Drugs and crime essay

The link between drug use and crime is not a new one. For more than twenty years, both the National Institute on Drug Abuse and the National Institute of Justice have funded many studies to try to better understand the connection. One such study was done in Baltimore on heroin users. This study found high rates of criminality among users during periods of active drug use, and much lower rates during periods of nonuse (Ball et al. 1983, pp. 119-142). A large number of people who abuse drugs come into contact with the criminal justice system when they are sent to jail or to other correctional facilities. The criminal justice system is flooded with substance abusers. The need for expanding drug abuse treatment for this group of people was recognized in the Crime Act of 1994, which for the first time provided substantial resources for federal and state jurisdictions. In this paper, I will argue that using therapeutic communities in prisons will reduce the recidivism rates among people who have been released

from prison. I am going to use the general theory of crime, which is based on self-control, to help rationalize using federal tax dollars to fund these therapeutic communities in prisons. I feel that if we teach these prisoners some self-control and alternative lifestyles that we can keep them from reentering the prisons once they get out. I am also going to describe some of todays programs that have proven to be very effective. Gottfredson and Hirschi developed the general theory of crime. It According to their theory, the criminal act and the criminal offender are separate concepts. The criminal act is perceived as opportunity; illegal activities that people engage in when they perceive them to be advantageous. Crimes are committed when they promise rewards with minimum threat of pain or punishment. Crimes that provide easy, short-term gratification are often committed. The number of offenders may remain the same, while crime rates fluctuate due to the amount of opportunity (Siegel 1998).

Criminal offenders are people that are predisposed to committing crimes. This

does not mean that they have no choice in the matter, it only means that their

self-control level is lower than average. When a person has limited

self-control, they tend to be more impulsive and shortsighted. This ties back in

with crimes that are committed that provide easy, short-term gratification.

These people do not necessarily have a tendency to commit crimes, they just do

not look at long-term consequences and they tend to be reckless and

self-centered (Longshore 1998, pp. 102-113). These people with lower levels of

self-control also engage in non-criminal acts as well. These acts include

drinking, gambling, smoking, and illicit sexual activity (Siegel 1998). Also,

drug use is a common act that is performed by these people. They do not look at

the consequences of the drugs, while they get the short-term gratification.

Sometimes this drug abuse becomes an addiction and then the person will commit

other small crimes to get the drugs or them money to get the drugs. In a mid-western study done by Evans et al. (1997, pp. 475-504), there was a significant relationship between self-control and use of illegal drugs. The problem is once these people get into the criminal justice system, it is hard to get them out. After they do their time and are released, it is much easier to be sent back to prison. Once they are out, they revert back to their impulsive selves and continue with the only type of life they know. They know short-term gratification, the “ quick fix if you will. Being locked up with thousands of other people in the same situation as them is not going to change them at all. They break parole and are sent back to prison. Since the second half of the 1980s, there has been a large growth in prison and jail populations, continuing a trend that started in the 1970s. The proportion of drug users in the incarcerated population also grew at the same time. By the end of the 1980s, about one-third of those sent to state prisons had been

convicted of a drug offense; the highest in the countrys history (Reuter

1992, pp. 323-395). With the arrival of crack use in the 1980s, the strong

relationship between drugs and crime got stronger. The use of cocaine and heroin

became very prevalent. Violence on the streets that is caused by drugs got the

publics attention and that put pressure on the police and courts.

Consequently, more arrests were made. While it may seem good at first that these

people are locked up, with a second look, things are not that good. The cost to

John Q. Taxpayer for a prisoner in Ohio for a year is around $30, 000 (Phipps

1998). That gets pretty expensive when you consider that there are more than

1, 100, 000 people in United States prisons today (Siegel 1998). Many prisoners

are being held in local jails because of overcrowding. This rise in population

is largely due to the number of inmates serving time for drug offenses (Siegel

1998). This is where therapeutic communities come into play. The term

therapeutic community has been used in many different forms of treatment, including residential group homes and special schools, and different conditions, like mental illness, alcoholism, and drug abuse (Lipton 1998, pp. 106-109). In the United States, therapeutic communities are used in the rehabilitation of drug addicts in and out of prison. These communities involve a type of group therapy that focuses more on the person a whole and not so much the offense they committed or their drug abuse. They use a community of peers and role models rather than professional clinicians. They focus on lifestyle changes and tend to be more holistic (Lipton 1998, pp. 106-109). By getting inmates to participate in these programs, the prisoners can break their addiction to drugs.

By freeing themselves from this addiction they can change their lives. These therapeutic communities can teach them some self-control and ways that they can direct their energies into more productive things, such as sports, religion, or work. Seven out of every ten men and eight out of every ten women in the

criminal justice system used drugs with some regularity prior to entering the criminal justice system (Lipton 1998, pp. 106-109). With that many people in prisons that are using drugs and the connection between drug use and crime, then if there was any success at all it seems like it would be a step in the right direction. Many of these offenders will not seek any type of reform when they are in the community. They feel that they do not have the time to commit to go through a program of rehabilitation. It makes sense, then, that they should receive treatment while in prison because one thing they have plenty of is time.

In 1979, around four percent of the prison population, or about 10, 000, were receiving treatment through the 160 programs that were available throughout the country (National Institute on Drug Abuse 1981). Forty-nine of these programs were based on the therapeutic community model, which served around 4, 200 prisoners. In 1989, the percentage of prisoners that participated in these

programs grew to about eleven percent (Chaiken 1989). Some incomplete surveys

state today that over half the states provide some form of treatment to their

prisoners and about twenty percent of identified drug-using offenders are using

these programs (Frohling 1989). The public started realizing that drug abuse and

crime were on the rise and that something had to be done about it. This led to

more federal money being put into treatment programs in prisons (Beckett 1994,

pp. 425-447). The States were assisted through two Federal Government

initiatives, projects REFORM and RECOVERY. REFORM began in 1987, and laid the

groundwork for the development of effective prison-based treatment for

incarcerated drug abusers. Presentations were made at professional conferences

to national groups and policy makers and to local correctional officials. At

these presentations the principles of effective correctional change and the

efficacy of prison-based treatment were discussed. New models were formed that

allowed treatment that began in prison to continue after prisoners were released

into the community. Many drug abuse treatment system components were established

due to Project REFORM that include: 39 assessment and referral programs

implemented and 33 expanded or improved; 36 drug education programs implemented

and 82 expanded or improved; 44 drug resource centers established and 37

expanded or improved; 20 in-prison 12-step programs implemented and 62 expanded

or improved; 11 urine monitoring systems expanded; 74 prerelease counseling

and/or referral programs implemented and 54 expanded or improved; 39 post

release treatment programs with parole and 10 improved; and 77 isolated-unit

treatment programs started. In 1991, the new Center for Substance Abuse

Treatment established Project RECOVERY. This program provided technical

assistance and training services to start out prison drug treatment programs.

Most of the states that participated in REFORM were involved with RECOVERY, as

well as a few new states. In most therapeutic communities, recovered drug users

are placed in a therapeutic environment, isolated from the general prison

population. This is due to the fact that if they live with the general

population, it is much harder to break away from old habits. The primary

clinical staff is usually made up of former substance abusers that at one time

were rehabilitated in therapeutic communities. The perspective of the treatment

is that the problem is with the whole person and not the drug. The addiction is

a symptom and not the core of the disorder. The primary goal is to change

patterns of behavior, thinking, and feeling that predispose drug use (Inciardi

et al. 1997, pp. 261-278). This returns to the general theory of crime and the

argument that it is the opportunity that creates the problem. If you take away

the opportunity to commit crimes by changing ones behavior and thinking then

the opportunity will not arise for the person to commit these crimes that were

readily available in the past. The most effective form of therapeutic community

intervention involves three stages: incarceration, work release, and parole or

other form of supervision (Inciardi et al. 1997, pp. 261-278). The primary stage

needs to consist of a prison-based therapeutic community. Pro-social values

should be taught in an environment that is separate from the normal prison

population. This should be an on-going and evolving process that lasts at least

twelve months, with the ability to stay longer if it is deemed necessary. The

prisoners need to grasp the concept of the addiction cycle and interact with

other recovering addicts. The second stage should include a transitional work

release program. This is a form of partial incarceration in which inmates that

are approaching release dates can work for pay in the free community, but they

must spend their non-working hours in either the institution or a work release

facility (Inciardi et al. 1997, pp. 261-278). The only problem here is that

during their stay at this facility, they are reintroduced to groups and

behaviors that put them there in the first place. If it is possible, these

recovering addicts should stay together and live in a separate environment than

the general population. Once the inmate is released into the free community, he

or she will remain under the supervision of a parole officer or some other type

of supervisory program. Treatment should continue through either outpatient

counseling or group therapy. In addition, they should also be encouraged to

return to the work release therapeutic community for refresher sessions, attend

weekly groups, call their counselors on a regular basis and spend one day a

month at the facility (Inciardi et al. 1997, pp. 261-278). Since the early

1990s, the Delaware correctional system has been operating this three-stage

model. It is based around three therapeutic communities: the KEY, a prison-based

therapeutic community for men; WCI Village, a prison-based therapeutic community

for women; and CREST Outreach Center, a residential work release center for men

and women. According to Inciardi et al. (1997, pp. 261-278), the continuing of

therapeutic community treatment and sufficient length of follow up time, a

consistent pattern of reduction of drug use and recidivism exists. Their study

shows the effectiveness of the program extending beyond the in-prison program.

New Yorks model for rehabilitation is called the Stayn Out Program. This

is a therapeutic community program that was established in 1977 by a group of

recovered addicts (Wexler et al. 1992, pp. 156-175). The program was evaluated

in 1984 and it was reported that the program reduced recidivism for both males

and females. Also, from this study, the time-in-program hypothesis was

formed. This came from the finding that successful outcomes were directly

related to the amount of time that was spent in treatment. Another study, by

Toumbourou et al. (1998, pp. 1051-1064), tested the time-in-program hypothesis.

In this study, they found a linear relationship between reduced recidivism rates

and time spent in the program as well as the level of treatment attained. This

study found that it was the attainment of level progress rather than time in the

treatment that was most important. The studies done on New Yorks Stayn Out

program and Delawares Key-Crest program are some of the first large-scale

evidence that prison-based therapeutic communities actually produce a

significant reduction in recidivism rates and show a consistency over time. The

programs of the past did work, but before most of the programs were privately

funded, and when the funds ran out in seven or eight years, so did the programs.

Now with the government backing these types of programs, they should continue to

show a decrease in recidivism. It is much more cost effective to treat these

inmates. A program like Stayn Out cost about $3, 000 to $4, 000 more than the

standard correctional costs per inmate per year (Lipton 1998, pp. 106-109). In a

program in Texas, it was figured that with the money spent on 672 offenders that

entered the program, 74 recidivists would have to be prevented from returning to

break even. It was estimated that 376 recidivists would be kept from returning

using the therapeutic community program (Eisenberg and Fabelo 1996, pp.

296-318). The savings produced in crime-related and drug use-associated costs

pay for the cost of treatment in about two to three years. The main question

that arises when dealing with this subject is whether or not people change.

According to Gottfredson and Hirschi, the person does not change, only the

opportunity changes. By separating themselves from people that commit crimes and

commonly do drugs, they are actually avoiding the opportunity to commit these

crimes. They do not put themselves in the situation that would allow their low

self-control to take over. Starting relationships with people who exhibit

self-control and ending relationships with those who do not is a major factor in

the frequency of committing crimes. Addiction treatment is very important to

this countrys war on drugs. While these abusers are incarcerated it provides

us with an excellent opportunity to give them treatment. The will not seek

treatment on their own. Without treatment, the chances of them continuing on

with their past behavior are very high. But with the treatment programs we have

today, things might be looking up. The studies done on the various programs,

such as New Yorks Stayn Out and Delawares Key-Crest program, prove that

there are cost effective ways available to treat these prisoners. Not only are

they cost effective, but they are also proven to reduce recidivism rates significantly. These findings are very consistent throughout all of the research, there are not opposing views. I believe that we can effectively treat these prisoners while they are incarcerated and they can be released into society and be productive, not destructive. Nothing else has worked to this point, we owe it to them, and more importantly, we owe it to ourselves. We can

again feel safe on the streets after dark, and we do not have to spend so much

of our money to do it.

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##FOOTER##