

When a vein bulged below his elbow crease, I instructed him to insert the needle. He did, and as he pulled on the plunger blood surged back into the syringe. The nurse removed the rubber hose and our patient injected himself with whatever concoction he had prepared. We made him a gift of the tourniquet.

I had never imagined that my medical career would lead me to assist an addict's self-administration of an illicit psychoactive substance in a musty Downtown Eastside hotel. Even on the way up to his room I was not expecting to do anything of the sort; my intention was to discuss his HIV treatment. Under the circumstances, however, it was the best I could do for him. Without that help, Claude would have persisted in his attempts to inject a neck vein, a procedure with a high risk ratio. I had no realistic hope of dissuading him from self-injection, let alone of "curing" his long-established drug habit. The immediate goal was to reduce potential harm and, beyond that, to establish a relationship with Claude in which he could feel open and trusting enough to receive medical support and advice.

Such was my rapid immersion in harm reduction.

Claude died over two years ago from complications of HIV. He had been one of the Portland's longtime residents, one whose highly original personality and sense of humor make him stand out among the ranks of the departed. He was not a "difficult patient" after all—only someone who liked to do things his way and did not readily trust authority. He was an accomplished artist. A small, finely crafted aluminum-wire bicycle, a memento of his dexterity and creative skill, stands on the windowsill of my kitchen to this day, a gift from Claude. During his last four years, even though his medical treatment was compromised by his addiction, we did much to extend his life, to prevent symptoms, and, in the end, to ease his physical and emotional distress.

What is harm reduction?

CHAPTER 28

Reducing Harm

Whatever the arguments in its favor, a rational, evidence-based, and integrated drug policy is unlikely to emerge in the near future. With no enlightened social consensus on the horizon, we are left with the question—still an important one—of how to limit the harm suffered by the addict. In this chapter we'll explore the hotly debated and much-misunderstood issue of harm reduction.

Nearly eight years ago, on my very first day as the Portland doctor, I was guided up to the top floor of the old hotel to meet a resident described as a "difficult patient." As the nurse and I entered his room, Claude, a man from Quebec in his late thirties, was kneeling on the floor, peering down into a mirror that lay horizontally on his bed. Grimacing, head tilted to one side, his prematurely graying hair falling over his temples, Claude pulled on the skin and muscles of his neck with his left hand while he attempted to inject a vein with some cloudy fluid from the syringe he held in his right. I watched as he poked himself in the neck once or twice without finding a blood vessel. "*Tabernac*," came the well-known Quebecois curse.

"You're asking for a brain abscess if you keep that up," I said, becoming alarmed at this inept display. "Let's see if we can't find you a safer spot to inject." Wrapping a rubber tourniquet from the nurse's bag around Claude's left arm, I asked him to pump his hand a few times.

Harm reduction is often perceived as being inimical to the ultimate purpose of "curing" addiction—that is, of helping addicts transcend their habits and heal. People regard it as coddling addicts, as enabling them to continue their destructive ways. It's also considered to be the opposite of abstinence, which many regard as the only legitimate goal of addiction treatment. Such a distinction is artificial. The issue in medical practice is always how best to help a patient. If a cure is possible *and* probable without doing greater harm, then cure is the objective. When it isn't—and in most chronic medical conditions cure is not the expected outcome—the physician's role is to help the patient with the symptoms and to reduce the harm done by the disease process. In rheumatoid arthritis, for example, one aims to prevent joint inflammation and bone destruction and, in all events, to reduce pain. In incurable cancers we aim to prolong life, if that can be achieved without a loss of life quality, and also to control symptoms. In other words, harm reduction means making the lives of afflicted human beings more bearable, more worth living. That is also the goal of harm reduction in the context of addiction.

Although hard-core drug addiction is much more than a disease, the harm-reduction model is essential to its treatment. Given our lack of a systematic, evidence-based approach to addiction, in many cases it's futile to dream of a cure. So long as society ostracizes the addict and the legal system does everything it can to heighten the drug problem, the welfare and medical systems can aim only to mitigate some of its effects. Sad to say, in our context harm reduction means reducing not only the harm caused by the disease of addiction, but also the harm caused by the social assault on drug addicts.

We will look shortly at some harm-reduction measures. First, however, we'll dispense with two prevalent arguments against harm reduction: that it squanders resources on undeserving people who are the authors of their own misfortune and that it justifies and enables addiction.

If our guiding principle is that a person who makes his own bed ought to lie in it, we should immediately dislodge much of our health care system. Many diseases and conditions arise from self-chosen habits or circumstances and could be prevented by more astute decisions. According to a recent study by British Columbia's health officer, the provincial government spends \$1.8 billion dollars on diseases caused by unhealthy lifestyles.¹ The average per capita health care cost for those with no risk factors is "\$1,003 compared with \$2,086 per capita for those with three risk factors, including smoking, being overweight/obese and physically inactive."² All of these factors, we might say, represent "choices," and even after a heart attack, for instance, some patients will continue to bring these risks upon themselves. The same is true of people with chronic bronchitis who persist in smoking, skiers who brave moguls and steep slopes despite having sustained fractures, and people who remain in a stressful marriage despite requiring treatment for depression or anxiety. No cardiologist, respiratory specialist, orthopedic surgeon, or psychiatrist would refuse treatment on the ground that the problem was self-inflicted.

When it comes to drug addicts, some people believe we ought to apply different criteria. One afternoon in August 2006 I called a CBC radio program to discuss Insite, Vancouver's controversial supervised injection facility for drug users. Just before the moderator turned to me, he interviewed an officer of the Royal Canadian Mounted Police (RCMP). Dozens of addicts who have overdosed at Insite have been successfully resuscitated, the host pointed out. Lives have been saved that might otherwise have been lost. That's not necessarily a good thing, the Mountie



spokesman explained. "It's well known that negative consequences are the only major deterrent to drug use. If you are saving people's lives, you are sending the message that it's safe to use drugs." This officer, on behalf of Canada's national law enforcement agency, seemed willing to let people die in the hope of teaching a lesson. He seemed unaware, or not to care, that in the 1990s Vancouver's injection users had received an average of 147 such "lessons" every year in the form of overdose deaths, without any discernible deterrent effect.³

It would be encouraging to believe that such a dark perspective is confined to the minds of some police officers. Not quite so. At about this same time the *Globe and Mail* published an article on Insite that approvingly quoted Anthony Daniels, a retired British psychiatrist. "I suppose the argument for the safe injection site is it would reduce the number of deaths," he told *Globe* columnist Gary Mason. "But I don't see why we should reduce the number of deaths. It is not our responsibility to do so. It is the responsibility of the addicts themselves. If they want to inject themselves with heroin, it's a very bad choice. If people die from it, I don't feel any particular guilt because I don't feel any responsibility for it."⁴

It would have been instructive to know whether or not the psychiatrist and his faithful scribe at the *Globe* were willing to extend this principle to other groups, such as, say, smokers with lung cancer or emphysema, type A business executives who work themselves into a heart attack, battered women who remain loyal to an abusive partner, or people injured in automobile accidents in full knowledge of the risks of driving. According to this same logic, no smoker should be defibrillated and brought back to life after a heart attack, and no one who drinks alcohol should receive a blood transfusion in the wake of intestinal bleeding. Anyone worried about the possibility of a myocardial infarction or a stroke ought to wear a large badge identifying him as a nonsmoker, nondrinker, regular exerciser, and nonconsumer of trans-fatty acids. Absent such a marker, no bystander should even dial 911 on their behalf.

Although we are all responsible for our lives, no human or medical principle dictates that we refuse to help others whose own decisions have brought trouble upon their heads—unless we believe that in trying to help them, we are perpetrating greater harm. That would perhaps be the case if harm reduction could be shown to enable substance abuse. But as we have seen, hard-core drug users do not wait to be "enabled," and there are few harsh consequences they haven't yet experienced. There is no evidence from anywhere in the world that harm-reduction measures encourage drug use. Denying addicts humane assistance multiplies their miseries without bringing them one inch closer to recovery.

There is also no contradiction between harm reduction and abstinence. The two objectives are incompatible only if we imagine that we can set the agenda for someone else's life regardless of what he or she may choose. We cannot. Short of extreme coercion there is absolutely nothing anyone can do to induce another to give up addiction, except—as discussed in the previous chapter—to provide the island of relief where contemplation and self-respect can, perhaps, take root. Those ready to choose abstinence should receive every possible support—much more support than we currently provide. But what of those who don't choose that path?

The impossibility of changing other people is not restricted to addictions. Try as we might to motivate another person to be different or to do this or not to do that, our attempts founder on a basic human trait: the drive for autonomy. "And one may choose what is contrary to one's own interests and sometimes one *positively* ought," wrote Fyodor Dostoyevsky in *Notes from the Underground*. "What man wants is simply *independent* choice, whatever that independence may cost and wherever it may lead." The issue is not whether the addict would be better off without his habit—of course he would—but whether we are going to abandon him if he is unable to give it up. Are we willing to care for human beings who suffer because of their own persistent behaviors, mindful

that these behaviors stem from early life misfortunes they had no hand in creating?

The harm-reduction approach accepts that some people—many people—are too deeply enmeshed in substance dependence for any realistic “cure” under present circumstances. There is, for now, too much pain in their lives and too few internal and external resources available to them. In practicing harm reduction, we do not give up on abstinence—on the contrary, we may hope to encourage that possibility by helping people feel better, bringing them into therapeutic relationships with caregivers, offering them a sense of trust, removing judgment from our interactions with them, and giving them a sense of acceptance. At the same time, we do not hold out abstinence as the holy grail, and we do not make our valuation of addicts as worthwhile human beings dependent on their making choices that please us.

Harm reduction is as much an attitude and way of being as it is a set of policies and methods. Dr. Bruce Perry's words are worth recalling here: “We need to be very loving, very accepting, and very patient with people who have these problems. And if we are, they will have a much higher probability of getting better.”

Specific harm-reduction practices depend on resources and need. One such practice is the prescription of methadone. These days I write regular methadone scripts for over one hundred patients. The drug is a synthetic narcotic that occupies opiate receptors on brain cells, blocking the access of heroin molecules to the same binding site. When ingested orally, it does not cause a high in chronic narcotic users, but for many addicts it prevents heroin craving and also withdrawal symptoms such as nervousness, pain, diarrhea, and nausea.⁵ It's long-acting, so a once-daily dose will see most people through twenty-four hours.

It is estimated that there are sixty thousand to ninety thousand illicit opioid abusers in Canada, but only about a quarter are receiving treatment.⁶ U.S. treatment figures would be much lower given the near impossibility of obtaining this medication in many jurisdictions.

We offer methadone maintenance to addicts not to cure them of their narcotic dependence but to transfer that dependence to a narcotic that is legal, that is safe if ingested properly, and that prevents them from having to prostitute themselves, steal, and beg to avoid withdrawal. An addict chooses methadone when he tires of the endless daily scrounging for illicit narcotics and of the consequences of always having to dodge the law. None of my methadone patients would accept abstinence as an alternative to heroin use, and even with methadone the heroin craving remains irresistible for some.

There is no drug analogous to methadone to help with cocaine addiction. There have been some potentially encouraging trials with methylphenidate (Ritalin) and other stimulant preparations, and I have had some limited success in prescribing such medications to decrease people's reliance on cocaine and crystal meth. For a few patients, the difference has been dramatic. I would like to see long-acting stimulants investigated more vigorously, despite their own addiction potential. It would be preferable, if possible, to have people dependent on an oral stimulant in a controlled dose than on smoked or injected cocaine or crystal meth.

Needle exchange is another harm-reduction tactic: users bring in dirty syringes and needles and are given new ones. The spread of HIV and hepatitis C from one person to another occurs by way of body fluids, specifically blood or sexual secretions. Clean, unshared needles limit disease transmission, as does the use of condoms during intercourse. Clean needles also help prevent skin infections, abscesses, and the spread of bacteria via the bloodstream. Even this simple measure is opposed by those who believe, once more, that somehow it condones or encourages addiction.

As of this writing, the U.S. government refuses to support needle exchange programs on the grounds that it encourages addiction, as if the addict were just waiting for federally funded clean needles to embark upon and maintain his habit. Why this hidebound resistance to a simple harm-reduction and disease-prevention method? “People often talk

about American's Puritan origins as the reason for opposition to needle exchange," says Daniel Wolfe, the deputy director of the New York-based International Harm Reduction Development program at the Open Society Institute, "but it's actually evangelism that underlies most of the politics against needle exchange. To give someone a needle or methadone is seen as giving up on the idea that they can be 'saved,' and as a moral failure for both drug user and care provider. The moral reality of leaving drug users to die of HIV because you refuse to adjust this vision of redemption to reality, or the moral implications of turning our anti-harm-reduction ideology into a global crusade go unexamined.... The ban on federal funds for needle exchange in the United States—the only such restriction in the world—finds further reinforcement in the American hostility to central government assistance to people in need."⁷

Unless, one is tempted to add, the people in need—owing to their own poor choices—are shareholders of Freddie Mac or Fannie Mae.

Not all addicts will accept methadone as a substitute (just as for some others whose drug of choice is morphine, neither methadone nor heroin will do). In such cases we can leave the addict to fend for herself in the underworld jungle, or we can offer heroin or morphine unadulterated by who knows-what impurities, to be self-injected in a clean environment with uncontaminated needles. We are neither condoning nor encouraging addiction: the addiction exists and will continue to savage that person's life no matter what we believe. Our only choice is between compassion and indifference. By administering heroin in a controlled fashion, we are attempting to minimize harm for the addict, with the social benefit of reducing crime, squalor, and medical expenses.

The North American Opiate Medication Initiative (NAOMI) is a trial of controlled heroin administration in several cities, including Vancouver, where the project operates out of a corner storefront one block

away from the Portland Hotel. A spokesperson in the office of John Walters, then director of the White House Office of National Drug Control Policy, called it "an inhumane medical experiment."⁸

There is another way to see it: the NAOMI trial is evaluating a method to lessen society's inhumanity toward drug addicts. The study's chief value may be to convince skeptics, since from the medical and social perspectives evidence is hardly required: we have decades of experience in Europe to draw on. In the United Kingdom opiate maintenance programs were administered from the 1920s to the 1970s but fell into disfavor under heavy U.S. opposition. Since then, despite the War on Drugs—or perhaps, in part, owing to it—the number of British opiate addicts has soared exponentially.⁹

One exception to the abandonment of heroin maintenance in the United Kingdom has been the Drug Dependency Service in the Merseyside area. All addicts registering with the program are offered treatment, including inpatient detoxification. Only about 10 percent elect approaches leading to abstinence; the rest are prescribed narcotics in various forms, from the injectable to the inhaled. Among the results has been the second-lowest rate of HIV-positive drug users in all English regions, less than a quarter of the national average, as well as a reduction in criminal activity. "In 1991, the Merseyside police were the only force in the U.K. to register a decrease in crime rates."¹⁰

In the 1990s Switzerland, facing Europe's highest HIV infection rate from injection drug use, initiated a trial of either heroin maintenance or methadone treatment supplemented with heroin. The findings were the following:

- Fitness for work improved considerably: permanent employment more than doubled.
- The patients' housing situations rapidly improved and stabilized (in particular, there was no homelessness).
- There was no fatal overdose due to prescribed substances.
- There were no notable disturbances in local neighborhoods.

- There were significant economic benefits in terms of savings per patient-day, owing to marked reductions in legal and health costs.
- Among participants there was a marked decrease in crime of all kinds, from shoplifting to drug dealing—in the case of hard drugs, from 46.9 percent to 8.2 percent.
- Overall, offenses dropped by 68 percent. According to the Central Criminal Register, the number of convictions dropped by 80 percent among addicts enrolled in the program.¹¹

The Swiss achieved these effects, write two North American academic researchers, “through a careful evaluation of prescribed heroin for over 1,000 of the country’s most refractory, long-term heroin addicts—*targeting the most difficult of individuals who have had long-term difficulties with substance misuse and repeated failures with traditional abstinence based approaches to treatment*. The Swiss studies showed unequivocally that prescribing heroin produces substantial declines both in illicit drug use and in criminal activity for this most problematic group. In addition, they provided clear evidence of improved social reintegration, i.e., better housing, more gainful employment, fewer drug associates, and more contact with previously estranged families and friends.”¹²

The current NAOMI project’s largest flaw is that the study’s limitations curtail the time an addict can take part in it. Jenny, a twenty-nine-year-old Portland Hotel resident and sex-trade worker, was in my office a few weeks ago, asking to be reinstated on methadone. For a year she had been receiving heroin at the NAOMI site. Her health had improved, and contrary to previous times, during this period I had not had to treat her for infectious diseases. Now she presented with a red, swollen right leg and an abscess in her groin, where she had self-injected street heroin. The problem? Her scheduled participation at NAOMI had come to an end. Owing largely to U.S. opposition, heroin maintenance is unavailable in Canada outside this research project. “I would bet any amount of money the U.S. has exerted extreme pressure on Canada to abort this trial,” Dr. Alex

Wodak, a prominent Australian addiction physician, said when NAOMI was just beginning.¹³ Dr. Wodak, director of the Alcohol and Drug Service at St. Vincent’s Hospital in Sydney, was in a position to know. U.S. opposition had helped to abort an Australian heroin trial in 1997.

We in Vancouver have also not been spared White House advice regarding Insite, the supervised injection site (SIS) administered by the Portland Hotel Society in conjunction with local health authorities. John Walters, the former White House drug czar, has called this project state-assisted slow suicide.¹⁴

When you walk into the injection room at Insite on Hastings Street you see about a dozen cubicles, each with a sink, clean needles, a large mirror, lighting, a towel, and alcohol swabs for cleansing the skin. At first blink it’s as if you’d entered the dressing room in an off-Broadway theatre. A nurse is present at all times, observing the addicts who occupy the cubicles and wrap clean tourniquets around their arms before they probe their own veins with syringe and needle. Next door is a “chill lounge,” where coffee is served and where staff and counselors engage addicts in conversation. There is also a treatment room at the facility and all the equipment and medications needed for resuscitating overdosed users. That equipment has not lain idle: in an eighteen-month period there were nearly five hundred overdoses at Insite but no deaths. The accepted assumption is that there is about a 5 percent mortality rate without intervention, in which case twenty-five lives have been saved—to the likely disapproval of the Mounties and the British psychiatrist Dr. Daniels who, we may guess, would also prefer to see addicts continue to inject themselves with puddle water, as was sometimes the case prior to Insite.

More than five thousand users are registered with Insite, of whom over six hundred visit on any given day. None of the fears generated before this facility began to operate in 2003 have been realized: it has not encouraged drug use or drug-related crime; it has not brought more

In the Realm of Hungry Ghosts

Close Encounters with Addiction

Gabor Maté, MD

Foreword by Peter Levine



North Atlantic Books
Berkeley, California

The Ergos Institute
Lyons, Colorado

2010