Drugs, Crime, and the Criminal Justice System

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The relationship between drug use and crime has been debated for more than a century by a variety of groups, including researchers, representatives of law enforcement, politicians, treatment specialists, social commentators, and even casual observers. Central to the debate are two competing models of the drug "problem" that have shaped the nature and direction of state and federal drug control policies (Inciardi 1992). On the one hand, there is the *criminal model of drug abuse*. This posture, actively pursued by the police and political establishments, holds that "addicts" ought to be the objects of vigorous enforcement activity because the great majority of them are members of criminal subcultures, gangs, and organizations. To support this view, law enforcement organizations point to the experiences of their officers and agents, and to numerous studies that demonstrate that most addicts were already criminals before they began using drugs.

The counterpoint to the criminal model is the *medical model of drug abuse*, a notion fostered by the medical community as early as the late nineteenth century. Although physicians had been among the first to contend that "morphinism" and "cocainism" were the result of moral weaknesses, they emphasized also that addiction itself was a chronic and relapsing disease. As such, the medical model argues that the addict should be dealt with as any other patient suffering from some physiological or medical disorder.

ENSLAVEMENT THEORY OF ADDICTION

Concomitant with the medical model is what has become known as the "enslavement theory of addiction." Although the origins of the theory date back to nineteenth-century America with the early clinical writings about morphine dependence, its most complete statement appears in the work of David W. Maurer and Victor H. Vogel. In the third edition of their *Narcotics and Narcotic Addiction* (1967), Maurer and Vogel stated:

> *First, the potential addict begins to take very small doses of some addicting drug, let us say morphine, or heroin. He either does not realize what the drug will do to him, or he knows that others have become addicted but believes that it will never happen to him.*
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> *Second, the addict notices that the amount of the drug he has been taking does not "hold" him . . . and eventually he increases the frequency until he is taking a shot four to six times daily.*
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> *Third, as the habit increases in size over a period of weeks or months, the addict who must buy his drugs from bootleg sources finds that more and more of his wages go for drugs and that he has less and less for the other necessities; in fact, other things come to mean less and less to him, and he becomes heavily preoccupied with simply supporting his habit.*
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> *Fourth, it becomes obvious to him that he must have increasing amounts of money on a regular basis, and that legitimate employment is not likely to supply that kind of money. Therefore, some form of crime is the only alternative. (Mauer and Vogel 1967:286–87)*

The theory, of course, is not without some logic. During the latter part of the nineteenth century and the early years of the twentieth, the use of narcotics was fairly widespread, and both morphine and heroin were available readily through legal channels. In 1914, however, the Harrison Act was passed. It was a revenue code that required all people who imported, manufactured, produced, compounded, sold, dispensed, or otherwise distributed cocaine and opiate drugs to register with the Treasury Department, pay special taxes, and keep records of all transactions. In effect, the Harrison Act defined the possession of narcotic drugs as illegal, and users had to embrace the black market to obtain their drugs. Since that time, the possession of heroin has remained a crime, and most users have criminal records.

Influenced more by the criminal than the medical model, government approaches to drug abuse control evolved a variety of avenues for reducing both the supply of and the demand for illicit drugs. Supply-and-demand reduction strategies initially were grounded in the classic deterrence model: Through legislation and criminal penalties, individuals could be discouraged from using drugs; by making an example of traffickers, the government could force potential dealers to seek out other economic pursuits.

RESEARCH ON THE DRUGS–CRIME CONNECTION

Despite the contentions of the enslavement theory, there has never been any solid empirical evidence to support it. From the 1920s through the close of the 1960s, hundreds of studies of the relationship between crime and addiction were conducted (Austin and Lettieri 1976). Invariably, when one analysis would support enslavement theory, the next would affirm the view that addicts were criminals first, and that their drug use was but one more manifestation of their deviant lifestyles. In retrospect, the difficulty lay in the way the studies had been conducted, with biases and deficiencies in research designs that rendered their findings to be of little value.

Research since the middle of the 1970s with active drug users in the streets of New York, Miami, Baltimore, and elsewhere has demonstrated that enslavement theory has little basis in reality. All of these studies of the criminal careers of heroin and other drug users have convincingly documented that although drug use tends to intensify and perpetuate criminal behavior, it usually does not initiate criminal careers. In fact, the evidence suggests that among the majority of street drug users who are involved in crime, their criminal careers were well established prior to the onset of either narcotics or cocaine use (Inciardi 1992; Nurco et al. 1985; Tonry and Wilson 1990).

Based on these data and the findings of numerous other studies, it would appear that the inference of causality, that the high price of drugs on the black market per se causes crime, is not supported. On the other hand, these same data also suggest that drugs drive crime in that careers in drugs tend to intensify and perpetuate criminal careers.

DRUGS AND VIOLENT CRIME

Three models of drug-related violence have been suggested—the psychopharmacologic, the economically compulsive, and the systemic. The *psychopharmacological model* of violence suggests that some individuals, as a result of short-term or long-term ingestion of specific substances, may become excitable, irrational, and exhibit violent behavior. The paranoia and aggression associated with the cocaine psychosis fit into the psychopharmacological model, as does most alcohol-related violence. The *economically compulsive model* of violence holds that some drug users engage in economically oriented violent crime to support drug use. This model is illustrated in the many studies of drug use and criminal behavior that have demonstrated that although drug sales, property crimes, and prostitution are the primary economic offenses committed by users, armed robberies and muggings do indeed occur. The *systemic model* of violence maintains that violent crime is intrinsic to the very involvement with illicit substances. As such, systemic violence refers to the traditionally aggressive patterns of interaction within systems of illegal drug trafficking and distribution.

WAR ON DRUGS

From the early 1970s through the beginning of the twenty-first century, American drug policy has embraced two strategies, "supply reduction" and "demand reduction." The supply reduction strategy emphasizes drug enforcement programs, interdiction (intercepting and destroying drugs before they reach the country), and foreign assistance initiatives, all aimed at keeping drugs out of the country, off the streets, and arresting and incarcerating drug users, dealers, and traffickers. The demand reduction strategy stresses education, prevention, treatment, and research, while maintaining basic law enforcement initiatives.

Virtually every presidential administration since the early seventies has supported a "war on drugs," and as such, supply reduction has always taken precedence over demand reduction. Successive "wars" on drugs served to engender a criminal justice process in the United States that appears to be "drug driven" in almost every respect. In the legislative sector, new laws have been created to deter drug involvement and to increase penalties for drug-related crime. In the police sector, funding has served to expand street-level drug enforcement initiatives, which, in turn, have increased the number of drug crime arrests. In the judicial sector, the increased flow of drug cases has resulted in overcrowded dockets and courtrooms, as well as the creation of new drug courts, special dispositional alternatives for drug offenders, and higher conviction and incarceration rates. In the correctional sector, the results include the further crowding of already overpopulated jails and penitentiaries, the establishment of liberal release policies, and experimentation with new prison-based drug treatment programs.

DRUG COURTS

Specialized drug courts emerged during the latter part of the 1980s as a strategy to manage the growing numbers of drug-involved offenders coming to the at-

tention of the criminal justice system, and by the beginning of the twenty-first century they were popular throughout the United States. The label "drug court" is actually a generic term for several different kinds of court-based initiatives. These approaches include special courts or judges, distinctive case management systems, or pretrial diversion programs (Inciardi, McBride, and Rivers 1996). Many of these entities function as traditional courts by hearing evidence and adjudicating guilt, whereas others serve as special "plea bargaining" forums. Many handle only first offenders, and others have no such limitations. Most drug courts fit within one or a combination of three models: dedicated drug treatment, speedy trial, and differentiated case management.

Dedicated drug treatment courts use court-monitored drug treatment under a deferred prosecution or deferred sentencing arrangement. Arrestees are given the opportunity for treatment, and their progress is closely monitored through urinalysis and reports from the treatment program. Negative behavior can result in short periods of jail confinement, but court personnel recognize that relapse to drug use often is a part of the recovery process. As such, drug court clients are given several chances to prove themselves. Positive behaviors are rewarded with decreased reporting requirements, and successful completion may result in the charges being dropped or a lesser sentence being imposed. The goals of these courts are to (1) concentrate drug case expertise in one courtroom, (2) link defendants to community-based drug treatment, (3) address other defendant needs through effective case management, (4) reduce drug use and recidivism, (5) relieve pressures on nondrug caseloads, (6) and increase overall trial capacity.

Courts set up for speedy trials and differentiated case management bring all felony (and sometimes misdemeanor) drug charges together into one courtroom. Multiple charges against defendants are combined into single hearings, with consistent and firm dates for plea negotiations, trials, and filing motions set by the judge. Prosecutors, defense attorneys, and judges work together within consistent guidelines to resolve cases quickly through pleas, bypassing jury trials when possible. The goals of these courts are to (1) concentrate drug case expertise in one courtroom, (2) reduce the time to disposition, without compromising due process or public safety considerations, (3) reduce the pending drug felony caseload, (4) relieve pressures on nondrug caseloads by diverting drug felonies out of mixed calendar courtrooms, and (5) increase overall trial capacity. In most instances, these courts hear only drug felony cases.

Drug courts appear to be effective and have several benefits. First, judges, prosecutors, and public defenders assigned to drug courtrooms become specialists and therefore are able to process cases more quickly and efficiently. Second, new rules for courtrooms—such as early and complete discovery and firm trial dates—encourage early plea negotiation and settlement. Third, segregating drug cases can speed the processing of both drug and nondrug cases. Fourth, the nature of law enforcement results in large numbers of relatively standardized cases; therefore, it reduces the likelihood that defendants will seek a trial and streamlines the case preparation and investigation process for prosecutors. Fifth, and perhaps most importantly, for many drug-involved offenders, diversion into treatment carries the potential for breaking their cycles of crime and addiction.

TREATMENT ALTERNATIVES TO STREET CRIME

Treatment Alternatives to Street Crime, better known as TASC, is a program designed to serve as a laison between the criminal justice system and community treatment programs. As a program for substance-abusing arrestees, probationers, and parolees, its more than 120 sites in 25 states make it the most widely supported form of court diversion in the United States (Inciardi et al. 1996).

TASC provides an objective and effective bridge between two separate institutions: the justice system and the treatment community. The justice system's legal sanctions reflect community concerns for public safety and punishment, whereas the treatment community emphasizes therapeutic relationships as a means for changing individual behavior and reducing the personal suffering associated with substance abuse and other problems. Under TASC supervision, community-based treatment is made available to drug-dependent individuals who would otherwise burden the justice system with their persistent and associated criminality.

TASC programs were initiated in 1972 in response to recognized links between substance abuse and criminal behavior. The mission of TASC is to participate in justice system processing as early in the continuum as acceptable to participating agencies. TASC identifies, assesses, and refers appropriate drug- or alcohol-dependent or both types of offenders accused or convicted of nonviolent crimes to community-based substance abuse treatment as an alternative or supplement to existing justice system sanctions and procedures. TASC then monitors the drug-dependent offender's compliance with individually tailored progress expectations for abstinence, employment, and improved social and personal functioning. It then reports treatment results back to the referring justice system component. Clients who violate conditions of their justice mandate, TASC, or treatment agreement are usually sent back to the justice system for continued processing or sanctions.

To motivate treatment cooperation by the substance abuser, TASC combines the influence of legal

sanctions for probable or proven crimes with the appeal of such innovative justice system dispositions as deferred prosecution, creative community sentencing, diversion, pretrial intervention, probation, and parole supervision (Leukefeld and Tims 1992). Through treatment referral and closely supervised community reintegration, TASC aims to permanently interrupt the cycle of addiction, criminality, arrest, prosecution, conviction, incarceration, release, readdiction, criminality, and rearrest.

TASC programs not only offer renewed hope to drug- and alcohol-dependent clients by encouraging them to alter their lifestyles while remaining in their own communities, but they also provide important incentives to other justice and treatment system participants. TASC can reduce the costs and relieve many processing burdens related to substance abuse within the justice system through assistance with such duties as addiction-related medical situations, pretrial screening, and posttrial supervision.

The treatment community also benefits from TASC's legal focus, which seems to motivate and prolong client cooperation in treatment programs and ensures clear definition and observation of criteria for treatment dismissal or completion. Public safety also is increased through TASC's careful supervision of criminally involved clients during their community-based treatment. Evaluations of the TASC effort indicate that the majority effectively link criminal justice and treatment systems, identify previously untreated drug-involved offenders, and intervene with clients to reduce drug abuse and criminal activity.

THERAPEUTIC COMMUNITIES IN CORRECTIONS

Given the growing numbers of drug-involved serious offenders coming to the attention of federal and state correctional systems, since the late 1980s a growing number of jurisdictions have placed treatment programs inside prison walls. However, there are many phenomena in the prison environment that make drug rehabilitation difficult. The availability of drugs in prisons is a pervasive problem. Moreover, in addition to the one-on-one violence that seems to be a concomitant of prison life, there is the violence associated with inmate gangs, often formed along racial lines for purposes of establishing and maintaining status, "turf," and unofficial control over certain sectors of the penitentiary. Given these circumstances, the drug treatment approach that appears to be the most effective is the therapeutic community (or "TC" as it is commonly called).

The TC is a total treatment environment isolated from the rest of the prison population—separated from the drugs, the violence, and the norms and values that rebuff attempts at rehabilitation. The primary clinical staff of the TC are typically former substance abusers—"recovering addicts"—who themselves were rehabilitated in TCs. The treatment perspective of the TC is that drug abuse is a disorder of the whole person—that the problem is the *person* and not the drug, that addiction is a *symptom* and not the essence of the disorder. In the TC's view of recovery, the primary goal is to change the negative patterns of behavior, thinking, and feeling that predispose drug use. As such, the overall goal is a responsible drug-free lifestyle.

Recovery through the TC process depends on positive and negative pressures to change, and this is brought about through a self-help process in which relationships of mutual responsibility to every resident in the program are built. Or as the noted TC researcher Dr. George De Leon described it:

> *The essential dynamic in the TC is mutual self-help. Thus, the day-to-day activities are conducted by the residents themselves. In their jobs, groups, meetings, recreation, personal, and social time, it is residents who continually transmit to each other the main messages and expectations of the community. (DeLeon 1985:824)*

In addition to individual and group counseling, the TC process has a system of explicit rewards that reinforce the value of earned achievement. As such, privileges are *earned*. In addition, TCs have their own specific rules and regulations that guide the behavior of residents and the management of their facilities. Their purposes are to maintain the safety and health of the community and to train and teach residents through the use of discipline. TC rules and regulations are numerous, the most conspicuous of which are total prohibitions against violence, theft, and drug use. Violation of these cardinal rules typically results in immediate expulsion from a TC.

The first corrections-based TC was established in 1962 in Nevada State Prison as an extension of Charles Dederich's Synanon program. Several more appeared during the latter half of the 1960s. In 1967, the Federal Bureau of Prisons established a TC in its Danbury, Connecticut, institution. As part of Governor Nelson A. Rockefeller's Narcotic Addiction Control Commission and its civil commitment program for heroin addicts, a small TC program was piloted in New York's Green Haven Prison, a maximum security facility some 90 miles north of Manhattan. At about the same time, the New York City Addiction Services Agency organized TC units in Rikers Island and Hart Island penitentiaries.

From the early 1970s through the mid-1980s, prison-based TCs seemed to come and go—in Arkansas, Connecticut, Georgia, Michigan, Nebraska, New York, Oklahoma, South Carolina, Virginia, the federal system, and elsewhere. Along with the prison TCs established in the 1960s, almost all were closed, the result of prison crowding, state budget deficits, staff burnout, and changes in prison leadership. In a few instances, shut-

downs were precipitated by inmate residents smuggling drugs and alcohol into the TC units. In others, custodial officers distrusted TC staff and operations and deliberately sabotaged the programs. Prison TCs reemerged during the 1980s, and preliminary follow-up studies indicated positive results (Camp and Camp 1990; Toch 1980).

Based on experiences with correctional systems and populations, with corrections-based drug treatment, and with the evaluation of a variety of correctional programs, the most appropriate strategy for effective TC intervention with inmates involves a three-stage process (Hooper, Lockwood, and Inciardi 1993). Each stage in this regimen of treatment corresponds to the inmate's changing correctional status—incarceration, work release, and parole (or whatever other form of community-based correction operates in a given jurisdiction).

The *primary stage* consists of a prison-based therapeutic community designed to facilitate personal growth through the modification of deviant lifestyles and behavior patterns. Segregated from the rest of the penitentiary, recovery from drug abuse and the development of prosocial values in the prison TC involves essentially the same mechanisms seen in community-based TCs. Therapy in this primary stage is an on-going and evolving process. Ideally, it endures for 9 to 12 months, with the potential for the resident to remain longer, if necessary. As such, recruits for the TC are within 18 months of their work release date at the time of treatment entry.

It is important that TC treatment for inmates begin *while they are still in the institution,* for a number of reasons. In a prison situation, time is one of the few resources that most inmates have an abundance of. The competing demands of family, work, and the neighborhood peer group are absent. Thus, there is the *time* and opportunity for comprehensive treatment—perhaps for the first time in a drug offender's career. In addition, there are other new opportunities presented—to interact with "recovering addict" role models; to acquire prosocial values and a positive work ethic; and to initiate a process of education, training, and understanding of the addiction cycle.

Since the 1970s, work release has become a widespread correctional practice for felony offenders. It is a form of partial incarceration whereby inmates are permitted to work for pay in the free community but must spend their nonworking hours either in the institution, or more commonly, in a community-based work release facility or "halfway house." Inmates qualified for work release are those approaching their parole eligibility or conditional release dates. Although graduated release of this sort carries the potential for *easing* an inmate's process of community reintegration, there is a negative side, especially for those whose drug involvement served as the key to the penitentiary gate in the first place.

This initial freedom exposes many inmates to groups and behaviors that easily can lead them back to substance abuse, criminal activities, and reincarceration. Even those receiving intensive TC treatment while in the institution face the prospect of their recovery breaking down. Work release environments in most jurisdictions do little to stem the process of relapse. Since work release populations mirror the institutional populations from which they came, there are still the negative values of the prison culture. In addition, street drugs and street norms tend to abound.

Graduates of prison-based TCs are at a special disadvantage in a traditional work release center since they must live and interact in what is typically an antisocial, nonproductive setting. Without clinical management and proper supervision, their recovery can be severely threatened. Thus, secondary TC treatment is warranted. This *secondary stage* is a "transitional TC"—the TC work release center or TC "halfway house."

The program composition of the work release TC is similar to that of the traditional TC. There is the "family setting" removed from as many of the external negative influences of the street and inmate cultures as is possible; and there is the hierarchical system of ranks and job functions, the rules and regulations of the environment, and the complex of therapeutic techniques designed to continue the process of resocialization. The clinical regimen in the work release TC also addresses the correctional mandate of "work release."

In the *tertiary stage,* clients have completed work release and are living in the free community under the supervision of parole or some other surveillance program. Treatment intervention in this stage involves outpatient counseling and group therapy.

Follow-up studies indicate that corrections-based therapeutic communities are effective in reducing relapse and recidivism (Field 1989; Martin et al. 1999; Wexler, Falkin, and Lipton 1990). Research also suggests that although the TC may be the most effective approach for drug-involved offenders, other approaches have positive effects as well.

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