

The relationship between drugs and violence in the United States of America

BOX 3B

Dr. Paul J. Goldstein

There are no standardized empirical indicators, nor is there even a consensus, on definitions of drug-related violence. There are no national data bases in the United States of America, in the criminal justice or the health care systems, that routinely specify the relationship between drugs and violence. Certainly there are no data that allow for comparative analyses of drug-related violence, or comparative assessments of trends over time, between nations or other localities.

A decade ago the author formulated a tripartite conceptual framework of the relationships between drugs and violence.¹ The intent was to provide a 'definition' of drugs/violence relationships that could advance both research and practice. Drugs and violence, it was argued, could be related in three different ways – psycho-pharmacologically, economic-compulsively, or systemically.

The psycho-pharmacological model suggests that some persons, as a result of ingesting specific substances, may become excitable and/or irrational, and may act in a violent fashion. Psycho-pharmacological violence may also result from the irritability associated with withdrawal syndromes or 'crashes' from particular substances; and may involve substance use by either victims or perpetrators of violent events. In other words, substance use may contribute to a person behaving violently, or it may alter a person's behaviour in such a manner as to bring about that person's violent victimization. Finally, some persons may ingest substances purposively in order to reduce nervousness or to boost courage and thereby facilitate the commission of previously intended violent crimes.

The economic compulsive model suggests that some persons feel compelled to engage in economic crimes in order to finance costly drug use. Sometimes these economic crimes are inherently violent, as in the case of robbery, and sometimes the violence results from an unintended or extraneous factor in the social context in which the economic crime is perpetrated. Such factors include the perpetrator's nervousness, the victim's reaction, the presence or absence of weapons carried by either victim or perpetrator, the intercession of bystanders, and so on.

The systemic model refers to the normally aggressive patterns of interaction within systems of drug distribution. Most systemic violence arises from the conditions of doing business in a black market. Examples of systemic violence include territorial disputes between rival dealers, assaults and homicides committed within particular drug dealing operations in order to enforce normative codes, robberies of drug dealers, elimination of informers, punishment for selling adulterated or bogus drugs, assaults to collect drug-related debts.

A series of research studies were undertaken to validate and elaborate on the tripartite conceptual framework. These projects included ethnographic studies of male and female drug users and distributors in New York City; retrospective analyses of police records on homicides throughout New York State; prospective analyses of police data on homicides during active case investigations in New York City.² Key findings are described below.

Economic compulsive violence was rare in all studies. Substance users generally supported their drug use through non-violent economic crime, e.g.,

prostitution, petty theft such as shoplifting, con-games, or through working in the illicit drug business. These illicit 'career options', combined with typically short-term and/or part-time employment, reduced the likelihood that substance users would engage in violent predatory theft.

Psycho-pharmacological and systemic violence were the most common forms of drug-related violence. Psycho-pharmacological violence was most frequently (75% – 95% of the time in all studies) associated with alcohol use, but tended not to have fatal outcomes. Recurring contexts for psycho-pharmacological violence included spousal altercations, fights in bars or in parks between young males, confrontations between prostitutes and inebriated customers.

Systemic violence tended to be associated with whatever particular drug was dominating illicit street markets at the time that data were being collected. Through the roughly fifteen years that the author has been engaged in drugs/violence research, the primary drug related to systemic violence has changed from heroin to powder cocaine to crack cocaine. Had the research been undertaken in the USA in the 1930s, the primary illicit drug associated with systemic violence would, undoubtedly, have been alcohol.

A certain cyclical pattern appears to occur with regard to systemic violence. When a new drug first begins to 'take off' in popularity, and the number of new users is growing exponentially, there seems to be little violence. This is because there is more demand than supply, dealers are primarily focused on obtaining sufficient product to meet demand, and there is little reason to invade another dealer's 'turf' when one cannot even meet demand in one's own territory. Increases in one's pool of customers are achieved naturally because of increasing numbers of customers in a specific territory. This phase of an emerging drug market tends to be relatively brief in specific locations. It lasts for about six months.

Violence tends to begin to rise when the growth rate in the number of new users begins to level out. Dealers are now obtaining increased supply, demand is levelling off and, in order to increase

market share, it becomes necessary to invade rival territories. Dealers also become more conscious of their need to limit costs in their enterprise, such as subordinates who are stealing drugs or money from them. Such persons are likely to be physically beaten or killed. Finally, users who have become used to the new drug begin to perpetrate con-games, such as selling bogus drugs, in order to support their continued use. Such con-games may result in violent altercations. Violence may occur between fraudulent sellers and duped purchasers, or as a response against sellers of bogus drugs by dealers who wish to prevent their 'turf' from getting a bad reputation among potential purchasers.

When drug-related homicides occur, the vast majority is systemic in nature. In part this is because drug traffickers usually carry firearms, and spontaneous altercations are most likely to end in death if one or more of the parties involved is armed. In part this is because the violence may have been initiated in an instrumental fashion specifically designed to kill an intended victim, e.g., to eliminate a rival dealer, to 'make an example' of a subordinate who had violated norms in a drug-dealing operation.

Much systemic violence, while occurring in a drug context, is also 'face-saving' violence. Persons who are cheated on a drug transaction, or low-level drug dealers whose territory is infringed upon, may retaliate in order to save face. These persons might be equally likely to retaliate violently if they were cheated in a card game, or if their spouse or lover was cheating on them. It is possible to speculate that individuals with low self-esteem, and few accomplishments to feel proud about, would feel the most ego-threat from loss of face in a particular situation and be the most likely to respond violently. If illicit drug markets were to go away tomorrow, much of the systemic violence that currently occurs within a drug context and is related to saving face might still occur, just in a different, non-drug-related context.

These findings provide evidence that certain common assumptions about drug-related violence are incorrect or exaggerated, or are the result of misinterpretation of data.³ A critical research question, which has important policy implications,

is whether risks for drug-related violence exist primarily in the effects of the drugs (i.e., psycho-pharmacological), or in certain socio-economic or legal contexts (i.e., systemic or economic compulsive) in which drug users and traffickers operate.

Participants in current drug policy debates, e.g., legalization vs prohibition vs harm reduction, frequently take sides on this research question on the basis of ideology rather than information. A comparison of two of the previously cited studies illuminates some of the issues involved.

A 1986 retrospective analysis of police records on all homicides that occurred in 1984 in New York State (N=1768) was performed.⁴ It was found that police did not record useful information pertinent to drug relatedness. New York City, which accounted for 83% of the state's homicides that year, would not let the research team examine their case files individually and were eliminated from the analysis. Thus, data on these 1984 homicides were collected from small cities, towns and rural areas in New York State, and were extracted from police case files not maintained for the purpose of documenting the drug relatedness of homicide.

A 1988 study addressed the inadequacies inherent in using existing police records to attempt to document drug relatedness of violence. In this study,⁵ a data collection instrument was included in detectives' case files in a sample of precincts in New York City. The data collection form was designed to gather a wide range of information about the drug relatedness of homicide that is not typically gathered by police. Formerly, when such information was known to the police, it was seldom recorded in a systematic fashion. Collection of data was supplemented by follow-up interviews with investigating detectives.

Data from the 1984 study indicated that most drug-related homicides were psycho-pharmacological. Data from the 1988 study indicated that a majority of the drug-related homicides were systemic. It is difficult to account fully for the variation in findings between these two studies. The 1984 analysis is based on jurisdictions outside New York City, while the 1988 sample is entirely from New York City. The 1984 data were collected

retrospectively from existing police records that were not designed to document drug-relatedness, whereas 1988 data were collected specifically for the study purposes during ongoing police investigations. The 1984 homicides were committed before the widespread marketing and availability of crack, whereas the 1988 homicides occurred during a peak year of crack use and distribution. However, while the proportion of drug-related homicides that were classified as psycho-pharmacological varied greatly, from 59% in the 1984 study to 14% in the 1988 study, one important factor remained constant – alcohol was consistently the primary drug involved in the overwhelming majority (about 95%) of psycho-pharmacological cases in both studies. It is difficult to find in these data support for a blanket condemnation of all drugs as containing a potential for producing violent behaviour in users.

The drugs/violence nexus has traditionally existed within the criminal justice arena. However, in recent years the public health and medical communities have 'discovered' violence and have made a substantial commitment to address all aspects of the violence problem.⁶ The most important new perspective that the field of public health brings to the issue of violence is a focus, from the very outset, on the outcome of reducing mortality and morbidity due to violence – rather than on any particular method, discipline, or ideology for achieving that outcome. A focus on mortality and morbidity is, of necessity, a focus on people who have suffered injuries.

The public health approach does not differentiate between victims of violence and perpetrators of violence. This is a quasi-legal distinction that has little meaning for public health practitioners. In fact, the distinction between perpetrators and victims has little empirical reality either. Whilst carrying out ethnographic studies of drugs/violence relationships in New York City, the author tried to classify participants in violent events as perpetrators or victims. This turned out to be extremely difficult. Most violent events involved altercations between persons in which both parties bore responsibility for the violence that ultimately took place. Frequently both parties received injuries. Sometimes the person who initiated the violence

was the only one injured, or the most seriously injured. The modal role of actors in these violent events was 'co-disputant', because it was so often impossible for observers to classify persons as victims or perpetrators.

There are local data that clearly link substance use with injury, especially injury resulting from violence. Urban trauma injury patients frequently use drugs and/or alcohol prior to their injury.⁷ The connection between prior alcohol or drug use and firearm-related injury is especially strong, usually occurring in a majority of victims.⁸ Marzuk et al.,⁹ studied all deaths (n=14,843) among New York City residents from 1990 – 1992 that the medical examiner certified as being due to intentional or unintentional injury. Cocaine metabolites were found in 27% of these fatal injuries; free cocaine was detected in 18%. About two-thirds of all deaths following cocaine use involved trauma injury. The authors note that if fatal injury after cocaine use was considered as a separate cause of death, it would rank among the five leading causes of death among those 15 to 44 years of age in New York City. In a study done in the Cook County (Chicago) Hospital Trauma Unit¹⁰ 86% of trauma injury patients manifesting alterations in mental status (n=623) tested positively for substance use, either through urine toxicology or serum analysis. The most common substances found were alcohol, cannabinoids, and cocaine. Patients below the age of 40, and Afro-American patients, were the most likely to test positively.

In the summer of 1993, a study was made of patients admitted to the six Level I (the most serious) trauma centres in Chicago.¹¹ The sample included all injury victims seen in each hospital during a one-month period. Findings included the following: 40% of cases resulted from intentional injury, i.e., violence; 29% resulted from motor vehicle crashes; 18% resulted from other unintentional injury, e.g., falls. Of the assault cases, 45% involved firearms, 25% involved cutting or piercing instruments. Victims of intentional injury were significantly younger than victims of unintentional injury.

Significant relationships were found between drug use in the past year and trauma injury recidivism: 54% of past-year cocaine users, as compared to

31% of non-users, reported prior hospital admission for trauma injury. Fifty-six percent of past-year cannabis users, as compared to only 28% of non-users, were trauma recidivists; and 67% of past-year heroin users, as compared to 35% of non-users, were trauma recidivists.

Alcohol consumption at the time of injury was strongly related to intentional injury. Forty-seven percent of violence victims reported drinking at the time of their injury, compared to only 27% of victims of unintentional injury. But alcohol was the only substance in which consumption at the time of the injury was related to violent injury.

While cocaine, heroin, and cannabis consumption in the past year were significantly related to violent injury, no statistically significant relationship was found between consumption of these substances at the time of injury and violent injury. These findings suggest that illicit drug use may be less likely to be psycho-pharmacologically related to violent injury, but may indicate involvement in a lifestyle which places the user at risk for violent injury. Such lifestyle issues could include gang involvement (which did emerge as a salient dimension in these data), drug distribution involvement (which did not), as well as psychological dimensions such as risk-taking.

DISCUSSION

The relationships between drugs and violence are varied and complex. This paper has not touched upon broader socio-political dimensions, such as narco-terrorism and drugs-for-guns transactions, that have emerged in diverse locations from Central and South America to Asia, but rather has focused on drugs/violence issues in the USA. The concepts and data presented here have primarily described the process and sequels of drugs/violence relationships as they affect America's urban poor.

It was suggested that cyclical trends in violence were associated with specific phases of drug markets. Recent dramatic decreases in homicide rates in the USA, especially in major urban areas such as New York City, are consistent with this cyclical analysis. The establishment of new illicit drug market relationships and territories tends to

be a violent process. However, at some point equilibrium and accommodation begin to be reached between suppliers, dealers and consumers. In addition, socio-cultural norms, especially in communities suffering the most from high rates of drug use and which are centres for street level distribution, begin increasingly to reject behavioural excesses associated with local drug use and trafficking. At this time, rates of violence begin to decline.

Unfortunately, they are likely to increase again when the next new drug craze commences and new drug markets need to be forged. This certainly describes the American experience with cocaine. Homicide rates peaked from 1979 – 1981, when new markets for powder cocaine were being established and Cuban and Colombian syndicates warred for control of middle level distribution. In the mid-1980s, when these hostilities abated, even though

there was plenty of cocaine being distributed and used, there were dramatic decreases in the homicide rate. In fact, the mid-1980s witnessed the lowest homicide rates in a 20-year period.

Then, in the late 1980s, the crack wars commenced and homicide rates soared. Jamaican and Dominican groups were heavily involved in distribution. High rates of drug-related violence and homicide were evident through the early 1990s. Then, in the mid-1990s the homicide rate again decreased dramatically. While there are various theories for the recent reductions in violence in the USA, and many politicians willing to accept full credit, it appears that crack markets may have simply followed a pattern similar to powder cocaine markets a decade earlier. Unfortunately, the American criminal justice and health care systems are still not collecting the sort of data needed for a more definitive elaboration of this issue.

REFERENCES

1. Goldstein, P. J., 'The Drugs' Violence Nexus: A Tripartite Conceptual Framework', *Journal of Drug Issues*, 15 (4), pp 493 – 506, 1985; Goldstein, P. J., 'Drugs and Violent Crime', in Weiner, N. A. and Wolfgang, M. E., (eds), *Pathways to Criminal Violence, Beverly Hills*, Sage, pp 16 – 48, 1989.
2. Brownstein, H., Goldstein, P. J., 'A Typology of Drug Related Homicides', in Weisheit, R. A., (ed), *Drugs Crime and the Criminal Justice System*, Cincinnati, Anderson, pp 171 – 192, 1990; Brownstein, H., Shiledar-Baxi, H., Goldstein, P.J., Ryan, P., 'The Relationship of Drugs, Drug Trafficking and Drug Traffickers to Homicide', *Journal of Crime and Justice*, 15 (1), pp 25 – 44, 1992; Fendrich, M., Goldstein, P. J., Tarshish, C., Bellucci, P., 'Longitudinal Measurement of Substance Use in Ethnographic Samples', *Journal of Community Psychology*, 20, pp 326 – 342, 1992; Goldstein, P. J., 'Homicide Related to Drug Trafficking', *Bulletin of the New York Academy of Medicine*, 62 (5), pp 509 – 516, 1986; Goldstein, P. J., 'The Impact of Drug-Related Violence', *Public Health Reports*, 102, (6), pp 625 – 627, 1987; Goldstein, P. J., 'Cocaine and Crime in the United States', in Bruno, F., (ed), *Cocaine Today: Its Effects on the Individual and Society*, Rome, United Nations Interregional Crime and Justice Research Institute, pp 238 – 245, 1991; Goldstein, P. J., 'Drug Abuse and Violence', Proceedings of the Inaugural Symposium on Crime and Punishment in the United States: Drugs and Violence in America, Washington, United States Sentencing Commission, pp 87 – 98, 1993; Goldstein, P. J., 'Drugs and Violence: Myth and Reality', in Joseph, L., (ed), *Crime, Communities and Public Policy*, Chicago, University of Chicago Center for Urban Research and Policy Studies, pp 181 – 200, 1995; Goldstein, P. J., Hunt, D., Des Jarlais, D., Deren, S., 'Drug Dependence and Abuse', in Amler, R. W. and Dull, H. B., (eds), *Closing the Gap: The Burden of Unnecessary Illness*, New York, Oxford University Press, pp 89 – 101, published as a special supplement to the *American Journal of Preventive Medicine*, 3 (5), 1987; Goldstein, P. J., Brownstein, H. H., Ryan, P.J., Bellucci, P., 'Crack and Homicide in New York City, 1988: A Conceptually Based Event Analysis', *Contemporary Drug Problems*, 16 (4), pp 687, 1989; Goldstein, P. J., Bellucci, P., Spunt, B., Miller, T., 'Volume of Cocaine Use and Violence: A Comparison Between Men and Women', *Journal of Drug Issues*, 21 (2), pp 345 – 367, 1991a; Goldstein, P. J., Bellucci, P., Spunt, B., Miller, T., 'Frequency of Cocaine Use and Violence: A Comparison Between Men and Women', in Schober, S. & Schade, C. (eds), *The Epidemiology of Cocaine Use and Abuse*, Rockville, National Institute on Drug Abuse, Research Monograph No. 110, pp. 113 – 138, 1991b; Goldstein, P. J., Brownstein, H.H., Ryan, P.J., 'Drug Related Homicide in New York: 1984 and 1988', *Crime and Delinquency*, 38 (4), pp 459 – 476, 1992; Ryan, P. J., Goldstein, P. J., Brownstein, H. H., Bellucci, P., 'Who's Right? Different Outcomes when Police and Scientists View the Same Set of Homicide Events, New York City, 1988', in DeLaRosa, M., Lambert, E., Gropper, B. (eds), *Drugs and Violence Causes, Correlates and Consequences*, Rockville, National Institute on Drug Abuse, Research Monograph No. 103, pp 239 – 264, 1990; Spunt, B., Goldstein, P.J., Bellucci, P., Miller, T., 'Drug Related Violence among Methadone Maintenance Treatment Clients', *Advances in Alcohol and Substance Abuse*, 9, (3/4), pp 81 – 99, 1990a; Spunt, B., Goldstein, P. J., Bellucci, P., Miller, T., 'Race/ Ethnicity and Gender Differences in the Drugs-Violence Relationship', *Journal of Psychoactive Drugs*, 22 (3), pp 293 – 303, 1990b.
3. Center on Addiction and Substance Abuse, 'Legalization: Panacea or Pandora's Box, White Paper No. 1', September, 1995; Center on Addiction and Substance Abuse, 'Substance Abuse and Urban America; Its Impact on an American City', New York, February, 1996.
4. Goldstein, P. J., Brownstein, H. H., Ryan, P. J., 'Drug Related Homicide in New York: 1984 and 1988', *Crime and Delinquency*, 38 (4), pp. 459 – 476, 1992.

5. Goldstein, P. J., Brownstein, H. H., Ryan, P. J., Bellucci, P., 'Crack and Homicide in New York City, 1988: A Conceptually Based Event Analysis', *Contemporary Drug Problems*, 16 (4), pp 687, 1989.
6. National Medical Association Surgical Section, 'Position Paper on Violence Prevention: A Resolution of Trauma Surgeons Caring for Victims of Violence', *JAMA* 273, pp 1788 – 1789, 1995; Koop, C. E., Lundberg, G., 'Violence in America; Time to Bite the Bullet Back', *JAMA* 267, pp 3075 – 3076, 1992; Rosenberg, M. L., Fenley, M., (eds), *Violence in America: A Public Health Approach*, New York, Oxford University Press, 1991.
7. Soderstrom, C., Tiflis, A., Shankar, B., 'Marijuana and Alcohol Use Among 1023 Trauma Patients', *Archives of Surgery*, 123, pp.733 – 737, 1988; Bailey, D., 'Comprehensive Toxicology Screening in Patients Admitted to a University Trauma Center', *Journal of Analytical Toxicology*, 10, pp 147 – 149, 1986.
8. Smith, S. M., Goodman, R., Thatcher, S., Burton, A., Parsons, J., Hudson, P., 'Alcohol and Fatal Injuries; Temporal Patterns', *American Journal of Preventive Medicine*, 5, pp 296 – 302, 1989; McGonigal, M. D., Cole, J., Schwab, C., Kauder, D., Rotondo, M., Angwood, P., 'Urban Firearm Deaths: A Five Year Perspective', *Journal of Trauma*, 35, pp 532 – 537, 1993; Tardiff, K., Marzuk, P., Leon, A., 'Homicide in New York City: Cocaine Use and Firearms', *JAMA* 272, pp 43 – 46, 1994, Kizer, K. W., Vassar, M., Harry, R., Layton, K., 'Hospitalization Charges, Costs and Income for Firearm-related Injuries at a University Trauma Center', *JAMA* 273, pp 1768 – 1773, 1995.
9. Marzuk, P. M., Tardiff, K., Leon, A., Hirsch, C., Stajic, M., Portera, L., Hartwell, N., Irfan Iqbal, M., 'Fatal Injuries after Cocaine Use as a Leading Cause of Death Among Young Adults in New York City', *New England Journal of Medicine*, 332, pp.1753 – 1757, 1995.
10. Sloan, E. P., Zalenski, R., Smith, R., Sheaff, C., Chen, E., Keys, N., Crescenzo, M., Barrett, J., Berman, E., 'Toxicology Screening in Urban Trauma Patients: Drug Prevalence and its Relationship to Trauma Severity and Management', *Journal of Trauma*, 29, pp 1647 – 1653, 1989.
11. Goldstein, P. J., Smith, R., Freels, S., 'Drugs and Violent Injury: Pilot Data from Chicago Trauma Centers', Report to the United States Sentencing Commission, Task Force on Drugs and Violence Crime, 1996, (in press).

Additional References Used:

- Leukefeld, C.G., 'The Clinical Connection: Drugs and Crime', *International Journal of the Addictions*, 20, pp 1049 – 1064, 1985.
- Martin, M. J., Hunt, T., Hulley, S., 'The Cost of Hospitalization for of Firearm Injuries', *JAMA* 260, pp 3048 – 3050, 1988.
- Miller, T. R., Lestina, D., 'Patterns in US Medical Expenditures and Utilization for Injury, 1987', *American Journal of Public Health*, 86, pp 89 – 93, 1996.
- Silver, B. A., Sporty, L., 'Behavioral Correlates and Staff Recognition of Alcohol Use in a University Hospital Trauma Service', *Psychosomatics* 31, pp 420 – 425, 1990.