OUT OF HARM'S WAY

Traditional Approaches to Addictions Aren't Working. It's Time to Take a Radical Approach, Says UW Professor Alan Marlatt

Harm reduction isn't an easy pill for many people to swallow.

Just suggest legalizing needle exchanges, letting some alcoholics drink in moderation rather than face abstinence, allowing heroin addicts to get methadone treatment, or loosening drug laws and wait for the reaction.

Chances are you'll have to duck to avoid the fusillade unleashed by former federal drug czars, the alcoholism treatment community, law enforcement officials and others.

"The United States is still paying in broken lives, fear, violence, and damaged newborns for the tacit decriminalization (of drugs) won by the counterculture in the '60s," wrote *New York Times* Columnist A.M. Rosenthal.

"It is time to state the truth. ... The legalization movement is cruel because it would create more addicts, more abused children, more victims of muggings and robbery, millions every single year. It is selfish because it would move the burden of fighting drugs from the totality of society to neighborhoods that already suffer most. It is both cruel and selfish because it glides over the ruined lives of those who abuse drugs, legally or not," he stated.

But, slowly, harm reduction--which European countries have used for years--has edged onto the stage as an alternative solution to devastating social and health problems facing the U.S., even as a response to the spread of AIDS.

So what is harm reduction and why does it inflame passions so readily?

"It is a pragmatic and humane approach to help people change risky behavior," explains UW Psychology Professor Alan Marlatt, director of the UW's Addictive Behaviors Research Center and one of harm reduction's leading advocates.

UW Professor Alan Marlatt. Photo by Mary Levin.

"It's humane because you have to meet people on their own terms rather than confronting them on yours. You want to encourage them to give up a behavior, but if a person can't, you don't want to reject them and keep them from treatment. Traditional treatment programs for substance abuse are confrontational. Without abstinence, people are kicked out of treatment. That's an inhumane way to deal with problems.

"It's pragmatic because harm reduction accepts substance use as a fact of life and recognizes its role as a way of coping with the consequences of social problems. It does not try to remove a person's primary

coping mechanisms until others are in place," he added.

But just the mere mention of harm reduction is enough launch attacks from some of its opponents.

"It is a cop-out, a refusal to face the problem," says Dr. Gabriel Nahas, a professor of anesthesiology at New York University (NYU) and a consultant to the United Nations Commission on Narcotics. "Under a general harm reduction policy you have an increased acceptance of the use of other drugs such as heroin and cocaine."

What bothers many opponents of harm reduction is how it deals with abstinence. While staying "clean and sober" is a goal, harm reduction doesn't insist on abstinence or make it a condition for treatment.

Not all substance abusers can give up their addictions cold turkey, says Marlatt. So advocates believe, for example, that it is far better to help a problem drinker to cut back on the quantity of alcohol he consumes than it is to deny him treatment altogether.

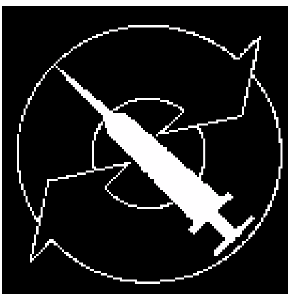
Marlatt likes to use the analogy of a thermometer. When an activity gets "too hot" or dangerous, counselors seek to bring the temperature down by reducing the harmful consequences of the behavior a step at a time. If there is a raging 104-degree fever, at first you try to bring it down a degree or two rather than all the way back to 98.6.

"The idea is to reduce harm by degrees and just a few can make a big difference," explains Marlatt. "Unfortunately, we have an all or nothing approach in our society."

Others, however, doubt moderation will work. "To ask a recovered addict to engage in `responsible heroin shooting' or a compulsive gambler to play for just small amounts is to ignore the whole psychology and physiology of addiction," wrote the late Seattle University psychologist and alcoholism authority James Royce. "Alcoholism is not a simple learned behavior that can be unlearned, but a habitual disposition that has profoundly modified the whole person, mind and body."

NYU Professor Nahas agrees. "There is no step-by-step," he says, adding that the pattern of drug addiction is ingrained in the genetic strcture of the brain. "The brain of the addict is incapable of refusing the drug. We're dealing with a biological phenomenon, an altered brain that can only save itself by stopping taking the drug entirely."

To those who oppose the approach, Marlatt points to a number of programs using harm reduction taking root in Washington state. Among them are:



* The Tacoma Needle Exchange Program, the first legalized syringe exchange for intravenous drug users. It has spawned more than 80 similar programs across the United States. Exchanges allow IV drug users to trade their old needles for new sterile ones, thereby reducing addicts' risk of exposure to AIDS and other diseases and cutting health care costs to the community.

Rates of hepatitis B and C among drug users who didn't use the needle exchange were five to seven times higher than among addicts who did use the exchange, according to studies conducted by epidemiologist Holly Hagan, now with the Seattle-King County Health Department. "This is pretty strong evidence of a protective effect from the program," she says.

* Birth to Three Project, a recently completed UW pilot program to help high-risk new mothers with little access to prenatal medical care deal with multiple problems. Aimed at women who have alcohol and drug

alcohol addictions, the $1.4 million study tried to reduce future incidences of fetal alcohol syndrome. Research, led by UW Psychiatry Professor Ann Streissguth, shows that this program also can help the women deal with variety of other risks to themselves and their children including sexual abuse, domestic violence, homelessness and poverty.

* Lifestyles 94, a 10-year UW study that is tracking 450 college students and their drinking behavior through college and beyond. Researchers, headed by Marlatt, also are evaluating a UW intervention program that is designed to reduce the risks associated with binge drinking, a common behavior among college students.

In all these programs, harm reduction offers a public health approach that counters a pair of views dominating American policy: a crime model and a disease model of drug use and addiction.

Under the crime model, the use or distribution of illegal drugs deserves punishment. It assumes illicit drug use or sales are morally wrong, leading to the "war on drugs." The goal of this war is to reduce the supply of drugs and, ultimately, create a drug-free society.

The disease model considers addicts to be sick people suffering from biological or genetic illness and is most often linked to alcoholics. This approach tries to reduce the supply of drugs by cutting the individual's demand or desire for illegal substances through treatment.

Both of these models are anchored by a belief in "zero tolerance." Much of present American drug policy and treatment are based on this concept. Contemporary policy tars any use of illegal drugs, whether it is an occasional use of marijuana or a daily habit of heroin, with the same unyielding brush. Similarly, virtually all alcohol and drug treatment programs insist on total abstinence as a precondition. Neither the crime nor the disease model attempts to distinguish between light and heavy use and simply considers all use equally criminal or sick.

"Harm reduction tries to step back from labeling human behavior right or wrong, legal or illegal. It only looks at whether that behavior is helpful or harmful to the individual and society," explains Marlatt.

"It shifts the focus away from drug use or other dangerous habits to the consequences of addictive behavior and it offers a wide range of possible ways designed to reduce those harmful consequences. Harm reduction accepts the reality that many people use drugs and engage in a variety of high-risk behavior and that the idealistic visions of a drug-free society are unlikely to become a reality."

Harm reduction's stand on drug laws, in particular, brings a strong response. "A lot of resistance stems from fear," Marlatt explains. "People think the decriminalization of marijuana would be the first domino to fall. They believe people would pour into the streets to buy crack cocaine if you lifted the prohibition on drugs. This isn't based on any data. Besides, nobody wants people to be able to buy drugs like candy and ice cream.

"If you based the law and prohibition on mortality rates, cigarettes would be the first thing to go. But if you based the law on medical benefits, marijuana would be legalized."

Prohibition inevitably creates problems and exacts a severe toll on the economy, Marlatt believes.

"If you prohibit something, a large percentage of people will want it. Other will sell it. So prohibition creates a market for the substance and a situation where it is available and can't be controlled. What has happened is that the war on drugs is making us pay a heavy human and economic price," he adds.

But NYU's Nahas says prohibition worked during the first half of the century in America. "There were very

severe sentences to the traffickers and it was a social taboo. It was a program which worked in the past," he says. "Historically drug use in America is a very recent phenomenon." He favors the policies in Singapore, which mandates treatment for users and imposes severe penalties, including the death sentence, on traffickers.

When discussing decriminalization, both sides use The Netherlands as an example. The Dutch decriminalized marijuana use in 1976. After it was legalized, marijuana use temporarily increased during the first year and then the rate fell, leveling off at a rate that is lower than when it was illegal. Usage among Dutch teenagers presently is one-fifth the rate of American teens. This shows that marijuana usage does not surge with legalization; it can actually drop, says Marlatt.

The harm reduction movement in the United States grew out of the Dutch experience and programs in a number of other western nations including England, Canada and Australia. Drug abuse increasingly became a significant problem in the Netherlands in the late 1960s and early '70s. As a response, the Dutch gradually adopted the public health perspective.

Previously strict laws were softened. Revision of the Dutch Opium Act in 1976 made a legal distinction between drugs of unacceptable risk such as heroin, cocaine, LSD and amphetamines and those so-called "soft drugs" with a lower risk, marijuana and hashish. This de facto legalization of marijuana allows people to openly buy the drug in designated "coffee shops" where they are not exposed to sellers who peddle hard drugs.

Later, Dutch drug addicts began demanding services and further changes in drug policy. The first Dutch needle exchange program was established in Amsterdam in 1984 and a year later the country adopted a so-called drug normalization policy. This policy, which takes a position between a war on drugs and total legalization, tries to minimize the harm stemming from drug use and be attentive to the needs of drug users. One study of the Dutch approach concluded that "normalization seems to have produced a context where the addict more resembles an unemployed Dutch citizen than a monster endangering society."

But Nahas states that since decriminalization The Netherlands has seen "a significant increase in the smoking of marijuana and the uses of other drugs and a marked increase in criminality." He cited studies that show a 30 percent increase in drug-related seizures due to heroin and cocaine use and a 33 percent increase in deaths due to firearms from 1988 to 1993.

"The Netherlands has become the drug center of Europe," he declares. Asked why the Dutch tolerate this situation, he replies, "The government doesn't want to change the policy. The drug traffickers and drug pushers have too much influence. But there is a strong movement among the public to change it."

"Places that have tried decriminalization or legalization have either rescinded liberalized laws or are currently rethinking them based on the increase of crime and other social problems," says Susan Kaplin, a researcher at Drug Watch International, a private drug-prevention agency.

Kaplin feels that prevention, not harm reduction, will win the war on drugs. "Harm reductionists have claimed that prevention and the war on drugs have not worked, despite the multitude of studies which clearly show that prevention programs for young people do work," she says.

Opposition by Drug Watch International and other programs has slowed acceptance of harm reduction in the United States. However, since the Tacoma Needle Exchange Program was founded in 1988 as the first government-funded program to reduce the risk of HIV infection among IV drug users, the pace of acceptance has increased. Eight years later, Washington State alone has 10 programs operating in seven cities. Across the country, there are more than 80 needle exchange programs.

In the alcoholism treatment arena, the number of programs advocating moderation has begun to proliferate. These self-help programs operate much like the traditional Alcoholics Anonymous model with one big exception--their aim is moderation rather than abstinence.

"The experience has been that some people in these program start with moderation and eventually realize that they want to quit drinking," says Marlatt. "One-third of the people in these programs wind up quitting. However, we are still out of touch with 75 to 80 percent of the people in this country with drinking problems. We need to offer more alternatives so people will come in and try them. We need programs that offer a low threshold, not barriers to people, ones that allow individuals to take small steps in less harmful directions."

In solving alcohol or drug addiction, Nahas disagrees. "I believe in the straightforward, medical solution--abstinence." Particularly for drug abuse, harm reduction has "dismally failed in the past," he adds. "I favor the rational, historical and moral solution of this problem." He wonders why a society would allow the use of a substance "that impairs the mind of man, his progeny and society, inviting disasters for future generations."

Widespread acceptance of harm reduction certainly won't come quickly. But as drugs, alcohol and AIDS continue to ravage society and the debate on how to solve these problems goes on, harm reduction adherents believe their ideas should be carefully tested, not dismissed out of hand.

"Reality will force the issue and make these kinds of harm reduction programs available to people," believes Marlatt. END

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