A view from America

CRIME AND COMPULSORY TREATMENT

Interviewed recently for Druglink, one of America's most respected authorities on the workings of the drug market says the division between treating drug dependence and punishing drug offences has to end. In Britain too (see box) the trend is towards treating rather than jailing the drug misusing offender.

Bruce Johnson

Druglink: We recently had the mayor of Washington on our television screens very worried about a rapid increase in murders in Washington due almost exclusively to underground battles between groups of drug suppliers. Is that really happening?

Bruce Johnson: It's actually happening. Strangely enough, very few crimes committed by drug abusers are the ones people are afraid of. That is, being robbed and then assaulted. 'Innocent' people do not get killed during robberies by heroin or drug abusers.

By far the most important and growing area of violence happens *within* the drug business and drug trade. Probably most homicides connected to drugs now involve a supplier who gives drugs 'on loan' to people who are supposed to sell the drugs and return money to him. Those sellers do not return the right amount of money or otherwise violate some other rule and are 'offed', as they say on the streets, for failure to repay their loans. With the rise in crack distribution there now also seems to be a rise in inter-group battles between drug selling organisations and drug selling groups. Although we do not have much scientific evidence for that, we do have many good police and journalistic reports.

Druglink: Your research into drug use in the early '80s showed there was a vast amount of 'business' going on at street level. Has it changed since then?

Bruce Johnson: For heroin, it's very much the same. There is primarily a freelance relationship between heroin suppliers, users/sellers, and their customers. Each person gets a supply for that day and returns the money to their supplier, but that association may not carry over to the next day.

With the rise of crack we have seen the development of crack dealing organisations dominated by persons who may take cocaine frequently but are not addicted. Suppliers put large quantities of cocaine and crack on the streets and have developed very systematic recruitment of people who they then tend to keep on as sellers. Crack dealing groups are now well armed and more worried about their competitors — other crack selling organisations like themselves — than they are about the police.

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Druglink: In the United States at the moment there seems to be great interest in compulsory treatment. Can you say something about why that's emerged and what your views are on it?

Bruce Johnson: This interest is a direct outgrowth of much of the research into the addict's life on the streets and into their progress in treatment and correctional criminal justice settings. A key finding has been the high crime rates and how much economic harm addicts are doing while on the streets, especially in the form of drug selling and distribution. Another major finding is that people tend to reduce their criminality substantially while in treatment but not necessarily after release from prison or after treatment.

Compulsory treatment is probably the most effective way to control the largest number of criminally active heroin users. The jail and prison systems are overloaded with incarcerated addicts and there's thousands more to go. In 1980 there were roughly half a million people in US jails and prisons. By 1986 that figure had reached three-quarters of a million.

Druglink: How many of those are drug users?

Bruce Johnson: In 1980, 20 per cent or less were heroin or cocaine abusers. Now it is probably running, in the United States as a whole, at just under 50 per cent. In New York, Miami, Los Angeles, Chicago, Detroit, Washington D.C. and several other large cities, 75-80 per cent of those incarcerated are there for drug selling or because of drug-related crimes such as robbery, burglary or shoplifting. Given current trends and policies, by the year 2000 those incarcerated on drug charges alone could easily reach 50 per cent of all US prisoners.

In New York it now costs $25,000 a year to keep an average offender in prison. I have made projections that the cost will rise to $50,000 a year by the year 2000. Each new cell we need to build will cost about $75,000. It's a very expensive proposition. If society were at all cost-conscious, it would realise that for the same amount of money you could place five to ten street heroin abusers in treatment — people who would have received a prison sentence, except for the fact that there are not enough cells for them. If they could be placed under some kind of mandatory non-custodial supervision, it would have an important impact in reducing their criminality — not to zero, but to much lower levels. This could be achieved through a combination of careful controls over their behaviour and keeping them in treatment during their supervision.

Druglink: Are you advocating compulsory treatment?

Bruce Johnson: These are ideas that I and colleagues of mine in New York are trying to promote but, for the most part, the criminal justice system is responding in the usual way. They admit there is a serious problem with heroin and cocaine users but don't know what to do about it, so they tend to ignore it.

Recently in New York City there has been some movement. Jails there are now willing to provide not just methadone detoxification but also to begin heroin addicts on methadone maintenance treatment. On release they are referred into maintenance programmes in the community.

Druglink: Are you saying that you have methadone maintenance in prison?

Bruce Johnson: Yes, but so far only in New York City. This is a new programme that began about a year ago and our office is beginning an evaluation funded by the National Institute on Drug Abuse.

Druglink: Would your research lead you to be in favour of compulsory treatment in the community as well as treatment in prison?

Bruce Johnson: Yes. The current division between criminal justice and voluntary drug treatment doesn't work well. We need to work toward developing a new approach to community supervision that combines something like probation with something like treatment, but in new and ingenious ways. We have got to spend a lot of money and effort in the future trying to figure out how to make it work. That's going to necessitate careful thinking, collaboration between magistrates or judges, probation depart-

Bruce Johnson of Narcotic and Drug Research Inc was the principal author of Taking Care of Business *(Lexington, 1985), a report of a US government funded research project into the economics of crime by heroin abusers. A co-author of the book was the late Edward Preble, extracts from whose 1969 paper "Taking Care of Business" were re-printed in* ***Druglink*** *July/August 1988.*

ments, treatment officials and community/voluntary drug treatment programmes.

Druglink: What sort of response are you getting from probation officers and drug treatment workers to these ideas?

Bruce Johnson: The ideas are going over better in the prison system at this point than in the probation field. Two of my colleagues in New York are developing a model for a modified therapeutic community in the wards of state prisons. Roughly a year before an offender is to be released or placed on parole, they enter a therapeutic community in such a prison setting. They become involved in a whole new set of expectations, learning how to stand on their own, how to confront life and to prepare themselves for entry into an outside therapeutic community while on parole.

A condition of their parole is frequently that they are to be enrolled in drug treatment after prison. If they violate conditions of parole, then they have to be brought back. It's not clear yet how it's going to work out with people who abscond while in treatment in the community, whether they are going to be returned to prison.

Druglink: What about drug treatment providers, how do they respond to the idea?

Bruce Johnson: Most voluntary programmes believe strongly in the voluntary nature of treatment and that people cannot become abstinent or even become appropriate treatment clients unless they really come in with a desire to get better.

But voluntary admission doesn't work very well with clients who are criminally active and not motivated to get 'better'. These are precisely the clients researchers have shown are most likely to drop out, relapse to heroin addiction and return to criminality. The voluntary sector is not very eager to have these kinds of clients so the debate continues about whether they will even accept such court-mandated clients. Many won't, but a few have taken some cases. As almost everywhere, such services are seriously underfunded in relation to the kind of people they have.

Druglink: How do you make sure that treatment options are used as an alternative to prison?

Bruce Johnson: There seems to be one very clear solution to that problem. The easiest, simplest and cheapest solution is to stop expanding the number of prison cells. If prisons don't have any place to put people, they have to make decisions as to who is serious enough to justify those cells.

Druglink: What have been the main lessons that we might learn from the last 20 odd years of drugs/crime research in the States?

Bruce Johnson: The first lesson is how intractable the problem is, how easily drugs can spread and continue in society, and how difficult it is to interrupt patterns of criminality. I think we must learn much more about how the illegal drug market works. This involves ethnographic research, talking to people who are dealing in drugs, understanding how they do their business and what shape the illicit drug market takes, in order to understand how better to intervene.

The thing that the United Kingdom is doing best is its response to the AIDS crisis. The framework set by the Rolleston Committee in 1926 was that of a public health approach to the drug problem. It has, under various guises, continued down to the current time. This gives you the flexibility to address the AIDS problems without strong moralistic overtones.

Without question, the best example of the power of that flexibility is your response to AIDS. I am just amazed, from an American perspective, to read the reports on AIDS published here since 1985. Your health ministry made a good decision in asking that a systematic evaluation be done of syringe exchange schemes. Very broad outlines were given. Programmes were opened in sites across the country. Within a bare two years those evaluation findings have led to major policy shifts which support syringe exchange schemes. The United Kingdom is miles ahead of the United States in trying to answer these difficult AIDS questions, because the UK's primary response reflects a reliance on public health measures. ■

US experience with compulsion. UK scheme could involve drug agencies

In January 1987 the US National Institute on Drug Abuse (NIDA) sponsored a meeting of researchers to review experience with civil commitment and other forms of compulsory treatment. The aim was to see if compulsory treatment could reduce the spread of HIV.

Presented to the meeting were the results of 25 years of experience with civil commitment in 25 US states, under which addicts, even if not convicted of an offence, may be referred to a period of compulsory treatment in state or federal institutions.

Eighteen states have also enacted Treatment Alternatives to Street Crime (TASC) programmes. TASC identifies potential drug or alcohol treatment clients among accused or convicted non-violent offenders. The aim is to arrange their referral to community-based treatment as an alternative to further criminal proceedings. Failure to adhere to treatment or legal requirements results in the client being ejected back into the criminal justice system.

Based on experience with TASC and civil commitment, the researchers agreed that legal coercion could play a positive role by improving retention in treatment which increases the probability of a successful outcome. As NIDA's summary put it:

"The consensus suggests that, based on the research that indicates that treatment is effective in reducing intravenous drug abuse and that the length of time in treatment is positively related to treatment success, the criminal justice system is important for identification and retention of drug abusers in treatment." Prime targets for compulsory treatment were identified as chronic injecting drug abusers who had committed an offence and showed the potential to benefit from treatment.

In Britain civil commitment in the form of compulsory detention of addicts during the withdrawal period was proposed by a government advisory committee in 1965 but rejected. There are no treatment facilities run by either national or local government specifically for convicted drug misusers and treatment in prison is practically non-existent, though some outside drug agencies do advise and support drug dependent prisoners.

Neither is there any formal national system for diverting addicts out of the criminal justice system and into treatment on the lines of the US TASC programme. However, a substantial proportion of referrals to residential rehabilitation programmes come via the criminal justice system and some new local initiatives (such as the Southwark arrest referral scheme) are attempting to provide treatment alternatives for arrested drug users.

Implementation of the Home Office consultative paper *Punishment, Custody and the Community* (HMSO, 1988) could dramatically alter this situation. It suggests a number of measures aimed at "reducing the use of imprisonment by introducing a form of punishment which leaves the offender in the community".

To this end, the Government proposes to introduce a new order giving courts the power to place a range of requirements on offenders who would otherwise be sent to jail. Among these are curfews, attendance at day centres, community service, and the controversial scheme enabling offenders to be electronically tagged.

Any of these and more may be applied to drug misusers, especially those who commit other non-drug offences such as burglary. But the paper also has specific suggestions for the compulsory treatment of alcohol or drug misusers.

"The programme for the offender could also include regular attendance at work, education or training and treatment for misuse of alcohol or drugs ... Although more coordinated and intensified effort is being put into the care of drug misusers who go to prison, the chances of dealing effectively with a drug problem are much greater if the offender can remain in the community and undertakes to cooperate in a sensibly planned programme to help him or her come off drugs. Such a programme would aim, in the first instance, to secure a transition from illegal consumption to a medically supervised regime designed to reduce the harm caused to the individual by drugtaking and would be based on a realistic plan for tackling the addiction in the context of his or her other problems. Monitoring by urine tests by the agency providing the treatment could be part of the regime."

What the green paper doesn't address is how the agencies to receive court referrals can be persuaded to go along with the scheme. Most drug agencies believe voluntary referral is an important step on the road to recovery and are unhappy about accepting compulsory clients. The probation service too is against the green paper's proposals which put them more in the role of a supervisor than a carer. It may be that the extra treatment capacity needed to make wholesale diversion from custody possible can only come through services specially set up by the Home Office.

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