Between Rights and Rhetoric: Assessing the Government of Canada's Public Health Policy on Opioid Injection Drug Use (2015-2019)

*Entre droits et rhétorique : Évaluation de la Politique de santé publique du
gouvernement du Canada sur l'utilisation de drogues injectables aux opioïdes
(2015-2019)*

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Between Rights and Rhetoric: Assessing the Government of Canada's Public Health Policy on Opioid Injection Drug Use (2015-2019)

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Until 2015 Canadian public health policy on opioids was criticized for being rhetorical, lacking clear definition, and falling foremost on the side of enforcement. This article examines how the 2015 election of a new federal government introduced an alternative approach to opioid injection drug use, framing opioids as public health and human rights issue within Canadian policy. This article assesses the government's commitment to a human rights approach to opioids and problematizes ambiguities in its approach. It raises questions about the politicized nature of the government's strategy and whether Canada's response remains caught between rights and rhetoric.

Jusqu'en 2015, on reprochait à la politique canadienne de santé publique sur les opioïdes d'être rhétorique, de ne pas avoir de définition claire et de tomber avant tout du côté de l'application de la loi. Cet article examine comment l'élection en 2015 d'un nouveau gouvernement fédéral a introduit une approche alternative à l'utilisation de drogues injectables aux opioïdes, en encadrant les opioïdes comme des questions de santé publique et de droits de la personne dans la politique canadienne. Cet article évalue l'engagement du gouvernement à l'égard d'une approche des droits de la personne à l'égard des opioïdes et problématise les ambiguïtés dans son approche. Il soulève des questions sur la nature politisée de la stratégie du gouvernement et sur la question de savoir si la réponse du Canada demeure coincée entre les droits et la rhétorique.

Canada is experiencing a serious and growing public health crisis related to opioid injection drug use. According to the Canadian Institute for Health Information (CIHI), hospitalization rates due to opioid injection drug use have increased 27% over the past 5 years. Worldwide, Canada ranks second behind only the United States (US) in global per capita consumption of prescription opioids (KANE 2016). Data reported by Canada's Public Health Agency reveals that from January to September 2017 there were at least 2,923 opioid-related deaths, corresponding to a 45% increase in the number of opioid-related deaths when compared to the same time-period in 2016 (PUBLIC HEALTH AGENCY OF CANADA 2018). Compounding challenges in containing this crisis, illicit opioids containing fentanyl, an opioid 100 times more potent than morphine, and carfentanil, a powerful opioid used to tranquilize elephants, have flooded the black market causing a surge in opioid morbidity and mortality (ROBERTSON and HOWLETT 2017; THE CANADIAN PRESS 2017).¹

¹ For an in-depth historical overview of the mass marketing of opioids in North America by Purdue Pharma and others see: CRAIG 2019; ROBERTSON and HOWLETT 2017; THE CANADIAN PRESS 2017.

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Globally, an estimated 16 million people inject drugs in over 150 countries (MATHERS et al 2008). The international policy response to this grim reality has been mixed. In many parts of the globe punitive approaches to drug control, which stigmatize and criminalize people who inject drugs (PWIDs), continue to fuel widespread human rights violations. In some countries including China, Iran, Saudi Arabia, and Vietnam people have been executed for drug-related offences (FXB CENTER FOR HEALTH AND HUMAN RIGHTS 2014). Conversely, Taiwan has had a harm reduction policy in place since 2005 (CHEN 2011). All 28 European Union (EU) member states have also included support for harm reduction in their national policies with needle/syringe exchange programs, opioid agonist therapy (OAT), and supervised consumption services (SCS) operational in many EU nations (SANDER 2016). In the US a “public health emergency” was also declared by President Donald Trump in 2017; however, the US continues to lag behind other Western nations with SCS yet to be established due to a lack of funding and several federal and state policies that have been interpreted to imply their illegality (NATIONAL HARM REDUCTION COALITION 2020; SALAM 2017). Historically, drug policies around the globe have also placed disproportionate barriers on the ability of PWIDs to access housing and other supports related to social determinants of health (UNITED NATIONS OFFICE ON DRUGS AND CRIME 2017; FXB CENTER FOR HEALTH AND HUMAN RIGHTS 2014; JURGENS 2010). This highlights the role that stigma and criminalization play in shaping the risk environment in which PWIDs use drugs and intersect public safety and health systems.

Alternative approaches to addressing opioid injection drug use such as harm reduction and decriminalization put the harms experienced by PWIDs at the centre of action to reduce drug-related risks, rather than on prevention of drug use itself. So called “harm reductionists” recognize that people may be unable or unwilling to abstain from injection drug use but can still make positive choices about their health (FXB CENTER FOR HEALTH AND HUMAN RIGHTS 2014; ELLIOTT et al 2005).

These alternative approaches may also encompass efforts to strengthen PWID’s economic, social, and political rights - including the provision of legal services, outreach, and capacity-building programs to enable PWIDs to exert greater autonomy over their lives. This involves the application of international human rights law, as extolled in the United Nations Universal Declaration of Human Rights (UDHR), to opioid injection drug use and recognizes how human rights violations contribute to drug-related harms, including pre-conditions that make PWID’s vulnerable to drug use.

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The significance of linking human rights to opioid injection drug use revolves around two principal arguments. First, human rights violations contribute causally to injection drug-related harms (SANDER and LINES 2016; HATHAWAY and TOUSAW 2008; ELLIOTT et al 2005; KEANE 2003; EZARD 2001). Second, under the UDHR states have a responsibility to provide health services via the right to health that explicitly sets out “the right of all peoples to a standard of living adequate for health and well-being, including access to medical care,” (UNITED NATIONS 1948, article 25). Harm reductionists further assert that a human rights approach can be reflected in the supportive public policy responses of countries like Portugal that has approached injection drug use as a health and social policy issue rather than one of enforcement (KRISTOF 2017; SPECTER 2011).

In Canada, “rights-oriented” harm reductionists have sought to reform drug policy around a human rights-based approach for decades (HYSHKA et al 2019). However, despite growing concerns over a spike in the severity of opioid overdoses, until 2015 the Canadian government’s policy toward opioid injection drug use was criticized for being largely rhetorical, lacking clear definition, and falling first and foremost on the side of enforcement (HYSHKA et al 2019; HATHAWAY and TOUSAW 2008; COHEN and CSETE 2006; HATHAWAY 2002).

The election of a new federal government in 2015, coupled with a rapid spike in the severity of the opioid crisis, which brought about increased media attention and renewed advocacy, resulted in an enabling environment for the government to commit to alternative approaches to addressing opioid injection drug use in federal drug policy. This is evident in the Government of Canada under Prime Minister Justin Trudeau projecting a public health and human rights lens onto opioid injection drug use in Canada (HEALTH CANADA 2018d). This article assesses the Government of Canada’s public policy approach found in the “New Canadian Drugs and Substances Strategy” (new CDSS), which emphasizes an integrated health system response to opioid use that explicitly links health, harm reduction, and other human rights (HEALTH CANADA 2016). It analyzes the government’s legislative and legal commitments and its public policy discourse, employed to frame opioid injection drug use as health and human rights issue within Canadian policy. While policy making does not occur in a political vacuum, with the federal government representing only one actor, albeit important, this article is interested in the federal role in shaping opioid injection drug use policy and how it has exercised this role, through analysis of its primary reliance on legislative and legal powers (FOREST and MARTIN 2018). Linking health care to human rights places unique obligations onto the federal government

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in realizing its policy objectives. This is because under the Canadian Charter of Rights and Freedoms the federal government is responsible for ensuring what citizenship entails for all Canadians and affirming these rights at the individual level (FOREST and MARTIN 2018).

The article sheds light on the ambiguities, tensions, and outstanding issues in the government's public policy toward opioid injection drug use. Ultimately, this article suggests that the language adopted and commitments contained in the new CDSS have culminated in a delicate "balancing act" with respect to federal drug policy. On the one hand, the government has extended beyond previous drug policies in Canada to explicitly incorporate human rights into its national approach. However, its failure to address some key aspects of a human rights orientation, such as decriminalization, enhancing the autonomy of PWIDs, and addressing the root causes of drug use, leaves questions remaining about the politicized nature of the new CDSS and the government's full commitment to a human rights-based approach to opioid injection drug use, suggesting central areas for future research.

Methods

As this article is interested in understanding the federal government's response to the opioid crisis in the first four-year term of the Trudeau government, content analysis was used to assess government legislation and discourse on opioid injection drug use in Canada. Federal Canadian drug laws, policy, and regulations are well documented and publicly available through government sources such as legislation, press releases, webpages, public policy program resources, public statements, and policy reports. For this study, policy documents and statements that speak to the new CDSS, which sets out the government's policy approach, and "An Act to amend the CDSA" (Bill C-37) that sets out the legal framework for the implementation of the new CDSS, were key subjects of focus for the analysis.

Because Canada is a federation with 14 jurisdictions of governmental authority spread between federal, provincial, and territorial governments, it was also important to review documents that addressed how the federal government's policies impact the responses of provinces/territories toward the opioid crisis. Communications were coded according to their latent content, the themes and underlying meanings that emerged from the analysis relating to the literature on opioid injection drug use as health and human rights issue. The themes were then organized according to those that addressed legislative and legal content and those which reflected discourse and communications. A total of 50 governmental sources were consulted in developing the assessment put forth in this article.

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A Human Rights Approach to Opioid Injection Drug Use Policy

By placing responsibilities on the state to uphold certain obligations toward individuals, and enforceable limits on its conduct, a human rights approach to opioid injection drug use provides clear parameters for the treatment of PWIDs. Human Rights provides the normative commitment for alternative drug use approaches through the pro-harm reduction conditions that states must create to realize human rights. Harm reduction, for its part, provides the evidence-base for principled human rights interventions (ERDMAN 2012; ELLIOTT et al 2005). In this sense, the human rights framework has the potential to “level the playing field” between punitive and pro-harm reduction approaches by strengthening the normative and legal weight of alternative approaches in addressing opioid injection drug use (COHEN and CSETE 2006).

A human rights approach to opioid injection drug use is rooted in legal, public health, and moral arguments (HARM REDUCTION INTERNATIONAL 2019). The cornerstone protection of the right to health in international law is found in Article 12 of the International Covenant on Economic, Social and Cultural Rights (ICESCR) to which Canada is a signatory nation. The international covenants are legally binding for those states that have ratified them, obligating those states to respect, protect, and fulfill the rights outlined in the covenants (EZARD 2001). The ICESCR requires all parties to the covenant to take steps to fully realize the right to health through the “prevention, treatment, and control of epidemic, endemic, occupational, and other diseases; [and] [t]he creation of conditions which could assure to all medical service and medical attention in the event of sickness,” (UNITED NATIONS 2000).

The Committee on Economic, Social and Cultural Rights (CESCR), the legal body charged with drafting official interpretations of, and monitoring state compliance with, the ICESCR has found that the right to health further encapsulates a “right to control one’s health and body,” (UNITED NATIONS 2000). Viewing health through the lens of human rights, therefore, encompasses elements of human dignity and personal autonomy. It calls on signatory nations to prioritize health interventions that are “most likely to increase autonomy amongst those least able to exercise it without outside help” and to “protect the right of the informed individual to make healthy choices for him or herself,” (MEIER and SHELLEY 2006).

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According to the CESCR the right to health also extends to underlying social determinants of health such as access to adequate sanitation and healthy living and environmental conditions (SANDER and LINES 2016). The Committee has asserted that “inadequate and deficient housing and living conditions are invariably associated with higher mortality and morbidity rates,” (OFFICE OF THE COMMISSIONER FOR HUMAN RIGHTS 1992). From a public health perspective, negative population-level health consequences result when PWIDs fear punitive action and suffer human rights abuses. Harm reduction and drug treatment services fail to function effectively, and drug related harms, including injection-driven morbidity, mortality, and the spread of infectious diseases are made worse (UNITED NATIONS 2010; GLOBAL COMMISSION ON HIV AND THE LAW 2012).

Although a human rights-based approach to opioid injection drug use has existed in various forms for decades, debate persists regarding clarification of its defining characteristics and principles (CHEN 2011; HATHAWAY and TOUSAW 2008; HUNT 2004; KEANE 2003; HATHAWAY 2002; EZARD 2001). Critical work in this area has included consideration of the relationship between personal autonomy and public health, legalization (decriminalization) and harm reduction, and risk and vulnerability (SANDER and LINES 2016; ERDMAN 2012; CHEN 2011; HATHAWAY and TOUSAW 2008; HUNT 2004; KEANE 2003; EZARD 2001; HATHAWAY 2001). These debates have been positioned along a continuum of “weak” to “strong” rights (HUNT 2004). On one end of the continuum, “weak rights” place emphasis on collective longevity and public health over the primacy of personal autonomy. On the other end, “strong rights” emphasize the sovereignty one has over one’s health (CHEN 2011).

Harm reductionists who advocate for a “weak rights” approach put public health outcomes ahead of the individual rights of PWIDs and changes in their status under the law (HATHAWAY and TOUSAW 2008). Supporters invoke the logic of health optimization meaning that, if they can be deployed effectively, strategies which prevent injection drug use and decrease drug dependence are favoured above the right of PWIDs to pursue a right to drug use (HUNT 2004). Practically speaking, this means that so-called “weak rights” harm reductionists might endeavour to realize a consensus-based approach that privileges the desire of the majority to enjoy “drug-free” communities, be provided with health care services, and decrease opioid drug dependence at the population level (COHEN and CSETE 2006). “Weak rights” is, thus, normatively neutral, concerned with the risks and harms of injection drug use rather than with its legal or moral status. This perspective does afford some pragmatic political legitimacy that can enable governments to take health actions on high-risk behaviours, often amidst contentious, ideological, or conflicting public opinion

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on injection drug use. From this viewpoint, it is asserted that the ideas expressed, those of protecting life and health, are so widely accepted that they can be framed as “value-neutral” public health goods on which political consensus and public support can be reached (ERDMAN 2012)

For his part, Andrew Hathaway (2001) has argued against a “value-neutral” discourse of opioid injection drug use in favour of an explicit articulation of its deeper moral concerns. In Hathaway’s view, a human rights approach offers a necessary moral grounding for arguments for social, legal, and/or policy reform around injection drug use. Proponents of a “strong rights” approach assert that its power lies in the constitution of PWIDs as autonomous individuals and active citizens vis-à-vis the state that governs them (CHEN 2011). From this perspective, punitive approaches are not only irrational but immoral because they violate the autonomy of the individual (KEANE 2003; HATHAWAY 2001). In this sense, human rights define the boundary of constraints within which individuals are free to define their own health choices (HATHAWAY 2002). It is important to note that this relies on the right to education and information in order for individuals to make informed decisions. It further relies on institutional arrangements and capacity-building mechanisms that enable people to meaningfully participate in their health choices (SANDER and LINES 2016).

Perhaps not surprisingly, many who subscribe to a “strong rights” view advocate for the decriminalization for personal use of most, if not all, illicit drugs. A fundamental human right to use illicit drugs has even been proposed as an adjunct to the UDHR (HUNT 2004). Organizations such as The Beckley Foundation argue that there is an inherent “tension between prohibition on the one hand, and health and human rights concerns on the other,” (TAKAHASHI 2009, 770). Similar assertions have been made by The Canadian HIV/AIDS Legal Network, which states that “criminalization of people who use drugs is undermining public health efforts, including the response to HIV ... [and] stigmatizing people who use drugs through criminalizing them undermines their human rights,” (TAKAHASHI 2009, 770).

Regarding the relationship between risk and vulnerability, Nadine Ezard (2001) has argued that the paradigm of harm reduction should be expanded to include “vulnerability reduction” in addition to reducing risky behaviours. For Ezard, a focus on human rights is important because it highlights the obligation of the state to reduce not only behavioural risks related to drug use but the underlying vulnerabilities that predispose individuals to drug-related harms in the first place (KEANE 2003). Vulnerability is here understood as the “broad complex of individual and social factors which underlie and increase

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predisposition to risk” that arise “out of and are reinforced by past and present social context” and restrict “individual capacity to effect control over one’s life,” (EZARD 2001, 212-213). From a policy perspective, taking vulnerability into account allows the root causes of opioid injection drug use related to social determinants of health and drug-related stigma to be brought into drug use policy in broader areas such as mental health, education, housing, and poverty reduction.

The differences outlined in the literature demonstrate that adopting a discourse of human rights will not provide an easy end to debates about opioid injection drug use policy, nor can this be expected to be easily clarified in public policy discourse. In particular, this suggests there may be a fundamental tension between a demand for access to health care provided by the state and a demand for freedom from state regulation, both of which may be expressed in the language of rights (KEANE 2003).

A Brief History of Injection Drug Use Policy in Canada

Harm reduction in Canadian drug use policy dates back to the launch of the National Drug Strategy (NDS) in 1987, with its stated aim to reduce the harm “to individuals, families and communities from the abuse of drugs,” (HATHAWAY 2002, 398). This signalled an important shift away from a punitive “war on drugs” approach to one that sought to strike a balance between enforcement and health (HATHAWAY and TOUSAW 2008). Despite being strong on harm reduction rhetoric, however, the implementation of the Strategy has been widely criticized from a harm reduction perspective. The majority of funds allocated for prevention went toward police-controlled drug education and less than half of funds earmarked for treatment were ever made available (HATHAWAY and TOUSAW 2008). Moreover, drug charges rose during the first period of the Strategy, from 1987 to 1992, and the proportion of drug offenders in Canadian prisons grew from 9% to 14% (HATHAWAY and TOUSAW 2008; HATHAWAY 2002). In 1996, the Controlled Drugs and Substances Act (CDSA) was introduced, representing Canada’s federal drug control statute, which is still in place today subject to a number of amendments (JUSTICE LAWS WEBSITE 1996). The Act claimed to be “a harm reduction law ... that takes a public health approach to the problem of drug abuse rather than a moralistic, punitive one which views such abuse as criminal,” (HATHAWAY and TOUSAW 2008, 12).

Paralleling these developments, in the 1990s injection drug use reached crisis levels in the City of Vancouver, British Columbia (BC) (HATHAWAY and TOUSAW 2008). The adoption in 2001 of a four-pillar approach to injection drug use was widely regarded as a watershed moment for harm reductionists (COHEN

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and CSETE 2006). Vancouver's approach also stressed balance through its four-pronged emphasis on harm reduction, prevention, treatment, and law enforcement (COHEN and CSETE 2006). In September 2003, Insite opened in Vancouver, Canada's first SCS to receive formal exemption from the federal government under Section 56.1 of the CDSA. Section 56.1 exempts "any person or class of persons or any controlled substance ... from the application of all or any of the provisions of this Act or the regulations if, in the opinion of the Minister, the exemption is necessary for a medical or scientific purpose or is otherwise in the public interest," (HEALTH CANADA 2011). The site was initially established as a three-year pilot project under the condition that the program would be rigorously evaluated (FOREMAN-MACKEY and KAZATCHKINE 2019).

Although criticized for embracing harm reduction in theory rather than practice, the federal government continued to vocalize support for harm reduction until 2005 when a new government openly opposed to harm reduction was elected. A new National Anti-Drug Strategy (NADS) was introduced in 2006, which officially eliminated harm reduction from Canada's federal drug strategy, and in 2007 information about harm reduction was removed from Health Canada's website (CRAIG 2019). This turn toward a pro-enforcement stance on injection drug use would continue for nearly a decade under the direction of Prime Minister Stephen Harper's Conservative government.

In 2008 harm reduction came under further threat when the federal Minister of Health indicated that Insite's exemption under the CDSA would not be renewed, effectively threatening to make the clinic illegal (FOREMAN-MACKEY and KAZATCHKINE 2019; SMITH 2011; HATHAWAY and TOUSAW 2008). Harm reductionists in Canada took the government to court over its decision. They won a ruling in the BC Supreme Court that the federal government's decision was unconstitutional because it violated injection drug users' right to life, liberty, and security of the person under Section 7 of the Canadian Charter of Rights and Freedoms (SUPREME COURT OF CANADA 2011).

The government appealed and lost in the BC Court of Appeal, and then again in the Supreme Court of Canada (SCC) in 2011, when the SCC unanimously ordered the federal Minister of Health to grant Insite's continued exemption. The court noted that the minister's decision was "arbitrary," by undermining the CDSA's objectives of public health and safety, and "grossly disproportionate," as it created a risk of harm to Insite's clients by denying them lifesaving health services (SUPREME COURT OF CANADA 2011). However, the SCC did not go so far as to grant the rights of PWIDs to use and be in possession of illegal

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drugs writ large, as in the same decision the justices dismissed a cross-appeal against the constitutionality of the CDSA's prohibition on illegal-drug possession (SMITH 2011).

In June 2013, the federal government responded by imposing a new law called "The Respect for Communities Act" (Bill C-2), which established enhanced rules for the operation of SCS. The law mandated a highly burdensome application process for obtaining ministerial exemption for SCS and required that provincial/territorial governments, city officials, and law enforcement be more involved, which at the time failed to facilitate collaboration, as many politicians and police were opposed to SCS (CRAIG 2018; HOWLETT 2018). Ultimately, the legislation proved to be a significant obstruction to further harm reduction expansion in Canada (FOREMAN-MACKEY and KAZATCHKINE 2019).

In addition, Prime Minister Harper's tenure in government was characterized by a hollowing out of the federal government's scientific and public health infrastructure with lasting impacts on federal health capacity and the ability of the Pan-Canadian Health Organizations (PCHOs) to shape federal policy on opioids under the Trudeau government. Historically, the federal government has provided leadership, funding, and support for regional and inter-governmental policies and programming to address and control substance use in Canada. It is further responsible for overseeing laws and regulations pertaining to substance use. Though these functions typically involve some negotiation with the provinces/territories concerning the appropriate role of the federal government in health care, the limited role that the Conservative government sought to pursue under Prime Minister Harper was unprecedented.

There has been well documented criticism levelled against Harper's government for the elimination of research programs intended to create scientific evidence to inform policy, including agencies such as the Canadian Institutes of Health Research (CIHR) that faced substantial cuts. Likewise, the overhaul of scientific communications policies resulted in scientists being blocked from communicating information to the public (LINNITT 2013; BELLUZ 2012). A scathing editorial published in the Canadian Medical Association Journal (CMAJ) ahead of the 2015 federal election, for example, asserted that for "much of the last decade, Canadian federal health policy has been conspicuous by its absence," (STANBROOK 2015). The editorial continued that "recent years have seen Canada's health care system race to the bottom of quality rankings compared with peer nations ... Currently, among countries in the Organisation for Economic Cooperation and Development, only the United States ranks lower," (STANBROOK 2015). This view was corroborated by a 2018 external review of the PCHO's that found that "for a decade, the federal government chose to limit

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its function largely to funding provincial and territorial transfers, and backed away from engaging in matters of health policy,” (FOREST and MARTIN 2018, 115). The CMAJ editorial concluded that “[m]any essential aspects of health care are a federal responsibility, and our biggest, most complex problems in the health care system cannot be solved without federal leadership,” (STANBROOK 2015).

Policy Motives and International Legal Context Surrounding the new CDSS

Against this backdrop, the election of a new federal Liberal Government under Prime Minister Trudeau in October 2015 that expressed direct support for alternative approaches to addressing opioid injection drug use signaled a potential softening of relations between the Canadian government and harm reductionists (FOREMAN-MACKEY and KAZATCHKINE 2019). During the 2015 election Prime Minister Trudeau campaigned on a platform that sought to present the Liberal party as a progressive and “transformative” alternative to incumbent Prime Minister Harper, pledging to deliver real change to create a “strong middle class,” bring back “open and honest government,” and “unmuzzle scientists,” (THE CANADIAN PRESS 2019; BRYDEN 2016; LIBERAL PARTY OF CANADA 2015b). The commitments contained in the Liberal’s Platform such as “pan-Canadian collaboration on health innovation,” “increasing the availability of high-quality mental health services,” and the legalization of recreational cannabis also set up heightened expectations among harm reductionists for the government to reverse policies that had been implemented by the Conservatives (LIBERAL PARTY OF CANADA 2015a).

Additionally, the government’s “pan-governmental focus on two important expressions of the value of equity - gender equity and reconciliation with Indigenous peoples - have put this concept front and center in the public discourse” (FOREST and MARTIN 2018, 104). Not surprisingly harm reductionists have harnessed onto human rights and equity as key aspects of any policy response to opioid injection drug use on the part of the Trudeau government.

Indeed, although opioid injection drug use was not a central policy issue in the 2015 election, it was brought into the political consciousness of the election by a wide range of interest groups in Canada, including medical professionals, harm reduction advocates, and civil society, largely as a response to policies such as Bill C-2. Both the Canadian Medical Association and Canadian Nurses Association, for example, were very vocal in their opposition to Bill C-2, even producing Briefs in 2015 for the Standing Senate Committee on Legal and Constitutional Affairs that criticized Bill C-2 for imposing unnecessary

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restrictions to establishing SCS (CANADIAN MEDICAL ASSOCIATION 2015; CANADIAN NURSES ASSOCIATION 2015).

At the same time, networks of harm reduction advocates, notably across Toronto and Vancouver, became increasingly formalized in response to fentanyl and carfentanil permeating the drug supply. Utilizing social media, Toronto harm reduction advocates developed close connections with activists in Vancouver, where fentanyl had arrived on the streets in 2014, to “share news from the frontlines, offer advice and support to one another, and strategize on how best to push their respective governments to adopt more controversial health-care policies,” (LUPICK 2017). Like their Vancouver counterparts, Toronto activists formalized their activities under umbrella organizations, such as the Toronto Harm Reduction Alliance, to present a unified front to decision-makers and take “matters into their own hands” where they perceived that government failed to act to address opioid mortality and morbidity (LUPICK 2017). This includes establishing unsanctioned “pop-up” Overdose Prevention Sites (OPS) and collaborating with advocates in Vancouver to draft instructions for how other cities can follow the examples set by Vancouver and Toronto (LUPICK 2017).

Complicating matters, in their study of policy actors’ views on harm reduction policy in Canada’s provinces/territories, Hyshka et al (2019) found “considerable ambivalence towards further efforts to strengthen formal provincial/territorial policies” with some actors opposed to formal policy development because it “allowed them to be more creative or responsive in their own program and service delivery,” (2019, 6). Such findings create challenges for federal and provincial/territorial policy-makers in garnering broad-based support for alternative approaches to opioid injection drug use, whether these lean closer to “weak” or “strong” rights on the policy continuum.

However, the same study also noted that “reforming federal drug policy has long been seen as an important policy objective amongst more ‘rights-oriented’ members of Canada’s harm reduction policy community, and decriminalization of drug possession has been a key advocacy objective for many harm reduction proponents in recent years,” (HYSHKA 2019, 6). Indeed, as the opioid crisis has not abated in national “hot-spots,” calls have increased for decriminalizing opioids for personal use. This has particularly been the case at the epicentre of the crisis in BC where activists have called on the federal government to decriminalize and regulate narcotics (MULLIN 2017; KIRKUP 2017).

At the provincial/territorial level, soon after Prime Minister Trudeau’s government took office there was a surge in the number and geographic spread of

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overdose deaths related to fentanyl that has continued to impact every corner of the country. As the number of overdose deaths increased unabated, in April 2016 BC's Provincial Health Officer (PHO) declared a province-wide public health emergency under the Public Health Act. This represented the first time a public health emergency had been declared by a province/territory in response to the opioid crisis (HENRY 2019). Additionally, in 2017 BC's PHO called on the federal government to strongly consider the decriminalization of drugs for personal possession as a means of destigmatizing drug use (KIRKUP 2017). Other hard-hit provinces include Alberta where fentanyl-related fatalities were 61.4% higher in the first quarter of 2017 than the same period in 2016 (HOWLETT 2018) and Ontario where between 2016 and 2017 the rate of emergency department visits due to opioid poisoning rose by 73% (CANADIAN INSTITUTE FOR HEALTH INFORMATION 2018). This dramatic rise in opioid-related overdoses resulted in a period of renewed interest in harm reduction and increased pressure on the federal government from provinces/territories to implement policies to help alleviate the burden of the opioid crisis at the provincial/territorial level (HYSHKA 2019).

Likewise, public opinion has shifted away from a "not in my backyard" attitude toward harm reduction toward greater recognition of opioid use as a "crisis" as opioids have infiltrated "the backyard" of the "middle class" that Trudeau has committed to "strengthening," (KOLLA et al 2017). This can be seen in the results of an Angus Reid Institute public opinion poll conducted in 2018 that found that one-in-eight (12%) Canadians report having close friends or family members who have become dependent on opioids in the last five years. The poll further reported that more than one-in-four Canadians (26%) believe that opioid dependency represents a "crisis," and a further four-in-ten (42%) say it is "a serious problem" in Canada. Moreover, the majority of those polled offered strong support for SCS (67%) and mandatory treatment programs for those who overdose (85%) (ANGUS REID INSTITUTE 2018). Despite the softening of attitudes toward opioid injection drug use, however, the high level of support for mandatory treatment programs is suggestive of potentially greater willingness among the broader public to back a "weak" rights approach to opioid injection drug use. This raises questions over the likelihood of the government receiving widespread support for stronger rights-based elements such as decriminalization and empowering PWIDs to define their own health choices.

Finally, it is important to consider the international legal context in which federal drug policy is conceived and how this has influenced the Trudeau government's position on decriminalizing opioids under the new CDSS. Canada is signatory to the three UN treaties that form the international legal framework

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of the global drug-control regime: the 1961 Single Convention on Narcotic Drugs, the 1971 Convention on Psychotropic Substances, and the 1988 Convention against Illicit Traffic in Narcotic Drugs and Psychotropic Substances. Together, these treaties establish international control measures to prevent the diversion of narcotics and psychoactive substances into illegal channels, while ensuring their availability for medical and scientific purposes (ARMENTA and JELSMA 2015). In moving to legalize cannabis for recreational use Trudeau's government has been accused by a range of international actors such as the International Narcotics Control Board of being in violation of its obligations under these conventions, which has had spill-over implications for debates in Canada over the decriminalization of opioids (ZIMONJIC and BLOUIN 2018). Ultimately, international reaction to Canada's decision to legalize recreational cannabis places Trudeau's government in an uncomfortable position regarding domestic pressure to decriminalize opioids. While this may make sense from a public health perspective, the Trudeau government must ask itself whether it wants to risk accusations that it continues to violate its international drug treaty obligations, or worse be forced to "crash out" of these treaties and lose its ability to exert broader influence over the international drug-control regime that regulates more than 100 substances (MACNAB 2018). As will be seen, decriminalization remains a central issue in assessing the Trudeau government's policy response to the opioid crisis, and the international legal context renders Canada caught between a "rock and a hard place."

Navigating an Alternative Course in Canada's Injection Drug Policy - The Legislative and Legal Landscape of the new CDSS

Upon entering office Prime Minister Trudeau's government moved swiftly to abandon its predecessor's "anti-drug" stance stating that "the NADS did not reflect this government's approach," (HEALTH CANADA 2016). Rather the government committed to the "restoration of harm reduction" in Canadian drug policy and to reframing the opioid crisis as a public health issue (HOWLETT 2018).

In December 2016, the government replaced the NADS with the new CDSS. The new CDSS invokes a formal four-pillar approach to addressing injection drug use in Canada: Prevention; Treatment; Harm Reduction; and Enforcement (HEALTH CANADA 2018c). Highly reminiscent of Vancouver's four-pillar approach, the Government of Canada's strategy raises similar questions regarding whether a "balanced" approach to drug policy that frames law enforcement and public health objectives as mutually reinforcing is feasible, or if there might be inherent inconsistencies among the goals of the different "pillars," (COHEN and CSETE 2005). A mere 2% of the 202 commitments reached at an

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Opioid Summit co-hosted by the federal government in 2016 focused specifically on enforcement, though, indicating that a public health framework is guiding the new CDSS (CANADIAN CENTRE ON SUBSTANCE USE AND ADDICTION 2017). However, harm reduction specifically constituted only 8% of the commitments, with 25% and 35% respectively focusing on treatment and prevention, leaving open the issue of whether a “weak rights” approach has been favoured above “strong rights” commitments (CANADIAN CENTRE ON SUBSTANCE USE AND ADDICTION 2017).

Human rights are also explicitly referenced in the goals and guiding principles of the new CDSS. The stated goal of the new CDSS is to “protect the health and safety of all Canadians by minimizing harms from substance use for individuals, families and communities,” (HEALTH CANADA 2018d). The government pledges to encourage the “development of policies and programs designed to defend and promote the health, dignity and human rights of people who use drugs,” (HEALTH CANADA 2018d). Under the “Compassionate” principle the government further commits to treat “problematic substance use as a health issue and not a moral one, and recognizes that stigma associated with substance use can be harmful to people who use drugs and lead to violations of their dignity and human rights,” (HEALTH CANADA 2018d). To achieve this, the government makes specific reference to elements of a stronger rights-based approach. This includes approaching injection drug use as a “health and social issue,” a commitment to addressing the “root causes” of injection drug use and to “reducing stigma,” and working in collaboration with a broad range of actors, including PWIDs, in the development of policies and programs (HEALTH CANADA 2018d).

It remains unclear, however, how the “root causes” of injection drug use are substantively addressed under the “prevention” pillar of the new CDSS. On September 5, 2018, a 90-day consultation was launched to gather ideas on potential next steps under the new CDSS. This culminated in the publication “What We Heard: Strengthening Canada’s Approach to Substance Use Issues,” which notes the importance of focusing on “preventing problematic substance use from occurring in the first place” by making mental health care more accessible, increasing affordable housing and housing first strategies, and exploring a range of income and social support options (HEALTH CANADA 2019b). Although reducing stigma through public education that seeks to alter how substance use is talked about is a centerpiece of the new CDSS, broader social policies pertaining to housing and poverty reduction have not been reflected in the new CDSS nor has legislation in these areas explicitly integrated injection drug use. For instance, the National Housing Strategy Act, while making reference to the linkages

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between affordable housing and beneficial health outcomes, fails to address the roles that lived experience of unstable housing and homelessness play in predisposing individuals to injection drug use (JUSTICE LAWS WEBSITE 2019).

Nevertheless, the Government has allocated health policy funding toward addressing the root causes of opioid injection drug use through a “comprehensive, compassionate, collaborative and evidence-based” approach (CANADIAN INSTITUTES OF HEALTH RESEARCH 2019). Intended to support research relevant to one or more of the four pillars of the new CDSS, funds have been directed to CIHR to award grants across several funding streams including Opioid Crisis Knowledge Synthesis (\$1.85 million CAD) and Evaluations of Interventions to Address the Opioid Crisis (\$1.5 million CAD). In 2018, 22 Knowledge Synthesis grants were awarded “to address the pressing evidence needs of knowledge users ... and help tackle the most urgent elements of the opioid crisis, including opioid-related mortality rates ... sub-populations and biological and social determinants,” (CANADIAN INSTITUTES OF HEALTH RESEARCH 2019). In 2019, 15 projects received support through the Evaluations stream. These projects aim to analyze the “effectiveness of opioid crisis-related interventions ... the efficacy of prevention (including pain management), harm reduction and treatment interventions” to help “healthcare and health services providers make informed decisions” and “help to inform changes to national, provincial, municipal and/or private health policy,” (RESEARCHNET 2020).

Drawing on the Government’s commitment to address the root causes of opioid injection drug use through a strategy that meets the physical, mental, and social needs of an individual, the framework for action set out in the new CDSS also commits to working with the provinces/territories to establish a coordinated system of care for PWIDs. This is recognized at the federal level in comments such as those of then Minister of Health, Ginette Petitpas Taylor, which reveal the Government of Canada’s commitment to work with provinces/territories: “we can’t deal with this alone. There’s no one single solution to this, and we recognize that we have to work with the provinces and the territories and front-line workers,” (HESA 2017). Complicating the interrelationship of human rights, health, and opioid injection drug use in the Canadian context is the fact that healthcare is an inter-jurisdictional issue with the federal, provincial/territorial, and municipal governments each having a role in the delivery of health services. Instead of having a single national plan, a patchwork of 13 provincial and territorial health care insurance plans exist. This allows for some degree of differentiation in the specific policies and programs implemented across the provinces/territories.

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Recognizing this complexity, the federal government has sought to provide support and work alongside the provinces/territories in addressing the opioid crisis. For example, in December 2016, the federal and provincial/territorial governments established a Special Advisory Committee (SAC) on the Epidemic of Opioid Overdoses to focus on urgent issues related to opioid overdose, morbidity, and mortality. The SAC is a time-limited mechanism for public health collaboration and information sharing between jurisdictions related to the opioid crisis in Canada (PAN-CANADIAN PUBLIC HEALTH NETWORK 2017). Furthermore, through the Substance Use and Addictions Program (SUAP), a federal contributions program delivered by Health Canada, the government provides financial support to provinces/territories to strengthen responses to drug and substance use issues. SUAP funding, comprising approximately \$50 million CAD annually as of 2018 in grants and contributions funding, is intended to support evidence-informed and innovative initiatives across health promotion, prevention, harm reduction, treatment, and rehabilitation (HEALTH CANADA 2020f). In addition, as part of Budget 2018, the federal government announced a one-time transfer of funds in the amount of \$150 million CAD to the provinces/territories to improve access to evidence-based treatment services (HEALTH CANADA 2020c).

Concerning the “harm reduction” pillar of the new CDSS, according to drug laws in Canada, the unauthorized possession of a controlled substance is a crime under Section 4 of the CDSA (JUSTICE LAWS WEBSITE 1996). Given that some harm reduction interventions such as SCS take place in settings where PWIDs bring pre-obtained illicit drugs to consume, both clients and staff are at risk of prosecution for possession when accessing and/or working in these sites without federal exemption. There are currently three options under the CDSA for obtaining exemptions from potential criminal liability. These are SCS-specific ministerial exemption under Section 56.1; general ministerial exemption under Section 56; and regulations made by Cabinet under Section 55 (FOREMAN-MACKEY and KAZATCHKINE 2019).

In 2017, the government repealed the “Respect for Communities Act” and replaced it with “An Act to amend the CDSA” (Bill C-37). While Bill C-37 did not remove Section 56.1 of the CDSA, it did take steps to replace onerous legislative requirements by streamlining the application and renewal process for SCS and adding in new transparency provisions. According to the government, “reducing the number of criteria relieves the administrative burden on communities seeking to establish a supervised consumption site, without compromising the health and safety of those operating the site, or the surrounding community,” (HEALTH CANADA 2017). Bill C-37 also removed the

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prerequisite of the Harper government that provinces/territories must submit letters of support before SCS applications would be approved. This effectively overrides provincial/territorial ability to block SCS should these governments be hostile towards the implementation of harm reduction interventions in their jurisdiction. As of March 14, 2019, there were 40 sites currently approved by the Government and another 12 sites under review (HEALTH CANADA 2020e).

Bill C-37 further restored the Minister of Health's authority to issue an exemption under the broader Section 56, and the power of the federal Cabinet to issue regulations under Section 55, which could be used to protect PWIDs from the risk of criminal prosecution for possession of a controlled substance (FOREMAN-MACKEY and KAZATCHKINE 2019). As of January 2019, Cabinet had not used its authority under Section 55, nor had the government taken steps to decriminalize drugs listed as controlled substances under the Act for personal use (FOREMAN-MACKEY and KAZATCHKINE 2019).

The government has used this restoration of powers, however, to create more flexible and responsive avenues to reduce regulatory red tape and enable communities to respond to spikes in opioid overdose. One way this has been achieved is through the issuance of class exemptions under Section 56 to provinces/territories to establish temporary OPS on the basis that this is "in the public interest," (FOREMAN-MACKEY and KAZATCHKINE 2019). According to Health Canada, "all provinces and territories have been authorized by Health Canada to establish Urgent Public Health Need Sites until September 30, 2021," (HEALTH CANADA 2020a). OPS can be set up and services deployed quickly to respond to outbreaks where other more permanent interventions like SCS are not available. It should be noted, however, that this reduction in regulatory red tape was a reactionary rather than proactive policy response to the opening of numerous unsanctioned "pop-up" OPS by volunteers to meet the urgent needs of those hardest hit by the opioid crisis, often while awaiting bureaucratic approval for permanent SCS. Moreover, the voluntary nature of this work to fill gaps in harm reduction supports has meant that OPS are notoriously under resourced, which has exacted a large emotional toll on individuals staffing OPS (TAHA et al 2019). This has resulted in questions regarding the prospects for success of such "stop-gap" initiatives and the need for more responsive, long-term policies that enable harm reduction services to be rolled out quickly in areas of high need.

In addition, while practitioners and advocates have agreed that Bill C-37 does streamline the application process for communities who wish to open SCS, tensions persist over the continued treatment of SCS and OPS as "exceptional" within the legislation rather than as vital health services, requiring formal

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exemption from criminal prosecution (FOREMAN-MACKEY and KAZATCHKINE 2019). Some practitioners have further argued that a wealth of information is still required by Health Canada before a decision on an exemption is made. The Canadian Drug Policy Coalition, the Canadian HIV/AIDS Legal Network, Pivot Legal Society, and the Canadian Medical Association all sent submissions to the Senate Standing Committee on Legal and Constitutional Affairs after the introduction of the Bill. However, their calls for reduced regulation and a reconsideration of decriminalization have not yet been adopted (CANADIAN DRUG POLICY COALITION 2017).

The government has additionally taken some steps under the “enforcement” pillar of the new CDSS to lessen punitive responses related to possession of illicit opioids for personal use, focusing instead on deterring illicit supply. For example, in addition to provisions pertaining to SCS, Bill C-37 also “prohibits unregistered importation of designated devices that may be used in the illicit manufacture of controlled substances, such as pill presses and encapsulators,” (HEALTH CANADA 2017). It further amends the Customs Act removing an exemption that prevents Canadian border officers from opening mail weighing 30 grams or less in order to try and prevent opioids, such as fentanyl that can be batched in small quantities to evade detection, from entering Canada illicitly through the postal system (HEALTH CANADA 2017).

In May 2017, the “Good Samaritan Drug Overdose Act” was also passed with the stated objective to contribute to the Government of Canada’s efforts to transform Canada’s criminal justice system “to make it more just, compassionate and fair,” (HEALTH CANADA 2019a). The Act grants some legal protection for people who experience or witness an overdose and call emergency services from charges for possession of a controlled substance under the CDSA. The Act applies to anyone seeking emergency support during an overdose, including persons experiencing an overdose (HEALTH CANADA 2018d).

Additionally, in the search for effective responses to the opioid crisis, the government has explored alternative “strong rights” policy approaches such as that of Portugal, which in 2001 decriminalized illegal drugs for personal consumption.² In July 2017, then-Health Minister Jane Philpott and then-Justice Minister Jody Wilson-Raybould travelled to Portugal along with Canada’s Chief

² Although drug trafficking remains a criminal offence in Portugal, anyone caught with less than a 10-day drug supply is sent to a Commission for the Dissuasion of Drug Addiction, a panel made up of a lawyer, a doctor and a social worker that decides on a penalty, usually a warning, a fine or a recommendation to seek treatment for addiction. No one is imprisoned, and possession is treated as an administrative violation (COLETTA 2018).

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Public Health Officer Dr. Theresa Tam to learn about the Portuguese approach to drugs (KIRKUP 2017). The Hon. Wilson-Raybould said in a statement that “[w]hat I saw and heard from our Portuguese hosts during our time here will provide valuable input as we continue our government’s review of Canada’s criminal justice system,” (KIRKUP 2017).

In April 2018, at the Liberal party convention, party members voted overwhelmingly in favour of decriminalizing all illicit drugs and passed a resolution to this effect (MAJOR and KAPELOS 2018). However, the Trudeau government has made it clear that it has no plans to act on the resolution. In September 2017, Prime Minister Trudeau communicated his government’s position that decriminalization is not the approach Canada will take stating, “[w]e are making headway on this and indeed the crisis continues ... but we are not looking at legalizing any other drugs than marijuana for the time being,” (BAINS 2017). Again, in April 2018, soon after the Liberal party convention, then-Justice Minister Wilson-Raybould reiterated that she is open to a conversation on decriminalizing small quantities of drugs but that the government is “not moving forward with ... decriminalization,” (HARRIS 2018).

Federal Policy Discourse and Communications under the New CDSS

The reframing of opioid injection drug use as a public health crisis appeared early on in the policy discourse of the Trudeau government. In November 2016, the first time the federal government brought policy makers and medical experts together to devise strategies to address opioid injection drug use, the Minister of Health vowed to use every tool at her disposal to address the “national public health crisis,” (HOWLETT 2017). An Opioid Conference and Summit were hosted consecutively over two days, co-chaired by then-Health Minister Philpott and then-Ontario Minister of Health and Long-Term Care Eric Hoskins, with seven provincial/territorial ministers of health attending. This represented the Government of Canada’s first major pan-Canadian effort to address opioid injection drug use.

The stated objective of the Summit was to “establish a collective response to the opioid crisis and to identify specific actions required to address the crisis in Canada,” (CANADIAN CENTRE ON SUBSTANCE USE AND ADDICTION 2017). The Summit culminated in the release of the “Joint Statement of Action to Address the Opioid Crisis.” This Statement reflected a collective commitment by the summit participants to “work within their respective areas of responsibility to improve prevention, treatment, harm reduction and enforcement associated with problematic opioid use through

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timely, concrete actions that deliver clear results,” (CANADIAN CENTRE ON
SUBSTANCE USE AND ADDICTION 2017).

During the same period harm reductionists working in the field of injection drug use noted a distinct change in Health Canada's communication style and responsiveness. For instance, it was reported that Health Canada staff began to directly reach out to SCS applicants to reopen discussions about expanding SCS, and that staff responded promptly to inquiries and maintained communication throughout the application process (FOREMAN-MACKEY and KAZATCHKINE 2019). Health Canada's overall approach to opioid drug use was also described as a more flexible, public health-centered model (FOREMAN-MACKEY and KAZATCHKINE 2019). In addition, the exemption and approval process for harm reduction interventions and projects receiving funding through the government's Harm Reduction Fund, which supports community-based initiatives to reduce rates of Hepatitis C and HIV, became more transparent. Application requirements and guidance documents are clearly published on Health Canada's website (HEALTH CANADA 2018b) and approved applications as well as the status of open applications are publicly available (HEALTH CANADA 2020e; FOREMAN-MACKEY and KAZATCHKINE 2019).

The government also sought to open the door to consultations, including with PWIDs, on strengthening its policy approach to the opioid crisis. In 2018, the government released the “Background Document: Public Consultation on Strengthening Canada's Approach to Substance Use Issues.” This document outlined the government's intention to launch an online public consultation asking “Canadians for new and innovative ideas on how to further strengthen the federal government's health-focused approach to substance use issues through the CDSS,” (HEALTH CANADA 2018d). The document provides background information on areas that the government is interested in receiving input on, grouped according to themes such as: “addressing root causes of problematic substance use;” “reducing stigma;” “improving access;” “exploring innovative approaches to harm reduction;” and “applying a health lens to regulation and enforcement activities,” (HEALTH CANADA 2018d).

In regards to harm reduction specifically, the federal government's definition as of 2018, overtly references an approach that is people-centered, “meets people where they are at”, “acknowledges that each person is different”, and “enhances the ability of people who use substances to have increased control over themselves, their families, and their communities,” (PUBLIC HEALTH AGENCY OF CANADA 2020). It is clear in the discourse employed to

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communicate its strategy that the Government has embraced a human rights lens through its dual focus on risk and vulnerability reduction and recognition of the personal autonomy of PWIDs to make choices over their health.

Likewise, the Minister of Health has emphasized both the severity of the crisis and its prioritization as a key issue within the government's agenda on numerous occasions. In the immediate aftermath of the Opioid Summit in November 2016, then-Minister of Health Philpott committed the government to responding to the "serious and growing opioid crisis," (IRELAND 2016). The government's "Federal Action on Opioids" webpage in 2018 further acknowledged "[t]he growing number of opioid-related overdoses and deaths is a national public health crisis" and stated that "[t]he Minister of Health has made addressing this crisis a top priority," (HEALTH CANADA 2020b). The Minister of Health reiterated this in the House of Commons session of the Standing Committee on Health in December 2017. In her remarks the Hon. Ginette Petitpas Taylor stated that, "[w]ith respect to the work that we've done in the opioid crisis, ... It's certainly an area of priority of mine as Minister of Health," (HESA 2017). She continued, "I have to say that the first briefing that I received as Minister of Health was specifically on the opioid crisis and it's my number one priority, which I'm dealing with on a regular basis, on a daily basis," (HESA 2017).

The government also reiterated its recognition of the importance of the language used "to talk about substance use," which "has a direct and profound impact on people who use substances, the way others treat people who use substances, and the policy and program approaches taken to address problematic substance use," (HEALTH CANADA 2018d). To this end, the government initiated a national campaign to end stigma intended to educate the public on the opioid crisis, shape the nature of discourse on opioid injection drug use around non-discriminatory "people-first" language, and normalize the crisis as a public health issue. The campaign's website recognizes that stigma matters because it can prevent people who use drugs from getting help as "[p]eople who are stigmatised often feel ashamed, alone and judged," (HEALTH CANADA 2020d). The government has allocated \$18.7 million over five years to address the stigma faced by PWIDs, including launching a new national, multi-year public education campaign to reshape Canadian attitudes and perceptions about PWIDs (HEALTH CANADA 2018a). This has included a public education campaign delivered through posters, online videos, webpages, and commercials that have run nationally in an effort to reach Canadians with the government's message.

However, not all of the government's statements have so clearly identified the government's level of commitment to the opioid crisis, leaving the government open to accusations of politicized vagueness and noncommittal

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rhetoric (HYSHKA et al 2019). For example, in December 2018, the Health Minister stated in the House of Commons that declaring opioids a “public health emergency” in Canada would do little to assuage the problem, despite the fact that to do so would unlock funding and emergency response mechanisms that could assist in responding to areas hardest hit by opioid morbidity and mortality (CRAIG 2019). The Government of Canada's website also continues to refer to a “national public health crisis,” making the federal government's classification of the epidemic unclear and calling into question the government's commitment to concrete actions that could be rapidly deployed through the declaration of an “emergency,” (VOON 2017).

Conclusion

It is still too early to evaluate the effectiveness of the new CDSS in terms of concrete health outcomes; however, in 2018, the opioid crisis showed no signs of abating. According to the government's own figures, in the first half of 2018 2,066 opioid-related deaths occurred. Therefore, between January 2016 and June 2018 more than 9,000 lives were lost to the opioid crisis in Canada (HEALTH CANADA 2018e).

Nevertheless, the approach adopted by the government during its first four-year term does extend opioid injection drug use as a public health and human rights issue further than any previous national drug policy in Canada, and concrete actions have been taken.³ To date, the legislative and legal actions of the government signal a shift in approach, moving opioid injection drug use away from the emphasis of previous legislation on punitive measures toward an array of integrated public health responses. Moreover, the introduction of the Good Samaritan Act, discursive emphasis on addressing stigma and the root causes of substance use, and the establishment and expansion of flexible responses like SCS and OPS demonstrate the government's efforts to explicitly embed its approach in a “stronger” rights-based framework.

On the other hand, despite the anti-stigma and people-first rhetoric that is interspersed throughout the government's legislative and verbal commitments, harm reductionists are unlikely to be fully satisfied by the commitments made, and actions taken, on opioid injection drug use. The government's failure to address the exceptional status of harm reduction interventions such as SCS and OPS indicates that regardless of political rhetoric, opioid injection drug use

³ See: “Infographic: Government of Canada - Federal Actions on Opioids – December 2018,” for a listing of concrete actions that have been taken by the federal government from the introduction of the new CDSS to December 2018 (HEALTH CANADA 2018e).

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continues to be framed in terms of a temporary problem to be solved through short-term measures rather than a societal reality requiring the long-term integration of health and social policy. Although committing to address the root causes of injection drug use, the government's failure to address social determinants of health through the integration of injection drug use in other policy areas such as housing and poverty reduction leaves it open to criticism that it has not met its commitment to tackle the underlying vulnerabilities that predispose individuals to drug-related harms. Furthermore, Cabinet has thus far not exercised action on Section 55 of the CDSA nor taken decisive steps toward decriminalization.

This has resulted in inconsistencies between action and rhetoric regarding the human rights approach to health in the new CDSS; although enforcement has been de-emphasized it still remains a central pillar of the government's formal response. Ultimately, this indicates that in practice the government may be threading a needle between a "weak" and "strong" rights approach to opioid injection drug use, and future research is needed to more rigorously explore the intentionality behind this observation on the part of government. Whether this delicate balancing act will stand up should the opioid crisis continue unabated, or worsen, remains to be seen. In the end the new CDSS risks satisfying no one.

In addition, the outcome of the 2019 federal election that resulted in a minority liberal government under Prime Minister Trudeau raises questions about the long-term status of a policy approach that links health and human rights. One wonders about the ability of the Liberal government to continue to advance the new CDSS and which, if any, of the other federal parties the government could leverage to support its strategy. Likewise, the issue of decriminalization of illicit opioids for personal use remains unanswered. Will Prime Minister Trudeau continue to pay lip service to calls from the grassroots within his own party to adopt a stronger rights stance, or take concrete steps toward decriminalization in order to maintain political support from "backbenchers" in his government? Alternatively, the reality of the continued politicization of the opioid crisis could result in a dismantling of the steps that have been achieved if the government is forced to work with a party that is not supportive of an approach that couples health and human rights in addressing opioid injection drug use in order to move other aspects of its political platform forward.

In Canada, all signs indicate that the morbidity and mortality associated with opioid injection drug use is a long-term health and social policy issue, and addressing this crisis will require a similarly long-term, comprehensive, and depoliticized response. The challenge is becoming less about "what" should be

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done, and increasingly more about “how” approaches are framed and interventions implemented to ensure they are effective, consistent, and scalable (KPMG 2018). In the current context of a minority government, the Trudeau government can continue to build upon the commitments it has made to a human rights-based approach by attempting to seek out supportive political allies and introducing more comprehensive legislation that explicitly links opioid injection drug use to the social determinants of health.

This includes deepening its commitments to address mental health by continuing to recognize the roles that stigma plays in exacerbating drug-related harms. Opioid injection drug use could also be embedded in other social policy legislation recognizing the role of “root causes” in predisposing individuals to drug-related harms. Such comprehensive legislation would help to depoliticize opioid injection drug use and move the opioid crisis away from its framing as an “exceptional problem” toward normalizing opioid injection drug use as an issue to be included in a broad cross-section of health and social legislation, at least for the foreseeable future. Harm reductionists must continue to play strong roles in local, provincial/territorial, and national advocacy, utilizing national and international human rights tools and the precedent set through the federal government's explicit linking of health and human rights to do so.

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