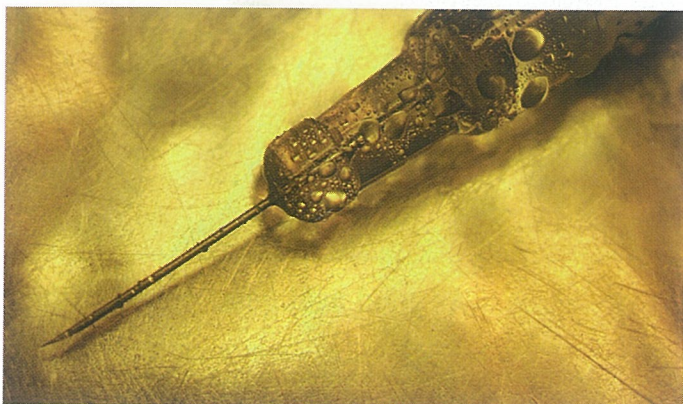


POINT OF VIEW



ON NEEDLES, DRUGS, AND GRADUALISM

By Scott Kellogg, PhD

I was pleased to read that the New Jersey State Legislature approved a compromise version of a bill that would support the use of needle exchange programs to help combat the spread of HIV and hepatitis C among those addicted to drugs. Hopefully, these programs will reduce the death rate and motivate active users to enter into treatment. Nonetheless, efforts to pass this legislation have not been without controversy.

Drug addiction treatment is, simultaneously, one of the most contentious and creative areas in psychiatry. The situation in New Jersey has again brought into focus the ongoing disagreements and differing perspectives of harm reduction and abstinence-oriented treatment advocates. For the harm reductionists, who seek to reduce the dangers of drug and alcohol use without first requiring abstinence or sobriety, needle exchanges save lives. For many traditionalists, who often believe abstinence should not only be the goal of treatment, but also a requirement for admission to a program, needle exchanges are akin to government endorsement of drug use or, according to one New Jersey State senator, a modern-day version of the Tuskegee Syphilis Study—a notorious experiment in which proper medical care was purposely withheld from a group of syphilitic African American men.

Gradualism (Kellogg, 2003; Kellogg & Kreek, 2005) is a philosophical approach that seeks to be a third force between harm reduction and traditional abstinence-oriented treatment. It is a perspective that seeks to build on the strengths of both camps while minimizing their downsides. Recovery from alcoholism and drug addiction is seen as taking place along a continuum in which addicted individuals gradually change their relationships, behaviors, identities, and drug use; this view involves a reenvisioning of the healing process.

To begin, many abstinence advocates do not seem to understand the purpose of harm reduction interventions, nor do they see their relationship to recovery. In turn, harm reduction providers frequently fail to locate their efforts within a recovery-oriented context. This lack of mutual understanding and communication leads to situations such as the one in New Jersey, in which a potentially lifesaving intervention is viewed as a form of genocide or drug-use promotion.

From a gradualist perspective (Kellogg, 2003; Kellogg & Kreek, 2005), a good place to start building bridges is through clarifying the goals of various harm reduction interventions. Building on work by Alex Wodak, MD (1994), and Bart Majoor, PhD, I have organized harm reduction interventions into three overlapping categories: Staying Alive, Maintaining Health, and Getting Better (Kellogg, 2003). Staying Alive interventions have a very short time span and are geared toward protecting drug users from seriously harming or killing themselves from the direct and immediate effects of drugs or alcohol.

In cities across the United States, active drug users are currently being taught how to administer *naloxone*, an opiate antagonist, to peers who may be suffering from a heroin overdose. Naloxone has the ability to reverse this process; early reports show this is a promising program for reducing heroin-related deaths in cities where this program has been implemented (Galea et al., 2006). A more familiar Staying Alive intervention has been the designated driver program. Again, the goal is to protect intoxicated individuals from harming themselves, and in this case, others.

The Maintaining Health category includes interventions focused on protecting people from HIV, hepatitis C, and other negative consequences that come from using substances. Here, the time period is much longer, as these are negative consequences that will emerge over time. The intent would be to not only reduce exposure to diseases, but also minimize the exacerbation of existing disorders. Needle exchanges could be seen as fitting into this group, as would substance use management programs that teach users how to use drugs or alcohol in safer ways.

The third group, Getting Better, would encompass interventions focused on controlling or reducing drug use, if not necessarily eliminating it. Interventions centered on moderation would be relevant here, as would the harm reduction psychotherapies of Andrew Tatarsky, PhD (2002, 2003), Patt Denning, PhD, and Jeannie Little (Denning, Little, & Glickman, 2004). These are psychotherapeutic approaches aimed at helping patients both understand and control their drug use, so they can reduce their level of risk.

When we look at the broad range of ways people recover from addictive disorders, numerous psychosocial commonalities emerge that are relevant to the project of making connections between the harm reduction and the traditional recovery communities. First, most addicted individuals are in a state of ambivalence about their use: part of them wants to continue, and part of them wants to stop (Miller, 2000). This would support a process of gentle but continual engagement—especially in the beginning. Second, relationship is a core motivator for life change (Tatarsky, 2002, 2003). New relationships mean new possibilities. The needle exchanges and street outreach work that is often one of their key components provide an opportunity for contact and relationship-building with addicted individuals who are often not connected to or interested in abstinence-oriented treatment programs. Through the provision of goods and services and an open and generally affirming attitude, connections may be built that can serve as the foundation for change.

The third factor is that people, not just addicted individuals, typically respond well to positive reinforcement (Petry, 2000; Stitzer, Iguchi, Kidorf, & Bigelow, 1993). More than 30 years of research has shown that alcohol- and drug-dependent individuals will make dramatic changes in their addictive behavior when presented with social and



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material reinforcements for doing so. While this principle is still underutilized in harm reduction settings, a punitive attitude toward patients is still often the norm in mainstream treatment facilities—which may contribute to the high dropout rates.

The fourth factor is that at the heart of one's ability to sustain abstinence or sobriety is the process of identity transformation (Biernacki, 1986; Kellogg, 1993). People who recover successfully are typically able to not only make meaningful connections to outside groups, but also change their inner sense of self. This is a common factor whether the individual does this through Alcoholics Anonymous, Self Management and Recovery Training, a therapeutic community such as Daytop or Phoenix House, a church or other religious institution, a renewed commitment to the family, enrollment in a school, or dedication to a job. All these situations help give the individual a new self-definition and an identity that can help them resist drugs and the drug-using lifestyle.

The implications of all of this, as Alan Marlatt, PhD (Marlatt & Kilmer, 1998), at the University of Washington has pointed out, is that addiction treatment programs would do well to make themselves user-friendly, attractive, and reinforcing. On a broader scale, this means legislation that prohibits those with drug convictions from receiving money for education is likely to increase the probability of relapse because it is blocking access to new identities. This is also true of hiring practices that exclude those with addiction histories.

The gradualist challenge to the abstinence-oriented community is to place a core emphasis on relationships, make their programs more humanistic and affirming, and understand that recovery is a process

during which it may be necessary to work with patients as they wrestle with their substance use—and not require them to stop using as a condition for admission.

Lastly, despite our best efforts (and even in ideal circumstances), people will relapse and return to their addictions. A treatment system that can interact with drug and alcohol users in all states of addiction with varying levels of motivation can help save lives and get them back to health and stability more quickly. From this perspective, harm reduction interventions can serve as a safety net, a therapeutic web to help break their fall (Kellogg, 2003).

Gradualism envisions a treatment continuum that begins with contact. This then becomes connection and relationship and ends with the creation and/or transformation of identity. In terms of substance use, the individual may go from addictive use, to safer use, to reduced use, to intermittent use, to cessation or true moderation, if appropriate. Hopefully, through engaging with the gradualist vision, a more integrated addiction treatment community can be created so all addicted individuals can get the help they need.

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References are available by sending an e-mail to references@gypub.com.