

COMMUNITY ENGAGEMENT

The Harms of Drug Prohibition: Ongoing Resistance in Vancouver's Downtown Eastside

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VANCOUVER AREA NETWORK OF DRUG USERS*

There are numerous studies that examine the Downtown Eastside (DTES) of Vancouver, British Columbia, and chronicle its transition from prosperous colonial settlement in the late 1800s to Canada's poorest urban neighbourhood today.¹ The DTES has a long history of experiencing state-sanctioned race, class, and gendered violence and of resisting that violence. In this article, we highlight the DTES as the epicentre of Canada's first narcotic drug laws and its history of actively resisting punitive and prohibitionist drug policy.

Canada's *Opium Drug Act, 1908*, and subsequent early drug criminalization legislation, was the result of race, class, and gender tensions that led to legal and social discrimination against Chinese Canadians as well as to the demonization and criminalization of smoking opium,

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¹ See, for example, Kay Anderson, *Vancouver's Chinatown: Racial Discourse in Canada, 1875-1980* (Montreal and Kingston: McGill-Queen's University Press, 1991); Rob Brownie and Annabel Vaughan, "Transient Vancouver: A Difficult Typology," in *Unfinished Business: Photographing Vancouver Streets 1955 to 1985*, ed. Bill Jefferies, Glen Lowry, and Gerry Zaslove, 33-39 (BC: Presentation House Gallery and Westcoast Line, 2005); John Price, "Orienting the Empire: Mackenzie King and the aftermath of the 1907 race riots," *BC Studies* 156 (2007): 53-8r; Leslie Robertson and Dara Culhane, *In Plain Site: Reflections of Life in Downtown Eastside Vancouver* (Vancouver: Talonbooks, 2005); and Peter Ward, *White Canada Forever* (Montreal and Kingston: McGill-Queen's University Press, 2008). Central to many of these studies is the impact of colonization (past and present) and the recognition that the DTES and the city of Vancouver are located on unceded Musqueam, Squamish, and Tsleil-Wautth First Nations territory. White settlers in British Columbia further consolidated their political power by disenfranchising non-white settlers, including Chinese, Japanese, and South Asian people.

a drug that white moral reformers associated with Chinese men.² Calls from colonists – including politicians, labour leaders, and workers – for a “white Canada” and “white British Columbia” at a 1907 anti-Asian riot that began in the DTES played a major role in the formation of early drug laws and policies.³ Following Canada’s first narcotic law, the *Opium Drug Act, 1908*, Chinese Canadians and opium dens became the focus of police profiling. The closure of opium dens and the deportation of Chinese Canadian men increased into the 1920s.⁴

Canada’s new narcotic drug laws were accompanied – and driven – by the demonization of non-white and poor people who consumed newly criminalized drugs. White women who visited opium dens were constructed as fallen women entrapped by foreign Others – women who abandoned Christian morals, home, and family for a life of addiction and degradation.⁵ These criminalized drug consumers, formerly legal subjects, felt the full brunt of Canada’s drug laws. In response to the criminalization of drugs such as opium in smoking form and non-medicinal heroin, morphine, and cocaine, an illegal drug market emerged in Canada. The result of this was that illegal drugs were available at inflated prices and their quality could not be assured.

By the late 1940s, British Columbia had the most visible illegal drug-using population in all of Canada: white, poor, and working-class users of heroin, morphine, and cocaine.⁶ Nevertheless, the population of illegal drug users was relatively small, estimated to be around 1,101 persons in 1955, most of whom were living in the Vancouver area.⁷ At that time, long prison sentences for drug possession offences – and a high rate of recidivism – was the most common outcome of Canada’s punitive drug laws.⁸ After criminalizing drugs, Canada, unlike other Western nations such as Britain, prescribing for addiction purposes to “known addicts” was criminalized. The federal government also failed to set up any

² Neil Boyd, “The Origins of Canadian Narcotics Legislation: The Process of Criminalization in Historical Context,” *Dalhousie Law Journal* 8, 1 (1984): 102–36; Canada, Report by W.L. Mackenzie King, “*On the need for the suppression of the opium traffic in Canada*,” no. 36, Ottawa: King’s Printer, 1908; Melvyn Green, “A History of Canadian Narcotics Control: The Formative Years,” in *The Social Dimensions of Law*, ed. Neil Boyd, 24–40 (Scarborough: Prentice-Hall, 1986).

³ Boyd, “Origins”; Susan Boyd, *Busted: An Illustrated History of Drug Prohibition in Canada* (Winnipeg: Fernwood, 2017); Price, “Orienting the Empire”; Ward, *White Canada Forever*.

⁴ P.J. Giffen, Shirley Endicott, and Sylvia Lambert, *Panic and Indifference: The Politics of Canada’s Drug Laws* (Ottawa: Canadian Centre on Substance Abuse, 1991).

⁵ Emily Murphy, *The Black Candle* (Toronto: Thomas Allen, 1973 [1920]).

⁶ Boyd, *Busted*; Canada, Parliament, Senate Special Committee on the Traffic in Narcotic Drugs in Canada, *Proceedings* (Ottawa: Queen’s Printer, 1955).

⁷ Canada, *Proceedings*, 663, 667.

⁸ *Ibid.*, 329–31.

publicly funded drug treatment centres. The Narcotic Division and law enforcement controlled drug policy. In Canada, people who consumed illegal drugs were framed as criminals, and drug prohibition was framed primarily as a criminal justice matter. As a result, draconian laws and prison time were advanced as primary solutions to curtailing the illegal drug trade and keeping people away from newly criminalized drugs. The Narcotic Division advocated for abstinence from illegal drugs; however, they warned that even if an “addict” achieved abstinence, they would remain a menace to society due to their criminal nature.⁹

From 1933 until his death in 1957, Ernest Edward Winch, Co-operative Commonwealth Federation (CCF) member of Parliament in British Columbia, emerged as one of the strongest opponents of Canada’s drug laws and of framing people who used illegal drugs as “criminal.” Winch championed the setting up of legal “narcotic maintenance treatment” for people dependent on opioids and advocated for an end to imprisonment for drug possession. In 1955, he spoke in Vancouver before the Senate Special Committee on the Traffic in Narcotic Drugs. He eloquently argued that Canada’s drug laws primarily punished the poor and the working class and, in contrast to the prevailing view, that most people dependent on illegal “narcotics” had been law-abiding prior to their dependency.¹⁰ In 1952, the Community Chest and Council of Greater Vancouver’s Special Committee on Narcotics held its first meeting, and later recommended the immediate establishment of publicly funded narcotic clinics (drug maintenance clinics) and moving away from a criminal justice approach towards a health perspective.¹¹ Unfortunately, Winch and the Community Chest’s recommendations were ignored by the federal government, narcotic clinics were not set up, and no publicly funded drug treatment centre of any type were created. Rather than repealing punitive drug laws, the Senate recommended increasing penalties for drug trafficking.¹²

However, the province of British Columbia had a different response from that of the federal government, funding the Narcotic Addiction Foundation of British Columbia (NAFCB) in 1955 (Winch was a member of the NAFCB board of directors). The foundation’s Vancouver community clinic opened in 1958. The clinic included outpatient services and

⁹ Giffen, *Panic*, 381.

¹⁰ *Ibid.*

¹¹ George Stevenson, Lewis Lingley, George Trasov, and Hugh Stansfield, “Drug Addiction in British Columbia: A Research Survey,” unpublished manuscript, University of British Columbia, 1956.

¹² *Ibid.*; Canada, *Proceedings*, 955.

a four-bed residency exclusively for men choosing voluntary withdrawal from narcotics. By 1959, the Vancouver clinic introduced a methadone withdrawal program, marking the first time that methadone was used for drug treatment in Canada. In 1963, the clinic began to prescribe methadone for prolonged treatment rather than solely for withdrawal purposes.¹³ Thus, Canada's first drug substitution program was established in Vancouver, followed in 1970 in Ontario by the Addiction Foundation of Ontario's establishment of a formal methadone treatment program at its Toronto unit.

Unfortunately, the federal government did not view these innovative provincial initiatives as a rebuke to its criminal justice approach; rather, it hunkered down and, in 1961, enacted the *Narcotic Control Act*. This act is distinguished as being one of the most punitive drug laws enacted by a Western nation at that time. It included up to life imprisonment for drug trafficking and seven years' imprisonment for drug possession. The silver lining within this punitive act was a provision that allowed doctors to prescribe methadone to people dependent on narcotics. Nevertheless, the demonization of illicit drug users continued, and punitive laws, prison time, and abstinence from criminalized drugs remained the primary goals of drug policy in Canada.

However, in the 1970s, alongside punitive controls, publicly funded treatment services grew following the recommendations of the Canadian Commission of Inquiry into the Non-Medical Use of Drugs.¹⁴ The commission also recommended the authorized use of methadone maintenance therapy (MMT); however, it also pointed out the limitations of MMT. In its *Treatment and Final Reports*, the commission stated: "On balance, however, we believe that the availability of heroin maintenance will increase the capacity of the overall treatment process to win patients from the illicit market and for this reason it is a justified experiment."¹⁵ Thus, the commission recommended that heroin maintenance should be made available as a treatment option for those who did not respond to MMT.¹⁶ Unfortunately, this recommendation regarding heroin maintenance was not implemented as the federal government and the

¹³ Narcotic Addiction Foundation of British Columbia, *A Short History of Narcotic Dependence and Treatment in British Columbia* (Vancouver: Narcotic Addiction Foundation of British Columbia, 1967); H.R. Williams, *Treatment and Rehabilitation of Drug Users* (Vancouver: Narcotic Addiction Foundation of British Columbia, 1966).

¹⁴ Canada, *Final Report of the Canadian Commission of Inquiry into the Non-Medical Use of Drugs* (Ottawa: Information Canada, 1973). <http://publications.gc.ca/site/eng/9.699765/publication.html>.

¹⁵ *Ibid.*, 169.

¹⁶ *Ibid.*, 170.

Canadian Medical Association remained opposed.¹⁷ In 1974, the BC NDP government examined establishing heroin drug maintenance programs and also supported more diverse drug treatment services in the province. However, when the conservative Social Credit Party won the 1975 provincial election such plans were abandoned.¹⁸

Right into the 1990s abstinence remained the primary drug treatment goal for drug dependency in Canada. However, if a person was not able to maintain abstinence from opioids, and if abstinence-based treatment options failed her repeatedly, she could be considered for methadone maintenance treatment – if it was available in her region. Unlike other Western nations, where legally prescribed heroin, morphine, and methadone were drug treatment options, in Canada substitution drugs other than methadone were demonized regardless of their effectiveness.¹⁹ To be clear, abstinence-based treatment and MMT worked for some people, but not all. The Canadian Commission of Inquiry into the Non-Medical Use of Drugs highlights this fact in its *Treatment and Final Reports*.²⁰ However, prior to the 1990s, no other options were available to people who used illegal drugs. This was to have terrible consequences. By the 1990s, Canada's punitive drug policies, a poisoned illegal drug supply, and lack of effective substitution treatments and harm reduction services led to a public health emergency in Vancouver.

In the 1990s, the authors of this *BC Studies* article, alongside other activists in Vancouver, witnessed and fought to end an epidemic of preventable illicit overdose deaths and rising HIV and hepatitis C rates in the DTES. At that time, after much struggle, harm reduction services and an end to drug prohibition emerged as solutions to what was a preventable crisis. Inside and outside Canada, harm reduction services were originally advanced by drug user groups.²¹ Due to the failure of all levels of government to address the growing public health crisis, a number of activist groups emerged to provide alternative services and spaces in the DTES for people who used criminalized drugs. Thus, a social movement for harm reduction and social justice emerged as activists and organizations struggled to address the crisis. What made the resistance in the 1990s different from earlier resistance to Canada's punitive drug policy

¹⁷ Ibid., 169.

¹⁸ Ian Waddell, *Take the Torch: A Political Memoir* (Gibson, BC: Nightwood Editions, 2018), 45.

¹⁹ Canada, *Proceedings*, 73.

²⁰ Canada, *Final Report*.

²¹ Practical, non-moralistic harm reduction services aim to lessen harms stemming from drug use, including those stemming from drug prohibitionist policies. Needle distribution, substitution programs, and supervised injection sites are examples of some harm reduction initiatives.

approach was that those people most affected by drug prohibition – people with lived experience of it – were integral to it.

In 1991, on the cusp of the public health crisis in the DTES – with rising numbers of overdose deaths, HIV, and hepatitis C – women came together to form the Drug and Alcohol Meeting Support for Women (DAMS), the first women-centred harm reduction program for pregnant women, mothers, and their children. Although DAMS met in a number of places, including Christ Church Cathedral, it eventually settled into Blood Alley in the DTES. This groundbreaking group emerged to address the unmet needs of women and children.²² Women who use criminalized drugs have long been vilified as more deviant than men who use similar drugs. However, prior to the 1990s, moral condemnation of women did not lead to more services; rather, women’s experiences remained largely invisible and unaddressed. Since the 1980s, a growing body of feminist research has revealed how punitive drug prohibitionist laws and policies influence, shape, and intersect with criminal justice, health, child welfare, and child protection polices as well as fuel discrimination and stigmatization of women who are suspected of using drugs.²³ Inspired by Dr. Mary Hepburn’s unique and pragmatic Women’s Reproductive Health Services set up in the mid-1980s in Glasgow, Scotland, and in recognition of the needs of women, women-only harm reduction services were established inside and outside the DTES, including DAMS in 1991, Sheway in 1993, and the first women-centred harm reduction maternity program, Fir Square Combined Maternity Care Unit, in BC Women’s Hospital in 2003.

Feminist drug studies also point to how the regulation of women, especially poor and racialized women, intersects with the regulation of sexuality, reproduction, mothering, and drug consumption.²⁴ Gender, race, class, and sexuality intersect with all aspects of drug policy and practice.²⁵ To counter the harms stemming from drug prohibitionist policies, DAMS came together to support women members and to advocate for the adoption of harm reduction practices, especially in relation

²² In the 1990s, DAMS was facilitated by Margaret Michaud, Olive Phillips, and Susan Boyd.

²³ Susan Boyd, *Mothers and Illicit Drugs: Transcending the Myths* (Toronto: University of Toronto Press, 1999); Susan Boyd, *From Witches to Crack Moms: Women, Drug Policy, and Law*, 2nd ed. (Durham, NC: Carolina Academic Press, 2015); Nancy Campbell, *Using Women: Gender, Drug Policy, and Social Justice* (New York: Routledge, 2000); Nancy Campbell and David Herzberg, “Gender and Critical Drug Studies: An Introduction and an Invitation,” *Contemporary Drug Problems* 44, 4 (2017): 251–64.

²⁴ Boyd, *Mothers and Illicit Drugs*, 2015; Campbell and Herzberg, “Gender and Critical Drug Studies.”

²⁵ Campbell and Herzberg, “Gender and Critical Drug Studies,” 251.

to pregnancy and mothering. Rather than focus on abstinence, family stability and reunification were the primary goals of DAMS in response to child protection practices and the apprehension of their children by the state. Yet, in the 1990s (similar to today), pregnant women and mothers who used illegal drugs were intent on keeping a low profile because child apprehension was a constant – and often realized – threat in their lives, especially for Indigenous women, who made up the majority of DAMS members and who were especially vulnerable to systemic gendered colonial and drug policy violence.²⁶

There is a direct relationship between discriminatory policies and stigmatization for both women *and* men who use illicit drugs. Discriminatory drug laws and policies (e.g., child protection, housing, drug treatment) “activate stigma” against people who use criminalized drugs and produce social inequality.²⁷ Therefore, the experiences and outcomes of drug use are shaped by one’s social status and environment. Consequently, Indigenous people, poor people, and people of colour bear the brunt of drug prohibitionist policies.

As the 1990s progressed and illicit overdose deaths, HIV/AIDS, and hepatitis C rates continued to rise, activists in the DTES persisted, linking the crisis to drug prohibitionist policies. In the 1990s, they called for more harm reduction services, including expanded needle distribution, heroin-assisted treatment, and the opening of an official supervised injection site. They looked to other nations (such as the UK and the Netherlands) that had established these life-saving services. The Portland Hotel Society (PHS) was a critical organization in responding to the crisis in the DTES and was instrumental in organizing pivotal public events to bring attention to the preventable deaths and raise awareness of the crisis. The Killing Fields event in 1997, memorialized in Bud Osborn’s poem below, was one of many public events PHS helped organize in the DTES in the 1990s. It and others sought to bring attention to the harms of drug prohibition and to honour the lives, memories, and deaths of people living in the DTES.²⁸

In response to government inaction in the 1990s, people who used drugs and their supporters set up their own unofficial supervised injection sites, including the Back Alley on Powell Street in 1996. In 1997, people came

²⁶ In the early 1990s, families and friends began to protest because Indigenous women and sex workers who went missing in the DTES were later found murdered.

²⁷ See Imogen Tyler and Tom Slater, “Rethinking the Sociology of Stigma,” *Sociological Review Monographs* 66, 4 (2018): 732 (discussion on stigma).

²⁸ Susan Boyd, Donald MacPherson, and Bud Osborn, *Raise Shit! Social Action Saving Lives* (Halifax: Fernwood, 2009).

together in Oppenheimer Park and the Four Square Street Church to identify issues in the DTES; these meetings culminated in the establishment of the Vancouver Area Network of Drug Users (VANDU) in 1998 – the first drug user union in Canada. VANDU was co-founded by Bud Osborn, poet and social justice activist, and Ann Livingston, a long-time activist for the rights of people who use criminalized drugs. VANDU advocated for the human rights of its members; provided support, harm reduction supplies, and education; and lobbied for safer injection sites and an end to drug prohibition. VANDU continues to act as a unique peer-led union that has gained international recognition for its activism and services, and it remains a vital organization in the DTES and beyond.²⁹

Thanks to the efforts of activists, the Vancouver-Richmond Health Board finally declared a public health emergency in 1997. Yet the promised federally sanctioned supervised injection site did not open its doors in the DTES until 2003, and although harm reduction services did ultimately expand, abstinence-based programs remained central and punitive drug laws continued (and continue) to produce harm. In a circular way, the growing need for harm reduction services is directly linked to prohibitionist policies. Globally, punitive drug prohibitionist laws and policies are now being understood as producing harm, including overdose deaths, HIV/AIDS and hepatitis epidemics, human rights violations, stigmatization, drug-trade violence, increased incarceration, child apprehension, and barriers to effective health and harm reduction services.

Drug prohibitionist policies create a lethal environment. Without access to safe legal drugs, people who use criminalized drugs buy on the illegal market. In the illegal market, drug quality and quantity are always in question. Those who witnessed the 1990s never thought another crisis could happen. Yet, due to the fact that drug prohibition continues and harm reduction services – including flexible drug substitution programs and overdose prevention sites – were never fully set up, by 2010 illicit drug overdoses again began to increase. Illicit drug overdose death is the outcome of a poisoned illegal drug supply and a lack of legal access to a safe drug supply. In April 2016, as illicit overdose deaths continued to increase, the province of British Columbia declared a public health emergency. This time around, the drug fentanyl and its analogues are contributing to a poisoned illegal drug supply.

²⁹ Ibid.; Vancouver Area Network of Drug Users (VANDU), *History*, 2018), <https://vandureplace.wordpress.com>.

The drug overdose crisis has affected all of Canada; however, it is being felt most acutely in British Columbia, with the DTES being hit especially hard.³⁰ Vancouver remains the epicentre of the current crisis as more people have died here than in any other city – and the overdose rate is the highest in the province. In British Columbia alone, there were 1,452 deaths in 2017.³¹ Across Canada, in the same year, just under four thousand people in total died from a preventable illegal drug overdose death. It is predicted that the 2017 number of preventable deaths will be surpassed in 2018.³² Although people from diverse class and ethnic backgrounds have died from illegal overdoses in British Columbia, as with drug arrests, it is poor and marginalized people who are the most vulnerable, with Indigenous people especially overrepresented. Preliminary findings estimate that Indigenous people account for about 10 percent of all fatal overdose deaths in British Columbia. Indigenous people in British Columbia are also three times more likely to die from an illegal overdose than are non-Indigenous people. Indigenous women are five times more likely to die from an illegal overdose than are non-Indigenous women.³³

In defiance of federal law, in order to save lives, VANDU set up an unsanctioned overdose prevention room in 2012. In 2016, activists in the DTES set up two more unsanctioned overdose prevention sites (informal supervised injection and smoking sites). Rather than wait for federal approval, in December 2017 the BC government allocated funding to organizations to set up “authorized” overdose prevention sites within their existing services. These innovative services are one response to the harms produced by drug prohibition.

Since VANDU opened its doors in 1998, more than fifteen other drug user unions have emerged across Canada, including a national union. These peer-led groups are at the forefront not only of saving lives but also of advancing the human rights of their members and addressing their concerns. To be clear, harm reduction is not a panacea, and harm reduction services are not necessarily liberatory. However, for grassroots groups such

³⁰ Statistics Canada, “Drug Overdose Crisis: Socioeconomic Characteristics of Those Dying of Illicit Drug Overdoses in British Columbia, 2011 to 2016,” *Daily*, 13 November 2018, <https://www150.statcan.gc.ca/n1/daily-quotidien/181113/dq181113a-eng.htm>.

³¹ British Columbia Coroners Service, *Illicit Drug Overdose Deaths in BC January 1, 2008 – August 31, 2018*, <https://www2.gov.bc.ca/assets/gov/birth-adoption-death-marriage-and-divorce/deaths/coroners-service/statistical/illicit-drug.pdf>.

³² *Ibid.*

³³ First Nations Health Authority, “Overdose Data and First Nations in BC: Preliminary Findings,” 2017, http://www.fnha.ca/newsContent/Documents/FNHA_OverdoseData-AndFirstNationsInBC_PreliminaryFindings_FinalWeb.pdf.

as drug user unions, harm reduction services are “on the ground responses” to the changing needs of their members, who experience ongoing structural violence stemming from drug prohibition, colonialism, and economic and social policies that shape their everyday lives.

In the late 1990s, activists brought attention to the overdose crisis in the DTES, and, in defiance of federal law, set up alternative services and demanded change. Similarly, activists inside and outside the DTES are once again responding – and bringing our attention – to the illicit drug overdose crisis in British Columbia by setting up alternative services, such as overdose prevention sites, and demanding that drug prohibition end now. Activists argue that, in order to save lives, legal access to safe drugs must be a component of policy and services. The current crisis stems from the failure of federal, provincial, and municipal governments to fully adopt and fund diverse culturally and gender-appropriate harm reduction services. An end to drug prohibition is essential so that people who use drugs are no longer discriminated against and are no longer vulnerable to a poisoned drug supply.

Just as in the illegal drug overdose crisis today, so in the 1990s people were dying from drug overdose.³⁴ Also in this issue is an excerpt from a book highlighting the overdose epidemic in the DTES in the 1990s and the social justice movement that emerged. Due to our failure to end punitive drug prohibitionist policies then, unfortunately, that material continues to be relevant today.



National Day of Action, 2017. Photo by Canadian Drug Policy Coalition.

³⁴ To be clear, people die every year from illegal drug overdose; however, in the 1990s and in 2016, increases in overdose deaths have led to the declaration of a public health emergency.