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Criminogenic of the Older Adult with Addiction: Case Study

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Honors Project

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The Italian philosopher, Cesare Beccaria (1738-1794) was among the first to query the type of methods used to discipline offenders. Beccaria's thinking and others of his time started the movement now called classical criminology (Marion, 2002). Classical Criminology was grounded in the faith that criminal behavior is rational with costs and benefits of their actions. Also he believed the punishment should fit the crime, not the person.

The lens by which a society views crime can be the determinate factor of how their social control policies are created and implemented. The fear of deviant behavior is echoed by its citizens, as to how the government will protect and serve their communities. If justice is considered to be blind and a fair process to all of its citizens, then the poor and minorities are sometimes not treated with the fairness this population deserve. According to Ballantine & Roberts (2010), some conflict theorist argue the criminal justice system depicts the threat of crime as a threat from poor people and minorities which creates a victimization in members of society.

In its earliest conception, crime prevention was regulated by the local government. The Federal Bureau of Investigation was created in 1908 for the purposes of gathering statistics. The criminal justice system function is to prevent crimes with two types of deterrence. The first is the general deterrence which is the prevention of crimes by a specific person. The second is specific deterrence, this is the prevention of future crimes by a specific person (Marion, (2002). If these two deterrents were functioning coincidently for social justice, then our current rates of incarceration is not a reflection of this approach.

The approach of social justice was not the initial method to address drug addiction in the United States. This is reflected in this country having the highest rates of prison population in the

world, with a rate of 762 per 100, 000 (Weatherspoon, (2014). The sentencing guidelines based on the Rockefeller drug laws of the 1970s were statues passed by the New York legislature which penalized drug use in the state of New York (Marion & Oliver, (2015). The mandatory minimum sentence was 15 years to life. These were created out of society's fear of the "*drug addict*" or "*pusher*", especially within the African American communities. These sentencing guideline were the most penalizing of all the laws passed. This type of justice was more reactive, and did not view the addiction of the user as its primary concern, but instead the reaction was to the crime, committed during the drug use or drug sales.

The early view of addiction was of weakness that could be corrected with punishment. This was punctuated when many of the legal scholars rejected the concept of the disease model of addiction which was embraced by the treatment community. This concept base focuses on the patient, and family education (Thombs & Osborn, 2013). The removal of the negative stigma associated with addiction is more conducive for clients seeking treatment, and for their outcomes. This progress can also be seen in the DSM-5 removal of such stigmatizing terms as "abuser", replacing it with "use". One could understand why drug use of the baby boomers population may be viewed and treated differently than a new user. Drug use in the older adult can be caused by psychological, and environmental factors.

Albert Bandura's social learning theory view human behavior as based on the interaction between internal and external influences and an appreciation of the role of symbolization in cognition. Central to this imitation, new responses may be learned or the characteristics of existing response hierarchies may be changed as a function of observing the behavior of others. (Robbins, Chatterjee, & Canda, (2012). This case study demonstrates how both environmental and learned behaviors can affect the addiction and criminal behavior of an older adult subject.

Case Study

This African American single male is sixty four years old with an eighth grade education. He currently lives with relatives. He is on unemployment disability. He has a clinical diagnosis of cocaine dependence with sustained full remission. The family history indicates alcohol and other drug addiction (AOD). Both of his parents, several siblings, and an aunt and an uncle experienced years of poly-addiction. This demonstrates the multi-generational history that has taken place within his family.

Addiction History

Drug of Use	First Use	Regular Usage	Route
Alcohol	**8 years old**	**25 years old**	**Oral**
Cocaine	**20 years old**	**28 years old**	**Oral/Snorting**
Tobacco	**10 years old**	**15 years old**	**Oral**

Progression of use

The client first sampled alcohol by taking little sips of his father's drinks at the age of 8 years old. He entered junior high school, where he started to drink more frequently with his peers. This caused legal problems from incarcerations to suspension of his driving privileges. His tolerance increased and the use of other drugs such as marijuana and cocaine became prevalent. By age of 28 years, he was using alcohol and cocaine daily. He was experiencing tolerance decrease. His drug usage progressed while he was in prison. His AOD use has been a present problem in his life. After the client's mother had passed away in 1990, he reported feelings of harming himself. He was treated for depression in an outpatient setting.

Legal History

The client has had over twenty interactions with the justice system. All of these have been alcohol and other drug related. At the age of thirteen, he was sent to a juvenile detention center, by his late twenties he was selling cocaine. Due to his activities in the sales and transportations of drugs over a 20 year period. He was sentenced to 5 years in state prison, and 15 year in federal prison. The last infraction he occurred, was his operating vehicle under the influence (OVI) of a drug. Akron Municipal OVI Court, then mandated he seek treatment for his addiction, as an alternative to a jail sentence.

Literature Review

Initially such drugs as opium, cocaine, and morphine were used for medicinal purposes. In the 1800s, opium was used to treat many physical, and mental aliments. These included diarrhea, fever, and insomnia. The coca plant is used in many native cultures in tribal rituals, and was used by Sigmund Freud for exhaustion. Morphine was named for the Greek god Morpheus, by Friedrich Wilhelm Adam Sertuner who first extracted the drug from opium. Its use in America dates back to the Civil War, where soldiers used it as a pain reliever.

This continued the *laissez-faire* movement the nation was experiencing, but it was now moving into the age of reform. The Temperance and prohibition movements, challenged the moral fortitude of the country. This started the view of drug and alcohol use as a social problem. There were three legislation passed between 1906 and 1918 related to the current federal guidelines and drug policies. “The 1906 Pure Food and Drugs Act regulated pharmaceutical manufacturing and sales. The Harrison “Narcotics” Act regulated opioids and cocaine with doctors or pharmacists who prescribe these drugs were required to pay a tax. Finally, alcohol

prohibition was ratified in 1918 and implemented in 1919 (Hart & Ksir, 2013). The Internal Revenue collected taxes on alcohol starting in 1913. This was thought to be a deterrent for alcohol use.

The times between 1920s and 1930s were found to be a strengthening and enforcement of the previous drug and alcohol laws. Heroin manufacturing was prohibited. Marijuana was taxed and criminalized. Prohibition was repealed. The federal government formed many new agencies to combat addiction. Alcoholic Anonymous was founded in Akron, Ohio in 1935. The Federal Bureau of Narcotics first commissioner stated, "*Jail offenders, then throw away the key*" (Marion & Oliver, 2015, p. lxi). It was believed minorities were contributors to the crimes taking place. Dating back as early as the 1800s the perception of minorities was steeped in negative stereotyping. Chinese were the focus of the opium laws. In the 1930s, Mexican immigrants were labeled as "*drug crazed criminals"*. The 1980s use of crack cocaine by the urban poor of which were mainly African American, were demonized by political leaders (Robinson & Scherlen, (2014). In 1914, Dr. Edward William proclaimed most attacks on white women were a direct result of the cocaine-crazed Negro brain (Marion & Oliver, 2015).

During the 1940s, methadone was first used in the treatment of heroin. The Opium Poppy Control Act, prohibited the possession or growing of the opium poppy without a license, and Narcotics Anonymous (NA) was created for both men and women who were experiencing major drug issues. The Boggs Act of 1951, imposed mandatory minimum sentencing for those who violated the Marijuana Tax Act. By 1957, and Alateen was formed.

The beginning of the 1960s, it was reported by the United States to the UN Commission on Narcotic Drugs that it had 44, 906 addicts. The American Medical Association adopted the concept of alcohol as a disease. The Drug Abuse Prevention and Control Act reduce the penalty

for marijuana possession, but police were now able to perform drug searches. The Vietnam War of the 1970s became a major problem for U.S. soldiers. President Nixon, also created the phrase "*War on Drugs*". A new agency called the Drug Enforcement Administration was formed to manage the drug policy of America. The Drug Abuse Warning Network (DAWN) was created to gain knowledge about how widespread the drug abuse was in America. By the end of the 1970s there was a recorded 25 million Americans using illegal drug (Marion & Osborn, (2015).

Fuel by the media with reports by Dan Rather on crack cocaine after the death of prominent basketball college athlete Len Bias in the 1980s. Celebrities were also in the spotlight for their drug use, these included Richard Pryor, and James Belushi. This era also established the Crack Cocaine epidemic which was especially devastating to the New York City urban areas. A new phrase was coined such as "*crack babies"* for those mothers who babies were born addicted to the crack cocaine.

The Attorney General of Florida Janet Reno, established the first drug court in the nation, it served as the foundation for all succeeding drug courts. The Office of National Drug Control Policy was created under President George H. Bush with the appointment of Drug Czar William Bennett. His approach was the demoralization, and social unacceptability of drug use. Mr. Bennett only appropriated one-third of the agency's budget to drug treatment with the other spending focused on drug enforcement. Also the Anti-Drug Abuse Act in 1986 under President Ronald Regan was created. This Act allocated $6 billion for interdiction and enforcement to fight the new crack epidemic.

The Act of 1986 created stiff mandatory penalties for narcotics trafficking. These were based on the quantity of the product thought to be sold by large scale dealers. The threshold for crack was set by simply dividing the threshold for powder by 100, thus establishing the 100:1

ratio. The Sentencing Commission created the sentencing guidelines one year later. Congress created a mandatory minimum penalty for simple possession of crack, again distinguishing the two forms of cocaine. (Nelson, (2010). Under this new law, selling five grams of crack cocaine, held the same sentence as selling 500 grams of powder cocaine, which is five years mandatory minimum. When selling 50 grams of crack cocaine, the sentence is ten years mandatory minimum, the same as selling 5,000 grams of powder cocaine (Breuer, (2009). These laws had an adverse effect on the incarceration rates. A shift could also be seen in the racial population within the federal prison.

The incarceration rates in the federal prison system are racially disproportionate; with minorities making up the largest part of the population. These inmates are mainly convicted of crack cocaine. As of 2006, African American convicted of federal crack cocaine offense was 82 percent, while Caucasians with the same offences were 9 percent. In the same year for powder cocaine, 27 percent were African American, 14 percent were Caucasians and 58 percent were Hispanic. Since the inception of drug laws, addiction is still prevalent with the latent functions of these laws creating a black market for illicit drug sales and use (Marion & Oliver, (2015). The United States spends billions of dollars on drug control, and yet of the industrialized countries, America has the worst drug problem.

According to Marion and Oliver, (2015), between 1980 and 2006, drug arrests tripled, from 500,000 to over 1.5 million nationwide. The Harm Reduction model and programs such as needle distribution should be a consideration for future policy. The Drug Reform Act of 1986 signed by President Ronald Reagan had numerous implications. The appropriation of $97 million to build new prisons can be seen as the reactive implementation to the drug problem. On the

other hand, $200 million was allocated for drug education, and $240 was earmarked for drug treatment.

In the history of research, diagnosis, and treatment of substance abuse in the United States, the focus has primarily been on the younger generation. One example of this is the lack of development of assessment tools for the older population. Also the older adult was viewed as non-users of other recreational drugs (Duncan, Nicholson, White, Bradley, & Bonaguro, (2010). The earliest information about the elderly and substance abuse was in 1964 (D'Archangelo, (1993). The lack of early empirical research was due to many factors which included insufficient knowledge, limited research data, and hurried office visits. The baby boomers experience denial and fear of being stigmatize with a drinking problem as some contributing factors for the lack of empirical evidence. The older generation also perceive their drinking as going against societal norms. The stigma and social perception harbor feelings of disapproval and shame by their fellow co-horts (NEDS, (2002). Ageism that the older adult with substance abuse is not worth the amount of time or they may die soon, further contributes to the problem.

The Federal Interagency Forum on Aging-Related Statistics, (2010), reported the older population is projected to double in size over the next 30 years, increasing to 70 million by 2030. The suggested correlation between the increase in baby-boomer and the increase in substance abuse use is a positive relationship. This is partly because this generation has used more illicit drugs and heavy alcohol compared to the previous generations. This problem has been called an "*an invisible epidemic"*, (Sorocco & Ferrell, (2006).

Ageism also plays an important role in the perpetuation with attitudes towards how the older adult is characterized. For example, the thought may exist that the older person will die soon so why put in the time, and resources into this population for such services as treatment,

and research. According to Dowling, Weiss, & Condon, (2008), the current screening assessment tools being utilized by health and treatment providers are not adequately operationalized for the older adult.

The questions asked on the CAGE and the Michigan Alcoholism Screening Test (MAST) were not appropriate for the older adult. In using the CAGE, health professional could not detect all of the problem drinkers. The recommendation was to add more questions about the quantity and frequency of use to better identify drinking problems in the older adult (NEDS, (2002). One of the examples of how the health care professionals are more invested in the younger generation, is the examination of the cost associated with the older adult with addiction. This calculation of cost and benefits is convoluted by higher cost of general health care among the aging adult. These professionals may not fully understand the risk factors associated with substance use. This may be due to the fact of the symptoms of substance abuse mimicking biological aging in the older adult.

Some of these risk factors affecting the older adult substance user are depression, anxiety, loss, bereavement, social isolation, and living alone. An individual can become depressed and anxious from a multiple of reasons. The loss of their freedom from living in their own homes to now living in a facility, this could be a move not welcomed by the individual, and could be a difficult transition. There could be a loss of fulfilment the individual receives from work lost by forced early retirement. This “invisible epidemic” has been compounded by issues specific to the older adult such as misdiagnosis, fear, and denial. Misdiagnosis of the abuse may occur, especially when the symptoms are similar to those of other comorbid medical, mental and behavioral disorders, such as diabetes, dementia, and depression. These diagnoses can also be seen in the older inmate population.

According to Maschi, Suftin, & O'Connell, (2012), 10 percent of the general inmate population is 50 years and older. Statistical data demonstrates half of these older adults are diagnosed with a mental health issues, such as major depression, schizophrenia, and dementia. The challenges facing elderly inmates are those of self-impose self-confinement, victimization, lack of adequate health care, and further drug use (Watson & Morehouse, (1991). Some within this population also experience functional limitation in their activities of daily living (ADL). The requirement of assistance with eating, toileting, and ambulation demonstrates the intensive services needed to care for some of these inmates. There is also limitation of mobility which produces the need for special equipment such as wheelchairs, walkers, and special shoes (Snyder, Van Wormer, Chadha, and Jaggers, (2009).

The notion incarceration is supposed to deter the older user or the older user would find sobriety in prison can be a misnomer. Rowell, Wu, Hart, Haile, and El-Bassel, (2012) examine how participants with a history of drug use, reported using drugs during a time frame consistent with incarceration. Another consideration is the assimilation to the prison environment. This is known as the "*inmate subcultures*". This psychological adjustment involves subjection to "*inmate society"* and its norms (Alpert, (1985). The psychological stressors of prison confinement also is a major contributing factor to the acceleration of the aging inmate.

President George H. Bush signed the Alcohol, Drug Abuse, and Mental Health Reorganization Act (ADAMHA) in 1992. This act brought three research institutes under the National Institute of Health. Its focus was on research and services for mental health and substance abuse to better serve this population. This was for a greater exchange of information about these issues. Also created was the Substance Abuse and Mental Health Administration (SAMHSA). Today this agency has many significant program such as treating co-occurring

disorders, transforming the mental health public systems, the prevention of homelessness, and checking on the spread of such diseases as Acquired Immunodeficiency Syndrome (AIDS) and the Human Immunodeficiency Virus (HIV). Even though many of these programs service those with mental health and addiction issues within the community. Little is known about these co-morbid problem, especially in the older adult inmate population.

The research of treatment of those inmates with co-morbid mental health issues and crime are multifaceted. Some researchers suggest the relationship is clarified by the fact individuals with mental disorder are more likely to present with risk factors for criminality, in particular substance abuse and psychopathy (Martin, Dorken, Wamboldt, & Wooten, (2012). While the setting of institutionalization may be seen as ideal for servicing multiple factors including mental health, criminal attitudes, poor problem solving skills, and substance abuse. The barriers for this effectiveness are large caseloads, lack of continuum of care after release, and the inconsistencies in building of a strong therapeutic relationship. Canada, Engstrom, & Jang, (2014) suggest the stakeholder advocate for alternatives to prison for older adults. Diversion programs, and alternative courts such as drug and mental health courts are the recommendations.

From its earliest inception in Miami, Florida. The purpose of drug courts was to reduce the recidivism rates of the offender, reduce the failure to appear at trial rate, and provide at least some level of treatment services (Cooper, 2003). As general observations were reported, over 50% of the drug court participants has been previously incarcerated for charges related to drug use. Many had poly-addictions, the expansion of the treatment and support services to participants, and the program being developed to other types of cases such as domestic violence. These courts have been established not only for adults, but for juveniles, as well as Native

Americans. This implication for social work is the ability to service the many diverse populations of our agencies with the inclusion of rural areas.

A part of the advocacy for social worker in addressing the alternatives to incarceration for our older adults is how our society treats its elders (Williams, Lindquist, Sudore, Strupp, Willmott, and Walters (2006). This is the reflection of the morals care these older inmates receive, and the burden on tax payers. Some of these inmates are in need of services that can be provided by social workers such as hospice and palliative care. Another consideration should be early release programs.

In using drug treatment program as part of the release from prison, the examination of what is the most effective treatment outcomes for the older adult should be a part of the program evaluation for the social worker before a recommendation should be made. Treatment approaches should include age-specific services. The Older adult respond better to treatment when among their peers. The consideration of running therapy groups at a slower pace, is also a part of the special needs associated with the cognitive learning of the older adult. Due to longer withdrawal symptoms from detoxification by the older adult, longer lengths of stays at treatment facilities would provide services more conducive to completing treatment (NEDS, 2002).

Cognitive-behavioral therapy for the older adult emphasizes the teaching of skills needed to control their drinking behavior. By examine antecedents, behaviors, and consequences, the user can have more of a self-management, and client empowerment of their addiction. Brief intervention as a treatment approach involves education, contracting, and advice. One of the advantages of this type of intervention is the use in a home setting which provides convenience to the outpatient client. As with the consideration for alternative treatment to incarceration of the older adult with addiction such as drug court. Examining whether to treat the addiction of the

user or punish the criminal behavior of the older adult should be a part of the assessment for the risk of recidivism.

Researcher has found there was no association between increased age and criminogenic cognition. This cognition is the thinking styles promoted by criminal behavior (Mandracchia, (2012). Research literature illustrates drug use is part of a continuum of criminogenic need, but the type of drug use can be positively influenced by substance abuse treatment (Taxman, Caudy, & Ainsworth, (2014). Recidivism pattern are also associated with the drug of choice. Crack cocaine users are six time more likely to reoffend than non-crack users, about three times greater for heroin user than non-opioids users, and about two and half times greater for cocaine users than non-cocaine user. Harder illicit drugs like cocaine and opioids for the user who completed treatment had declines in criminal days (Taxman, Caudy, & Ainsworth, (2014).

Understanding how our criminal justice system was formed and the functioning of the laws during the various points in our history, demonstrates how those laws have effected the citizen of society. As drug use and crime changed, so did the laws, and the sentencing associated with the guidelines. The latent functions were unequal incarceration of certain ethnic groups, but also an argument could be made for the issues faced by the older adult inmate with addiction.

Older adult with addiction who commit crimes should be considered for alternative programs or treatment instead of incarceration such as drug courts or treatment services. Social workers have the opportunity to assume the roles for advocacy for policy change in sentencing that increases the geriatric inmate population. Alternative treatment programs for the reduction of recidivism rates would also reduce the increasing overcrowding of our prisons. Also as the baby boomer population increases, the need for academia to include aging curriculum in the

education and field placement of social work student would better prepare these students for future practice.

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