

# DRUG TREATMENT AS A CRIMINAL SANCTION

FRANKLIN E. ZIMRING\*

The 1980s witnessed the most rapid expansion in the rate of imprisonment in the United States in memory.<sup>1</sup> The growth in imprisonment for all offenses was unprecedented but the expansion in punishments for drug offenses was particularly large. Nationally, it is estimated that commitments to prison for drug offenses increased three times faster than the general rate of imprisonment after 1986.<sup>2</sup> In California, the number of drug offenders in the prisons increased fifteenfold during the 1980s.<sup>3</sup> By 1991, more persons were in California prisons for drug crimes than were in prisons in that state for all crimes in 1979.<sup>4</sup>

The number of drug offenders on probation, on parole, in alternative programs, and in jail is also vast. For this reason, the policies taken toward drug offenders in the state criminal justice systems of the United States during the 1990s will be one key determinant of criminal justice policy in general. The treatment of drug offenders raises significant theoretical as well as practical questions in the criminal justice environment in the 1990s. Just when observers were confident that the rhetoric of rehabilitation had been removed from criminal sentencing in the United States, programs to substantiate or supplement criminal sanctions with drug treatment have taken center stage in discussions of how to treat drug offenders.

Drug treatment provides a new context for debates concerning the proper role of compulsory treatment programs in criminal justice—although how new of a context is one key question for the debaters. Just as we have assumed the unpopularity of “coerced cures” as part of a regime of criminal sentencing, a new cluster

---

\* William Simon Professor of Law; Director, Earl Warren Legal Institute, Boalt Hall, University of California, Berkeley.

1. See generally FRANKLIN E. ZIMRING & GORDON HAWKINS, *THE SCALE OF IMPRISONMENT* (1991).

2. LAWRENCE A. GREENFELD, U.S. DEPARTMENT OF JUSTICE, *PRISONS AND PRISONERS IN THE UNITED STATES* 4 (1992).

3. FRANKLIN E. ZIMRING & GORDON HAWKINS, *PRISON POPULATION AND CRIMINAL JUSTICE POLICY IN CALIFORNIA* 32-35 (1992).

4. *Id.* at 32.

of treatment programs attracts enthusiastic support in popular and professional circles. Is the drug context different? Is it time to rethink general conclusions about compulsory treatment as part of prison programming?

This paper concerns what might be called the jurisprudence of compulsory drug treatment in the criminal justice system. It considers three linked questions: Is compulsory treatment of criminal offenders permissible? Are there conflicts between principles of drug treatment and requirements of just punishment? Is compulsory treatment for criminal offenders with substantial histories of drug offenses a good idea?

The first and second questions raise concerns mainly about justice in particular regimes of drug treatment in criminal justice systems, while the third question mixes concern about the justice of treatment programs with worries about their efficacy. I will argue that questions of fairness should be initially distinguished from contentions about the effectiveness of various regimes of drug treatment. While those who doubt the justice of particular regimes of penal treatment are also frequently skeptical about the efficacy of such treatments, a failure to keep apart these two disparate types of objections invites confusion.

The strategic aim of the paper is to test the compulsory drug treatment of criminal offenders against some of the themes that emerged from earlier writings which identified compulsory rehabilitation as the animating purpose of correctional systems. I conclude that compulsion in drug treatment should not be categorically excluded from the sanctioning system, but that the burden of demonstration of the value of compulsion is on its proponents; and the burden has not yet been met.

The next three sections of this paper take up the three questions in the order just stated. A brief concluding section tries to translate some of the paper's analysis into practical guidelines for the administration of drug treatment programs as part of the administration of programs of criminal sanctions.

## I. SHOULD COMPULSORY DRUG TREATMENT BE PERMITTED?

Criminal punishments are compulsory by definition; compulsion is the essence of a practice that is administered for punitive reasons. It would thus seem that any objections to compulsory drug treatment must be phrased not in terms of an argument against compulsion in sanctions but rather as an assertion that the

combination of treatment processes and criminal justice compulsion is illegitimate.

The goals of drug treatment are certainly permissible objectives of a criminal law of drug control. We can identify a strong state interest in altering the drug behavior of many criminal defendants. If possession and use of a substance can be punished as criminal, the same state interest that justifies the prohibition inheres in programs designed to reduce the predilection of individuals to use illicit drugs. Further, if the use of licit or illicit substances is intimately connected with an individual's prior criminality, a drug-crime linkage provides an adequate state interest for trying to reduce the harmful consequences of future drug- or alcohol-influenced behavior.

So, the ends of drug treatment programs are legitimate for a large number of criminal offenders. And the means (compulsion) are a defining and thus permissible characteristic of criminal punishments generally. What then is the problem?

A frequently raised objection to compulsory treatment adverts to the inconsistency of the logic or philosophy of effective treatment with compulsion as a strategy. I take this to be the gist of Professor Norval Morris's objection to the compulsory application of the individualized treatment model, when he stated, "[t]he fallacy lies in the reliance on its coercive application outside the proper constraints of a due respect for human rights. So the task is to liberate the individualized treatment model, within the prison setting, for those who for reasons other than treatment are incarcerated."<sup>5</sup>

But why is the individualized treatment model antithetical to coerced processes? Here Professor Morris asserts

[t]he model of medical treatment that underlies the present advocacy of prison training programs is itself flawed. It suffers fundamentally from a belief that psychological change can be coerced. In psychological treatment of abnormal behavior it is widely agreed that conventional psychotherapy, particularly if it is of the psychoanalytic variety, must be voluntarily entered into by the patient if it is to be effective. By contrast, in physical medicine the cooperation of patient, although desirable, is not always necessary . . . .<sup>6</sup>

This objection, proposed specifically in relation to prison programs, should apply to psychologically-based treatment pro-

---

5. NORVAL MORRIS, *THE FUTURE OF IMPRISONMENT* 27 (1974).

6. *Id.* at 17.

grams throughout the criminal justice system. It is not clear whether Morris would classify most drug treatment programs as sufficiently close to psychoanalytically-oriented individualized treatment as to be covered by sweeping assertions that such therapies do not change behavior when imposed on nonvolunteers.

Professor Morris's objections are an amalgam of ethical and pragmatic doubts, and it is difficult to tie his concerns to one central animating fault. Morris contends that coerced treatment is both ineffective and unethical. Whether the ethical objections would prove decisive for Professor Morris if prison-based programs worked well is left in doubt.

Further, it is not entirely clear whether models of volitional control—central to Morris's ethical objections—have direct application to drug and alcohol treatment. If the abusive behavior, which is the target of treatment interventions, can be characterized as something other than volitional, then the objective of a treatment intervention is to restore individual behavior to volitional control.

A wide range of inducements or coercions has been justified in settings other than criminal justice to launch treatment interventions because the target of intervention is in the throes of a chemical dependency that deprives him of effective free will.<sup>7</sup> So the enrollment of offenders into drug or alcohol treatment by inducements based on lowering punishments is consistent with the wide range of inducements and coercions used by employers, families, and others at the front end of chemical abuse treatments outside the criminal justice systems. Thus, there is no apparent conflict between the requirements of drug treatment for voluntariness, as such treatments are currently administered, and either command enrollment as a criminal sentence or inducements based on lowering punishments from those that ordinarily would be imposed.

Indeed, if the only objection to compulsory treatment is the need for totally voluntary choice, it does not follow that treatment programs could not achieve some results despite the use of coercion. There can be little doubt that behavior-changing therapies work better on those who wish to change. But a wide range of public programs—including compulsory education and military

---

7. Cf., M. Douglas Anglin, *Ensuring Success in Corrections-Based Interventions with Drug-Abusing Offenders*, Address at the University of California at Berkeley (May 11, 1990), in *CONFERENCE ON GROWTH AND ITS INFLUENCE ON CORRECTIONAL POLICY—PERSPECTIVES ON THE REPORT OF THE BLUE RIBBON COMMISSION 124-36* (1991).

training—are carried out on the assumption that fully volitional participation is not essential to the behavioral change. While scarce treatment resources might best be given to volunteer subjects, there is no basis in current literature for supposing that coerced drug and alcohol programs are categorically ineffective.

A justified premise for treatment does not, of course, mean that all acts performed in the name of drug treatment are permissible. Needlessly punitive, independently harmful, and irrational activities can and should be challenged. The special dangers that exist when a treatment regime is administered in a total institutional setting, far removed from other community settings and safeguards, require heightened scrutiny of such programs for compliance with civil liberties safeguards as well as strict quality control in monitoring treatment conditions. But there is nothing in the mission or methods of most drug treatment programs that forecloses the possibility of administering a treatment system as part of a criminal sanction.

## II. DRUG TREATMENT AND JUST PUNISHMENT

There may be no necessary clash between drug treatment programs and the requirements of a just system of criminal sanctions. It is, however, quite likely that there are conflicts between the requirements of justice in establishing criminal sanctions systems and the criteria one might otherwise wish to use for imposing social control in the name of drug treatment.

The most serious vice of sanctioning systems that were associated with the rehabilitative ideal was their tendency to distort the definition of just proportion in punishment to serve the interests of programs aimed at rehabilitating offenders.<sup>8</sup> In formal terms, the way in which rehabilitative regimes dealt with the conflict between just proportion requirements and rehabilitative program needs was to deny the existence of the conflict. What was required for treatment was, by definition, just. Such an assumption served to corrupt both the jurisprudence of criminal punishment and the treatment programs that marched under the banner of the rehabilitative ideal.

There is a consensus among academic observers on the excesses of state power under rehabilitative regimes of criminal sanctions, but opinions differ regarding how the lessons about previous ex-

---

8. FRANCIS A. ALLEN, *THE BORDERLAND OF CRIMINAL JUSTICE: ESSAYS IN LAW AND CRIMINOLOGY* 25-41 (1964).

cesses should be applied to current circumstances. One alternative is a regime in which compulsion in treatment is strictly prohibited, the solution preferred by Professor Morris.<sup>9</sup> A second path would greet claims for the appropriateness of compulsory treatment with suspicion and would require the close scrutiny of such programs both in prisons and in community settings. This second path, allowing some role for compulsory programs, creates the responsibility for administering programs without abuse. This section discusses the distortions that an emphasis on compulsory treatment may introduce into a criminal sanctioning system and some specific patterns of sanctioning that should be avoided.

The two basic flaws of rehabilitative punishment were the overreach of state power in the name of treatment and the maldistribution of criminal sanctions that occurred when treatment needs rather than deserts were put forward as the basis for distributing punishments. While these two vices were related, I believe there is sufficient distinction between them to justify separate discussion. My impression is that the demands of drug treatment are not currently distorting drug sanctions, in large part because of the other forces at work inflating the punishment of drug offenders.

#### A. *Overreach*

If the purpose of prison is the rehabilitation of criminal offenders, why not administer the system so that an individual offender is imprisoned until the treatment program directed toward his cure has succeeded? In retrospect, the ethical objection to this strategy seems clear: the prisoner's punishment is being neither defined nor limited by the culpability of his acts. Such is the clarity of hindsight.

The appropriate preventive to overreach in the name of treatment was offered by Professor Morris a quarter century ago: "[P]ower over a criminal's life should not be taken in excess of that which would be taken were his reform not considered as one of our purposes."<sup>10</sup> This general maxim works well to prevent extensions of social controls which are explicitly grounded on treatment needs. But the alternative to overreach is somewhat harder to apply; perceptions of the need for treatment do not alone influence legislative and administrative definitions of appro-

---

9. See MORRIS, *supra* note 5, at 26-27.

10. NORVAL MORRIS & COLIN HOWARD, *STUDIES IN CRIMINAL LAW* 175 (1964).

priate sentencing parameters for particular categories of offenders.

For drug offenders, there are two likely patterns of sanctioning overreach. First, there might be systems that mandate secure confinement for the sake of treatment in situations where an offender may not currently be incarcerated at all. When facing a decision of penal confinement or not—the so-called “in/out” decision—belief in the efficacy of coerced treatment will generate pressure for a custodial response, even for minor drug crimes. The second distorting pressure of a compulsory rehabilitation regime would be toward sentencing the drug abuser to much more penal confinement or penal supervision than would otherwise be deserved to accommodate the needs of treatment programs and aftercare.

Of these two overreach dangers, the second apparently generates the largest number of practical problems currently encountered. In juvenile justice, there is some pressure to create custodial sentences for drug-abusing delinquents to initiate treatment. But the belief in compulsory treatment processes exerts less pressure on the lengthening of terms of penal confinement for adults; initial terms of treatment in most drug programs are far shorter than the usual prison term or period of probationary supervision. A treatment motivation would increase the custodial stakes for the criminal sanctioning decision only when the combination of confinement and treatment would be urged as an alternative to unqualified probation or short jail terms.

Larger possibilities of overreach exist in extending the length of time for drug monitoring and possible compulsory re-treatment of drug abuse. The most likely extension of normal terms of penal supervision and confinement that could come from drug treatment logic would be a period of several years of aftercare and supervision.

One rather discouraging reason why the prospect of compulsory drug treatment does not exert much pressure to increase criminal sanctions for drugs is the enthusiastic support for long sentences of drug offenders in the name of condemnation, deterrence, and incapacitation.<sup>11</sup> Under these circumstances, the system authorizes so much power over a criminal's life in the name of the other purposes of punishment that restricting the reach of compulsory treatment to the current drug sentencing parameters is a relatively unimportant gesture.

---

11. See, e.g., 18 U.S.C. § 3565 (1988 & Supp. III 1991).

### *B. Distributive Injustice*

The second general danger associated with dedicating a penal system to compulsory treatment is that perceptions about the need for and responsiveness to treatment (rather than considerations of harm done or the culpability of actors) will become the major influence on the distribution of sanctions. To the extent that enthusiasm for treatment produces overpunishment of drug offenders, the problems and patterns have been discussed in the previous subsection. But a treatment orientation might also produce circumstances where some drug offenders are underpunished.

There are three ways in which treatment emphasis might produce underpunishment of drug offenders relative to other offenders, but only one seems a real possibility in the proximate future. An enthusiasm for prison-based treatment might violate desert limits if earlier release upon completion of treatment occurred prior to the minimum punishment necessary to reflect the seriousness of the offense. This does not seem like a major problem in the current administration of sanctions for drug offenders. Somewhat more likely, problems could arise because community-based or residential drug treatment programs are proposed as an alternative to imprisonment for persons convicted of possession or sales offenses. Diversion from prison to such programs could be seen as a problem if conditions of drug treatment constituted a lesser deprivation of liberty than the minimum punishment believed necessary for retributive purposes.

In theory, then, diversions to treatment might violate cardinal or ordinal principles of proportionality if demands of retributive justice exceeded the unpleasantness of the treatment program, and no other punishment was exacted.<sup>12</sup> But given the current environment in which sentencing decisions are made about drug offenders, undue leniency to the drug offender, even in a context of compulsory treatment, is not a major problem. Drug offenders who enter treatment programs will ordinarily be subject to sufficient social controls to meet the minimum retributive requirements of community justice. And offenders with drug problems and histories will almost always receive sufficient punishments when compared to those imposed on nondrug-involved defendants so that an unfair advantage for the drug offender is unlikely.

A much more likely equity problem would stem from the substantial difference in penal treatment between offenders who

---

12. See ANDREW VON HIRSCH, *PAST AND FUTURE CRIMES* (1985).

succeed in drug treatment programs and those who fail. If the rationale behind incarceration of drug offenders is purely retributive, in order to justify continued incarceration of an offender whose treatment has not been successful, the failure in treatment must amount to an additional sanctionable offense.

Put another way, incarceration functions beyond its efficacy as a vehicle for rehabilitation. The equity of incarceration necessarily includes consideration of maintaining custody of an offender for no other reason than to effect punishment. Retribution, or a repayment of a debt to society through the infringement of an offender's liberty, figures into the rationale for custody in the first place. A large disparity between the lengths of penal sanctions administered to treatment successes and to treatment failures raises problems of equity even if success in treatment is a distinguishing characteristic that justifies some degree of leniency.

If a dramatic difference in sentences for persons convicted of the same crime—and therefore susceptible to the same degree of social censure—were to be based only on how well an offender was doing in prison or in community-based treatment, the appearance of injustice would be obvious. But where the gap in sanctions between treatment successes and failures is created only after drug recidivism or failure to conform to a monitoring program's requirements, some difference seems justified in the extent of social control. The critical question is how much of a difference in total sanctions can be justified for individuals convicted originally of similar crimes but with different records of success in treatment and aftercare.

This question is critical because the combination of short initial sanctioning with protracted periods of drug monitoring is a rapidly growing strategy, currently used in thousands of drug-related cases in major prison systems such as those in California.<sup>13</sup> The typical pattern is one of confinement with or without treatment, followed by drug monitoring and community aftercare, followed by sanctions including reimprisonment in the event of noncompliance.<sup>14</sup> In California, by 1989, about half of each year's prison admissions were persons recommitted for parole violations.<sup>15</sup> Often these pa-

---

13. Joan Petersilia, *Crime and Punishment in California*, in *URBAN AMERICA: POLICY CHOICES FOR LOS ANGELES AND THE NATION 189-90* (James B. Steinberg et al. eds., 1992).

14. *Id.* at 190.

15. *Id.* See also Sheldon Messinger & John Berecochea, Don't Stay Too Long But Do Come Back Soon: Reflections on the Size and Vicissitudes of California's Prisoner Population, Address at the University of California at Berkeley (May 10, 1990), in *CON-*

role violations were for repeated positive urine tests. Under these circumstances, a parolee's failure in the monitoring program could double or triple the effective sanction for the original crime. This combination of social control followed by drug monitoring will take place whether or not any treatment regime is part of the initial sanctions.

This pattern is not the moral or jurisprudential equivalent of extending prison terms based solely on an individual's poor performance in prison programs or of doling out radically different initial prison terms that are based on only differential parole predictions. In the typical drug monitoring scenario, additional sanctions are based on demonstrated individual failures in community trials rather than prediction of failure. At some point, however, the continuation of social control for subsequent events increasingly attenuated from the initial charge becomes troublesome. Conviction on new criminal charges rather than revocation of parole or administrative procedures should be required before further punishment is administered. In the alternative, a state legislature could limit additional punishment on administratively-determined failure in drug programs to a set term such as eighteen months. Although the determination of a statutory maximum for additional punishment may have little empirical justification, it is no less necessary because it is arbitrary.

### III. PROGRAM EFFECTIVENESS AND PROGRAM JUSTIFICATION

Are there compulsory drug treatment programs that work? Compulsion in treatment must be instrumentally linked to success in community settings before it can be justified. The first part of this segment discusses the appropriate standard for judging the effectiveness of compulsory drug treatment of convicted offenders. The second section discusses how the degree of coercion in treatment may interact with other elements of the treatment program to produce different outcomes for different types of treatment in different criminal justice settings. I then use this notion of multiple components to emphasize two substantial gaps which exist between the knowledge concerning program effects in making specific program decisions and the information that is currently available.

---

ERENCE ON GROWTH AND ITS INFLUENCE ON CORRECTIONAL POLICY—PERSPECTIVES ON THE REPORT OF THE BLUE RIBBON COMMISSION 24-31 (1991).

A. *The Appropriate Standard of Effectiveness*

On what evidence should we conclude that coercive drug treatment programs are an effective policy tool in criminal justice? I disagree with the conclusion that compulsory treatments are effective policy when a population of convicted offenders shows less recidivism after compulsory treatment than a similar population would show after no treatment. Using this "larger than zero" standard is inappropriate because the same effects might be produced by offering all of the members of the convicted offender group drug treatment, and only treating those who elect to undertake the treatment on a voluntary basis. A comprehensive voluntary drug treatment program may have an equal or greater success rate than a comprehensive coercive drug treatment program. If a volunteer segment of convicted offenders has favorable treatment outcomes, those outcomes do not depend on coercive pressures into treatment.

The aggregate impact of a coercive program should be greater than the benefits that would be achieved by offering the same program to the same population on a voluntary basis before compulsory treatment is justified. In a society that places positive value on individual freedom, there is extra social cost that is associated with compulsion, so that additional benefits attributable to compulsion are the appropriate criterion for measuring program success.

But those who insist that programs treating convicted offenders demonstrate treatment effects equal to those found among noncriminal volunteers for treatment propose a standard for minimum success that is unrealistically high. Professor Morris argues that the scarcity of treatment resources favors reserving their availability for volunteers who would probably have higher rates of measured success.<sup>16</sup>

But the real question is not whether coerced offenders will have rates of success equal to other treated populations, but rather whether the success achieved among convicted offenders will justify the costs of their treatment. If treatment is cost-effective, the answer to the scarcity of treatment resources is that more resources should be provided. Since the criminal justice drug-abusing population includes the highest of the high-rate offenders, any measurable success in the treatment of this group is apt to produce

---

16. See MORRIS, *supra* note 5, at 14-15.

results that are cost-effective in dollar terms, and to carry more dramatic social savings than positive treatment outcomes generated by more cooperative subjects with less threatening base expectancies for crime and drug abuse.

The appropriate standard would be to deem compulsory treatment approaches successful when they produce a significantly larger aggregate desistance from drugs and reduction in future criminality than is achieved by offering voluntary drug treatment to the same population. Any compulsory treatment that produces significantly lower recidivism rates will almost certainly also produce monetary savings in excess of the marginal dollar cost of extending the treatment to the entire target population.

### *B. Classification of Treatment*

Regimes of drug treatment that might be used in the criminal justice system will differ on at least three dimensions that may influence their efficacy: the degree of coercion associated with administration, the institutional setting where the treatment is administered, and the substantive content of the treatment.

#### 1. The Degree of Coercion

The concept of coercion to treatment is not a unitary one. Some elements of coerciveness enter into most treatment decisions in the sense that external pressures motivate subjects to seek change in their lives. And no regime of treatment that depends on voluntary personal compliance can be imposed entirely against the will of the subject of treatment. The pressures that are brought to bear on convicted offenders to enter drug treatment programs range from social pressures to participate in programs, to inducements such as the avoidance of harsh conditions associated with confinement, to promised reductions in periods of confinement, to forced exposure to the initial stages of the treatment process. Unless the degree of coercion associated with treatment is irrelevant to treatment effects (and this is not known), the extent to which external pressures are used and the type of pressures employed will be variables that might well affect treatment outcomes.

#### 2. The Institutional Setting

A second variable that can be expected to influence efficacy is the environment in which a treatment program is administered. Programs administered in conjunction with criminal sanctions can

be located in settings that vary from community-based institutions which require the subject to leave home and work for only part of the day, to community-based residential facilities, to the total institutional environment of the prison.

Professor Morris argues that the criminal justice setting is of particular importance if the candidate for treatment is in prison:

Few decisions are uncomplicated by the desire to please others, to fulfill obligations, to achieve place or profit; why should the prisoner be so protected from sanctions and incentives to participate in programs which are for his own good as well as ours?

. . . On the continuum of coercion from unfettered and anonymous freedom to physical compulsion, the line of commitment to a prison by order of a criminal court is of such dramatic force and of such labeling consequence that it is a rational line to draw. . . .

The total institution has such massive impact on its charges, its authority is so annihilative of free choice, that it is essential for us to protect, so far as we can for his sake and for ours, the prisoner's freedom not to be in any treatment programs.<sup>17</sup>

Under this view, inducements and pressures to enter a treatment regime that might be allowed if the subject were a candidate for probation or for a community-based drug treatment program would be forbidden in the prison environment. This is because the psychological force associated with a particular threat or promise will vary with the nature of the current living setting and general range of choice opportunities that are open to offenders.

This perspective allows for the possibility that inducements to drug treatment not allowable in a prison program would be permitted for outpatients as a condition of their probation in the community. Strictly speaking, the degree of inducement or compulsion to this community-based alternative might be every bit as extensive as in prison-based programs, but the environment of the decision is more conducive to a free, but hard, choice in a community setting and thus may be allowed. In practical terms, then, some forms of compulsory treatment might be allowed as diversions from the prison environment but forbidden as adjuncts to it.

### 3. Substantive Content of the Treatment

There is also a large range of variation in the substantive content of treatment programs. Substance abuse treatment can

---

17. *Id.* at 19-20.

range from one-to-one conversational insight therapies to aversive conditioning regimes that may depend on treatment mechanisms as unconversational as electric shock. And in the large space between the conversational and the chemical, there are major distinctions for individual versus group therapies, between peer versus hierarchical treatment strategies, as well as a wide range of treatment appeals and degrees of monitoring and sanctions for noncompliance. Obviously, different types of treatment strategies can be expected to produce different treatment outcomes. Almost as obvious, different levels of coerciveness and different criminal justice settings may interact with different strategies of treatment to produce divergent outcomes.

So, a wide variety of different treatments and treatment settings complicates the ability to generalize about the nature and impact of compulsory drug treatment. Further, there are substantial differences in types of drugs and types of drug users that argue against general theories of drug treatment effects.<sup>18</sup> What an enormous coincidence it would be if the thousands of different drug/drug user/drug treatment combinations had the same sorts of impact.

### C. *What's Known, What Can Be Learned*

Obviously, no set of findings could cover the whole range of drug treatment issues, so the lack of a variety of documented research results to match the variation in forms of treatment is no surprise. We can never research the full range of drug treatment issues and should thus concentrate resources on answering the few specific questions which carry the greatest policy importance. On that theme, a review of some current research suggests two particularly critical gaps in knowledge about the advisability of coercing drug treatment.

First, while the combination of drug treatment and drug monitoring systems with sanctions for failure have been shown to reduce drug usage and criminality,<sup>19</sup> I know of no research that examines the separate role of the treatment. If drug surveillance

---

18. Eric D. Wish & Bruce D. Johnson, *The Impact of Substance Abuse on Criminal Careers*, in 2 CRIMINAL CAREERS AND "CAREER CRIMINALS" (Alfred Blumstein et al. eds., 1986).

19. M. Douglas Anglin & George Speckart, *Methadone Maintenance in California: A Decade's Experience*, in THE YEARBOOK OF SUBSTANCE USE AND ABUSE (L. Brill & C. Winier eds., 1983).

systems acting alone produce the same level of behavior change, the case for compulsory therapy has not been made.

That surveillance systems work for nonvolunteer subjects is no surprise. But unless we simply relabel the whole process as therapy, it is necessary to determine whether treatment components produce any marginal benefits. Random assignment into treatment plus surveillance versus pure surveillance conditions should provide powerful evidence on the distinctive effects of treatment.

A second limitation of current research is that the aggregate impact of making treatment compulsory has not been addressed. A competitive trial of importance to this issue would compare the group outcomes associated with treating all eligible subjects on a compulsory basis with the outcomes produced when all are offered treatment but only volunteers receive it. This is one of the priority research projects recommended in my conclusion.

#### IV. SOME OPERATIONAL CONCLUSIONS

As drug offenses and drug-using offenders become ever more important in the administration of criminal justice, I would suggest five conclusions of operational importance to criminal justice in the drug treatment area. My own short list of drug treatment policies involves two items concerning volunteers for drug treatment in criminal justice. Although this paper focuses on compulsory processes, it is important to realize that current treatment resources in both community and custodial settings fall far short of estimated needs and frequently are insufficient to meet the demands of a purely volunteer treatment program.

1. When drug treatment resources are insufficient to cover all convicted offenders who qualify for them, treatment space should first be allocated to volunteers. Drug treatment resources are still sufficiently scarce so that probation personnel report substantial shortages.<sup>20</sup> When rationing scarce treatment resources among otherwise eligible criminal justice clients, the case for preferring volunteers seems obvious. Ethically, as well as clinically, those who seek treatment deserve a first priority in the allocation of scarce resources whether or not their responsiveness to treatment is measurably greater than that of nonvolunteers. Meeting volunteer demand is thus a policy precondition to the serious discussion of compulsory treatment.

---

20. JOAN PETERSILIA & SUSAN TURNER, *INTENSIVE SUPERVISION FOR HIGH-RISK PROBATIONERS: FINDINGS FROM THREE CALIFORNIA EXPERIMENTS* (1990).

2. As the concentration of drug users in American prisons increases, the case for some version of treatment-on-demand in prison is quite strong. Even if prison-based programs are inherently less effective than community-based treatment, prisoners are restrained from being treated in more promising settings by an act of state that generates some obligation to provide services importantly linked to the conditions that produced imprisonment. As long as prison-based treatment holds some hope for effect, it is inappropriate to use general skepticism about prison programs as an excuse for nonprovision of treatment opportunities. If treatment might be the best use of the inmate's prison time, the resources necessary for treatment should be provided.

3. A random-assignment experiment should compare a control group of drug offenders to which voluntary drug treatment is made available to an experimental group of drug offenders who have no choice but to participate in a treatment program. This experiment would be a significant test of the policy logic of compulsory drug treatment. As noted earlier, the policy argument for compulsory treatment could have its first direct favorable evidence if the compulsory treatment group in this study yields better aggregate success than the group to which voluntary treatment was made available.

4. In community-based treatment settings, there is a need to evaluate competitively programs of drug surveillance alone against compulsory treatment programs with surveillance characteristics. Whatever the argument about compulsory treatment might concern, no one objects to compulsory surveillance of drug users by chemical means as a criminal sanction, and few would doubt the capacity of monitoring systems to influence the behavior of non-volunteers. The critical policy question is whether such systems standing alone produce equivalent results to those claimed now for compulsory treatment, including surveillance. A direct test of this hypothesis is not difficult to construct.

5. The most important policy competition of the 1990s may be community drug treatment and surveillance sanctions as an alternative to the combination of short prison time followed by community drug surveillance. Drug-abusing property felons and drug users convicted of possession and trafficking crimes together constitute the most frequent new prisoner in most American systems.<sup>21</sup> A decisive preference for either community-treatment-cum-

---

21. GREENFELD, *supra* note 2, at 14.

surveillance or imprisonment could make a difference approaching the hundreds of thousands in the cases sent to prison over the next decade. If treatment and surveillance can offset the incapacitation advantages of short-term imprisonment by reducing the subsequent drug-taking and criminality of treated groups, a shift in sanctioning policy with a large potential for shifting offender populations from prisons can be justified.

