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Re-visioning Drug Use: A Shift Away From Criminal Justice and Abstinence-based Approaches

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Introduction

The use of drugs is highly prevalent in the United States, yet the current landscape of drug policy and practice is failing individuals, families, communities, and society at large. Since 2002, drug use has increased from 8.3% to 9.2% of the population aged 12 and older, meaning that 23.9 million Americans have used an illicit drug (National Institute on Drug Abuse, 2012). In New York City alone, there has been an 84% increase in heroin overdose deaths between 2010 and 2012 (Goodman, 2014). These trends are occurring despite policies and practices promoting prohibition and abstinence. The current approach to drug use has failed to provide needed treatment, as only 2.5 million of the 23.1 million people needing treatment received it in 2012 (National Institute on Drug Abuse, 2012). Beyond failing to provide treatment, the current approach has greatly exacerbated the harms of substance use for individuals and has destroyed the fabric of families, communities, and society. In order to address drug use, we need to move away from this punitive, zero tolerance perspective to a more humane and accepting public health model that incorporates harm reduction and social work philosophies.

1 Policy Informs Practice

Drug policy, on both the national and state level, informs the way drug use is understood and treated. As drug use is most often criminalized in the US, the objectives of the War on Drugs are prohibition and control, which lead to the practices of punishment, particularly incarceration, and abstinence-only treatment. Together, these policies and practices have not only failed to adequately combat drug use, but have exacerbated the harms associated with drug use.

1.1 US National Drug Policy

The themes of national drug policy, commonly referred to as the War on Drugs, are criminalization, prohibition, and control. This approach was solidified in the Controlled Substances Act of 1970, which has since been amended several times. This legislation established the Drug Enforcement Agency and criminalizes almost all pharmacological substances, attaching criminal penalties to their possession, use, and sale (Drug Enforcement Agency [DEA], 2012). Many scholars contend that the War on Drugs was formally declared with the passage of the Federal Anti-Drug Abuse Act in 1988, which sought to create a drug-free America, emphasizing prohibition in a criminal justice framework (Marlatt, 1998). It established harsh mandatory minimum sentencing guidelines for drug offenses, virtually eliminating judicial discretion when deciding on prison terms for drug offenders. Many states similarly established fixed minimums, as well as three strikes law mandating life sentences for anyone convicted of a third offense, no matter its severity (Alexander, 2010). The Anti-Drug Abuse Act also mandated abstinence-based drug policy, thus offering support for abstinence-only treatment approaches (MacMaster, 2004).

Many other policies and Supreme Court rulings have had the effect of expanding and strengthening this criminal justice approach. For example, several Supreme Court rulings have circumvented the 4th amendment and increased the ability of police officers to stop and search people without reasonable suspicion, finding that consent searches (complying with an officer's request to search) and pretext stops (using traffic violations as a pretext to search for drugs) are constitutional (Alexander, 2010). The DEA's 1984 Operation Pipeline trains law enforcement to use these tactics in their search for drugs, and the 1988 Edward Byrne Memorial State and Local Law Enforcement Assistance Program offers federal aid in the form of funding, training, intelligence, and technical support and equipment to agencies specializing in drug enforcement activity. SWAT teams are even used during drug raids (Alexander, 2010). The message is clear: drug use is considered highly criminal activity that will be punished harshly.

1.2 New York State Drug Policy

New York State has implemented particularly draconian drug policies, though work is currently being done to reverse these trends. In 1973, the Rockefeller Drug Laws (named after Governor Nelson D. Rockefeller) were enacted. They established mandatory minimum sentences of 15 years to life for possession of 4 ounces of narcotic substances, including marijuana, or sale of 2 ounces. These were one of the harshest in the nation, and several states followed suit, such as Minnesota and Michigan (Gray, 2009).

The penalties were relaxed in 2004 when Governor George Pataki passed the Drug Law Reform Act, which reduced the minimum to 8 to 20 years and allowed those previously convicted to apply for lighter sentences. These punishments were still seen as very harsh, prompting Governor Paterson to continue reforms in 2009. His reforms eliminated some mandatory sentences, made low-level offenders eligible for treatment, and applied these changes retro-actively (Gray, 2009). Additionally, though marijuana remains illegal under federal law, New York has also decriminalized small amounts of marijuana possession. If in public view, however, which often occurs during police searches, criminal penalties, including incarceration, can be imposed (Gray, 2009). Despite the beginnings of reform, New York remains tough and punitive in its approach to drugs.

1.3 Policy Produces Failing Practices: Punishment/Incarceration

These national and state policies thus lay the framework for how drug use is handled, producing a system of control. In New York, and generally nationwide, this means drug use is met with either punishment or treatment aimed at abstinence. These practices have not only failed to effectively address drug use and crime, but have also revealed the glaring problems with the current set of policies.

Before detailing the specific failures of both punishment and abstinence-only programs, it is important to note that policies of drug control have often served to exacerbate the harms associated with substance use. This zero-tolerance approach stigmatizes, marginalizes, and criminalizes people who use drugs, thus intensifying the health and social costs of use (Marlatt, 1998). Aside from the vast economic, health, and social costs of incarceration, which will be addressed in the next section, there are additional harms resulting from criminalization and prohibition. Serious health risks are increased by the lack of quality control and safety regulations governing the production and distribution of illegal drugs, and drug paraphernalia criminalization increases the spread of infectious disease, such as HIV/AIDS (Barnett, 2009). Other studies find that repressive policies and fear of arrest,

stigmatization, or other consequences preclude drug users from accessing health services and increase the risk of drug overdose, disease transmission, and death (Global Commission on Drug Policy, 2011). Additionally, drug control policies have eroded civil liberties, producing a social cost that may exceed the costs associated with actual drug use. There seems to be a "drug exception" to the Constitution, as law enforcement conducts warrantless searches and seizures, and the use of drug tests violates individuals' rights to privacy (Stevenson, 2011). It is clear that repressive drug policy may actually contribute to the harms associated with drug use. The use of incarceration to punish drug use highlights this concept even further.

The policies related to the War on Drugs have produced the system of mass incarceration now plaguing American society, as punishment for drug possession, use, and sale largely takes the form of imprisonment. Since the 1970s, the incarcerated population has swelled to ten times its size, from fewer than 200,000 to 2 million people (Currie, 2013). By 2007, over 7 million people were incarcerated, on probation, or on parole (Alexander, 2010). This exponential increase can be explained by the policies of the War on Drugs, as drug offenders have been the fastest growing segment of the prison population since the 1980s (Currie, 2013). Drug arrests have tripled since 1980, with four out of five being for possession only, and the percentage of drug arrests resulting in prison sentences, rather than other alternatives, has quadrupled. Thus, drug offenses constitute two-thirds of the increase in federal prison populations and over half the increase on the state level (Alexander, 2010). In 2006 alone, drugs were involved in three-fourths of incarcerations (The National Center on Addiction and Substance Abuse at Columbia University [CASA], 2010).

The explosion in the criminal justice response to drugs applies to youth as well. In the year 2000 alone, of the 2.4 million juveniles between the ages of 10 and 17 who were arrested, almost 80% of the arrests were related to substance use. Over half tested positive for drugs at the time of the arrest, with 92% of these testing positive for marijuana (CASA, 2004). Similarly, in the 1990s, almost 80% of the growth in drug arrests for adults can be explained by marijuana possession (Alexander, 2010).

In New York State prisons, the percentage of drug offenders ballooned from 11% in 1973 to 35% in 1994, largely due to the Rockefeller Drug Laws, which have since been relaxed. Consistent with nation-wide trends, non-violent, low-level drug possession and sales accounted for much of the increase (Gray, 2009). According to Governor Paterson, as cited in Gray (2009), 84% of offenders lacked any prior history of violence, and many of those incarcerated were struggling with substance use and were selling to feed their habits. Beyond ineffective at reducing or eliminating drug use, the practice of incarceration has proved harmful on multiple levels, including for individuals, families, communities, and society at large.

Individuals

Individuals convicted of a drug crime face a myriad of hardships both while incarcerated and upon release. The culture of incarceration generally undermines rehabilitation efforts, and the vast majority of drug users in jails and prisons do not even receive substance use treatment (Stevenson, 2011). One study found that 85% of those incarcerated were substance-involved; 1.5 million of the 2.3 million individuals in jail or prison met DSM-IV criteria for substance abuse or addiction, and another 450,000 had histories of abuse or their crime was related to drugs or alcohol (CASA, 2010). A 2004 study found that 53% of state inmates, 45% of federal inmates, and 68% of jail inmates met DSM-IV criteria for substance abuse or

dependence (The Sentencing Project, 2008). Only 11-17% of inmates with substance use issues, however, received any treatment while incarcerated, as federal, state, and local governments spent only 1% of funds for substance-involved offenders on prevention and treatment (CASA, 2010). People are thus released back into society without treating their substance use, essentially guaranteeing a return to substance use and greater chances of recidivism.

The difficulties continue upon release, especially for those convicted of a felony, who experience severe collateral consequences as a result of their incarceration. They often do not receive appropriate services while in prison to address their mental health, substance use, educational, and employment needs (The Sentencing Project, 2008). They then face a plethora of barriers upon re-entry related to finding stable housing, obtaining employment, receiving public benefits (such as food stamps or welfare), and accessing higher education, as discrimination against those convicted of a drug crime is legal in these life areas (Alexander, 2010). Though it has been demonstrated that housing, employment, and education can improve substance abuse outcomes, these needs are largely unmet for those returning from prison (Lattimore, Steffey, & Visher, 2010). They are additionally politically disenfranchised, as many states remove voting rights for those in prison and those with a felony conviction (Weaver & Lerman, 2011). The stigma, as well as the legal and social exclusion, weakens social ties and community attachment, thus making it very difficult to abstain from drugs and lead a life free of crime (Alexander, 2010).

Families & Communities

Punishing drug users through incarceration is detrimental for families, as family cohesion is often destroyed (Marlatt, 1998). Incarceration can destabilize couples because of the separation, distrust, and stigma extended to both partners while one is incarcerated, and it also reduces the likelihood of marriage (Western & Wildeman, 2009). Many incarcerated individuals are parents as well. Ten million children nationwide have experienced parental incarceration in their lifetime, and 60% of people in New York prisons report having a child (The Osborne Association, 2013). Imprisonment affects the ability to play a parental role, and children often experience instability in their home life and education, particularly if their mother is incarcerated (Kruttschnitt, 2010). Parental incarceration exacerbates childhood behavioral and mental health problems (such as aggression, depression, and anxiety), which then affects school success, drug use, and delinquency, as well as later adult criminal activity, occupational attainment, and family formation (Wakefield & Wildeman, 2011; Kruttschnitt, 2010). Parental incarceration also increases the risk of children living in poverty or entering foster care. The separation and loss are made even more painful because of the shame, stigma, ambiguity, and lack of compassion and social support attached to parental incarceration; this phenomenon is often referred to as disenfranchised grief (The Osborne Association, 2013).

This instability extends to communities as well. Mass incarceration due to the War on Drugs has led to the systematic imprisonment of whole groups of the population, as one third of New York's prison population comes from just seven (out of 50) community board districts (Weaver & Lerman, 2011). This means that resources and potential wage earners and community members are removed from their communities, which are plagued by high unemployment, inadequate school systems, lack of funding and services, and police presence and surveillance (Visher & Travis, 2011). The disruptive influence of incarceration thus extends to all children and families in high-incarceration neighborhoods (Wakefield & Wildeman, 2011). This is particularly true when there are high rates of female incarceration

because women are often a major source of social capital. They are generally invested in informal and community social networks, serving as the glue that keeps neighborhoods together by participating in community institutions, such as schools, churches, and social gatherings. When they are removed, community instability is enhanced (Kruttschnitt, 2010).

Society & Public Safety

Incarceration is similarly costly for society, in terms of economics and public safety. The cost of incarceration has quadrupled in the last two decades. One study, by the Vera Institute, showed that the cost to taxpayers in 40 states totaled $39 billion; in New York, the per-inmate cost stands at $60,076 (Henrichson & Delaney, 2012). The money funneled into the criminal justice system is thus money that cannot be spent or invested on other services, such as education, health care, and social services.

Despite the immeasurable growth of incarceration and criminal justice spending, the imprisonment increases have had no effect on the crime rate (Currie, 2013). In the wake of the Rockefeller Drug Laws and the increase in drug convictions, New York saw no measurable decrease in crime (Gray, 2009). In fact, these policies may be undermining public safety. As those returning from prison have difficulty meeting their needs, substance use and recidivism rates remain high. In New York, the Rockefeller Drug Laws were met with an increase in recidivism rates (Gray, 2009). Studies show that young people sentenced to adult prison are more likely to re-offend, to re-offend sooner, to commit more serious offenses, and to commit more offenses (Young & Gainsborough, 2009).

Drug prohibition policies and the criminal justice approach to drug control may actually even increase and exacerbate violent crime. Illegal drugs and violence are linked because of the illegal drug markets that are unregulated by the government, not because of the pharmacological effects of drugs. The violence is related to drug prohibition rather than to drug use itself, as illegal markets compete for territory and consumers (Barnett, 2009). This threat to public safety is thus a direct result of the criminalization of drugs.

Racism

With documented racial disparities in every stage of criminal justice involvement from arrest to incarceration, punishment as a response to drug use is even more problematic because racial groups are treated differently for the same criminalized behavior. African Americans constitute as high as 80% to 90% of incarcerated drug offenders in some states, including New York (Alexander, 2010; Gray, 2009). One study of youth ages 12-17 found that African American youth were 1.6 times as likely to get arrested once and 2.5 times as likely to get arrested multiple times, as compared with white youth. This disparity existed despite higher rates of reported substance use and drug-selling activity among white youth (Kakade, et al., 2012). Another study of 18- to 25-year-olds found that arrest and imprisonment was more common for African American males than attending college or joining the military (Comfort, 2012). While African Americans only constitute 13% of the overall population, they represent 38% of the incarcerated population; despite representing 17% of their age group, African American youth make up 46% of juvenile arrests and 41% of waivers to adult court (The Sentencing Project, 2008). The chances of spending time in prison across the lifespan are 32% for black males, 17% for Hispanic males, and 6% for white males (The Sentencing Project, 2008). In terms of drug offenses, black people are 10 times more likely to be sent to prison than whites (Denning & Little, 2012).

These disparate rates of criminal justice involvement differentially affect family and community stability based on race. Compared to 1.8% of white children, 3.5% of Hispanic children and 11.4% of African American children have an incarcerated parent (The Osborne Association, 2013). As parental incarceration exacerbates mental health and behavioral problems, these racial differences in incarceration have implications for racial disparities in education, occupational attainment, and well being in adulthood. Mass incarceration thus plays a role in the intergenerational transmission of racial inequality. These effects are experienced by all residents of a high-incarceration community (Wakefield & Wildeman, 2011). Moreover, people of color are less likely to receive alternative sentences that keep them in programs in their communities. These communities of color then experience reduced social cohesion, disrupted family ties, and reduced incomes (The Sentencing Project, 2008).

Additionally, racial disparity in the criminal justice system cultivates public mistrust in the system, which hinders public safety. Without a sense that the system is fair, confidence in it is weakened. This is especially true in terms of the relationship between communities and law enforcement as the partnership is eroded by mistrust and suspicion (The Sentencing Project, 2008).

1.4 Policy Produces Failing Practices: Abstinence Only Treatment Approaches

Coupled with incarceration, the current nature of drug policies produces a treatment approach emphasizing abstinence only, which has been ineffective in addressing drug use. As the Federal Anti-Drug Abuse Act mandated abstinence-based drug policy, it led to abstinence-only treatment programs and to the Drug-Free Schools and Community Act Amendment of 1989, mandating all schools and colleges to implement abstinence-based policies in regard to drug use by students (MacMaster, 2004). One study found that 99% of substance abuse treatment centers nationwide ascribe to an abstinence orientation (MacMaster, 2004).

Relying on abstinence approaches has been ineffective and counter-productive. Though not specific to the US, a study by the United Nations estimates that illegal drug consumption has actually increased globally by 34.5% for opiates, 27% for cocaine, and 8.5% for cannabis (Global Commission on Drug Policy, 2011). Similarly, school-based abstinence programs have not deterred young people from alcohol and drug use. One study showed that alcohol and drug use actually increased among youth from 1975 to 1996, during the wake of the War on Drugs (Marlatt, 1998). Another study shows that among youth aged 15-17 years old, 27.5% of African American youth and 35.6% of white youth have used illegal drugs, and 48.4% of African American youth and 66.1% of white youth have consumed alcohol (Kakade, et al., 2012).

Abstinence-based approaches are also not always practical or appropriate. First, these approaches often lose credibility with youth because they fail to acknowledge the pleasures of drug use, as well as the fact that many adults in young people's lives have used or currently use drugs and yet are not addicts. They also alienate people who have or will experiment with drugs because they consider all use to be abuse. They do not seem to distinguish between levels of use, even though light and heavy users pose very different risks (Resnicow & Drucker, 1999). Additionally, research shows that most clients in abstinence-based substance abuse treatment do not abstain and do not complete programs. Many others do not have access to such programs due to monetary and other obstacles, such as abstinence as a pre-requisite for admission. For example, drug users who are not interested in immediate abstinence often go untreated because they are seen as resistant. Individuals are then often

faced with a choice between abstinence-based treatment or no treatment at all (MacMaster, 2004).

Thus, zero tolerance policies and abstinence-based programs have failed to eliminate drug use, which may have actually increased, and have failed to address the harms of use. In fact, these policies have been a source of drug-related harms themselves, as prohibition and its enforcement leads to some direct harms (i.e. incarceration and its negative consequences) and exacerbates others (i.e. negative health outcomes).

Mandated Treatment

Additional research demonstrates that mandated drug treatment, which is often the alternative to incarceration offered to drug offenders, may not be effective either. Drug courts were established in the 1980s in response to exploding prison populations, many of whom faced drug-related charges, and the resulting enormous costs (Ekstrand, 2005). In New York State alone, the Division of Probation and Correctional Alternatives funds 165 alternative to incarceration (ATI) programs (New York State Division of Criminal Justice Services, n. d.). While some studies provide solid evidence for reductions in recidivism as a result of these programs, the evidence is much more limited related to substance use outcomes (Ekstrand, 2005).

Studies indicate that mandated treatment does not produce significant reductions in substance use and that coerced treatment actually hinders recovery by interfering with internal motivation, engagement, and compliance. For example, one study found reductions in drug use during program participation, but no reductions a year after program completion (Ekstrand, 2005). The bulk of research that shows positive treatment outcomes emphasizes program completion as the marker of success and does not assess continued sobriety once participants are discharged from the program (Kras, 2012). The study by Ekstrand (2005) thus demonstrates that perhaps these results are inaccurate, rendering mandated treatment less successful than some research indicates.

A different study found that the chances of relapse for those court mandated to attend treatment were 1.7 times greater than for those without such legal pressure (Brecht, Anglin, & Dylan, 2005). Similarly, Cosden, et al. (2010) revealed that a lack of personal commitment and too many program demands contributed to unsuccessful program completion, while personal motivation enhanced completion. This study seems to indicate, then, that mandated treatment may be unsuccessful. In much the same vein, Schroder, Sellman, Frampton, and Dering (2009) found that participants were more likely to drop out if they reported less internal motivation, more external pressure to attend treatment, lower expectations that treatment would help, and less inclusion in the goal-setting process, which may all be characteristics of mandated treatment.

It thus seems clear that incarceration and mandated, abstinence-only approaches are ineffective in addressing drug use and its harms, demonstrating that alternatives are sorely needed.

2 An Alternative Approach: Harm Reduction

The War on Drugs and its policies of prohibition have produced enormous costs, both economic and human. Current policies have created a system of mass incarceration, with all of its attending human costs and racial inequities, and have relied on ineffective abstinence-

only approaches. It seems the prohibition of drugs has caused more harm than actual drug use (Denning & Little, 2012). Harm reduction represents a viable alternative option that has demonstrated success in addressing drug use and its harms, including crime. It initially emerged as a philosophy and set of practices in the 1980s in response to the HIV/AIDS crisis, with the goal of reducing the spread of the virus among drug users. Harm reduction aims to reduce drug-related harms to individuals, families, and communities by focusing on the negative consequences of drug use and prohibition (Denning & Little, 2012).

Harm reduction is largely a public health intervention, involving a compassionate, human approach and pragmatic strategies that include safer drug use (i.e. needle exchange programs, wound care, overdose prevention), moderation management (i.e. controlled drinking, methadone-maintenance programs), education, and abstinence when desired and appropriate. The approach accepts drug use as a realistic part of life and works to mitigate its negative effects rather than to punish or ignore those who engage in this behavior (Denning & Little, 2012). The overarching goal is to improve the quality of life for individuals, families, communities, and society at large by eliminating the negative consequences of drug use (Marlatt, Larimer, & Witkiewitz, 2012).

Harm reduction involves work on multiple levels: the individual, the environment, and laws and policies. First, in terms of prevention and treatment, education and training are emphasized to prevent and minimize harms in regard to individuals and groups. This includes gaining awareness and knowledge about drug use and its consequences, training in coping skills, and promoting healthier and risk-reducing behaviors. Second, harm reduction works for environmental change by increasing the availability of harm-reducing tools and settings, such as designated driver programs, needle exchange programs, and safe-injecting sites. Third, this approach seeks to reform laws and policies, particularly zero-tolerance. Examples include policies increasing the availability of these tools or policies aimed at decriminalization (Marlatt, 1998; James, 2007).

Why Harm Reduction Can Improve Drug Treatment and Outcomes

Harm reduction can improve both the health and treatment of drug users, as well as outcomes, in a myriad of ways. First, it is more empirically-based than more traditional approaches that rely on fear- and morality- based messages or "just say no" mantras. Its principles and strategies rely on research findings and scientific demonstrations of what works to reduce harm, such as the effectiveness of needle exchange programs and reductions in disease transmission (James, 2007). This emphasis on empirical evidence stems from harm reduction as a public health alternative, rather than as a moral/criminal or disease model. The moral model has led to the current US drug control strategy of prohibition and punishment, and the disease model has led to the emphasis on abstinence-only treatment, which have both failed. Harm reduction shifts to a focus on the consequences of use, empirically evaluating their extent of harm and ways to reduce them (Marlatt, 1998).

There are other advantages of moving away from the disease model, which posits that drug addiction is a disease that cannot be cured but rather can be controlled through abstinence. The language of this model limits the way we think about drug use. For example, terms such as "addict" and phrases such as "once an alcoholic, always an alcoholic" stigmatize people and imply a loss of control and autonomy, constricting individuals' behavioral possibilities. The only acceptable goal is abstinence, which creates a dichotomy between "clean and sober" and "dirty," limiting the types of relationships users may have with drugs. Harm reduction

recognizes that an individual's relationship with drugs is much more complex, involving biological, psychological, social cultural, and spiritual aspects, and thus expands possibilities for change (Denning & Little, 2012). Additionally, the imposed goal of abstinence may not coincide with the client's relationship to drugs or his or her goals, creating resistance. Optimal outcomes are achieved when the client, not the program or counselor, chooses the goals. This is precisely what harm reduction allows (Denning & Little, 2012).

Second, harm reduction is more inclusive and expands access to treatment. Traditional approaches equate use with abuse and do not differentiate among levels of use or a hierarchy of risk. This alienates people who do not identify as addicts and who may be occasional or experimental users; these individuals may face very different risks and have very different needs than heavy users (Resnicow & Drucker, 1999). One study conducted by the United Nations found that of the 250 million drug users worldwide, less than 10% could be categorized as dependent or "addicts" (Global Commission on Drug Policy, 2011). While users who are not addicted do indeed face certain harms, such as risk of overdose, they are generally excluded by approaches that define any use as addiction (Denning & Little, 2012). Harm reduction, on the other hand, addresses each person's individual relationship with substances and their patterns of use, rendering it more inclusive. Treatment providers acknowledge the uniqueness of each user, and, in partnership with the user, formulate an individualized plan to reduce harm (Marlatt, 1998). Interventions reflect the specific needs, goals, and ideas of the individual, the family, and the community (Denning & Little, 2012), and they are flexible and culturally competent (Marlatt, Larimer, & Witkiewitz, 2012).

Harm reduction expands access to treatment because it increases the options offered to drug users. It offers an alternative outside of the choice between abstinence or punishment and between abstinence or no treatment at all (Marlatt, 1998). It offers a middle ground between complete abstinence and continued harmful behaviors, thus reducing negative consequences and increasing the opportunities and pathways for change (Marlatt, Larimer, & Witkiewitz, 2012). It recognizes that those who are not ready for abstinence still have needs that should be met. Similarly, while traditional prevention programs promote zero-tolerance and "just say no," those based on harm reduction principles include those who may have already tried drugs. As harm reduction usually involves a low-threshold, street-based outreach component, it reduces formal (and informal) barriers to treatment (James, 2007). It expands access to treatment by eliminating abstinence as a precondition and by reducing the stigma associated with substance use. People are most motivated to seek treatment when they have personally experienced the negative effects of using drugs, such as financial loss, relationship problems, or health issues. By focusing on these harms (as well as forming more adaptive coping mechanisms) rather than by labeling "addiction" as the problem, which often produces stigma, people are more likely to seek treatment and support (Marlatt, 1998; James, 2007).

Third, harm reduction expands the possibilities for positive change while maintaining abstinence as an available option. Harm reduction broadens the definition of recovery to include any positive change, not just abstinence. While it recognizes abstinence as an ideal outcome, it accepts alternatives that reduce harm. High recidivism rates for those incarcerated and high relapse rates for those treated demonstrate that abstinence may not be the only acceptable outcome (Stevenson, 2011). Harm reduction views both risky behavior and change along a continuum and encourages gradual approaches to reduce negative consequences. While abstinence is still the ideal endpoint, people can minimize their risky behavior and its harmful effects along the way. Any decrease in harm is viewed as a positive change (Marlatt, 1998). Abstinence is one of many goals, which are placed on a hierarchy, beginning with

immediate and realistic goals and working toward risk-free use or no use at all (Denning & Little, 2012).

Harm reduction and drug treatment can be integrated because harm reduction is compatible with abstinence-based goals while providing additional benefits to individuals and communities. Abstinence is included in goal-setting and individualized plans if it is acceptable, appropriate, and desirable for the individual. Though harm reduction offers additional pathways to change for those who are not ready, willing, or able to achieve complete abstinence, it still supports abstinence as the best way to minimize harm. Though it does not impose abstinence, it supports abstinence as a client-generated goal (Marlatt, Larimer, & Witkiewitz, 2012). It has been demonstrated that clients fare better when they have the choice of treatment and goals. Harm reduction and traditional drug treatment can work in tandem on certain common goals, such as saving lives by reducing deaths and helping people foster healthier lifestyles (Marlatt, 1998).

Harm reduction strategies often provide additional benefits because their scope extends beyond eliminating use. Interventions are aimed at multiple levels, including the individual, family, community, and society. For example, education may be used on the individual and family level to reduce harm and improve health, formation of needle exchange programs on the community level, and decriminalization of use at the societal level (Marlatt, Larimer, & Witkiewitz, 2012). Expanding intervention points widens the possibilities for positive change.

Last, and perhaps most importantly, harm reduction improves outcomes. Evidence of its benefits in terms of health and crime has been demonstrated in the literature. For example, one global study found that countries that implemented comprehensive harm reduction strategies experienced the lowest rates of HIV and other infectious disease transmission (less than 5%), and countries that introduced harm reduction in response to increasing HIV rates were able to contain the spread and reverse the trend. On the other hand, countries relying on prohibition and control have seen the highest rates of HIV, up to 40%. In this study, the US fell under the category of partial harm reduction implementation, with HIV prevalence rates for drug users at about 15% (Global Commission on Drug Policy, 2011). Countries that have implemented evidence-based public health measures and drug treatment have demonstrated crime reduction, health improvement, and improvement in dependence conditions (Global Commission on Drug Policy, 2011).

Another study, in Canada, demonstrated reductions in morbidity, mortality, and crime rates after the formation of a legally exempt safe injection facility. The facility was able to substantially reduce the harms resulting from prohibition by reducing unsafe drug use, reducing overdose deaths and disease, and facilitating direct and timely contact with health and treatment services (Hathway & Tousaw, 2008). Though this study focused on injection drug users, harm reduction strategies have been formulated for a wide range of substances, including alcohol, nicotine/tobacco, opiates, crack/cocaine, marijuana, hallucinogens, prescription drugs, and others (Marlatt, 1998). A comprehensive review of the literature assessing harm reduction for each substance is beyond the scope of this article, but the evidence is promising. Due to the emphasis on individualized, culturally competent plans, harm reduction can also be applied to diverse populations, including adolescents, African Americans, Native Americans, Hispanic and Latino populations, and Asian American and Pacific Islander populations (Marlatt, Larimer, & Witkiewitz, 2012).

Harm reduction can thus improve the treatment and outcomes of drug users, their families, their communities, and society. It represents a very promising alternative to punishment, incarceration, and abstinence-only approaches.

3 Implications and Recommendations

The Obama administration has made some recent shifts in the conceptualization of drug use. They view drug policy as public safety and public health problems rather than as a war on drugs, and they no longer use the term "War on Drugs." The current administration prefers treatment over incarceration and has taken some small steps toward harm reduction, such as eliminating the federal ban on syringe exchange programs (Marlatt, Larimer, & Witkiewitz, 2012). In New York as well, there have been reforms regarding mandatory sentencing and treatment eligibility for low-level offenders (Gray, 2009).

These changes, however, are not enough. There is still an excessive reliance on criminal justice solutions to substance use, undermining health and public safety (Cockburn, Heller, & sayegh, 2013). In New York State, there are still 54,200 people in prison, not including the jail population ("New York Leading Way," 2014), and the state's drug incarceration rate remained at approximately 11,000 in 2008 (Gray, 2009). Even those in drug courts who often receive abstinence-based treatment alternatives are still at a high risk for incarceration due to relapse (Cockburn, Heller, & sayegh, 2013). It is thus essential that we continue the shift away from criminal justice approaches and that we expand the treatment options, particularly harm reduction, offered to drug users. Social work can play a critical role in this fundamental shift.

3.1 Implications for Social Work

Compatibility Between Harm Reduction and Social Work

The compatibility between harm reduction and social work values, knowledge, and skills is undeniable, pointing to ways that the two can be integrated as a treatment approach to substance use. First, both are empowering because they are client-centered and user-driven. Social work values the right to self-determination, to setting one's own goals (NASW, 2008). Traditional substance use treatment assigns the goal of abstinence to the client, undermining self-determination; the majority of clients, for example, do not present with abstinence as their treatment goal (MacMaster, 2004). Harm reduction, on the other hand, attempts to meet clients "where they are" and develop strategies for change in a collaborative way, placing value on the client's own needs, ideas, and goals (Denning & Little, 2012). Harm reduction has been conceived as a "bottom-up," grassroots approach because the basis has come from local community-based efforts, with enormous input from recovering and active drug users. This is in stark contrast to "top-down" approaches promoted by policymakers or government officials in power (Marlatt, 1998). Participation from those using the services is crucial for the success of harm reduction (Marlatt, Larimer, & Witkiewitz, 2012), which is consistent with social work's ethical responsibility to public participation (NASW, 2008).

Harm reduction is additionally non-pathologizing and nonjudgmental, other key characteristics of the social work profession. It comes from a pragmatic sense of acceptance, recognizing that some people may not give up using drugs and that harmful behavior is a fact of life (Denning & Little, 2012). This acceptance facilitates compassion because rather than judging or denigrating drug users, harm reduction accepts the behavior and seeks to reduce the harm and suffering of individuals and society (Marlatt, 1998). In order to do this, an open, nonjudgmental dialogue needs to occur so that users can assess and address the consequences.

Pathologizing behaviors may only isolate users and hinder such honest discussion. Harm reduction even utilizes nonjudgmental language, moving away from terms such as addict, clean vs. dirty, abuse, and dependence (Marlatt, Larimer, & Witkiewitz, 2012; Denning & Little, 2012). It expands the definition of abstinence, which can have many meanings for different people, such as abstinence in certain settings (i.e. work) or abstinence from one drug at a time (Marlatt, 1998).

This language and perspective creates an atmosphere of respect that values the dignity and worth of each person, consistent with social work ethics (NASW, 2008). Further, harm reduction is strengths-based, a key principle of social work practice. It targets immediate and realistic goals that can be achieved. Any positive change, not just abstinence, is recognized and validated. This validation builds self-efficacy and a sense of competence, which can then be channeled to make further changes (Marlatt, 1998). Complete abstinence from drug use may not be a reasonable or realistic initial expectation for many clients. For example, one study found that only 10-15% of service users were ready for action toward abstinence (MacMaster, 2004). Rather than forcing abstinence, harm reduction meets clients where they are and targets changes that are desirable and realistic. This technique draws on clients' strengths and can enhance their motivations to make further changes, which may include eventual abstinence (MacMaster, 2004).

Third, both harm reduction and social work emphasize the person-in-environment, recognizing the role of the environment and the larger social context in influencing human behavior. Harm reduction acknowledges that risky behaviors may occur for a reason and may be both adaptive and mal-adaptive. For example, someone may drink to reduce the symptoms of depression. Exploring these pros and cons of use can lead to a better understanding of why the behavior occurs and how it can be reduced or eliminated (Marlatt, Larimer, & Witkiewitz, 2012). Moreover, rather than focusing solely on biological or psychological factors on the individual level, both harm reduction and social work utilize an ecological systems perspective, incorporating factors at the family, peer, and community levels and taking into account broader social, economic, and political contexts in influencing substance use (Marlatt, Larimer, & Witkiewitz, 2012). This perspective produces holistic interventions aimed at multiple levels, which as previously discussed, widens the possibilities for positive change.

Some proponents have even posed the concept of the risk environment to explain the contexts and spaces, both social and physical, where harm is created or reduced. The micro environment encompasses peer influence, social norms and values, neighborhood factors, and social settings, while the macro environment includes the legal and policy landscape, material and social inequalities, and cultural context (Rhodes, 2002). This idea posits that both the determinants and remedies of harm are environmental; by understanding the environmental factors that produce harm, we can create environments to reduce it. The focus for change shifts from solely individuals to the social situations, structures, and contexts that individuals inhabit (Rhodes, 2002). The concept of the risk environment is thus consistent with the ecological systems perspective, as both offer a comprehensive approach addressing the individual, the community, and the environment.

Last, harm reduction is consistent with social work's regard for human rights and social justice (NASW, 2008). Harm reduction involves community-based engagement, as we have seen, as well as human rights and social justice frameworks. From a human rights perspective, harm reduction is viewed as a basic human right that should be in the control of affected individuals and communities. Harm reduction advocates fight for the basic human rights, such

as health care and housing, of people who have been marginalized and disenfranchised due to their drug use. In the same vein, harm reduction values local knowledge, collaborating with individuals and communities to produce culturally competent interventions (Marlatt, Larimer, & Witkiewitz, 2012). This is directly in line with social work's valuing of cultural competence and social diversity (NASW, 2008).

In terms of social justice, a core social work value (NASW, 2008), harm reduction seeks to change the larger social context that produces inequality (Marlatt, Larimer, & Witkiewitz, 2012). Social justice is understood as both distributive justice, or the unequal distribution of material resources and opportunities such as health care and housing, and as structural inequities, or inequalities in the social structures and institutions that distribute goods such as respect, power, and decision-making ability (Pauly, 2008). Both forms of injustice often run along racial, class, and gender lines, and both produce harms for drug users, such as poverty, unemployment, and lack of housing, education, and social support. Policies of prohibition and abstinence further marginalize drug users by imparting stigma on use, threatening their freedom, worsening their health, and excluding them from mainstream society. Applying a social justice framework, harm reduction seeks to change policies that create harm and to eliminate the inequities that exacerbate harm. It seeks to establish a more inclusive society (Pauly, 2008).

Integrating Harm Reduction and Social Work

Reducing harm is highly consistent with social work practice, as the overarching goal of both is to improve the quality of life for clients. Addressing the health, social, emotional, and economic harms of substance use thus fits with social work practice. Several key harm reduction strategies are also utilized by social workers, making the integration quite natural. First, assessment is a critical component of both practices. Client behaviors are evaluated as helpful or harmful, and the focus is on gathering information about the consequences of use and the level of severity of use. Assessment then informs treatment goals and interventions (Karoll, 2010).

Other strategies in common include motivational interviewing, reframing, and offering hope. Motivational interviewing (MI) is a key aspect of harm reduction (Karoll, 2010). Enhancing motivation for change is usually a task of social workers as well, who can use MI to achieve this objective. An evidence-based practice, MI follows the stages of change of pre-contemplation, contemplation, preparation, action and maintenance (MacMaster, 2004). The practitioner meets the client at whatever stage they are at and encourages positive actions toward movement through the stages, or actions toward reducing the risk of harm. When clients achieve even small successes, they are validated and motivation is increased to make further positive changes (Karoll, 2010). Client behavior can also be re-framed into a more positive light. For example, substance use can be re-framed as a coping mechanism that the client learned to deal with life stressors and that is no longer effective. This re-frame implies that clients are capable of learning other coping skills and utilizing additional resources, which offers hope and further enhances motivation (Karoll, 2010). These strengths-based strategies are highly consistent with social work knowledge and skills.

Harm reduction psychotherapy has emerged as one way to integrate harm reduction and traditional psychotherapy. Harm reduction psychotherapy is client-centered, as the clinician and client work together to form solutions according to the goals of the client. As such, abstinence is not a pre-requisite for treatment, and there is a recognition that the client may

prioritize other needs rather than changing drug use, such as housing. Goal setting depends on the client's assessment of his or her own needs (Denning & Little, 2012; Marlatt, 1998). Practicing harm reduction psychotherapy requires an open mind, cultural competence, trust in and respect for the client, and clinical training. This approach, based on empirical evidence and clinical experience, combines the public health principles of harm reduction with psychodynamic and cognitive models of therapy (Denning & Little, 2012).

In harm reduction psychotherapy, a strengths-based approach, clients participate in healing, self-affirming, therapeutic relationships. This therapeutic alliance serves as the foundation for change, which is generally incremental. Clients are usually conflicted about substance use, as use sometimes helps them and sometimes causes problems. Harm reduction psychotherapy involves an exploration of such conflicts, as well as the pros and cons of use, so that the client can gain a better understanding of their relationship to drugs and their conflicts about use (Marlatt, 1998). In terms of cognitive therapy, clinicians can help clients explore their automatic thoughts, feelings, and cognitive distortions that contribute to drug use, as well as develop alternatives (Marlatt, 1998). Harm reduction psychotherapy is just one example of the ways in which harm reduction and social work are suitable for integration.

3.2 Recommendations

Moving away from criminal justice and abstinence-based approaches to drug use and treatment requires changes at multiple levels, including perspective, policy, and practice.

Perspective

Drug use needs to be understood and treated from a public health perspective, rather than from a criminal justice, moral, or disease model. Criminal justice perspectives have produced mass incarceration and the criminalization of individuals and communities, while medical/disease models have reduced access to treatment to only those seeking abstinence. Framing drug use as a public health issue, however, creates the opportunity to shift the landscape of drug policy and practice. The timing is right for this paradigm shift for both policymakers and the general public due to the passage of the Affordable Care Act (ACA). The ACA treats substance use as a health issue and mandates that insurance plans cover substance use treatment as part of healthcare (Cockburn, Heller, & sayegh, 2013). This provides the backdrop for a major shift in drug policy, a shift that moves from a criminal justice approach to a health-oriented framework. This health-oriented framework does, however, contain some contradictions. For example, in some European countries where it is practiced, criminalization still occurs. Additionally, a health framework can lead to usage of the disease model, which is problematic. Despite these issues, a health-oriented perspective has the potential to inform useful policy and practice changes.

Policy & Practice

At the policy level, several changes would promote this paradigm shift. A radical move away from criminalization-based policy toward health-based policy would involve decriminalization. While seemingly far-fetched, the ACA also provides an opportunity to advocate for decriminalization. It is contradictory that the ACA treats substance use as a health problem while the policies remaining from the War on Drugs treat substance use as a criminal behavior. To remain consistent with the health approach of the ACA, the role of the criminal justice system needs be to reduced or eliminated with respect to drug use (Cockburn,

Heller, & sayegh). The most effective way to do this would be to decriminalize personal use of drugs, as well as the possession of drug-related paraphernalia.

Decriminalization movements in other countries dispel the myth that drug use and crime would explode if drug use were not handled by the criminal justice system. For example, Portugal has decriminalized the personal use of drugs, and police officers refer those found in possession of drugs to social workers and other staff, who help identify their needs and connect them to treatment if necessary. The results have been positive: drug-related crime, addiction, and overdose deaths have decreased; drug arrests and the prison population have declined; treatment and the use of health services has increased; and the stigma associated with drug use has been mitigated (Cockburn, Heller, & sayegh, 2013).

While the majority of the US may not be ready for full-scale decriminalization, there are other, smaller policy and practice changes that can make a difference. For example, promoting the use of alternatives to incarceration for drug offenders can increase the number of people who have access to treatment and can reduce the prison population. Harm reduction should be included as a treatment option, rather than mandating abstinence-based programs, in order to expand access. In conjunction with this, individuals in treatment or on probation or parole should not be violated, discharged from treatment, or at risk of incarceration due to relapse. Health-based policies would recognize relapse as part of the recovery process, rather than enacting punitive consequences.

The use of pre-booking diversion programs should also be expanded. This requires policies that allow front-end diversion and programs and practices designed to treat drug users and keep them out of the criminal justice system. An innovative program in Seattle, the Law Enforcement Assisted Diversion (LEAD) program provides a noteworthy example of how policy and practice can move away from criminal justice and toward health. In LEAD, individuals arrested for drug possession, low-level drug sale, and prostitution are eligible for pre-booking diversion. Rather than going through the jail and court systems, police offers connect these individuals directly to case management services, including healthcare, substance use treatment, harm reduction, education, and housing. Charges are never filed as long as the individual remains engaged in services or successfully completes the program. Moreover, services and treatment are based on harm reduction, so people do not face sanctions, such as discharge, re-arrest, or incarceration, for relapses. Early analysis shows that participants are continuing to engage in services and are reducing their criminal activity (Cockburn, Heller, & sayegh, 2013).

LEAD demonstrates how policy and practice can work to reduce the use of criminal justice and abstinence-based approaches even within the existing framework of drug criminalization. This program shows how harm reduction can be integrated into policy and practice without requiring decriminalization or legalization. Such programming should be used in cities across the nation while advocates and reformers work for complete decriminalization.

4 Conclusion

Given that drug use appears to be a permanent part of society, we should embrace any program or policy designed to reduce the harmful health, social, and economic consequences of use. Criminal justice and abstinence-based approaches have largely done the opposite. It is not realistic to punish or coerce someone out of drug use; only evidence-based practices and treatment can produce change for individuals, families, communities, and society. Such practice needs to involve a dramatic shift away from the criminal justice system. New York

State has demonstrated that reducing the prison population not only saves money, but also does not lead to an increase in crime ("New York Leading Way," 2014).

Similarly, moving away from abstinence-based approaches does not undermine sobriety. On the contrary, abstinence and harm reduction can work together to form a comprehensive continuum of services for substance users, many of whom are inappropriate or ineligible for abstinence-based services but still have treatment needs. Interventions should be matched with client needs, a central tenet of social work. Involvement in harm reduction services can not only improve lives, but can also enhance motivation and the potential for further change, which may include abstinence. Shifting away from criminal justice and abstinence-only approaches and toward a framework of health that incorporates harm reduction and social work philosophies can greatly improve the quality of life for drug users, their families and communities, and society overall.

References

Alexander, M. (2010). The new Jim Crow: *Mass incarceration in the age of colorblindness*. New York, NY: New Press.

Ashton, J.R. & Seymour, H. (2010). Public health and the origins of the Mersey model of harm reduction. *International Journal of Drug Policy, 21*(2), 94-96.

Barnett, R. E. (2009). The harmful side effects of drug prohibition. *Utah Law Review*.

Brecht, M., Anglin, M., & Dylan, M. (2005). Coerced treatment for methamphetamine abuse: Differential patient characteristics and outcomes. *American Journal of Drug & Alcohol Abuse, 31*(2), 337-356.

Cockburn, C., Heller, D., & sayegh, g. (2013). *Healthcare not handcuffs: Putting the Affordable Care Act to work for criminal justice and drug policy reform*. New York, NY: Drug Policy Alliance & American Civil Liberties Union.

Comfort, M. (2012). It was basically college to us: Poverty, prison, and emerging adulthood. *Journal of Poverty, 16*, 308-322.

Cosden, M., Baker, A., Benki, C., Patz, S., Walker, S., & Sullivan, K. (2010). Consumers' perspectives on successful and unsuccessful experiences in a drug treatment court. *Substance Use & Misuse, 45*(7-8), 1033-1049.

Currie, E. (2013). *Crime and punishment in America*. New York, NY: Picador.

Denning, P. & Little, J. (2012). *Practicing harm reduction psychotherapy: An alternative approach to addictions, 2nd edition*. New York, NY: The Guilford Press.

Drug Enforcement Administration. (2012). Title 21 United States Code (USC) controlled substances act (USC, 2012 Edition). Washington, DC: U.S. Government Printing Office.

Ekstrand, L. E. (2005). Adult Drug Courts: Evidence Indicates Recidivism Reductions and Mixed Results for Other Outcomes: GAO-05-219. *GAO Reports,* 1.

Global Commission on Drug Policy (2011). War on Drugs. Retrieved from http://www.globalcommissionondrugs.org/wpcontent/themes/gcdp_v1/pdf/Global_Commission_Report_English.pdf

Goodman, J. D. (2014, April 3). Proposal would provide New York police with kits to combat overdoses. *New York Times*. Retrieved from http://www.nytimes.com/2014/04/03/nyregion/new-york-program-to-help-police-get-a-kit-to-combat-overdoses.html?smid=nytnow-share&smprod=nytnow&_r=0.

Gray, M. (2009, April 2). A brief history of New York's Rockefeller drug laws. *Time*. Retrieved from http://content.time.com/time/nation/article/0,8599,1888864,00.html.

Hathaway, A. D. & Tousaw, K. I. (2008). Harm reduction headway and continuing resistance: Insights from safe injection in the city of Vancouver. *International Journal of Drug Policy, 19*(1), 11-16.

Henrichson, C. & Delaney, R. (2012). *The price of prisons: What incarceration costs taxpayers*. New York, NY: Vera Institute of Justice.

James, D. (2007). Harm reduction background. *Alberta Alcohol and Drug Use Commission*.

Kakade, M., Duarte, C., Liu, X., Fuller, C., Drucker, E., Hoven, C., & … Wu, P. (2012). Adolescent substance use and other illegal behaviors and racial disparities in criminal justice system involvement: Findings from a US national survey. *American Journal of Public Health, 102*(7), 1307-1310.

Karoll, B. R. (2010). Applying social work approaches, harm reduction, and practice wisdom to better serve those with alcohol and drug use disorders. *Journal of Social Work, 10*(3), 263-281.

Kras, K. (2013). Offender perceptions of mandated substance abuse treatment: An exploratory analysis of offender experiences in a community-based treatment program. *Journal of Drug Issues, 43*(2), 124-143.

Kruttschnitt, C. (2010). The paradox of women's imprisonment. *Daedalus, 139*(3), 32-42.

Lattimore, P.K., Steffey, D.M, & Visher, C. A. (2010). Prisoner reentry in the first decade of the twenty-first century. *Victims & Offenders, 5*(3), 253-267.

MacMaster, S. A. (2004). Harm reduction: A new perspective on substance abuse services. *Social Work, 49*(3), 356-363.

Marlatt, G. A. (Ed.) (1998). *Harm reduction: Pragmatic strategies for managing high-risk behaviors*. New York, NY: The Guilford Press.

Marlatt, G. A., Larimer, M. E., & Witkiewitz, K. (Eds.) (2012). *Harm reduction: Pragmatic strategies for managing high-risk behaviors, 2nd edition*. New York, NY: The Guilford Press.

The National Association of Social Workers. (2008). Code of ethics. Retrieved from http://www.socialworkers.org/pubs/code/code.asp.

The National Center on Addiction and Substance Use at Columbia University. (2004). *Criminal neglect: Substance abuse, juvenile justice, and the children left behind*. New York, NY.

The National Center on Addiction and Substance Use at Columbia University. (2010). *Behind bars II: Substance abuse and America's prison population*. New York, NY.

National Institute on Drug Abuse. (2012). *Drug facts: Nationwide trends*. Bethesda, MD.

New York leading way on prison reform. (2014, March 13). *Newsday*. Retrieved from http://www.newsday.com/opinion/editorial-new-york-leading-way-on-prison-reform-1.7384167.

New York State Division of Criminal Justice Services (n. d.). *Alternative to incarceration (ATI) programs*. Retrieved from http://www.criminaljustice.ny.gov/opca/ati_description.htm.

The Osborne Association. (2013). *Children of incarcerated parents fact sheet*. New York, NY.

Pauly, B. (2008). Harm reduction through a social justice lens. *International Journal of Drug Policy, 19*(1), 4-10.

Resnicow, K. & Drucker, E. (1999). Reducing the harm of a failed drug control policy. *American Psychologist, 54*(10), 842-843.

Rhodes, T. (2002). The 'risk environment': A framework for understanding and reducing drug- related harm. *International Journal of Drug Policy, 13*(2), 85-94.

The Sentencing Project. (2008). *Reducing racial disparity in the criminal justice system: A manual for practitioners and policymakers*. Washington, DC.

Schroder, R., Sellman, D., Frampton, C., & Deering, D. (2009). Youth retention: Factors associated with treatment drop-out from youth alcohol and other drug treatment. *Drugs and Alcohol Review, 28*(6), 663-668.

Stevenson, B. (2011). Drug policy, criminal justice, and mass imprisonment. Retrieved from http://www.globalcommissionondrugs.org/wpcontent/themes/gcdp_v1/pdf/Global_Com_Bryan_Stevenson.pdf

Visher, C. A. & Travis, J. (2011). Life on the outside: Returning home after incarceration. *The Prison Journal, 91*(3), 102s-119s.

Wakefield, S. & Wildeman, C. (2011). Mass imprisonment and racial disparities in childhood behavioral problems. *Criminology & Public Policy, 10*(3), 793-817.

Weaver, V. M. & Lerman, A. E. (2011). Political consequences of the carceral state. *American Political Science Review, 104*(4), 817-833.

Western, B. & Wildeman, C. (2009). The black family and mass incarceration. *Annals of the American Academy of Political and Social Science*, 621.

Young, M. C. & Gainsborough, J. (2000). *Prosecuting juveniles in adult court: An assessment of trends and consequences*. Washington, DC: The Sentencing Project.

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