

**Criminal convictions and psychosocial variables of  
765 drug abusers who sought treatment at  
William Street Clinic  
January 1979 - December 1982  
Perth, Western Australia,**

**Paper presented at 53rd ANZAAS Congress  
Perth Western Australia**

**May 16-20 1983**

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## Introduction

There is deep concern in the community about the social and economic costs of drug addiction, particularly in relation to heroin addiction: Alexander & McCaslin (1974); Austin & Lettieri (1976); Chambers (1974); Cushman (1974); Greene (1981); Greenberg & Adler (1974); Lukoff (1974); Maddux & Desmond (1979); Messinger & Zitrin (1965); Mott (1981); O'Donnell (1966); Wardlaw (1978); and Winick (1967). This body of literature, which has focussed on the consequences of heroin addiction rather than on the wider range of equally addictive and harmful drugs such as alcohol, has identified an association between drug addiction and crime.

As heroin use has been recognised as exacting high personal, social and economic costs for both the individual and society, this has stimulated the study of antecedent factors that may result in addiction, which if they could be identified, could mean that investment in preventive programs would be cost effective and provide longer term benefits and savings.

For this reason a large amount of research has been undertaken to identify and demonstrate what, if any, developmental, familial and psychological factors may be associated with or predispose a person to becoming addicted to heroin. For instance, British studies which have shown heroin addicts tend to have histories of juvenile delinquency prior to their introduction to opiates, suggest heroin addicts may not resort to crime solely for reasons of economic necessity to support a heroin habit. One such view states that

*“(a)ccceptance of a drug habit by young addicts involved identification with delinquent patterns and the development of a criminal lifestyle. These young patients came from a delinquent population with a potential for antisocial activity which attracted them towards a drug habit. Their criminality and drug dependency emerged as a combined expression of a general deviancy.”* Gordon (1973: 209)

Research by Mott (1975) indicated that the use of opiates by males increased when there are prior criminal convictions whereas other research by Wiepert et al (1979) found that there is a significant prognostic implication of a history of juvenile delinquency in females and subsequent addiction. There is also Australian research by Egger et al (1976) that supports the predictive value of juvenile delinquency and specific family background variables, such as family instability, illness in the household, alcohol abuse and psychiatric problems in a parent, as factors predictive of addiction.

## Source of data

In January 1979 the Western Australian Alcohol and Drug Authority (ADA) introduced a standardised assessment module, which included a ‘drug users module’, for welfare and medical staff to complete when assessing all first time admissions for those seeking treatment for drug problems to its residential and non-residential programs based in Perth, Western Australia (WA).

This assessment module was completed at first interview by a social worker, as part of a social assessment in conjunction a subsequent separate medical and health assessment by a medical practitioner, to support a treatment plan. Data collected for the drug use module by a social worker was used to support an evaluation and assessment of treatment suitability and setting of goals and included information provided by a client about the principal drug of abuse and other types of drug use, involving details of age of initiation, quantity and patterns of use, duration of use, mode of administration for each type of drug.

The assessment was structured to elicit a history of drug use by asking a person at admission to provide a detailed history of heroin use to enable decision making about the type of pharmacological support that would be provided as treatment, with the preferred treatment being linctus methadone dispensed and consumed on a daily basis from an onsite pharmacy.

In July 1979 the ADA established a separate treatment facility known as William Street Clinic (WSC) in Northbridge, an inner city central admission and outpatient treatment facility for all persons with primary drug problems related to substances other than alcohol. (Prior to the establishment of WSC the ADA conducted combined inpatient and outpatient treatment and assessment facilities in West Perth for those with problems primarily related to alcohol as well as other types of drugs such as prescription drugs, hallucinogens, amphetamine type stimulants and heroin.)

The purpose of WSC was to separately assess and treat those who had problems related to illicit drugs from those attending the alcohol oriented programs which had operated in West Perth since 1974 and to conduct an oral methadone program for the management of heroin addicted individuals in the Perth metropolitan area.

## **Methods**

A retrospective study was conducted of all new admissions in the four year period from January 1979 to December 1982. Data from the drug users module concerned with offending, familial, demographic and social variables was extracted and analysed to identify possible antecedents of the population of individuals who primarily sought treatment at ADA for heroin addiction.

Although the WSC sample cannot be regarded as representative of the population of heroin users in Perth, the survey is of value because it represents, in particular, a large opportunistic sample of heroin addicts who attended a West Australian methadone clinic. The sample may also provide additional information about antecedent factors and characteristics of Australian drug users who sought treatment for a range of drug problems, excluding alcohol, at a specific purpose facility.

## **Limitations of data**

This data may lack external validity to substantiate recall of self reported drug use. The problem of the reliability and validity of self report measure has been recognised in the area of crime: Kraus & Bowmaker (1982); and Warner (1982) and the use of alcohol: Maisto et al (1982). Though most of the concern about validity of self reports of drug use relates to questionnaires, the research in this area indicates recent and current drug use is under reported: Bale (1979); Dube et al (1981); and Goodstadt et al (1978).

In relation to heroin users, it is suggested that some of data elicited during the assessment session may involve over reporting rather than under reporting of heroin use, even though studies reported by Stanton (1977) indicate heroin addicts do not routinely distort past drug usage. Over reporting may have occurred due to a demand function arising from the assessment process as there was a requirement that an individual needed to demonstrate sufficient severity of current addiction to maximise the likelihood of acceptance into the methadone program.

In some instances clients may have been required to undergo a naloxone antagonist test to verify the existence of a current addiction to heroin. Also, as a number of those who sought admission to treatment were also facing pending court appearances, it was advantageous for there to be an account of a severe level of addiction at admission, as subsequently this could be an important factor to be used in sentencing to mitigate offending following conviction where the addiction was considered to have contributed to offending.

## **Results and Discussion**

### **Primary drug of abuse**

In the four year period a total of 765 persons were admitted to the ADA's outpatient program at WSC for the treatment of a drug (other than alcohol) related problem. Analysis of the frequency of the prime drug of abuse of the 761 clients for whom there is valid data indicated that opiate abuse (ie heroin, methadone or other opioid) constituted three quarters (74.9%) of all admissions. See Table 1 (page 7).

Of these 570 persons in the opioid group, 16 were a special group of licit opiate abusers, persons who were referred to the ADA for assessment so that they could continue to receive a prescription analgesic (Schedule 8 drug) for the continued management of chronic pain condition by their own general practitioner under authority of the Commissioner for Public Health.

In Table 1 (page 7) shows that heroin was the most significant primary drug of abuse, involving 56.2% of the sample, followed by the other opiates group (12.4%) and the methadone group (6.3%). Overall there were a total of 554 intravenous opiate users who sought treatment at WSC.

## **Birthplace**

Of the 736 persons for which there was valid data concerning birthplace, 509 were recorded as being born in Australia, of whom 241 (32.7%) were Western Australian born. The relatively low proportion of West Australian born persons may indicate that mobility could be a factor for a sizeable proportion of those attending WSC, especially given as there were restrictive criteria applied at this time for people being able to readily enter methadone treatment programs in New South Wales, Victoria or Queensland.

The high mobility of heroin users has been noted by Bell (1980) and confirms that sensitivity to differential law enforcement activities can mean that heroin addicts will shift from one jurisdiction to another. If the majority of the population of persons born outside of WA who attended WSC were doing so to avoid police or because of limited or narrowly defined treatment services in their usual State of residence, this underscore the need for a coordinated national approach to the management of those addicted to heroin.

## **Age**

The mean age of the sample was 26 years (SD = 6.73), with the oldest group being those who were abusers of prescription type drugs (Table 1, page 7).

## **Use of different drug groups**

The drug use module had a detailed list of specific drugs that were grouped pharmacologically. All clients at admission were asked usage of any of these drugs and the age of first use of any drug in each group. Results of these responses provided a frequency distribution of drug usage by the population who attended WSC and indicates that except for anti histamines and barbiturates, there were generally high frequencies of use of a wide range of drugs by those who sought treatment at WSC.

Table 2 (page 8) indicates there was a progression with age in drug use, from the use of tobacco and alcohol in mid teens, followed by cannabis (mean age 16 years) and hallucinogens such as LSD and psilocybin (mean age 18 years), then by late teens use of psychostimulants, sedatives, hypnotics and tranquillisers medication and use of opiates (mean age 20 years). A similar clustering and age related hierarchy of drug use has been reported elsewhere: Hamburg et al (1975).

There was an earlier mean age of first usage by females than males for a number of drugs, but this difference only achieved significance at the .05 level in relation to use of hallucinogens, hypnotics, barbiturates and tranquillisers, sedatives and anti depressants.

Similar gender related differences with high rates of use by females than males of these types of drugs has been reported in community surveys: Healy (1979); and Heine and Mant (1979). However, this finding appears to contradict results from a survey of a non treatment population which indicated a distinct pattern of an earlier age of drug usage by males than females: Fleming et al (1982).

## Offending

The five dichotomised variables for which criminal convictions were recorded in the drug use module were - being on probation at admission, having prior convictions as a juvenile, having convictions for one or more drink driving offences, having drug convictions and having other convictions.

Table 3 (page 8) which summarise the analysis of these five variables and shows that for all variables except the probation variable, the differences between males and females reached statistical significance and would appear to support other research that there are higher levels of social deviance by males than females: Warner (1982).

Table 4 (page 8) indicate there was a difference between those with or without convictions on the three conviction variables (ie juvenile convictions, drug convictions and other convictions), with respect to age of first usage of opiates and alcohol, duration of years of intravenous drug use at the time of admission and mean age at admission. Statistically significant differences for age and duration of use variables occur between those who had and had not been convicted.

Table 4 (page 8) also shows that offenders are younger at admission than non-offenders. It may be offenders are more heavily involved in drugs and require treatment at an earlier age. However, it was found that only the drug offender group had a statistically significant longer duration of time from first use of an opiate to admission for treatment for drug abuse.

## Psychosocial factors

In the drug use module data was also collected on a range of psychosocial variables. These were sex, birthplace (Australia or non Australia), living circumstances (with two parents, with spouse/cohabitation, with one parent or family relatives, sharing with friends, at group quarters or alone), family upbringing to age 18 (intact or disrupted), parents marital status (at admission), marital status (cohabiting or not cohabiting, own alcohol use (problem or no problem), problematic alcohol use in family (problem or no problem and problematic drug use in family (problem or no problem).

Table 5 (page 9) summarises the major findings with respect to these variables. Statistically significant differences were found on a small number of the variables, involving the upbringing and alcohol use variables, which were found to be significantly related to juvenile convictions and other convictions, but not to drug convictions.

A reported family history of drug problems was related to drug convictions and family history of alcohol was related to other convictions, though these differences were just outside the 5% significance level.

## Conclusion

The results of this retrospective descriptive study of 765 clients who presented for treatment for the first time at WSC with a primary non alcohol drug problem indicates opiate users constituted the largest single group. The results from analysis of the psychosocial variables in this population of drug users would indicate that for many of these individuals there is an increased likelihood of non drug problems of one kind or another in late teens and early adulthood: Hamburg et al (1975); and Graeven & Schaefer (1978).

The results from this survey appear to support the proposition that drug abusers who had committed juvenile offences were involved in alcohol use and opiate use at an earlier age than non-offenders, suggestive as being a consequence of an overall pattern of social deviance. The earlier introduction to drugs and the subsequent development of abuse problems seems to be related to the interaction of an individual's involvement in a deviant lifestyle and the specific problems in his/her family or origin, such as parental separation and drug and alcohol problems in other family members.

The earlier use of alcohol seems to be predictive of the development of drinking problems and this may to an unknown extent may also increase the likelihood of committing and being convicted for criminal offences.

The duration of time between reported first opiate use and presentation for treatment does not necessarily mean that for an individual all of this time involved to heroin. But it would seem many heroin users would have been required to sustain a continuous involvement over extended periods of time in crime and other high income producing lifestyles to be able to minimise the too frequent occurrence of withdrawal symptoms and other negative consequences of drug addiction.

Other findings suggested a familial history of alcohol and other drug problems were related to subsequent deviance. For instance, with respect to a significant number of male drug abusers, there was a history of difficulties with their own use of alcohol, which seemed to be significant in the increased likelihood of troubles with the law.

Those clients who had a previous conviction were found to have had an earlier age of usage of opiates and alcohol, were younger at admission and had been injecting drugs and using opiates over a longer duration of time than persons not convicted for any offence. A history of juvenile convictions seemed to be specifically related to the earlier use of opiates and alcohol.

There may also be an increased occurrence of heroin addiction if a person was convicted as part of a pattern of offending involving use of a wide range of both licit and illicit drugs from their teenage years. The findings of a high level of prior offending in this WA treatment population lend credence to the view that

*“if addiction is conceptualised as a form of immaturity, then it is not surprising to find that: (a) the disorder, like adolescence, gets better with time; (b) when symptoms are removed, they need not be replaced with others; and (c) ex-addicts can manifest new defences. If the addict's brief defect is related to immaturity, it is not surprising that stable early object relations and previous ability to achieve independence (eg employment) should be more important to prognosis than drug use per se.”* Vaillant (1966: 583)

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## Tables

**Table 1: Drug group at admissions by mean age**

Drug group	Cases	Mean age	SD	%
Heroin	428	24.45	3.634	56.2
Methadone	48	26.01	6.533	6.3
Other opioids	94	30.83	10.488	12.3
Hypnotics	12	29.97	11.128	1.6
Benzodiazepines	44	29.83	11.189	5.8
Barbiturates	30	25.61	7.847	4.0
Phenothiazines	3	30.64	7.847	0.4
Antidepressants	2	30.92	0.943	0.3
Psychostimulants	19	25.49	8.027	2.5
Hallucinogens	14	21.92	5.343	1.8
Cannabis	25	21.74	3.562	3.3
Anti histamines	6	19.22	2.589	0.8
Cough mixtures	24	22.96	3.149	3.1
Other	12	23.33	7.802	1.6
<b>Total</b>	<b>761</b>	<b>25.59</b>	<b>6.735</b>	<b>100.0</b>

**Table 2: Mean age of first usage of drugs (all admissions) by sex**

Drug group	Mean age first used			Significance
	Males	Females	Persons	
Tobacco (n = 622)	14.47	14.92	14.64	F = 2.381, df = 1, 621, NS
Alcohol (n = 620)	15.12	15.49	15.25	F = 2.511, df = 1, 619, NS
Cannabis (n = 627)	16.31	16.22	16.28	F = 0.114, df = 1, 626, NS
Hallucinogens (n = 532)	17.78	17.09	17.53	F = 7.185, df = 1, 531, p = .008
Anti-histamine (n = 293)	19.0	18.51	18.83	F = 0.943, df = 1, 292, NS
Psychostimulants (n = 463)	19.0	18.98	19.32	F = 2.491, df = 1, 462, NS
Hypnotics (n = 499)	19.91	18.98	19.55	F = 3.80, df = 1, 498, p = .05
Barbiturates (n = 360)	20.32	19.02	19.80	F = 5.57, df = 1, 359, p = .019
Opiates (n = 639)	20.23	19.57	20.0	F = 2.258, df = 1, 638, NS
Tranquilliser/sedatives/anti-depressants (n = 545)	20.97	19.59	20.44	F = 6.943, df = 1, 544, p = .009

**Table 3: Prior convictions at admission by sex**

Conviction variable	Sex	n	%	Significance
On probation	M (n = 435)	52	12.0	$\chi^2 = 0.342$ , df = 1, NS
	F (n = 246)	34	13.8	
Juvenile convictions	M (n = 407)	124	30.5	$\chi^2 = 15.815$ , df = 1, p = <.001
	F (n = 237)	38	16.0	
Drink driving/DUI convictions	M (n = 413)	85	20.6	$\chi^2 = 29.836$ , df = 1, p = <.001
	F (n = 231)	10	4.3	
Drug convictions	M (n = 431)	188	43.6	$\chi^2 = 7.457$ , df = 1, p = .006
	F (n = 237)	77	32.5	
Other convictions	M (n = 424)	191	45.0	$\chi^2 = 17.299$ , df = 1, p = <.001
	F (n = 240)	68	28.3	

**Table 4: Convictions by selected age and duration of use variables**

	Yes	No	Significance
<b>Juvenile convictions</b>			
Mean age first used opiate	18.30	20.49	F = 19.194, df = 1, 566, p = <.001
Mean age first used alcohol	14.04	15.6	F = 32.891, df = 1, 567, p = <.001
Years of intravenous use	5.05	4.18	F = 7.123, df = 1, 492, p = .008
Mean age at admission	23.59	26.05	F = 18.314, df = 1, 640, p = .001
Years from first opiate use to admission	5.48	5.19	F = 0.570, NS
<b>Drug convictions</b>			
Mean age first used opiate	18.87	20.73	F = 18.922, df = 1, 589, p = <.001
Mean age first used alcohol	14.88	15.45	F = 5.596, df = 1, 585, p = .018
Years of intravenous use	5.08	3.91	F = 17.592, df = 1, 518, p = <.001
Mean age at admission	24.53	26.09	F = 9.797, df = 1, 663, p = .002
Years from first opiate use to admission	5.71	5.04	F = 4.13, df = 1, 587, p = .043
<b>Other convictions</b>			
Mean age first used opiate	19.0	20.5	F = 11.955, df = 1, 586, p = .001
Mean age first used alcohol	14.79	15.49	F = 8.432, df = 1, 581, p = .004
Years of intravenous use	4.94	4.14	F = 7.685, df = 1, 512, p = .006
Mean age at admission	24.36	26.15	F = 12.73, df = 1, 660, p = .001
Years from first opiate use to admission	5.50	5.21	F = 0.786, NS

**Table 5: Selected cross tabulations by psychosocial variables**

	n	%	Significance
<b>Juvenile convictions</b>			
Raised in intact family (n = 463)	104	22.5	$\chi^2 = 5.847$ , df = 1, p = 0.016
Raised in disrupted family (n = 181)	58	32.0	
Alcohol use - self: no problem (n = 435)	96	22.1	$\chi^2 = 7.760$ , df = 1, p = .005
Alcohol use - self: problem (n = 157)	53	33.8	
<b>Drug convictions</b>			
Drug use - family: no problem (n = 417)	153	36.7	$\chi^2 = 3.484$ , df = 1, p = .062
Drug use - family: problem (n = 113)	53	46.9	
<b>Other convictions</b>			
Raised in intact family (n = 477)	172	36.1	$\chi^2 = 5.752$ , df = 1, p = .016
Raised in disrupted family (n = 187)	87	46.5	
Alcohol use - self: no problem (n = 439)	151	34.4	$\chi^2 = 12.226$ , df = 1, p = <.001
Alcohol use - self: problem (n = 167)	84	50.3	
Alcohol use - family: no problem (n = 389)	138	35.5	$\chi^2 = 3.56$ , df = 1, p = .059
Alcohol use - family: problem (n = 157)	70	44.6	