

**Harm Induction vs Harm Reduction:
Comparing American and British Approaches to Drug Use**

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Abstract

The disease model, while still the predominant conceptualization guiding U.S. treatment is now being challenged by the harm reduction model, highly developed in Britain. This paper examines both positions in light of historical/cultural differences related to Puritan zealotry and argues that with regard to illegal drugs, America's War on Drugs actually inflicts harm. The huge government expenditure, spread of AIDS, criminalization of drug users, and treatment neglect are just several of the negative consequences.

Who we are is who we were (Amistad, 1998)

A nation's value system and treatment of persons who violate the norms are closely intertwined. The norms we will be concerned with in this paper are those related to excessive use of alcohol and other drugs. This paper will compare and contrast British and American orientations to substance use and to substance abusers. Special emphasis is placed on social change, social definitions of crisis and trends in addictions treatment. A history of the harm reduction model (a model that helps clients control their drinking and drug use) will be presented against the backdrop of the American traditional disease model of addiction. The term "harm induction" in the title refers to a war on drugs which has become a war on people, a policy that promotes criminalization over counseling persons with addictive problems. The conclusion of the paper will examine treatment modalities such as motivational enhancement therapy, a therapy introduced by American academics, further developed by British academics and practitioners and now being reintroduced to the United States, especially in schools of social work. Will the harm reduction model be successful in the U.S.? What are the advantages? What are the drawbacks? What will be the effect on the disease concept of addiction? How about the funding sources? Implications for social work education and our graduates in the field are considered. Arguments are informed by an international exchange program between Midwestern and British social work departments.

Background Information

Through an international exchange arrangement with the University of Hull in northeastern England, faculty and students from our department of social work

(University of Northern Iowa) have had the opportunity to engage in joint research/learning projects. A common point of interest between the two institutions is the offering of a substance abuse specialization. At the time of this writing, two British students have completed field placement at U.S. substance abuse treatment centers, three British faculty members have visited our departments and local agencies, three of our faculty and three of our students have conducted research or taken courses at the University of Hull. Future plans are underway for joint publication efforts and presentation papers at European conferences. All participants have benefited greatly from the exchange of knowledge; several of us have been astonished at the contrasting approaches to substance abuse treatment by our two countries.

Because culture and substance use interact and shape each other, as Amodeo and Jones (1997) remind us, they are inextricably connected. Before examining the role of alcohol and other drugs in contemporary Britain and the United States, we will look at America's British heritage, and view the peculiar form that this heritage took on American shores. That Puritan influence (in values if not in specific attitudes toward alcohol) is a major variable affecting substance abuse treatment in the U.S. will be a major argument of this paper. We will come to see that the more diversified and flexible approach which we find in modern day Britain is every bit as much a manifestation of the British psyche as the more dogmatic and standardized U.S. approach is of the American psyche. Paralleling the common roots in language, the similarity in core values between these two Anglo-Saxon countries is more striking than the differences. This paper is concerned with differences as they are reflected in contrasting drug policies and social work education in substance abuse.

Historical Background

Today there are over 70 million people, approximately one-fourth of all Americans, descended from those early English/American colonists who were recorded in the 1st U.S. Census in 1790 (McGill and Pearce, 1996). Like the very language that shapes our every thought and deed, the present-day American value system is rooted in the New England experience, in the foundation laid down by the colony of religious zealots in Massachusetts Bay. The essence of this foundation was the holy experiment known to the world as Puritanism. In his classic, Wayward Puritans: A Study in the Sociology of Deviance, Kai Erikson (1966) provided a colorful portrait of this society and of the dissenters among them. Theirs was a society run by the clergy whose role it was to interpret the scriptures for guidance in all matters of living. Indeed, back in England, the English had found their narrow liberalism and lack of humor baffling. To Puritans who reached Massachusetts, the truth was perfectly clear: God had chosen an elite few to represent Him on earth. It was their responsibility to control the destinies of others.

Influenced by the doctrines of predestination, the Puritans believed that persons were either to be saved or condemned -- this was their destiny. Sooner or later persons would give evidence of the category to which they belonged. Those who had reason to fear the worst would inevitably sink to the lowest echelons of society. In accordance with the will of God, punishment for offenders was harsh.

We find the peculiar ethos of Puritanism in evidence in American society today. Despite the modern secularism, the Puritan ethic manifests itself in the severity of punishment, the moralism pertaining to "welfare cheats," common criminals, and users of illegal substances. The uniqueness of this history is important because many of the differences between Old and New World attitudes concerning drug use and the work ethic have their origins in these humble beginnings. Sexual prudery and enforced abstinence from drink, however, were not a part of the Puritan scene. The Puritans regarded drinking intoxicants a conducive to good health. The restrictions against consumption of alcohol were added later, after the impact of hard liquor had become a cause for concern (Bryson, 1994). The spirit of Puritanism -- the rigidity and punitiveness, however, survived in these later developments, and in many of the policies of today.

Two Paths Diverge

In spite of centuries of influence and borrowing in both directions, there invariably comes a time when cultural elements, previously suppressed, rise to the surface and there is a shift in paradigm. So it was with Britain's earlier uncritical acceptance of the American disease model of addiction. As Butler (1997) explains, the disease model had not been long institutionalized under the influence of the World Health Organization when it began to come under close scrutiny internationally. By 1980, in fact, the World Health Organization had done a complete turnabout on this subject. While a new public health perspective favored prevention through high taxes and other controls on consumption, a major policy shift in the U.K. was toward an interdisciplinary community level approach set out to help people reduce the harm to themselves by helping them control their level of consumption.

Geared toward voluntary, well motivated clients (clients are worked with very gently to enhance their motivation), the European harm reduction approach is clearly more compatible with the British than with the American mindset. The American disease concept, as Collins et al. (1990) indicate, emerged out of the vacuum of the post-prohibition era when the almost cultlike AA movement attained tremendous influence over the medical community and general public. Unlike the disease formulation which viewed alcoholism as irreversible and the alcoholic as having an abnormal condition, the predominant British view is that problem drinking exists along a continuum. Ideas about loss of control and the necessity for abstinence are seen as rigid and unhelpful.

So although over 1,000 AA groups exist in England and Wales, and the 12 Step approach still occupies a prominent place in the private sector of treatment, there had been a reconceptualization in Britain of what used to be called alcoholism but is now generically termed "problem drinking". Councils on Alcohol constitute the largest network of services for problem drinkers. The counseling model is eclectic, client-centered and non-directive. One-on-one therapy is the norm, with partners of problem drinkers being offered extensive services as well. Consistent with British individualism, the focus is on personal responsibility and self control (Baldwin, 1990). The approach is

to help the consumer (as the client is commonly called) determine his or her course of action; this might entail reducing one's alcohol intake or giving up drinking altogether.

America's War on Drugs

Like its predecessor, Prohibition, America's War on Drugs represents a desperate attempt to curb the unstoppable. The focus is placed on punishment rather than on treatment. More Americans are imprisoned today for drug offenses than for property crimes (Will, 1993); 70 percent of the federal government's expenditure on the drug problem goes to law enforcement agencies, and just 30 percent for prevention and treatment (Mauer, 1995). Criminalizing the use of substances highly pleasurable (to some) and addictive (to others) raises the rate of crimes committed to procure the substance. Putting drug dealers in jail boosts the price of drugs, thus making the selling of them more lucrative. A high percentage of murders among the young in urban areas is related to this business. (During Prohibition, similarly, the murder rate soared.)

Drug offenders now make up more than half of all the inmates in federal prisons. Violent criminals are released early to make room for nonviolent drug offenders who are incarcerated on mandatory-length prison terms (van Wormer, 1997). Moreover, as law professor Wisotsky (1993) argues, public safety is sacrificed when the law enforcement efforts are diverted from more serious crimes to crimes such as possession of marijuana. Higher taxes are raised to pay for this all-out effort and for the new jails and prisons being built to hold all those arrested and convicted.

Relevant to the issue of human rights, Wisotsky laments the substantial erosion of constitutional protections that have resulted from the drug-use crack-down. The War on Drugs, he states, is a war on the rights of all of us, directed not against the drugs themselves but against the people. With virtually everyone a suspect, all citizens must be observed, checked, screened, and tested continually. Law enforcement officials joined by U.S. military forces have the power to canine sniff and search almost at will as the laws on search and seizure are interpreted broadly in favor of local police and federal drug agents. And punishments for drug possession have become draconian.

In the United Kingdom, similarly, although the punishments seem amazingly lenient by American standards, a package of tough anticrime measures gives police and the courts far more power than previously. And there is talk under Tony Blair's Labour Party regime of launching a British war on drugs. The British attitude toward illegal drug use, however, is far more medical than punitive. For example, needle exchange programs in which clean needles are exchanged for clients' dirty ones are widely implemented in Britain. In the U.S., in contrast, Congress refuses to fund such programs because of the message they might send to the public.

The American top-down, coercive approach to the identical crisis facing Britain -- an upsurge on HIV infection transmitted through the sharing of needles by desperate drug injectors -- illustrates a crucial difference in the experience of crisis within the American as compared to British context. The British (and other European) reliance on the concept of heroin maintenance seems quite bizarre from the standpoint of a country steeped in

military values. However, with the death toll related to the war on drugs so high and given the utter failure of severe measures to control drug use, many addiction experts are looking to other solutions.

British Pragmatism

In 1821 in his celebrated autobiography, Confessions of an English Opium Eater, Thomas De Quincey introduced the western world to the reality of drug addiction. Taking opium, De Quincey (1950:258) discovered that "portable ecstasies might be had corked up in a pint bottle: and peace of mind could be sent down in gallons by the coach mail."

The British government has tried in vain for many years to tackle the problems of heroin. The trend has been to shift between legal and medical remedies, often under the influence of U.S. drug policies and political pressure. By 1918, in fact, Britain legislated against opium use despite the absence of any serious problems caused by this drug. Yet by 1926, Great Britain's physicians regained control of the addiction issue and now could prescribe heroin for addicts as they wished (Jonnes, 1995).

In 1971, however, due to the influence of Toryism, the Misuse of Drugs Act was passed; medical prescribing of heroin came to carry heavy penalties. This situation persisted until 1988 when a major health crisis associated with the use of shared needles (chiefly the spread of AIDS) precipitated a return to medical management of drug use (Franey, Power, and Wells, 1993). In the interests of public health, harm minimization became the overriding goal.

In the Scottish novel, Trainspotting, Irvine Welsh (1993:241) reviews the history from the perspective of an AIDS support group:

Most members of "HIV and Positive" were intravenous drug-users. They picked up HIV from the shooting galleries which flourished in the city in the mid-eighties, after the Dread Street surgical suppliers was shut down. That stopped the flow of fresh needles and syringes. After that, it was large communal syringes and share and share alike. I've got a mate called Tommy who started using smack through hanging around with these guys in Leith.

Whereas the United States relies almost exclusively on law enforcement efforts, in short, the British policies are more flexible with a strong emphasis on medicalization of treatment for addicts. In Britain after the 1970s, in tandem with increasing cynicism concerning the effectiveness of the model transported from Minnesota, a new public health approach focused on control of societal patterns of consumption. The polarized view of addiction began to give way to what Butler (1997) terms "a more pragmatic" harm reduction model which now plays a central role in the provision of services. Reacting to European pressure this time, the World Health Association has moved away from the disease model as well.

The medical approach to drug use is consistent with British practicality, humanism and a more casual attitude on the eastern side of the Atlantic (apart from Ireland) toward the traditional vices. "Ground up" initiatives in the interest of clients and public health are endorsed by national policy. The prescribing of injectables, including heroin and cocaine, as well as methadone, has once again come onto the national agenda (Franey et al., 1993). Cigarettes -- "reefers" -- containing either heroin, methadone, or cocaine -- are a popular treatment option. Statutory drug services including National Health Service Drug Dependence Units and Community Drug Teams provide multidisciplinary treatment that avoids stigmatizing drug users to stem the spread of disease. Regional community services, particularly those incorporating an outreach component, form a pivotal foundation of AIDS work. Reducing the profit potential in selling illicit products to drug dependent persons is a secondary benefit of the distribution of drugs and drug paraphernalia under close medical supervision.

The upsurge in HIV infection transmitted through the sharing of needles by desperate drug injectors is a crisis the world over. How a nation reacts to this crisis is a reflection of the cultural ethos. The British (and Dutch) reliance on the concept of heroin maintenance seems quite bizarre from the standpoint of a country like the U.S. steeped in military values. Nevertheless, with the death toll related to the war on drugs so high and given the utter failure of severe measures to control drug use, many addiction experts in this country are beginning to look at other approaches. Pragmatism is not always politically feasible, however.

The problem of alcohol and other drug use, and even the question of whether or not it is a problem, and the treatment and legal aspects: these cannot be viewed simply within the present-day context. These phenomena must be viewed culturally and historically.

With regard to British culture and its Anglo American counterpart, a basic core of value dimensions can be identified. Relevant to addiction treatment, the following core values are relevant: emotional restraint, rugged individualism and independence, work and mobility, nuclear family orientation, and moralism. These values are associated with both success and its *alter ego*, stress. Carried to extremes, such values as the work ethic can cause personal pain, and personal pain, as we know, is associated with substance abuse.

Interventions such as "*working* the 12 Steps," in fact, were developed to help persons from an individualistic, work oriented background, middle class men, for whom the stress of living had become too much. The stress management aspects of the "the Program" in conjunction with the self improvement aspects are culturally relevant. The dictum, "one day at a time," for example, is a help in curbing the worry wart in people. Many of the punitive aspects of programs designed for court-ordered treatment, however, with their endless urinalysis tests, and harsh confrontation aspects may be culturally alienating to persons brought up moralistically to trust and be trusted, and, above all, to have personal pride.

The fact that punitiveness plays such a prominent role in American drug policy initiatives (the bulk of the resources go into the war on drugs, after all) undoubtedly is a legacy of Puritan antecedents. Accordingly, of all the joint British/American core values, the value of moralism stands out as most singularly American. Under the rubric of this worldview, the disease model offers benefits that a stress on individual responsibility does not. At the personal level, the disease concept helps curb the internalized moralism and sense of personal shame concerning the loss of control that is addiction. Then there is the question of treatment. In a country without nationalized health care, treatment funding would soon dry up if chemical addiction were not regarded as an illness but, rather, as just a bad habit.

On the other hand, a model helping people to minimize the harm they do to themselves with drugs or alcohol has a great deal to offer. I will go further: in order to help people help themselves, it is absolutely essential that we work *with* our clients and not against them: harm reduction in this sense must be regarded as a viable treatment option. We can still regard addiction as an illness, in fact, without insisting on total abstinence.

The Harm Reduction Model

The medical profession, according to an article in the Journal of the American Medical Association (Cotton, 1994), is the cornerstone of an alternative approach to drug policy generally referred to as harm reduction. For heroin and other drug users, the harm reduction approach emphasizes providing care over punishment and attenuation of problems over cure. The focus is on protection of the user from the hazards of obtaining a supply on an illegal market, hazards which include exposure to crime, violence, and disease. The war on drugs' toll includes deaths generated by use of contaminated, unregulated chemicals, the spread of hepatitis, tuberculosis, and AIDS through the sharing of contaminated needles, and the social breakdown in America's inner cities which have become the focus of drug turf battles and law enforcement crackdowns (Skolnick, 1994). The cost of incarcerating illicit drug users is astronomical; more than 20 percent of men and 30 percent of women in U.S. prisons are there for drug violations. The war on drugs is largely a war on African American and Latina women. Black females were more than twice as likely as Latinas and 8 times more likely than white females to be in prison in 1996 (Bureau of Justice Statistics, 1998). Most of them were sentenced for drug violations.

What we now call harm reduction was originally formulated in response to hepatitis outbreaks among Dutch injection addicts (Price, 1996). The emergence of the AIDS epidemic in the early 1980s gave an urgency to this alternative approach. Several European countries, consistent with their "cradle-to-grave" social welfare programs moved to medicalize drug use and thereby monitor the drug user's behavior.

Included under the rubric of harm reduction are measures built under the assumption that the client will decide himself or herself whether or not to continue to take drugs; treatment of the user with dignity; the establishment of centers for trading clear

needles for dirty ones to protect the health of users; and the provision of a safe drug supply (for example, of heroin or methadone) under medical supervision.

Tenets of Harm Reduction Model

Continuum vs Dichotomizing

Whereas the 12 Step model is built on a polarized conceptualization -- either you are an alcoholic or you are not; either you can drink or it's "one drink, one drunk," addiction under the harm reduction model is conceived as running along a continuum. Most substance misusers, it is believed, can learn to curb their intake. The goal is not abstinence, therefore, but to reduce the harm. Somewhat surprisingly, under this model, therapists do occasionally give advice (Barber, 1994). For example, a client (called consumer) may be persuaded to switch from injecting heroin to snorting it. Or he or she is referred to a doctor who will prescribe methadone or heroin in such dosage as to stabilize the user. For drug injectors, a needle exchange program exchanges clean needles for dirty ones free of charge. In this way, the drug user's behavior can be monitored, and he or she can be encouraged to enter treatment. Advice, always, is geared toward practiced ways of reducing harm. Abstinence is presented as a highly viable but not essential option.

Client Naming of the Problem vs Labeling

"I am an alcoholic." "I am a compulsive overeater." "I am an addict." Such appellations have no place in most European treatment centers. The client is asked, "What are the benefits of drinking, using?" "Why do you see it as a problem?" Clients provide the definition of the situation, the problem is what they perceive as the problem. Clients are not defined in terms of the illness as in, "I am the illness" but, rather, are encouraged to recognize that having an illness or problem is only a part of who they are. The codependency label, of course, clearly the most controversial of the popular labels, is not applied (van Wormer, 1995).

Choice vs Standardization

To be empowered, people need to realize they have the power to choose from a wide range of options. Despite the myth that the harm reduction model promotes controlled drinking and drug use, proponents of this model leave it up to the client to find the solution. This is a client-centered approach in the tradition of Carl Rogers (1951). There is no one-size-fits-all list of steps or standard processes, such as breaking denial. Addiction is not viewed here as irreversible but rather, the harm reduction model is bound on the notion that everyone has free will. The decision to drink or use is viewed not as a sign of disease but as a free choice.

Belief in Motivation vs Resistance

In Britain clients generally are viewed as amenable to change. They are viewed as progressing through the basic process of change which extends from precontemplation to contemplation to determination to change to maintenance of results (Prochaska and DiClemente, 1992). As in client-centered counseling, resistance in clients is not met with confrontation but with empathy and reflection, creating the kind of positive atmosphere which is conducive to change (Barber, 1994).

Focus on Health vs Disease

Assessment is in terms of the positive, measuring fitness rather than disease, unlike the 12 Step approach. Yet central to both approaches is the view that drug abuse is certain to undermine the user's health and also to impoverish his or her social environment. Users, therefore, are provided with feedback of these effects whenever possible. More direct advice can be given very effectively, as studies show, by medical practitioners (Barber, 1994).

Which approach, social workers will want to ponder, is more consistent with the *strengths* perspective of social work -- the disease model or harm reduction approach? Strikingly, the harm reduction formulation, with its accentuation of the positive, stress on the human potential of all persons, in its view of the client as teacher as well as learner in the empowerment emphasis, the non-user of labels and forced dichotomies is entirely congruent with the strengths/empowerment approach. Conversely, the focus on humility, making amends for wrongs, admitting to being powerless over the substance, to name a few of the disease model precepts, have been called into question by social workers (see van Wormer, 1995).

Implications for Social Work

So ingrained in the U.S. is the abstinence model that abstinence as a universal client goal is rarely questioned. Often, in fact, a pledge to abstain from all mood altering drugs is a requirement for acceptance into the treatment program. When treatment compliance is court ordered, the client who admits to alcohol or other drug use may end up in serious trouble, possibly involving a return to jail. This policy, moreover, typically extends to the alcohol and drug counselors themselves who face dismissal for chemical use.

When the focus of treatment, however, is on promoting healthy lifestyles and on reducing problems rather than on the substance use per se, many clients can be reached who would otherwise stay away (Graham, Brett, and Bacon, 1994). Focus on reducing the harm caused by alcohol and drug use, rather than on the use itself is consistent with social work's holistic, meet-the-client-where-he/she-is approach. The harm reduction approach recognizes the importance of giving equal emphasis to each of the biopsychosocial factors in drug use. Together, in collaboration, the counselor and client consider a broad range of solutions to drug misuse, abstinence being only one of several. Forcing the client to admit to addiction to a substances as a way of "breaking through denial," according to proponents of this approach, can lead to resistance and a battle of wills between worker and client.

All these arguments, pragmatic as opposed to dogmatic, have been introduced to America through international conferences and exchanges. The 12 Step Program, similarly, has made inroads in Europe, especially in private clinics where its success with a certain type of client -- extroverted, severely addicted, structure seeking -- is reminiscent of the American experience.

The cross fertilization of ideas such as that between a university in the north of England and one in the American Midwest has greatly enhanced both social work programs. For instance, students trained in the one-on-one harm reduction treatment modality have chosen a field placement in the U.S. to learn group techniques consistent with the 12 Step model. At the same time, Midwestern students who have never before questioned the goal of total abstinence for alcoholics much less heroin users have come to consider the advantages of administration of the drug in a therapeutic, medical setting. Faculty members on both sides of the Atlantic have broadened their horizons and come to appreciate how much the treatment apparatus is a product of time and place, how strongly politics enters into the equation of what is done and not done, sometimes into what even can be talked about.

Seen in international context, one aspect of the American approach without merit is the government's waging of the War on Drugs, a war absorbing the efforts and energy of the police, courts, jails, prisons, armies, and taxpayers. The corruption entailed in prohibition of certain addictive substances -- heroin, marijuana, cocaine, and alcohol for those under age 21 -- could be avoided altogether if these drugs were regarded more realistically as are other addictives such as alcohol and tobacco.

Sometimes the laws are more harmful in their consequences than the problem they were enacted to prevent. Enforcement of laws restricting possession of injection equipment, for example, encourages the sharing of needles and syringes. And the passage of policies restricting federal funding of needle exchanges encourages risky needle sharing likewise. Nevertheless, intravenous drug use has become the most important factor in the spread of AIDS in the U.S. As many as 10,000 such infections could have been prevented over the last decade had clean needles been supplied to addicts, according to a report from the International Conference on AIDS in Vancouver (Bennett, 1996). This estimate includes the exposure of spouses and (unborn) children of drug users whose deaths are caused indirectly by the needle contamination.

Conclusion

Under the harm reduction model, social work intervention would be geared toward community prevention work and early treatment of drug users to monitor their use and life style. Because the abstinence model emphasizes treatment after the drug dependent has "hit his or her bottom," an opportunity to introduce life saving measures at early stages of drug use and problem drinking is lost. In the words of British drug counselor speaking before an American audience, "You are failing to meet the needs of a very significant number of people out there. I'm thinking especially of adolescents who do not identify with a label such as alcoholic or addict but who could benefit from help on their own terms" (Hobby, 1996).

American social workers would do well to work toward public health policies to control the epidemic of disease and crime associated with illicit drug use. Advocacy for more extensive funding of needle exchange programs such as that of New York City is essential. Public health and drug treatment providers should be aware of successful outreach intervention strategies and incorporate them into state and local AIDS

prevention programs (McCoy, Rivers, and Khoury, 1993). British social workers who have the advantage of living in a country with a national health service and government sponsored harm reduction policies can advocate to maintain the present system which is now under threat by elements from the far right. And they can turn their attention to the need for preventive measures within prison systems where random sharing of injection equipment is rampant. Methadone maintenance and needle exchanges are vital to stem the HIV/AIDS epidemic among the population. The ostrich-like behavior of British prison authorities in relation to drug injection mirrors their earlier resistance to distribution of condoms, however, and renders social change difficult (Harding and Nelles, 1995). In the U.S. , similarly, denial of prisoner drug use and sexuality hinder the introduction of life saving measures in the face of an epidemic of major proportions.

The harm reduction approach is much more consistent with social work values of client-centeredness and self-determination than is the current predominant zero-tolerance approach. The metaphors of war distract us from the human and social aspects of addiction and demonize people with problems. Harm reduction services, in contrast, provide individualized treatment and strengthen community action. The cost saving of prevention of HIV via projects involving indigenous outreach workers compares favorably with the costs of treating people with AIDS. Spurred by the enormity of excess crime, violence, and disease associated with prohibition, harm reduction is being implemented in parts of Europe, and discussed at conference across the U.S. In the Netherlands where the most comprehensive services have been offered, no apparent increase in illegal drug use has resulted (Cotton, 1994). Shifting the allocation of anti-drug resources to focus on treatment -- early intervention -- and prevention is clearly the key to breaking the cycle of hard-core addictive use and the transmission of HIV associated with illicit drug use. Perhaps the recognition that many of the adverse consequences of nonmedical drug use can be prevented without increasing drug use itself will lead us to base progress on scientific research findings rather than on political expediency. But in the meantime the death toll continues to climb.

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