mains of cognition, mood, behaviour, ADLs and social interaction. Caregivers can be asked to focus on the ability to participate in conversations, anxiety, and the behaviours of agitation and aggression.

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Competing interests: Dr. Gauthier and Dr. Herrmann are the principal investigators in the ongoing Canadian randomized study comparing memantine with placebo, sponsored by Lundbeck Canada. Seven years ago, Dr. Gauthier was awarded (through a peer-reviewed process) a research chair funded by the Canadian Institutes of Health Research and Rx&D Canada's Research-Based Pharmaceutical Companies (via a pool of funds from different companies, including Lundbeck Canada). Both Dr. Gauthier and Dr. Herrmann have received speakers' honoraria and consultant fees from Lundbeck Canada. No competing interests declared for Florian Ferreri or Catherine Agbokou. None of the authors received any honoraria for writing this letter.

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Dealing with alcoholism

Stephen Hwang, in his commentary on homelessness and harm reduction,[1] notes the severe limitations of the study by Tiina Podymow and colleagues,[2] including the small number of subjects and the unreliability of self-reported evidence. As an addictions counsellor for many years, I have yet to encounter anyone meeting the DSM-IV criteria for alcoholism who accurately reports consumption levels; either they lie deliberately or, alas, they are too befuddled to recall. In addition, people with alcoholism tend to be "people-pleasers," telling the researcher or counsellor what they think he or she wants to hear, which compounds the problems of self-reporting.

If you want to get at the truth about attempts to cut down, consider attending 3 or 4 "open" meetings of Alcoholics Anonymous a week for a year. Although the evidence provided at AA meetings is also self-reported, it has 2 advantages: the people involved are likely to be sober and therefore less fearful of telling the truth, and there will be considerably more "subjects," which should also increase the reliability.

One thing that I have discovered is that until and unless a person with alcoholism discovers what he or she would rather do than drink, there will be considerable difficulty in abstaining or maintaining abstinence. There is also the frequently unspoken terror of stopping. It can take an awful lot of time and effort to bring any addict to that point, but at least by working within the framework of the transtheoretical model,[3] the process can be started.

The idea of giving a person with alcoholism a drink every hour on demand because it will help him "cut down" or reduce harm appalls me. If it's such a good idea, why don't we suggest the same for smokers?

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[Dr. Hwang responds:]

The main finding of the study by Tiina Podymow and colleagues[1] was that the homeless participants in their harm reduction program had significantly fewer numbers of emergency department visits and police encounters after entry into the program, as determined by a review of hospital and police records. Data on these service utilization outcomes were no doubt more reliable than the self-reported data on alcohol consumption.

Few would argue that one of our duties as physicians is to encourage patients with alcoholism to strive to abstain from alcohol. Many of these individuals may find it helpful to participate in programs such as Alcoholics Anonymous. But what do we recommend to someone who drinks 8 bottles of wine a day, sleeps on the street and expresses an unwillingness to contemplate abstinence? Harm reduction programs such as the one described provide a means of engaging these people in a way that may ultimately lead to

positive change in their lives. Podymow and colleagues suggest that this approach may reduce certain societal costs related to high service utilization, but the question of whether it reduces harm at the individual level remains unanswered.

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[Drs. Podymow, Turnbull and Coyle respond:]

The focus of our study[1] was to examine harm reduction in a subset of chronically homeless individuals suffering from long-standing severe and refractory alcoholism. These are people who were at an extreme of alcohol addiction, who were homeless and who daily drank to unconsciousness and for whom abstinence-based programs had failed or been refused. The purpose of the program was not to impose alcohol cessation but rather to reduce the harm that these people experienced by providing shelter-based, controlled alcohol administration. This approach would reduce, for example, alcohol-seeking behaviour, panhandling, street violence and the consumption of nonbeverage alcohol, and in so doing would also reduce the use of crisis services.

The attitude that a program must always and only aim to cure the addiction fails to aid those who fall outside of abstinence-based programs. Abstinence may be the ultimate goal in the treatment of addiction, but for homeless people who have severe, unremediable alcoholism and who have refused abstinence-based programs, the program we describe offers complementary strategies in the overall management of alcohol addiction.

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