California Becomes the First State to Defelonize Drug Use

November 7, 2014

by Johnny Magdaleno

Introduction by Terence T. Gorski

An army of concerned citizens, including myself, has advocated against excessive prison sentences for non-violent drug offenders and reinvesting the money spent on incarceration to community-based addiction treatment and solid approaches for developing sober communities.

California, previously a leader in incarcerating nonviolent drug addicts, has reversed direction in the passage of proposition 47. Hopefully, as a result of the recent election, a trend in changing from a War on Drugs Policy to a Public Health Addiction Policy that includes a strong emphasis on developing sober communities based upon the attraction to re benefits of recovery rather than the fear of punishment.

I believe that this type of legislation that is based upon the principles of decriminalization and reclassification of nonviolent drug possession and personal use can be a good thing.

The folloI believe that the fact. Here’s why:

1. Sentences for nonviolent drug offenders are draconian and have introduced racial bias due to how how and where drug laws are enforced.

2. The War on Drugs Policy has been an expensive failure in terms of managing the national epidemic of drug addiction.

3. Provisions in the legislation will redirect the funding saved by reducing the prison population to community reentry programs, expansion of community-based treatment resources, and the building sober communities based upon the attraction of living among sober and responsible rather than the threat of incarceration.

4. Many children now orphaned because of parental incarceration can be reunited with their families instead of being warehouses in child welfare systems.

This can be a tremendous contribution to a better future if the process of family unification is supported by effective family therapy, drug prevention and treatment,
5. Police and court resources can be redirected to their true mission, stopping violent crime and protecting our communities from violent criminals.


This defelonization of drug use alone is only one part of the managing the problem. Addiction professionals, including Social Workers, Psychologist’s, and Counsels will need to stand up with other community leaders to develop policies and programs that support and encourage sobriety and responsibility, strongly discourage alcohol and drug abuse, and make concerted efforts to de-glomorize drinking and drug use. A planned program for holding up as heroes and role models the sober and responsible people who make positive contributions to their communities.

Drugs of Abuse

Drug legalization, nonviolent deu offenses, prison reform, Proposition 47, war on drugs

Drug War

Evidence-based Treatment

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Spirituality

Strange

Strength

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Terrorism

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Training

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Posted by Tony Gorski

Drug War Policy and The Prison Industrial Complex

July 29, 2014

By Lisa M. Hammond and Terence T. Gorski

GORSKI BOOKS

The war around the War on Drugs is a battle between public health and criminal justice. It’s a battle between conservatives calling for imprisonment and progressives calling for public health solutions. It’s the legacy of Barry Goldwater, Richard Nixon, Nelson Rockefeller, and others, who used the fear of crime to build campaigns around law and order. While these conservative politicians were pounding the bully pulpit and demanding that every drug offender is punished, Congress was eliminating mandatory minimum sentences and mainstream public opinion considered drug addiction to be a public health problem, not an issue for the criminal courts.

The battle between public health and criminal justice began to move right with the graphic depiction of drug addicts as immoral and dangerous criminals. Rockefeller demonstrated his commitment to law and order when he crushed the Attica prison uprising, and took the lead in the War on Drugs by proposing the harshest drug laws in the country. The War on Drugs rhetoric and Rockefeller drug laws were arguing a correlation between crime and drug abuse. To further fuel the debate, the economic recession of 1973-75, saw escalating crime and the proliferation of criminal drug activity as economic alternatives. Americans wanted to solve the crime problem and believed that the enemy was drugs and all who used them. What started out as a policy to reduce drug abuse has resulted in the mass incarceration of drug addicted individuals. Public health lost the battle to treat drug abuse in 1986, with the passage
The punitive impact of the War on Drugs policy can also be seen in the Welfare Reform Act, Section 115, where legislation has placed a lifetime ban on Temporary Aid to Needy Families (TANF) and Food Stamp benefits for all convicted drug felons. Coincidently, the Coalition for Federal Sentencing Reform found that more than 80% of the female prisoner population are mothers, and 70% of these are single parents. Since 1990 the annual rate of growth of the female inmate population has averaged 8.8%, higher than the 6.9% average increase in the number of male inmates. (12) By year end 1997 women accounted for 6.4% of all prisoners' nationwide, up from 5.7% in 1990. (13)

Female incarceration rates, though substantially lower than male incarceration rates, reveal similar racial and ethnic disparities. Black females (with an incarceration rate of 188 per 100,000) were more than twice as likely as Hispanic females (78 per 100,000) and eight times more likely than white females (28 per 100,000) to be in prison in 1996. (14) Inmates at year end 1990 and 1996 reveal differences in the sources of growth between male and female inmates. During this period the number of female inmates serving time for drug offenses doubled, while the number of male inmates in for drug offenses rose 55%. (15) The number serving time for violent offenses, however, rose at about the same pace (up 57% for men and 58% for women). (16)

Denying TANF benefits and food stamps to convicted drug felons imposes grave hardship on the children of these individuals and creates additional barriers to success after imprisonment. A former felon without readily marketable skills will not be able to seek immediate employment upon release. Hence, without a social safety net, this individual will have no choice but to engage in behaviors that may lead to recidivism. Women with children and inadequate means of financial support will resort to prostitution and drug dealing to provide for family essentials.

The National Institute on Drug Abuse estimates the economic cost from alcohol and drug abuse was $276 billion in 1995. (17) Since that time there have been significant increases in expenditures to incarcerate, but not solve the social ills that lead to drug abuse was $276 billion in 1995. (17) Since that time there have been significant increases in expenditures to incarcerate, but not solve the social ills that lead to drug addiction.
transportation and security. Currently, the stocks of both PZN and WHC publicly traded are increasing year-over-year, with WHC currently holding more than 30,000 beds as well as contracts for prisoner healthcare services, While the second largest developer and operator of private prisons in the U.S., has contracts to manage 70,000 prison beds in more than 80 facilities. This trend suggests a significant increase in the development of the prison industry.

Prisons are becoming increasingly important to the U.S. economy. Addictions are a disease with bio-psycho-social causes, whose prevalence has increased over the past year. There are 10.5 million Americans who abuse or are addicted to drugs and alcohol. There are 10.5 million victims of drug related crimes each year. There are 700,000 infants exposed in utero to illicit drugs each year. There are 132,000 premature deaths as a consequence of drug and alcohol problems. Drug abuse is a problem with many social ramifications. There are 26 million Americans who abuse or are addicted to drugs and alcohol. (28) There are 10.5 million victims of drug related crimes each year. (29) There are 700,000 infants exposed in utero to illicit drugs each year. (30) There are 132,000 premature deaths as a consequence of drug and alcohol problems. (31) Drug abuse is a problem.

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People who support incarceration, vote for new prison bonds and give their tacit assent to a proliferating network of prisons and jails. But prisons do not solve social problems. Without addressing the underlying social issue, a burgeoning penal infrastructure will continue to grow in order to accommodate an exponentially increasing population of caged people. However, the economics of the private prison industry are in many respects similar to those of the lodging industry. An inmate at a private prison is like a guest at a hotel and the economic incentive is to book every available room and encourage every guest to stay as long as possible. (33)

Prisons are becoming increasingly important to the U.S. economy. Prison privatization is the most obvious example of opportunistic capitalism in the current development of the prison industry. Prison Realty Trust (PZN), the largest private prison company in the U.S., builds and manages prisons in Australia, Puerto Rico, the U.K., and the U.S. It owns 50 prisons, 49 in the U.S., and it manages more than 70,000 prison beds in more than 80 facilities. The company recently identified California as its “new frontier.” (34) Wackenhut Corrections Corporation (WHC), the second largest developer and operator of private prisons in the U.S., has contracts to manage more than 40 facilities in the U.S., the U.K., and Australia. It boasts more than 30,000 beds as well as contracts for prisoner healthcare services, transportation and security. (35) Currently, the stocks of both PZN and WHC publicly traded are increasing year-over-year, with WHC currently holding more than 30,000 beds as well as contracts for prisoner healthcare services, while the second largest developer and operator of private prisons in the U.S., has contracts to manage more than 40 facilities in the U.S., the U.K., and Australia. It boasts more than 30,000 beds as well as contracts for prisoner healthcare services, transportation and security. (35)
Addiction is a disease, not a moral failing. We need to treat the cause of drug abuse through public health and reinstate social resources to combat the risk factors leading to abuse. When an offender enters a California prison, he is surveyed for more than 50 skills and placed in a facility with targeted skill needs according to his ability. Corporations ranging from J.C. Penny and Victoria’s Secret to IBM and Toys R Us utilize prison labor to cut costs and increase profits.

Private prison companies are the only most visible component of the increasing corporatization of punishment. Government contracts to build prisons have bolstered the construction industry. The architectural community has identified prison design as a major new niche. Technology developed for the military, such as “Night Enforcer” goggles and “Hot Wire” fencing, by companies like Westinghouse are being marketed for use in law enforcement and punishment. Moreover, corporations that appear to be far removed from the business of punishment are intimately involved in the expansion of the prison industrial complex. Prison construction bonds are one of the many sources of profitable investment for leading financiers such as Merrill Lynch. MCI charges prisoners and their families outrageous prices for telephone calls by adding a $3.00 surcharge to every call.(36) A pay phone at a prison can generate as much as $15,000 per year.(37) The business is so lucrative that MCI installed its inmate phone system, Maximum Security, throughout the California prison system at no charge. (38) As part of the deal MCI provides the California Department of Corrections a 32% share of all revenues from inmates’ phone calls.(39)

Financiers and high-tech industries are not the only ones reaping profits from incarceration. Nordstrom’s department stores sell jeans that are marketed as “Prison Blues,” as well as T-shirts and jackets made in Oregon prisons. The advertising slogan for these clothes is “made on the inside to be worn on the outside.” Maryland prisoners inspect glass bottles and jars used by Revlon and Pierre Cardin, and schools throughout the world buy graduation caps and gowns made for Jostens by South Carolina prisoners.(40)

“For private business,” writes Eve Goldberg and Linda Evans “prison labor is like a pot of gold. No strikes. No union organizing. No health benefits, unemployment insurance, or workers’ compensation to pay. No language barriers, as in foreign countries. Treatment costs are zero. Treatment can produce a profit of $15,000 per year.” (37) The business is so lucrative that MCI installed its inmate phone system, Maximum Security, throughout the California prison system at no charge. (38) As part of the deal MCI provides the California Department of Corrections a 32% share of all revenues from inmates’ phone calls. (39)

Although prison labor is quite profitable for the private companies that use it, incarceration does not produce wealth for the public sector. On the contrary, it devours wealth that could be used for education, drug rehabilitation, programs to combat HIV, child care, housing, and job creation for the unemployed.

The Prison Industrial Complex is an interweaving of private business and government interests. Private capital has become enmeshed in the punishment industry. Although the primary purpose of prisons is social control and the public rationale is the fight against crime, the results are clearly profit on the backs of disadvantaged populations

Reframing the War on Drugs policy to a national public health policy on substance abuse treatment would not only reduce costs and improve national health, but also make our communities safer, lower taxes, improve workplace productivity and reduce health care costs. Addiction is a disease, not a moral failing. Addiction is primarily a health care problem with criminal justice implications. It is not primarily a criminal justice problem with healthcare implications. We need to get the relationship straight. Treatment is the most effective way to reduce drug and alcohol addiction, and dramatically reduce drug and alcohol related crime and health care costs. Treatment cuts health care costs. Treatment improves economic welfare. Treatment is cheaper than enforcement, prosecution and incarceration.

Three decades after the War on Drugs began, we have developed a prison industrial complex, with seemingly unstoppable momentum. The line between public interest and private interest has blurred. The crackdown on drugs has not stopped drug use, but it has taken thousands of unemployed and potentially angry young men and women off of the streets and has created a growing prison population and new industrial complex. Our failure to spend on relatively inexpensive measures, such as drug treatment and probation, has forced us to increase spending on prisons. However, as criminal justice increasingly devours social resources it does not add to social wealth. Building more prisons to address drug abuse is like building more graveyards to deal with a fatal disease.

We need to treat the cause of drug abuse through public health and reinstate social resources to combat the risk factors leading to abuse. The goal is simple, to reduce drug abuse and the constellation of associated problems and costs. We can achieve this goal through a continuum of health care services orchestrated by a Public Health Addictions Policy.


5. Ibid.


7. Ibid.


10. Ibid.


14. Ibid.

15. Ibid.

16. Ibid.


20. Ibid.

21. Macallair D., Taqi-Eddin K., Schiraldi V. Class Dismissed: Higher Education vs. Corrections During the Wilson Years. [article online]; (San Francisco, CA; Justice Policy Institute); available from http://www.cjij.org/jpi/classdis.html; Internet.

22. Wisely, Willie, California Expanding Prison Industrial Complex. [article online]; (Berkeley, CA, Prison Activist Resource Center); available from http://www.prisonactivist.org; Internet.

23. Macallair D., Taqi-Eddin K., Schiraldi V. Class Dismissed: Higher Education vs. Corrections During the Wilson Years. [article online]; (San Francisco, CA; Justice Policy Institute); available from http://www.cjij.org/jpi/classdis.html; Internet

24. Wisely, Willie, California Expanding Prison Industrial Complex. [article online]; (Berkeley, CA, Prison Activist Resource Center); available from http://www.prisonactivist.org; Internet.


26. Macallair D., Taqi-Eddin K., Schiraldi V. Class Dismissed: Higher Education vs. Corrections During the Wilson Years. [article online]; (San Francisco, CA; Justice Policy Institute); available from http://www.cjij.org/jpi/classdis.htm I; Internet.


29. Ibid. Section 5.1
30. Ibid. Section 4.4.2.2
31. Ibid. Section 1.3
37. Ibid.
38. Ibid.
39. Ibid.
41. Goldberg, E., Evans L. The Prison Industrial Complex and the Global Economy. [article online]; (Berkeley, CA, Prison Activist Resource Center); available from http://www.prisonactivist.org

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Bibliography


Goldberg, E., Evans L. The Prison Industrial Complex and the Global Economy. [article online]; (Berkeley, CA, Prison Activist Resource Center); available from http://www.prisonactivist.org


Lotke, Eric. New Growth Industries: The Prison Industrial Complex. [article online]; (Washington, DC: Multinational Monitor); Nov. 1996 Vol. 17 No. 11; available from http://www.essential.org/monitor/hyper/mm1196.06.html ; Internet
Solitary Confinement: Research and Experiences
January 10, 2014

Has anyone following this blog been in prison and served time in solitary confinement. Dr. Grassian, a trusted colleague, is interested in interviewing people to further his research on the impact of solitary confinement. Please review the correspondence below. If you can help Dr. Grassian find people willing to be interviewed please contact him.

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Chestnut Hill, MA 02467
(617) 244-3315
stgrassian@gmail.com

Please read our correspondence below for more information.

Dear Mr. Gorski,

Thanks for your words of support. As you know, addictions and imprisonment are so tightly connected; I am pleased to learn of your work reaching out to those who have experienced both.

Earlier this year I made a commitment to try to collect stories of individuals who, now released back into the community, had spent a great deal of time in solitary confinement. I would greatly appreciate any referrals you might have of individuals who have experienced this and might be willing to share their experience (of course, confidentiality would be maintained).

I hope the new year finds you well and that your work continues to make a difference.

Stuart Grassian  M.D.

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On Tue, Dec 24, 2013 at 12:46 PM, <stgrassian@aol.com> wrote:
— original Message —

From: ttgorski <ttgorski@gmail.com>
To: stgrassian <stgrassian@aol.com>
Cc: Tresa Watson <tresa@cenaps.com>; Terence T. Gorski <ttgorski@gmail.com>; Dr. Stephen Grinstead <sgrinstead@cenaps.com>
Sent: Mon, Dec 23, 2013 2:30 pm
Subject: Thank You For You Work

Dear Dr. Grassian,

I have been delinquent in expressing my gratitude and and telling you about how useful your work has been to me. As a means f introduction I am an author and a trainer/consultant specializing in addiction and related mental health problems. I have developed a popular model of Relapse Prevention Therapy (RPT) and
through me uncountable addiction professionals trying to understand the unusual and difficult to deal problem they have in treating patients who have been incarcerated. When I started trying to meet the needs of these counselors, I constructed a concept called Post Incarceration Syndrome (PICS). Initially it was very popular, until of course, the economy and climate of addiction treatment radically changed through the influence of Government Policy.

Here are links to several internet resources that show how your work has influenced me:
1. My blog republishing a basic article that has been reference and reposted many times: https://terrygorski.wordpress.com/2013/10/26/the-post-incarceration-syndrome-pics/

This is just a sample of the many people who have spread your ideas which are contained in the concept of Post Incarceration Syndrome. I wanted you to know that your has, is, and will continue to make a difference to me and countless lives that your research and writing have changed for the better. Thank you for your contributions and you career work.

Terence T. Gorski
<table>
<thead>
<tr>
<th>Type Of Drinker</th>
<th>% Of Population</th>
<th>% Alcohol Consumed</th>
</tr>
</thead>
<tbody>
<tr>
<td>Abstainers</td>
<td>33%</td>
<td>0%</td>
</tr>
<tr>
<td>Light Drinkers</td>
<td>34%</td>
<td>7.9%</td>
</tr>
<tr>
<td>Moderate Drinkers</td>
<td>24%</td>
<td>26.3%</td>
</tr>
<tr>
<td>Heavy Drinkers</td>
<td>9%</td>
<td>65.8%</td>
</tr>
</tbody>
</table>

**Incidence Of Chemical Dependence**

Conservative estimates indicate that approximately 10% of the adult population in the United States is suffering from alcohol dependence and 5% of the United States population is drug dependent. Therefore, a total of 15% of the general population of the United States is chemically dependent at any given time. Alcohol and drug use and dependence among criminal offenders is more common. Nearly 100% use both alcohol and drugs on a regular basis. The vast majority of criminal offenders fall into the moderate or heavy drinking categories. Approximately 70% of all inmate populations across the United States are incarcerated for alcohol and drug related crimes ranging from intoxication at the time of the crime to illegal drug trade.

**Chemical Dependency In The United States**

<table>
<thead>
<tr>
<th>Use Pattern</th>
<th>General</th>
<th>Offenders</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. A/D Use</td>
<td>66%</td>
<td>100%</td>
</tr>
<tr>
<td>2. A/D Dependence</td>
<td>15%</td>
<td>70%</td>
</tr>
</tbody>
</table>

**Alcohol Use And Crime**

Statistics show that 54% of violent criminals are under the influence of alcohol at the time of the crime and 40% are under the influence of alcohol when committing property crimes. With drug crimes, meaning illegal drug trade, 29% are drunk or high on drugs while engaging in those transactions and 64% are under the influence of alcohol when committing public order offenses. This is a total average of 48% of the criminal population being under the influence of alcohol at the time they commit a crime.

The statistics are striking when looking at violent crimes and the violent criminal. Fifty-four percent of all violent criminals are under the influence of alcohol and drugs at the time of the crime. Many report using alcohol and drugs to gain the courage to facilitate the violent acts. Others say that alcohol or drugs break down impulse control which causes them to react spontaneously with violent behavior in high stress situations.

A breakdown of violent crime reveals that 49% of murderers are intoxicated at the time of the murder. Statistics show that 68% of manslaughter convictions, 52% of rapes and sexual assaults, and 62% of non-sexual assaults occur while the offender is intoxicated.

**Types Of Alcohol And Drug Problems Among Inmates**

When focusing on the types of alcohol and drug problems among criminal offenders, it is essential to use DSM-III-R categories and the two subcategories of substance use disorders. The first subcategory is chemical abuse disorders. People with chemical abuse disorders get into trouble as a result of their alcohol and drug use, but they are not physiologically addicted. They have not achieved high levels of tolerance and dependence, and do not go through withdrawal when they attempt to stop. It is estimated that about 28% of all inmates in the United States or 40% of all inmates committing alcohol and drug related crimes are diagnosed as having chemical abuse disorders.

The next DSM-III-R subcategory is chemical dependency disorders or substance dependency disorders. Forty-two percent of all inmates in the United States have chemical dependency disorders and approximately 60% of those committing alcohol and drug related crimes are diagnosed as having chemical dependency disorders.

**Alcohol And Drug Abuse And Antisocial Personality**

Offenders with alcohol and drug related crimes can be divided into three categories. In the first category, the crime is a symptom of the non-addictive use of illegal drugs in persons who do not have chemical use disorders or criminal personalities. A good example of this is the man who does not have a drug problem getting arrested for using and selling marijuana. Only 5% of criminal offenders fall into this category of people who are arrested on drug charges who are not chemically dependent.

In the second category, crime is a symptom of chemical dependency. For example, a heroin addict begins to commit burglaries to support his habit. Another example is an alcoholic who is down on his luck and, at moments of poor impulse control, steals money to purchase alcohol or shoplifts in a liquor store in order to get alcohol. Approximately 15% of the inmate population falls into this category. Once the chemical dependency goes into remission and the person gets sober, the criminal behavior will spontaneously disappear.

In the third category, alcohol and drug use is a symptom of a criminal personality. These people basically have DSM-III-R Cluster B personality disorders in conjunction with their chemical use, but are not chemically dependent. They have the personality disorder that predisposes them to act out against authority, break rules, and commit crimes primarily for thrill seeking behavior. They are abusers, but are not addicted. They comprise approximately 15% of the population where alcohol and drugs are involved.
By far, the largest category is where crime is both a symptom of chemical dependency and criminal personality traits which is approximately 65% of the chemically dependent criminal offenders. This is important information to consider in determining treatment strategy because many criminals who are chemically dependent seek sobriety so they can become more efficient criminals. They realize that because of the loss of control they are getting caught and their goal is to get sober so they will not get caught again.

The conclusion here is a very simple one. Most criminal offenders who commit alcohol and drug related crimes have serious chemical use disorders. Few criminal offenders are social drinkers or recreational drug users. There will always be the exception, but they are few and far between.

**Alcohol And Drug Problems and Criminal Recidivism**

Alcohol and drug problems are related to criminal recidivism. Fifty-one percent of repeat offenders have chemical use disorders, the majority of them untreated. In inmate populations among the United States, less than 15% of the chemically dependent criminal offenders today get any type of treatment for their chemical dependency. Of the 15% that do receive chemical dependency treatment, for 70% of them the only intervention available is voluntary attendance at Alcoholics Anonymous and other twelve step meetings with only about 30% of the current inmate population being exposed to structured chemical dependency programs across the entire inmate population of the United States.

Alcohol and drug use among parolees is associated with three things – breaking parole and probation, renewed criminal behavior, and re-arrest for criminal activity. If a parolee starts to drink and use drugs, the likelihood of engaging in criminal activity that leads to re-arrest is very high and results in new arrests and convictions. The basic sequence is breaking parole and probation requirements, going back into criminal behavior, getting caught, and returning to the legal system to start the entire cycle all over again.

**Antisocial Behavior Is Common Among Criminal Offenders**

Commit Antisocial Acts – 100%

Habitual Criminals – 75%

### Antisocial Personality Disorders

How many criminal offenders commit antisocial acts? One hundred percent of the inmate population commits antisocial acts. Stanton Samenow and Dr. Samuel Yochelson studied hard-core criminal offenders and found that for every one time a criminal is caught, most have committed at least 100 previous crimes for which they have not been caught.

Habitual criminals represent 75% of the offender population. Seventy-five percent of habitual criminals have a criminal personality disorder, criminal personality style, or a collection of criminal personality traits that need to be dealt with and addressed if they are going to be successfully rehabilitated.

Let’s look at the incidence of antisocial personality disorder in various populations. In the general population, approximately 4% of males and approximately 1% of females are diagnosed at any given time as having antisocial personality disorder. Fifteen percent of alcoholic males, a little over three times the incidence of the general population males, have diagnosable antisocial personality disorder and 10% of the alcoholic females have diagnosable antisocial personality disorder, which is nine times that of the general population females.

Of all male narcotics addicts, 32% have diagnosable antisocial personality disorder. Statistics of female narcotics addicts are not readily available as there are so many more male narcotics addicts than female narcotics addicts.

In prison inmate populations, 50 to 80% of the inmates have diagnosable antisocial personality disorder.

### Criminal Personality Disorders

Criminal personality disorder consists of deeply entrenched, highly destructive tendencies. There are basically four DSM-III-R Cluster B personality disorders that tend to coexist to some degree as a mixed personality disorder.

**DSM-III-R Cluster B Personality Disorders**

1. Antisocial (Rule Breakers)
2. Narcissistic (Egotistical and Self-Centered)
3. Histrionic (Disruptive Attention Seekers)
4. Borderline (Chaotic and Volatile)

The antisocial personality disorder features compulsive, rule-breaking behavior. People with antisocial personality disorder have difficulty with authority; they have poor impulse control; they have no respect for established authority; they tend to find it thrilling and exciting to break the rules and laws; and they enjoy this behavior.

The second personality disorder is the narcissistic personality disorder. People with narcissistic personality disorder are egotistical and self-centered; they tend to believe that other people exist merely as instruments to their well-being; and they have a tremendous tendency to personalize everybody else, turn them into objects,
Punishment Alone Does Not Work

It is proven that punishment alone will not stop criminals with chemical use disorders from using alcohol and drugs. Threatening consequences will not stop chemical use either. Monitoring for alcohol and drug use through urinalysis is not enough to interrupt the obsession, compulsion, craving, and the maladaptive life patterns that lead these people back to chemical use.

Similarly, punishment alone will not stop criminals with criminal personality disorders from committing crimes because of the fact that the higher the risk, the greater the attraction to the crime. People who have severely antisocial personalities are attracted to criminal thrill-seeking behavior. The higher the risk of a criminal act, the greater the high produced when the act is committed. Many people with antisocial personalities are excitement junkies who are addicted to criminal and sexual thrill seeking. Criminal grandiosity also programs criminals to “put themselves to the test” by proving that they can commit high risk crimes and get away with it.

Criminal behavior is expanding and reaching epidemic proportions. The simple humane warehousing of criminal offenders will not meet the needs of this nation. Jails are overcrowded and are getting more so every day. The solution is not to build more jails as the criminal population will expand to fill the jails that are available.

There is significant evidence that treatment alternatives to incarceration are reducing recidivism and increasing positive adjustment back into society following episodes of incarceration.

For Treatment Alternatives To Work …
Criminal Offenders Must Be Screened
And Concurrently Treated For …
1. Chemical Use Disorders
2. Criminal Personality Disorders
3. Mental Disorders

In order for treatment alternatives to work, every criminal offender must be screened and concurrently treated for three distinct categories of disorders. The first category is chemical use disorders; the second category is criminal personality traits and disorders, i.e. DSM-III-R Cluster B personality disorders; and the third category is mental disorders as many people with severe substance use disorders and personality disorders also have another Axis I diagnosis of schizophrenia, panic disorders, or phobias.

Policies must be established universally at county and local levels were diagnostic and treatment procedures are integrated into the criminal justice system as a standard operating procedure. Until this level of integration exists, the chemical dependency and behavioral health programs will be viewed as add-on programs. The goal must be integration. How do we integrate these programs into the criminal justice system, into the prison systems, into the probation and parole systems so they become the normal way of doing business in an enforcement and incarceration environment?

First, screening needs to be done prior to sentencing. Technology must be enhanced and proper evaluation tools must be used to screen for chemical use disorders, criminal personality disorders, and mental disorders.

Secondly, treatment must be concurrent with punishment. There must be treatment during incarceration. The ideal, of course, is to turn all of our criminal institutions into rehabilitation environments, set up varieties of therapy to address different needs, and provide concurrent treatment to every criminal offender.

Limited resources must be applied to their best advantage. Intensive rehabilitation should occur towards the end of the inpatient incarceration period. In this way, the offender learns sober and responsible coping strategies while they are in the criminal justice system population which prepares them for the transition period out of the criminal justice system population.

Ongoing treatment must be a mandatory condition of parole and probation. This is becoming a widespread practice. Criminal offenders are being sentenced to ongoing treatment as a mandatory condition of probation and parole and there are very strict consequences if this condition is not adhered to. Any person breaking the treatment protocol must receive rapid disciplinary action where the offender is returned to incarceration. Contingencies should be devised where the first break in treatment structure results in a return to jail for three days; the second break results in a two week incarceration; the third break results in a return to jail for 30 to 60 days, and the fourth break results in returning to jail to finish off the entire sentence.

Inmates need to know that there are consequences to breaking their rehabilitation structure after they are out of the institution. These people must be kept on a long-term continuum of care. This must be linked into the probation, parole, and the court procedures so that if a person breaks the treatment regimen, strict consequences follow.

Criminal Personality Disorders and Chemical Use Disorders
Are Coexisting Disorders That Are Best Treated Together
There should be treatment alternatives to incarceration for criminals who have two coexisting disorders — criminal personality disorders and chemical use disorders. People having these two disorders should be screened and evaluated for placement in specialty programs when they enter the criminal justice system. Some offenders will go into incarceration environments; some will go into primary treatment; some will go into relapse prevention programs. A profile of specialty programs should be made available to them.

Criminal personality disorders and chemical use disorders are coexisting disorders that must be treated together. If you attempt to treat the chemical dependency while not treating the criminal personality traits of a chemically dependent criminal offender, the offender is at high risk of relapse to alcohol and drug use. Similarly, if a person has severe antisocial traits and the antisocial traits are treated but the chemical use disorder is not focused upon, the person will relapse into drinking and drug use and all of the antisocial traits will return.

Why is this? The reason is because there is a very definite relationship between chemical dependency and criminal personality disorders. There are three links in the chain that bind these disorders together. The first link in the chain is mutual predisposition. Predisposition is a term used to describe the factors that set the person up to get the disorder. Criminal personality disorder increases the risk of chemical dependency. Substance use and abuse is a feature of criminal personality disorder. People with Cluster B personality disorders, especially antisocial personality disorder, drink and drug heavily. If they have the genetics that make them sensitive for physiological dependence and addiction to alcohol and drugs, they are very likely to become addicted.

Chemical dependency increases the risk of criminal personality traits and disorders. If a person moves into a progressive history of alcoholism or drug addiction, he turns to illicit antisocial behaviors and to an illegal drug culture in order to survive and maintain his active addiction. For example, a drug addict enters a criminal underground of illicit behaviors to acquire and use a drug. The addict enters a dangerous criminal underworld which conditions his behavior and creates criminal personality traits as an adjustment reaction to moving into the criminal underground life.

People in this type of underground existence have antisocial tendencies. They are entranced or excited about the prospect of this underground existence, but once they get into it, there is a progressive involvement in more violence and more criminality. This mutual predisposition forms the first link in the chain between chemical dependency and criminal personality disorder. Alcohol abuse brings a person right back into their contact with the illicit drug culture.

The second link between chemical dependency and criminal personality disorder is symptom reinforcement. Once chemical dependency and criminal personality traits develop, there is symptom reinforcement. Criminal personality disorder promotes alcohol abuse as a condition and a necessary prerequisite for its existence. Large numbers of criminal offenders who use alcohol and drugs will tell you that the reason they use is to give them courage to get ready for the act, it allows them to recover from the act, or it enhances the thrill of the criminal behavior. Alcohol and drugs are being used purposefully as an extension and exaggeration of the benefits that the criminal gets from criminal behavior.

Alcohol and drug abuse promotes antisocial behavior by lowering habitual and impulse control making criminals susceptible to poor judgment that results in renewed criminal behavior. The third link in the chain between chemical dependency and criminal personality disorder is reciprocal relapse where alcohol and drug use triggers criminal behaviors and criminal behaviors trigger alcohol and drug abuse.

Because chemical dependency and criminal personality disorder are closely linked, there needs to be concurrent diagnosis and treatment. Abstinence from alcohol and drug use must be the primary goal in our rehabilitation setting in the criminal justice system. Controlled drinking and controlled use of illicit drugs should not be on the criminal justice agenda for this nation.

Another goal should be abstinence from criminal behaviors. Of course, this is very clear within the criminal justice system. There is an intrinsic link between alcohol and drug use and abuse and criminal recidivism and the goals for both must be tied together.

Alcohol, drug, and criminal life style patterns must be changed through internal changes in thinking patterns, emotional management patterns, behavioral patterns, and making external structural changes in the person’s life style.

All programs need to have a very strong foundation in holistic health. Physical rehabilitation, proper diet and exercise, proper stress management, psychological rehabilitation focusing on changing thinking and emotional management strategies, behavioral control strategies, behavior enhancement techniques, and social rehabilitation are necessary.

The CENAPS Model of Treatment

The CENAPS Model of Treatment is different from other models in that it is integrative and it is evolutionary. The CENAPS Model is not a revolutionary, new model. Revolutionary models tear down the past and propose a bold, new approach to the future. They believe what came before is basically irrelevant. The CENAPS Model takes various approaches and tries to come up with a unified field theory and
The goal is to integrate what is already known, consolidate it, and overcome the language problems that are so divisive among different therapeutic specialties. A uniform set of terms and uniform nomenclatures must be established to continue this movement.

The CENAPS Model Combines ...

A Biopsychosocial Disease Mode
Of Chemical Dependence
With Criminal Personality Theory
To Create A Practical System For Treating
Chemically Dependent Criminal Offenders

The CENAPS Model is a biopsychosocial disease model for chemical dependency. Rehabilitation must consist of broad-based biopsychosocial intervention.

The CENAPS Model of Treatment is being integrated with criminal personality theory. The model is taking the chemical dependency treatment field and is integrating it with the psychotherapy community and the criminal justice rehabilitation program to create a unified, evolutionary understanding of how to treat chemically dependent criminal offenders.

The goal is to create a practical system for treating chemically dependent criminal offenders. The CENAPS Corporation has developed this tool. With the assistance of the Office of Treatment Improvement, The CENAPS Corporation has developed three manuals. One of these manuals is a relapse prevention workbook for criminal offenders. Another manual is an instruction guide for counselors, probation and parole officers, and prison guards. Anyone who is working with criminal offenders can access an instruction guide to use this practical technology. The third manual is a briefing document containing figures and statistics which will be available to administrative judges and high level decision makers to help them in supporting this thrust in rehabilitation.

The CENAPS Model Integrates ...

1. Cognitive Therapy
2. Affective Therapy
3. Behavioral Therapy
4. Social Systems Therapy

The CENAPS Model integrates cognitive therapy techniques. The CENAPS Model is primarily an applied cognitive therapy interested in changing addictive and criminal thinking patterns. Stanton Samenow’s book Understanding the Criminal Mind and the three-volume series on the criminal personality by Samuel Yochelson and Stanton Samenow contain excellent illustrations of the criminal personality.

The CENAPS Model of Treatment is also based upon a broad spectrum of cognitive therapy principles. Affective therapy is used to cope with unmanageable feelings that drive addictive and criminal behaviors. There is an emotional charge, an emotional drive, and a thrill seeking or sensation seeking component. Emotional integration is necessary for a person to recover. A specific emotional management strategy must be developed for coping with addictive and criminal behaviors.

Crime is the end product of a sequence of maladaptive, self-defeating behaviors. Chemical use is the end result of a long sequence of maladaptive, self-defeating, coping behaviors that have become deeply entrenched and associated with cues and triggers in a person’s life style. This type of behavioral reconditioning or behavioral programming strategies must be integrated into every comprehensive treatment program.

Social system therapy is designed to change addiction-centered and crime-centered social networks with particular focus upon employment, social, and intimate networks.

Almost all criminal offenders with criminal personality traits have significant problems achieving and maintaining intimate relationships. Almost always, their intimate and family relationships are exploited and abusive where their mate or family members are relegated to objects and are used and abused for criminal, violent, and sexual thrill seeking behaviors. When addressing rehabilitation in these populations, intimate relationships must also be addressed. Dysfunctional intimate relationships are a major relapse trigger. My book Getting Love Right is a simple guide for relapse-prone alcoholics on how to have healthy relationships.

An instrument called the Biopsychosocial Assessment Grid (BAG) is a biopsychosocial disease model for diagnosis and assessment. The Biopsychosocial Assessment Grid is a way of looking at relevant physical, psychological, and social valuables for the purpose of differential diagnosis of chemical dependency and criminal personality traits. The BAG system can be extended simply by adding columns for any other dual diagnosis you wish to add. You can create the BAG categories by simple analysis of symptomatology and breaking it down physically, psychologically, and socially in a similar format.

The Developmental Model of Recovery emphasizes that recovery unfolds over a long period of time in stages. Each stage requires a different primary treatment focus. There are different goals and tasks in each stage of recovery, and the treatment plan must shift with each stage of recovery. A chemically dependent criminal offender must be locked into a long-term, accountable rehabilitation program for a minimum period of three to five years if he is going to see any significant changes occur.

The CENAPS relapse prevention therapy model deals with the problem of
Recidivism. Relapse prevention strategies are very powerful in preventing relapse, but unless they are coupled with biopsychosocial models of diagnosis to treat coexisting illnesses that surface and treat the physical, psychological, and social symptoms of the disorders, relapse prevention is going to be very limited.

Relapse prevention therapy is a vitally needed link in the rehabilitation chain, but of and by itself it is insufficient to handle the massive problem of chemical dependency and criminal relapse.

The CENAPS Model has been expanded to meet the needs of the criminal justice system by integrating the diagnosis and treatment of chemical use disorders, both abuse and dependency with criminal personality disorders.

The CENAPS Model is compatible with twelve step principles. This model follows the twelve step tradition. It is practical and easy to use. It is easily adaptable to inpatient, residential, and outpatient programs and is adaptable to working in residential and camp-like environments in the criminal justice system. The CENAPS Model of Treatment is oriented to the real world of the criminal justice system and is adaptable and flexible.

The CENAPS Model Provides Diagnostic And Treatment Methods For:

1. Transitional Patients
2. Primary Patients
3. Relapse-Prone Patients
4. Family Members

The CENAPS Model provides diagnostic methods for basically four categories of clients or patients. The first is what we call transitional patients. These are involuntary patients who are in strong denial and definitely have alcohol and drug problems. Everyone knows this except them. They may be willing to abstain from alcohol and drug use for a little while to avoid the consequences, but still want to be social drinkers. They are actively antisocial in everyone’s mind except their own. They believe they are simply innocent victims of the system. If they weren’t victimized by that rape victim who screamed too loud or the police officer that came to arrest them, they would not be in this trouble.

The CENAPS Model provides diagnostic and treatment methods for primary patients. Primary patients know they have a problem and realize that if they do not change their alcohol and drug use patterns and their personality, they are going to be incarcerated again. When you mix transitional patients and primary patients together, the transitional patients destroy the efficacy of treatment for the primary patients. Differential screening and differential placement of transitional patients and primary patients is strongly recommended.

The CENAPS Model also provides diagnostic and treatment methods for relapse-prone patients. Relapse-prone patients know they are chemically dependent and have antisocial tendencies. They have learned recovery strategies and have attempted to use them, but have failed. They have encountered some obstacle that they could not manage. Relapse prevention therapy is a special treatment designed for people who are unable to stay in recovery in spite of their desire to do so.

The CENAPS Model also provides treatment for family members. Family members may relapse into codependent behaviors of enabling, controlling, and care taking. When the chemically dependent person is surrounded by these types of people, their reality testing and sanity checking disappears, they lapse back into inappropriate, irresponsible behaviors, and relapse rates go up.

What is diagnosis? Diagnosis in the CENAPS Model is an organized system for identifying the symptoms of the disease or disorder. The patient must recognize and take ownership of his disease or disorder. CENAPS diagnostic methods are designed to provide professional diagnosis, but most importantly to guide patients through self-diagnostic procedures so that they use themselves and other clients in their groups as an active laboratory to learn about what is wrong with them that is causing them to get into trouble.

Components Of The CENAPS Model

1. Biopsychosocial Addiction Model
2. Developmental Model of Recovery (DMR)
3. Relapse Prevention Therapy

Treatment in the CENAPS Model is defined as an organized system for bringing the symptoms of a disease or disorder into remission. Effective treatment produces changes in the way a person thinks, feels, and acts and, as a result, produces changes in their life style. This is a goal-oriented, change-oriented strategy which looks at internal changes in thinking, feeling, and action urges.

Chemical use disorders are the regular, heavy use of alcohol and drugs resulting in psychosocial dependence. “I need alcohol and drugs to psychologically feel good about myself and to socially function.”

This results in personal, social, and occupational impairment. “I cannot function personally. Things are happening personally that upset me and I cannot function socially. When I get into social situations, I upset people and create problems.”

It also creates occupational impairment. “I cannot maintain a productive job. I cannot work in a problem-free manner.

Chemical use disorders basically involve the pathological use of alcohol and other
Criminal personality disorders fall under Cluster B personality disorders which are:

- characterized by dramatic, emotional, and erratic behavior.
- include antisocial personality disorder, histrionic personality disorder, borderline personality disorder, and narcissistic personality disorder.

Criminal personality is defined as an habitual way of perceiving, thinking, feeling, and acting, and relating to others that results in constant opposition to established authority, acting out against others, and chronic and compulsive rule breaking and criminal behavior.

If a person has problems with chemical use and they continue to use alcohol and drugs in spite of the problem, he or she probably has a chemical use disorder. This is a very simple, practical, diagnostic standard.

Chemical use results from chemical use in genetically predisposed persons. Abuse does not require a genetic predisposition which is where many hard-line chemical dependency disease concept people get into trouble. They do not recognize that there are non-addictive abusers who get into trouble with alcohol and drugs. They are psychosocially predisposed. Their chemical use causes personality disorganization and life style problems, but does not cause major physiological changes or high levels of tolerance, dependence, and withdrawal. Chemical abuse is often a symptom of antisocial personality disorder. Many people with antisocial personality disorders, about 15% of the criminal population, will show up as non-addicted abusers.

Substance dependence disorders can be defined as chemical use in genetically predisposed persons that causes brain dysfunction resulting in tolerance and withdrawal, personality disorganization resulting from a toxic brain, life style problems, and progressive biopsychosocial deterioration. The chemical use problems take on a life of their own, independent of life style circumstances. For genetic research distinguishing between the progression of abuse disorders and the progression of dependency disorders, refer to George Vaillant’s book The Natural History of Alcoholism, which reports on a forty-year study of young men diagnosed in their teens who became alcohol and drug dependent.

The Relapse Progression

1. Stable Recovery
2. Relapse Warning Signs
3. Renewed Alcohol/Drug Use And Criminal Behavior

There is progression from abuse to dependence. Genetically predisposed people who use and abuse chemicals become addicted. Chemical abuse can, but does not always, progress to chemical dependency. The majority of chemically dependent people go through a progression of stages. Approximately one-third of patients will be instant alcoholics and instant addicts, whereas the other two-thirds will follow through a progression of stages.

The CENAPS Model of Treatment focuses upon the concept of a continuum of alcohol and drug problems and mirrors the President’s commission which explained in their report entitled Broading the Base of Alcoholism Treatment that it is helpful to think of degrees of severity of alcohol problems from mild, to moderate, to severe. The CENAPS Model does differ with that report in that it recognizes that people with severe alcohol and drug problems have dependence disorders. These dependence disorders constitute an objective and verifiable disease state. Once people have severe problems with alcohol and drugs, less than 2% of those people are able to return to controlled drinking. Therefore, chemically dependent people with severe alcohol and drug problems should not have the goal of controlled drinking.

On the other end, we have people with abuse disorders who have mild problems with alcohol and drugs, but are not addicted. These people will benefit from self-control training if they do not have a coexisting mental or emotional disorder that is aggravated by alcohol and drug use.

Borderline cases, the most difficult cases, either are severe abusers or early stage addicts, but it is difficult to determine which. Treatment principles are essentially the same for both disorders. How people deal with borderline cases depends upon their theoretical bias.

What are these treatment principles? Basically, recovery from chemical dependency requires three things. First, recovery requires abstinence from alcohol and drugs. A definite abstinence goal must be set and measurement techniques, such as blood alcohol and urinalysis surveillance, must be used to make sure this is being maintained.

Secondly, recovery requires identifying and changing thoughts, feelings, and behaviors and isolating the specific thoughts, feelings, and behaviors that lead a person back to chemical use. We must identify and change irrational thinking, unmanageable feelings, and self-defeating behaviors and identify and change addiction-centered life style patterns.

Thirdly, recovery requires deep personality and value change which is often called advanced recovery work or Stage II recovery work. If this deep personality change and value change does not occur, the person will relapse.

Criminal personality is defined as an habitual way of perceiving, thinking, feeling, acting, and relating to others that results in constant opposition to established authority, acting out against others, and chronic and compulsive rule breaking and criminal behaviors.

Criminal personality disorders fall under Cluster B personality disorders which are:
antisocial (compulsive rule breakers), narcissistic (egotistical, self-centered people), histrionic (disruptive attention-seekers), and chaotic (volatile).

As there is a continuum of alcohol and drug problems, there is also a continuum of criminality. The assessment of the continuum of criminality is not black or white. Problem arise with people who fall into the mid range of the continuum of criminality. There are mild, moderate, and severe problems with criminal behavior and antisocial tendencies. A majority of people have at least low level antisocial potential. This may grow into actual, observable traits that may cause people to act out in criminal ways until this escalates into criminal personality disorder where the person is out of control.

Recovery is a long-term process of biopsychosocial rehabilitation. Brief therapies will not work with chemically dependent criminal offenders who have antisocial personality traits. The CENAPS Model is the tool necessary for integrating chemical dependency and the treatment of criminal personality disorders.

Remember, there is hope! Chemically dependent criminal offenders are difficult to treat; they are not impossible to treat. Recovery is possible if both disorders are concurrently addressed and long-term treatment is provided systematically in an integrated context in the criminal justice system.

Bibliography


Is there a recognizable post-incarceration syndrome among released “lifers”?

November 5, 2013

Terence T. Gorski developed a construct for counseling long-term offenders returning to the community which he called THE POST INCARCERATION SYNDROME (PICS).

A study conducted by Marieke Lima and Maarten Kunst reviewed Gorski’s PICS model which suggests that some released prisoners experience a unique set of mental health symptoms related to, but not limited to, post-traumatic stress disorder. They sought to empirically assess whether there is a recognizable post-incarceration syndrome that captures the unique effects of incarceration on mental health.

They conducted in-depth life interviews with 25 released “lifers” (individuals serving a life sentence), who served an average of 19 years in a state correctional institution. They assessed to what extent the symptoms described by the participants overlapped with other mental disorders, most notably PTSD.

They found that a specific cluster of mental health symptoms that is related to long-term incarceration. In addition to PTSD, this cluster was characterized by:

1. Institutionalized personality traits,
2. Social–sensory disorientation, and
3. Alienation.

Our findings suggest that post-incarceration syndrome constitutes a discrete subtype of PTSD that results from long-term imprisonment.

Recognizing Post-Incarceration Syndrome (PICS) may allow for more adequate
recognition of the effects of incarceration and treatment among former inmates and ultimately, successful re-entry into society.

ON THE INTERNET:
The Psychological Impact of Incarceration: Implications for Post-Prison Adjustment
Craig Haney
University of California, Santa Cruz
December 2001
http://aspe.hhs.gov/hsp/prison2home02/haney.htm

Comprehensive Incarcerated Persons Reform, Rehabilitation, And Reentry Act
(C.I.P.R.A.), Presented To Hon. Eliot Spitzer, Governor of The State of New York
http://www.realcostofprisons.org/writing/cipra.doc

PICS Article In Science Direct

Drug War Policy: Get Tough and Be Dumb
Approaches To Addiction That Don’t Work
October 30, 2013

The abuse and addiction to alcohol and other drugs are primarily and health problems, not criminal problems. Alcoholics and Drug Addicts are sick people who need to get well, not bad people who need to be punished. More investment should be made in early intervention and treatment.

Enforcement should once again focus upon major producers and dealers. Individual who break the law while using alcohol and other drugs should be punished for the crime they committed and referred to treatment for the related alcohol or drug use disorder.

Treatment has proven to be less expensive and more effective than criminal justice interventions. Imprisonment for drug status offenses is the most expensive and least effective way to deal with the nation’s alcohol and drug problems. A primary focus on enforcement at the expense of treatment is a GET TOUGH – BE DUMB policy that has not, cannot, and will not work.

People should be prosecuted for crimes committed under the influence of alcohol and/or drugs, the only exception being drug status offenses (i.e. personal possession and use). Drunk driving, for example, is a crime and people should be responsible for putting others in harm’s way. Mandatory drunk driving programs that include treatment have much lower recidivism rates than just legal punishment of the drunk driving. Drunk driving is and should be a crime. Public intoxication is not a crime in most states. Separating the symptoms of addiction from other criminal behaviors makes it easier to see when treatment vs. punishment is most appropriate.

We need to separate the disease of alcoholism and drug addiction from criminal behavior. This is hard to do under two conditions:

(1) When people attempt to excuse all criminal behavior as a symptom of addiction and use treatment to avoid punishment; and

(2) When all alcohol and drug use is viewed as a crime to be severely punished under the mistaken belief that punishment will somehow cure addiction.

To make these distinctions we need to carefully think about our drug laws, the war on drugs, and the diagnostic standards used for both addiction and antisocial personality disorder.
Getting convicted of a drug felony can be a real buzz-killer when looking for a job in a crumbling economy. It seems like in America today no one can ever repay his or her debt to society. I know addicts with over 20 years of sobriety who were arrested and convicted on drug status offenses for personal possession and use who still find it to be a problem when trying to get a job or a security clearance.

“Only alcoholics or addicts can make themselves sober responsible people. The only thing the legal system can do is to make them miserable if they refuse to try.”
~ Judge Dennis Challeen ~

GORSKI BOOKS: www.relapse.org – GORSKI TRAINING: www.cenaps.com
GORSKI ON FACEBOOK: www.facebook.com/GorskiRecovery

LIVE SOBER – BE RESPONSIBLE – LIVE FREE

The Post Incarceration Syndrome (PICS)
October 26, 2013
By Terence T. Gorski
Permission is given to reproduce this article with proper referencing.

The Post Incarceration Syndrome (PICS) is a serious problem that contributes to relapse in addicted and mentally ill offenders who are released from correctional institutions. Currently 60% of prisoners have been in prison before and there is growing evidence that the Post Incarceration Syndrome (PICS) is a contributing factor to this high rate of recidivism. (Haney 2001, Ditton 1999)

The concept of a post incarceration syndrome (PICS) has emerged from clinical consultation work with criminal justice system rehabilitation programs working with currently incarcerated prisoners and with addiction treatment programs and community mental health centers working with recently released prisoners.

This article will provide an operational definition of the Post Incarceration Syndrome (PICS), describe the common symptoms, recommend approaches to diagnosis and treatment, explore the implications of this serious new syndrome for community safety, and discuss the need for political action to reduce the number of prisoners and assure more humane treatment within our prisons, jails, and correctional institutions as a means of prevention. It is my hope that this initial formulation of a PICS Syndrome will encourage researchers to develop objective testing tools and formal studies to add to our understanding of the problems encountered by released inmates that influence recovery and relapse.

Post Incarceration Syndrome (PICS) – Operational Definition
The Post Incarceration Syndrome (PICS) is a set of symptoms that are present in many currently incarcerated and recently released prisoners that are caused by being subjected to prolonged incarceration in environments of punishment with few opportunities for education, job training, or rehabilitation. The symptoms are most severe in prisoners subjected to prolonged solitary confinement and severe institutional abuse. (The severity of symptoms is related to the level of coping skills prior to incarceration, the length of incarceration, the restrictiveness of the incarceration environment, the number and severity of institutional episodes of abuse, the number and duration of episodes of solitary confinement, and the degree of involvement in educational, vocational, and rehabilitation programs.

The Post Incarceration Syndrome
(PICS) is a mixed mental disorders with four clusters of symptoms:

(1) Institutionalized Personality Traits resulting from the common deprivations of incarceration, a chronic state of learned helplessness in the face of prison authorities, and antisocial defenses in dealing with a predatory inmate milieu,
Post Traumatic Stress Disorder (PTSD) from both pre-incarceration trauma and trauma experienced within the institution,

Antisocial Personality Traits (ASPT) developed as a coping response to institutional abuse and a predatory prisoner milieu, and

Social-Sensory Deprivation Syndrome caused by prolonged exposure to solitary confinement that radically restricts social contact and sensory stimulation.

Substance Use Disorders caused by the use of alcohol and other drugs to manage or escape the PICS symptoms.

PICS often coexists with substance use disorders and a variety of affective and personality disorders.

Symptoms of the Post Incarceration Syndrome (PICS)

Below is a more detailed description of four clusters of symptoms of Post Incarceration Syndrome (PICS):

1. Institutionalized Personality Traits:
   Institutionalized Personality Traits are caused by living in an oppressive environment that demands: passive compliance to the demands of authority figures, passive acceptance of severely restricted acts of daily living, the repression of personal lifestyle preferences, the elimination of critical thinking and individual decision-making, and internalized acceptance of severe restrictions on the honest self-expression thoughts and feelings.

2. Post Traumatic Stress Disorder (PTSD)
   Post Traumatic Stress Disorder (PTSD) is caused by both traumatic experiences before incarceration and institutional abuse during incarceration that includes the six clusters of symptoms:
   (1) Intrusive memories and flashbacks to episodes of severe institutional abuse;
   (2) Intense psychological distress and physiological reactivity when exposed to cues triggering memories of the institutional abuse;
   (3) Episodes of dissociation, emotional numbing, and restricted affect;
   (4) Chronic problems with mental functioning that include irritability, outbursts of anger, difficulty concentrating, sleep disturbances, and an exaggerated startle response.
   (5) Persistent avoidance of anything that would trigger memories of the traumatic events;
   (6) Hyper-vigilance, generalized paranoia, and reduced capacity to trust caused by constant fear of abuse from both correctional staff and other inmates that can be generalized to others after release.

   PTSD related to PICS may be the result of the traumatic grief that arises as a result of interpersonal trauma experienced as a betrayal of attachment. Leach and colleagues reported in The distinct set of symptoms associated with it were first recognized in the 1990s. Losses associated with traumatic grief can be either death or non-death related. A variety of studies have demonstrated that many prisoners have suffered from losses and trauma throughout their lives, and in many instances they have never received any support or interventions to address resultant problems. There is convincing evidence that there could be a relationship between many of the maladaptive behaviors demonstrated by the prisoners reported in the paper as PICS and may be related to the high rates of recidivism seen in many developed countries (and which in Australia have been reported as high as 77%) may be related to traumatic grief. (Leach et al 2008)

3. Antisocial Personality Traits
   Antisocial Personality Traits (APA 1994, Forrest 1994, Hemple et al 1995) are developed both from preexisting symptoms and symptoms developed during incarceration as an institutional coping skill and psychological defense mechanism. The primary antisocial personality traits involve the tendency to challenge authority, break rules, and victimize others. In patients with PICS these tendencies are veiled by the passive aggressive style that is part of the institutionalized personality.

   Patients with PICS tend to be duplicitous, acting in a compliant and passive aggressive manner with therapists and other perceived authority figures while being capable of direct threatening and aggressive behavior when alone with peers outside of the perceived control of those in authority.

   This is a direct result of the internalized coping behavior required to survive in a harshly punitive correctional institution that has two set of survival rules: passive aggression with the guards, and actively aggressive with predatory inmates.

4. Social-Sensory Deprivation Syndrome
   The Social-Sensory Deprivation Syndrome is caused by the effects of prolonged solitary confinement that imposes both social isolation and sensory deprivation. These symptoms include severe chronic headaches, developmental regression, impaired impulse control, dissociation, inability to concentrate, repressed rage, inability to control primitive drives and instincts, inability to plan beyond the moment, inability to anticipate logical consequences of behavior, out of control obsessive thinking, and borderline personality traits.

5. Reactive Substance Use Disorders
   Many inmates who experience PICS suffer from the symptoms of substance use disorders. Many of these inmates were addicted prior to incarceration, did not receive treatment during their imprisonment, and continued their addiction by
securing drugs on the prison black market.

Others developed their addiction in prison in an effort to cope with the PICS symptoms and the conditions causing them. Others relapse to substance abuse or develop substance use disorders as a result of using alcohol or other drugs in an effort to cope with PICS symptoms upon release from prison.

PICS Symptoms Severity

The syndrome is most severe in prisoners incarcerated for longer than one year in a punishment oriented environment, who have experienced multiple episodes of institutional abuse, who have had little or no access to education, vocational training, or rehabilitation, who have been subjected to 30 days or longer in solitary confinement, and who have experienced frequent and severe episodes of trauma as a result of institutional abuse.

The syndrome is least severe in prisoners incarcerated for shorter periods of time in rehabilitation oriented programs, who have reasonable access to educational and vocational training, and who have not been subjected to solitary confinement, and who have not experienced frequent or severe episodes of institutional abuse.

Reasons To Be Concerned About PICS

There is good reason to be concerned because about 40% of the total incarcerated population (currently 700,000 prisoners and growing) are released each year. The number of prisoners being deprived of rehabilitation services, experiencing severely restrictive daily routines, being held in solitary confinement for prolonged periods of time, or being abused by other inmates or correctional staff is increasing. [viii]

The effect of releasing this number of prisoners with psychiatric damage from prolonged incarceration can have a number of devastating impacts upon American society including the further devastation of inner city communities and the destabilization of blue-collar and middle class districts unable to reabsorb returning prisoners who are less likely to get jobs, more likely to commit crimes, more likely to disrupt families. This could turn many currently struggling lower middle class areas into slums. [ix]

As more prisoners are returned to the community, behavioral health providers can expect to see increases in patients admitted with the Post Incarceration Syndrome and related substance use, mental, and personality disorders. The national network of Community Mental health and Addiction treatment Programs need to begin now to prepare their staff to identify and provide appropriate treatment for this new type of client.

The nation’s treatment providers, especially addiction treatment programs and community mental health centers, are already experiencing a growing number of clients experiencing the Post Incarceration Syndrome (PICS). This increase is due to a number of factors including: the increasing size of the prisoner population, the increasing use of restrictive and punishing institutional practices, the reduction of access to education, vocational training, and rehabilitation programs; the increasing use of solitary confinement and the growing number of maximum security and super-max type prison and jails.

Both the number of clients suffering from PICS and the average severity of symptoms is expected to increase over the next decade. In 1995 there were 463,284 prisoners released back to the community. Based upon conservative projections in the growth of the prisoner population it is projected that in the year 2000 there will be 660,000 prisoners returned to the community, in the year 2005 there will 887,000 prisoners returned to the community, and in the year 2010 1.2 million prisoners will be released. [x] The prediction of greater symptom severity is based upon the growing trend toward longer periods of incarceration, more restrictive and punitive conditions in correctional institutions, decreasing access to education, vocational training, and rehabilitation programs; the increasing use of solitary confinement and the growing number of maximum security and super-max type prison and jails.

Clients with PICS are at a high risk for developing substance dependence, relapsing to substance use if they were previously addicted, relapsing to active mental illness if they were previously mentally ill, and returning to a life of aggression, violence, and crime. They are also at high risk of chronic unemployment and homelessness. (Leach et al 2008)

Post Release Symptom Progression

This is because released prisoners experiencing PICS tend to experience a six stage post release symptom progression leading to recidivism and often are not qualified for social benefits needed to secure addiction, mental health, and occupation training services.

Stage 1 of this Post Release Syndrome is marked by Helplessness and hopelessness due to inability to develop a plan for community reentry, often complicated by the inability to secure funding for treatment or job training;

Stage 2 is marked by an intense immobilizing fear;

Stage 3 is marked by the emergence of intense free-floating anger and rage and the emergence of flashbacks and other symptoms of PTSD;

Stage 4 is marked by a tendency toward impulse violence upon minimal provocation;

Stage 5 is marked by an effort to avoid violence by severe isolation to avoid the triggers of violence;
Stage 6 is marked by the intensification of flashbacks, nightmares, sleep impairments, and impulse control problems caused by self-imposed isolation. This leads to acting out behaviors, aggression, violence, and crime, which in turn sets the stages for arrest and incarceration.

Currently 60% of prisoners have been in prison before and there is growing evidence that the Post Incarceration Syndrome (PICS) is a contributing factor to this high rate of recidivism.

Reducing The Incidence Of PICS

Since PICS is created by criminal justice system policy and programming in our well-intentioned but misguided attempt to stop crime, the epidemic can be prevented and public safety protected by changing the public policies that call for incarcerating more people, for longer periods of time, for less severe offenses, in more punitive environments that emphasize the use of solitary confinement, that eliminate or severely restrict prisoner access to educational, vocational, and rehabilitation programs while incarcerated.

The political antidote for PICS is to implement public policies that:

(1) Fund the training and expansion of community based addiction and mental health programs staffed by professionals trained to meet the needs of criminal justice system clients diverted into treatment by court programs and released back to the community after incarceration;

(2) Expand the role of drug and mental health courts that promote treatment alternatives to incarceration;

(3) Convert 80% of our federal, state, and county correctional facilities into rehabilitation programs with daily involvement in educational, vocational, and rehabilitation programs;

(4) Eliminate required long mandated minimum sentences;

(5) Institute required universal prerelease programs for all offenders with the goal of preparing them to transition into community based addiction and mental health programs;

(6) Assuring that all released prisoners have access to publicly funded programs for addiction and mental health treatment upon release.

READ PERSONAL ACCOUNTS OF EXPERIENCES WITH PICS:
– A Personal Case Study With Post Incarceration Syndrome

REFERENCES:

Abramsky, Sasha; When They Get Out, Atlantic Monthly, June, 1999 p. 30

American Psychiatric Association, Diagnostic and Statistical Manual of Mental Disorders (DSM IV), Fourth Edition, 1994 (Pg 424 – 429; Pg 645 – 650; Pg 175 – 272)

Ditton, Paula M. Mental Health and Treatment of Inmates and Probationers, Bureau of Justice Statistics, July 11, 1999 (NCJ-174463), (http://www.ojp.usdoj.gov/bjs/)


Sabol, William, Urban Institute, Washington DC
An aggressive expletive supplement to an obscene hand gesture (typically unraised middle finger) directed at someone the insulting party believes to be a heavy user of web-based computer services that feature "share this" links. The line-cutter turns to the objector, raises a middle finger and states menacingly, "Hey, dweeb. Share this!" #expletive #rss #twitter #tweet #share this. by TrumanBurbank April 09, 2011. 3. 1. Get a Share this! mug for your daughter Zora. buy the domain for your pet vlog. sharethis.club. sharethis.life. Customize, download and install our easy-to-use share buttons and other publishing tools for your website or blog. Grow your audience. Win the internet!  Grow Your Audience. Tools to enhance your site and engage your visitors. Get Share Buttons. Free To Use • Easy Installation • Mobile Optimized. Grow Your Audience. Tools to enhance your site and engage your visitors. Get Share Buttons. Free To Use • Easy Installation • Mobile Optimized. Tools trusted by millions of publishers.