

## NOTE

### WHAT'S SO CIVIL ABOUT CIVIL COMMITMENT?: BALANCING THE STATE'S INTEREST IN TREATING SUBSTANCE DEPENDENCE WITH THE PROTECTION OF INDIVIDUAL LIBERTY INTERESTS

#### I. INTRODUCTION

In many ways, Natalie Ciappa's senior year at a Long Island high school was like that of every other senior. She spent time with her brothers and with friends. She enjoyed watching horror movies with her family. She was a cheerleader and a gifted singer in an all-county chorus. She applied to colleges and intended to study criminal psychology at a state university.<sup>1</sup> Natalie was also addicted to heroin.<sup>2</sup>

Natalie's parents were concerned that she was using drugs, but they did not know the extent of their daughter's addiction. While their concern was enough to prompt a discussion about drug treatment, Natalie did not want to get treatment and her parents did not force her.<sup>3</sup> Instead, her parents attempted to control Natalie's drug use by enforcing rules at home. They searched her room for drugs, tracked her cell phone calls, and monitored her internet activity.<sup>4</sup> Despite her parents' attempts to keep Natalie away from drugs, on May 25, 2008, her parents discovered Natalie in her bedroom, unconscious and not breathing.<sup>5</sup> Rescue workers revived Natalie and her parents were told at the hospital that she had overdosed on heroin.<sup>6</sup>

Although Natalie's parents now understood the severity of her addiction to drugs and wanted to admit her into a drug treatment facility,<sup>7</sup> New York law did not permit them to do so without Natalie's consent.<sup>8</sup> Natalie had turned eighteen only ten weeks before her near-

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1. Jennifer Maloney, *Parents' Search for Daughter, 18, Ends in Their Worst Nightmare*, NEWSDAY (Long Island, N.Y.), June 23, 2008, at A3.

2. See Doreen Ciappa, *A Mother's Pain*, NEWSDAY (Long Island, N.Y.), July 10, 2008, at A3.

3. *Id.*

4. Joye Brown, *Her Parents' Love Couldn't Save Her*, NEWSDAY (Long Island, N.Y.), July 10, 2008, at A2.

5. *Id.*

6. *Id.*

7. See Ciappa, *supra* note 2.

8. See N.Y. MENTAL HYG. LAW § 22.07(b) (McKinney 2006) (requiring that treatment for substance dependence be voluntary).

fatal overdose, and therefore was legally an adult.<sup>9</sup> “When she overdosed . . . we thought, thank God, now they’ll put her in [drug treatment] . . . but we discovered that, no, she’s 18. And even if a kid dies and has to be resuscitated and brought into a hospital, the parents still can’t put them into rehab.”<sup>10</sup> Although her parents were responsible for her medical bills, once she turned eighteen they could no longer make medical decisions for Natalie.<sup>11</sup>

On June 21, 2008, Natalie went to a party and did not return home.<sup>12</sup> After a frantic search, her parents found her “lying face down on a couch in her friend’s rec room . . . .”<sup>13</sup> Her parents immediately performed CPR, but the attempt to resuscitate their daughter was unsuccessful.<sup>14</sup> Only three weeks after Natalie’s parents learned of her addiction and that they had no authority to get her drug treatment, Natalie died of a heroin overdose.<sup>15</sup>

Unfortunately, Natalie’s story is not unique. Drug abuse is a widespread problem in the United States<sup>16</sup> and non-medical use of narcotics by young adults has increased in recent years.<sup>17</sup> Heroin has become the “trendy drug of choice among teenagers”<sup>18</sup> and, particularly in the Northeast, its use among young adults in suburban and rural communities is rising.<sup>19</sup> Reports of heroin-related deaths of young adults nationwide<sup>20</sup> support Natalie’s parents’ contention that the law should

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9. Brown, *supra* note 4.

10. Ciappa, *supra* note 2.

11. *Id.*

12. Maloney, *supra* note 1.

13. *Id.*

14. Brown, *supra* note 4.

15. Ciappa, *supra* note 2.

16. OFFICE OF APPLIED STUDIES, SUBSTANCE ABUSE & MENTAL HEALTH SERVS. ADMIN., U.S. DEP’T OF HEALTH & HUMAN SERVS., RESULTS FROM THE 2007 NATIONAL SURVEY ON DRUG USE AND HEALTH: NATIONAL FINDINGS 16 (2008) (reporting that an estimated 19.9 million Americans aged twelve or older had used an illicit drug during the month preceding the survey).

17. *Id.* at 21 (finding that from 2002 to 2007, non-medical use of prescription pain relievers increased by 12%, rising to 4.6% among adults ages eighteen to twenty-five). According to the account of a detective sergeant who heads the Neighborhood Enforcement Special Operation Team in Fourth Precinct of Suffolk County, New York, heroin use by teenagers and young adults has increased dramatically in the last two years. Stephanie Altherr, *Smithtown Chooses to Fight*, NEWSDAY (Long Island, N.Y.), Oct. 4, 2009, at A2 (reporting an increase in arrests for heroin possession from 15 in 2004 to 117 in 2008 in Smithtown, N.Y.).

18. *Heroin Has New Victims*, WASH. TIMES (D.C.), Aug. 5, 2008, <http://www.washingtontimes.com/news/2008/aug/05/heroin-has-new-victims/>; see also Altherr, *supra* note 17 (“[O]piates—particularly prescription narcotics such as oxycodone—[are] the party drugs of choice for the 16- to 24-year-old crowd.”).

19. See Richard G. Jones, *Heroin’s Hold on the Young*, N.Y. TIMES, Jan. 13, 2008, at NJ1 (reporting that New York and New Jersey have high rates of heroin use among teenagers).

20. See, e.g., Altherr, *supra* note 17 (reporting that since January 2006, thirty people have died in Suffolk County, New York after overdosing on heroin or other opiates); Rex Hall Jr. & Julie

give parents more power to get their adult children necessary drug treatment.<sup>21</sup>

Drug and alcohol dependence are serious problems that have consequences on the quality of life of the addicted person, as well as on society.<sup>22</sup> Use of illicit drugs and alcohol is common in American society. For some people, however, use becomes abuse, and then dependence. It is widely accepted that it is imperative for a substance-dependent individual to receive treatment in order to achieve long-term sobriety.<sup>23</sup> Unfortunately, many of the people needing treatment do not receive it because they do not have the insight necessary to identify the problem.<sup>24</sup> Frequently, they require another person—a parent, a doctor, or a member of law enforcement—to recognize the problem.<sup>25</sup>

Requiring a person to seek treatment for a substance addiction is not a new idea. The criminal justice system has been mandating

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Mack, *Dying for Drugs: Toll from Opiate Overdose Rises Among Young People in Kalamazoo Area*, KALAMAZOO GAZETTE, Aug. 10, 2008, at 10 (reporting sixteen opiate-related deaths of teens and young adults in Kalamazoo County, Michigan since 2003); Jones, *supra* note 19 (reporting that three young adults died of heroin overdoses within one year in a small Connecticut town); Lourdes Medrano, *Teen Heroin Use Rising on NW Side*, ARIZ. DAILY STAR, July 20, 2008, at A1 (contending that police officers in Tucson, Arizona have noticed a rise in heroin addiction among teens and young adults, and reporting three local teen deaths by heroin overdose since 2007); Su-jin Yim, *Oregon Sees a Surge in Overdoses and Use by Teens, a Fact a Milwaukie Mom Knows All Too Well*, OREGONIAN, June 22, 2008, at A1 (reporting a 29% increase in deaths from heroin overdose in the last year in Oregon, for a total of 115 people in 2007).

21. Brown, *supra* note 4. At a town meeting concerning the rising problems of heroin use among young adults in Smithtown, New York, one mother said that her son is living on the streets and is addicted to heroin. She told the silent room that for the last four years she has been fighting to save her son from his addiction. Altherr, *supra* note 17.

22. See *infra* Part II.A.

23. The international community generally recognizes the necessity of treatment for substance dependence. “While drug-dependent persons may be imprisoned because of unlawful activity associated with their drug dependence, it remains urgent that dependent and harmful use of substances be considered as a health problem and treated accordingly.” World Health Org. [WHO], Substance Abuse Dep’t Social Change & Mental Health, *Drug and Alcohol Dependence Policies, Legislation and Programmes for Treatment and Rehabilitation*, at 63, WHO/HSC/SAB/99.10 (1999) (prepared by Lane Porter et al.), available at [http://whqlibdoc.who.int/hq/1999/WHO\\_HSC\\_SAB\\_99.10\\_chap1-7.pdf](http://whqlibdoc.who.int/hq/1999/WHO_HSC_SAB_99.10_chap1-7.pdf); see also Controlled Drugs and Substances Act, 1996 S.C., ch. 19, § 10(1) (Can.) (declaring that the purpose of sentencing for drug offenses “is to contribute to the respect for the law and the maintenance of a just, peaceful and safe society while encouraging rehabilitation, and treatment in appropriate circumstances . . .”) (emphasis added).

24. See OFFICE OF APPLIED STUDIES, SUBSTANCE ABUSE & MENTAL HEALTH SERVS. ADMIN., U.S. DEP’T OF HEALTH & HUMAN SERVS., THE NSDUH REPORT: REASONS FOR NOT RECEIVING SUBSTANCE ABUSE TREATMENT 2 (2003), available at <http://oas.samhsa.gov/2k3/SAnoTX/SAnoTX.pdf>.

25. See Douglas B. Marlowe et al., *Assessment of Coercive and Noncoercive Pressures to Enter Drug Abuse Treatment*, 42 DRUG & ALCOHOL DEPENDENCE 77, 78 (1996) (discussing the role of legal and social networks in identifying the need for and facilitating the entry into drug dependence treatment).

treatment for substance-abusing offenders for more than thirty years.<sup>26</sup> Treatment is often mistakenly thought to be effective only if the person has hit “rock bottom,”<sup>27</sup> a term used to indicate a readiness to change. Contrary to this belief, legal coercion into treatment generally correlates positively with treatment retention,<sup>28</sup> which is associated with long-term sobriety.<sup>29</sup> Other non-legal extrinsic factors such as pressure from families and employers, homelessness, and financial problems<sup>30</sup> are also considered valuable to the treatment process.<sup>31</sup> Treatment following a civil commitment for substance addiction relies on similar extrinsic factors, and therefore it can be inferred that civil commitment will also result in an increased likelihood of long-term sobriety.<sup>32</sup>

This Note posits that parents and other caregivers should be able to initiate state action committing individuals over the age of eighteen to short-term treatment where (1) the individual meets the diagnostic criteria for drug or alcohol dependence; and (2) the state finds sufficient evidence that there is a substantial risk of harm because of the drug or alcohol dependence. In order to protect the liberties of the individual, however, this Note suggests more stringent procedural and substantive laws pertaining to civil commitment for substance dependence. Part II provides an overview of the pervasiveness of substance abuse in the United States. This Part then discusses the ramifications of substance abuse on society and specifically on the criminal justice system. Part III discusses the effectiveness of legally coerced treatment. It begins with

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26. OFFICE OF NAT'L DRUG CONTROL POLICY, EXECUTIVE OFFICE OF THE PRESIDENT, DRUG POLICY INFORMATION CLEARING HOUSE FACT SHEET: DRUG TREATMENT IN THE CRIMINAL JUSTICE SYSTEM 4 (2001), available at <http://www.whitehousedrugpolicy.gov/publications/pdf/944406.pdf>.

27. See William R. Miller, *Increasing Motivation for Change*, in HANDBOOK OF ALCOHOLISM TREATMENT APPROACHES: EFFECTIVE ALTERNATIVES 89, 90-91 (Reid K. Hester & William R. Miller eds., 2d ed. 1989).

28. David Farabee et al., *The Effectiveness of Coerced Treatment for Drug-Abusing Offenders*, 62 FED. PROBATION 3, 5, 7 (1998); Matthew L. Hiller et al., *Motivation as a Predictor of Therapeutic Engagement in Mandated Residential Substance Abuse Treatment*, 29 CRIM. JUST. & BEHAV. 56, 70 (2002).

29. See Douglas Young, *Impacts of Perceived Legal Pressure on Retention in Drug Treatment*, 29 CRIM. JUST. & BEHAV. 27, 28 (2002).

30. See Marlowe et al., *supra* note 25, at 78, 81.

31. Matthew L. Hiller et al., *Problem Severity and Motivation for Treatment in Incarcerated Substance Abusers*, 44 SUBSTANCE USE & MISUSE 28, 35 (2009).

32. See Anna C. Burke & Thomas K. Gregoire, *Substance Abuse Treatment Outcomes for Coerced and Noncoerced Clients*, 32 HEALTH & SOC. WORK 7, 11 (2007) (finding that coerced clients were almost three times more likely than non-coerced clients to report abstinence from alcohol and drugs six months following discharge from treatment); see also Dominique Bourquin-Tièche et al., *Involuntary Treatment of Alcohol-Dependent Patients: A Study of 17 Consecutive Cases of Civil Commitment*, 7 EUR. ADDICTION RES. 48, 51 (2001) (discussing increased abstinence from alcohol following civil commitment).

an analysis of motivation for treatment and the role of coerced, extrinsic factors. This Part goes on to discuss the use of legal coercion in the criminal justice system, focusing specifically on drug treatment courts. This Part ends with a look at coercive treatment in the civil system. Part IV offers a detailed description of the legal constraints to civil commitment for substance dependence, addressing the constitutional requirements of procedural and substantive due process. Finally, Part V proposes a model rule for civil commitment of people suffering from substance dependence, where there is a substantial risk of harm because of this dependence. This Part recommends that all states adopt the proposed statute, but that the rise in heroin use among young adults in New York necessitates that the statute be adopted by New York.

## II. PERVASIVENESS OF SUBSTANCE ABUSE IN THE UNITED STATES

### A. *The Impact of Substance Abuse on Society*

The American Psychiatric Association (“APA”) defines substance dependence<sup>33</sup> as “[a] maladaptive pattern of substance use, leading to clinically significant impairment or distress, as manifested by *three* (or more) of the following, occurring at any time in the same 12-month period<sup>34</sup>: tolerance; withdrawal; higher quantity of substance or frequency of use than intended; desire or unsuccessful attempts to reduce use; much time given to obtaining, using, or recovering from the substance; reduced social, occupational, or recreational activities due to use; and use continued despite persistent physical or psychological problems caused or exacerbated by use.<sup>35</sup> Substance abuse<sup>36</sup> is a

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33. AM. PSYCHIATRIC ASS’N, DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS 181 (4th ed. 1994). Alcohol dependence has the same criteria as other drugs. *See id.* at 195.

34. *Id.* at 181 (emphasis added).

35. *Id.* Compare the criteria for substance dependence with the criteria for substance abuse, which requires

[a] maladaptive pattern of substance use leading to clinically significant impairment or distress, as manifested by *one* (or more) of the following, occurring within a 12-month period: (1) recurrent substance use resulting in a failure to fulfill major role obligations at work, school, or home . . . (2) recurrent substance use in situations in which it is physically hazardous . . . (3) recurrent substance-related legal problems . . . (4) continued substance use despite having persistent or recurrent social or interpersonal problems caused or exacerbated by the effects of the substance . . .

AM. PSYCHIATRIC ASS’N, *supra* note 33, at 182-83 (emphasis added). During his term as senator, Vice President Joseph Biden introduced a bill which defined addiction and recognized that the “term ‘abuse’ used in connection with diseases of addiction has the adverse effect of increasing social stigma and personal shame, both of which are so often barriers to an individual’s decision to seek treatment.” Recognizing Addiction as a Disease Act of 2007, S. 1011, 110th Cong. § 2 (2007).

pervasive, costly<sup>37</sup> problem in American society that transcends geographic and racial lines.<sup>38</sup> Although substance abuse affects all populations, the highest rates of substance abuse and dependence occur in young adults, ages eighteen to twenty-five.<sup>39</sup> Whereas only 1% of people over the age of twenty-five are drug dependent, this figure rises to almost 6% of people ages eighteen to twenty-five.<sup>40</sup> Similarly, while less than 3% of people over the age of twenty-five are dependent on alcohol, more than 7% of people between the ages of eighteen and twenty-five suffer from alcohol dependence.<sup>41</sup> Also, significantly, males are more than two times as likely to abuse substances than females.<sup>42</sup> Substance abuse is also associated with lower levels of education,<sup>43</sup>

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Recent reform in New York drug policies has also recognized that addiction is a disease for which treatment is a necessity. "Today, drug use and addiction will no longer be considered solely a criminal matter in this state but a public health matter as well. We know that drug addiction is a disease for which there are better, more humane, more effective and less costly alternatives than prison." Assemblyman Sheldon Silver, Remarks at the Rockefeller Drug Law Press Conference (Apr. 24, 2009), *available at* <http://assembly.state.ny.us/Press/20090424a/> (discussing reform to the Rockefeller Drug Laws).

36. National and state surveys on substance use often combine statistics on substance abuse and substance dependence, although the difference is acknowledged. *See, e.g.*, OFFICE OF APPLIED STUDIES, *supra* note 16, at 71-76; ARTHUR HUGHES ET AL., DEP'T OF HEALTH & HUMAN SERVS., DHHS PUBL'N NO. SMA 08-4311, STATE ESTIMATES OF SUBSTANCE USE FROM 2005-2006 NATIONAL SURVEYS ON DRUG USE AND HEALTH 57-59 (2008), *available at* <http://www.oas.samhsa.gov/2k6state/2k6state.pdf>.

37. "[I]n 2002, the economic cost of drug abuse to the United States was \$180.9 billion." NAT'L DRUG INTELLIGENCE CTR., U.S. DEP'T OF JUSTICE, PROD. NO. 2006-Q0317-001, NATIONAL DRUG THREAT ASSESSMENT 2006, at 36 (2006).

38. In 2007, rates of substance dependence or abuse varied slightly by region of the country, with the Midwest the highest (10.0%) and the Northeast the lowest (8.1%). Prevalence differed slightly by race, with 9.4% of whites, 8.5% of blacks, and 8.3% of Hispanics suffering from substance abuse or dependence. OFFICE OF APPLIED STUDIES, *supra* note 16, at 75-76.

39. HUGHES ET AL., *supra* note 36, at 57-58. One explanation for the lower rates of drug use amongst older individuals is the "aging out" phenomenon, which theorizes that older people may be more receptive to treatment or may grow tired of the addicted lifestyle. *See* Michael Rempel & Christine Depies Destefano, *Predictors of Engagement in Court-Mandated Treatment: Findings at the Brooklyn Treatment Court, 1996-2000*, in DRUG COURTS IN OPERATION: CURRENT RESEARCH 91 (James J. Hennessy & Nathaniel J. Pallone eds., 2001); Jerome J. Platt et al., *The Prospects and Limitations of Compulsory Treatment for Drug Addiction*, 18 J. DRUG ISSUES 505, 511-12 (1988). *But see* Diana M. Hartel et al., *Gender Differences in Illicit Substance Use Among Middle-Aged Drug Users With or at Risk for HIV Infection*, 43 CLINICAL INFECTIOUS DISEASES 525, 527 (2006) (finding that 40% of people who had ever used cocaine or heroin continued use into middle-age).

40. HUGHES ET AL., *supra* note 36, at app. B, tbl.19.

41. *Id.* at app. B, tbl.17.

42. OFFICE OF APPLIED STUDIES, *supra* note 16, at 75 (finding 12.5% as compared to 5.7%, respectively).

43. *Id.* at 76 (comparing 7.5% of college graduates with 9.8% of people who did not graduate from high school abuse or are dependent on substances).

higher levels of unemployment,<sup>44</sup> and increased risk of homelessness.<sup>45</sup> Additionally, children of drug abusers suffer a higher risk of abuse or neglect because the need to obtain and use drugs may become a higher priority than the children's health and welfare.<sup>46</sup>

Because one of the effects of substance abuse is ill health and disease,<sup>47</sup> visits to the emergency department are common. In 2006, there were an estimated 958,164 visits to the emergency department<sup>48</sup> because of illicit drug use.<sup>49</sup> One-third (303,715) of these visits were individuals between the ages of eighteen and twenty-nine.<sup>50</sup> Although drug abuse generally has negative effects on health, injection drug use especially increases the health risks for the drug abuser. In 2000, there were 30,000 new cases of hepatitis C in the United States; an estimated 60% were injection drug users.<sup>51</sup> Injection drug users are also particularly susceptible to contracting HIV/AIDS, and sadly the survival rate for people with AIDS is lower when the disease is contracted by injection drug use.<sup>52</sup> Despite the grave risks associated with injection

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44. *Id.* (finding that 20.0% of unemployed adults, as compared with 10.1% of full-time employed adults and 10.6% of part-time employed adults abuse or are dependant on substances); *cf.* NAT'L DRUG INTELLIGENCE CTR., *supra* note 37, at 36 (contending that employers are negatively affected financially by employees who abuse drugs because of increased absenteeism, lost productivity, and increased use of medical benefits).

45. Jonathan B. Vangeest & Timothy P. Johnson, *Substance Abuse and Homelessness: Direct or Indirect Effects?*, 12 ANNALS EPIDEMIOLOGY 455, 459 (2002) (linking substance abuse indirectly to homelessness).

46. NAT'L DRUG INTELLIGENCE CTR., *supra* note 37, at 36.

47. *Id.*

48. An Act by Congress in 1986 entitled the Emergency Medical Treatment and Active Labor Act ("EMTALA") prohibits emergency departments from refusing treatment to the uninsured and underinsured. 42 U.S.C. § 1395dd(a) (2006). In 2001, 4.2 billion dollars in revenue was lost due to emergency physicians providing EMTALA-related care. JOINT COMM'N RES., MANAGING PATIENT FLOW: STRATEGIES AND SOLUTIONS FOR ADDRESSING HOSPITAL OVERCROWDING 24 (2004).

49. OFFICE OF APPLIED STUDIES, SUBSTANCE ABUSE & MENTAL HEALTH SERVS. ADMIN., U.S. DEP'T OF HEALTH & HUMAN SERVS., DHHS PUBL'N NO. SMA 08-4339, DRUG ABUSE WARNING NETWORK, 2006: NATIONAL ESTIMATES OF DRUG-RELATED EMERGENCY DEPARTMENT VISITS 19 (2008).

50. *Id.* at 23.

51. CTR. FOR DISEASE CONTROL & PREVENTION, DEP'T OF HEALTH & HUMAN SERVS., VIRAL HEPATITIS AND INJECTION DRUG USERS 3 (2002), [http://www.cdc.gov/idu/hepatitis/viral\\_hep\\_drug\\_use.pdf](http://www.cdc.gov/idu/hepatitis/viral_hep_drug_use.pdf). Although there are other methods of contraction, in the United States, the transmission of hepatitis C most often occurs by injection drug users sharing needles. One-third of injection drug users ages eighteen to thirty are infected with hepatitis C; this number rises to 70% to 90% of older injection drug users, indicating an increased risk of contraction associated with continued use of injection drugs. *See* Hepatitis C FAQs for Health Professionals, <http://www.cdc.gov/hepatitis/HCV/HCVfaq.htm> (last visited Oct. 29, 2009); *see, e.g.*, Stephen Smith, *Hepatitis C Rises Among Young People*, BOSTON GLOBE, May 8, 2007, at A1 (reporting a correlation between the 300% increase in hepatitis C from 2001 to 2005 among young adults ages fifteen to twenty-five and the state-wide epidemic of heroin use).

52. NAT'L DRUG INTELLIGENCE CTR., *supra* note 37, at 36.

drug use, a national survey conducted in 2004 indicated that more than 3.5 million people have injected illicit drugs in their lifetime; 14% were between the ages of eighteen and twenty-five.<sup>53</sup>

Despite the pervasiveness of substance abuse and dependence, the treatment gap is significantly wide. The treatment gap represents the number of people who need treatment for substance abuse or dependence, but who do not receive it in a specialty facility such as an inpatient or outpatient drug and alcohol rehabilitation facility, a hospital, or a mental health center.<sup>54</sup> In 2000, 4.7 million people needed treatment for drug abuse or dependence, but only 16% (0.8 million) received it.<sup>55</sup> This treatment gap represented 1.7% of the total national population. By 2006, this number had increased to 2.5%.<sup>56</sup> Close to 24 million people needed treatment for a problem with drugs or alcohol in 2006; however, only 11%<sup>57</sup> (2.5 million) received the necessary treatment.<sup>58</sup> Most people who abuse or are dependent on substances do not perceive the need for treatment.<sup>59</sup> Therefore, despite the severity and pervasiveness of substance abuse and dependence, the majority of people who need treatment do not receive it.<sup>60</sup> Legally mandated treatment could narrow the treatment gap by providing treatment to individuals who meet the diagnostic criteria of substance dependence, regardless of the individual's recognition of a problem.

### *B. The Impact of Substance Abuse on the Criminal Justice System*

It is well-established in addiction research that there is an association between substance abuse and crime.<sup>61</sup> Rates of illicit drug

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53. *Id.*

54. *See* HUGHES ET AL., *supra* note 36, at 59.

55. OFFICE OF APPLIED STUDIES, SUBSTANCE ABUSE & MENTAL HEALTH SERVS. ADMIN., U.S. DEP'T OF HEALTH & HUMAN SERVS., DHHS PUBL'N NO. SMA 02-3640, NATIONAL AND STATE ESTIMATES OF THE DRUG ABUSE TREATMENT GAP: 2000 NATIONAL HOUSEHOLD SURVEY ON DRUG ABUSE 4 (2002), *available at* <http://oas.samhsa.gov/TXgap/TXgap.pdf>.

56. *See* HUGHES ET AL., *supra* note 36, at 59.

57. Of admissions to publicly funded substance abuse treatment programs in 2006, 10.4% were ages fifteen to nineteen, 14.4% were ages twenty to twenty-four, and 14.0% were ages twenty-five to twenty-nine. NAT'L INST. ON DRUG ABUSE, U.S. DEP'T OF HEALTH & HUMAN SERVS., NIDA INFOFACTS: TREATMENT STATISTICS 1-2 (2008), <http://www.nida.nih.gov/PDF/InfoFacts/TreatmentStats08.pdf>.

58. *Id.* at 1.

59. In 2002, only 6% of people with untreated drug abuse or dependence and less than 5% of those with untreated alcohol abuse or dependence reported a perceived unmet treatment need. OFFICE OF APPLIED STUDIES, *supra* note 24, at 2.

60. *Id.* (reporting that in 2002 only 18% of people needing treatment for an illicit drug problem and 8% of people needing treatment for an alcohol problem received treatment).

61. Sharon M. Boles & Karen Miotto, *Substance Abuse and Violence: A Review of the Literature*, 8 AGGRESSION & VIOLENT BEHAV. 155, 169 (2003); Alfred S. Friedman, *Substance*



use are significantly greater in criminal justice populations as compared with the general population.<sup>62</sup> Although there may not be a causal relationship because of other influencing factors, substance abuse is considered a predisposing factor to criminal, especially violent, behavior.<sup>63</sup> Alcohol or drug use often occurs prior to or during the commission of violent crimes.<sup>64</sup> One study also indicates that individuals who abuse multiple drugs are twice as likely to commit offenses and to commit twice the number of offenses as compared to abusers of a single drug.<sup>65</sup>

The necessity of addressing substance abuse within the criminal justice system has become apparent. In 2002, national costs of the criminal justice system attributed to drug abuse were almost 30 billion dollars.<sup>66</sup> Only ten years earlier, the cost to the criminal justice system was half that amount.<sup>67</sup> In 2000, drug-related offenders accounted for 21% of the state and 57% of the federal prison population.<sup>68</sup>

Also significant is the correlation between drug use and the commission of violent crimes. In 2004, almost 28% of violent offenders in state prison and 24% in federal prison were under the influence of drugs at the time the offense was committed.<sup>69</sup> Almost 50% of violent offenders in both state and federal prison admitted drug use in the month prior to the offense.<sup>70</sup> Another concern is that the commission of property crimes in order to support a drug habit correlates to escalating

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*Use/Abuse as a Predictor to Illegal and Violent Behavior: A Review of the Relevant Literature*, 3 AGGRESSION & VIOLENT BEHAV. 339, 350-51 (1998); Eric L. Sevigny & Phyllis D. Coontz, *Patterns of Substance Involvement and Criminal Behavior: A Gender-Based Cluster Analysis of Pennsylvania Arrestees*, 52 INT'L J. OFFENDER THERAPY & COMP. CRIMINOLOGY 435, 435 (2008).

62. Arthur J. Lurigio, *Drug Treatment Availability and Effectiveness: Studies of the General and Criminal Justice Populations*, 27 CRIM. JUST. & BEHAV. 495, 496 (2000).

63. Friedman, *supra* note 61, at 350.

64. Boles & Miotto, *supra* note 61, at 169.

65. Trevor Bennett & Katy Holloway, *The Association Between Multiple Drug Misuse and Crime*, 49 INT'L J. OFFENDER THERAPY & COMP. CRIMINOLOGY 63, 74 (2005).

66. OFFICE OF NAT'L DRUG CONTROL POLICY, EXECUTIVE OFFICE OF THE PRESIDENT, THE ECONOMIC COSTS OF DRUG ABUSE IN THE UNITED STATES: 1992-2002 § IV-6 (2004), available at [www.ncjrs.gov/ondcpubs/publications/pdf/economic\\_costs.pdf](http://www.ncjrs.gov/ondcpubs/publications/pdf/economic_costs.pdf). In 2002, societal costs related to drug abuse totaled 29.051 billion dollars (9.785 billion dollars was spent on police protection, 2.336 billion dollars on legal adjudication, 14.236 billion dollars on state and federal corrections, and 2.694 billion dollars on local corrections). *Id.*

67. *Id.* (finding that in 1992, estimated costs of drug abuse in the criminal justice system were 14.5 billion dollars).

68. Bureau of Justice Statistics, U.S. Dep't of Justice, Criminal Offenders Statistics, <http://www.ojp.gov/bjs/crimoff.htm> (last visited Sept. 12, 2009).

69. CHRISTOPHER J. MUMOLA & JENNIFER C. KARBERG, U.S. DEP'T OF JUSTICE, PUBL'N NO. NCJ 213530, DRUG USE AND DEPENDENCE, STATE AND FEDERAL PRISONERS, 2004, at 5, tbl.4 (2006), available at <http://bjs.ojp.usdoj.gov/content/pub/pdf/dudsfp04.pdf>.

70. *Id.*

drug use.<sup>71</sup> In 2004, 17% of state and 18% of federal prisoners said that they committed the crime for which they were incarcerated in order to get money for drugs.<sup>72</sup>

Attempts to reduce distribution and use of illicit drugs through increased penalties have been ineffective.<sup>73</sup> President Richard Nixon first declared the nation's war on drugs in 1971,<sup>74</sup> in part because soldiers fighting in Vietnam were returning to the United States addicted to heroin.<sup>75</sup> Subsequent legislation attempted to control drug importation and distribution in the United States through tactics such as the establishment of mandatory minimum sentences,<sup>76</sup> increased bail amounts, and asset forfeiture for drug-related offenses.<sup>77</sup> The harsher penalties for drug-related offenses were intended to use fear of punishment to deter drug use.<sup>78</sup> However, research has indicated that neither perceived legal risk nor actual legal penalty is related to the prevalence of drug use.<sup>79</sup>

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71. See Lurigio, *supra* note 62, at 496.

72. Bureau of Justice Statistics, U.S. Dep't of Justice, Drug Use and Crime, <http://www.ojp.usdoj.gov/bjs/DCF/duc.htm> (last visited Sept. 12, 2009).

73. Lurigio, *supra* note 62, at 496.

74. "I am transmitting legislation to the Congress to consolidate at the highest level a full-scale attack on the problem of drug abuse in America." President Richard Nixon, Special Message to the Congress on Drug Abuse Prevention and Control (June 17, 1971), available at <http://www.presidency.ucsb.edu/ws/index.php?pid=3048>.

75. *Id.*; see also Dana Adams Schmidt, *President Orders Wider Drug Fight; Asks \$155-Million*, N.Y. TIMES, June 18, 1971, at 1 (discussing addiction treatment for soldiers serving in Vietnam).

76. President Barack Obama said during his campaign for the presidency that he "would review mandatory minimum drug sentencing and give first-time, nonviolent drug offenders a chance to serve their sentence in drug rehabilitation programs instead of prison." Nedra Pickler, *I'd Ease Drug-Sentencing Laws: Obama*, CHI. SUN-TIMES, Sept. 30, 2007, <http://www.suntimes.com/news/politics/obama/581041,CST-NWS-obama30.article>.

77. JAMES P. GRAY, WHY OUR DRUG LAWS HAVE FAILED AND WHAT WE CAN DO ABOUT IT: A JUDICIAL INDICTMENT OF THE WAR ON DRUGS 27 (2001); see also RON CHEPESIUK, THE WAR ON DRUGS: AN INTERNATIONAL ENCYCLOPEDIA 240-41 (1999).

78. COMM'N ON BEHAVIORAL & SOC. SCIS. & EDUC., INFORMING AMERICA'S POLICY ON ILLEGAL DRUGS: WHAT WE DON'T KNOW KEEPS HURTING US 191 (2001).

79. *Id.* at 191-92 (summarizing the results of several studies); see also Robert MacCoun & Peter Reuter, *Drug Control*, in THE HANDBOOK OF CRIME AND PUNISHMENT 207, 213 (Michael Tonry ed., 1998) (claiming that fear of sanctions does not have a deterrent effect because "individuals do not use sanctioning risk information in the manner implied by rational choice models" and that increased severity in sanctioning is counterproductive to the goals of reducing drug-related offenses). Despite evidence that increased punishment does not result in a decrease of drug use, federal agencies have claimed the opposite. For example, the Drug Enforcement Administration asserts that enforcement of drug laws discourages drug use by increasing the legal risk associated with use, citing as proof an anecdotal *Newsweek* article written by a self-proclaimed casual drug user. DRUG ENFORCEMENT ADMIN., U.S. DEP'T OF JUSTICE, SPEAKING OUT AGAINST DRUG LEGALIZATION 7 (2003), available at [www.usdoj.gov/dea/demand/speakout/speaking\\_out-may03.pdf](http://www.usdoj.gov/dea/demand/speakout/speaking_out-may03.pdf) (citing Charles Van Deventer, *I'm Proof: The War on Drugs Is Working*, NEWSWEEK, July 2, 2001, <http://www.newsweek.com/id/78578>); see also MICHAEL TONRY, MALIGN

Instead, research has indicated that substance abuse treatment is a more effective method of reduction of drug use and associated crimes within the criminal offender population.<sup>80</sup> Recognizing this need for substance abuse treatment, legal coercion has become a common method of obtaining treatment for substance-abusing criminal offenders.<sup>81</sup> In 2006, the criminal justice system served as the primary source of referral to treatment for substance abusers aged eighteen to twenty-five.<sup>82</sup> Involuntary civil commitment into drug and alcohol treatment programs will enable individuals with diagnosed substance dependence to receive necessary treatment without requiring prior entry into the criminal justice system.

### III. EFFECTIVENESS OF LEGALLY COERCED SUBSTANCE ABUSE TREATMENT

#### *A. Motivation to Change as a Factor in Coerced Treatment*

Motivation is considered a critical factor in participation, retention, and success of drug and alcohol treatment.<sup>83</sup> Individuals entering substance abuse treatment programs generally report extrinsic, coercive motivations for seeking treatment including pressure from families and employers and situations such as homelessness, financial difficulties, and legal difficulties.<sup>84</sup> While “coercion” is frequently thought of as a legal mandate to enter substance abuse treatment, within addiction literature the word “coercion” can be used to refer to “a probation officer’s recommendation to enter treatment, a drug court judge’s offer of a choice between treatment or jail, a judge’s requirement that the offender enter treatment as a condition of probation, or a correctional

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NEGLECT—RACE, CRIME, AND PUNISHMENT IN AMERICA 19-24 (1995) (discussing assertions made by the director of the Department of Justice’s Bureau of Justice Statistics concerning the inverse relationship between incarceration and crime rates).

80. Lurigio, *supra* note 62 at 500-06; *see also* Frank S. Pearson & Douglas S. Lipton, *A Meta-Analytic Review of the Effectiveness of Corrections-Based Treatments for Drug Abuse*, 79 PRISON J. 384, 405, 407 (1999). *But see* Farabee et al., *supra* note 28, at 5, 8 (attributing mixed positive and negative results to type of program and characteristics of offender).

81. *See generally* Farabee et al., *supra* note 28, at 3 (1998) (discussing the referral rate of the criminal justice system to substance abuse treatment programs).

82. OFFICE OF APPLIED STUDIES, SUBSTANCE ABUSE & MENTAL HEALTH SERVS. ADMIN., U.S. DEP’T OF HEALTH & HUMAN SERVS., THE DASIS REPORT: FIRST-TIME AND REPEAT ADMISSIONS AGED 18 TO 25 TO SUBSTANCE ABUSE TREATMENT: 2006, at 4 (2008), <http://www.oas.samhsa.gov/2k8/timesTX/timesTX.pdf>.

83. Hiller et al., *supra* note 28, at 56-58.

84. *See* Marlowe et al., *supra* note 25, at 78, 81.

policy of sending inmates involuntarily to a prison treatment program.<sup>85</sup> Although coerced treatment conflicts with the principle of autonomy,<sup>86</sup> mandatory treatment of substance dependence may enable autonomy.<sup>87</sup>

People who are addicted really do not have the full capacity to be self-determining or autonomous because their addiction literally coerces their behavior. They cannot be autonomous agents precisely because they are caught up in the behavioral vice that is addiction. If that is so, then it may be possible to justify compulsory treatment for finite periods of time that could rectify this situation and restore the capacity for autonomy.<sup>88</sup>

While it has been argued that coerced treatment is likely to fail because the person may be entering treatment prior to recognizing and wanting to change problematic behaviors,<sup>89</sup> temporary coerced treatment may enable autonomous treatment decisions based on intrinsic motivation, free from coercion imposed by addiction.<sup>90</sup> However, the assumption that all people referred to treatment by the criminal justice system lack any intrinsic motivation for treatment is not empirically supported.<sup>91</sup>

Although a common goal<sup>92</sup> of treatment programs is for clients to internalize the motivation for treatment and recovery,<sup>93</sup> extrinsic

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85. Farabee et al., *supra* note 28, at 3.

86. “[T]he distinction between voluntary and coerced treatment is critical because coerced or forced treatment violates the patient’s fundamental right to liberty, and the clinician’s obligation to respect patient autonomy.” Douglas P. Olsen, *Influence and Coercion: Relational and Rights-Based Ethical Approaches to Forced Psychiatric Treatment*, 10 J. PSYCHIATRIC & MENTAL HEALTH NURSING 705, 707 (2003). Autonomy in health care is defined as “a fundamental expression of respect for the humanity of patients [that gives] priority to the patients’ treatment goals . . . .” *Id.* at 706.

87. Arthur L. Caplan, *Ethical Issues Surrounding Forced, Mandated, or Coerced Treatment*, 31 J. SUBSTANCE ABUSE TREATMENT 117, 118 (2006). The relationship between coerced treatment and autonomy suggests a moral imperative in mandating treatment for substance dependence. *See id.* at 118, 120.

88. *Id.* at 118.

89. Miller, *supra* note 27, at 89.

90. Caplan, *supra* note 87, at 119-20 (identifying addiction as a form of coercion because cravings for the drug control behavior).

91. Farabee et al., *supra* note 28, at 6 (reporting findings that 50% of clients in a prison-based treatment program and 40% in a community-based program said that they would have entered the program without pressure from the criminal justice system); Hiller et al., *supra* note 28, at 70 (finding a high degree of variability in the intrinsic motivation of offenders referred to substance abuse treatment by the criminal justice system).

92. The goal of shifting extrinsic motivation to intrinsic may not be necessary, as a recent study found that “higher levels of employment problems, family problems, mental health, and physical health problems were related to higher treatment motivation scores.” Hiller et al., *supra* note 31, at 35.

motivational factors are useful in retaining clients in the substance abuse program.<sup>94</sup> Retention in substance abuse treatment programs is a primary concern because research indicates that length of time in treatment is a significant predictor of positive outcomes, including reducing drug rate and recidivism into the criminal justice system.<sup>95</sup> Knowledge of the consequences of failure to succeed in a substance abuse treatment program, as well as a belief that the consequences will be enforced, positively affects retention among legally mandated clients.<sup>96</sup> As one study found, “legally referred clients entered treatment earlier in their addiction career than would otherwise have been the case and . . . they stayed in treatment longer—both circumstances that are conducive to better outcome.”<sup>97</sup> Therefore, the extrinsic motivations of clients who are legally mandated or coerced into substance abuse treatment programs can increase program retention, thereby increasing positive treatment outcomes such as reduced drug use and recidivism.

#### *B. Legally Mandated Treatment After Entry into the Criminal Justice System*

It is generally understood within the addiction treatment community that mere incarceration of substance abusers without treatment fails to ameliorate the problem,<sup>98</sup> and therefore recidivism of substance use and criminal behavior is likely.<sup>99</sup> Once a substance abuser enters the criminal justice system, there are several different treatment modalities that may be available.<sup>100</sup> Programs offered within the prison system make up the first treatment modality.<sup>101</sup> These may range from intensive, highly structured, residential therapeutic communities, to outpatient programs (inside the prison setting) consisting of counseling, peer group support, and vocational counseling.<sup>102</sup> In-prison residential treatment has been shown to be effective in reducing drug use and criminality, but the need

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93. See Carl G. Leukefeld & Frank M. Tims, *Compulsory Treatment: A Review of Findings*, in *COMPULSORY TREATMENT OF DRUG ABUSE: RESEARCH AND CLINICAL PRACTICE* 236, 243 (Carl G. Leukefeld & Frank M. Tims eds., 1988).

94. Farabee et al., *supra* note 28, at 5.

95. Young, *supra* note 29, at 28.

96. *Id.* at 51.

97. Farabee et al., *supra* note 28, at 5.

98. See *supra* note 23.

99. See *supra* Part II.B.

100. OFFICE OF NAT'L DRUG CONTROL POLICY, *supra* note 26, at 3.

101. See *id.* at 3-4.

102. *Id.*

for treatment in prisons exceeds treatment availability;<sup>103</sup> only a small percentage of inmates needing treatment receive services.<sup>104</sup> Therefore, although treatment in prisons is effective, the demand cannot be fully met. The second treatment modality consists of programs offered as a condition to probation or parole.<sup>105</sup> As most offenders are managed through probation and parole supervision, community-based treatment services provide needed drug and alcohol treatment.<sup>106</sup>

Finally, drug treatment within a diversionary program may be offered as an alternative to incarceration.<sup>107</sup> Drug Treatment Courts emerged in the late 1980s<sup>108</sup> and have become a popular method of treatment as a cost-effective<sup>109</sup> alternative to incarceration for substance-abusing offenders.<sup>110</sup> A study comparing the effectiveness of drug courts in New York<sup>111</sup> to prison without treatment found that subsequent arrest

103. Matthew L. Hiller et al., *Recidivism Following Mandated Residential Substance Abuse Treatment for Felony Probationers*, 86 PRISON J. 230, 232 (2006).

104. Lurigio, *supra* note 62, at 510-11.

105. A recent study on the effectiveness of probation-based treatment was inconclusive. Hiller et al., *supra* note 103, at 239.

106. *See id.* at 232.

107. OFFICE OF NAT'L DRUG CONTROL POLICY, *supra* note 26, at 4.

108. *Id.* Drug Treatment Courts had their inception in the United States, but in the late 1990s Canada also implemented Drug Treatment Courts. The Canadian Drug Treatment Courts were modeled after the United States Drug Treatment Courts, but modified in order to conform to the Canadian legal system. Benedikt Fischer et al., *Compulsory Drug Treatment in Canada: Historical Origins and Recent Developments*, 8 EUR. ADDICTION RES. 61, 65 (2002).

109. Costs of prosecution and imprisonment are reduced when the "defendant . . . successfully divert[s] from the traditional [penal] system." OFFICE OF NAT'L DRUG CONTROL POLICY, *supra* note 26, at 5 ("For example, the drug court operating in Washington, D.C., has reported that a defendant processed through a drug court saves the District between \$4,065 and \$8,845 per client in jail costs; prosecution costs are also reduced by an estimated \$102,000, annually.")

110. Deborah K. Shaffer et al., *Examining the Differential Impact of Drug Court Services by Court Type: Findings from Ohio*, 6 DRUG CT. REV. 33, 36 (2008), available at <http://www.ndci.org/sites/default/files/ndci/DCRV11%5B1%5D.pdf>.

111. Although drug courts have been effective, the New York State Commission on Sentencing Reform has called for reforms in the state's drug laws in order to ensure treatment options are being offered consistently to eligible drug offenders. N.Y. STATE COMM'N ON SENTENCING REFORM, THE FUTURE OF SENTENCING IN NEW YORK STATE: RECOMMENDATIONS FOR REFORM 79 (2009), available at [http://criminaljustice.state.ny.us/pio/csr\\_report2-2009.pdf](http://criminaljustice.state.ny.us/pio/csr_report2-2009.pdf) [hereinafter RECOMMENDATIONS FOR REFORM]. A 2002 study of the 198 most populated counties in the United States (including nine counties in New York State) indicated that the number of African-Americans admitted to prison for drug offenses was twice the number of whites, even though the number of white drug users is five times higher than African-American drug users. JUSTICE POLICY INST., THE VORTEX: THE CONCENTRATED RACIAL IMPACT OF DRUG IMPRISONMENT AND THE CHARACTERISTICS OF PUNITIVE COUNTIES 10 (2007), [www.justicepolicy.org/images/upload/07-12\\_REP\\_Vortex\\_AC-DP.pdf](http://www.justicepolicy.org/images/upload/07-12_REP_Vortex_AC-DP.pdf). In part because of racial disparities in prisons across the country and in New York, the Commission on Sentencing Reform recommended establishing a "uniform statewide diversion program for drug-addicted non-violent felony offenders" in order to ensure that treatment is available to all criminal offenders meeting eligibility criteria. RECOMMENDATIONS FOR REFORM, *supra*, at 78-79.

rates of people that completed a drug court program were “29 percent lower over three years.”<sup>112</sup> Drug courts have been shown to be highly effective at reducing drug use and recidivism of criminal behavior<sup>113</sup> and have long-term implications for reducing costs of prosecution, incarceration, public assistance, and health care.<sup>114</sup> As of 2003, New York had saved an estimated 254 million dollars in prison-related expenses by diverting eligible<sup>115</sup> drug offenders into drug courts in lieu of incarceration.<sup>116</sup>

The target population of drug courts is generally non-violent offenders with substantial addiction problems.<sup>117</sup> Drug courts are not intended for individuals with long criminal histories.<sup>118</sup> Defendants often plead guilty in exchange for a deferred judgment or probation, conditioned on successful completion of the drug court program.<sup>119</sup> Similar to civil commitment for substance dependence, drug courts may be considered an early intervention program for individuals suffering from substance addiction.<sup>120</sup>

Drug courts adopt a team approach to treating offenders, bringing together treatment providers, prosecutors, defense attorneys, and judges.<sup>121</sup> The treatment model combines community-based treatment

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112. Paul von Zielbauer, *Court Treatment System Is Found to Help Drug Offenders Stay Clean*, N.Y. TIMES, Nov. 9, 2003, at 33.

113. OFFICE OF NAT'L DRUG CONTROL POLICY, *supra* note 26, at 4-5.

114. Charles J. Hynes, *Prosecution Backs Alternative to Prison for Drug Addicts*, CRIM. JUST., Summer 2004, at 28, 30.

115. *See infra* notes 117-19 and accompanying text.

116. *See* von Zielbauer, *supra* note 112.

117. CARY HECK, NAT'L DRUG COURT INST., MONOGRAPH SERIES 6, LOCAL DRUG COURT RESEARCH: NAVIGATING PERFORMANCE MEASURES AND PROCESS EVALUATIONS 4 (2006), available at <http://www.ndci.org/publications/NRACReport.pdf>; *see also* RECOMMENDATIONS FOR REFORM, *supra* note 111, at 97 (recommending a “Judicial Diversion” model which would provide the possibility of diversion to treatment for both first- and second-time non-violent felony drug offenders).

118. *See* HECK, *supra* note 117, at 4.

119. Morris B. Hoffman, Commentary, *The Drug Court Scandal*, 78 N.C. L. REV. 1437, 1462 (2000). *But see* Richard C. Boldt, *Rehabilitative Punishment and the Drug Treatment Court Movement*, 76 WASH. U. L.Q. 1205, 1211-12 (1998) (discussing due process concerns because failure to successfully complete the drug court program may result in a lengthier incarceration than would have been imposed had the defendant been initially adjudicated in a traditional criminal court); Fischer et al., *supra* note 108, at 66 (“The fact that many offenders have to plead guilty to their charge in order to enter the drug treatment court may represent a threat to offenders’ due process rights. These constitutionally protected rights are often undermined under circumstances of termination of treatment for non-compliance and redirection to the traditional criminal justice process.”).

120. *See* HECK, *supra* note 117, at 4.

121. Lurigio, *supra* note 62, at 508.

(outpatient, residential, or a combination) with judicial supervision.<sup>122</sup> The programs are designed to last a significant length of time in order to improve treatment outcomes.<sup>123</sup> Participants submit to regular drug screening and appear before the court frequently.<sup>124</sup> Rewards for progress may include fewer court appearances and less intensive treatment, whereas participants may receive community service or short jail stays as sanctions for program noncompliance.<sup>125</sup>

The existence and value of the legally coercive nature of drug courts has been a subject of debate within the addictions field.<sup>126</sup> An argument has been made that drug courts are really “voluntary programs that do not diminish the right to refuse treatment.”<sup>127</sup> Eligible defendants are given the choice between the drug court program and traditional case processing.<sup>128</sup> However, traditional case processing frequently involves incarceration, and the significance of that pressure should be viewed as potentially coercive.<sup>129</sup> “When coercion is employed in the drug treatment court system, it does not involve forcing the defendant to receive treatment . . . it is the careful leverage of judicial authority to encourage the offender to choose the most statistically probable opportunity for rehabilitation and a better life.”<sup>130</sup> Additionally, drug courts may be justifiably<sup>131</sup> coercive because of the positive relationship between perceived legal coercion and retention in treatment and the subsequent correlation to positive treatment outcomes.<sup>132</sup> Drug courts are an effective method of diverting people with substance abuse problems out of the criminal justice system while providing them with the treatment necessary to reduce alcohol and illicit drug use.

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122. *See id.*; MICHAEL REMPEL ET AL., CTR. FOR COURT INNOVATION, THE NEW YORK STATE ADULT DRUG COURT EVALUATION: POLICIES, PARTICIPANTS AND IMPACTS 18 (2003).

123. *See* Lurigio, *supra* note 62, at 515 (finding that duration of treatment is positively related to treatment outcome and that three to nine months is the ideal treatment duration); *see also* REMPEL ET AL., *supra* note 122, at 20 (stating that of the New York drug courts evaluated, six of the eleven drug courts require at least one year of participation prior to successful completion of the program).

124. Lurigio, *supra* note 62, at 508.

125. *Id.*; Patricia L. Arabia et al., *Sanctioning Practices in an Adult Felony Drug Court*, 6 DRUG CT. REV. 1, 6 (2008), <http://www.ndci.org/publications/DCRVII.pdf>.

126. Marlowe et al., *supra* note 25, at 77.

127. Peggy Fulton Hora & Theodore Stalcup, *Drug Treatment Courts in the Twenty-First Century: The Evolution of the Revolution in Problem-Solving Courts*, 42 GA. L. REV. 717, 746 (2008).

128. *Id.*

129. *See* Toby Seddon, *Coerced Drug Treatment in the Criminal Justice System: Conceptual, Ethical and Criminological Issues*, 7 CRIMINOLOGY & CRIM. JUST. 269, 278 (2007).

130. Hora & Stalcup, *supra* note 127, at 753.

131. “Some commentators have directly linked the question of ethics with that of effectiveness, arguing that coerced treatment is only ethically justifiable if it achieves positive outcomes.” Seddon, *supra* note 129, at 280.

132. *See supra* Part III.A.



### C. Legally Mandated Treatment in the Civil System

Civil commitment of individuals suffering from substance dependence provides a method of coercing the person into treatment without requiring entry into the criminal justice system.<sup>133</sup> “Civil commitment is a legal procedure that allows narcotics addicts or other drug addicts to be committed to a compulsory drug treatment program, typically involving a residential period and an aftercare period in the community.”<sup>134</sup> Early intervention of coerced treatment, without necessitating entry into the criminal justice system, may reduce social costs associated with substance dependence.<sup>135</sup>

Civil commitment for substance abuse is accepted within the international community. In 1967, the World Health Organization (“WHO”)<sup>136</sup> issued a statement proclaiming that “[a]dequate treatment and rehabilitation should, if necessary, be ensured by civil commitment of drug-dependent persons to medical authority, which would provide direction and supervision of their care, from initial diagnosis to rehabilitation.”<sup>137</sup> Twenty-one years later, WHO continues to support compulsory treatment of substance dependence “in exceptional crisis situations of high risk to self or others . . . .”<sup>138</sup> Civil laws in some European countries allow for commitment of substance dependent individuals.<sup>139</sup> Although in the United States many state statutes do not

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133. See BRUCE J. WINICK, *CIVIL COMMITMENT: A THERAPEUTIC JURISPRUDENCE MODEL* 43 (2005) (discussing that deprivation of liberty generally requires a finding of guilt in the criminal justice system, but that the purpose of civil commitment is preventative detention).

134. M. Douglas Anglin & Yih-Ing Hser, *Legal Coercion and Drug Abuse Treatment: Research Findings and Social Policy Implications*, in *HANDBOOK OF DRUG CONTROL IN THE UNITED STATES* 151, 152 (James A. Inciardi ed., 1990).

135. Brian R. Rush & T. Cameron Wild, *Substance Abuse Treatment and Pressures from the Criminal Justice System: Data from a Provincial Client Monitoring System*, 98 *ADDICTION* 1119, 1120 (2003).

136. The U.N. encourages WHO to work “with governments with a view to facilitating access to drug treatment programs and to strengthen the capacity of primary health care programs to respond to drug-related health problems.” Lane Porter, *Comparative Drug Treatment Policies and Legislation*, 29 *INT’L LAW.* 697, 703 (1995).

137. WHO, *Services for the Prevention and Treatment of Dependence on Alcohol and Other Drugs*, at 42, WHO Technical Rep. Ser. No. 363 (1967), available at [http://whqlibdoc.who.int/trs/WHO\\_TRS\\_363.pdf](http://whqlibdoc.who.int/trs/WHO_TRS_363.pdf).

138. U.N. OFFICE ON DRUGS & CRIME, WHO, *DISCUSSION PAPER: PRINCIPLES OF DRUG DEPENDENCE TREATMENT* 10 (2008), [http://www.who.int/entity/substance\\_abuse/publications/principles\\_drug\\_dependence\\_treatment.pdf](http://www.who.int/entity/substance_abuse/publications/principles_drug_dependence_treatment.pdf).

139. Loi fédérale sur les stupéfiants [Federal Narcotics Act], Oct. 3, 1951, *Recueil systématique du droit fédéral* [RO] 812.121, art. 15b, (Switz.) available at [http://www.admin.ch/ch/f/rs/812\\_121/a15b.html](http://www.admin.ch/ch/f/rs/812_121/a15b.html) (permitting involuntary hospitalization of drug-dependent persons for the purpose of treatment); Lag om vård av missbrukare i vissa fall (Svensk författningssamling [SFS] 1988:870) (Swed.), translated in *The Care of Alcoholics, Drug Abusers and Abusers of Volatile Solvents (Special Provisions) Act*, LVM 1989, SFS 1988:870, available at

permit civil commitment for substance abuse,<sup>140</sup> several states do have legislation allowing for civil commitment of substance abusers.<sup>141</sup>

Social and legal coercion are considered key elements of civil commitment for substance dependence.<sup>142</sup> Social pressures, including legal social controls like court-ordered treatment, employee assistance programs, and persuasive interpersonal controls initiated by family or friends, are an important part of the process of initiating treatment for substance dependence.<sup>143</sup> Entry into treatment without legal coercion may still not be completely voluntary, as family members, friends, and employers are often an important part of the decision to seek treatment through their comments, suggestions, and efforts to control the substance use.<sup>144</sup> Family members can generally initiate civil commitment proceedings,<sup>145</sup> thus emphasizing the importance of social pressures in coerced treatment.

Most empirical research on coerced treatment focuses on the criminal justice system;<sup>146</sup> however, civil commitment has been shown to be effective in reducing substance use. California's Civil Addict

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<http://www.unodc.org/enl/showDocument.do?lng=fr&language=FRE&documentUId=693> (permitting civil commitment of persons abusing alcohol or drugs, provided that "as a result of the abuse, he [1] is seriously endangering his physical or mental health. [sic] [2] runs an obvious risk of ruining his life, or [3] is liable to inflict serious injury on himself or some person closely related to him."); see also Bourquin-Tièche et al., *supra* note 32, at 49 (discussing civil codes in Europe that permit civil commitment of alcoholics and illicit drug users); Esther Grichting et al., *Modes and Impact of Coercive Inpatient Treatment for Drug-Related Conditions in Switzerland*, 8 EUR. ADDICTION RES. 78, 79 (2002) (discussing involuntary civil commitment for drug dependence in Switzerland); Porter, *supra* note 136, at 712 (discussing Swedish legislation that enables involuntary civil commitment for substance dependence treatment). See generally Jessica Palm & Kerstin Stenius, *Sweden: Integrated Compulsory Treatment*, 8 EUR. ADDICTION RES. 69 (2002) (providing an overview of how the Swedish statute permitting compulsory substance abuse treatment is applied).

140. E.g., N.Y. MENTAL HYG. LAW § 22.09(e) (McKinney 2006) (prohibiting involuntary substance dependence treatment). However, substance dependence does not prevent the civil commitment of a person suffering from a concurrent mental illness. N.Y. MENTAL HYG. LAW § 9.37(g) (McKinney 2008).

141. E.g., MASS. GEN. LAWS ANN. ch. 123, § 35 (West 2003) (permitting involuntary commitment of alcoholics or substance abusers for up to thirty days); N.C. GEN. STAT. § 122C-287 (2007) (permitting involuntary commitment of substance abusers for up to 180 days).

142. See T. Cameron Wild, *Social Control and Coercion in Addiction Treatment: Towards Evidence-Based Policy and Practice*, 101 ADDICTION 40, 40 (2006).

143. *Id.*

144. See WHO, *supra* note 23, at 64.

145. MASS. GEN. LAWS ANN. ch. 123, § 35 (West 2003) (allowing a spouse or blood relative to initiate civil commitment proceedings); N.C. GEN. STAT. § 122C-281 (2007) (allowing "[a]ny individual who has knowledge of a substance abuser who is dangerous to himself or others" to initiate civil commitment proceedings).

146. Bourquin-Tièche et al., *supra* note 32, at 49.

Program (“CAP”), which was established by 1961 legislation,<sup>147</sup> allowed for the civil commitment of anyone addicted to drugs.<sup>148</sup> Although generally CAP was used to divert people arrested for drug related offenses or property crimes from the traditional criminal justice system,<sup>149</sup> CAP had a provision permitting involuntary commitment of people who had not been charged with a crime.<sup>150</sup> CAP was effective in reducing daily narcotics use<sup>151</sup> as well as criminal recidivism.<sup>152</sup> CAP’s success indicates that civil commitment can have an important effect on reducing drug use among substance-dependent individuals.<sup>153</sup> These findings are supported by a more recent study evaluating the effectiveness of civil commitment of people dependent on alcohol.<sup>154</sup> The study reports a positive correlation between civil commitment and long-term abstinence from alcohol.<sup>155</sup> Thus, involuntary civil commitment for substance dependence effectively reduces drug use and should be an option for treatment.

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147. The Supreme Court stated in dicta that a state could enact legislation that enabled civil commitment for substance abuse. *Robinson v. California*, 370 U.S. 660, 664-65 (1962) (“In the interest of discouraging the violation of such laws, or in the interest of the general health or welfare of its inhabitants, a State might establish a program of compulsory treatment for those addicted to narcotics. Such a program of treatment might require periods of involuntary confinement. And penal sanctions might be imposed for failure to comply with established compulsory treatment procedures.”) (citation omitted).

148. Anglin & Hser, *supra* note 134, at 153.

149. *Id.*

150. *Id.* at 152.

151. *Id.* at 153 (reporting a reduction of drug use by 21.8%, seven years after commitment, as compared to a 6.8% reduction among those not civilly committed).

152. *Id.* (reporting a reduction of criminal activities by 18.6%, seven years after commitment, as compared to a 6.7% reduction among those not civilly committed).

153. See M. Douglas Anglin, *The Efficacy of Civil Commitment in Treating Narcotic Addiction*, in *COMPULSORY TREATMENT OF DRUG ABUSE*, *supra* note 93, at 11.

154. Bourquin-Tièche et al., *supra* note 32, at 51-52.

155. *Id.* at 51. Limitations to this study should be noted, however. This study involved a small sample and no control group and therefore implicates the need for more research rather than broad conclusions. However, it is important to recognize that the results in this study are consistent with the evaluation of CAP. Therefore, although there are few studies on the efficacy of civil commitment for substance dependence, the studies that have been conducted consistently indicate positive outcomes, such as reduced substance use and abstinence from alcohol and drugs. See *id.* at 54; Anglin, *supra* note 153, at 11; Anglin & Hser, *supra* note 134, at 153.

#### IV. EXISTING LEGAL CONSTRAINTS ON INVOLUNTARY CIVIL COMMITMENT FOR SUBSTANCE ABUSE

##### *A. Procedural Due Process Rights*

Legislatures must consider the rights afforded by the Due Process Clause of the Fourteenth Amendment<sup>156</sup> when drafting a statute for civil commitment for substance dependence. Procedural due process rights require that certain procedural safeguards be in place, such as a hearing and a right to counsel.<sup>157</sup> An individual cannot be civilly committed for substance dependence without a fair procedure to determine his dangerousness to himself or others.<sup>158</sup>

While the Supreme Court has not clearly defined the procedures required,<sup>159</sup> in *Mathews v. Eldridge*<sup>160</sup> it identified three factors to consider when determining if the procedures in place adequately protected the individual's due process rights:

First, the private interest that will be affected by the official action; second, the risk of an erroneous deprivation of such interest through the procedures used, and the probative value, if any, of additional or substitute procedural safeguards; and finally, the Government's interest, including the function involved and the fiscal and administrative burdens that the additional or substitute procedural requirement would entail.<sup>161</sup>

The sufficiency of the procedures a state puts in place for a civil commitment of substance abuse is determined by using the *Mathews* factors.<sup>162</sup> However, since the Court has not determined specific procedures to be necessary,<sup>163</sup> there are many procedures that a state can adopt in order to ensure that the procedural due process rights are protected.

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156. "[N]or shall any State deprive any person of life, liberty, or property, without due process of law . . ." U.S. CONST. amend. XIV, § 1.

157. Michael P. Rosenthal, *The Constitutionality of Involuntary Civil Commitment of Opiate Addicts*, 18 J. DRUG ISSUES 641, 643 (1988).

158. JOHN E. NOWAK & RONALD D. ROTUNDA, CONSTITUTIONAL LAW § 13.4 (5th ed. 1995).

159. *Id.*

160. 424 U.S. 319, 334-35 (1976).

161. *Id.* at 335.

162. *Id.*

163. NOWAK & ROTUNDA, *supra* note 158, § 13.4.

One procedure that states implement in order to safeguard the individual's rights is a hearing.<sup>164</sup> Due process may not always require an immediate hearing so long as the other procedures in place sufficiently protect the individual's rights, as indicated by the *Mathews* test.<sup>165</sup> However, continuation of a challenged civil commitment without a hearing would violate the individual's due process rights.<sup>166</sup> At the hearing, the state must establish the substantive elements by clear and convincing evidence,<sup>167</sup> however, state legislatures are permitted to impose a higher burden of proof on the state, so long as there is a rational basis to do so.<sup>168</sup>

Another procedural issue that is specific to commitment for substance dependence is whether parents and close relatives can participate as parties in the proceeding.<sup>169</sup> Family may have information about the individual's drug use and the impact such use has on every day life. This information can be valuable to the court in deciding whether the individual is dependent on a substance, and whether there is likely to be harm because of substance use.<sup>170</sup> Although the family members may have interests adverse to the interests of the individual facing commitment,<sup>171</sup> the Court in *Heller* found that a rule permitting close relatives as parties was not a violation of the person's procedural due process rights in a mental retardation commitment hearing.<sup>172</sup> The Court evaluated the rule using the *Mathews* factors, and held that procedural rights were sufficiently protected:<sup>173</sup>

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164. *Ibur v. State*, 765 So. 2d 275, 276 (Fla. Dist. Ct. App. 2000) (holding that appellant had a due process right to be present and testify at involuntary commitment hearing).

165. *See Mathews*, 424 U.S. at 335.

166. *Rodriguez v. City of New York*, 72 F.3d 1051, 1062 (2d Cir. 1995).

167. *Addington v. Texas*, 441 U.S. 418, 431-33 (1979); e.g., N.C. GEN. STAT. § 122C-287 (2007) (The court must find "by clear, cogent, and convincing evidence that the respondent is a substance abuser and is dangerous to himself or others . . .").

168. *Heller v. Doe*, 509 U.S. 312, 325 (1993) (upholding Kentucky's civil commitment procedures that required a clear and convincing evidence standard for mental retardation, but a proof beyond a reasonable doubt standard for mental illness).

169. *See id.* at 330.

170. *See id.* at 331.

171. *Id.* *But see* Principles for the Protection of Persons with Mental Illness and the Improvement of Mental Health Care, G.A. Res. 46/119, princ. 1(6), U.N. Doc. A/RES/46/119/Annex (Dec. 17, 1991) [hereinafter Principles] ("The counsel shall not in the same proceedings represent a mental health facility or its personnel and shall not also represent a member of the family of the person whose capacity is at issue unless the tribunal is satisfied that there is no conflict of interest.").

172. *Heller*, 509 U.S. at 330-31.

173. *Id.*

[W]e simply do not understand how [family members'] participation as formal parties in the commitment proceedings increases "the risk of an erroneous deprivation," of respondents' liberty interest. Rather, . . . these parties often will have valuable information that, if placed before the court, will increase the accuracy of the commitment decision.<sup>174</sup>

Like family members of individuals with mental retardation, family members of people addicted to drugs and alcohol are likely to have information concerning the extent and impact of the addiction on the individual's life<sup>175</sup> that would reduce "the risk of an erroneous deprivation"<sup>176</sup> of liberty. Therefore, it is probable that the *Heller* decision would be extended to permit family members as parties in substance dependence commitment hearings.

The right to counsel is another procedural safeguard.<sup>177</sup> The Supreme Court has not decided if there is a constitutional right to counsel in civil commitment hearings.<sup>178</sup> The Court has, however, said in dicta that there is a right to appointed counsel when loss of the case would result in depriving an indigent litigant of his physical liberty,<sup>179</sup> which should be read to include civil commitment.<sup>180</sup> Some state courts have subsequently found that the right to counsel attaches when involuntary commitment is sought,<sup>181</sup> and state legislation on civil commitment for substance dependence may provide for counsel during

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174. *Id.* at 331 (quoting *Mathews v. Eldridge*, 424 U.S. 319, 335 (1976)).

175. See MARINA BARNARD, *DRUG ADDICTION AND FAMILIES* 25 (2007) (discussing behavioral changes attributed to drug use often noticed by family members).

176. *Mathews*, 424 U.S. at 335.

177. John Parry, *Involuntary Civil Commitment in the 90s: A Constitutional Perspective*, 18 MENTAL & PHYSICAL DISABILITY L. REP. 320, 325 (1994).

178. *Id.* But see Principles, *supra* note 171, at princ. 1(6) ("The person whose capacity is at issue shall be entitled to be represented by a counsel. If the person whose capacity is at issue does not himself or herself secure such representation, it shall be made available without payment by that person to the extent that he or she does not have sufficient means to pay for it.").

179. *Lassiter v. Dep't of Soc. Servs.*, 452 U.S. 18, 26-27 (1981); see also Joseph Frueh, Note, *The Anders Brief in Appeals from Civil Commitment*, 118 YALE L.J. 272, 283 (2008) ("[T]he [*Lassiter*] Court effectively proclaimed that appointed counsel was imperative in any proceeding that threatened the loss of physical liberty.").

180. "Due to the analytical link to criminal law, most respondents in civil commitment have the right to counsel appointed and paid by the state . . ." Jennifer L. Wright, *Protecting Who From What, and Why, and How?: A Proposal for an Integrative Approach to Adult Protective Proceedings*, 12 ELDER L.J. 53, 65 (2004).

181. *In re Commitment of S.L.*, 462 A.2d 1252, 1259 (N.J. 1983); see also *Ibur v. State*, 765 So. 2d 275, 276 (Fla. Dist. Ct. App. 2000) (holding that there is a due process right to be represented by counsel at an involuntary commitment hearing).

the proceedings.<sup>182</sup> Courts have also found that waiver of counsel in a civil commitment hearing must be done intelligently or the waiver is invalid.<sup>183</sup> However, even in jurisdictions that provide counsel to indigent individuals in civil commitment proceedings, the quality of the representation is inconsistent.<sup>184</sup>

There are two models of client representation followed by attorneys—the “adversarial” approach” and the “best interests” approach.”<sup>185</sup> An attorney following the adversarial approach “acts as a zealous advocate for his client’s wishes, which usually are against hospitalization, regardless of whether he believes that the client needs treatment.”<sup>186</sup> In mental health courts, attorneys generally follow the best interests approach, deferring to the findings of the state psychiatrist.<sup>187</sup> Attorneys acting under the best interests approach presume that the mentally ill need state protection and exhibit paternalistic behavior in commitment proceedings.<sup>188</sup> The non-adversarial role of defense attorneys in civil commitment proceedings is consistent with the role of defense attorneys in other mental health legal proceedings, including Drug Treatment Courts.<sup>189</sup> The Supreme Court has justified judicial deference to psychiatrists in civil commitment proceedings, explaining that the fallibility of psychiatric diagnosis cannot be avoided by shifting the decision to the court because the court will reasonably defer to the medical professional when making medical decisions.<sup>190</sup> The Court

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182. *E.g.*, MASS. GEN. LAWS ANN. ch. 123, § 35 (West 2003) (“The person shall have the right to be represented by legal counsel . . . . If the court finds the person indigent, it shall immediately appoint counsel.”); N.C. GEN. STAT. § 122C-286(d) (2007) (“If the respondent is indigent . . . counsel shall be appointed to represent the respondent . . .”).

183. *E.g.*, *Honor v. Yamuchi*, 820 S.W.2d 267, 270-71 (Ark. 1991).

184. Michael L. Perlin, *Fatal Assumption: A Critical Evaluation of the Role of Counsel in Mental Disability Cases*, 16 L. & HUM. BEHAV. 39, 43-45 (1992) (discussing the historic inadequacies of meaningful counsel in involuntary civil commitment hearings).

185. Christyne E. Ferris, Note, *The Search for Due Process in Civil Commitment Hearings: How Procedural Realities Have Altered Substantive Standards*, 61 VAND. L. REV. 959, 962 (2008).

186. *Id.*

187. *See id.*

188. *Id.* at 970-71.

189. Boldt, *supra* note 119, at 1245. In Drug Treatment Courts, defense counsel is no longer primarily responsible for giving voice to the distinct perspective of the defendant’s experience in what remains a coercive setting. Rather, defense counsel becomes part of a treatment team working with others to insure that outcomes, viewed from the perspective of the institutional players and not the individual defendant, are in the defendant’s best interests.

*Id.*

190. *Parham v. J. R.*, 442 U.S. 584, 609 (1979); *see also Addington v. Texas*, 441 U.S. 418, 429 (1979) (“Whether the individual is mentally ill and dangerous to either himself or others and is in need of confined therapy turns on the *meaning* of the facts which must be interpreted by expert psychiatrists and psychologists.”).

noted that “the supposed protections of an adversary proceeding to determine the appropriateness of medical decisions for the commitment and treatment of mental and emotional illness may well be more illusory than real.”<sup>191</sup> However, judicial deference to medical opinions does not justify an attorney’s deference to the opinion of a state doctor when: “The primary role of a respondent’s counsel is to represent the perspective of the respondent and to serve as a vigorous advocate for the respondent’s wishes. It is not to substitute his or her judgment about what is in the best interests of the respondent.”<sup>192</sup> Defense attorney deference to the state doctor’s opinion about the necessity of civil commitment is inconsistent with the client’s presumed interest in remaining free from confinement.<sup>193</sup>

The best interests approach is contrary to the traditional client-lawyer relationship,<sup>194</sup> where even in cases of a client with diminished capacity, the attorney and client should maintain a normal client-attorney relationship, as far as reasonably possible.<sup>195</sup> One critic of the best interest approach suggests that attorneys believe they act in the best interests of their clients when, in fact, prejudices against the mentally ill<sup>196</sup> cause attorneys to “roll over and play dead in civil commitment proceedings . . . .”<sup>197</sup> Civil commitment hearings often last only minutes,<sup>198</sup> and have been described as “perfunctory rituals that either presume the existence of mental illness and satisfaction of the

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191. *Parham*, 442 U.S. at 609.

192. ELIZABETH H. STANN & INGO KEILITZ, NAT’L INST. OF MENTAL HEALTH, *IMPROVING THE PRACTICE OF INVOLUNTARY CIVIL COMMITMENT* 86 (1989).

193. Ferris, *supra* note 185, at 969-70 (“[M]entally ill patients may not be able to express their desires cogently; in that case, the adversarial attorney will presume that the client favors liberty over commitment. This approach respects the autonomy of the patient by assuming that he can make his own decisions regarding his care and that he deserves freedom unless it can be proven otherwise.”); accord Michael L. Perlin & Robert L. Sadoff, *Ethical Issues in the Representation of Individuals in the Commitment Process*, 45 L. & CONTEMP. PROBS. 161, 173 (1982).

194. “The normal client-lawyer relationship is based on the assumption that the client, when properly advised and assisted, is capable of making decisions about important matters.” MODEL RULES OF PROF’L CONDUCT R. 1.14 cmt. 1 (2007).

195. MODEL RULES OF PROF’L CONDUCT R. 1.14 (2007). “Reasonably” “denotes the conduct of a reasonably prudent and competent lawyer.” MODEL RULES OF PROF’L CONDUCT R. 1.0 (2007).

196. Grant H. Morris, *Pursuing Justice for the Mentally Disabled*, 42 SAN DIEGO L. REV. 757, 766 (2005) (arguing that the belief that mentally ill people are unable to determine what is best for them and that courts should rely on the opinions of doctors is based on a prejudice against the mentally ill).

197. *Id.*

198. WINICK, *supra* note 133, at 144 (reporting that commitment hearings last an average of 3.8 to 9.2 minutes).



commitment criteria or only superficially inquire into these issues.”<sup>199</sup> Lawyers who take the best interests approach often fail to investigate the facts offered by the state supporting the need for involuntary commitment.<sup>200</sup> They perform little or no cross-examination of the state’s expert witnesses,<sup>201</sup> do not seek less restrictive alternatives than commitment,<sup>202</sup> and often offer no contradiction to the state’s allegations of mental illness.<sup>203</sup>

The best interests approach that is so common in commitment hearings “has turned the adversarial model into a farce and a mockery in which procedural rights are accorded in only a formal way so as to effectuate what judges, lawyers, and clinicians perceive to be the best interests of the patient.”<sup>204</sup> The best interests approach undermines the procedural protections afforded by the Due Process Clause.<sup>205</sup>

Instead, in order to provide effective counsel, attorneys representing substance dependent patients against whom the state is seeking commitment should proceed under the adversarial approach.<sup>206</sup> A person’s right to freedom from restraint, a right which may be taken away at civil commitment hearings, is so important that it is imperative

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199. *Id.* But see *K.W. v. Logansport State Hosp.*, 660 N.E.2d 609, 615 (Ind. Ct. App. 1996) (holding that allegations that the attorney’s counsel was “perfunctory” in a recommitment proceeding did not rise to the level of ineffective assistance of counsel).

200. WINICK, *supra* note 133, at 144; *accord* Ferris, *supra* note 185, at 972.

201. WINICK, *supra* note 133, at 144; *accord* Ferris, *supra* note 185, at 972. State law may also specifically identify the right of the respondent to present independent expert or other testimony to contradict the state’s evidence. *E.g.*, MASS. GEN. LAWS ANN. ch. 123, § 35 (West 2003).

202. WINICK, *supra* note 133, at 144; *accord* Ferris, *supra* note 185, at 972.

203. WINICK, *supra* note 133, at 144.

204. Bruce J. Winick, *Therapeutic Jurisprudence and the Civil Commitment Hearing*, 10 J. CONTEMP. LEGAL ISSUES 37, 41 (1999).

205. *Id.* at 43.

206. “The benchmark for judging any claim of ineffectiveness must be whether counsel’s conduct so undermined the proper functioning of the adversarial process that the trial cannot be relied on as having produced a just result.” *Strickland v. Washington*, 466 U.S. 668, 686 (1984) (involving a criminal proceeding). The two-pronged test for ineffective counsel created by *Strickland* requires both that counsel’s performance was below the standard of reasonableness and a determination that had counsel’s performance been reasonable, the outcome of the trial would have been different. *Id.* at 687. Many states have adopted the *Strickland* standard into civil commitment proceedings because of the potential for substantial loss of liberty. *E.g.*, *Pope v. Alston*, 537 So. 2d 953, 956-57 (Ala. Civ. App. 1988) (using *Strickland* standard to reject an ineffective counsel claim based on insufficient contact with attorney before hearing because attorney cross-examined witnesses and forcefully argued his client’s position); *In re Mental Commitment of Grey B.*, No. 99-1781-FT, 1999 WL 970895, at \*2 (Wis. Ct. App. Oct. 26, 1999) (using *Strickland* standard to reject an ineffective counsel claim because of attorney’s failure to object to the state’s expert witness). *But see* Phyllis Coleman & Ronald A. Shellow, *Ineffective Assistance of Counsel: A Call for a Stricter Test in Civil Commitments*, 27 J. LEGAL PROF. 37, 60 (2003) (arguing that the *Strickland* standard in civil commitment hearings fails to adequately protect people facing involuntarily commitment because *Strickland* has a presumption in favor of the attorney).

that the attorney zealously advocates for the client's wishes, regardless of what the attorney believes is in the best interest of the client.<sup>207</sup> Although mandatory treatment of substance dependence may enable autonomy,<sup>208</sup> the presumption<sup>209</sup> of the adversarial attorney that the client does not want to be committed serves as a check on the state's powers. Inadequate procedural safeguards also risk violating substantive due process, because when an attorney does not serve as a zealous advocate for his client, it reduces the state's burden of proving the substantive dangerousness standard.<sup>210</sup>

### B. Substantive Due Process Rights

Legislation for civil commitment for substance abuse must meet the substantive due process requirements of the Fourteenth Amendment.<sup>211</sup> The substantive due process right triggered by civil commitment grants that an individual is to be free from unnecessary bodily restraint, unless a mentally ill individual is found to be a danger to himself or others.<sup>212</sup> After *Robinson v. California*,<sup>213</sup> legislatures and lower courts assumed that a state could enact legislation permitting civil commitment of narcotic addicts.<sup>214</sup> Although *Robinson* could be read to suggest that involuntary commitment laws would be permitted so long as the state has a rational basis for the legislation,<sup>215</sup> courts have recognized that "[a]n involuntary civil commitment is a 'massive curtailment of liberty[]' . . . ."<sup>216</sup> Therefore, in order to comply with due process

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207. John J. McCullough, III & Joseph A. Reinert, *The Necessity of Individual Rights and Procedural Justice in the Civil Commitment Process: A Response to the Notion of "Therapeutic Justice"*: [sic], Vt. B.J., June 2002, at 51, 52.

208. See *supra* notes 86-91 and accompanying text.

209. See *supra* note 193 and accompanying text.

210. Ferris, *supra* note 185, at 974-75; see also Part IV.B.

211. U.S. CONST. amend. XIV, § 1.

212. NOWAK & ROTUNDA, *supra* note 158, § 13.4(a).

213. *Robinson v. California*, 370 U.S. 660, 664-65 (1962); see *supra* note 147.

214. Rosenthal, *supra* note 157, at 644.

215. The Court's statement that such treatment be "[i]n the interest of discouraging the violation of such laws, or in the interest of the general health or welfare of its inhabitants . . ." suggests that commitment laws are constitutional if related to a public good. *Robinson*, 370 U.S. at 664-65. Deprivation of "garden variety . . . libert[ies] . . . is constitutional if rationally necessary to the achievement of a public good." JESSE H. CHOPER ET AL., *CONSTITUTIONAL LAW: CASES—COMMENTS—QUESTIONS* 377 (10th ed. 2006) (quoting Ira C. Lupu, *Untangling the Strands of the Fourteenth Amendment*, 77 MICH. L. REV. 981, 1030 (1979)); see also *O'Connor v. Donaldson*, 422 U.S. 563, 580 (1975) ("Commitment must be justified on the basis of a legitimate state interest . . .").

216. *Rodriguez v. City of New York*, 72 F.3d 1051, 1061 (2d Cir. 1995) (quoting *Vitek v. Jones*, 445 U.S. 480, 491 (1980)); see also *Youngberg v. Romeo*, 457 U.S. 307, 316 (1982) ("Indeed, '[I]berty from bodily restraint always has been recognized as the core of the liberty

requirements, civil commitment laws are justified only by a “compelling state interest.”<sup>217</sup>

Traditional justifications of state intrusion on individual liberty include the state’s police power<sup>218</sup> and *parens patriae*.<sup>219</sup> Both of these justifications were used in *O’Connor v. Donaldson*,<sup>220</sup> where the Supreme Court held that “a State cannot constitutionally confine without more a nondangerous individual who is capable of surviving safely in freedom by himself or with the help of willing and responsible family members or friends.”<sup>221</sup> The Court held that the state must show at least one of the following three justifications for civil commitment: danger to self or others, inability to care for oneself, or the necessity of treatment to cure a mental illness.<sup>222</sup> Additionally, the overall effectiveness of compelled treatment is important when a court mandates civil commitment because the Court has held civilly committed mentally retarded individuals have a constitutional right to minimally adequate habilitation.<sup>223</sup> The Court’s holding that “liberty interests require the State to provide minimally adequate or reasonable training to ensure safety and freedom from undue restraint”<sup>224</sup> should be extended to other reasons for civil commitment, including substance dependence.

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protected by the Due Process Clause from arbitrary governmental action.’ . . . This interest survives criminal conviction and incarceration. Similarly, it must also survive involuntary commitment.” (quoting *Greenholtz v. Inmates of the Neb. Penal & Corr. Complex*, 442 U.S. 1, 18 (1979) (Powell, J., concurring in part and dissenting in part)). *But see* *Jacobson v. Massachusetts*, 197 U.S. 11, 26 (1905) (“[T]he liberty secured by the Constitution of the United States to every person within its jurisdiction does not import an absolute right in each person to be, at all times and in all circumstances, wholly freed from restraint.”).

217. *Reno v. Flores*, 507 U.S. 292, 301-02 (1993) (interpreting the Fourteenth Amendment’s due process clause to “forbid[] the government to infringe certain ‘fundamental’ liberty interests *at all*, no matter what process is provided, unless the infringement is narrowly tailored to serve a compelling state interest”).

218. *Mills v. Rogers*, 457 U.S. 291, 296 (1982) (discussing a state’s “police power interest in maintaining order within the institution and in preventing violence”).

219. *Id.* (identifying a state’s “*parens patriae* interest in alleviating the sufferings of mental illness and in providing effective treatment”). *Parens patriae* is defined as “the state in its capacity as provider of protection to those unable to care for themselves . . . .” BLACK’S LAW DICTIONARY 1144 (8th ed. 2004).

220. 422 U.S. 563, 582-83 (1975) (discussing the historic exercise of state police and *parens patriae* powers).

221. *Id.* at 576.

222. *Id.* at 573-74, 576; *see also* *Principles*, *supra* note 171, at princ. 11(6)(b) (“An independent authority [who], having in its possession all relevant information, . . . is satisfied that, . . . having regard to the patient’s own safety or the safety of others, the patient unreasonably withholds such consent” [may administer treatment without the patient’s consent].).

223. *Youngberg v. Romeo*, 457 U.S. 307, 319 (1982).

224. *Id.* “The basic requirement of adequacy . . . may be stated as that training which is reasonable in light of identifiable liberty interests and the circumstances of the case.” *Id.* at 319

State police power provides the justification of civil commitment based on a finding that the individual is dangerous to others, in that the state has a strong interest in protecting the community from dangerous individuals.<sup>225</sup> As the state's *parens patriae* interest is in protecting individuals whose illness makes them unable to make rational treatment decisions, it provides the justification for civil commitment based on danger to oneself, inability to care for oneself, and the necessity of treatment.<sup>226</sup>

State statutes permitting involuntary civil commitment for substance dependence must integrate the *O'Connor* dangerousness standard into the legislation. For example, the Massachusetts statute on civil commitment for substance abuse requires that the court find the person "is an alcoholic or substance abuser and there is a likelihood of serious harm as a result of his alcoholism or substance abuse . . . ."<sup>227</sup> Similarly, North Carolina requires that the respondent be "a substance abuser and . . . dangerous to himself or others . . . ."<sup>228</sup> In order to commit an individual, the state must demonstrate dangerousness by "clear, cogent, and convincing evidence."<sup>229</sup>

However, the *O'Connor* dangerousness standard is too broad to adequately protect the liberty rights of the substance-dependent person<sup>230</sup> because it requires neither an overt act nor a likelihood of imminent danger.<sup>231</sup> Instead, the mere inability to help oneself may be sufficient proof of dangerousness to oneself.<sup>232</sup> As substance dependence involves persistent and compulsive drug-taking behavior despite negative consequences,<sup>233</sup> a finding of substance dependence alone may be

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n.25. When determining what is reasonable, deference should be given to the judgments of qualified professionals. *Id.* at 322-23.

225. WINICK, *supra* note 133, at 43.

226. *Id.* at 42.

227. MASS. GEN. LAWS ANN. ch. 123, § 35 (West 2003).

228. N.C. GEN. STAT. § 122C-287 (2007).

229. *Id.*; see also *Jones v. United States*, 463 U.S. 354, 362 (1983).

230. *But see* Alison Pfeffer, Note, "Imminent Danger" and Inconsistency: The Need for National Reform of the "Imminent Danger" Standard for Involuntary Civil Commitment in the Wake of the Virginia Tech Tragedy, 30 CARDOZO L. REV. 277, 302 (2008) (discussing the argument that the imminent danger and overt act requirements are under-inclusive and unreasonable).

231. See *Project Release v. Prevost*, 722 F.2d 960, 973-74 (2d Cir. 1983) (holding that the New York civil commitment scheme for mental illness met the due process requirements despite its lack of an overt act requirement).

232. *O'Connor v. Donaldson*, 422 U.S. 563, 574 n.9 (1975) ("[E]ven if there is no foreseeable risk of self-injury or suicide, a person is literally 'dangerous to himself' if for physical or other reasons he is helpless to avoid the hazards of freedom either through his own efforts or with the aid of willing family members or friends.").

233. Jordi Camí & Magí Farré, *Mechanisms of Disease: Drug Addiction*, 349 NEW ENG. J. MED. 975, 975 (2003); see *supra* notes 33-34 and accompanying text.

sufficient proof that an individual is “helpless to avoid the hazards of freedom,”<sup>234</sup> according to the *O'Connor* standard. However, the sufficiency of a finding of substance dependence to demonstrate dangerousness is contrary to *O'Connor*, which held that a finding of mental illness<sup>235</sup> alone does not justify involuntary civil commitment.<sup>236</sup> Instead, the state must also meet the dangerousness standard.<sup>237</sup> Although the imminent danger standard is still used, broader standards such as “substantially probable” harm have been upheld.<sup>238</sup> North Carolina’s statute on civil commitment for substance abuse defines danger to oneself even more broadly, requiring a finding of “reasonable probability” of either serious physical debilitation, suicide, or self-mutilation in the near future.<sup>239</sup>

While inpatient civil commitment for substance dependence should be an option, because it is a “massive curtailment of liberty,”<sup>240</sup> it should only be imposed when the court finds that a lesser restrictive alternative would be inadequate. The Court stated that even if the government has a legitimate purpose, “that purpose cannot be pursued by means that broadly stifle fundamental personal liberties when the end can be more narrowly achieved.”<sup>241</sup> This has been interpreted by many states to require that civil commitment be the least restrictive alternative, thus requiring the court to consider other options such as outpatient and community-based treatment.<sup>242</sup>

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234. *O'Connor*, 422 U.S. at 574 n.9.

235. “The American Psychiatric Association strongly and unequivocally affirms its position that all substance-related disorders are diagnosable mental illnesses for which effective treatments are readily available.” AM. PSYCHIATRIC ASS’N, INCLUSION OF SUBSTANCE-RELATED DISORDERS AS PSYCHIATRIC DISORDERS IN ANY PROGRAM DESIGNED TO ASSURE ACCESS AND QUALITY OF CARE FOR PERSONS WITH MENTAL ILLNESS: POSITION STATEMENT 1 (2002), available at [http://archive.psych.org/edu/other\\_res/lib\\_archives/archives/200213.pdf](http://archive.psych.org/edu/other_res/lib_archives/archives/200213.pdf).

236. *O'Connor*, 422 U.S. at 575 (“A finding of ‘mental illness’ alone cannot justify a State’s locking a person up against his will . . .”).

237. *Id.* at 573-74; see also *Kansas v. Hendricks*, 521 U.S. 346, 358 (1997) (finding that the Court has upheld civil commitment statutes that couple proof of dangerousness with mental illness).

238. See generally *In re Commitment of Dennis H.*, 647 N.W.2d 851 (Wis. 2002) (upholding a civil commitment statute with a broader standard than imminent danger).

239. N.C. GEN. STAT. § 122C-3(11) (2007).

240. *Vitek v. Jones*, 445 U.S. 480, 491 (1980).

241. *Shelton v. Tucker*, 364 U.S. 479, 488 (1960).

242. *E.g.*, HAW. REV. STAT. § 334-60.2(3) (1993) (permitting involuntary hospitalization for substance abuse if there is “no suitable alternative available through existing facilities and programs which would be less restrictive than hospitalization”); see also Principles, *supra* note 171, at princ. 9(1) (“Every patient shall have the right to be treated in the least restrictive environment and with the least restrictive or intrusive treatment appropriate to the patient’s health needs and the need to protect the physical safety of others.”).

Permitting involuntary commitment for the lesser standard of substance abuse<sup>243</sup> will result in confinement of individuals for whom less restrictive alternatives, such as outpatient programs, may be just as effective.<sup>244</sup> In *Kansas v. Hendricks*,<sup>245</sup> the Court said that it is the role of the legislature, not the courts, to define medical terms used within statutes, and the Court did not require the use of specific terminology.<sup>246</sup> However, unlike in *Hendricks*, the use of “substance abuse” in commitment laws does not “narrow[] the class of persons eligible for confinement to those who are unable to control their dangerousness.”<sup>247</sup> Rather, “substance abuse” is over-inclusive<sup>248</sup> and is likely to result in an erroneous deprivation of liberty.<sup>249</sup> Instead, civil commitment laws should be narrowly tailored, requiring a finding of substance dependence rather than substance abuse.

## V. RECOMMENDATIONS

The Court has found that it is the role of the state legislatures to write civil commitment statutes and to define the terminology used within those statutes.<sup>250</sup> The unwillingness of the Court to involve itself in the legislative role of deciding the circumstances necessary for civil commitment has resulted in variations between states’ civil commitment laws, especially concerning civil commitment for substance dependence.<sup>251</sup> Among states that have statutes for involuntary civil commitment for alcohol or drug related reasons, there are gaps between the procedural and substantive due process rights facially protected by the statutes and the rights that are actually protected by the practice of

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243. See *supra* notes 34-35 and accompanying text.

244. See *supra* Part III.

245. 521 U.S. 346 (1997).

246. *Id.* at 358-60 (rejecting *Hendricks*’ contention that “a ‘mental abnormality’ is *not* the equivalent to a ‘mental illness’” and upholding legislation enabling civil commitment due to the mental abnormality of sex offenders).

247. *Id.* at 358.

248. See, e.g., N.C. GEN. STAT. § 122C-3(36) (2007) (“‘Substance abuse’ means the pathological use or abuse of alcohol or other drugs in a way or to a degree that produces an impairment in personal, social, *or* occupational functioning.”) (emphasis added).

249. Cf. *Heller v. Doe*, 509 U.S. 312, 331 (1993). But see *Addington v. Texas*, 441 U.S. 418, 429 (1979) (“It cannot be said, therefore, that it is much better for a mentally ill person to ‘go free’ than for a mentally normal person to be committed.”).

250. *Hendricks*, 521 U.S. at 359.

251. Compare N.Y. MENTAL HYG. LAW § 9.37 (McKinney 2006) (prohibiting involuntary civil commitment on the basis of substance abuse without concurrent mental illness), with MASS. GEN. LAWS ANN. ch. 123, § 35 (West 2003) (allowing involuntary civil commitment for substance abuse for up to thirty days), and N.C. GEN. STAT. § 122C-287 (1985) (allowing involuntary civil commitment for substance abuse for up to 180 days).

the courts.<sup>252</sup> In order to address these inconsistencies, a model statute must be proposed by the Substance Abuse and Mental Health Services Administration (“SAMHSA”), a federal agency under the Department of Health and Human Services.<sup>253</sup> The Law on Civil Commitment of Substance Dependant Individuals may be stated as follows:

- (1) A family member, friend, doctor, clergy, or member of the law enforcement may petition the court for the civil commitment of a substance dependent<sup>254</sup> individual.
- (2) A hearing shall occur during which:
  - (a) the respondent is present; and
  - (b) the respondent may be represented by counsel of his choice; if the respondent is indigent, counsel shall be appointed to represent him; and
  - (c) the respondent’s counsel represents the interests of the respondent in an adversarial fashion, including but not limited to cross-examination of state witnesses and production of expert and non-expert witnesses on behalf of the respondent.
- (3) If the court finds by clear, cogent, and convincing evidence that the respondent is a substance dependent individual and as a result of the substance dependence is dangerous to himself or others, it shall order for a period not in excess of ninety days commitment to and treatment by an inpatient facility.
  - (a) “Dangerous to oneself” is defined as actions in the relevant past which indicate a substantial risk of physical harm to oneself, including threats or attempts of suicide or serious bodily harm or other conduct demonstrating that the person is a danger to himself.
  - (b) “Dangerous to others” is defined as actions in the relevant past which indicate a substantial risk of physical harm to other persons, including homicidal or other violent behavior by which others are placed in reasonable fear of serious physical harm.

Although enactment of legislation on civil commitment would remain in the power of the states, the proposed rule would offer the states a model that, if followed, would protect the liberty rights of the individual while balancing the state’s interest in compelling treatment.

Although some courts have found that the right to counsel attaches in civil commitment proceedings<sup>255</sup> and state statutes reflect this

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252. *See supra* Part IV.A-B.

253. SAMHSA.gov, Agency Overview, <http://www.samhsa.gov/About/background.aspx> (last visited Sept. 12, 2009).

254. *See supra* notes 33-35 and accompanying text (providing the APA definition of substance dependence which should be used in the statute).

255. *In re* Commitment of S.L., 462 A.2d 1252, 1259 (N.J. 1983); *see also* *Ibur v. State*, 765 So. 2d 275, 276 (Fla. Dist. Ct. App. 2000).

holding,<sup>256</sup> the mere presence of counsel does not adequately protect the procedural or substantive due process rights of the individual facing deprivation of liberty. An adversarial attorney acting as a zealous advocate against civil commitment is imperative to lessen the risk of an erroneous deprivation of liberty.<sup>257</sup> An attorney acting in the “best interest” of the client is in effect another attorney for the state, representing the state’s interests, not the individual upon whose rights the state is impinging.<sup>258</sup> Even though an adversarial approach is consistent with the traditional client-lawyer relationship,<sup>259</sup> the adversarial role of the attorney must be specified in the statute because the best interests approach has become common in involuntary civil commitment hearings.<sup>260</sup>

A case-by-case analysis by the court of whether the state has proved its burden imposed by the dangerousness standard will ensure that the individual is not deprived of liberty unless commitment is the least restrictive alternative.<sup>261</sup> Additionally, the more narrowly tailored definition of substance dependence will reduce the risk of erroneous deprivation of liberty.<sup>262</sup> Civil commitment proceedings under the proposed statute would best serve to protect the liberty interests of the individual while addressing the need for compelled substance dependence treatment in limited circumstances.

State adoption of the proposed statute would allow for earlier intervention and treatment of drug dependent individuals, while ensuring that they are not erroneously deprived of their liberty rights. Adoption of such legislation is imperative in all states, including New York. The prevalence of substance abuse and addiction is a serious problem in New York, as it is nationwide.<sup>263</sup> Although New York has successfully implemented criminal diversion programs such as drug courts, these programs target people who have already escalated to the point where they are in the criminal justice system.<sup>264</sup> Current New York law leaves a large gap in substance dependence treatment, in that it does not provide a way to legally mandate treatment to substance dependent individuals

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256. MASS. GEN. LAWS ANN. ch. 123, § 35 (West 2003); N.C. GEN. STAT. § 122C-286(d) (2007).

257. See McCullough & Reinert, *supra* note 207, at 52.

258. See Winick, *supra* note 204, at 41-43 (discussing the ineffective representation of clients in mental health courts).

259. See MODEL RULES OF PROF’L CONDUCT R. 1.14 (2007).

260. Winick, *supra* note 204 at 41-43.

261. See *supra* text accompanying notes 243-244.

262. See *supra* notes 247-48 and accompanying text.

263. See *supra* Part II.

264. See *supra* notes 107-20 and accompanying text.



prior to their entry into the criminal justice system.<sup>265</sup> This gap in treatment has the potential to lead to tragic outcomes, as it did with Natalie Ciappa. The rise of heroin use amongst teenagers and young adults increases the dangerousness of the treatment gap.<sup>266</sup> In order to address this gap in treatment, New York, as well as all the other states, should adopt the proposed statute.

## VI. CONCLUSION

Although substance abuse is a pervasive, costly problem in American society, many states do not have legislation permitting compelled inpatient treatment within the civil system. Coerced treatment is very common after entry into the criminal justice system and is generally viewed as successful in reducing drug use and recidivism. Compelling treatment only upon entry into the criminal justice system is insufficient to meet societal needs, particularly in light of the pervasiveness and cost of substance abuse and the correlation between substance abuse and violent crime. Therefore, states should adopt the proposed statute permitting civil commitment for substance dependence in order to provide necessary treatment without first requiring entry into the criminal justice system.

Coerced treatment is generally viewed as an effective method of treating substance dependence. Empirical research also supports the efficacy of civil commitment in treating substance dependence. Although coercion in the criminal context is more common in the United States, legally mandated substance dependence treatment in the civil context has historical roots and is accepted and practiced throughout the world. Civil commitment would provide necessary and effective substance dependence treatment to individuals regardless of entry into the criminal justice system. The ability of a state to compel treatment is imperative, especially in light of the rise of narcotic use across the nation.

Although the state has an interest both in providing treatment and preventing illicit drug use, civil commitment imposes a very significant restriction on liberty and therefore invokes the Due Process Clause of the Fourteenth Amendment. In order to balance the state's interest with the liberty interest of the individual, the proposed statute incorporates stricter procedures and a more narrowly defined class of individuals against whom the statute could be applied. Therefore, the proposed statute should be adopted by New York and all other states in order to provide necessary treatment to substance dependent individuals.

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265. See N.Y. MENTAL HYG. LAW § 22.09 (McKinney 2006).

266. See *supra* Part I.

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\* J.D. candidate, 2010, Hofstra University School of Law; M.S.W. University of Kentucky. I would like to thank Professor Janet Dolgin for the support and guidance she has provided to me throughout my law school career. I would also like to extend my gratitude to the editors of the *Hofstra Law Review*, particularly Benjamin Rattner and Gianfranco Cuadra, for their invaluable contributions to this Note. Finally, this Note is dedicated to the memory of my father, David Abensur, whose challenges in life fueled my dedication to the field of substance abuse treatment.