Social Workers as Potential Agents for Drug Policy Reform

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Abstract: *There is a growing recognition that our society must address systemic racism, mass criminalization and violent policing with alternative responses to crises in communities. Reform advocates have increasingly proposed that social workers, equipped with the skills and training to de-escalate tensions and respond to mental health and substance use crises, should work in teams alongside police officers. Despite broad support by community stakeholders, law enforcement, and the National Association of Social Workers (NASW), this approach remains fraught if we do not critically examine our role as agents of social control in such systems. A clear case study is the War on Drugs, wherein social workers have assumed the role of frontline enforcers through our employment in the criminal legal and child welfare systems, health care, and coercive drug treatment programs. The harsh and punitive laws stemming from the War on Drugs have contributed to the mass criminalization of people who use drugs, devastated communities, separated families, and so much more. Our focus should shift towards upstream advocacy for policies to reduce the scope of the criminal legal system altogether. We propose suggestions to re-envision social work's role in less punitive and carceral responses.*

Keywords: *Drug policy, harm reduction, criminal legal system, child welfare, decriminalization, social workers*

Although many mark the beginning of drug criminalization in the U.S. with President Nixon's Comprehensive Drug Abuse Prevention and Control Act of 1970, the foundations of punitive drug control policy were first laid at the turn of the 20th century with San Francisco's local ordinance against opium smoking (Davenport-Hines, 2001). In fact, the 1970 Act was unique because it was the first federal drug policy that tied funding for drug control and law enforcement with funding for drug treatment and research. However, far more resources were spent on enforcement versus treatment: between 1985 and 2000, "drug offenses accounted for two-thirds of the rise in the federal inmate population" (Netherland & Hansen, 2017, p. 217), disproportionately affecting Black and Brown people despite comparable rates of drug use across racial groups (Koch et al., 2016).

The Anti-Drug Abuse Act of 1986 was passed to address a perceived crisis of drug use in general, but the sale and use of crack cocaine in poor Black neighborhoods and the births of "crack babies" were particularly sensationalized in the media (Beaver, 2010; Reinarman & Levine, 1997). Controversially, the Act specified new minimum sentencing laws that applied differentially to crack cocaine and powder cocaine (Beaver, 2010; Davenport-

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Hines, 2001; Reinarman & Levine, 1997). The penalties for possessing crack cocaine were 100 times those for powder cocaine (i.e., 10 grams of crack cocaine would lead to the same penalties as 1,000 grams of powder cocaine). Crack cocaine was allegedly more addictive, more harmful to users and fetuses, and more associated with violent crime than powder cocaine, but subsequent research and advocacy has both disproven these myths and highlighted their impact on racially disproportionate sentencing practices (Beaver, 2010). Eventually, President Obama's Fair Sentencing Act reduced the penalty ratio from 100:1 to 18:1 and created pathways for individuals with crack cocaine convictions to have their sentences reviewed.

In recent years, lawmakers and the public alike have come to view drugs as a public health issue, leading to meaningful steps to reduce our reliance on punishment and incarceration to address drug use and addiction. However, racial and economic disparities remain in who gets treatment and who gets criminalized: the most privileged people who use and sell drugs remain minimally impacted by the legal system, while those most marginalized are disproportionately criminalized and face insurmountable barriers to adequate healthcare (Camplain et al., 2020; Netherland & Hansen, 2017). There were more drug-related arrests in 2019 in the United States than for any other offense: nearly 1.6 million arrests in total, and more than arrests for all violent and property crimes combined (Federal Bureau of Investigations [FBI], 2020). Roughly 20% of all people incarcerated in jails and prisons – 450,000 people – were convicted of drug offenses, half of whom are Black or Latinx (Prison Policy Institute, 2020; The Sentencing Project, 2018); an additional 700,000 people are on parole or probation due to drug-related charges (Bureau of Justice Statistics, 2020). Meanwhile, national estimates suggest that 20.4 million people in the United States met criteria for a substance use disorder (SUD) in 2019, yet only 10.3% received treatment for it in the past year—a rate which has not increased in recent years (Substance Abuse and Mental Health Services Administration [SAMHSA], 2020a). Clearly, a criminal approach to drug use still impacts a significant number of people while most people with SUDs remain disconnected from treatment and other services.

"Cogs in the Wheel" of the Criminal Legal System

As Reisch and Jani (2012) highlight, social work practice has been shaped by institutional and ideological forces whose values and aims are often antithetical to those of the social work profession itself. Staffed in various sectors of the prison industrial complex—such as jails and prisons, probation and parole programs, and re-entry services—social workers act as "well-intentioned cog[s] in the wheel" (Buser, 2020, para. 6). While we enter these spaces with the best of intentions, it is critical to address the ways that criminality, social norms, and constructions of "appropriate behavior" are defined by white, Protestant, middle-class, colonialist ideals. Leotti (2020) addresses this notion in her analysis of racism and social work practice, citing "social work's professional identity of helper is built upon colonial scripts of whiteness," and therefore "serves as a centralizing, organizing principle for practice" (p. 470). Consequently, social workers are forced to focus on client situations as being the result of individual choices and decision-making, rather than oppressive structural barriers, systemic racism, and the influence of history and social environments on people's lives (Leotti, 2020; Reisch & Jani, 2012). Embracing an

ecological perspective can further gear social work practice towards centering the interactions between systemic racism, the criminal legal system, and individual experience to better understand how our clients are impacted by these intersections and more effectively determine our role in our work. In doing so, we can better serve system-involved clients by critically examining connections between existing racialized societal arrangements and marginalization—including how we may uphold such notions and the implications for addressing clients' needs.

In probation and parole, social workers carry out duties associated with law enforcement, serving as "synthetic" parole or probation officers (Miller, 2013)—combining social work and law enforcement tactics to maintain surveillance and supervision of their clients through drug testing, monitoring client whereabouts, and programmatic compliance. Despite our commitment to advancing human rights and social justice (NASW, 2017), when working within a system focused on social control and oppression, social workers often act as gatekeepers and enforcers to the characteristic coercion and violence of these systems. When faced with "dual loyalty" (Buser, 2020, para. 11)—responsibility to employer versus responsibility to clients—challenging the human rights violations we bear witness to (such as extended use of solitary confinement, lack of access to medical care and substance use treatment, and so on) comes second to prioritizing bureaucratic processes and compliance requirements imposed upon us as social workers (Jarldorn, 2019). In such a position, "social workers' ability to exercise these choices is constrained by the priorities of others, particularly the political and economic interests of individuals and groups with different goals, such as policy makers, foundations or individual donors" (Reisch & Jani, 2012, p. 1137). In examining these constraints, the conflict perspective can guide us in questioning and challenging the structural functions of incarceration and community surveillance to evaluate who it is we are truly serving, as this perspective calls on social workers to confront the disconnect between so-called criminal justice and social justice to work towards meaningful change on a systemic level. By working in carceral and punitive systems without challenging the structural forces dictating our work, we uphold the values of oppressive systems while failing to adequately serve our clients.

The "Civilizing Violence" of Drug Courts and Mandated Treatment

In light of the rampant issues in the criminal legal system and a recognition that drug use is a public health issue, many have advocated for alternatives to incarceration for people charged with low-level drug offenses. Drug courts have emerged as the one of the most prominent criminal justice reforms with broad bipartisan support, numbering over 3,000 across the United States (Office of Justice Programs, 2020) and processing over 120,000 people per year (Marlowe et al., 2016). From their inception, drug courts have been hailed as low-cost alternatives to incarceration that engage people in necessary substance use treatment and interrupt the cycle of "revolving door nature of justice" (Flores et al., 2018, p. 7). Drug court participants are subjected to "a significantly more intensive case management approach," incorporating regular drug testing, mandated individual and/or group therapy sessions for addiction treatment, workforce development programs, and a variety of other interventions (Witkins & Hays, 2019, p. 973). By building a

multidisciplinary team of actors from the criminal justice system and social service field, drug courts supervise every aspect of participants' lives to ensure abstinence from drugs and accession to employment.

Drug court scholars and program providers have referred to this synthesis of criminal proceedings with therapeutic practice as *therapeutic jurisprudence*. Therapeutic jurisprudence is "both a legal perspective and a social movement" that examines how legal actors and systems can have a restorative (or detrimental) impact on "criminal offenders" (Madden & Wayne, 2002, p. 488). In theory, practitioners of therapeutic jurisprudence utilize aspects of the person-in-environment (PIE) perspective, addressing participants' substance use in the larger context of their physical and mental health, economic stability, and social environment (Kondrat, 2013). In practice, however, judges with little to no addiction expertise wield ultimate decision-making power over participants' treatment course, often barring people from evidence-based treatments such as methadone or buprenorphine due to stigma (Friedman & Wagner-Goldstein, 2016). The drug court philosophy is based on a "carrot-and-stick" approach: reward good behavior and punish bad behavior (Kaye, 2019). Staying abstinent and obtaining employment – no matter how painful the withdrawal or how menial or low-wage the work – are examples of good behaviors that judges reward with verbal praise (Gallagher et al., 2019). The failure to maintain sobriety or employment, drug courts promise, will be met with "swift and certain sanctions" (Fisher, 2014, p. 761). Punishments can include apology letters for misbehavior; mandated work details; and even *shock incarceration,* a period of confinement ranging from 24 hours to a week or more at a time (Fisher, 2014; Lilley, 2017). Incarceration in the context of drug courts is often constructed as a "therapeutic move" or a "timeout," where relapsing participants detox in jail when they struggle to remain sober on the outside (Gibbs et al., 2021, p. 41). Sanctions are not uniform across drug courts, and in fact may vary from participant to participant within a single court: drug court providers reject strictly regimented sanctions, yet discretionary sanctions "are not always levied in a progressive manner" (Gibbs et al., 2021, p. 40), disproportionately falling on participants who struggle to meet the court's standards (Gibbs et al., 2021). In addition to directly participating in the sanctioning process, social workers and case managers who work with drug courts are compelled to report any instance of program non-compliance so their clients receive "appropriate" punishment.

The combination of carceral and non-carceral sanctions often extends the time that participants spend under criminal supervision far beyond that of a traditional jail sentence (Drug Policy Alliance [DPA], 2011). While "successful" participants may spend less time behind bars, "any benefits realized from a lower incarceration rate are offset by the long sentences imposed on participants when they fail the program" (Sevigny et al., 2013, p. 416). This pattern is particularly insidious, considering that low-income and Black individuals are more likely to be arrested for low-level drug offenses; disqualified from participating in drug courts in the first place; and expelled from drug court treatment programs, thus sentencing them to the maximum jail or prison time dictated by their initial conviction (DPA, 2011). These differences are not immutable, but a result of both individual and structural biases that lead providers across disciplines to treat "some addicts — who just happen to be poorer and/or members of communities of color — [as] sicker

than others, requiring a more forceful dose of medicine to recover" (Whetstone & Gowan, 2017, p. 109). This punitive approach to problematic drug use deprives clients of their right to self-determination and perpetuates racist notions of criminality and delinquency.

Court-mandated treatment undermines the establishment of trust and a collaborative spirit between social workers and their clients. An investigation of "strong-arm" rehab centers in the United States found that many social workers and case managers view their clients as not only addicted to drugs, but also "addicted to the lifestyle" (Whetstone & Gowan, 2017, p. 91). The "drugs lifestyle" is characterized by tardiness, impulsivity, defiance, and disrespect for authority; while seemingly colorblind and class-blind, this collection of traits harks back Patrick Moynihan's manifesto on the "culture of poverty" supposedly instilled in Black youth by their absent fathers and overbearing mothers (Kaye, 2019, p. 71). Social workers and counselors in "strong-arm" rehab centers often view themselves as agents of "habilitation," treating their clients as "deceitful, manipulative, impulsive, and openly defiant… criminal-addicts [who] had not been properly socialized and needed to be remade rather than restored" (Whetstone & Gowan, 2017, p. 92). Kerwin Kaye (2019) has referred to this punitive treatment as a kind of *civilizing violence*, akin to the brutality enacted against enslaved Africans and Indigenous peoples under the guise of inducting them into *proper personhood*. This context of coercion and punishment breeds hostility between social workers and their clients. Therapist-client confidentiality is necessarily waived as in-session interactions are routinely submitted for judicial review (Roberts et al., 2015). All disclosed drug use or urge to use drugs is reported to the court to ensure "swift and certain sanctions," up to and including jail time (Fisher, 2014, p. 761). Behaviors and attitudes brought up in counseling sessions, regardless of their direct relevance to a participant's drug use, are frequently introduced in court proceedings and scrutinized for adherence to the court's recommendations (Tiger, 2011). Through these proceedings, social workers become key decision makers in all aspects of a participant's life, controlling where and with whom they live and spend leisure time; what jobs they take and how long they stay; when they can see their children; whether they can pursue a GED or other educational requirements; and their self-conception as full human beings (Kaye, 2019).

The drug court paradigm rests on racist ideology. The so-called "drugs lifestyle" and "culture of poverty" are not intractable social problems, but oppressive social constructions that drug court professionals weaponize against impoverished and racially marginalized individuals. No social worker should intentionally or negligently promote such ideas, for they are anathema to social workers' ethical mandate to uphold the dignity and worth of every person (NASW, 2017). Relying on the criminal legal system to coerce people into treatment is unjustifiable when voluntary, holistic services provide comparable or better outcomes (American Public Health Association [APHA], 2013). Social workers must critically consider our roles in legitimizing racist drug war mythologies and challenge punitive measures against people who use drugs within drug courts and the programs that serve them.

Social Work and Separation in the Family Regulation System

Approximately half of all social workers in the U.S. serve families and children, largely in the context of child protection, child welfare, and foster care agencies (Bureau of Labor Statistics, 2020). The child welfare system is a clear example of a call for help that leads to the dispatch of a social worker, rather than a law enforcement officer: yet, the harmful consequences are just as devastating. Most reports to child welfare agencies are for neglect (Administration for Children & Families [ACF], 2020), often due to drug use or the possibility of it. Insufficient evidence links drug use with child maltreatment (i.e., neglect) and compromised parenting skills, yet any trace or suspicion of marijuana use (or any illicit substance) by the parent can lead to an investigation with the risk of losing custody (Hart, 2021). This is a crude instrument at caseworkers' disposal, as it assumes the use of any drug is cause for neglect. Furthermore, substantial research has demonstrated the determinative role of race in child removal (Siegel, 2021).

When a neglect case is opened, the relationship between social worker and parent can become punitive in nature, rather than collaborative and supportive. Caseworkers assign parents rigorous and cumbersome family service plans that typically include parenting skills classes and other interventions which may incorporate surveillance, such as drug testing and family court conferences—all in addition to their caregiving responsibilities. Rather than identifying family attributes and assets and strengthening them with the provision of resources (such as childcare and/or in-home supports targeting root causes of neglect to promote family preservation), "at-risk" children are typically removed and placed into foster care without prevention measures implemented or after punitive interventions are deemed unsuccessful (Roberts & Sangoi, 2018).

Family regulation systems disproportionately target Black, Brown, and Indigenous families (Roberts & Sangoi, 2018) and their involvement can inflict significant long-term trauma and disruption for the children and families (ACF, 2020). For the families in which marijuana use is involved, it is particularly significant as it may be the sole reason their case is opened and intensely investigated (Ketteringham, 2019). In the name of child safety and well-being, social workers act as a surveillance mechanism in the regulation and control of families of color.

The criminalization of drugs and poverty perpetuated by the child welfare system directly conflicts with our profession's mission—and often results in greater harm to the children and families under the system's microscope. Not only do children suffer poorer physical and mental health when separated from parents, but parents suffer as well: women of color with substance use disorders whose children are forcibly removed from their care are uniquely vulnerable to relapse and overdose (Thumath et al., 2021). In areas with high overdose rates, child removal has increased significantly in recent years, yet treatment and support services to parents are significantly lacking (Waite et al., 2018). This is a crucial issue, especially as multiple states are at capacity for foster care, leading to children being placed in remote out of state locations, making reunifications less likely (Child Welfare Information Gateway, 2017; The Imprint, 2017). Furthermore, the criminalization and stigmatization of substance use during pregnancy leads people to avoid seeking treatment for fear of losing their child and/or being incarcerated (Stone, 2015). Placing emphasis on punishment rather than support and connection, social workers involved in the family

regulation system are putting children and parents at greater risk of physical and mental health complications.

Recommendations for Change

Action Step 1: Join the Movement to Advance Drug Policy Reform

The fifty year-long war on drugs has not eliminated drug use, addiction, or overdose, but has actually created the conditions for an unregulated drug market, a violent underground drug economy, and stigma that deters many from seeking help (Coyne & Hall, 2017). One of the most important aspects of ending the drug war is decriminalizing drug use and possession. Nearly 87% of all drug-related arrests are for personal possession, entrenching over a million people into the criminal legal system annually while saddling them with lifelong criminal records (FBI, 2020). Many of these individuals have substance use disorders that will go unmanaged as long as they are faced with the trauma of arrest rather than given access to harm reduction services, medical care, or substance use treatment. In fact, drug enforcement sabotages efforts at achieving recovery by inhibiting access to housing, employment, and public benefits; stripping individuals of their citizenship and/or deporting them; and impeding their ability to retain custody of their children and provide for their families. It is by no coincidence that the majority of those ensnared in the ever-widening net of the drug war are from low-income communities of color, locking in generational trauma and impacting their ability to accumulate intergenerational wealth (Siegel, 2021). Criminalization is especially harmful in the context of the current overdose crisis killing people by the thousands. It is essential that people who use drugs feel safe contacting the authorities to seek help, report an overdose, or alert them to dangerous batches of drugs—for example, heroin adulterated with the powerful synthetic opioid fentanyl (Lohman & Malinowska, 2019). Provisional US overdose data indicate that there were an estimated 102,568 drug overdose deaths in the United States during the 12-month period ending in November 2021, an increase of 15.7% during the same period the year before (Ahmad et al., 2022).

In 2020, Oregon approved the first all-drug decriminalization ballot measure in the United States, which removes criminal penalties for drug possession while expanding the state's network of harm reduction and evidence-based addiction treatment services (Health Justice Recovery Alliance, 2021). A racial impact study found that this could reduce drug convictions among Oregonians of color by 90% (Oregon Justice Commission, 2020). A study conducted by the Oregon Health Authority on outcomes at the one-year anniversary of implementation found that 67 organizations and 11 tribal organizations received over $30 million of funding for substance use treatment, peer support, harm reduction and housing and over 16,000 people accessed services (2022). This could serve as a model piece of legislation to show that when people are not punished and services are affordable, accessible, and evidence-based, people will seek help.

Marijuana legalization also remains an important area of drug policy reform, since one-third of all drug possession arrests are for marijuana, and Black people are over three times more likely to be arrested than white people despite comparable rates of use (American

Civil Liberties Union, 2020; FBI, 2020). State campaigns for legalization have gained increasing support as public opinion has shifted in recent years, and revenues from regulated markets have been used to increase funding for prevention and treatment services.

By advocating for drug policy reform, we are actively alleviating the burden of punitive systems that harm our clients. In eliminating criminal sanctions related to drug use, we can break down barriers to housing, treatment, employment, and many other resources that contribute to one's dignity, worth, and well-being. As professionals who are ethically obligated to support our most vulnerable and marginalized communities while challenging social injustice, social workers must advocate for policies that contribute to the end of the war on drugs.

Action Step 2: Reinvest in Communities through Expanded Treatment Options and Harm Reduction Services

Successful implementation of decriminalization is contingent on reinvesting in communities most impacted by the drug war. We must ensure equitable access to an evidence-based continuum of care for people who use drugs – from harm reduction services, to low-threshold outpatient treatment, to intensive residential treatment. The availability of a broad range of services serves to improve health and well-being and reduce contact with the criminal legal and other punitive systems among people who use drugs. This will particularly benefit those who are most at risk of drug-related harms and in the greatest need of services, such as people who inject drugs (PWID) and people experiencing homelessness (APHA, 2013).

As noted earlier, 90% of people with SUDs did not utilize substance use treatment services: among those who perceived an unmet need for treatment, the top reason for not seeking treatment was an unwillingness to pursue total abstinence (SAMHSA, 2020a). Many harm reduction interventions reduce the likelihood of fatal drug-related consequences without imposing sobriety, including syringe service programs (SSPs), naloxone access initiatives, overdose prevention centers, and drug checking services. Unfortunately, due to the criminalization of drug paraphernalia and stigma against illicit drug use, most of these interventions are inaccessible in most of the United States, particularly in politically conservative states, rural communities, and communities of color. Many states still do not have legal SSPs, and those that do cannot meet demand; there are only two functioning legally sanctioned overdose prevention centers in the entire nation; and harm reduction is absent from most addiction treatment programs. Increasing access to SSPs, overdose prevention centers, and harm reduction services can increase referrals to addiction services as well as transform addiction treatment to accommodate a wider range of drug use behaviors and desires.

Social workers can expand access to drug treatment for underserved populations by connecting clients to harm reduction services as well as becoming harm reduction practitioners ourselves. Harm reduction and social work are ideologically aligned, centering client self-determination, meeting the person where they are at, and working collaboratively to advance autonomy and client-defined goals (Vakharia & Little, 2016).

In acknowledging a client as the sole expert on their life experiences, social workers collaborate with clients in treatment planning and goal setting: treatment evaluations are based on quality-of-life factors and individual signs of progress, rather than on paternalistic definitions of progress determined by a judge or program. Social workers should connect clients with harm reduction services that can provide safer use education and supplies relative to the client's expressed interest. Equally important — if not more so — is the active participation of social workers in the harm reduction sphere as educators, providers, and advocates. Though harm reduction closely aligns with the social work ethic of client self-determination, social work education on people who use drugs has thus far failed to meaningfully integrate harm reduction practices and encourage social workers to become harm reduction specialists.

Action Step 3: Employ a Critical Race Theory Lens to Repair the Harms of the Drug War

To truly challenge anti-drug stigma perpetuated by institutional racism and advance the health and safety of those we serve, social workers should incorporate critical race theory (CRT) into practice. As a framework aimed at transforming the relationship between race, racism, and power which uphold racial inequality, CRT challenges the ways society and social processes reflect the white experience (Kolivoski et al., 2014). This is especially crucial at a time when Black, Latinx, and other people of color are less likely to receive medication-assisted therapy (MAT) despite increasing rates of opioid overdose fatalities (Jordan & Jagede, 2020). To adequately expand services for all who wish to receive them, social workers employing a CRT lens can better understand how these populations continue to be disproportionately harmed by drug war enforcement and are therefore systematically less likely to access existing treatment options for opioid use disorder (Jordan & Jagede, 2020, p. 415).

Employing CRT in practice is vital to justly reinvesting in low-income and communities of color that have been devastated by the war on drugs, where too often an emphasis on criminalization prevents funds from being allocated to community-building resources and public entities (Chung & Pearl, 2020) such as schools, parks, and healthcare facilities. Through a CRT lens, reinvestment efforts include building capacity among community members to collaboratively address community-defined social problems.

To address the varying aims of reinvestment, we must not only do work in marginalized communities, but commit to doing long-term, collaborative work with community leaders and local advocates. Instead of ushering in predominantly white, licensed (and therefore graduate-educated) social workers to define and control essential social services, repairing harm must be centered on the voices and knowledge of local stakeholders. CRT acknowledges that historically, the voices and experiences of people of color have been systematically left out of mental health and substance use treatment systems (Kolivoski et al., 2014). As Reisch (2019) points out, "Social work's response to the challenges faced by marginalized populations frequently reflected a seemingly intractable cultural divide that separated social workers from the people with whom they worked" (p. 595). Commonly led by state and local governments, community reinvestment

efforts have been found to often reflect the priorities of policymakers and local officials, failing to take into consideration the needs of residents (Chung & Pearl, 2020). Incorporating CRT into social work practice requires uplifting the voices of affected communities through establishing trust and working with local community-based organizations, drug user advocates and people who use drugs, and outreach workers on the ground who are already doing harm reduction work. By centering as experts those most impacted by the harms of drug policy, social workers can better ensure access to services is not only expanded but done so in a way that amplifies the demands of the communities we serve (Kolivoski et al., 2014).

Action Step 4: Support Community-Based Justice & Public Safety Initiatives

Social workers should support and advance efforts to implement public safety initiatives that divert crisis intervention duties from police to community organizations. Without the presence of law enforcement, mental health practitioners and community members can effectively deescalate conflict while demonstrating respect, dignity, and humanity toward those in crisis. Rather than threatening incarceration and perpetuating the harms of the carceral system, crisis intervention teams can connect people to the resources they need to live fulfilling lives, including stable housing, childcare, and employment.

Police have become default responders to all types of emergencies due to the absence of appropriate non-police options in most communities (Friedman, 2020). Currently, there are over 6,000 independent call centers, including fire departments, emergency management and law enforcement, in the U.S. (911.gov, n.d.), and most calls placed to these centers are unrelated to crime (Neusteter et al., 2020). Though mental health crises comprise only 10% of all 911 calls, they have been the pretext of 25% of all fatal police shootings over the past six years (Coles et al., 2021). 911 calls for behaviors not presenting as threats to public safety must be diverted to professionally trained behavioral health practitioners and community public safety teams, as police involvement – particularly for Black, Latinx, and Indigenous people in crisis – is far too often a matter of life and death (SAMHSA, 2020b).

Diversion and Alternative Response Models

Law Enforcement Assisted Diversion/Let Everyone Advance with Dignity (LEAD) began ten years ago in Seattle to counter the disastrous impact of the war on drugs by responding to low-level drug and public order offenses with referrals to harm reduction and other social services (LEAD National Support Bureau, n.d.). With 50 parallel programs operating across the country and numerous more in progress, LEAD's model engages a range of stakeholders, such as civil rights advocates and community leaders, to create preemptive interventions aimed at interrupting the cycle of arrest, incarceration, and recidivism. Referred individuals participate in an intensive harm reduction case management program that is premised upon a trauma-informed model that addresses problematic substance use and mental health issues as well as unstable access to employment, housing, and other resources individuals need to thrive. In lieu of abstinence-only edicts, LEAD practitioners offer participants a full array of interventions, including

MAT. That said, prosecutors and police remain present in LEAD programs, intervening should a participant be re-arrested. A study comparing LEAD participants to a comparison group found that LEAD clients had 1.4 less yearly average jail bookings, over 40 less days per year in jail detention, and were 88% less likely to be incarcerated (Collins et al., 2019). There were significant governmental budgetary savings as well: legal fees for non-LEAD participants rose to nearly $6,000, whereas legal costs for participants in LEAD declined by $2,100. While this framework represents an important step towards a gentler war on drugs, future iterations of this model should strongly consider eliminating police involvement.

Based in Austin, Texas, Integral Care's Expanded Mobile Crisis Outreach Team (EMCOT) began as a "dispatch and co-response" pilot program in 2013 prior to achieving full operational capacity in 2014 (Arellano, 2020). EMCOT aimed to provide a more appropriate response to mental health crises via 911 calls by adding mental health clinicians to work in tandem with Emergency Medical Service (EMS) responders and, subsequently, the Austin Police Department (APD). In February 2021, the county's 911 call center became the first in the country to add a separate prompt for mental health calls: if the operator believes no safety risk is present to the caller or public, the call is diverted to a mental health team from Integral Care, a long-standing community-based mental health center (Integral Care, n.d.). EMCOT clinicians can potentially address concerns via phone or dispatch a mobile crisis unit until they can arrive to conduct a mental health assessment and connect a person in crisis to behavioral health services on a voluntary basis. For a 90-day period after the crisis assessment, EMCOT keeps in touch with clients to ensure continual access to case management, counseling, and addiction treatment, which take place at client-preferred community-based locations (The Meadows Mental Health Policy Institute for Texas, 2019). Nearly 100% of EMCOT participants avoided jail time; almost 80% also avoided inpatient stays at hospitals or psychiatric units. Compared to the cost of $700 per police officer dispatch, EMCOT dispatches cost only $400 (DeLaus, 2020). EMCOT's incredible success has led to a budget increase to $3 million annually, enabling clinicians to provide around-the-clock diversion services (Thornton, 2020). Furthermore, Austin's newly created Reimagine Public Safety Fund aims to provide funding for alternatives to policing initiatives throughout the city.

Operated by White Bird Clinic, a Federally Qualified Health Center and entrusted community institution providing services for both emotional and physical health in Eugene, Oregon for more than half a century (White Bird Clinic, n.d.), CAHOOTS (Crisis Assistance Helping Out On The Streets), a pioneer in community-based alternate public safety responses to law enforcement when established over 30 years ago, functions as a 24/7 free, voluntary, and confidential program using mobile crisis teams comprised of medics and highly trained behavioral health practitioners to respond to non-violent emergency calls. It has perhaps become the most influential model of its kind due to the abundance of media attention over the years spotlighting its positive impact (Gerety, 2020). Funded primarily by the city, teams de-escalate and stabilize individuals with emergencies related to substance use and mental health among others, humanely using the least amount of intervention while relying on existing partnerships with a network of resources in the local community to ensure continuity of care following the immediate crises (Program in

Criminal Justice Policy and Management, 2021; White Bird Clinic, 2020a). In 2017, 17% of calls to the Eugene Police Department were answered by CAHOOTS (White Bird Clinic, 2020b). Over a 5-year period, 2014-2019, CAHOOTS' on the ground response levels nearly doubled (9,646-18,583; Eugene Police Department, n.d.), and in 2019, police back up was requested in only 1% of the 24,000 calls. The CAHOOTS program in Eugene yielded an approximate annual cost savings of $8.5 million in public safety funds in addition to an estimated $14 million savings in both ambulance transport and emergency room services for 2019 (White Bird Clinic, 2020a). For fiscal years 2018-2021, a more than 20% increase in funding allocation from the city was realized (Eugene Police Department, n.d.). The cost of preventing the potential harms from law enforcement, though, cannot be understated (White Bird Clinic, 2020a).

As communities continue to grapple with reimagining public safety, the groundbreaking CAHOOTS ACT, sponsored by two members of Congress, was incorporated into the $1.9 trillion American Rescue Plan 2021 signed by President Biden in March 2021 (Butler & Sheriff, 2021). The Act is premised upon the CAHOOTS mobile crisis team model, thereby serving as a powerful impetus for the development and implementation of similar initiatives to counter the criminalization of emergency responses to mental health crises in the U.S. As alternatives to law enforcement in the public safety domain progress, states using mobile crisis intervention units will be eligible to receive an enhanced matching Medicare rate of 85% for three years, likely spurring a proliferation of these programs across the nation (Butler & Sheriff, 2021).

Public community safety approaches and models with limited to no law enforcement contact can be achieved through diverted funding from restructured police budgets (Pearl, 2020). These models should fall under the auspices of a separate civilian-led governmental Office of Public Safety with its own designated emergency response call number. Not only will this communicate a meaningful message from the government about its commitment to safer emergency response systems, particularly to those most impacted by police violence, but it could increase the likelihood of a sustainable funding stream from the government (Pearl, 2020). One such program in development is the Albuquerque Community Safety department, a cabinet-level civilian department of community safety premised upon a public health framework. It is slated to have a 911 public safety diversion option for calls involving substance use and addiction, mental health issues, and homelessness that are deemed non-violent at point of phone contact, and staffing will include social workers and violence prevention specialists, among others (City of Albuquerque, 2020). Additionally, we advocate for drug reform decriminalization laws coupled with harm reduction centered approaches that fall within the public health sphere, thereby avoiding the trauma of further criminalization of public order behaviors (Sherman, 2020).

Best Practices for Planning Public Safety Initiatives

Public safety initiatives must begin with the assembly of a diverse task force composed of a wide range of stakeholders, including faith/community leaders, civil rights advocates, restorative/transformative justice activists, and behavioral health providers (Denver Task

Force, 2021). Task forces should elevate the contributions of people with lived expertise on drug use, police brutality, and mass incarceration, centering their vision of what safety means in their communities (Policing Project & The Justice Collaboratory, 2021; Virani & Gasser-Ordaz, 2020). Essential to this process is the task force's independence from the influence of elected officials and meaningful power over program development and implementation. Task force members will be charged with developing comprehensive training for call center operators; staffing of behavioral and mental health specialists; and creating emergency response protocols adaptive to a wide variety of situations. Community-based public safety initiative planners would do well to incorporate funding streams and safeguards (Pearl, 2020; Virani & Gasser-Ordaz, 2020); program evaluation and intervention; and advocacy for complementary policy proposals, including all-drug decriminalization (Sherman, 2020).

As the movement towards reimagining public safety progresses, the next generation of social work students should be at the forefront of critically analyzing existing models and programs as well as those in the pipeline, while gaining an essential appreciation of historical underpinnings (Gregory, 2021; Jacobs et al., 2021). Through first-hand experiential learning, students should be challenged to devise innovative alternative models through participation in the creation of initiatives with communities served via field placements and/or arrangements offered by schools (Jacobs et al., 2021). Applying the core ethical principles from the NASW Code of Ethics, such as challenging social injustice and respecting the inherent dignity and worth of the person (NASW, 2017), in addition to racial justice, those on the path to professional practice will thereby acquire valuable and necessary knowledge and skills to inform their practice (Reisch & Jani, 2012). Our actions require efforts towards relinquishing our role in systems of oppression; social workers must embrace preventing and mitigating harm rather than participating in its infliction (Jacobs et al., 2021).

Discussion and Conclusion

The values and principles outlined in the social work profession's Code of Ethics must not continue as merely words on a document. Striving for social justice, respecting the dignity and worth of all clients and communities, and addressing the root causes of social problems must be inherent in social work practice, especially when working with populations historically marginalized and oppressed by the very institutions we represent. It is not enough to denounce stigma and discrimination when we are actively contributing to it. At a time when calls for anti-racism, police reform, and social change are becoming mainstream we must look inward at the role of social workers, past and present, in creating today's social conditions to determine how we can better contribute to creating an equitable society. In other words: we must examine our positionality to hold ourselves accountable to take social work's guiding principles from print to practice.

In the drug policy sphere, until we not only recognize, but challenge the oppressive rules, regulations, and practices that often come before our clients in the criminal justice, drug court, and family regulation systems (among others), we are merely enforcing our own form of social control. By advocating for and enacting decriminalization, harm

reduction, community reinvestment, and community-based public safety initiatives in our practices and policies, we can begin to detract our complicity in maintaining the status quo and instead provide anti-carceral, person-centered social work services. Critical to this approach is incorporating the voices of those disproportionately impacted by social, economic, and racial injustices. As we commit to looking within our profession to improve social work practices and principles, assessment and evaluation along the way will be tantamount to ensuring the sustainability of services rooted in human rights, anti-racism, and social justice.

References

911.gov. (n.d.). *Tour a 911 call center or PSAP.* https://www.911.gov/project_toura911callcenterorpsap.html

Administration for Children & Families. (2020, January 15). *Child abuse, neglect data released: 29th edition of the Child Maltreatment Report.* https://www.acf.hhs.gov/media/press/2020/child-abuse-neglect-data-released

Ahmad F. B., Rossen L.M., Sutton P. (2022, April 13). *Provisional drug overdose death counts*. National Center for Health Statistics. https://www.cdc.gov/nchs/nvss/vsrr/drug-overdose-data.htm

American Civil Liberties Union. (2020). *A tale of two countries: Racially targeted arrests in the era of marijuana reform.* https://www.aclu.org/report/tale-two-countries-racially-targeted-arrests-era-marijuana-reform

American Public Health Association. (2013). *Policy statement: Defining and implementing a public health response to drug use and misuse.* https://www.apha.org/policies-and-advocacy/public-health-policy-statements/policy-database/2014/07/08/08/04/defining-and-implementing-a-public-health-response-to-drug-use-and-misuse

Arellano, R. (2020). *Update on mental health diversion.* Austin Council Manager System. http://www.austintexas.gov/edims/pio/document.cfm?id=348966

Beaver, A. L. (2010). Getting a fix on cocaine sentencing policy: Reforming the sentencing scheme of the Anti-Drug Abuse Act of 1986. *Fordham Law Review, 78,* 2531-2575. https://ir.lawnet.fordham.edu/cgi/viewcontent.cgi?article=4535&context=flr

Bureau of Justice Statistics. (2020). *Corrections Statistical Analysis Tool (CSAT)-Parole.* https://www.bjs.gov/parole/

Bureau of Labor Statistics. (2020). *May 2020 national occupational employment and wage estimates: United States.* https://www.bls.gov/oes/current/oes_nat.htm.

Buser, M. (2020, November 2). The ethical conflict of social work within a carceral system. *Filter.* https://filtermag.org/social-work-carceral-system/

Butler, S. M., & Sheriff, N. (2021, June 22). *How the American Rescue Plan Act will help cities replace police with trained crisis teams for mental health emergencies*.

Brookings. https://www.brookings.edu/research/how-the-american-rescue-plan-act-will-help-cities-replace-police-with-trained-crisis-teams-for-mental-health-emergencies/

Camplain, R., Camplain, C., Trotter II, R. T., Pro, G., Sabo, S., Eaves, E., Peoples, M., & Baldwin, J. A. (2020). Racial/ethnic differences in drug- and alcohol-related arrest outcomes in a southwest county from 2009 to 2018. *American Journal of Public Health, 110*, S85-S92. https://doi.org/10.2105/AJPH.2019.305409

Child Welfare Information Gateway. (2017). *Supporting successful reunification* [Bulletin]. https://www.childwelfare.gov/pubPDFs/supporting_reunification.pdf

Chung, E., & Pearl, B. (2020, July 29). *How to reinvest in communities when reducing the scope of policing.* Center for American Progress. https://www.americanprogress.org/issues/criminal-justice/reports/2020/07/29/488305/reinvest-communities-reducing-scope-policing/

City of Albuquerque. (2020, 15 June). *Mayor Tim Keller to refocus millions in public safety resources with first-of-its-kind civilian response department* [Press Release]. https://www.cabq.gov/mayor/news/mayor-tim-keller-to-refocus-millions-in-public-safety-resources-with-first-of-its-kind-civilian-response-department

Coles, M., Hicks, D., Portillo, M., Posey, E., Siedman, J., & Shah, K. C. (2021, April). *Safety beyond policing: Promoting care over criminalization*. Stanford Center for Racial Justice. https://www-cdn.law.stanford.edu/wp-content/uploads/2021/03/Selective-De-Policing-Policy-Lab-report-April-2021.pdf

Collins, S. E., Lonczak, H. S., & Clifasefi, S. L. (2019). Seattle's law enforcement assisted diversion (LEAD): Program effects on criminal justice and legal system utilization and costs. *Journal of Experimental Criminology, 15*(1), 201-211. https://doi.org/10.1007/s11292-019-09352-7

Coyne, C. J., & Hall, A. R. (2017, April 12). Four decades and counting: The continued failure of the war on drugs. CATO Institute. *Policy Analysis.* https://www.cato.org/sites/cato.org/files/pubs/pdf/pa-811-updated.pdf

Davenport-Hines, R. (2001). *The pursuit of oblivion: A global history of narcotics 1500-2000*. Weidenfeld & Nicolson.

DeLaus, M. (2020, November 16). *Alternatives to police as first responders: Crisis response programs.* Albany Law School Government Law Center. https://www.albanylaw.edu/centers/government-law-center/policing/explainers/Documents/GLC-Alternatives-to-Police-as-First-Responders-Explainer.pdf

Denver Task Force. (2021, May). *Recommendations for transforming public safety in Denver.* http://www.denvertaskforce.org/uploads/1/2/5/5/125541169/reimagining__public_safety__recommendations_.pdf

Drug Policy Alliance. (2011). *Drug courts are not the answer: Toward a health-centered approach to drug use.* https://drugpolicy.org/sites/default/files/Drug%20Courts%20Are%20Not%20the%20Answer_Final2.pdf

Eugene Police Department. (n.d.). *CAHOOTS.* https://www.eugene-or.gov/4508/CAHOOTS

Federal Bureau of Investigations. (2020). *2019 Crime in the United States.* https://ucr.fbi.gov/crime-in-the-u.s/2019/crime-in-the-u.s.-2019/topic-pages/persons-arrested

Fisher, C. (2014). Treating the disease or punishing the criminal?: Effectively using drug court sanctions to treat substance use disorder and decrease criminal conduct. *Minnesota Law Review, 99*(2/3), 747-781. https://papers.ssrn.com/sol3/papers.cfm?abstract_id=2712833

Flores, P. S., Lopez, J. A., Pemble-Flood, G., Riegel, H., & Segura, M. (2018). An analysis of drug treatment courts in New York State. *Rockefeller Institute of Government's Center for Law & Policy Solutions.* https://rockinst.org/wp-content/uploads/2018/05/5-23-18-Drug-Court-Report.pdf.

Friedman, B. (2020, April). *Disaggregating the police function* (Working Paper No. 20-03). New York University School of Law. https://papers.ssrn.com/sol3/papers.cfm?abstract_id=3564469

Friedman, S., & Wagner-Goldstein, K. (2016). *Medication-assisted treatment in drug courts: Recommended strategies*. www.courtinnovation.org/sites/default/files/documents/MATindrugCourtsFinal.pdf

Gallagher, J. R., Nordberg, A., Szymanowski, S., & Malone, S. E. (2019). A behind-the-scenes perspective on the key components of drug court: A narrative analysis. *Journal of Human Behavior in the Social Environment, 29*(7), 909-921. https://doi.org/10.1080/10911359.2019.1635550

Gerety, R. M. (2020, December 28). *An alternative to police that police can get behind.* The Atlantic. https://www.theatlantic.com/politics/archive/2020/12/cahoots-program-may-reduce-likelihood-of-police-violence/617477/

Gibbs, B. R., ten Bensel, T., Doyle, M. K., & Wakefield, W. (2021). The drug court team and discretionary decision-making: A mixed-methods examination of sanctioning responses to continued participant alcohol and other drug use. *Criminal Justice Policy Review, 32*(1), 27-48. https://doi.org/10.1177/0887403420904127

Gregory, J. A. (2021). Social work as a product and project of whiteness. *Journal of Progressive Human Services, 32*(1), 17-36. https://doi.org/10.1080/10428232.2020.1730143

Hart, C. L. (2021). *Drug use for grown ups: Chasing liberty in the land of fear.* Penguin Press.

Health Justice Recovery Alliance. (2021). *Drug Addiction Treatment & Recovery Act facts*. https://healthjusticerecovery.org/facts

Integral Care. (n.d.). *Integral Care.* https://integralcare.org/en/about-us/

Jacobs, L. A., Kim, M. E., Whitfield, D. L., Gartner, R. E., Panichelli, M., Kattari, S. K., Downey, M. M., McQueen, S. S., & Mountz, S. E. (2021). Defund the police: Moving towards an anti-carceral social work. *Journal of Progressive Human Services, 32*(1), 37-62. https://doi.org/10.1080/10428232.2020.1852865

Jarldorn, M. (2019). Radically rethinking social work in the criminal (in)justice system in Australia. *Journal of Women and Social Work 35*(3), 327-343. https://doi.org/10.1177/0886109919866160

Jordan, A., & Jegede, O. (2020). Building outreach and diversity in the field of addictions. *The American Journal on Addictions, 29*(5), 413-417. https://doi.org/10.1111/ajad.13097

Kaye, K. (2019). *Enforcing freedom: Drug courts, therapeutic communities, and the intimacies of the state.* Columbia University Press. https://doi.org/10.7312/kaye17288

Ketteringham, E. (2019, May 8). Families torn apart over pot: As N.Y. moves to legalize marijuana, it must fix agonizing disparities that take children away from black and brown mothers and fathers. *Daily News.* https://www.nydailynews.com/opinion/ny-oped-families-ripped-apart-over-pot-20190508-qtrnmuyztzfr7let4vxjxga7zm-story.html

Koch, D. W., Lee, J & Lee, K. (2016). Coloring the war on drugs: Arrest disparities in Black, Brown, and white. *Race and Social Problems, 8*(4), 313-325. https://doi.org/10.1007/s12552-016-9185-6

Kolivoski, K. M., Weaver, A., & Constance-Huggins, M. (2014). Critical race theory: Opportunities for application in social work practice and policy. *Families in Society, 95*(4), 269-276. https://doi.org/10.1606/1044-3894.2014.95.36

Kondrat, M. E. (2013). Person-in-environment. *Encyclopedia of Social Work.* https://doi.org/10.1093/acrefore/9780199975839.013.285

LEAD National Support Bureau. (n.d.). *LEAD National Support Bureau.* https://www.leadbureau.org

Leotti, S. M. (2020). The discursive construction of risk: Social work knowledge production and criminalized women. *Social Service Review, 94*(3), 445-487. https://doi.org/10.1086/710562

Lilley, D. R. (2017). Did drug courts lead to increased arrest and punishment of minor drug offenses? *Justice Quarterly, 34*(4), 674-698. https://doi.org/10.1080/07418825.2016.1219760

Lohman, D., & Malinowska, K. (2019). Rights-based approach to overdose epidemic must include decriminalization. *Health and Human Rights Journal*.

https://www.hhrjournal.org/2019/01/rights-based-approach-to-opioid-epidemic-must-include-decriminalization/

Madden, R. G., & Wayne, R. H. (2002). Constructing a normative framework for therapeutic jurisprudence using social work principles as a model symposium. *Touro Law Review, 18*(3), 487-502. https://digitalcommons.tourolaw.edu/cgi/viewcontent.cgi?referer=&httpsredir=1&article=1507&context=lawreview

Marlowe, D. B., Hardin, C. D., & Fox, C. J. (2016). Painting the current picture: A national report on drug courts and other problem-solving courts in the United States. *National Drug Court Institute.* https://www.ndci.org/wp-content/uploads/2016/05/Painting-the-Current-Picture-2016.pdf

Miller, J. (2013). Contemporary modes of probation officer supervision: The triumph of the "synthetic" officer? *Justice Quarterly, 32*(2), 314-336. https://doi.org/10.1080/07418825.2013.770546

National Association of Social Workers. (2017). *NASW code of ethics.* https://www.socialworkers.org/About/Ethics/Code-of-Ethics/Code-of-Ethics-English

Netherland, J., & Hansen, H. (2017). White opioids: Pharmaceutical race and the war on drugs that wasn't. *BioSocieties*, *12*(2), 217-238. https://doi.org/10.1057/biosoc.2015.46

Neusteter, S. R., O'Toole, M., Khogali, M., Rad, A., Wunschel, F., Scaffidi, S., Sinkewicz, M., Mapolski, M., DeGrandis, P., Bodah, D., & Pineda, H. (2020, September). *Understanding police enforcement: A multicity 911 analysis.* Vera Institute of Justice. https://www.vera.org/downloads/publications/understanding-police-enforcement-911-analysis.pdf

Office of Justice Programs. (2020). *Drug courts* [Fact Sheet]. U.S. Department of Justice. https://www.ojp.gov/pdffiles1/nij/238527.pdf

Oregon Criminal Justice Commission. (2020). *Racial and Ethnic Impact Statement-Initiative Petition 44*. https://sos.oregon.gov/elections/Documents/fec/IP44-REI-Statement.pdf

Oregon Health Authority. (2022). Access to care: Reporting outcomes. https://drugpolicy.org/sites/default/files/access_to_care_reporting_outcomes_non_anonymized_final_003.pdf

Pearl, B. (2020, October 15). Beyond policing: Investing in offices of neighborhood safety. *Center for American Progress*. https://www.americanprogress.org/issues/criminal-justice/reports/2020/10/15/491545/beyond-policing-investing-offices-neighborhood-safety/

Policing Project, & The Justice Collaboratory. (2021, January). *Reimagining public safety: First convening report.* https://www.policingproject.org/rps-first-convening-report

Prison Policy Institute. (2020). *Mass incarceration: The whole pie 2020.* https://www.prisonpolicy.org/reports/pie2020.html

Program in Criminal Justice Policy and Management. (2021, April 7). *Reimagining community safety #18: The CAHOOTS model with Tim Black* [Video]. Harvard Kennedy School Malcolm Wiener Center for Social Policy. https://www.hks.harvard.edu/centers/wiener/programs/criminaljustice/news-events/reimagining18-tim-black-cahoots

Reinarman, C., & Levine, H. G. (Eds.). (1997). *Crack in America: Demon drugs and social justice.* University of California Press.

Reisch, M. (2019). Lessons from social work's history for a tumultuous era. *Social Service Review, 93*(4), 581-607. https://doi.org/10.1086/706741

Reisch, M., & Jani, J. (2012). The new politics of social work practice: Understanding the context to promote change. *British Journal of Social Work, 42*, 1132-1150. https://doi.org/10.1093/bjsw/bcs072

Roberts, D., & Sangoi, L. (2018, March 26). Black families matter: How the child welfare system punishes poor families of color. *The Appeal*. https://theappeal.org/black-families-matter-how-the-child-welfare-system-punishes-poor-families-of-color-33ad20e2882e/

Roberts, M. R., Phillips, I., Bordelon, T. D., & Seif, L. (2015). A social worker's role in drug court. *SAGE Open, 4*(2), 1-9. https://doi.org/10.1177/2158244014535413

Sevigny, E. L., Fuleihan, B. K., & Ferdik, F. V. (2013). Do drug courts reduce the use of incarceration?: A meta-analysis. *Journal of Criminal Justice, 41*(6), 416-425. https://doi.org/10.1016/j.jcrimjus.2013.06.005

Sherman, S. A. (2020, July 22). *Many cities are rethinking the police, but what are the alternatives?* The Kinder Institute for Urban Research. https://kinder.rice.edu/urbanedge/2020/07/22/many-cities-are-rethinking-police-what-are-alternatives

Siegel, L. (2021). *Uprooting the drug war*. Drug Policy Alliance. https://uprootingthedrugwar.org/

Stone, R. (2015). Pregnant women and substance use: fear, stigma, and barriers to care. *Health and Justice, 3*(2), 1-15. https://doi.org/10.1186/s40352-015-0015-5

Substance Abuse and Mental Health Services Administration. (2020a). *Key substance use and mental health indicators in the United States: Results from the 2019 National Survey on Drug Use and Health.* Center for Behavioral Statistics and Quality. https://www.samhsa.gov/data/sites/default/files/reports/rpt29393/2019NSDUHFFRPDFWHTML/2019NSDUHFFR090120.htm

Substance Abuse and Mental Health Services Administration. (2020b). *Executive order safe policing for safe communities: Addressing mental health, homelessness, and*

addiction report. https://www.samhsa.gov/sites/default/files/safe-policing-safe-communities-report.pdf

The Imprint. (2017). *The foster care housing crisis.* https://imprintnews.org/wp-content/uploads/2017/10/The-Foster-Care-Housing-Crisis-10-31.pdf

The Meadows Mental Health Policy Institute for Texas. (2019). *Recommendations for first responder mental health calls for service: Data analysis, review, and program recommendations.* City of Austin. http://www.austintexas.gov/edims/pio/document.cfm?id=320044

The Sentencing Project. (2018). *Report of The Sentencing Project to the United Nations Special Rapporteur on Contemporary Forms of Racism, Racial Discrimination, Xenophobia, and Related Intolerance: Regarding racial disparities in the United States criminal justice system.* https://www.sentencingproject.org/publications/un-report-on-racial-disparities/

Thornton, R. (2020, August 18). *Integral Care set to address most mental health emergency calls without involving APD.* Austin Monitor. https://www.austinmonitor.com/stories/2020/08/integral-care-set-to-address-most-mental-health-emergency-calls-without-involving-apd/

Thumath, M., Humphreys, D., Barlow, J., Duff, P., Braschel, M., Bingham, B., Pierre, S., & Shannon, K. (2021). Overdose among mothers: The association between child removal and unintentional drug overdose in a longitudinal cohort of marginalised women in Canada. *International Journal of Drug Policy, 91, 1-21.* https://doi.org/10.1016/j.drugpo.2020.102977

Tiger, R. (2011). Drug courts and the logic of coerced treatment. *Sociological Forum, 26*(1), 169-182. https://doi.org/10.1111/j.1573-7861.2010.01229.x

Vakharia, S. P., & Little, J. (2017). Starting where the client is: Harm reduction guidelines for clinical social work practice. *Clinical Social Work, 45*, 65-76.

Virani, A., & Gasser-Ordaz, L. (2020, June). *What happens after we defund police? A brief exploration of alternatives to law enforcement.* UCLA School of Law Criminal Justice Program. https://law.ucla.edu/sites/default/files/PDFs/Criminal_Justice_Program/What_Happens_After_We_Defund_Police-202107-FINAL.pdf

Waite, D., Greiner, M. V., & Laris, Z. (2018). Putting families first: How the opioid epidemic is affecting children and families, and the child welfare policy options to address it. *Journal of Applied Research on Children: Informing Policy for Children at Risk, 9*(1), 1-35. https://digitalcommons.library.tmc.edu/cgi/viewcontent.cgi?article=1353&context=childrenatrisk

Whetstone, S., & Gowan, T. (2017). Carceral rehab as fuzzy penality: Hybrid technologies of control in the new temperance crusade. *Social Justice, 44*(2/3). 83-113. https://www.jstor.org/stable/26538383?seq=1#metadata_info_tab_contents

White Bird Clinic. (2020a). *Crisis assistance helping out on the streets: Media guide 2020.* https://whitebirdclinic.org/wp-content/uploads/2020/06/CAHOOTS-Media-Guide-20200626.pdf

White Bird Clinic. (2020b, October 29). *What is CAHOOTS?* https://whitebirdclinic.org/what-is-cahoots

White Bird Clinic. (n.d.). *About us.* https://whitebirdclinic.org/about/

Witkins, S. H., & Hays, S. P. (2019). Drug court through the eyes of participants. *Criminal Justice Policy Review, 30*(7), 971-989. https://doi.org/10.1177/0887403417731802

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