To Punish or to Treat

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To Punish or to Treat: 
Substance Abuse Within the Context of Oscillating Attitudes 
Toward Correctional Rehabilitation

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ABSTRACT Although its remote origins can be traced to the end of prohibition with the repeal of the Volstead Act in 1933, the nation’s “war on drugs” gathered massive strength in the early days of the Reagan administration. During the 1980s and 1990s, the decision of the nation, expressed through its legislators, seemed to be to “criminalize” drug use or abuse through imposition of harsh penalties for what had earlier been statutorily defined as relatively minor offenses and by eliminating judicial discretion in sentencing, so that mandatory incarceration was required for many offenses. Yet by 2000, the voters of California, the Governor and criminal court judges of New York, and even the nation’s “drug czar” had decided that they would rather, as described by the New York Times, “treat than fight.” This paper situates that sea change in posture within a context of oscillation toward the goals of corrections generally during an era in which “therapeutic nihilism” and “just deserts” appeared to have carried the day.

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To criminalize, or to medicalize—that is, and has been, the question on which societal attitudes toward the use of mood-altering substances of one or another sort have pivoted throughout the 20th century. If substance use, misuse, or abuse be encoded as criminal activity, the appropriate societal response is punishment; but if it be encoded as a medical (or even behavioral) condition (or illness), the appropriate societal response is clearly treatment.

Prohibition of the manufacture and sale of beverage alcohol constituted, of course, the century’s grand experiment in criminalization, both in the United States and in many European nations. If Hofmann and Hofmann (1975) are to be believed, wide-scale additions to the roster of “controlled dangerous substances” mandated by the Federal Congress during the 1930s came about at least in part as the consequence of the repeal of the Volstead Act in 1933, thereby rendering obsolete an entire industry that had been organized to police traffic in ethanol. Indeed, it was not until 1975, some 40 years after repeal of the Volstead Act, that alcoholism came to be definitively categorized, by act of Congress, no less, as a disease rather than as a “voluntary misbehavior” (Fingarette, 1988, 1990), albeit as an afterthought in an amendment to legislation concerning vocational rehabilitation—and a new industry was thereby born. But even as new professions (e.g., “certified alcoholism counselor”) and new institutions (rehabilitation centers, typically offering a 28-day residential treatment program) were generated, however, public inebriation remained a crime in most jurisdictions.

If the Hofmanns’ rendition seems too cynical a reading, yet it should be noted that, as this paper is written, the popular press has widely reported results of a RAND study that sharply counters the conventional wisdom that use of marijuana places one on the slippery slope that leads only to depravity, a finding that appears to support the Wall Street Journal’s famous (or infamous, depending upon one’s cherished beliefs) characterization of US drug laws as “the criminalization of the common pleasures of the underclasses.” Indeed, the RAND Corporation’s public affairs office (2002) itself asserted in a press release that results of the study “challenge an assumption that has guided US drug policies since the 1950s.”

The nation’s “war on drugs” dates, under that specific rubric, from the early days of the Reagan administration. It is a fair assessment to say that, during the 1980s and 1990s, criminalization of substance abuse constituted the dominant theme, so that laws governing the use, sale, importation, or manufacture of an ever-expanding litany of “controlled dangerous substances” (and their “work-alike” counterparts, whether obtained by prescription or even “over the counter”) were strengthened, with formal sanctions either attached thereto or rendered more severe. Making sanctions more severe included in some instances
legislatively mandating incarceration for offenses that either had not been earlier classified as felonies or in the imposition of penalty in situations in which there had previously been wide judicial latitude.

But at the cusp of the millennium there were strong indications on both ocean coasts of the nation that a tectonic shift had begun, yielding a situation in which, according to the *New York Times* (Wren, 2001), playing on the phrasing of a once-popular television commercial urging brand loyalty in the consumption of tobacco, even the nation’s “drug czar” had decided that he “would rather treat than fight.” It is the purpose of this paper to situate that emergent shift within the context of oscillation in societal attitudes and perceptions about who should be “punished” and who should be “treated” within, or under the aegis of, a correctional “system” comprised both of penal institutions and community agencies and resources.

**SCOPE OF THE CORRECTIONAL “SYSTEM”**

Official records of the Bureau of Justice Statistics, the agency of the US Department of Justice with responsibility for collating data of all sorts concerning the criminal justice system, suggest that some 5.7 million people were (to use the term current in Federal parlance) “under correctional supervision” (Maguire & Pastore, 1999, 462), distributed among prisons, jails, and parole and probation agencies (as depicted in Figure 1) during a single year near the end of the twentieth century. Those given to this sort of thing might want to observe that, in the aggregate, slightly more than 2% of the nation’s population of 280 million were thus “under correctional supervision” during the year in review.

Offenders under “community supervision” on probation or parole comprise nearly 70% of the total, outnumbering offenders incarcerated in state or Federal prisons as a result of felony convictions at a ratio greater than 3:1 and outnumbering the population of jails (composed of both accused offenders awaiting trial or the posting of bail and of convicted misdemeanants) at a ratio greater than 7:1. The matter of the type of facility in which offenders are held (prisons, with relatively stable populations serving sentences of specified lengths, vs. jails, with their revolving door clientele) and for how long represent important variables in the planning and delivery of medical, psychosocial, mental health, or other “treatment” services.

In general, psychosocial, treatment services are provided to incarcerated offenders by employees of the correctional authority (i.e., state, county, or Federal department of corrections), although a trend has emerged toward the “privatization” of many such services (Demone & Gibelman, 1990; Bowman, Hakim & Seidenstat, 1993; Kronick, 1993) in much the same way that correctional institutions have long contracted with private vendors to operate food preparation services. In either case, the character (and sometimes the fre-
quency) of treatment and/or rehabilitation services is determined by policies of the correctional authority, in their turn responsive to legislative and judicial instruction. In contrast, offenders under community supervision are usually served by social service or mental health agencies in the community whose policies are not controlled by the correctional authority. Generally, direct referral to relevant community agencies (including outpatient clinics at hospitals) is made by the probation or parole officer; less frequently, referral is made to community agencies or institutions under contractual relationships to serve offender clients.

It is a matter of more than passing interest that whites, who constituted 80% of the nation’s population in the 2000 census, comprise only 60% of the correctional population depicted in Figure 1. Similarly, according to the 2000 census, girls and women constituted 51% of the general population, but they represent only 16% of the correctional population. Demographic disparities between the population in general and the offender population clearly impinge upon the planning and delivery of correctional rehabilitation services.

**OSCILLATING ATTITUDES TOWARD CORRECTIONS**

At least since the time of the Marquis di Beccaria in the 18th century, the goals of corrections have been conceded to include incapacitation, retribution,
deterrence, and rehabilitation (Taylor & Brasswell, 1979; Welch, 1999), generally within the context of the principle of proportionality between offense and sanction traceable to the Code of Hammurabi in the 18th century BC and reinforced in the British Magna Carta three millennia later. In response to societal, political, and intellectual forces (Foucault, 1978), emphasis has of course shifted among and between these four goals over time, so that one or the other, or some permutation, may temporarily discernibly ascend and others recede.

Penance vs. Punishment: Rehabilitation as an American Tradition

Indeed, an oscillation of substantial proportions occurred not long after the founding of the American republic, when in 1787 the Quakers of Pennsylvania invented the penitentiary as an alternative to the prison, the purpose of which had historically been to punish and incapacitate. In contrast, the Quaker penitentiary was to be a place where offenders were confined to do penance through religious meditation and “spiritual exercises” and thus become “penitent” for their transgressions, in the process vowing irrevocably, with the aid of the Almighty, to forego wrongdoing forevermore.

However much the religious-spiritual dimension which shaped the Quaker invention may have eroded, there is little question that, half a century ago, if rehabilitation did not quite stand univocally as the primary goal of corrections (Lindner, 1949; American Friends Service Committee, 1971), it surely stood alongside incapacitation, deterrence, and retribution as primus inter pares. Legislators and the general public alike expected, and were willing to finance, the provision of rehabilitation services of various sorts for offenders incarcerated in the nation’s prisons and, sometimes, jails.

Pugh v. Locke: The Right of Prison Inmates to Mental Health “Care”

A perception of rehabilitation as a primary purpose in corrections is readily inferable in the landmark 1976 decision of Federal appellate court judge Frank M. Johnson in Pugh v. Locke, a case concerning the operation of the prisons of Alabama, later upheld by the US Supreme Court and, therefore, uniformly precedental throughout the nation. In his decision, Mr. Johnson imposed a wide-ranging set of “minimum Constitutional standards for inmates” that mandated “humane” and sanitary living conditions (with strict standards imposed to address prison overcrowding), “meaningful programs” staffed by qualified personnel, and at least first-line mental health care within correctional institutions (Fowler, 1976, 1987). Over the next two decades, no fewer than 37 states were ordered by the Federal courts to meet the standards specified in Pugh.

Federal courts in the southern tier had earlier issued the linchpin decisions in Donaldson v. O’Connor, Wyatt v. Hardin, and Wyatt v. Stickney, cases brought on behalf of patients confined in public mental hospitals. In upholding
those decisions, the US Supreme Court declared unequivocally that patients in mental hospitals have an absolute right to treatment and that to confine patients in the absence of treatment in effect constitutes involuntary imprisonment, in violation of the Constitutional guarantees against deprivation of liberty without due process contained in the 8th and 14th Amendments (Golann & Fremouw, 1976, 129-185).

But, although he affirmed the right of inmates to mental health care, Mr. Johnson stopped far short in Pugh of articulating a right to treatment. Instead, he ordered that prison administrators “shall identify those inmates who require mental health care within the institution and make arrangements for such care,” while simultaneously ordering that there should be “routine” provision for identification of “those inmates who, by reason of psychological disturbance or mental retardation require care in facilities designed for such persons” and for the transfer of prisoners thus identified to such (presumably forensic) psychiatric installations. From the judicial perspective, “treatment” thus appears to be that form of professional intervention provided in psychiatric hospitals, while “care” is that form of intervention to be provided in situ for prisoners whose disorders are not severe enough to warrant hospitalization. Although it has been at pains in its Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition to label an enormous array of human behaviors—including, indeed, a singular devotion to soft drinks that contain caffeine—as psychopathological, the psychiatric community has rather anomalously not chosen to quarrel with those distinctions, implicitly ceding the in situ treatment of offenders to non-psychiatrists (Schnapp & Cannedy, 1998; Badger, Vaughn, Woodward & Williams, 1999).

Pugh specifically adopts the mental health staffing ratios proposed by the Center for Correctional Psychology at the University of Alabama (Gormally, Brodsky, Clements & Fowler, 1972), which reduce to an overall ratio of one mental health specialist for each 91 inmates—specifically: one bachelor’s level mental health technician or correctional counselor for each 135 inmates; one psychologist for each 506 inmates; one social worker for each 578 inmates; one psychiatrist for each 4,048 inmates. Mr. Johnson’s ruling in effect held that these personnel were required to provide “mental health care” as a sort of first-line intervention within the prisons themselves, since the most severe cases were to be transferred to appropriate mental hospital facilities. It might be noted that inventories of mental health staffing in state prisons shortly after Pugh provided evidence of enormous discrepancies between those standards, staff actually employed and deployed, and staffing standards promulgated by such organizations as the American Correctional Association (Pallone & LaRosa, 1979; Pallone, Hennessy & LaRosa, 1980). In a similar context, at least one legal scholar (Mayer, 1990) has labeled the failure of correctional administrators to meet court-imposed standards an exemplar of Constitutionally impermissible “deliberate indifference.” And, in view of the definitive Pugh standards governing prison overcrowding, it is distressing to observe that,
nearly a quarter century after that historic decision, the number of prisoners held in correctional institutions exceeded the capacity of those institutions by 25% in the Federal system, 72% in California, 77% in Hawaii, 41% in Illinois, 20% in Indiana, 64% in Iowa, an astounding 230% in Massachusetts, 96% in Montana, 39% in Nebraska, 46% in New Jersey, 69% in Ohio, 51% in Pennsylvania, 55% in Virginia, 41% in Washington, and 48% in Wisconsin (Maguire & Pastore, 1999, 487). That the prison systems of 14 states, including several major population centers, and the Federal system itself apparently no longer perceive themselves bound by the “minimum Constitutional standards” enunciated in Pugh perhaps reveals a posture for which “deliberate indifference” may be too euphemistic a descriptor.

Martinson, “Nothing Works,” and the Seeds of Therapeutic Nihilism

However favorable to rehabilitation the prevailing ethos then seemed to be, countervailing forces were at work. Even the entertainment media entered the lists, with offender rehabilitation parodied mercilessly by director Stanley Kubrick in his 1971 film version of Anthony Burgess’ *A Clockwork Orange*. With the publication of the now-famous (or perhaps infamous) Martinson Report, empirical challenges were directly mounted against the primacy of rehabilitation as a goal in corrections. Media attention immediately surrounded publication of Martinson’s report on the efficacy of rehabilitation efforts in prisons (1974) largely because the government agency which had sponsored the study on which the report was based had formally suppressed its release.

In 1971, a major prisoner revolt had taken place at the New York state prison at Attica, ultimately claiming 43 lives. Among the “non-negotiable” demands made by leaders of the revolt were requests for increased quantity and quality in rehabilitation services; as Governor of the state, Nelson Rockefeller quickly agreed. However, there was underway at the time a major study of the effectiveness of rehabilitation programs of all sorts in correctional institutions of various sorts. Because its conclusions countered the state’s capitulation to prisoners’ demands, and because it constituted a “work for hire” and could thus quite legitimately be classified as “confidential,” state administrators ordered that no report of the research be released. But the leaders of the revolt knew of the study and of Martinson’s role as an investigator (though not the principal investigator). At their trial on varied criminal charges, they sought to mitigate responsibility by appealing to the evidence accumulated by the research team that showed rehabilitation to be relatively ineffective. The research saw the light of day only when the judge presiding in those trials ordered that the suppression be lifted. Thus it was that the “Martinson Report” (1974), published in the neo-conservative “journal of opinion” *The Public Interest* rather than in a peer-reviewed scholarly journal in the behavioral sciences, became almost instantly a focus of national press attention.
Martinson concluded that most offender rehabilitation regimens for adult prisoners constitute a colossal waste of professional energy and of taxpayers’ money. That dire judgment was mollified somewhat in a more detailed monograph by Lipton, Martinson and Wilks (1975)—and indeed mollified even further by Lipton (1995), the lead investigator, in a 20-year retrospective in the pages of this journal. But a similarly pessimistic conclusion was reached by Shamsie (1981) in an ambitious review of the research evidence on the effectiveness of similar rehabilitation efforts among juvenile offenders. Predictably, members of the professional community committed to rehabilitation as a governing purpose of corrections sought to answer the Martinson judgments (Cullen & Gilbert, 1982; Gendreau & Ross, 1979; Glaser, 1979), often with more heat than light. As Martinson (1976) himself suggested, these responses may have issued from a sense of disbelief that “all the well-intentioned efforts of the psychiatric, psychological, and social service communities, of the medical establishment, of the prisons and the jails, and even of the schools have yielded such disappointing results.”

The controversy reached even into the prestigious National Academy of Sciences, which commissioned a blue-ribbon panel to reanalyze the more than 200 studies of rehabilitation effectiveness on which the Lipton, Martinson and Wilks conclusions were based (Sechrest, White & Brown, 1979). Those excruciating reanalyses (Feinberg & Gramsbach, 1979) did little to alter the “gloomy conclusions” reached by Martinson, even though (in what may have been more a leap of faith than a reasoned scientific judgment) Sechrest, White and Brown, (1979, 34) focussed on flaws in the research design of the 200-plus studies which had yielded those negative conclusions: “The quality of the work that has been done...militate[s] against any policy reflecting a final pessimism.” Further reanalyses in Britain of the original data base (Hollin, 1990) similarly focused on the adequacy of the research design employed in the studies represented therein, but, like the National Academy of Science review, declined to draw any sharp conclusion, whether positive or negative. In Hollin’s (1990, 119-120) account:

The ambiguity in clinical outcome studies has been used in both the United Kingdom and the United States to fuel the doctrine maintaining that “nothing works”; that is, any attempt at rehabilitation is doomed to failure. . . . This research is often quoted by those in favor of therapeutic nihilism . . . [yet] the small number of acceptable studies immediately limits the data base from which any conclusions can be drawn, and the subject matter of these studies allows no conclusions to be made. . . .

Enter Meta-Analysis and Aptitude-Treatment Interaction

Chastened though it may have been, offender rehabilitation did not quite pass quietly into the dark night. Contemporaneously, the mental health and so-
cial service professions in general had begun to abandon the one-size-fits-all mindset that had once served as its anchor. Instead, great attention began to be paid to “aptitude-treatment interactions.” When treatment modalities were “customized” or differentiated for clients or patients with essentially similar “presenting problems,” with the customization geared to the characteristics of the individual, positive results seemed to ensue more dependably. A “disorder-aptitude-treatment interaction” approach (or “differential treatment model”) began, rather tentatively and perhaps stealthily, to be applied initially to criminal offenders in the community, then in institutions. Results were, in some cases, positive.

It also happened that, shortly after the National Academy’s re-review of the Lipton-Martinson-Wilks data, Smith, Glass and Miller (1980) published a monograph promoting a methodology for analyzing the effects of psychotherapy called “meta-analysis.” Utilizing relatively high-powered statistical techniques, meta-analysis facilitates the aggregation of data from studies that at first blush seem difficult to compare because they had used variant means of measuring outcomes, varying lengths of time after the termination of treatment before “outcome” was measured, and so on. Two decades after the appearance of the Martinson Report, and indeed during an era that had largely abandoned rehabilitation as the focal service in corrections, evidence began to emerge from studies utilizing the techniques of meta-analysis that to the bald “nothing works” formulation of the 1970s could quite properly be juxtaposed the proposition that “some things work for some offenders under certain conditions” (Gendreau & Andrews, 1990; Loesel, 1993, 1995; Hollin, 1999; Redondo, Sanchez-Meca & Garrido, 1999), a proposition that essentially restates the disorder-aptitude-treatment interaction,” or “differential treatment” model.

From “Just Deserts” to “Get Tough, Hang ’em High”– and the War on Drugs

At least to some extent fueled by empirical challenges to rehabilitation as a goal in corrections, conceptual challenges were launched by advocates of a “just deserts” policy (Morris, 1974; von Hirsch, 1976, 1984, 1985, 1988; Allen, 1981), who argued that how society deals with an adjudicated offender should follow precisely sanctions prescribed in the criminal code for the offense or offenses of which he/she has been convicted–so that the sanction is in essence predicated by the character of the offense, not the characteristics of the offender–and by the likelihood that he/she may re-offend, a prospect largely to be determined on the basis of the offender’s prior criminal record (Sherman & Hawkins, 1981). Moreover, that sanction should not be mitigated in any way by post-offense, post-conviction considerations like progress in a program of rehabilitation.

Accordingly, particularly since early release on parole had become in practice at least related to, if not contingent on, participation in such rehabilitation
programs, “just deserts” advocates also sought to curtail sharply parole eligibility. Such eligibility should pivot on completion of a mandatory and inflexible minimum proportion of the sentence imposed. As a codicil, a “just deserts” model quite logically holds that, if psychosocial rehabilitation in the correctional setting had proved dependably effective, its advantages should have been abundantly clear without the protection of equivocal statements about whether valid conclusions can or cannot be drawn from the body of evidence by resorting to the recondite modes of number-crunching demanded by meta-analysis, in feverish efforts to ferret out whatever small statistical advantages may lie therein. Explicitly, then, the “just deserts” model contends that correctional institutions should (once and for all) redefine themselves as places whose purposes are to deter and incapacitate—in short, to punish in precise and inflexible fashion.

“Just deserts” policies found substantial support in the Federal Congress. In a series of measures enacted with bipartisan support—epitomized by the Criminal Sentencing Reform Act (CSRA) of 1981, cosponsored in the Senate by Ted Kennedy and Strom Thurmond, as unlikely a pair of political bedfellows as can be imagined—the Congress embraced a “get tough, hang ’em high” posture toward the Federal correctional system. The pivots in the 1981 Act required

- that sentences to incarceration be rendered mandatory for offenders convicted of certain offenses, thus removing substantial discretion in sentencing previously ceded to judges; and
- that an offender serve a “mandatory minimum” portion of his/her sentence before becoming eligible for parole.

Since Federal prisoners constitute but a small minority of the correctional population of the nation, the 1981 Act directly affected only a tiny proportion of offenders under correctional supervision. But Federal legislation achieves its principal effects indirectly, by rippling outward through widespread imitation by the legislatures of the individual states.

In 1986, Congress enacted the Omnibus Crime Reduction Act (OCRA) as a cornerstone in the Reagan Administration’s War on Drugs. OCRA mandates incarceration for a variety of offenses related to the sale or possession of drugs (“controlled dangerous substances,” in the Federal lexicon) or of “drug paraphernalia,” the penalties for many of which had previously been left to the discretion of judges. Once again, as the “hang ’em high” bandwagon coursed through the nation, OCRA elicited wide imitation by the states.

The direct impact of CSRA and OCRA (and surrounding and supporting legislation) on the Federal prison system can be gauged fairly precisely by considering the data reported by the Bureau of Justice Statistics (Maguire & Pastore, 1999, 505) concerning drug offenders in Federal prison as a proportion of all Federal prisoners. In 1980, before either CSRA or OCRA, there were slightly more than 19,000 Federal prisoners, of whom 25% (4,749) were
drug offenders. In 1990, nine years after CSRA and four years after OCRA, the total Federal prison population had more than doubled to 47,000, with 52% (25,000) drug offenders. Within the space of a single decade, during which the general population had increased by only 10% (from 226 to 248 million), the number of Federal prisoners had increased by nearly 150%, or at a rate approximately fifteen times as great as the increase in the general population. Indeed, by 1990 there were 52% more drug offenders incarcerated than the total number of inmates in Federal prisons for any and all offenses ten years earlier. By 1998, the comparisons yielded even greater drama, with a total of 95,000 inmates, including 56,000 (57%) drug offenders. Thus, the number of drug offenders confined in Federal prisons in 1998 was very nearly treble the total number of offenders serving sentences in Federal prisons for any and all offenses in 1970. These data are depicted graphically in Figure 2.

In the prisons of the states, 20% were serving sentences for drug offenses in 1999 (Beck, 2000). In addition, slightly under 10% were serving sentences for a catch-all category called “public order offenses,” under which are subsumed “drunk driving” and “liquor law violations.” But some investigators have put the proportion of prisoners in state institutions with “diagnosable substance abuse or dependence disorders” as high as 74% (Peters, Greenbaum, Edens, Carter & Ortiz, 1998), even though the instant offense may involve neither alcohol nor drugs directly.

![Figure 2: Drug Offenders as a Proportion of All Federal Prisoners, 1970-98](image-url)
Whether as a function of a “just deserts” sentencing policy in general or of the mandatory sentencing of drug offenders in particular, the growth curve in the state prisons essentially replicates that in the Federal prisons. In 1980, there were 130 state prisoners per 100,000 of the general population (Maguire & Pastore, 1999, 491). By 1990, that rate had increased to 272 per 100,000 (approximately 110%) and, by 1998, to 415 per 100,000 (approximately 220%).

Although it primarily targets adult offenders, a “get tough, hang ’em high” posture extends to juvenile offenders as well, primarily by rendering certain offenses committed by juveniles at some ages (e.g., between 14 and 18) or at any age liable to prosecution and sanctioning under the adult, rather than under the more lenient juvenile, criminal code (Clement, 1997-a; Feld, 1998; Zimring, 1998; Kempf-Leonard & Peterson, 2000).

A “Just Deserts” Perspective on Mental Health Care vs. Rehabilitation

There is no more articulate spokesperson for the “just deserts” perspective than the distinguished legal scholar and criminologist Norval Morris. Even as “just deserts” activists contended vigorously to redefine the prison in particular and corrections more generally, Morris (1974, 14-15) drew capital distinctions between mental health care as a health service for confined offenders and mental health care as a component in a program of psychosocial rehabilitation for those conditions thought to be “causative” of criminal behavior:

“Rehabilitation,” whatever it means and whatever the program that allegedly gives it meaning, must cease to be a purpose of the prison sanction. This does not mean that the various . . . treatment programs within prisons need to be abandoned; quite the contrary, they need expansion. But it does mean that they must not be seen as purposive in the sense that criminals are to be sent to prison for treatment. . . . The system is corrupted when we fail to preserve this distinction and this failure pervades the world’s prison programs.

From that perspective, the terms of the debate about the primacy of punishment vs. rehabilitation seem not so much wrong-headed as wrong-ended. To regard mental health care as the purpose of imprisonment requires an unswerving conviction supported by strong empirical evidence that criminal behavior is the consequence of mental disorder. Hence, once the source disorder is remedied, the criminal behavior can be expected to cease. From comparison of epidemiological studies in the community, in mental hospitals, and in prisons, there is evidence that the relative incidence of mental disorder of any and all diagnosable sort (including “antisocial personality disorder,” virtually the defining diagnosis among at least persistent criminal offenders) is greater among prison inmates than in the general population—but not as great as that among mental hospital patients with respect to psychosis, virtually the defin-
ing diagnosis among at least repetitively-admitted mental patients (Pallone, 1991). But there is very scant evidence to support the conjecture that criminal behavior is, therefore, a function of remediable mental disorder of the same sort as that which characterizes mental hospital patients (Pallone & Hennessy, 1996, 1-20). Within the present context, that is perhaps another way of saying that, if a drug-dependent burglar is “cured” of his/her drug dependence, it is equally plausible to believe that he/she will thereafter become a more efficient burglar since consciousness will no longer be clouded as it is to believe that, because he/she no longer needs to support an expensive drug habit, he/she will thereafter become a model citizen.

TO THE DRUG WARRIOR
WHO WOULD RATHER TREAT THAN FIGHT

It is generally estimated that the annual cost of maintenance for a prisoner ranges between $42,000 and $55,000. For a fully informed and informative estimate, however, to that maintenance cost should be added the amortization costs incurred in constructing and equipping prison facilities, which may add another $15,000 to $45,000 per prisoner. However much it satisfies a primordial surge at the visceral level toward vengeance, a “get tough, hang ’em high” policy clearly imposes huge financial burdens upon the taxpayer; and therein lies one of the principal seeds of the Rebellion of 2000.

The taxpayers’ contribution to that Rebellion is best exemplified by the adoption of Proposition 36 by the voters of California, the most populous state in the union. As earlier observed, its prison system, operating at 172% capacity, had become hopelessly overcrowded, with a large proportion of inmates serving mandatory sentences for possession of controlled dangerous substances in quantities large enough to suggest nothing more sinister than personal (sometimes called rather too euphemistically termed “recreational”) use. Serious doubts had already been expressed as to whether punishment represents an optimal societal response to such offenses (Wexler, Blackmore & Lipton, 1991; Lipton, 1994). The key provision in Proposition 36 repeals the mandatory sentencing provisions of relevant statutes, with the expectation that those guilty of drug possession will instead be placed on probation but required to undergo treatment in the community, whether at the offender’s expense or at public expense. Proponents of Proposition 36 emphasized that, even were they to be borne by the public treasury, the annual per-person cost for outpatient treatment for drug use would require far less in cash outlay than current per-prisoner maintenance costs. Moreover, at least some proportion of drug offenders sanctioned in this way could be expected to maintain employment and continue to pay taxes, thus adding to—rather than depleting—the public treasury; and, finally, in some proportions of the cases, the costs of outpatient
treatment might be borne by third-party medical insurers or health maintenance organizations rather than the public treasury.

The perceptions and attitudes that motivated rebellion among a cadre of criminal court judges in New York were less well articulated, at least to the public press. Instead, these judges declared themselves essentially to be on strike, asserting that they would hear no further cases involving drug offenses for which incarceration is legislatively mandated until the state made provision for alternate, community-based drug treatment, whether through the by-then burgeoning Federally-financed “drug courts” that provide pretrial diversion (Peters & Murrin, 2000; Hennessy, 2001) or elsewise.

Some commentators saw in the declaration by the judges a prospective rebirth of the pretrial intervention strategies (Matthews, 1980) pioneered in the early 1960s by the New York State Narcotics Addiction Control Commission (and imitated elsewhere) under the Rockefeller gubernatorial administration, through which criminal charges lodged against a accused offender who is demonstrably drug-involved are held in abeyance until he/she has completed a course of treatment for addiction, in much the same fashion in which first-time DWI offenders are dealt with in traffic courts (Lucker & Osti, 1997). If treatment is successful, criminal charges are dropped. In the 1960s version, treatment was typically provided under the auspices of a correctional agency in a “secure” facility analogous to a locked forensic psychiatric hospital through long-term inpatient (nine-month) care and outpatient (27-month) aftercare, but the current version appears to favor shorter-term outpatient treatment in the community or even inpatient treatment in a “civilian” rather than “correctional” facility (Jenkins, 1995; Rose, 1997; Peters & Hills, 1999; Hennessy, 2001).

Another variation pursued with vigor in “drug courts” in some jurisdictions interposes treatment between conviction (typically, by virtue of a guilty plea) and sentence. If the drug-involved offender completes treatment satisfactorily and further maintains a drug-free lifestyle for a specified period thereafter (e.g., 12 months), the record of conviction is purged. But if the offender leaves treatment prematurely, he/she is immediately incarcerated to serve the custodial sentence for the offense to which he/she has pled guilty (or of which he/she has been convicted).

As if in response to the threat by the criminal court judges, the Republican Governor of New York proposed in mid-January 2001 a tripartite change in the way in which that state deals with illicit drug use. The key elements in the Governor’s plan (Perez-Pena, 2001) provided for

- “shorter prison terms for . . . nonviolent drug offenses,”
- “replacing mandatory imprisonment with treatment,” and
- “giving judges greater discretion in handling drug-related criminal charges”
Given the enormous aggregate population of California and New York, accounting for nearly 25% of the nation’s total, there seemed little question that what had started life as a taxpayers’ rebellion had rather rapidly given rise to a major change in policy with substantial implications for rehabilitation services for offenders both in the community and within correctional institutions.

These developments on the two coasts may represent but minor tremors in an otherwise placid landscape. Alternately, however, the Governor and the criminal court judges of New York and the voters of California may instead be the heralds of yet another oscillation, with rehabilitation once again in ascendancy. That such an interpretation is not woefully off the mark is nowhere better illustrated than in what was widely perceived as a wholesale change in strategy toward substance use and abuse proposed in the waning days of the Clinton Administration by Gen. Barry McCaffrey, then serving as the nation’s “drug czar.” McCaffrey had presided over a “war on drugs” with its genesis in the early days of the Reagan presidency. The governing policies of the “war on drugs” placed its greatest emphases

- on the “supply” side, on the interdiction of controlled dangerous substances at points of origin (replete with American paratroopers conducting raids on coca growing fields in Colombia and US aircraft and patrol boats assiduously guarding the nation’s permeable borders), and
- on the “demand” side, on the punitive incarceration of substance users in American prisons.

But, as he prepared to leave office, Gen. McCaffrey recommended that emphasis shift emphatically to prevention and treatment. The war on drugs, he proposed, should be supplanted by a “crusade against drugs.” In a published account of his unexpected conversion, *New York Times* writer Christopher Wren (2001) described McCaffrey as “the drug warrior who would rather treat than fight.”

It should not escape notice that the pendulum began to swing not as the result of an emergent flood tide of sentiment favoring humanitarian values over punitive postures, nor even on the basis of a philosophic premise that society has little right to regulate what people ingest, whatever the psychoactive and social consequences (Szasz, 1992; Nadelman, 1993), so that *neither* criminalization *nor* medicalization constitutes an appropriate societal response to substance use. Instead, the pendulum swing seems to have been motivated largely by financial considerations in relation to the relative ineffectiveness of punitive measures (Baum, 1991). Implicitly, the newly-emerging focus (truly, re-focus) on rehabilitation for drug offenders—that is to say, a preference for medicalizing rather than criminalizing—recognizes that punitive incarceration has simply failed either to halt the “epidemic” of drug use/abuse or to reduce recidivism following release from confinement, a position that echoes the long-standing conviction in the literature on penology that prisons are them-
selves schools for the perfection of the skills associated with crime and hardly harbors for their extirpation (Pallone, 1991; see also Hughes, this issue). Nor, moreover, should it escape notice that countervailing arguments favoring the status quo are being set forth both by “true believers” and by the “privateers” who operate prison facilities in some states and/or provide staff in other states and who thus stand at risk financially should medicalization once again become dominant in such fashion that the clinic replaces the prison as the principal venue. Such arguments will continue to be propounded at least until it becomes evident to the corporate sponsors of those privateers (and the lobbyists who represent them) that privatization of outpatient drug treatment facilities (especially residential facilities)—to be sure, under contract to state authorities and thus funded through the public treasury—represents fertile but as yet unplowed territory.

CURRENT MODALITIES IN THE CORRECTIONAL TREATMENT OF DRUG ABUSERS

Even though criminalization, “just deserts,” and “get tough” sounded the theme songs of the 1980s and 1990s, treatment and/or rehabilitation services were nonetheless offered in a variety of configurations within correctional institutions and in the community for court-referred or -involved clients. Indeed, the Federal government’s Substance Abuse and Mental Health Services Administration (2000) reported that, in a recent year, some 480,000 persons had been served in drug abuse treatment facilities nationwide. That very large total number includes the self-referred as well as those who have mis-used (or have self-identified as having mis-used) either prescription drugs or over-the-counter pharmaceutical preparations, so no assumption can be made about the proportion of the total properly classifiable as “drug offenders.”

“Service” might, for example, consist of a single session in which information is provided concerning meetings of self-help groups, whether for the inquirer or a friend or a relative. For clients referred through criminal justice channels, “treatment” might range from brief psychodidactic sessions in consequence of a “driving under the influence” warning to residential treatment programs in the community or within correctional facilities.

Modalities in use in the treatment of substance abusers under the aegis of the correctional system are sometimes modeled after the principles of “rational recovery” (Trimpey, 1996) but more often follow the “Twelve Step” model pioneered by the Alcoholics Anonymous movement and adopted by Narcotics Anonymous and, with somewhat lesser relevance, by Gamblers Anonymous and Sex Offenders Anonymous (Cotte, 1997; Anderson, 1999; Wildman, 2000). Treatment patterned after, or incorporating, the Twelve-Step model has been provided for offenders sometimes within correctional settings and sometimes, for probationers and parolees, in the community (Glatt, 1974; Brown,
1985; Greer, Lawson, Baldwin & Cochrane, 1990; Hirschel & Keny, 1990; Peters, May & Kearns, 1992; Scarpiti, Inciardi & Pottieger, 1993; Peters, Kearns, Murrin, Dolente & May, 1993; Wagoner & Piazza, 1993; Tims, Inciardi, Fletcher & Horton, 1997; Ronel, 1998). Direct treatment has in some instances also been provided when needed for family members (McGaha, 1993).

Although he examined only a sample of states and the Federal prison system, Lipton’s (1998) review of effectiveness data shows generally positive results for such intervention provided within correctional institutions; Peters and Hills (1999) reached similar conclusions in their review of data from programs in community settings.

In addition to the Twelve-Step model anchored in “talk therapy,” alternate and supplemental interventions have included psychodidactic components (Newbern, Danserau & Dees, 1997) to educate offenders about the biochemical effects of habituation to substances of various sorts and covert measures for sensitization and desensitization (Daniel & Dodd, 1990). In “last chance” cases that have proven refractory to milder treatment and in which life is imminently threatened, pharmacotherapy with substance-specific chemical antagonists (e.g., Antabuse in the case of alcohol addiction) has been medically prescribed (Karper, Bennett, Erdos & Krystal, 1994). However, it is a fair assessment to say that, within the correctional community, Twelve-Step programs are prized for their strong emphasis upon self-help and upon extension of help to others who have more recently engaged the process of recovery (Scott, Hawkins & Farnsworth, 1994).

Whatever the modality, focus has generally been placed sharply on relapse prevention (Knight, Simpson & Danserau, 1994) rather than on the antecedents to addiction or to its past criminal consequences. Special attention has sometimes been given to the differential pathways to addiction pursued by women (Clement, 1997-b). In view of the massive needs for such intervention among correctional clientele, pilot programs have occasionally been undertaken to train probation and parole officers as paraprofessionals to provide substance abuse treatment (Cunningham, Herie, Martin & Turner, 1998).

As an adjunct to, or even template for, Twelve-Step programs, “institutional therapeutic community” (ITC) programs have been at least provisionally implemented in some correctional institutions and represent the prevalent model for residential substance abuse treatment (R-SAT) programs in the community, especially those in which correctional or court-referred clients represent the majority (Mrad & Krasnoff, 1976; Knight, Simpson, Chatham & Camacho, 1997; McCorkel, Harrison & Inciardi, 1998; Siege, Wang, Carlson, Falck, Rahman & Fine, 1999; Knight, Hiller, Broome & D. W. Simpson, 2000). With appropriate modifications, correctional ITC programs apply principles evolved from the introduction of “milieu therapy” in psychiatric institutions in the 1920s (Rosenbaum, 1976).
Application of the pivotal premise that a patient’s entire institutional experience, and not merely the hour or two that he/she spends with a psychiatrist each week, should yield therapeutic benefit literally revolutionized the operation of psychiatric hospitals, so that a variety of functions and services, ranging from physical activities to occupational therapy and group therapy, were introduced. Because patients and staff, including nurses and ward orderlies, began to interact intensely with each other in a variety of social configurations, a sense of community typically ensued, in which each member sought to contribute to the well-being of other members.

In correctional institutions, contemporary ITC units have tended to focus on drug offenders. Despite inherent hierarchical and prospectively adversarial relationships, corrections officers as well as rehabilitation personnel are regarded as full members of correctional ITCs. Perhaps for that reason, membership in such units is typically limited to offenders who have had few prior convictions and have incurred few disciplinary infractions during the present confinement. It is normatively (and by design) the case that group discussion, whether leaderless or peer-led, comes to occupy a major portion of time that is not otherwise consumed with institutional routines.

Family intervention services are sometimes incorporated into the template, especially in programs targeted at juvenile offenders. These services range from customary family counseling (Stringfield, 1977) and psychodidactic modalities (Sagatun, 1991; Bayse, Allgood & Van Wyk, 1992) to more aggressive and intensive “family empowerment programs” (Cameron & Cadell, 1999; Dembo, Ramirez-Garnica, Rollie & Schmeidler, 2000; Dembo, Ramirez-Garnica, Rollie, Schmeidler, Livingston & Hartsfield, 2000) aimed at family preservation combined with parent education and reduction of recidivism. It is not infrequent that parents themselves require access to a variety of social, educational, or mental health services.

Once a staple in the armamentarium of behavior therapy, token economy programs (Ottomanelli, 1976, 2001; Toch, 1988) that “reward” participants for positive behavior and “fine” them for negative behavior are often incorporated into both ITC and R-SAT modalities. In what is likely the most ambitious token economy ever implemented (Ault & Weston, 1975), inmates confined in the prisons of Georgia were permitted to “earn” release on parole by accumulating the requisite number of tokens.

THE PROBLEM OF COERCED TREATMENT

Although society may believe that it is more appropriate to treat than to punish drug abusers (that is to say, that drug abusers “need” treatment), there is scant evidence that the abusers themselves generally “want” treatment. Indeed, there is reason to believe that criminally-offending drug abusers frequently prove resistant to rehabilitation services of virtually every sort, for a variety of
reasons ranging from the ego-syntonic character both of the abuse of drugs itself (surely self-rewarding) and of certain disorders prevalent in correctional populations (e.g., mania, psychopathic deviation) to a fixed perception that whatever is offered under the benefice of the correctional authority will ultimately prove punitive. For such reasons, offenders are likely to perceive as coercive and to be resisted (Sagatun, 1981; Polchin, 1999; Knight, Hiller, Broome & Simpson, 2000; Shearer, 2000) even the most non-intrusive, non-invasive modalities of treatment for what they do not perceive as disorders.

It is not necessary to underscore that the clinical skills required when prospective clients believe themselves to be coerced into treatment may differ substantially from those required when clients are eager for treatment for disorders, problems, or issues they have identified themselves. Operationally, it is not self-evident that evolving disorder-specific “standards of care” and statements of “empirically validated treatments” derived from clinical work with the “civilian” population apply with equal cogency to correctional clients coerced into treatment.

**SUMMARY**

Although its remote origins can be traced to the end of prohibition with the repeal of the Volstead Act in 1933, the nation’s “war on drugs” gathered massive strength in the early days of the Reagan administration. During the 1980s and 1990s, the decision of the nation, expressed through its legislators, seemed to be to “criminalize” drug use or abuse through imposition of harsh penalties for what had earlier been statutorily defined as relatively minor offenses and by eliminating judicial discretion in sentencing, so that mandatory incarceration was required for many offenses. Yet by 2000, the voters of California, the Governor and criminal court judges of New York, and even the nation’s “drug czar” had decided that they would rather, as described by the New York Times, “treat then fight.” This paper has situated that sea change in posture within a context of oscillation toward the goals of corrections generally during an era in which “therapeutic nihilism” and “just deserts” appeared to have carried the day.

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