

## Rethinking Assumptions about Drug Addiction and Treatment

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### INTRODUCTION

The War on Drugs is based in part on a number of assumptions—often implicit and unquestioned—about drugs and their use, abuse, prevention, and treatment. This Article articulates some of these assumptions, offers better alternatives, and thereby implies major changes that should be made to our drug policy.<sup>1</sup>

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<sup>1</sup> The issues discussed here, along with many others, are dealt with in detail in three edited works that include the rationales for and descriptions of a wide range of policy alternatives. DRUGS AND SOCIETY: U.S. PUBLIC POLICY (Jefferson M. Fish ed., 2006);

## I

## DRUGS HOOK VICTIMS VERSUS MISERABLE PEOPLE SELF-MEDICATE

One key assumption underlying drug prohibition is that drugs hook victims. Therefore, it has been argued, society should enforce prohibition to limit people's exposure to drugs and, consequently, the possibility of their succumbing to abuse.

The reality is far more complicated. While the drugs themselves certainly play a role in abuse, it is the personal characteristics of users—rather than mere exposure to particular substances—that play the critical role in determining whether individuals become abusers.

A major longitudinal study provides support for this principle. Its findings, summarized in the Abstract, have long been known, but they are startling to many non-experts, and are thus worth quoting in their entirety:

The relation between psychological characteristics and drug use was investigated in subjects studied longitudinally, from preschool through age 18. Adolescents who had engaged in some drug experimentation (primarily with marijuana) were the best-adjusted in the sample. Adolescents who used drugs frequently were maladjusted, showing a distinct personality syndrome marked by interpersonal alienation, poor impulse control, and manifest emotional distress. Adolescents who, by age 18, had never experimented with any drug were relatively anxious, emotionally constricted, and lacking in social skills.

Psychological differences between frequent drug users, experimenters, and abstainers could be traced to the earliest years of childhood and related to the quality of parenting received. The findings indicate that (a) problem drug use is a symptom, not a cause, of personal and social maladjustment, and (b) the meaning of drug use can be understood only in the context of an individual's personality structure and developmental history. It is suggested that current efforts at drug prevention are misguided to the extent that they focus on symptoms, rather than on the psychological syndrome underlying drug abuse.<sup>2</sup>

In other words, instead of “drugs hook victims,” a better causal model for drug abuse is “people with significant problems self-medicate.”<sup>3</sup> The policy implications of this model are significant.

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HOW TO LEGALIZE DRUGS (Jefferson M. Fish ed., 1998); IS OUR DRUG POLICY EFFECTIVE? ARE THERE ALTERNATIVES? (Jefferson M. Fish ed., 2000).

<sup>2</sup> Jonathan Shedler & J. Block, *Adolescent Drug Use and Psychological Health: A Longitudinal Inquiry*, 45 AM. PSYCHOLOGIST 612, 612 (1990).

<sup>3</sup> In addition, this description of drug use fits with what we know about adolescence. That is, in our individualistic culture, adolescence is a time of experimentation with different options during the transition from childhood to adulthood. Teenagers get summer

They suggest that dealing with the underlying personal and social problems of drug abusers—rather than treating them as criminals—and leaving non-abusers alone, would be a more effective policy. Recognizing the significant harms caused by prohibition, explored thoroughly elsewhere in this issue, provides the motivation to change the current strategy for dealing with drug abuse.

## II

### DRUGS ARE INHERENTLY DANGEROUS VERSUS MANY FACTORS AFFECT THE DANGEROUSNESS OF DRUGS

A second assumption underlying the War on Drugs is that drugs are inherently dangerous and need to be prohibited. Although detailing the harms caused by drugs is beyond the scope of this Article, I will discuss variables overlooked by the assumption that argue against a policy of prohibition.

Principally, the assumption neglects the effects of dosage level and mode of administration.<sup>4</sup> Higher dosage levels are associated with an increased risk for more serious problems, from dependency to death.<sup>5</sup> Similarly, while administering a substance by injecting it is a very efficient means of getting it into your system, it is also a dangerous one because of the increased risk of transmitting diseases like HIV and hepatitis through shared needles.<sup>6</sup>

Contrary to the above assumption, the “Iron Law of Prohibition” states that prohibition leads to higher dosage levels and more dangerous modes of administration.<sup>7</sup> History has called attention to this effect. Under alcohol Prohibition, the United States went from a

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jobs and part-time jobs, and are exposed to courses in a variety of disciplines so that they can make informed career decisions. Dating is an institution that provides young people with experience in forming, maintaining, and dissolving intimate relationships, so that they have a basis for selecting a life partner. In a similar way, teen experimentation with forbidden psychoactive substances can be seen as a way of learning their effects so that they can decide whether to use them in the future. *See generally* JEFFREY JENSEN ARNETT, *ADOLESCENCE AND EMERGING ADULTHOOD: A CULTURAL APPROACH* (2001).

<sup>4</sup> Other relevant variables, such as the situation in which the substance is used and the effects users expect it to have, are omitted from this discussion.

<sup>5</sup> Robert M. Gable, *Acute Toxicity of Drugs Versus Regulatory Status*, in *DRUGS AND SOCIETY*, *supra* note 1, at 149–61.

<sup>6</sup> Michael C. Clatts et al., *The Impact of Drug Paraphernalia Laws on HIV Risk Among Persons Who Inject Illegal Drugs: Implications for Public Policy*, in *HOW TO LEGALIZE DRUGS*, *supra* note 1, at 80–101.

<sup>7</sup> Harry G. Levine & Craig Reinerman, *The Transition from Prohibition to Regulation: Lessons from Alcohol Policy for Drug Policy*, in *HOW TO LEGALIZE DRUGS*, *supra* note 1, at 264.

nation of drinkers of safe beer (low-dosage alcohol) to drinkers of higher dosage and often dangerously contaminated whiskey.<sup>8</sup> After Prohibition, the country gradually returned to its preference for beer.<sup>9</sup>

A similar consequence follows naturally from the black market created by the War on Drugs. Black marketeers want to pack as much of an outlawed substance as possible into the minimum volume, which is the definition of a high-dosage level,<sup>10</sup> and purchasers, because of the inflated black market price, want the biggest bang for their buck. We have thus gone from smoked opium to injected heroin, from low dosage cocaine in the original Coca Cola to inhaled powdered cocaine to crack, and from lower THC levels in marijuana over time to higher levels.<sup>11</sup> In addition, because marijuana is bulky and has a strong odor, it has the black market disadvantages of taking up a lot of space and being relatively easy to detect. This drives up the price of marijuana relative to cocaine and heroin and creates an economic incentive for users to switch from soft drugs to hard drugs. Similarly, because injecting is so efficient a way of using an expensive substance, users have an economic motivation to use this more dangerous means of administration.

Therefore, policies aimed at simply prohibiting targeted substances have counterproductive effects on the dangerousness of the very practices they attempt to prevent.

### III

#### THE GATEWAY DRUG FALLACY

A common argument against making marijuana legal for adults, in a manner similar to alcohol and tobacco, is that marijuana users are likely to progress to more dangerous substances. The gateway drug idea probably arose because, if you ask heroin addicts, the great majority will tell you that they used marijuana first.<sup>12</sup>

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<sup>8</sup> Harry G. Levine & Craig Reinerman, *Alcohol Prohibition and Drug Prohibition: Lessons from Alcohol Policy for Drug Policy*, in *DRUGS AND SOCIETY*, *supra* note 1, at 43–45.

<sup>9</sup> *Id.* at 48.

<sup>10</sup> For example, as the labels on the bottles show, an ounce of whiskey (high dosage level) contains more alcohol than an ounce of wine—which, in turn, contains more alcohol than an ounce of beer.

<sup>11</sup> Jefferson M. Fish, *Rethinking U.S. Drug Policy*, in *DRUGS AND SOCIETY*, *supra* note 1, at 3.

<sup>12</sup> See *Study Disputes Marijuana “Gateway Drug” Theory*, STOPTHEDRUGWAR.ORG (Sept. 2, 2010), <http://bit.ly/Vix6JS>.

The problem with this retrospective inference is that the addicts also drank water and breathed air before using heroin. Philosophers call the fallacy *post hoc, ergo propter hoc* (“after this, therefore because of this”),<sup>13</sup> statisticians speak of arguing from correlation to causation,<sup>14</sup> and experimenters refer to “selection bias” (incorrectly choosing participants in a study).<sup>15</sup>

The correct prospective question is, “What percentage of cannabis users go on to use heroin?” One hundred eight million Americans have used cannabis, and four million have used heroin.<sup>16</sup> Thus, the probability that someone who used cannabis will not use heroin is greater than ninety-six percent. (This is true even if every single person who used heroin had a previous experience with marijuana or hashish—an assertion known to be false.<sup>17</sup> So ninety-six percent may well be an underestimate.)

In addition to the methodological critique of the gateway drug fallacy, there are a variety of drug-war-related reasons (as opposed to marijuana-related reasons) that might encourage an association of marijuana use with the use of other banned substances. As mentioned above, the inflated price of marijuana relative to more compact and less easily detectable substances creates an economic incentive to try more dangerous ones. “Drug education” programs that exaggerate marijuana’s hazards may lead some young people to discount information about the dangerousness of cocaine or heroin, and decide to try them. (If marijuana were legal, there would be age restrictions on its sale; under prohibition, illicit dealers view young people as additional customers.) And it is possible for drug policy to separate the markets for regulated substances—e.g., insisting that alcohol, tobacco, and marijuana be sold in three separate locations. Such policies make multiple purchases more inconvenient, and hence less likely. In contrast, black market dealers can offer one-stop-shopping—including marketing strategies like free samples and

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<sup>13</sup> S. MORRIS ENGEL, WITH GOOD REASON: AN INTRODUCTION TO INFORMAL FALLACIES 165 (Don Reisman & Julie Nord eds., 5th. ed. 1994).

<sup>14</sup> THOMAS D. COOK & DONALD T. CAMPBELL, QUASI-EXPERIMENTATION: DESIGN AND ANALYSIS ISSUES FOR FIELD SETTINGS 53–54 (1979).

<sup>15</sup> *Id.* at 53.

<sup>16</sup> *Illicit Drug Use Tables—1.1 to 1.92 (Prevalence Estimates)*, SAMHSA, <http://1.usa.gov/X82gR4> (last visited Feb. 28, 2013).

<sup>17</sup> See generally Mary Ellen Mackesy-Amiti et al., *Sequence of Drug Use Among Serious Drug Users: Typical vs Atypical Progression*, 45 DRUG AND ALCOHOL DEPENDENCE 185 (1997).

discounts for first-time buyers—that encourage experimentation with additional banned substances.

#### IV

##### DRUGS CAUSE CRIME VERSUS CRIMINALS USE ILLEGAL SUBSTANCES

Yet another assumption is that drug use causes people to become criminals. Actually, it is drug prohibition—i.e., the War on Drugs—that causes a black market, and it is this black market, and not the drugs themselves, that causes crime, corruption, and disease.<sup>18</sup>

Because some substances are illegal, people who use them are by definition committing criminal acts. However, the stronger claim, that otherwise normal individuals are transformed by using prohibited substances into antisocial predators, is both questionable psychologically and another example of arguing from correlation to causation.

It is true that, because of inflated black market prices caused by prohibition, some troubled self-medicators turn to drug dealing, prostitution, or other illegal activities to support their habit. However, we should not confuse them with career criminals. People who have rejected society's rules about respect for individuals and their property are more likely than law-abiding citizens to reject the rules regarding intoxicating substances. Just as a salaried employee may enjoy a few beers or martinis after work, a thief may do the same with marijuana or other illegal substances. The alcohol didn't cause the employee to do his job any more than the illegal drugs caused the thief to steal.

#### V

##### PUNISHMENT AND MANDATORY TREATMENT VERSUS REINTEGRATION INTO SOCIETY AND VOLUNTARY TREATMENT

Another set of mistaken assumptions underlies current policy regarding prevention and treatment. Current policy argues that, when it comes to illegal substances, (1) all use is abuse, (2) a policy of zero

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<sup>18</sup> For this reason, critics argue that the goal of drug policy should be to attack the black market instead of attacking drugs. The black market undermines the stability of friendly countries (witness Colombia and Mexico) and finances our enemies (al-Qaeda and the Taliban, for example). Attempts to suppress the black market by force merely spread it, from one country to another or, in response to local police crackdowns, from one neighborhood to another. A variety of legalization and regulatory policies aimed at shrinking the black market, both domestically and internationally, are discussed by contributors to the three works referenced in Part I. *See supra* note 1.

tolerance will discourage use and therefore abuse, (3) punishing users will send a powerful message to others and prevent them from going down the wrong path, and (4) mandatory drug treatment, offered by the courts as an alternative to imprisonment, is an effective and enlightened policy.

An alternative set of assumptions is that (1) only some use, when it is out of control and self-destructive, is abuse; (2) for many individuals and many psychoactive substances—both legal and illegal—controlled, non-problematic use is possible; (3) marginalizing problem users is counterproductive—a more effective strategy is to reduce the harm they do to themselves and others, and attempt to reintegrate them into society; and (4) mandatory treatment undermines the institution of psychotherapy and is less effective than voluntary treatment.

Tolerance is a virtue, so it is unfortunate that a slogan like “zero tolerance” has become part of the world of prevention and treatment. A better slogan might be “get a life.”

I remember the anxiety in the law enforcement community and among many Americans when the Vietnam War ended and the troops came home. The fear was that tens of thousands of drug-addicted, trained killers were about to descend on American society. It was assumed that the returnees’ cravings for illegal substances from marijuana to heroin would lead to an unprecedented crime wave, as their addictions forced them to come up with the money to support their habits.

It never happened. Yes, some continued to have a drug problem, and others sought treatment, but for the great majority of problem users, they simply stopped—on their own, with no professional help.<sup>19</sup>

This non-crime-wave makes no sense in terms of our “drugs hook victims” ideology, but it is easily understandable from the point of view of “people with significant problems self-medicate.” In Vietnam, the soldiers’ lives were in constant danger, and staying high made them feel better. Back home, staying high interfered with their reintegrating into American society. Work, family, love, a better future—all of these depended on attending to and living in reality, not blotting it out.

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<sup>19</sup> See Charlie, *Sobering Statistics for the Vietnam War*, NAT’L VIET. VETERANS FOUND., INC., <http://www.nationalvietnamveteransfoundation.org/statistics.htm> (last visited Mar. 1, 2013) (“There is no difference in drug usage between Vietnam Veterans and non-Vietnam Veterans of the same age group.”).

## VI

## MARGINALIZING ALL USERS VERSUS INTEGRATING PROBLEM USERS

When it comes to people who use intoxicating substances, we need to distinguish among experimenters, occasional users, regular users, heavy users, and problem users—those for whom out-of-control use disrupts their love, work, and social lives, and often the lives of others as well. While the latter comprise a small minority of users, they consume the majority of banned substances.<sup>20</sup> So, an additional problem is that laws that treat all users as problem users cast much too wide a net.

Furthermore, over an individual's life, the degree of use varies, waxing and waning according to many factors, including the degree of economic security and of stress, the availability of social support, and the quality of family and work relationships. This is one of the reasons that it is possible for many, though not all, problem users to return to a level of moderate, non-problematic use. In addition, work by G. Alan Marlatt and his colleagues has shown that abstinence need not be the only acceptable treatment outcome.<sup>21</sup> Furthermore, techniques have been developed for preventing relapse and for getting problem users back on track after a relapse.<sup>22</sup>

Years ago, I had a conversation with a marijuana activist. He was an intelligent college-educated young man who could have earned much more in another line of work, but his revulsion at our drug policy led him to sacrifice income for what he viewed as a worthy cause. "You know," he said, "I've actually been smoking very little these days." He described his situation: he worked long hours and needed to keep a clear head; he was in a serious relationship with a woman and wanted to focus his attention on her when they were together; and as a single adult he had responsibilities for feeding himself and maintaining his apartment. In essence, he had a life and was involved with highly valued activities, so marijuana functioned

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<sup>20</sup> This is known as the Pareto principle, or the eighty-twenty rule. Applied to business or illegal drug markets, it means that roughly eighty percent of sales come from twenty percent of customers (i.e., heavy users and problem users). VILFREDO PARETO, *MANUAL OF POLITICAL ECONOMY* (Ann S. Schwier & Alfred N. Page eds., Ann S. Schwier trans., 1971).

<sup>21</sup> See generally HARM REDUCTION (G. Alan Marlatt ed., 1998); RELAPSE PREVENTION (G. Alan Marlatt & Dennis M. Donovan eds., 2d ed. 2005); Mary E. Larimer et al., *Relapse Prevention: An Overview of Marlatt's Cognitive Behavioral Model*, 23 ALCOHOL RES. AND HEALTH 151 (1999).

<sup>22</sup> See generally Katie Witkiewitz & G. Alan Marlatt, *Relapse Prevention for Alcohol and Drug Problems: That Was Zen, This Is Tao*, 59 AM. PSYCHOLOGIST 224 (2004).

for him the way alcohol functions for occasional users of that substance—now and then providing a few hours of an altered state of consciousness, integrated into an otherwise fulfilling life.

By criminalizing all use, we marginalize problem users—the loss of social support diminishes their likelihood of recovery—and we also marginalize non-problem users who have the bad luck to get caught up in the criminal justice system, thereby creating serious problems for them where none existed.

## VII

### COMPULSORY TREATMENT VERSUS VOLUNTARY TREATMENT

Supposedly, compulsory drug treatment offers an enlightened option for users who have been arrested.<sup>23</sup> To understand why this is

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<sup>23</sup> The widespread use of compulsory treatment by drug courts and claims of effectiveness raise many methodological issues that are beyond the scope of this Article. Even assuming that the studies meet basic methodological requirements, such as the representativeness of the sample studied and the random assignment of subjects to different groups (many studies do not meet these criteria), they fall short by typically comparing recidivism rates between treated and untreated groups. A more appropriate comparison would be between the effectiveness of voluntary treatment and compulsory treatment.

I also think it would be instructive to respond to a point made by another author in this Issue. In Part VIII of his Article, Kevin Sabet asks, “Can drug users be *forced* to stop using drugs?” Kevin Sabet, *A New Direction? Yes. Legalization? No. Drawing on Evidence to Determine Where to Go in Drug Policy*, 91 OR. L. REV. 1153, 1175 (2013). I would argue that two more appropriate questions are: (1) “*Should* drug users be forced to stop using drugs?” and (2) “Can voluntary treatment help a larger proportion of problem users than compulsory treatment?”

The systems movement, which views problem behavior as embedded in a larger social context of patterned interactions, has transformed the field of family therapy. One pattern of interaction, known as a symmetrical escalation, is seen in phenomena such as the Cold War arms race, or the escalation in weapons and violence in the wars against drug cartels. A book by the family therapist Paul Watzlawick, *The Situation Is Hopeless, But Not Serious*, calls attention to the ways in which escalating attempts to solve an insoluble problem can create a much greater disaster than the problem itself. See generally PAUL WATZLAWICK, *THE SITUATION IS HOPELESS, BUT NOT SERIOUS* (1983).

Dr. Sabet begins with the assumption that drugs should be outlawed and recognizes that the policy has many undesired consequences. As I see it, his solution is—rather than changing the policy—to double down on it by targeting the undesired effects. This escalation creates even more undesired effects—for example, undermining the institution of therapy. The War on Drugs is like the Midas touch in reverse—everything it touches turns to muck. We would never put teachers on the beat to fight crime, but we put cops in the classroom to teach about drugs. And we would never put therapists on the bench, but now we have judges overseeing therapy. I sympathize with judges. They see the injustices perpetrated by the current system, and they want to make matters better. The problem is that, when therapists work for the court instead of for their clients, trust and confidentiality are undermined. This has consequences for all clients—not just those involved with the judicial system.

not the case, it is necessary to have a basic understanding of the way therapy works. To begin, therapy is based on trust. In voluntary therapy, the therapist is working for the client, and what happens in therapy is protected by confidentiality. That relationship allows the client to candidly discuss anything, including illegal drug use. If the client feels that therapy isn't working, she is free to leave altogether, or to seek another therapist. By contrast, in compulsory drug treatment, the therapist is working for the court, and seeking to leave therapy can be labeled as uncooperative behavior and result in imprisonment.

For non-problem users, therapy turns into a charade. The individual has to pretend he has a drug problem so that he can avoid going to jail. He then has to pretend to cooperate with the therapist because lack of cooperation could get him sent to jail. The therapist gets paid for her time, which provides an incentive to maintain the charade. Eventually, the client is deemed cured and has succeeded in avoiding jail by undergoing the lesser punishment of pretend therapy. Some people may actually benefit from the process by dealing better with various aspects of their lives, but this is hardly a justification for undermining the institution of therapy by making therapist and client coconspirators in a lie.

In order to understand the situation for problem users, it is necessary to consider the role of motivation in therapy. Here is a relevant joke:

Q: How many therapists does it take to change a light bulb?

A: Only one, but the light bulb has to want to change.

Why is it that the success rates in therapy are so much better for anxiety and depression than they are for substance abuse? The reason is that anxiety and depression are unpleasant, so clients are motivated to change. They are likely to cooperate with therapists because they

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What is needed is a change in the drug laws. Unfortunately, some miserable people have always abused substances; and some will continue to do so in the future. We need to accept that reality, and try to minimize the harm such people do to themselves and others. Dr. Sabet and I agree that the negative effects of alcohol are much greater than the combined negative effects of all illegal drugs. It follows, therefore, that—even if all illegal drugs were made legal for adults in varying ways, and regulated, and taxed according to a variety of plans—the negative effects of doing so would be much less than the negative effects of ending alcohol prohibition. The counterproductive effects of forcing people to stop using drugs are revealed by asking the question, “Should we force people to stop using tobacco and alcohol?” and imagining the social consequences. Actually, we already tried that with alcohol.

want to avoid or minimize unpleasant feelings and experience positive feelings instead. The situation is the opposite for overeating, risky sexual behavior, gambling, and substance abuse. These are pleasurable activities, so change—even if it is clearly better for the client—entails a loss of an important source of pleasure. Thus, when clients are self-motivated to change because they see that they are headed in a bad direction, they are more likely to cooperate with a therapist who suggests difficult or unpleasant tasks than they are with a court-ordered therapist who says “Change, or else!” This is one reason for the slogan “drug treatment on demand.”<sup>24</sup> You’ll get better results with people who want to change than with those who are forced to change against their will.

One form of brief therapy, known as solution-focused therapy,<sup>25</sup> describes three kinds of therapeutic relationships. In a customer relationship, the individual wants to change (technically, he is “willing to construct a solution”) and the therapist helps him to change.<sup>26</sup> In a complainant relationship, the client wants to complain, but is unwilling to change (e.g., “I’d be fine if only my spouse would change”).<sup>27</sup> In a visitor relationship, the individual has neither a complaint nor an interest in changing (e.g., a child has problems at school, his mother brings him for therapy, and his father, the visitor, comes because the therapist asked him to, although he isn’t sure what he is doing there).<sup>28</sup> In general, solution-focused therapists work directly toward change with customers and try to convert complainants and visitors into customers.<sup>29</sup>

A colleague suggested that compulsory treatment deserved a separate label as a fourth kind of relationship—a hostage relationship.

## CONCLUSION

By replacing the inaccurate assumptions and causal models underlying the War on Drugs, we are left with better alternatives

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<sup>24</sup> See generally Lynn D. Wenger & Marsha Rosemblum, *Drug Treatment on Demand—Not*, 26 J. PSYCHOACTIVE DRUGS 1 (1994).

<sup>25</sup> See generally STEVE DE SHAZER, *CLUES* (1988); STEVE DE SHAZER, *PUTTING DIFFERENCE TO WORK* (1991); STEVE DE SHAZER, *WORDS WERE ORIGINALLY MAGIC* (1994).

<sup>26</sup> Jefferson M. Fish, *Solution Focused Therapy in Global Perspective*, *WORLD PSYCHOL.*, Apr. 1995, at 43, 50.

<sup>27</sup> *Id.* at 50–52.

<sup>28</sup> *Id.* at 52.

<sup>29</sup> *Id.*

which point to a different way of understanding drug use and abuse, and to different drug policy options. These alternatives include (1) differentiating between problem users, who should be offered help, and non-problem users, who should be left alone; (2) shifting from a policy of punishing and marginalizing problem users to one of harm reduction and attempting to reintegrate them into society; (3) shifting from a policy of compulsory treatment to one of voluntary treatment; (4) recognizing that many (but not all) problem users can become occasional, non-problem users—abstention need not be the only acceptable treatment outcome; and (5) shifting from a near-exclusive treatment focus on the substance itself to building on positive aspects of people's lives, such as work, family, friends, activities, and interests.