Testimony of
Dr. Andrea Barthwell
Former Deputy Director
Office of National Drug Control Policy
"Harm Reduction or Harm Maintenance: Is There a Such Thing as Safe Drug Abuse?"
February 16, 2005
Subcommittee on Criminal Justice, Drug Policy and Human Resources

Background

Non-medical drug use is a preventable behavior, and addiction is a fundamental, yet treatable, disease of the brain. Years of research with both animals and humans have taught us that drugs of abuse have profound, immediate, and long-term effects on the chemical balance in the brain. Those who have had a drug-using experience, even if they are not currently using, are changed permanently by the experience.

Drug use can be described along a continuum, along which there are three groups: non-users, non-dependent users, and those with abuse or dependence.

Non-Users. Non-users are made up of those individuals who have never used, those who are not using, and those who intend "never to use again," who are sometimes described as being "in recovery." A key public policy goal is to keep non-users from using (or using again). An environment that supports a non-using norm also supports recovery.

Non-Dependent Users. Non-dependent users are made up of new users and more regular users who have not yet suffered the complications of their drug use. The non-dependent person is important because, while he does not actively recruit new users, he contributes to the spread of drug use and dependence. The non-dependent user sits at the crossroads of non-users and dependent users, able to return to a non-using state with the right incentives, yet apt to progress to a more chronic, severe, debilitating form of use with the wrong incentives.

Non-users contemplating drug use look to these non-dependent users as models for using drugs without significant consequences. Non-dependent users are not hard to find, particularly given that many are users of marijuana, which is associated with low rates of progression to dependence (in an environment of late-age initiation and low potency, one of ten individuals who try marijuana is reported to progress to dependence).

When individuals use a drug of abuse for the first time, they either stop when the drug fails to deliver all that was promised, or when external controls are applied, or they continue to use. New users' novel, pleasurable experiences, combined with their desires to normalize their own use, can lead them to recruit other new users. New users who fail to stop using often settle into a pattern of regular non-dependent use, and the vicious cycle continues.

Non-dependent users fuel specific drug epidemics in the United States, from cocaine, to heroin, to methamphetamine, to Oxycontin®. While public responses have focused on the drug itself, policies have failed to focus on the real source of the epidemic: the pool of non-dependent users who exist in every community across the country virtually unaffected by drug policy.

Abuse or Dependence. Regular use of drugs in sufficient amounts can lead to a state in which the user comes to prefer the drugged condition, and in which the brain chemistry is so disturbed that the user's voluntary control of his or her behavior is impaired. These hallmarks of addiction mean that it is difficult for dependent users to stop using and to maintain abstinence if they do stop. Thus, without strong outside intervention, a dependent user's drug use is likely to continue. The costs of dependent use – on the users themselves, their families, and society as a whole -- are profound.

In order to break the cycle of chronic drug use, drug-dependent individuals must undergo significant changes in their lifestyles and attitudes. They usually need help in doing so. Behavioral and psychosocial treatments are the cornerstone of services available to help dependent drug users achieve and sustain meaningful periods of abstinence.

Approach to Policy

Our nation's drug policies must be broadly designed to meet the following three goals:

1. Stop the initiation of drug use by reinforcing a non-using norm among non-users;
2. Change the risk-benefit analysis of non-dependent users to steer them away from use; and
3. Provide brief and early interventions for those who abuse drugs and treatment for those dependent on them.

Concerning the "war on drugs," the metaphor is perhaps helpful in calling attention to the serious dangers of drugs and that drug use is an endemic public health problem. Public health problems are best dealt with by the classical public health approaches -- prevention, early intervention, and treatment -- provided the procedures are based on solid findings of scientific research.

It is in our best interest to embrace scientifically sound polices and to reject in an informed way those polices and practices that do not help us to achieve our broad national goals, no matter how attached to them we may be. Finally, we must fully grasp that policies to address thorny issues cannot be allowed to prevail if they create unintended consequences in other areas that impede our national goals.

Drug Policy and Harm-Reduction

A perennial question among policymakers is whether harm reduction strategies make effective drug policies. The term "harm reduction" in drug policy refers to practices that promote "safer" ways to use drugs, in which the primary goal is to enable drug users themselves to direct the course of their own sanctioned drug use, not to stop their drug use.

At first glance, there may appear to be numerous societal analogies to policies that aim to reduce the harmful consequences of non-medical drug use, rather than eliminating such use itself. Safety implements, such as guard rails and seat belts, reduce the inherent dangers of automobile travel. The placement of lifeguards at public beaches reduces the likelihood of drowning. The development of protective gear for athletes, the requirement that motorcyclists wear helmets, and the placement of expiration dates on processed foods are technically harm reduction strategies. They seek not to prohibit potentially dangerous activities, but to alter the conditions under which

such activities occur and, thereby, reduce the incidence of negative consequences for individual participants and society as a whole.

There is, however, a logical flaw in equating harm reduction measures for the activities mentioned above with harm reduction strategies for drug use. Despite their risks, these activities involve common, socially acceptable behavior. Given that it would be neither desirable nor realistic to attempt to prohibit these activities, harm reduction is the only viable option.

The non-medical use of drugs, on the other hand, does not constitute common or socially acceptable behavior. Preventing non-medical drug use is both desirable and realistic. Sanctioning drug use, on the other hand, is not an acceptable practice and does not produce desirable outcomes.

For Public Health, Prohibition is Preferable

Harm reduction is a part of society's approach to harmful tobacco products because they are legally available (and it is presently unrealistic to attempt to prohibit them), yet they must be managed. Social policies that require the use of labeling and restrictions on advertising, and public health policies that permit the use of the nicotine patches and chewing gums in breaking the nicotine addiction, are attempts to lessen the harm of tobacco products that remain socially acceptable and beyond prohibition. These efforts are based upon an assumption that use occurs, and we must, as a society, manage it.

Contrasting tobacco products against crack cocaine illustrates that, when possible, prohibitions on use are preferable. Some 40 years after the harms of tobacco consumption became commonly known in the United States, 35 million "hard-core" nicotine addicts appear unable to quit. Nicotine provides an example of what can happen when a rewarding addictive drug is readily available.

Like nicotine, crack cocaine is easily administered; it is smoked. Animal self-administration experiments suggest that cocaine is greatly preferred to, and more addictive than, nicotine. Unlike tobacco, however, crack cocaine is prohibited. As a result, the number of Americans who use crack cocaine in any month is less than two million. The number who use it weekly or daily is less than one million. Easy availability, stemming from lax legal controls, has permitted far more people (often adolescents) to become addicted to nicotine than to the more pleasurable and addictive cocaine.

To avoid harm – not just reduce it -- those pleasurable yet addictive substances that are currently prohibited must remain prohibited. In the meantime, the notion of an outright prohibition of tobacco, for which harm reduction is merely a second-class public health approach, is becoming more and more socially realistic.

Harm Reduction Causes Harm

Harm reduction efforts are inconsistent with the three broad goals of drug policy.

First, harm reduction strategies cause harm to non-users. The best way to reduce harm to non-users is to keep them off drugs. The best way to keep them off drugs is to foster a non-using

norm. Harm reduction policies undermine the non-using norm by creating ambiguity as to the illegality, dangers, and social consequences of drug use.

Second, harm reduction strategies cause harm to non-dependent users. With pleasurable drug-using experiences and few, if any, consequences, the internal incentives for the non-dependent user to stop using are few. External influences are imperative to preventing the non-dependent user from progressing to abuse or dependence. Harm reduction strategies undermine the non-using norm and reduce external deterrents to drug use by perpetuating the notion that drug use can be controlled. Taking it one step further, harm reduction campaigns provide the actual tools for drug use.

Consistent with the notion that non-dependent users are the vector through which the disease of drug addiction is spread, it is no surprise that the primary architects of harm reduction efforts are non-dependent users themselves. They are the same advocates that push to legalize, decriminalize, and de-penalize drug use of all kinds.

Finally, harm reduction strategies cause harm to individuals suffering from abuse and dependence. Quite simply, treatment research recognizes that dependent users have lost voluntary control over their drug abuse. Whether they want to stop using makes no difference; stopping outright is necessary to treat the disease and ensure the patient's survival.

Medical Treatment Distinguished

The use of approved medications in achieving abstinence from non-medical drug use is not harm reduction. Approved medications can serve vital functions in the drug treatment process. Medications can make dependent users more comfortable during the early days and weeks of abstinence. This boost, in turn, can help to motivate the patient to remain abstinent and continue in treatment rather than resuming drug use in order to relieve withdrawal symptoms. Another function of medications is to alter the effects of drugs of abuse should they be ingested.

Heroin addiction deserves special mention. Methadone maintenance therapy (MMT) is a form of therapy akin to insulin replacement for diabetes. MMT is highly effective in resolving the signs and symptoms of addiction. It can prevent opiate withdrawal, diminish "drug craving," and free heroin users from the necessity of obtaining street drugs. Methadone patients are not chronically intoxicated, making it possible for them to live more stable and productive lives. Another important benefit of methadone is the reduced risk for the various adverse health consequences that accompany repeated injection, including HIV infection.

Studies have produced evidence of significant positive outcomes of MMT. Retention rates have been much higher than those for other treatment modalities, and methadone patients have had lower rates of criminality, arrest, and imprisonment.

Methadone maintenance has become increasingly restrictive in the United States, however. Regulations regarding dosage levels have become stricter, despite evidence that better outcomes are often obtained with higher doses, and the number of programs has contracted.

Specific Steps to Improve Drug Policy

Screening, Intervention, and Referral to Treatment. As with all progressive diseases of a catastrophic nature, earlier diagnosis and treatment produce better outcomes. Screening for drug use, followed by immediate intervention and referral to treatment, are keys to ensuring patients' long-term health. The alternative, a failure to diagnose and intervene in the early stages of drug use, will continue to reap less-than-optimal outcomes. It will leave society vulnerable to attempts to make moderated use – not abstinence -- the norm, while abstinence-based treatments will be cast as heartless, inhumane, and unachievable.

Reimbursement for Drug Treatment Services. Data confirm the benefits, if not the necessity, of sustained professional care for drug abusers. A common reason for ending treatment is the lack of available reimbursement for ongoing services. Dropout from treatment often results in relapse to drug use. The inability of those with an identified need to access necessary care contributes to a common belief that treatment does not work, supports the notion that people cannot recover from drug dependence, and bolsters the arguments of those who claim that treatment is futile but harm reduction is effective.

Reorganization and Expansion of Methadone Services. The loosening of overly restrictive methadone policies would improve the health and social functioning of chronic heroin injectors, including those on program waiting lists, those not amenable to or eligible for standard MMT programs, and those who are patients in AIDS and tuberculosis clinics. In addition, greater methadone availability can produce positive consequences for society by reducing drug users' reliance on street drugs, reducing criminality, and limiting the spread of HIV infection. Consistent with evidence of effectiveness in limited trials, federal regulations prohibiting methadone prescriptions for maintenance by physicians outside of formal MMT programs should be re-evaluated. Failure to re-focus our efforts here leaves us vulnerable to charges of insensitivity and efforts to "treat" dependent users with the very substances and modes of delivery that have ravaged their lives.

Support Medications Development. Medications such as methadone help to keep patients in treatment, and efforts to develop new medications must have support. Failure to support medications development programs enables harm reduction advocates to point to moderated drug use as a public health strategy.

Conclusion

When a drug of abuse becomes more available, more people use it. And those who use it, use it more. The number of individuals who encounter problems caused by the use of the drug then increases. Legal controls that restrict availability of drugs, including, but not necessarily limited to, prohibition, are effective means of reducing drug-induced problems.

Public policy should meet a minimum a standard of creating benefit to our broad goals while not increasing problems elsewhere. Scientifically based policies to prevent drug use, intervene in cases of non-dependent use, and treat problems of drug abuse and dependence best serve the public interest. Harm reduction strategies, on the other hand, fail to meet the minimum standard for sound public policy.