

The Relationship Between Crime and Drugs: What We Have Learned in Recent Decades

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Abstract—The focus of this article is criminal drug users and their changing behavior. Two important considerations are addressed within this topic. First, an overview of drug use is given, including a brief historical perspective on its treatment as well as its implications on crime. The article also discusses why substance abuse treatment in the criminal population is necessary and on what scale. Specifically, the etiology of the relationship between crime, violence and substance abuse is explored. It then delves into what has worked and what hasn't. Finally, recommendations are made regarding where the research indicates we should go from here.

Keywords—alcoholism, behavior, crime, substance abuse, treatment

The last fifteen years have seen a gradual return to medicalization of the treatment of addiction. As early as 25 A.D., literature

has made reference to “diseases of appetite.” In the 1700s and 1800s, physicians wrote (in support of the temperance movement) that substance use is not just a matter of desire or will, but indeed a presentation of a medical syndrome. In the 1960s and 1970s, there was increasing interest by professionals in more behavioral treatment approaches, partly due to the popularity of psychoanalytic philosophy. New discoveries in molecular biology, neuropharmacology, and genetic studies have led the way in the return to a medical approach to addiction. Inherent in this article is a challenge to those who essentially wish to state that addiction is a brain disease and, as such, is only treatable by biological

interventions. Certainly there are individuals of the criminogenic (substance-abusing offenders) addict population who truly have psychiatric disorders and for whom successful treatment can only occur if this pathology is appropriately addressed. This group aside, this article challenges the bias that biologic interventions are the only treatment approach for the criminal drug-abusing population.

The consideration of context is central to the discussion of treating the criminogenic drug taker, or the drug taker who ends up committing a crime in support of his or her drug dependence. For example, treating clients who are addicted but not necessarily criminogenic in the community (i.e., in an environment with a prosocial atmosphere) is decidedly different from treating the same individual in the context of an antisocial environment with a set of rules, norms and values that support deviance (and also literally physical survival), such as may be found within a penal setting. This article deals with the remaining criminogenic and addicted population of inmates with what we will refer to as the co-occurring disorder of crime and addiction, regardless of which came first. Specifically, in referring to “addiction,”

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the authors are not just referring to the medical definition of dependence from the DSM-IV. Criminogenic drug users often recidivate right after their release from prison, not because of biologic changes as a result of their dependence, but primarily because of their learned behavioral pattern. This is something that the DSM-IV, by focusing predominantly on biological criteria for dependence, fails to recognize.

For years now, opinions about who the addict was, and what treatment in fact worked, have been much like the story of the blind men trying to describe an elephant while feeling various parts of the elephant's anatomy. Each man swore that the part of the anatomy they touched was what an elephant is. We have repeatedly seen and heard zealous opinions about who addicts are and what method of treatment works for them. However, each of these affirmations is limited to the population that the particular provider has seen; and in particular not only the population that were seen, but those that stayed in treatment long enough to become familiar to the provider. A perfect historic example of this occurred in the early 1900s in the United States at the Towns Hospital in New York City. Dr. Towns became well known internationally for finding a cure for inebriation, whether it was from alcohol or opiates. He claimed his specialty was treating opiate dependence, and then sold this "solution" to the U.S. Congress. He traveled around the world telling leaders that he had an answer to the problem of addiction, based on his approach. This approach was essentially the excessive use of opiac, apomorphine, castor oil and sweats. When asked how he knew that his approach worked, he replied that he could tell for a fact that no one on whom he had used it had returned to his clinic.

This and similar examples have been repeated over and over again throughout history. These exaggerated claims later produce credibility questions. In particular this applies to the custody (prison or jail) setting; the population seen there is always substance-abusing offenders who *do* return, and never the successes. As a result of never seeing the successes and only seeing the returnees—the failures—the individuals who treat these people also have an opinion, not about what works, but that *nothing works* for this population. It is in this context that this article's discussion is begun.

THE COST OF DRUGS AND CRIME

Why should society even consider undertaking treating the "hopeless" criminogenic addict if all they are going to do is recidivate and end up once again incarcerated? Why should society treat *any* addict at all? The simple answer is that it costs too much not to. Looking at the leading causes of disability world wide, alcohol and drug use come in fourth place regardless of the country's social policy (Murray & Lopez 1996). The leading cause of disability worldwide is unipolar depression (51 million, 11% of all disability). It is followed by iron deficiency anemia (the second largest cause worldwide, affecting 5% of the disabled population).

The third greatest cause is falls, which affect 4% of that population. Alcohol and other drugs represent 3% to 6% of all other major causes of disability. Within this particular cause of disability, one must note that there is a difference between alcohol consumption and other drug taking. The social cost of illicit drug taking is higher than the social cost of the alcohol taking in millions of dollars. In 1990, the United States spent \$8.4 billion to treat AIDS and fetal alcohol syndrome, which both can be attributable to alcohol, drugs and mental health disorders (ADM). It spent \$67.8 billion to fight crime associated with ADM, \$80.8 billion on ADM-related health care costs, and lost \$313.6 billion in ADM-related social costs. Loss of productivity in the U.S. attributable to alcohol and drug use and mental health problems in 1990 cost \$157 billion. These healthcare costs can not be explained by adherence to any social policy, or whether certain drugs are illegal or not—and therein lies an important consideration in terms of disability and social cost.

The scientific literature points out that alcohol and other drugs have a multiplying effect on crime. A perfect and simple example is the association between crime and the availability of malt liquors. Consistently, city by city where it has been tracked, areas in which there has been a greater availability of malt liquors have a higher percentage of all crimes, in particular alcohol-related violence. Epidemiological statistics indicate that 60% to 80% of all crime is drug related (Mumola 1999). Drug arrests tripled in the 1980s, from 471,000 to 1,247,000 in 1989. It has quadrupled in the last twenty years (National Center on Addictions and Substance Abuse 1998). In California, arrests for drug sales and possession have risen from 7% of all arrests in 1983 to 24% in 1993 (National Center on Addictions and Substance Abuse 1998).

Thus, in addition to the cost of tracking illicit sales activity, a tremendous burden rests on the taxpayer for the dollars to build and maintain prisons. This becomes exceedingly poignant as prisons are increasingly used as a way of responding to this problem. As the costs of investigating, prosecuting and incarcerating addicts mount, the highest cost comes from recidivism. As Jeremy Travis, Director of the National Institute of Justice, pointed out at the 1999 National Assembly on Drugs, Alcohol Abuse and the Criminal Offender convened by the Department of Justice and General Barry McCaffrey (Director of the Office of National Drug Control Policy), half a million people are being released into the community every year from prison. Seventy percent to 80% of these individuals are judged now to have drug-related problems (i.e., are comorbid either way). Further, the great majority of them have been untreated. The statistics show that the untreated drug and alcohol users recidivate faster than controls who are non drug users, and usually their recidivism involves crimes other than simple parole violations.

THE SCALE OF THE DRUG/CRIME PROBLEM

The Columbia Center for Drug Studies estimated that in the 1990s the population of inmates needing drug treatment grew significantly. In 1996, 900,000 inmates in a prison population of 1,300,000 (69%) were in need of some form of drug treatment. Yet there were little more than 100,000 inmates (7.6%) in any kind of drug treatment, and not much of that treatment was intensive. The percentage of men who are testing positive for drugs at the time of arrest in various cities ranges from 60% to 80% for any drug in major metropolises such as Los Angeles, Phoenix, San Diego, Dallas, and Miami. The percentage of women testing positive for drugs at the time of their arrest has been skyrocketing in the last eight years, and has risen to between 60% and 70%. There are some cities in which more women are arrested while under the influence of drugs than men. An example of this phenomenon is occurring with amphetamines in San Diego during the last ten years. The percentage of men testing positive for methamphetamine in San Diego was 40%, while the percentage of women testing positive for methamphetamine in San Diego was 42%. The same negative trend appears to be traveling down the developmental pipeline, according to the juvenile arrest data. Around key cities (particularly in the Southwest and Midwest, including Los Angeles, Phoenix, San Diego, San Jose, and San Antonio), the number of violent crimes associated with drug-positive arrested youth is skyrocketing (U.S. Department of Justice, National Institute of Justice 1997). The percentage of juveniles nationwide testing positive for drugs at the time of arrest is 60% to 70%. Depending on the location, the most common drug youths test positive for is marijuana (50% to 60%). However, methamphetamine and cocaine continue to gain strength: 4% to 14% of juveniles tested positive for these drugs in 1998 (National Center on Addictions and Substance Abuse 1998).

This association between alcohol, drugs and crime exists outside America as well. The rates of crime have been escalating in all the developed countries, with the exception of South Korea and Japan. The crime rate in both of those industrial nations has been increasing as well, but not as rapidly as it has in the other countries. One of the most important factors contributing to such increases is the cocaine crisis. The international ADAM (Alcohol and Drug Abuse Monitoring) data reveals that in London over 60% of all arrests were associated with any drug: 10% of these arrests were for amphetamine, 40% for marijuana, close to 20% were for opiates, 10% for cocaine and (interestingly, compared to the arrest data in the U.S.) 8% were for methadone¹ (U.S. Department of Justice, National Institute of Justice 1999).

THE ETIOLOGY OF PROBLEM DRUG USE AND CRIME

So, the question may be, which comes first, crime or drug use? The answer is both. Many recent studies and interviews with offenders suggest that in approximately two-thirds of clients, criminal behavior precedes the onset of drug taking. This is particularly true when disruptive behavior with elements of violence has been observed in early childhood. In the remaining one third of these offenders, the drug taking came first. Many studies indicate that in 50% of youth, criminal behavior comes first, in 25% of youth the onset of drug taking precedes the first criminal act, and in the remaining 25%, substance use and criminal behavior started simultaneously. This process may evolve in one of several different ways: (1) people become deeply invested in drug taking and then become criminal as a way of supporting that drug taking, or (2) those who were minimally invested in the criminal behavior later used drugs and after a while became literally “addicted” to both. These individuals have a lifestyle addiction—an adrenal cortex stimulation due to crime—just as they do to the excitement of acquiring and consuming drugs. Speaking from the treatment perspective, the sequence of involvement does not direct treatment options.

In terms of delinquent behavior, most early adolescents who become involved in isolated delinquency and “passive crime” later decrease their involvement in such activity. In contrast, the majority of early adolescents who are involved in substance abuse as well as delinquent behavior remain involved in criminal behavior into their adult lives.

Risk Factors for Problem Drug and Alcohol Use

One of the most prominent risk factors and direct pathways to problem substance use is delinquency. Delinquency may first lead to substance use and then to problem drug taking, or may lead directly to problem drug taking. The literature also documents that one of the major forces at work in this pathology is cognitive distortion (Farabee et al. 1995). A person’s inability to really understand the inputs that are occurring around him/her may lead to drug use, and that may further lead to aggression. Aggression may then feed back and lead to drug use; both of them being affected by the pharmacologic dimensions of drug taking, distorted thinking, and aggression.

Further risk factors for problem drug taking include other comorbid conditions, such as depression and conduct disorder.

Risk Factors for Criminality

The psychological factors that contribute to and characterize criminality are numerous. They include: manipulation, impulsivity, low tolerance for frustration, the propensity and the need for danger or thrill seeking, poor consequential thinking, poor option generation, poor use of leisure time, affiliation in terms of social identity with the criminal class, easy dissatisfaction or boredom with conventional activity (i.e., the need for more excitement or adrenal dependence),

and a drug use history. Other criminogenic risk factors are alienation from general socialization, identifying with whole groups of people who have been socialized into gang behavior, an entitlement mentality, features of rage appropriate to a victim, egocentrism, the absence of empathy or remorse, blaming and externalizing as a common way of handling life, attachment to criminal activities as a form of self-definition, poor family connections and relationships, very poor or highly conflicted spousal relationships, consistent conflict with authority or any form of supervision, numerous conflicts with peers, the inability to sustain an activity for any length of time, excitability, a poverty of social skills, and an inability to see patterns in their responses (Andrews & Bonta 1998).

This may sound very much like typical teenage behavior. Granted, one may expect many of these features to some degree as a part of adolescence. However, in order to differentiate normal adolescence for criminogenic propensity, one has to pay very close attention to several key features. One of these is the propensity toward danger and thrill seeking. This does not include the teenager who goes to the river and gets up on the bridge and jumps in the river. It pertains to the young adult who goes to the river, goes to the bridge, climbs up on the highest pinnacle of that bridge, blindfolds himself, ties his leg behind his back and jumps off backwards. This behavior is very different than what would be the expected in normal adolescents who are pushing limits and risk-taking. Other key criminogenic characteristics include continually manipulating the environment, trying to change it, and dissatisfaction in doing anything for longer than three minutes. Specifically, this individual views himself as the center of everything and does not feel remorse or empathy for anyone or anything. His behavior is evident on the playground. He is continuously externalizing all responsibility by presenting the clear message: "I am the victim, they did it to me." This attitude is classically exemplified in the case of the criminal with a parole violation; "They violated me."

Risk Factors for Drug Abuse and Crime

There are several factors that play a role in combined crime and drug use. Looking at the behavior psychopharmacologically, one can see many examples of this. The most common cultural stereotype is that the use of stimulants results in violent behavior primarily due to neuropharmacological mechanisms of action. The fact of the matter is that the most common psychoactive substance with biochemical propensity to trigger violent or criminal behavior is alcohol.

Case Example One. Forty-two-year-old C. M. who has a history of drunk driving leaves the bar drunk and gets in his car ready to drive. At that time he sees in the distance a police car cruising. He has already had enough alcohol to impair judgment, he is behaving impulsively, and he gets in his car trying to get away. He steps on the gas and moves out thinking: "How am I going get out of this block fast enough and not to get caught for drunk driving." He turns the corner

and kills two kids who are walking by.

It is also true that there is violence associated with some of the stimulant drugs because they increase peoples' ability to concentrate and they become more focused on the dangers they perceive to be around them.

Case Example Two. Twenty-seven-year-old J. D. has been using cocaine or amphetamine for long periods of time and has been on a binge. He is sleep deprived. His nervous system is highly agitated and his ability to concentrate is remarkably acute. He can hear a leaf falling outside the door, a "noise" scratching down the hall. He grabs a baseball bat because he thinks: "If they're coming after me, I'm going to be ready and get them first."

There is no one more dangerous than someone who is paranoid and afraid he is going to get caught. These are the examples of some of the possible correlations between drug taking and violent behavior that we refer to as *neuropharmacological*.

In terms of casualties, alcohol clearly outweighs other drug use; there is more violence associated with alcohol use (Mason 1993; Moss & Tarter 1993). However, violence remains consistently high among adult male offenders who test positive for other drugs. In Dallas in 1998, out of 985 positive drug test cases, 280 of those cases were associated with violence (28%). In Los Angeles, 500 cases out of 950 drug-related cases were associated with violence (53%). In Phoenix, 150 out of 955 drug-related cases were associated with violence (16%). In San Diego, 225 drug-related cases were associated with violence, in San Jose close to 400, and in Miami well over 300 drug-related cases were also associated with violence. In addition, the association of the female population and violence is staggeringly high across the line as well: out of 400 drug-positive cases in Dallas, 60 cases were associated with violence (15%). In Los Angeles, 130 drug-related cases involving women were also associated with violence, and in Phoenix 80 drug-related cases were associated with violence (National Center on Addictions and Substance Abuse 1998). Of further increasing concern, the violence women are currently perpetrating replicates what male violence was phenotypically 15 years ago. This "typical male violence" 15 years ago included penetration wounds by knife and weapon, head banging, and clubbing.

Another important connection between drugs and violence is the one we refer to as *economic-impulsive*.

Case Example Three. Eighteen-year-old C. F., a heroin addict, runs out of money and drugs. She feels the first symptoms of upcoming withdrawal. She begins to shake, her hands sweat, and her anxiety heightens. She is ready to do just about anything to obtain money and consecutively the drug right away. She continues to feel sick and weak; there is neither time nor physical ability for a careful planning of a bank robbery or any other "sophisticated" crime. So, she takes a knife and with the knife in hand, she robs an old lady walking on the streets.

In this case, the young woman clearly doesn't have anything against the lady; her violent behavior is based on the strong impulse to get money and to avoid withdrawal. The economic-impulsive drug-violence connection seems to be the most common among drug addicts.

Finally, the third way in which drug taking and violent behavior can be connected is so-called *systemic* connection.

Case Example Four. A 24-year-old, high level drug dealer is not a user himself, just a dealer. When his clients have unpaid debts, including large sums of money, he does "whatever it takes" to make his profit. The outcome is typically death.

In this scenario there is no documented biochemical or other biological interaction between drugs and violence, but the relationship is clear.

Treatment Approaches

There have been a number of treatment approaches tried with the substance abusing, criminogenic population. The meta-analyses indicate that some treatment approaches have been unsuccessful, some have had mixed success, and some were partially successful or promising (Andrews 1998).

Unsuccessful approaches have included the "confrontation type." The recent publicity about drug boot camps is a perfect example; they do not work. In fact, they may make matters worse by mobilizing more gang activity in subjects than they would have otherwise been involved in prior to treatment. General social work and social agency approaches do not work, either. The "behavioral," vision quest, outward-bound programs have generally had no overtly successful outcomes.

Programs with mixed outcomes include the following: group counseling, individual therapy, and family interventions. When vocational training is tied in, one out of three has shown some promise. Employment training programs show very mixed results, with one out of three demonstrating positive results.

Behavioral training has been one of the generally successful strategies. Cognitive-behavioral activity has also generally been successful. Life skill cognitive-behavioral activity shows the most promise. This includes academic training, vocational training, and life, social, and coping skills education. Cognitive-behavioral programs are far better than just probation. Cognitive-behavioral program graduates recidivate at a rate of 18%, while regular probationers recidivate at a rate of 70%. Robust data now also support the idea that for the criminogenic drug taker, the therapeutic community approach is paying off. (Martin & Butzin 1999; Pearson & Lipton 1999).

Criminal sanctions versus treatment work in the opposite direction, meaning that treatment produces positive effects, while criminal sanctions by themselves really do not work for general criminal populations. In fact, criminal sanctions alone appear to increase recidivism. In comparing behavioral

versus nonbehavioral treatment, only those programs that are behavioral seem to pay off and reduce recidivism. These behavioral methods include: modeling, graduated practice, role-playing, reinforcement, extinction, resource provision, and concrete verbal suggestions.

Treatment success is self-evident when accomplished. It is demonstrated by a decrease in crime in our communities, a decrease in tax consumptive behavior, diminished illicit substance use, increased tax productive behavior, and increased personal well being. Such has been the case in a variety of pilot residential therapeutic communities which have been set up in one of the national models of treatment. These programs promote change by using rational authority approaches, prosocial reinforcement, and concrete problem solving, as discussed above. The results are promising, with rearrest rates as low as three times less for program graduates, a 90% drop in the incidence of crime, and a 90% increase in employment rates (Wexler et al. 1999).

THE EVOLUTIONARY RATIONALE FOR IN-PRISON THERAPEUTIC COMMUNITIES

As this article illustrates, there is an intimate connection between crime and drug taking: there is an increase in crime perpetrated by drug abusers and an unusually high rate of recidivism among substance-abusing criminals. Simply stated, there exists a causal relationship between these two entities. The reason for this is that one part of the criminal's behavior has not been addressed: that part is their substance abuse.

It appears self-evident that the previously mentioned behavioral methods should be addressed in treatment. At the same time, the research literature regarding what counselors pay attention to demonstrates an alarming disconnect. The issues of crime and employability generally take lowest priority in the treatment focus of counselors, professional or paraprofessional, doctoral level or high school level. This exemplifies a tremendous potential problem: the oversight of not targeting the central issues necessary for a successful, positive outcome.

Historically, as prison expansion continued, and great numbers of people began to crowd the prisons, there was a need for new prison construction. Such prison construction in some states cost a great deal, and for some the costs grew so large as to erode the available dollars for education. New York State faced this dilemma in the early 1980s. New York administrators within the correctional environment, recognizing the high rate of recidivism and quick return to custody of the population with drug problems, began to wonder if there was not some possible approach to reduce this recidivism. They chose to look at the large bodies of data on treatment used in the general community to determine which, if any, were useful for a population that had a profile similar to those that were within custody walls. They looked at NIDA's Drug Abuse Reporting Program (DARP)

data and the continuation of such data under the rubric of the Treatment Outcome Perspective Studies (TOPS). The result of their search primarily focused on the three models that were predominant in the culture at that point for the treatment of drug addiction:

1. residential therapeutic communities;
2. methadone maintenance programs; and
3. outpatient drug free treatment programs.

Each of these three models came into prominence in the mid-1960s and grew in use throughout the country as a result of these same studies. By comparing these models to one another with the goal of matching subject profiles to the inmate profile, the search indicated that the subjects going into therapeutic communities were more seriously impaired, had an absence of employment history, the presence of psychological problems, problems related to multiple drug-taking, and high recidivism rates—just like the inmates. Literally, the population in the therapeutic communities was more “criminogenic.”

Further, the therapeutic community aggregate data indicated a decrease in problem behaviors as long as five years posttreatment, as well as an increase in desirable, prosocial behaviors. The residential therapeutic community subjects showed greater decreases in their prevalence of predatory crime and positive changes in the prevalence of full-time employment.

New York then elected to utilize a therapeutic community model for both men and women in prison. They chose to contract out for the therapeutic community services and utilized a provider with the name “Staying Out.” Within two to three years after implementation, the Staying Out data appeared extremely promising, with rearrest rates that were three times less for program graduates and an increase in the amount of time before the return to custody for those who failed.

Other states began to attend to this data. Delaware, with a series of programs referred to as CREST, also implemented in-custody treatment using therapeutic communities. They noted from the New York data that after a couple of years, recidivism rates began to creep upward, although they never quite equaled the recidivism rates of those subjects that were untreated. To address this, Delaware officials felt that if continuing care was provided, one could improve the outcomes even further, qualitatively as well as quantitatively. The CREST Program personnel began to study the continuing care dimension as well as the in-custody dimension of treatment. They noted improvement across all variables, including remaining drug free and arrest free up to eighteen months posttreatment, once continuing care was added.

Seeking similar results, Texas also implemented therapeutic community treatment models throughout its prison system, with continuing care mandated as a part of parole. The results documented that program graduates had a 90% drop in the incidence of crime, a 65% drop in crack cocaine use, a 60% drop in heroin and other opiate use, and a 90%

employment rate (versus a 47% employment rate for the control group; see Farabee et al. 1995).

By the late 1980s, California had also implemented a model at Donovan Prison called “Amity” for the men and a model for the women at the woman’s institution called “Forever Free.” Both of these models began to show similar promise and outcomes of remarkably reduced recidivism—particularly when these programs were matched with continuing care—even under external rigorous examination (Wexler et al. 1999).

As more of this data became available, the nation took greater interest. A movement for expanded therapeutic communities arose in the state of California and elsewhere. There are, of course, problems that must be addressed. Is the model that has demonstrated effectiveness and positive outcomes being accurately replicated, especially in the rush to implement therapeutic communities across the nation? Is the staffing consistent? What are the standards that will be utilized in the various therapeutic community models? How large a population will they be asked to deal with? Will this population be voluntary or coerced?

Data in California begins to indicate that a coerced population, similar to that which occurred in Texas, can demonstrate clearly reduced recidivism. However, the early data also indicates that those with serious psychiatric illness are returning to custody at a far greater rate than their counterparts who are only “criminogenic addicted” who have been exposed to this TC treatment model (Wexler et al. 1999).

CONCLUSION

Further research is needed:

1. Randomized controlled studies are needed to ascertain the true value of therapeutic communities as “the gold standard” treatment approach.
2. Studies are required to examine and define what type of aftercare produces the optimal result. For example, following one year of treatment in a therapeutic community, is it best to keep continuing care “seamless,” i.e. provide aftercare using the same model, language and expectations, or can another model be just as useful post-custody? Would a combination of the two approaches work best for aftercare?
3. From the perspective of screening, assessment, and treatment placement, are there models that can demonstrate equivalent outcomes to therapeutic communities for the more intense, addicted drug-crime “lifestyler”? Specifically, can the cognitive restructuring model work as well for the challenging subject as it does for the individual who is modestly invested in the drug-crime lifestyle?
4. Can mutual attraction models be used in conjunction with the therapeutic community process, so that mutual attraction models like 12-Step programs,

which are virtually ubiquitous, can be additionally supportive to the inmate upon release?

5. What are the characteristics of those subjects for whom different treatment modalities produce results as well as the characteristics of those subjects for whom the treatment modalities did not work? This information is quite pertinent in terms of treatment matching.
6. What is the length of treatment time necessary to achieve optimal results, both for in-custody treatment as well as post-custody treatment?

What we do know now is that intensive and comprehensive treatment is necessary in order to reduce recidivism and promote prosocial behavior. This article has discussed the wide scope of a problem that has staggering social and economic cost to our community: the interface between crime and drugs. The research, as well as clinical experience, dictates that if treatment programs are to be successful, they must target not only drug dependence but a number of other risk factors for criminality, including cognitive distortions, delinquency, and comorbid conditions. Many people's view towards treating these individuals restricts "drug treatment" to simple drug rehabilitation. They fail to treat the criminal lifestyle involvement that has become as addicting for some as the drug itself. They fail to treat the person who has been assessed and diagnosed as having a drug use history and who was criminal before the drug use, in terms of the factors of the criminality. If these characteristics are not addressed in treatment, no matter how much drug abuse counseling and therapy are deployed, the result will remain an unsuccessful outcome. These clients may use fewer drugs, but they still commit crimes. If they continue to commit crimes, one excitement is going to produce the need for the other. The

research indicates that this is something that our society can not afford to allow.

NOTE

1. This number brings up a rather interesting point: what is the difference that so many of those arrested in England have methadone present, as compared to the United States? Is it due to looser prescribing practices, looser clinic practices, or have we in the United States been failing to test for methadone at the same rate as England because they presume that methadone will be found and so they test for it?

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