AFTER THE WAR ON DRUGS IS OVER: IMPLICATIONS FOR SOCIAL WORK EDUCATION

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This essay will not try to make a case for the legalization of drugs, although I and others have argued that point elsewhere (Bullington, 1997; Currie, 1993; McNeece, Bullington, Arnold, & Springer, 2002). In fact, Szasz (1992) argues for a free market for drugs, unfettered either by governmental prohibition of substances or governmental regulation of drug commerce. On the other hand, he also suggests that many of the mainstream proposals for the legalization or decriminalization of illicit drugs could lead to coerced treatment, because the money saved on enforcement would be diverted to treatment (Szasz, 1985, 1992).

We can pursue a policy of reducing the harm to individual drug users, to their families, and to society in general without legalizing drug use and thus avoid getting bogged down in the debate on legalization. Whether we choose to keep marijuana, cocaine, opiates and opioids, and designer drugs illegal or whether we eventually legalize, decriminalize, or depenalize them (MacCoun & Reuter, 2001) are different issues than the one at hand: what should social work do in the aftermath of the drug war. We do not even have to agree on whether substance abuse is a "disease," although defining it as such does have implications for policy (such as whether treatment will be covered by health insurance). Some individuals will choose to equate addiction to a substance with disease, while others will not (McNeece & DiNitto, 1998). We must only agree that the current federal policy for combating drug use, endorsed by most state and local governments, has not only failed, but has exacerbated the problem.

To fully understand the implications of this aftermath for social work, we should first look at the course of the war and its consequences. Until 1914 the United States had neither a drug problem nor a name for it (Szasz, 1985). The passage of the Harrison Act in that year and the hundreds of subsequent laws medicalizing and criminalizing the use of drugs has brought the "drug problem" to the public agenda. In 1971 President Nixon officially declared a "War on Drugs," with a drug-fighting federal budget of $600,000. Twenty-one years later, the United States is spending at least $40 billion on this war (Drug Policy Alliance, 2002a), while the number of drug-related arrests continues to skyrocket and only a fraction of drug users in need of treatment are actually receiving it. Just
how we are doing in the war on drugs depends on whom you ask. The current administration claims that we are winning, but many social workers, a number of prominent scholars, and a few public officials take a different view (DiNitto, 2002; Drug Policy Alliance, 2001; MacCoun & Reuter, 2001). According to Doweiko (2002), “the government’s effort to solve the drug abuse problem through law enforcement/interdiction has been a failure. Of course this does not stop law enforcement officials from trumpeting the successes of the past year or from hinting that, for just a few billion dollars more, it may be possible to eliminate the problem of recreational drug use in the United States” (p. 438).

It is difficult, if not impossible, to remove the political elements from the evaluation of any social policy, and therefore, assessing the impact of the war on drugs is problematic. Local police may interpret increases in drug arrests and drug seizures as indicators of the war’s success: more drug users and dealers are being arrested and more drugs are kept off the market. On the other hand, anti-drug programs such as community policing organizations and neighborhood prevention groups see decreases in arrests and seizures as indicators of success: fewer people are using and therefore fewer people are being arrested; fewer drugs are being smuggled into the neighborhood and therefore there are fewer seizures. The problem with most of the indicators used in the evaluation of the war on drugs is that there is little agreement on how to interpret them.

According to MacCoun and Reuter (2001), legalization has been an intellectually powerful but politically weak force in the United States for the past decade. They view the prohibition of illicit drugs as a well-entrenched fact of political life, despite previous disappointments with prohibition and despite the fact that prohibition produces a variety of negative consequences in addition to the direct effects of drug use (creation of black markets, corruption, reduced commitment to prevention and education programs, etc.), which are borne principally by the urban poor. MacCoun and Reuter (2001) look at drug policy according to three standards. Using a philosophical standard, the burden of proof would fall on the prohibitionists to justify the war on drugs, but “only libertarians believe this to be the applicable standard” (p. 12). Using a political standard, any policy change must meet the test of not offending fundamental values. Thus, it would be impossible to advocate a reduction of these negative consequences without a high degree of certainty that drug use, particularly among the young, would not be increased. Using a policy analytic standard, MacCoun and Reuter conclude with some confidence that consequence reduction measures, such as heroin maintenance programs in other nations, yield a net reduction in total drug-related harm. The research tends to support their conclusions, as I will demonstrate below. However, we will first examine some of the consequences of the United States’ current policy of zero tolerance.

**Consequences of the War on Drugs**

**Economic Cost**

In 1995 illegal drug use accounted for an estimated $110 billion in total expenses for law enforcement, incarceration, treatment, and “lost revenue,” and health care expenditures associated with drug use cost another
$12 billion (National Institute on Drug Abuse [NIDA], 1997). Since the early 1980s, the criminal justice system has felt the impact of the substance abuse problem as the number of offenders arrested on drug-related charges has increased dramatically and prisons throughout the nation have become inundated with drug offenders.

**Social Cost**

There is little doubt that drug users will continue to provide much of the fodder for the United States’ rapidly expanding correctional system well into the 21st century. During the last few decades, there have been record increases in the numbers of persons brought under some form of correctional control in the United States. In the early 1990s, the nation easily surpassed the Soviet Union and South Africa for incarceration rates, making the United States the standout leader among industrialized nations in the imprisonment of its citizens.

Between 1980 and 1997, the number of people entering prison for violent offenses increased by 82%; for nonviolent offenses, 207%; for drug offenses, 1,040%. In fact, the number of persons incarcerated for drug offenses today is almost the same as the entire prison population in 1980 (Center for Juvenile and Criminal Justice, 2001). At midyear 1999 there were 1,860,520 persons detained in the nation’s prisons and jails. This represents a substantial increase, from 1 out of every 218 U.S. residents in 1990 to 1 out of every 147 in 1999 (Bureau of Justice Statistics [BJS], 2000).

It is also clear that these increases were fueled largely by the war on drugs, as consequences of lengthier prison terms and mandatory sentencing for those caught with illicit substances. In 1999 there were more than 1.5 million arrests for drug offenses, with 80% of them for possession (Office of National Drug Control Policy, 2001). There were more than 700,000 arrests in the United States in 1997 related to marijuana alone (Federal Bureau of Investigation, 1998). By the mid-1990s, more than 52% of federal inmates were drug offenders, and drug violators accounted for nearly 30% of prisoners in state facilities (Irwin & Austin, 1994). Between 1990 and 1999, 60.9% of the population growth in federal prisons was due to the incarceration of drug offenders (BJS, 2001).

Despite these interdiction and enforcement efforts, the estimated number of drug-related emergency room admissions grew from 900,317 in 1994 to 1,100,539 in 2000 (Substance Abuse and Mental Health Services Administration, 2001). We may be taking many prisoners, and the number of drug-war casualties continues to rise, but that does not mean that we have won the war. While the casual use of certain illicit drugs has leveled off or decreased slightly, a disturbing number of people in the United States still use illicit psychoactive substances (Johnson, O’Malley, & Bachman, 2002).

**Unanticipated Consequences**

The results of these increased incarceration rates were often not what had been anticipated by those who fostered them. For example, in Florida it was discovered that various new penal provisions for drug offenders passed in the 1980s resulted in serious criminal offenders actually serving less time than they had
before, and in many violent offenders being released prematurely to make prison beds available for nonviolent drug offenders who had been incarcerated under mandatory sentencing policies (Rasmussen & Benson, 1994). Although these trends were eventually halted in the 1990s, at the time they had a marked effect on prison and nonprison correctional populations, and they will continue to influence the Florida penal system in the future.

The incarceration of a disproportionate number of minority drug offenders from inner cities has resulted in a destabilization of those communities (Mauer, 1990; Moore, 1996; Tonry, 1995). Racial minorities account for nearly 80% of all persons held in state prisons for drug offenses (BJS, 2001). On any given day in 2001, nearly one in eight African American males between the ages of 20 to 34 were in jail or prison. The war on drugs has therefore led to a dramatic increase in the imprisonment rates in inner-city communities, higher unemployment figures, higher incidence of welfare usage, and a large number permanently disenfranchised voters.

The United States must make fundamental changes in its approach to drug use and abuse if we are to ever make any progress in combatting these problems. This paradigm shift must include, at a minimum, a switch from the "zero tolerance" philosophy to a policy of harm reduction, as well as the eventual decriminalization or legalization of some currently illicit drugs. On that issue, a possible beginning could be the limited use of marijuana for medical purposes (McNeece et al., 2002), which is a policy that has already been blessed by voters and public officials in several communities.

The Need for a New Paradigm

During the 89 years that have elapsed since the passage of the Harrison Act in 1914 (the landmark federal legislation defining illicit drugs), the United States has taken an approach to its drug problem that is clearly prohibitionist and is dominated by criminal justice agencies, methods, and ideologies. Most often drug users have been considered criminals first, and only secondarily persons in need of treatment. Severe sanctions have been applied to violators in order to discourage their further involvement in illegal enterprises and to deter others from following the same path. Despite these aggressive attempts to control the problem, there is little evidence that these tactics have had their intended effects. Indeed, several contemporary observers have remarked that, given the degree of the United States' commitment, it is incredible that so little has been accomplished (Bugliosi, 1996; Bullington, 1997; Currie, 1993; Duke & Gross, 1993; Nadelmann, 1988).

The evidence that supports this position is easily accessible. For example, the United States continues to have the highest drug usage rates of any industrialized nation (Currie, 1993). While casual use among adolescents has declined slightly (Johnson et al., 2002), the number of persons arrested and incarcerated for drug violations increased by 20% between 1990 and 1999 (BJS, 2001). (A later BJS publication, 2002b, cites this increase in drug offenders during the same time period as 69%, but both figures are considerably lower than the 1,040% increase between 1980 and 1997 mentioned earlier. This discrepancy can primarily be explained by the varying definitions used for "drug offender"
and by the difference between state and federal drug offenders—the increase in state offenders has slowed dramatically in recent years, while the number of federal drug offenders continues to rise rapidly.) Comparing the funding for education and prevention programs with the funding for law enforcement and interdiction programs demonstrates that the drug war has not really targeted causal, recreational users. Rather the drug war has been fought against a much smaller group of "problematic" drug users, and that group has not been diminished. In fact, it now appears that the rate of such use has actually gone up, despite the extraordinary efforts made to eliminate it.

Other indicators of the failure of the U.S. drug policy efforts are easily observed. Despite huge increases in police confiscation of drugs, these substances are still available in great supply and in purer form than ever before. For example, the heroin that is currently being sold throughout the United States is now said to be as much as 90% pure, compared with the 3%-5% purity that was typically found during the 1960s (Coomber, 1997).

In the face of this compelling evidence it is difficult to understand how anyone can continue to support the present policies. Of course many persons do defend, often vigorously, the current approach to the drug problem. One example of this may be found in recent statements made by Robert L. DuPont (1996), the nation’s first appointed drug czar under the Nixon administration.

After more than a quarter of a century in the field of addiction medicine, I have found that the policy of prohibition . . .

remains the bedrock of the modern response to the risks posed by brain-rewarding chemicals . . . Harm reduction, a compromise between drug prohibition and legalization, is a failed policy since it undermines the clear and powerful message of prohibition. (p. 1942)

I disagree. Our aggressively pursued drug war has failed to accomplish its stated goals. The strong prohibitionist law enforcement and criminal justice orientation favored in the United States has simply not worked. On the other hand, it has resulted in the highest rate of incarceration in the Western world, corruption of public officials, alienation of a large segment of our youth, and the disintegration of many urban communities, especially those that are predominately African American or Hispanic.

**Enter Harm Reduction**

A very different drug policy approach is currently being enthusiastically implemented, and with considerable apparent success, in several nations in Western Europe. This strategy is generally called *harm reduction* and it promotes a public health rather than criminal justice perspective in making decisions about drug users and drug problems generally (McNeece et al., 2002; McNeece & DiNitto, 1998). The police role in these countries is largely restricted to attempts to control large-scale trafficking and sales of illegal substances. The Netherlands has been the clear leader in defining this "new" method for addressing drug problems, although similar approaches are also being tried in Switzerland, Spain, Italy, and Germany, as well as in
the Czech Republic and several other emerging democracies in Central Europe (MacCoun & Reuter, 2001).

The harm reduction philosophy is based on several underlying assumptions about the nature of drug use. The first of these is that drug use is in a sense inevitable, as we know of no societies, either ancient or contemporary, that have not promoted the use of some substances while opposing the use of others. Thus, the historical record alone provides irrefutable evidence that drug use will not go away, regardless of what is done to eliminate it. Given this observation, a policy that is based on the notion that a drug-free society can be achieved, such as the program which has been doggedly pursued in the United States during this century, is understood as impractical and doomed to failure.

A second defining characteristic of the harm reduction philosophy is that all drug use, of both licit or illicit substances, are treated as potentially problematic. Generally, distinctions made between legal and illegal drugs are artificial and have lead to a myopic focus solely on the illicit substances. Harm reduction advocates suggest that all drugs have the potential to be used either productively or harmfully. As a consequence, no distinction is made between these drugs based on their legal classification alone. Rather, differences are identified on the basis of the real damage that these drugs produce. Of course by this standard, the two generally favored social drugs, tobacco and alcohol, must appear at the head of the list of "problem" drugs because they are responsible for the most deaths. Therefore, they would also be included in any drug policy designed by harm reduction proponents.

A third feature of the harm reduction philosophy is that all drug problems must be fundamentally seen as public health rather than criminal justice concerns. While a criminal justice strategy emphasizes the interdiction of illicit drugs and the arrests of drug offenders, a public health strategy focuses on the interaction between the host, the agent, and the environment (McNeece & DiNitto, 1998). In this approach, various health agencies and professionals are expected to play key leadership roles in assessing and treating the problematic symptoms associated with the use of these substances. Law enforcement would continue to play a role in societal efforts to control illegal production, importation, and sales of illicit drugs. The key difference is that the police are denied the opportunity to pursue and arrest users, who are defined as people in need of treatment.

Finally, given the obvious reluctance of drug users to volunteer for treatment under the old, police-dominated system, new and very different forms of outreach must be developed to gain their confidence and to get them involved in therapeutic interventions. Of utmost concern is the establishment of contact between health authorities and problematic users. While the prohibitionist approach conditions users to hide and to resist efforts for providing treatment, harm reduction is designed to entice them through nonthreatening interventions and aggressive social work.

Harm Reduction Measures

Practically speaking, the harm reduction methods that are being explored in the Netherlands and elsewhere include the following
specific strategies for dealing with users (McNeece et al., 2002):

Street social workers establish initial contacts with users.

Friendly users are enlisted in the efforts to contact their fellows and to encourage them to come in to obtain health services.

Low-threshold programs are established to provide methadone in low doses to street addicts who are not yet willing to come in for help, and this without any contingent conditions such as that they give up all drug use or submit to urine tests—several methadone buses are used to deliver the drug on a daily basis to these users in their neighborhoods.

Free needles and needle exchange programs are in place to minimize the potential for HIV infections among injecting users.

Safe disposal receptacles are provided to individual users, and larger receptacles are placed in the apartments of known sellers.

Clinics are available for high dose methadone and regular medical care for those users who are willing to participate.

"Safe houses" have been established to allow addicts to come off the streets to "fix" in a clean, regulated environment, rather than on the streets.

A liberal dose of public advertising of the potential hazards of particular drugs, unsafe sex, needle sharing, and the like.

Large variety of treatment programs have been established to appeal to a wide range of users who are ready to undertake their own rehabilitation. (pp. 25–26)

Each of these tactics has been developed to provide a user-friendly environment in order to bring users back into the mainstream of society.

Research on Harm Reduction

For most harm reduction approaches, only anecdotal evidence or case studies are available. Studies of the utility of both methadone maintenance programs and needle or syringe exchange programs are more common. Because of the difficulty of randomly assigning intravenous drug users to experimental groups (clean needles) and control groups (shared needles), there are no randomized clinical trials. However there have been hundreds of comparative, longitudinal, and case studies regarding both methadone maintenance programs and needle or syringe exchange programs. A study of needle exchange programs (NEPs) was requested by Congress in 1991 and conducted by the General Accounting Office. It gave qualified support to such programs for decreasing needle sharing and for causing no increase in drug use (General Accounting Office, 1993; Normand, Vlahov, & Moses, 1995). Another report (Lurie et al., 1993) identified and reviewed almost 2,000 U.S. and foreign studies of NEPs, in addition to conducting site visits of 33 programs in 15 cities. Their conclusion
was that needle risk behavior was dramatically diminished, with no evidence of increased drug use or other public health dangers. One of the programs was found to not only reduce HIV risk behavior, but also to increase the entry of intravenous drug users into treatment (Kaplan, 1993). Another recent study of 269 intravenous drug users (Riley et al., 2002) concludes that higher rates of NEP service utilization is associated with increased use of drug treatments. A contemporary review of research on syringe exchange programs, or SEPs (Gibson, Flynn, & Perales, 2001), examined 42 studies, including 23 comparative projects in which needle behavior and HIV status of SEP participants were compared with intravenous drug users not involved with SEPs. Another 11 of the projects were longitudinal studies of SEP clients only. Two additional studies were conducted with both community samples and SEP users, and six others evaluated the ecological impact of SEPs (rate of seropositivity) on the community. The authors conclude that “there is substantial evidence that syringe exchange programs are effective in preventing HIV risk behavior and HIV seroconversion among IDU [intravenous drug users]” (p. 1338). This project was one of the more systematic reviews of harm reduction approaches, as it searched the published scientific literature in the English language between 1989 and 1999. The reviewers independently examined each of the studies, abstracting information about design, procedures, results, statistical controls, and study limitations. Criteria used in assessing the studies included the adequacy of statistical controls, sensitivity of outcome measures, statistical power, and where applicable, the meaningfulness of contrasts between users and nonusers of SEPs. Ljungberg et al. (1991) found a seroprevalence rate of zero in one Swedish city with an SEP, compared to prevalence of up to 60% in other cities without an SEP. The overwhelming bulk of the research evidence demonstrates the effectiveness of such harm reduction approaches as NEPs and SEPs.

The Drug Abuse Treatment Outcome Study (DATOS) followed more than 10,000 drug abusers and found a significant reduction in drug use by 2,966 clients in outpatient methadone clinics (NIDA, 1997). Based upon a review of the literature (approximately 100 individual studies and meta-analyses, but no randomized clinical trials) on methadone maintenance and NEPs and SEPs, the American Medical Association’s Council on Scientific Affairs concluded that such programs have been effective in reducing heroin use and attendant problems (crime, spread of STDs, etc.) in a cost-effective manner without any negative impact on public health (Yoast, Williams, Deitchman, & Champion, 2001). Regarding methadone maintenance programs, this Council reported that “the medical, social, and economic benefits of MMT [methadone maintenance treatment] have been verified by numerous scientific, clinical and policy studies” (p. 20). It also concluded that “given the scientific evidence, the Council on Scientific Affairs is convinced that none of the current arguments against NSEPs [needle and syringe exchange programs] has any scientific backing” (p. 32; the inclusion criteria for the Council’s review was not specified, but the review was based on a search of the major medical databases). A Cochrane
Review covered 20 randomized clinical trials of methadone treatment, including 1,357 randomized subjects, and concluded that tapered doses of methadone were effective in the treatment of heroin withdrawal syndrome (Amato, Davoli, Ferri, & Ali, 2002). Other studies (McLellan et al., 1996; Metzger et al., 1993) concluded that methadone maintenance treatment is an essential component to any HIV-prevention strategy. After reviewing almost 200 research studies and meta-analyses of HIV/AIDS intervention programs, Brown (1998) concluded that methadone treatment has the greatest capacity of any available treatment for reducing HIV risk behaviors. His review included research literature on treatment, service delivery and staffing issues, and two special populations—dually diagnosed clients and criminal offenders. Specific inclusion criteria were not identified.

**Research on Treatment**

All forms of drug treatment can be consistent with the harm reduction approach, as long as the intended objective is a decrease of negative consequences for the user or the community and not an insistence on total abstinence. However, if one advocates for the increased provision of treatment in general, then evidence on treatment effectiveness should also be examined. NIDA is unequivocal in stating that treatment for drug addiction is as effective as treatment for other chronic diseases such as diabetes and hypertension (NIDA, 1999a). In its *Principles of Drug Addiction Treatment: A Research-Based Guide*, NIDA (1999a) provides guidance on 12 specific methods of treatment. This guidance was based on a thorough review of the research literature on various treatment approaches, including those using randomized assignment (Azrina et al., 1996; Cornish et al., 1997; Crits-Christoph et al., 1999; Henggeler, Pickrel, Brondino, & Crouch, 1996; Higgins et al., 1994; McLellan, Arndt, Metzger, Woody, O'Brien, 1993; Silverman et al., 1996; Stephens, Roffman, & Simpson, 1994; Woody, McLellan, Luborsky, O'Brien, 1987; Woody, McLellan, Luborsky, O'Brien, 1995), and dozens of other studies using comparative or longitudinal designs. The most common outcome measure used in all of these studies was the reduction of drug use.

Fourteen recent reviews of treatment outcomes were conducted by the Cochrane Collaboration, an institution that categorizes research by the degree of scientific rigor; however, all but one were concerned with the effects of pharmacological treatment. The other review (Foxcroft, Ireland, Lister-Sharp, Lowe, & Breen, 2002) focused on primary prevention. It examined 56 randomized, nonrandomized, and interrupted-time series designs and found 20 of them to show evidence of effectiveness. Williams and Chang (2000) reviewed the relatively few studies on adolescent substance abuse treatment, finding most of them methodologically deficient. However, the stronger studies revealed that most adolescents who received treatment had significant reductions in substance use and related problems in the year following treatment.

The DATOS studies which were mentioned earlier (NIDA, 1997) demonstrated effectiveness not only for methadone treatment, but also for long-term residential programs, short-term inpatient programs, and outpatient programs, using posttreatment drug use
of 10,010 drug users in 11 cities who entered treatment between 1991 and 1993 as the outcome measure. A later NIDA review of research on treatment (1999b) found that a combination of individual and group counseling for cocaine addicts was more effective than other forms of treatment for reducing drug use. A 4-year follow-up of a randomized clinical trial with 118 substance-abusing juveniles provided evidence of the efficacy of multisystemic therapy (Henggeler, Clingempeel, Brondino, & Pickrel, 2002). At least 20 clinical trials have investigated the efficacy of motivational interviewing (MI) with substance abusers, and all but one found MI to be effective (Noonan, 2001). Schilling, El-Bassel, Finch, Roman, and Hanson (2002) found MI to be effective in encouraging alcohol abusers to participate in self-help programs after detoxification. In a review of the literature on cost-benefit analysis of drug treatment, Cartwright (2000) examined 18 cost-benefit studies “with scientific merit” and concluded that “a persistent finding is that benefits exceed costs, even when not all benefits are accounted for in the analysis” (p. 11). Later he admits that “these findings are compromised by many studies with weak research designs,” but then argues that “the benefits of drug abuse treatment are so robust that it appears that the conclusion of positive economic returns to society will stand as better studies are implemented” (p. 22).

NIDA has recently launched a Clinical Trials Network (www.drugabuse.gov/CTN) to test the efficacy of new treatments for drug addiction using rigorous research designs, and dozens of clinical trials are currently underway. It seems likely that our knowledge of drug treatment effectiveness will expand dramatically over the next decade.

It should be noted that the outcome measures associated with almost all of the research cited above are consistent with a harm reduction approach, but not with a zero tolerance or abstinence approach. These outcome measures include items such as reduction in drug use, reduction in the rate of needle sharing and other HIV risk behaviors, reduction in the rate of contagion of various diseases, reduction in the rate of crime, length of time in treatment, treatment completion rates, and posttreatment employment.

Harm Reduction—Meeting Unmet Needs

The results of harm reduction methods in the Netherlands have been quite impressive thus far. The goal of making treatment an attractive option has resulted in approximately 85% of Dutch drug addicts now being in contact with government agencies and helpers. This figure compares favorably with the estimated 10%–20% of U.S. addicts who are in contact with health officials (Bullington, 1995). Users throughout the Netherlands and other countries who have adopted similar methods are more likely to be receiving basic health care and nutritional advice, are experiencing fewer drug-related health problems such as abscesses, hepatitis, and AIDS, and are better able to live somewhat “normal” lifestyles, unlike their U.S. counterparts.

In assessing the outcomes of these harm reduction programs, one must keep in mind the goals of this philosophy. It is assumed that drug use will continue regardless of social attitudes about it and that the dominant
theme of intervention approaches must be based on reducing the harm that drugs do to those who consume them. By this measure, these programs have been very successful, although they have not eliminated drug use altogether, which was never their intention. None of this is to suggest, however, that the citizens residing in these nations approve of drug use; to the contrary, they often condemn it in the same manner that U.S. citizens do.

Based on the United States' failures with criminal justice methods, and the apparent successes experienced in these other nations, there is reason to hope that many of these same methods could be adopted here in the near future. Harm reduction can be undertaken anywhere, regardless of the dominant policy orientation (Erickson, 1996). Even with a prohibitionist policy, it would be conceptually possible to consider how harm reduction could be implemented to minimize drug-related negative consequences. There is already evidence, as cited above, that successful harm reduction efforts have been initiated in various locales throughout the United States. For example, a number of cities now promote NEPs or at least the provision of information regarding the use of sterile equipment and bleach to clean injection gear. There has been considerable resistance to such programs, however, as they are said to encourage drug use or signal societal approval. In several cases, these practices have been initiated in direct violation of state and or local laws which prohibit them. Methadone maintenance has also been available here for many years, and well over 100,000 addicts are currently being treated with the substitute narcotic. Although these programs are supposed to reduce the dosage one takes over time and eventually wean the addict entirely from the drug, most do not attempt or require this process.

Of course harm reduction can also be implemented as a prevention strategy with those who have not yet experimented with drugs. This would require that all drugs, whether legal or illegal, be included in these discussions; there can be no exemptions for socially favored substances. This strategy also necessitates abandoning the "Just Say No" claims, which are to be replaced by serious discussions of safe and unsafe use practices. To date, people in the United States have been very reluctant to accept such educational tactics, believing instead that this stance will ultimately lead to increased use (Rosenbaum, 1996). The evaluations of current U.S. primary prevention methods, however, have revealed that these do not produce their intended consequences; in other words, they do not prevent youth from experimenting with drugs (Gerstein & Greene, 2000; Lynam et al., 1999).

Ultimately, the adoption of large-scale harm reduction methods would require a significant shift in the United States' dominant prohibitionist drug policy and mindset. In order for these strategies to be successfully adopted, we would first have to jettison our long-held faith and commitment to punitive tactics in fighting wars against drug users. A public health strategy calls for an entirely different view of the user as a person in need of assistance, rather than as a criminal who is willfully subverting the law. Treatment for substance abuse addiction is a key component in the harm reduction approach. Recent estimates from the National Household Sur-
vey on Drug Abuse and the Uniform Facility Data Set indicate that approximately 5 million drug users needed immediate treatment in 1998, but only 2.1 million received it (ONDCP, 2000). The number of persons who wanted or who would have agreed to undertake treatment if it was available is unknown. Unfortunately, in the war on drugs, 75% of the expenditures is spent on domestic enforcement of drug laws and only 7% is used for treatment (RAND, 1994). A change from the prohibitionist approach to a harm reduction approach would free much of the funding currently used for enforcement and interdiction to be diverted to treatment and prevention. Arguments have been made elsewhere that this trade-off would be cost-effective (McNeece & DiNitto, 1998; Rasmussen & Benson, 1994).

While many skeptics might argue that these changes are highly unlikely, we need only look as far back as the last century to find these substances being treated very differently than they are now. Drugs were not then seen as constituting a major social problem, and they certainly did not pose a serious threat to the survival of the nation. This laissez-faire approach was not a result of fewer drug users, however, for there is a formidable array of data suggesting that there may have been as many serious or problematic users as there are today (Courtwright, 1982). Historian David Musto (1991) reminds us that even in this century our drug war hysteria has ebbed and flowed with succeeding generations. He argues that the lessons learned about the dangers of drugs by one generation are slowly replaced by a collective naïveté in later cohorts. One consequence of these fluctuations has been that the United States' drug policies have cycled from extreme, often hysterical levels of concern to apathy several generations later. The adoption of harm reduction measures could moderate these national mood swings and provide a much more consistent and enduring set of responses from one generation to another.

**Implications for Social Work Education**

The profession of social work should prepare for the end of the war on drugs whether we formally declare an end to it or simply declare a de facto "truce." If the United States shifts a substantial amount of its current resources from interdiction and enforcement to treatment and prevention, we will find ourselves faced with increased demand for our services. This has already happened in California, where proposition 36 has mandated treatment rather than incarceration for 1st and 2nd-time offenders (Drug Policy Alliance, 2002b). There is a fear that this new policy may overload the treatment system, and coerce many persons into treatment who may not actually need or want it.

The Association for Medical Education and Research in Substance Abuse has developed a *Strategic Plan* (Straussner & Senreich, 2002) for interdisciplinary faculty development in this area. They chide social work, nursing, and other helping professions for not preparing students with an adequate knowledge of alcohol and other drug abuse issues. I suspect that social workers, as well as social work students, have tended to shy away from working with substance-abusing clients for four reasons. First, these clients
have had a reputation for being difficult, and failures used to be more common than success stories. However, with rapidly expanding knowledge about how to more effectively treat these individuals (NIDA, 1999a), social workers may reconsider. Second, many of these clients have been stigmatized because their behavior has been labeled as “criminal,” and social workers have also shown a reluctance to work with justice-system clients (Gibelman & Schervish, 1997). If we legalize or decriminalize illicit substances, then perhaps social workers will be more willing to work with substance abusers who are not stigmatized by criminal records. Third, many states do not guarantee parity in health programs for substance use disorders. Therefore, many clients do not have access to social work services (DiNitto, 2002). Finally, most social workers are not adequately trained to work with substance abuse disorders. Adoption of a harm reduction approach to substance abuse could be expected to substantially increase the number of substance-abusing clients served by social workers. We need to be prepared.

**Substance Abuse Training**

Among the approximately 420 accredited baccalaureate programs and 140 accredited master’s programs in social work there is no agreement on the minimum training essential for practice in the area of substance abuse. The Council on Social Work Education’s (CSWE) Educational Policy and Accreditation Standards does not contain standards for alcohol and other drug content (CSWE, 2001). The apparent reason for not requiring content in particular practice areas such as substance abuse is the desire to allow programs to be free to design their own curriculum structure. Otherwise, specific interest groups could make a case for courses or curriculum content in justice-system issues, child welfare, family counseling, and hundreds of other areas (DiNitto, 2002).

However, with 71% of social workers reporting that they had dealt with clients with substance abuse disorders in the past year (O’Neill, 2001), it may be worthwhile to consider some minimal content in this area. There is concern among substance abuse experts that the current training in this field received by most social workers is inadequate (Flanzer, 2001). Findings from other studies suggest that the more courses students took with integrated alcohol and drug content, the more their assessments reported alcohol and drug problems with their clients (Gassman, Demone, & Albilal, 2001). Without the necessary training, many serious substance abuse issues will continue to go unnoticed and untreated. In a survey of 2,000 randomly selected members of the National Association of Social Workers, 81% reported some training in substance abuse, but only 38% reported formal coursework. The others had been enrolled in continuing education workshops or had clinical supervision in working with substance-abusing clients (O’Neill, 2001). With the explosion of knowledge in such areas as the neurobiology of addiction, even those social workers who have had formal training may need additional education (Erickson & Wilcox, 2001). A degree of cross-training in mental health will also be necessary because of the high proportion of clients who suffer from both substance abuse and mental health problems. Integrated substance
abuse and mental health treatment combined with specialized case management services are some of the elements of a useful model for social work substance abuse intervention (Drake, McLaughlin, & Minkoff, 1996; Hanson, 2001). However, care should be taken to avoid the problems of aggressive treatment associated with models such as PACT (Programs of Aggressive Community Treatment), because they can easily lead to coerced treatment and may not be effective (Gomory, 1999).

The missing component in substance abuse training, as in just about every other facet of social work education, is that we have done an inadequate job of linking students’ educational outcomes to the quality of services offered to clients. As Gambrill (2001) suggested, a systematic assessment method should be in place in every school of social work (and school of nursing, medicine, etc.) to determine whether the education received by BSW and MSW graduates enhances their ability to help clients. Sadly, that has not happened.

**Social Policy, Community Practice, and Research Issues**

When the war on drugs ends, providing clinicians with better training for work with substance-abusing clients is only one aspect of the necessary response. If we declared an end to the war today, concerted action by social workers still would be needed to modify or develop social policies consistent with a harm reduction approach. This would include efforts to destigmatize and reintegrate clients returning from the criminal justice system and to overturn decades of mistrust and suspicion in minority communities caused by racist drug war policies—such as harsher sentences for crack cocaine than powder cocaine (United States Sentencing Commission, 1997).

Social workers must redouble their efforts to advocate for better access to treatment, including parity for substance treatment in third-party health coverage (O’Neill, 2001). We must do this while avoiding coerced treatment, a likely scenario in communities offering to abandon punishment in favor of mandatory treatment. We must also end the ban on state-run public assistance programs for addicts (Adams, Onok, & Riker, 1998; DiNitto, 2002) and reverse current federal legislation that does not allow drug addicts and alcoholics to receive Social Security Disability Insurance (Conklin, 1997). We also need to change the laws to allow college students who are drug offenders eligibility for federal financial aid (American Civil Liberties Union, 2002).

With the increase of knowledge about substance abuse, we need to do a better job of translating research knowledge into clinical practice (DiNitto, 2002; Strausser & Senreich, 2002). Efforts such as the Clinical Trials Network, the 13 regional Addiction Technology Transfer Centers funded by the Center for Substance Abuse Treatment, and the same Center’s Practice/Research Collaboratives are steps in the right direction. Social work educators should be thinking of new ways to use the Internet and distance-learning strategies not only to carry new developments in knowledge to clinicians, but also to establish an ongoing dialog between researchers, clinicians, treatment organizations, policymakers, and consumers. This dialog should include matters of research and their ethical implications. For example, with the apparent possi-
bility of discovering hard evidence of genetic vulnerability for alcoholism (Reich et al., 1998), we need to decide what we should do with that knowledge and how we should incorporate it into our educational programs. The potential for its misuse is obvious.

**Conclusion**

It has become increasingly clear from the nation’s experience with the war on drugs that incarceration alone does little to break the cycle of illegal drug use and crime, that two thirds of offenders sentenced to incarceration for substance-related offenses are rearrested within 3 years (BJS, 2002a, p. 2), and that treatment has been shown to be effective in reducing both drug abuse and drug-related crime (NIDA, 1999a).

The funds we currently spend on drug interdiction, law enforcement, courts costs, and incarceration would allow us to make substantial progress in improving treatment and in making treatment available to those who need it. Reducing the number of people arrested and incarcerated for drug possession and other minor drug offenses would also allow the police to concentrate their efforts on more serious crimes, thus making our communities safer. Politically, the time for reform may be near, especially with the crises occurring in our health, mental health, and correctional systems that are tied directly to drug use (McNeece, 1997).

Professional social work should be preparing for the eventual end of the drug war—and its aftermath. We should begin immediately to train tomorrow’s social workers to not only work with substance-abusing clients, but also to be effective policy advocates for harm reduction.

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