disempowerment, undermining political and personal agency, the perpetuation of difficult living conditions, and of course, the loss of life itself. The critique developed here has sought to expose the cost of being "governed like that" (Foucault, 1978:45) - and the underlying continuity identified here prompts the enduring need to question how, "the more things seem to change, the more they may stay the same" (Karr, 1849).

However, as depoliticization and politicization are parallel processes, and are not mutually exclusive, the tireless activism in British Columbia among drug using communities calling for a regulated safe supply, urgent housing, and more can be seen as attempts to re-politicize the social, structural and political factors impacting the use of illicit drugs, by "challenging power relations and limits in order to establish new ones", as it garners increasing public attention in 2023 (Brunila, 2022: 4). Improved health outcomes and possibilities for agency for those in British Columbia, and elsewhere, who use illicit drugs and experience drug-related harms, likely hinge on a re-politicizing and thereby making visible the socio-cultural and political drivers of human suffering.

References

Adams V. (2010). Against global health? Arbitrating science, non-science, and nonsense through health. In Metzl J. M., Kirkland A. (Eds.), *Against health: How health became the new morality* (pp. 40–60). New York, NY: New York University Press.

Bacchi, C. (2009). *Analysing Policy*. Pearson Higher Education AU.

Bacchi, C., & Rönnblom, M. (2011). Feminist discursive institutionalism—What's discursive about it? Limitations of conventional political studies paradigms. *2nd European Conference on Politics and Gender,* Budapest, 13-15 January.

Bacchi, C. (2012). Why study problematizations? Making politics visible. *Open Journal of Political Science*, 02(01), 1–8. https://doi.org/10.4236/ojps.2012.21001

Bacchi, C. and Rönnblom, M. (2014). Feminist Discursive Institutionalism—A Poststructural Alternative. *NORA - Nordic Journal of Feminist and Gender Research*, 22:3, pp. 170-186. DOI: 10.1080/08038740.2013.864701

Bacchi, C. and Bonham, J. (2014). Reclaiming discursive practices as an analytic focus: Political implications. *Foucault Studies*, No. 17, pp. 173-192. ISSN: 1832-5203

Bacchi, C. (2015). Problematizations in Alcohol Policy: WHO's "Alcohol Problems." *Contemporary Drug Problems*, *42*(2), 130–147. https://doi-org.chain.kent.ac.uk/10.1177/0091450915576116

Bacchi, C. and Goodwin, S. (2016). *Poststructural Policy Analysis: A Guide to Practice.* NY: Palgrave Macmillan.

Bacchi, C. (2017). Introducing WPR. *Carol Bacchi*. https://carolbacchi.com/about/

Bacchi, C. (2018a). Drug Problematizations and Politics: Deploying a Poststructural Analytic Strategy. *Contemporary Drug Problems*, *45*(1), 3–14. https://doi.org/10.1177/0091450917748760a

Bacchi, C. (2018b). Comparing WPR and Critical discourse analysis. *Carol Bacchi.* https://carolbacchi.com/2018/05/14/comparing-wpr-and-critical-discourse-analysis/

Bacchi, C. (2021a). Poststructuralism and Critical Realism: Revisited. *Carol Bacchi*. https://carolbacchi.com/2021/02/28/poststructuralism-and-critical-realism-revisited/

Bacchi, C. (2021b). Widening the Ambit of WPR: Media Texts. *Carol Bacchi*. https://carolbacchi.com/?s=+Widening+the+Ambit+of+WPR%3A+Media+texts

Bacchi, C. (2021c). Widening the ambit of WPR: Interviews. *Carol Bacchi*. https://carolbacchi.com/?s=+Widening+the+Ambit+of+WPR%3A+interviews

Bacchi, C. (2021d). Widening the Ambit of WPR: https://carolbacchi.com/2021/06/30/widening-the-ambit-of-wpr-legislative-debates-and-official-pronouncements/

Bacchi, C. (2021e). What about "hybrids" and "mixed methods"? Is WPR the "bad cop"?. *Carol Bacchi.* https://carolbacchi.com/2021/08/31/what-about-hybrids-and-mixed-methods-is-wpr-the-bad-cop/

Bacchi, C. (2023a). Applying WPR to concepts: "Analysis of discourses", not "discourse analysis." *Carol Bacchi*. https://carolbacchi.com/2023/03/30/applying-wpr-to-concepts-analysis-of-discourses-not-discourse-analysis/

Bacchi, C. (2023b). Applying WPR to concepts: Questioning “risk”, “uncertainty” and “crisis.” *Carol Bacchi*. https://carolbacchi.com/2023/04/29/applying-wpr-to-concepts-questioning-risk-uncertainty-and-crisis/

Berridge, V. (1979). Opium in the Fens in Nineteenth-century England, *Journal of the History of Medicine and Allied Sciences*, Volume XXXIV, Issue 3, July 1979, pp. 293–313, https://doi-org.chain.kent.ac.uk/10.1093/jhmas/XXXIV.3.293

Bletsas, A. (2012). Spaces between: Elaborating the theoretical underpinnings of the ‘WPR’approach and its significance for contemporary scholarship. *Engaging with Carol Bacchi: Strategic interventions and exchanges*, 37-52.

Bourgois, Philippe. “Decolonising drug studies in an era of predatory accumulation.” *Third world quarterly* vol. 39,2 (2018): 385-398. doi:10.1080/01436597.2017.1411187

British Columbia Ministry of Health (2016). Health: Provincial health officer declares public health emergency. BC Government News, News Release. https://news.gov.bc.ca/releases/2016HLTH0026-000568

British Columbia Ministry of Mental Health and Addictions (MMHA) (2023). Ministry of Mental Health and Addictions: Escalated drug-poisoning response actions . *BC Government News,* News Release. https://news.gov.bc.ca/factsheets/escalated-drug-poisoning-response-actions-1#:~:text=B.C.%20is%20the%20first%20provinceprescribed%20safer%20supply%20opioid%20medications

Brunila, T. (2022). Depoliticization of politics and power: Mouffe and the conservative disposition in postfoundational political theory. *Frontiers in Political Science*, *4*. https://www.frontiersin.org/articles/10.3389/fpos.2022.974065

Burton, A., Sawatzky-Girling, B., & Westfall, J. (2022). Two Public Health Crises, Two Narratives: An Analysis of How Policymakers Have Managed British Columbia’s COVID-19 Pandemic and Potential Implications for the Ongoing Overdose Crisis. *Frontiers in Communication*, *7*. https://www.frontiersin.org/articles/10.3389/fcomm.2022.781564

Campbell, N. D. (2012). Medicalization and Biomedicalization: Does the Diseasing of Addiction Fit the Frame? In J. Netherland (Ed.), *Critical Perspectives on Addiction*

(Vol. 14, pp. 3–25). Emerald Group Publishing Limited. https://doi.org/10.1108/S1057-6290(2012)0000014005

Clarke, H., Bao, J., Weinrib, A., Dubin, R. E., & Kahan, M. (2019). Canada's hidden opioid crisis: The health care system's inability to manage high-dose opioid patients. *Canadian Family Physician*, *65*(9), 612–614.

Clarkson, B. (2023). *"A crisis of incomprehensible scale": B.C. chief coroner on 596 illicit drug deaths in first 3 months of 2023*. CTV News British Columbia. https://bc.ctvnews.ca/a-crisis-of-incomprehensible-scale-b-c-chief-coroner-on-596-illicit-drug-deaths-in-first-3-months-of-2023-1.6360303

Conrad, M. (2022, July 12). *Healthcare over handcuffs: Canada's bold drug policy*. New Thinking. https://www.newthinking.com/politics/healthcare-over-handcuffs-canadas-bold-drug-policy

Crocq, Marc-Antoine. "Historical and cultural aspects of man's relationship with addictive drugs." *Dialogues in clinical neuroscience* vol. 9,4 (2007): 355-61. doi:10.31887/DCNS.2007.9.4/macrocq

Dawes, D. E. (2020). *The Political Determinants of Health*. JHU Press.

Debbaut, S., & Kammersgaard, T. (2022). The "public health" approach to illicit drugs: An eradicative drug discourse in a sanitorial disguise? *Drugs, Habits and Social Policy*, *24*(1), 1–13. https://doi.org/10.1108/DHS-09-2022-0030

Degerman, D. (2020). The Political Is Medical Now: COVID-19, Medicalization and Political Theory. *Theory & Event*, *23*(5), S-61.

Fassin, D. (2009). Another Politics of Life is Possible. *Theory, Culture & Society*, *26*(5), 44–60. https://doi.org/10.1177/0263276409106349

Fassin, D. (2013). Chapter 5: This is Not Medicalization. In Milhet, M., Bergeron, D. H., & Hunt, M. G., eds. 2013. *Drugs and Culture: Knowledge, Consumption and Policy*. Ashgate Publishing, Ltd.

Fassin, D. (2018). Life: A critical user's manual. Polity Press.

Fischer, B., Vojtila, L. and Rehm, J. (2018). The 'fentanyl epidemic' in Canada – Some cautionary observations focusing on opioid-related mortality, Preventive Medicine,

Volume 107, 2018, p.p. 109-113, ISSN 0091-7435, https://doi.org/10.1016/j.ypmed.2017.11.001.

Foth, T. (2020). Humanitarian reason and the movement for overdose prevention sites: The NGOization of the opioid "crisis". Nursing Philosophy, 22(1), 1–12. https://doi.org/10.1111/nup.12324

Foucault, M. (1972). *Archaeology of Knowledge and the Discourse on Language* (1969). (trans. AM Sheridan Smith, 1972).

Foucault, M. (1978). "What is Critique?" in *The Politics of Truth*, eds. Sylvère Lotringer and Lysa Hochroth, (New York: Semiotext(e), 1997), transcript by Monique Emery, revised by Suzanne Delorme, et al., trans. by Lysa Hochroth. Originally a lecture given at the French Society of Philosophy, 27 May 1978, subsequently published in *Bulletin de la Société française de la philosophie* 84:2 (1990) 35-63.

Foucault, M. (1979) *The Will to Knowledge: The History of Sexuality One.* London: Penguin.

Fraser, S. (2020). Doing ontopolitically-oriented research: Synthesising concepts from the ontological turn for alcohol and other drug research and other social sciences. *International Journal of Drug Policy*, *82*, 102610. https://doi.org/10.1016/j.drugpo.2019.102610

Fraser, S., Pienaar, K., Dilkes-Frayne, E., Moore, D., Kokanovic, R., Treloar, C., & Dunlop, A. (2017). Addiction stigma and the biopolitics of liberal modernity: A qualitative analysis. *International Journal of Drug Policy*, *44*, 192–201. https://doi.org/10.1016/j.drugpo.2017.02.005

Frank, L.E., Nagel, S.K. (2017). Addiction and moralization: The role of the underlying model of addiction. *Neuroethics.* 10(1):129–39.

Galea, S., & Vlahov, D. (2002). Social determinants and the health of drug users: Socioeconomic status, homelessness, and incarceration. *Public Health Reports*, *117*(Suppl 1), S135–S145.

Gibbs, B., Workman, R., Kiefer, J. & Canlas, C. (2023). Canada's Health Crisis: Profiling Opioid Addiction in Alberta & British Columbia. Report for the Stanford Network on Addiction Policy (SNAP). https://addictionpolicy.stanford.edu/sites/g/files/

sbiybj25011/files/media/file/canadas-health-crisis-opioid-addiction-in-alberta-and-british-columbia-web-version-1.pdf

Goodyear, T. (2021). (Re)politicizing harm reduction: Poststructuralist thinking to challenge the medicalization of harms among people who use drugs. Aporia 13(1):26-35. DOI:10.18192/aporia.v13i1.5272

Harm Reduction International (HRI) (2016). "Report: Global State on Harm Reduction 2016." https://www.hri.global/files/2016/11/14/GSHR2016_14nov.pdf

Herzog, B. (2016). The Discursive Construction of Drug Realities: Discourses on Drugs, Users, and Drug-Related Practices. In M. O'Reilly & J. N. Lester (Eds.), *The Palgrave Handbook of Adult Mental Health: Discourse and Conversation Studies* (pp. 101–116). Palgrave Macmillan UK. https://doi.org/10.1057/9781137496850_6

Howarth, D., Standring, A. & Huntly, S. (2020). Contingent, contested and constructed: a poststructuralist response to Stevens' ontological politics of drug policy. International Journal of Drug Policy. 10.1016/j.drugpo.2020.102965.

Jalali, M. S., Botticelli, M., Hwang, R. C., Koh, H. K., & McHugh, R. K. (2020). The opioid crisis: A contextual, social-ecological framework. *Health Research Policy and Systems*, *18*(1), 87. https://doi.org/10.1186/s12961-020-00596-8

Jenkins, L. (2011). The Difference Genealogy Makes: Strategies for Politicisation or How to Extend Capacities for Autonomy. *Political Studies*, *59*(1), 156–174. https://doi.org/10.1111/j.1467-9248.2010.00844.x

Karr, A. (1849). Les Guêpes. Quote sourced here: https://www.bookbrowse.com/expressions/detail/index.cfm/expression_number/483/the-more-things-change-the-more-they-stay-the-same

Keane, H. (2009a). Foucault on methadone: Beyond biopower. *International Journal of Drug Policy*, *20*(5), 450–452. https://doi.org/10.1016/j.drugpo.2008.10.005

Keane, H. (2009b). Intoxication, harm and pleasure: An analysis of the Australian National Alcohol Strategy. *Critical Public Health*, *19*(2), 135–142. https://doi.org/10.1080/09581590802350957

KPMG (2018). *The Opioid Epidemic in Canada: Spotlighting Provincial Efforts to Address the crisis*. https://assets.kpmg/content/dam/kpmg/ca/pdf/2018/05/the-opioid-issue-brief.pdf

Kulkarni, A. (2022). B.C.'s toxic drug crisis has changed a lot since 2017—But the government's policies have not, say advocates. *Canadian Broadcasting Corporation* (CBC News). https://www.cbc.ca/news/canada/british-columbia/bc-ndp-toxic-drug-policy-1.6365992

Lancaster, K., & Rhodes, T. (2020). Towards an ontological politics of drug policy: Intervening through policy, evidence and method. *International Journal of Drug Policy*, *86*, 102932. https://doi.org/10.1016/j.drugpo.2020.102932

Landwehr, C. (2017). Depoliticization, Repoliticization, and Deliberative Systems. In P. Fawcett, M. Flinders, C. Hay, & M. Wood (Eds.), *Anti-Politics, Depoliticization, and Governance* (p. 0). Oxford University Press. https://doi.org/10.1093/oso/9780198748977.003.0003

Larocque, C., & Foth, T. (2021). Which lives are worth saving? Biolegitimacy and harm reduction during COVID-19. *Nursing Inquiry*, *28*(4), e12417. https://doi.org/10.1111/nin.12417

Legal Services Branch (2023, May 19). *Consolidated federal laws of Canada, Controlled Drugs and Substances Act*. https://laws-lois.justice.gc.ca/eng/acts/c-38.8/page-9.html

Lewis, M. (2018). Brain Change in Addiction as Learning, Not Disease. *New England Journal of Medicine*, *379*(16), 1551–1560. https://doi.org/10.1056/NEJMra1602872

Majeed, A. (2006). INTRODUCTION: Distribution of Powers and Responsibilities. In A. Majeed, R. L. Watts, D. M. Bronw, & J. Kincaid (Eds.), *Distribution of Powers and Responsibilities in Federal Countries* (pp. 3–7). McGill-Queen's University Press. http://www.jstor.org/stable/j.ctt7zsgr.4

Mazzuca, C., & Santarelli, M. (2022). Making it abstract, making it contestable: Politicization at the intersection of political and cognitive science. *Review of Philosophy and Psychology*. https://doi.org/10.1007/s13164-022-00640-2

Metzl, J., Kirkland, A., & Kirkland, A. R. (2010). *Against Health: How Health Became the New Morality*. NYU Press.

Michaud, L., van der Meulen, E., & Guta, A. (2023). Between Care and Control: Examining Surveillance Practices in Harm Reduction. *Contemporary Drug Problems*, *50*(1), 3–24. https://doi.org/10.1177/00914509221128598

MMHA (2017). British Columbia Ministry of Mental Health and Addictions 2017/18 - 2019/20

MMHA Service Plan. *Ministry of Mental Health and Addictions.*

https://www.bcbudget.gov.bc.ca/2017_Sept_Update/sp/pdf/ministry/mh.pdf

MMHA (2018). British Columbia Ministry of Mental Health and Addictions Responding to B.C.'s Illegal Drug Overdose Epidemic: Progress Update. *Ministry of Mental Health and Addictions.*

https://www2.gov.bc.ca/assets/gov/health/about-bc-s-health-care-system/office-of-the-provincial-health-officer/overdose-response-progress-update-apr-may2018.pdf

MMHA (2019). British Columbia Ministry of Mental Health and Addictions Escalating BC's response to the overdose emergency. *Ministry of Mental Health and Addictions.* https://www2.gov.bc.ca/assets/gov/overdose-awareness/mmha_escalating_bcs_response_report_final_26feb.pdf

MMHA (2021). British Columbia Ministry of Mental Health and Addictions. British Columbia applies for decriminalization in next step to reduce toxic drug deaths. *BC Government News*, News Release. https://news.gov.bc.ca/releases/2021MMHA0059-002084

NIDA (2022). National Institute on Drug Abuse, *Naloxone DrugFacts*: https://nida.nih.gov/publications/drugfacts/naloxone

PHO (2017). "British Columbia's Public Health Emergency: Progress Update on British Columbia's Response to the Opioid Overdose Crisis ", Office of the Provincial Health Officer, Joint Task Force on Overdose Prevention and Response. https://www2.gov.bc.ca/assets/gov/health/about-bc-s-health-care-system/office-of-the-provincial-health-officer/overdose-response-progress-update-jan2017.pdf

PHO (2019). "Stopping the Harm: Decriminalization of People Who Use Drugs in BC". Office of the Provincial Health Officer: *PHO Special Report.* https://www2.gov.bc.ca/assets/gov/health/about-bc-s-health-care-system/office-of-the-provincial-health-officer/reports-publications/special-reports/stopping-the-harm-report.pdf

Park, J. N., Rouhani, S., Beletsky, L., Vincent, L., Saloner, B., & Sherman, S. G. (2020). Situating the Continuum of Overdose Risk in the Social Determinants of Health: A

New Conceptual Framework. *The Milbank Quarterly*, *98*(3), 700–746. https://doi.org/10.1111/1468-0009.12470

QMJC (2023). A genealogy of 'addictive consumption', Society *for the Study of Addiction.* Qualitative Methods Journal Club : https://www.addiction-ssa.org/treatment-resources/qmjc-february-2023-a-genealogy-of-addictive-consumption/

Rancière, J. (1995). *La Mésentente : Politique et Philosophie*. Paris: Galilée.

Rancière, J. (1999). *Disagreement: Politics and Philosophy*. University of Minnesota Press.

Rancière, (2007) [1994]. *On the Shores of Politics.* London, New York: Verso.

Remling, E. (2018). Depoliticizing adaptation: A critical analysis of EU climate adaptation policy. *Environmental Politics*, 27(3), 477-497. https://doi.org/10.1080/09644016.2018.1429207

Reith, G. (2004). Consumption and its discontents: Addiction, identity and the problems of freedom. *The British Journal of Sociology*, *55*(2), 283–300. https://doi.org/10.1111/j.1468-4446.2004.00019.x

Roe, G. (2006). "Harm reduction as paradigm: Is better than bad good enough? The origins

of harm reduction", *Critical Public Health*, 15:3, 243-250. DOI: 10.1080/09581590500372188

Seddon, T. (2016), "Inventing drugs: a genealogy of a regulatory concept", *Journal of Law and Society*, Vol. 43 No. 3, pp. 393-415.

Smith, Christopher B. R. 2012. "Harm reduction as anarchist practice: a user's guide to capitalism and addiction in North America." *Critical Public Health*, 22:2, 209-221, DOI: 10.1080/09581596.2011.611487

Sørensen, E., & Torfing, J. (2017). The Janus Face of Governance Theory: Depoliticizing or Repoliticizing Public Governance? In P. Fawcett, M. Flinders, C. Hay, & M. Wood (Eds.), *Anti-Politics, Depoliticization, and Governance* (p. 0). Oxford University Press. https://doi.org/10.1093/oso/9780198748977.003.0002

Qualitiatve Methods Journal Club. (2023). QMJC February 2023: A genealogy of "addictive consumption." (n.d.). *Society for the Study of Addiction*. https://

www.addiction-ssa.org/treatment-resources/qmjc-february-2023-a-genealogy-of-addictive-consumption/

Spanjar, P. (2022, July 12). Disease Model of Addiction. *The Providence Projects.* https://providenceproject.org/resource-hub/disease-model-of-addiction/

Spooner, C., and Hetherington, K. (2005). Social determinants of drug use*. Sydney: National Drug and Alcohol Research Centre*, University of New South Wales.

Standring, A. (2018). Evidence-Framed Policymaking: The Depoliticization of European Drug Policy.

Stevens, A. (2010). *Drugs, Crime and Public Health: The Political Economy of Drug Policy*. Routledge-Cavendish. https://doi.org/10.4324/9780203844168

The Canadian Press. (2023, June 19). *Death toll for toxic drugs in B.C. surpasses 1,000 in first 5 months of the year | CBC News*. Canadian Broadcast Corporation (CBC). https://www.cbc.ca/news/canada/british-columbia/toxic-drug-deaths-bc-1000-2023-numbers-coroners-service-1.6881561

Vachon, R. (2020). Managing Morality and Building "Balance": Depoliticisation as Management in Canada's Federal Response to R. v. Morgentaler. Revue Gouvernance / Governance Review, 17(1), 25–44. https://doi.org/10.7202/1070341ar

Volkow, N. D., & Blanco, C. (2023). Substance use disorders: A comprehensive update of classification, epidemiology, neurobiology, clinical aspects, treatment and prevention. *World Psychiatry: Official Journal of the World Psychiatric Association (WPA)*, *22*(2), 203–229. https://doi.org/10.1002/wps.21073

Wood, M., & Flinders, M. (2014). Rethinking depoliticisation: Beyond the governmental. *Policy & Politics*, 42(2), 151–170. https://doi.org/10.1332/030557312X655909

Wood, M. (2016). Politicisation, Depoliticisation and Anti-Politics: Towards a Multilevel Research Agenda. Political Studies Review, 14(4), 521–533 https://doi.org/10.1111/1478-9302.12074