Drug addicts do not benefit from 'harm reduction,' but from rehabilitation and treatment

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On Aug 25 the BC government announced there has been a shocking rise in street drug deaths this year, 175 in the last month and, to date in 2020, more than 900 people, a 136 percent increase from July, 2019. Illicit drug-related death number "surpass deaths due to homicides, motor vehicle incidents, suicides and COVID-19 combined," according to chief coroner Lisa Lapointe. The chief culprit is toxicity in the drug supply, mainly lethal doses of fentanyl.

Worldwide, the toll taken by opioids and illicit drugs is astronomical. Drug use is directly or indirectly responsible for 11.8 million annual deaths. Over 350,000 people die from overdoses every year. More than half of them are under 50.

What is to be done? There is no magic bullet. Everyone agrees that alcohol and drug addiction are problems we are stuck with, and that mitigation of damage to individuals and society must be the goal, not complete elimination. Years ago, a consensus emerged in Canada around the principle of "harm reduction" as the only worthwhile approach in holding the line on drug-related deaths, a reversal of Canada's 2007 National Anti-Drug Society that had given equal weight to each of four policy pillars: prevention, treatment, law enforcement and harm reduction.

Harm reduction is the darling of progressive stakeholders in addiction management. Its most robust defenders tend to be ideologues, whose ultimate goal is the legalization of all drugs, beginning with marijuana, which has now been accomplished in Canada and some US states. Their social laboratory has been the municipal quagmire of Vancouver's Downtown Eastside (DTES), where the mentally ill, the culturally uprooted and the psychologically dysfunctional congregate, denizens huddled within a desolate matrix of cheap hotels, bars, brothels and—more recently—homeless camp

Once ensconced, they settle into a cycle of illicit-drug torpor and crime.

Here, Insite on East Hastings Street—opened in 2003 as the first safe injection site (SIS) in North America, where addicts can legally inject drugs under professional supervision—serves the DTES's population of about 18,000 sad souls.

Nobody who uses the site is morally judged, of course, because harm reduction is premised on the belief that addiction is an incurable illness akin to diabetes. Detox facilities are available, if requested, but no serious treatment is envisaged for this clientele, as treatment programs are premised on the belief that addicts have agency, and that addiction is surmountable. Whether a user is 66 and beyond hope of change, or 26 and highly eligible for successful rehabilitation in programs with a high success rate, even with enforced participation, all are received with compassion and scrupulous non-judgmentalism.

Advocates for SISs claim they bring down overdose death numbers, reduce rates of infection, encourage addicts to use social services and quell disorder in the streets. But in 2007 I interviewed other stakeholders in the addiction cycle and heard a different story. Dr. Stan de Vlaming, formerly head of addiction services at Vancouver's St. Paul's hospital, the main provider of services to DTES residents, told me, "The people who refer to Insite as a 'safe injection site' are perpetuating a dangerous misunderstanding. There is nothing safe about repeated daily injections that bypass a person's normal defence systems."

Al Arsenault, a retired police officer I interviewed, who had patrolled the "chemical gulag" of the DTES for more than half of his 27-year career, called Insite – and the needle-exchange program in particular—an "abject and utter failure." If injectors were responsible enough to return needles, he observed, they wouldn't be in the DTES. Ironically, the program augmented the presence of used needles in the area.

But that was back in 2007, and perhaps it was a little unfair to pass judgment on Insite after such a short time in official practice. How, after 17 years, and with social spending of about a million dollars a day, is the DTES faring well?

Christopher F. Rufo, documentary filmmaker, research fellow at the Discovery Institute's Center on Wealth and Poverty, and contributing editor to City Journal magazine, decided to find out. The result is a feature article in the spring, 2020 issue of City Journal, titled "The Harm in 'Harm Reduction'."

It's not doing so well, in fact, as the article's title implies. Rufo says the concentration of services in the DTES "has created a veritable death trap for addicts around British Columbia." The coronavirus only exacerbates an already grim situation. In retrospect, policymakers may come to question the wisdom of concentrating immunocompromised populations in dense clusters, "where they can become vectors for a catastrophic outbreak."

COVID-19 has only made a bad situation worse. It was already clear before the pandemic struck that Vancouver had failed to reduce rates of addiction, homelessness and criminality in those ten city blocks. The DTES is a veritable hub for escalating overdose deaths in the province, up 151 percent since 2008.

Simon Fraser University professor Julian Somers did a ten-year longitudinal study of outcomes in 433 addicts enrolled in Vancouver at Home, a program that offers addicts free housing and a range of services. He found that "despite the

high concentration of services and supports in the [Downtown Eastside], members of the current sample experienced significant personal decline rather than recovery, as evidenced by their involvements with criminal justice, large increases in acute care and prolonged homelessness."

Over the ten-year period, "participants' use of community medical services and hospital services each tripled, while criminal convictions and welfare receipt doubled." His study also notes that from 2005-2015, the number of homeless addicts who migrated to the DTES, incentivized by the services offered, rose from 17 percent to 52 percent of the overall population.

SIS advocates often boast of their perfect track record in the prevention of overdose deaths on their premises—indeed, that is the core claim and the one most often adduced to convince skeptics of its necessity—but that boast has always rung hollow for those close to the action.

Of course nobody dies under supervision, because there are trained staff to intervene with antidotes at the moment it is needed. Some of the people I interviewed in 2007 told me that it was quite common for Insite "clients" to consume higher doses than they would have in the streets, because they knew there was no risk attached while under supervision. In a video made by an amateur documentarian, secretly recorded conversations with Insite staff reveal that while nobody literally dies inside Insite, because they are instantly revived from their overdoses, unless they go to the hospital (which "75-90 percent" refuse to do), they may be dying in the street or in their lodging. So it is only in a technical sense that Insite can boast of zero fatalities. Outside Insite, Rufo notes, more than 1500 overdoses a year have taken place within a block of the facility.

While Insite, with its 12-seat injection room, recorded 189,837 safe visits in 2019, averaging 700 to 800 visits a day, that only represents about four percent of the total number of daily injections in the area. That doesn't seem like a very good return on a $3 million dollar annual budget and, according to a 2017 op ed in the National Post, the "more than 170 nonprofits clustered in an area of only a few blocks, all devoted towards supporting an increasingly dense community of addicts." The same op ed graphs the huge increases in population and crime since Insite opened.

The true believers in this realm are so politicized that heavy skepticism is recommended regarding the many "studies" that exude positivity on SISs. As Rufo observes, a single activist-researcher, Thomas Kerr, who had lobbied for the original funding for Insite co-authored all 33 studies of the facility from 2003-2009, a fact turned up and blogged by journalist Mark Hasiuk in 2013.

Some of these studies were produced in collaboration with the Vancouver Area Network of Drug Users, an activist group demanding that researchers agree to their rules. One of them states that any researchers working with them must become "allies" of their movement and present evidence of "how the research will contribute to the empowerment and liberation of people who use drugs." As Rufo drily and correctly observes, "This is the language of radicalism, not science."

For a more objective assessment, Rufo pivots to a RAND survey, which states that "nearly 80 percent of the literature on safe-injection sites is made up of studies from just two facilities: Insite in Vancouver and the Medically Supervised Injection Centre, in Sydney, Australia." The RAND report concludes that the studies are "neither rigorous nor definitive," and often ignore the potential for community-level harm and second-order effects. "We conducted out own assessment of the individual studies," the authors state, "and found that the evidence base concerning the overall effects of SCSs [supervised consumption sites] is limited in quality and location."

A vast gulf separates the activists behind the fatalistic SIS movement, whose goal is safe addiction maintenance in perpetuity, and those who push treatment, with recovery as the goal. Successfully recovered addicts are harm reduction's harshest critics.

Serge LeClerc, a former Saskatchewan MLA, who died in 2011, was a drug dealer who reversed a lifetime of drug-related dysfunction and crime following an inspirational encounter with a prison Samaritan. LeClerc earned two university degrees behind bars and became a passionate crusader for preventive drug education in schools. Of harm reduction, LeClerc said, "The disease model negates choice, but there is no one who is beyond redemption."

On a personal note, I would add in this regard, that in my privileged circle of friends, drug addiction is almost unheard of, but in the very few cases I recall, where teenagers got into drug-abuse trouble, the default attitude of their educated parents was extremely pro-active. No harm reduction for them, thank you; they sought out treatment at once, with no sparing of expense. Which puts me in mind of something else that retired police officer I mentioned above, Al Arsenault, told me: "The rich get treatment, the poor get harm reduction."

Portage Rehabilitation programs prove that robust intervention, especially in the early stages of addiction, works. Their

head researcher told me in 2007 that at their centre in Elora, Ontario, in follow-up surveys six months after discharge from their program, they found a nearly 86 percent decrease in drug use amongst adolescents and a 92 percent decrease for young adults.

If Insite had a practice of steering people under the age of, say, 35, into a treatment program, how many lives—the addicts' lives of course, but also their families and other members of their communities—would be enhanced when these addicts became "former" addicts, and lived out their days as value added, rather than burdens, to loved ones and society? Hundreds? Thousands? Harm reduction has proved inadequate as a strategy. It's time to shift our focus, and public funding, toward prevention and treatment.