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Harm reduction: closing the distance

Why are harm reduction programs a tough sell? One answer is that they appear to tolerate social phenomena that are undesirable, hazardous or, depending on one's perspective, the result of moral turpitude. Whether the issue is condom dispensers in high school washrooms or methadone maintenance, for many people harm reduction represents a capitulation before social ills that we ought to be routing out.

As for teen sex, the genie is out of the bottle. And, as to drug addiction, the chances of a rout are slim. Roughly 100 000 Canadians inject cocaine and heroin. Over one-third of new cases of HIV infection and more than 60% of new cases of hepatitis C result from injection drug use.[1] As Anita Palepu and colleagues report in this issue (page 415),[2] emergency department visits for preventable injection-related complications are common. In British Columbia, drug overdose is the leading cause of death in people aged 30 to 49.

Harm reduction is not a retreat from the high ground. It is the *only* ground on which to meet drug users in the here and now — a here and now that may include, in addition to the consuming fire of a chemical addiction, poverty, limited education, unemployment, a history of abuse and family dysfunction. Until now, in Canada, that meeting ground has taken the form of outreach and education, methadone maintenance and needle exchange. Methadone maintenance, about the only effective treatment for heroin addiction,[3] has been implemented only sporadically, mainly because of ideologic opposition. Similarly, needle exchange has had limited success. As Evan Wood and colleagues report (page 405),[4] despite needle exchange programs in Vancouver's Downtown Eastside, a substantial proportion of injection drug users still share needles.

In response to the growing crisis of drug abuse in many Canadian communities, a federal task force has called for the establishment of supervised injection sites, especially in major cities.[1] These facilities would provide a controlled environment where drug users can obtain sterile needles, naloxone when needed, vaccinations, medical care, social services and, not least, encouragement to enter rehabilitation programs.

Safer injecting sites operate in roughly a dozen European cities. In Canada, we can anticipate objections to taking such an active role in assisting drug injection, as opposed to merely handing out advice — or condemnation. There is a symbolic shift here, a closing of the moral distance between drug addict and public health worker. Drug injection, an actitivy that has no social legitimacy and hence no public space, becomes an activity with a publicly sanctioned and supported venue. It will take a certain *sang-froid* to see this idea through. It will require that we face up to the severity of the drug problem that Canadian communities are experiencing. There is no quick fix, either for addiction or its risk factors and effects. But we can make the lives of people with drug addictions a little better and neighbourhoods a little safer. Supervised injection rooms are a logical next step, one that combines the merits of realism and compassion. — *CMAJ*

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