adone patient requires the medicine once per day and does not get the characteristic high. Methadone is relatively inexpensive and greatly reduces the cost of heroin addiction to society. A person who has been stabilized on methadone and who is also emotionally stable (with or without medications described above) can in time perhaps consider withdrawal of the methadone, and if they are careful and determined enough, they may establish freedom from all opiates. Relapse remains the critical problem here, and as a result, methadone maintenance on an ongoing basis may be the best approach.

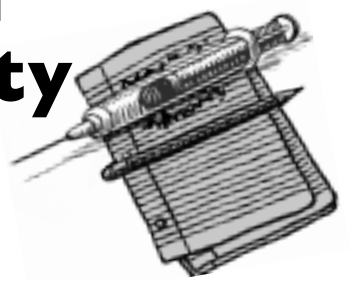
Conclusion

It is challenging for busy family doctors to find twenty minutes for a patient assessment, but taking time can be time-saving. Time must be spent or the patient will never be understood and a complete assessment is worth the effort.

In conclusion, identifying three important symptom groupings can lead to pharmacological treatment of depression, bipolar disorder, and Cluster B and C symptoms, in a general practice setting. With abstinence from drugs of abuse, use of community resources such as NA and AA, and psychological work such as counselling and writing exercises, a happier, healthier, more manageable life is achievable.

Mental Illness, Addiction and the Supervised Injection Facility

New Narratives on the Downtown Eastside



Dan Small, PhD

Dan is a medical anthropologist who has worked in the mental health field for many years and currently works with the Portland Hotel Society in Vancouver

I have been involved in numerous health sectors including Forensic Psychiatric Institute, clubhouses, review panels, the Centre for Excellence in HIV/AIDS, the Vancouver Area Network of Drug Users (VANDU), UBC Medical School, the BC Cancer Agency and the College of Physicians and Surgeons. In my role with the Portland Hotel Society, a community organization serving people in the Downtown Eastside, I have been involved in the set-up, implementation and management of North America's first legal supervised injection facility (SIF). In all these realms, I have found addiction to be one of the most challenging of phenomena for professionals to treat and address.

I believe that problems encountered in treating addiction are more to do with our underlying cultural† understandings of addiction than with any inherent obstacles in the people we try to help to help themselves. This essay examines some of the "cultural scaffolding" surrounding addiction,[1] or the ways we collectively assign meaning to certain people who struggle with both mental illness and/or addiction. It also looks at how the differences in how these meanings are constructed have hindered our approaches to providing help, to the detriment of the people with addiction. Finally, it describes how the new supervised injection site and the values represented by this approach, reflect an emerging set of meanings and approaches that is ultimately more hopeful.

I begin with the assumption that professionals organize their interactions based on narratives. A narrative is similar to a story‡ – and situating ourselves within an understandable story helps make our lives meaningful.[2] Our narratives provide meaning for important events in our lives (they answer the why-did-this-happen question) and construct a sense of plot (the beginning, middle and end) for our experiences.

Medical anthropologists refer to the narratives of professionals as 'therapeutic narratives,' and suggest that these play a vital function in their day-to-day interactions with those they help, and relate to things such as planning treatment schedules, determining which therapies will be undertaken initially, and ascertaining which side effects may be manifested.[2,3] Medical anthropologists take this a step further by suggesting that all interactions between clinicians and patients have a moral and redemptive component.[4] In mental health workers' narratives about people with both mental illness and substance abuse, addiction has traditionally been organized as separate from the mental illness component. I suggest that this separation has not been productive, and that we should instead focus on that which is similiar in these experiences: the quest for personal healing.

Narratives also often reflect upon on the personhood or humanity of those involved in them. By 'personhood,' we refer to aspects having to do with an individual's membership in society. Membership provides dignity, power and privilege in

notes

† By culture, I refer to a shared network of negotiated meanings based on implicit or explicit values

‡ While I will use the terms story and narrative interchangeably, it should be noted that literary theorists make a sharp distinction between the two concepts (see footnote reference #2). The term story refers to a series of events or experiences. In contrast, narrative refers to a specific discussion that describes events or experiences, rather than those events and experiences themselves. Narrative involves a guiding shape, provided by a plot, that structures our experiences and involves a social process, in the sense that the nature of various narratives are negotiated over time within communities. Illness narratives are but a smaller part of the overall life story of an individual

a community or society. The sociologist Goffman in his groundbreaking work on stigma,[5] describes how socially-compromising attributes of personhood such as having an addiction degrade an individual from a full person to a tarnished, diminished one. These individuals are aware of threats to their personhood brought by addiction, and that they occupy a lower social position and are placed at a social distance from others.

Historically, socially-alarming phenomena such as mental illness, criminality, drug addiction, illness, sexuality and death have been segregated or kept at a distance from the wider society.[6] Sometimes, this happens through the establishment of institutions such as hospitals, cancer treatment facilities, or hospices, which allow such issues to be concealed from the wider public. For instance, frightening things such as those living with IV drug addiction are hidden away in facilities such as supervised injection sites, contact centres and life skills centres in the Downtown Eastside, in order to reduce the anxiety these individuals create for members of the public. We have made people living with addiction into the modern-day cultural lepers whom we fear the most.

As suggested above, narratives contain moral components – in other words, they contain implicit or explicit values about what a community or society believes to be right and wrong. Narratives about people with mental illness have historically reflected certain values, represented by the following statements, suggesting that people with mental illness are:[7]

- disordered (versus ordered)
- irrational (versus rational)
- unproductive (versus productive)

Today, these values have been influenced by the process of medicalizing mental illness, which has lead to the establishment (or 'negotiation') of a new set of competing values, reflected by these statements:

- mental illness is a disease that can be treated
- people with mental illness are not to blame for their condition (popular wisdom is increasingly considering it to be a random medical event)
- people with mental illness deserve good medical care and services such as subsidized housing

Common cultural values (and statements) associated with people with addictions reflect some similar values, but others that reflect a harsher judgement. That is, that they are:

- unproductive (versus productive)
- irrational (versus rational)
- disordered (versus ordered)
- dangerous (versus safe)
- deceitful or manipulative (versus honest)
- non-contributors (versus contributors)

And that addicts:

- have made bad choices, choosing to use drugs and therefore are to blame for their condition
- should simply choose not to use drugs or be forced to stop using drugs through detox, medical treatment, drug court or jail
- are fundamentally undeserving of government (taxpayer funded) programs such as housing (Most social housing will not take active addicts as tenants)

Arguably, the newly-established supervised injection facility is a hot spot of 'meaning negotiation' where philosophies that are both disapproving and sympathetic about addiction meet one another. For those who oppose supervised injection facilities, there are a number of key cultural values associated with the SIF, including that the SIF:

- encourages drug use
- promotes addiction
- attracts addicts and social problems
- enables immorality (in the form of addiction)
- represents a surrender in the morally righteous war on drugs

Of interest, when the Portland Hotel Society was about to implement the SIF in partnership with the Vancouver Coastal Health Authority, I was invited to the United States Embassy to meet with Dr. David Murray, consultant to John Walters, US Drug Policy Coordinator (commonly referred to as the US Drug Czar) appointed by President George Bush. At this meeting, Dr. Murray cautioned against the implementation of the SIF based on the values described above. On a number of occasions in the discussion, he implied that the sovereignty of Canada might be jeopardized by the SIF and other harm reduction policies. This speaks to the different cultural values that underpin the drug policies in the United States and Canada.

In opposition to Murray's view, a number of cultural values and assumptions are at the heart of the position of those who support the SIF. These cultural values are summarized as follows:

- no one endorses addiction, but interventions that curb overdoses and the spread of infectious diseases have to be sought
- addiction cannot be stopped forcibly
- saving lives is fundamental (even lives of those making choices we disagree with)
- people need to be alive to seek treatment or withdrawal services
- practical, low-threshold intervention (e.g. provision of clean needles, supervised injection facility) can curb unhealthy injection practice
- reduction of public use of drugs by preventing people from injecting in alleyways is important
- providing services and support for people who continue their active addictions without forcing them to stop their addiction is okay

footnotes

1 Cruikshank, J. (1998). *The social life of narratives: Narrative and knowledge in the Yukon Territory.* Lincoln, Nebraska: University of Nebraska Press. (p. 27).

2 Mattingly, C. (1994). The concept of therapeutic 'emplotment'. *Social Science and Medicine, 38*(6), 811-822.

3 Mattingly, C. (1989). *Thinking with stories: Story and experience in a clinical practice.* Massachusetts Institute of Technology.

4 Good, B. (1996). *Medicine, rationality and experience: An anthropological perspective.* Cambridge: Cambridge UP.

5 Goffman, E. (1963). *Stigma: Notes on the management of spoiled identity.* New York: Simon and Schuster.

6 Giddens, A. (1997). *Modernity and self-identity: Self and society in the late modern age.* Stanford: Stanford UP.

7 Saris, AJ. (1994). *The proper place for lunatics: Asylum, person and history in a rural Irish community.* University of Chicago. (pp. 46-50).

8 This phrase is borrowed from Arthur Frank's (1997) book, beautifully titled: *The wounded storyteller: Body, illness and ethics.* University of Chicago Press.

The mental health field has not been effective in its treatment of people who also suffer from addiction. In my view, this is for a couple of reasons. Firstly, as I've suggested, the mental health field is not served well by separating mental illness and addiction into two distinct universes, based on distinct value systems. The underlying values of society and the corresponding cultural system of most mental health workers scorns people with addiction. This essay has tried to uncover some of these underlying cultural values that shape treatment and services for people living with active addiction.

Additionally, the mental health field's emerging concern on rehabilitation has a strong emphasis on changing people, which is at odds with the rather more basic supports that addicts require first. In contrast with the rehabilitation focus, the harm reduction philosophy underpinning the supervised injection facility is predicated on meeting addicts where they are in their lives right now and trying to support them rather than change them.

Addiction is not so much a struggle with disease as it is an ongoing attempt to heal. Central to the addict's healing journey is a quest for personal agency, hope for the future and a fundamental need for recognition of their value as a person: as a part of our collective humanity. People living with addiction are "wounded storytellers"[8] who have a larger story to tell us not only about themselves, but about ourselves and how we see them.

As professionals, we need to meet these individuals where they are today and not, based on our cultural values, where we want them to be. Attempts to change people (rehabilitation) need to be postponed in favour of more basic connections like providing a clean needle, treating an infection, changing a bandage, providing social housing or maybe just listening to a person's story – their narrative – over a cup of coffee. Putting aside our cultural values based on rehabilitation in favour of a less grandiose intervention is not a lost opportunity, but one that is set aside and saved for another day.

web resource

read more about harm reduction, relapse prevention for addictions, treatments for addictions, supervised injection sites and much more on our website at *www.mentalhealthaddictions.bc.ca*

related resource

Cassel, EJ. (1982). The nature of suffering and the goals of medicine. *New England Journal of Medicine, 306,* 639-645.

Helping People with Concurrent Disorders in the Justice System

The Seattle Mental Health Court Model

The following is excerpted from the proceedings of Vancouver City Hall, and are part of a report prepared by Councillor Jennifer Clarke in October 2001

Background

Like many cities, Seattle, Washington, has a significant group of people who are either homeless, mentally ill, substance abusers – or a combination of some or all of these things – who are repeat offenders of low-level offenses that formerly consumed expensive court and hospital services, with no improvement in their condition or to public order. Seattle officials say that prior to 1999, too many people were inappropriately getting caught in the justice system who should have been diverted out, due to a lack of quick entry routes to proper care. In June 1999, a task force recommended that the city integrate publicly-funded services for mentally ill and drug/alcohol offenders into a single administrative and service delivery authority.

The first point of entry into this system for many patients is either the Mental Health Court (MHC) or the Crisis Triage Unit (CTU) at Seattle's Harborview Medical Center, which link up and implement treatment, housing and case management solutions for the clients they see. Feedback from police, hospitals and court personnel is that these mechanisms have significantly cut down on the time people spend in jails, courts and hospitals. The results are diminished costs, decreased escalation of behaviour due to lack of early intervention, and