

**INVOLUNTARY CIVIL COMMITMENT:
A SOLUTION TO THE OPIOID CRISIS?**

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ABSTRACT

The United States is in the grip of a deadly opioid crisis, fueled by prescription opioids and the appearance of fentanyl in the drug supply. Despite the anguish that people with drug addictions experience, most people who are addicted to drugs do not seek treatment voluntarily. To that end, families are urging legislators to expand access to involuntary civil commitment, as a tool to combat the opioid crisis.

While courts have broad authority to confine people with substance use disorders, and doing so might be associated with positive outcomes, including reductions in drug use, using civil commitment to force people with substance use disorders into treatment despite their objections presents an ethical dilemma. States have the parens patriae authority to care for people who are unable to care for themselves, but in their current form, most civil commitment statutes reach people with substance use disorders who are competent to make treatment decisions. There is a place for civil commitment, but without a judicial determination of incompetence, using civil commitment to confine drug users is a dangerous exercise of the parens patriae power.

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I. INTRODUCTION

At age thirteen, John Carter began to experiment with drugs—mostly alcohol and marijuana.¹ By age fifteen, Carter was in rehab for the first time,² and by age eighteen, he began to use drugs intravenously.³ Addicted to heroin and cocaine, Carter cycled in and out of drug treatment programs three times over a three year period.⁴ Desperate for help, Carter’s family went to the police to have him committed to an inpatient drug treatment center, but because he was over eighteen, their

1. *Hearing on SB 220-FN: Relative to the Definition of Mental Illness for Purposes of Mental Health Services Before the S. Health and Human Servs. Comm.*, 2017 Session 2 (2017) (statement of Jack Carter).

2. *Hearing on SB 220-FN: Relative to the Definition of Mental Illness for Purposes of Mental Health Services Before the S. Health and Human Servs. Comm.*, 2017 Session 2 (2017) (statement of Kaitlyn Carter, sister of John Carter).

3. Statement of Jack Carter, *supra* note 1.

4. Statement of Kaitlyn Carter, *supra* note 2.

request was denied.⁵ Two weeks later, Carter died from a fatal overdose of fentanyl.⁶

By all accounts, the United States is in the grip of a deadly opioid crisis. In 2016, overdoses killed 64,000 Americans,⁷ more than the number of people killed in car accidents or by firearms, and at a faster rate than the HIV epidemic at its peak.⁸ Opioids work by binding to receptors in the brain, the spinal cord, and other parts of the body.⁹ When opioid receptors are stimulated, they reduce pain signals to the brain and in turn reduce the feeling of pain.¹⁰

Before the 1980s, doctors prescribed opioids primarily for short-term pain, or for cancer patients at the end of life, owing to concerns about long-term physical dependence and addiction.¹¹ By the 1980s, however, physicians began to focus on chronic pain.¹² Highly influential articles asserted that opioids could be used to treat chronic pain, with a minimal risk of addiction.¹³ By the mid-1990s, with the introduction of OxyContin, pharmaceutical companies began to market opioids aggressively for the treatment of long-term non-cancer pain.¹⁴ “This aggressive and at times

5. *Id.*

6. *Id.*

7. CTRS. FOR DISEASE CONTROL AND PREVENTION, PROVISIONAL COUNTS OF DRUG OVERDOSE DEATHS, AS OF 8/6/2017, at 1, https://www.cdc.gov/nchs/data/health_policy/monthly-drug-overdose-death-estimates.pdf.

8. Josh Katz, *Short Answers to Hard Questions About the Opioid Crisis*, N.Y. TIMES (Aug. 10, 2017), <https://www.nytimes.com/interactive/2017/08/03/upshot/opioid-drug-overdose-epidemic.html>.

9. *Misuse of Prescription Drugs*, NAT'L INST. ON DRUG ABUSE, <https://www.drugabuse.gov/publications/misuse-prescription-drugs/what-classes-prescription-drugs-are-commonly-misused> (last updated Jan. 2018).

10. *Id.*

11. Celine Gounder, *Who Is Responsible for the Pain-Pill Epidemic?*, NEW YORKER (Nov. 8, 2013), <https://www.newyorker.com/business/currency/who-is-responsible-for-the-pain-pill-epidemic>.

12. Rebecca L. Haffajee, *Preventing Opioid Misuse with Prescription Drug Monitoring Programs: A Framework for Evaluating the Success of State Public Health Laws*, 67 HASTINGS L.J. 1621, 1627 (2016).

13. See, e.g., Jane Porter & Hershel Jick, Letter to the Editor, *Addiction Rare in Patients Treated with Narcotics*, 302 NEW ENG. J. MED. 123 (1980). A second study published in 1986 by *Pain* asserted that narcotics could be “safely and effectively prescribed to selected patients” for non-cancer pain “with relatively little risk of producing the maladaptive behaviors which define opioid abuse.” Gounder, *supra* note 11; see also Pamela T.M. Leung et al., Letter to the Editor, *A 1980 Letter on the Risk of Opioid Addiction*, 376 NEW ENG. J. MED. 2194 (noting that “a five-sentence letter published in the *Journal* in 1980 was heavily and uncritically cited as evidence that addiction was rare” and “this citation pattern contributed to the North American opioid crisis” by allaying the concerns of medical professionals regarding the risks of addiction).

14. Andrew Kolodny et al., *The Prescription Opioid and Heroin Crisis: A Public Health Approach to an Epidemic of Addiction*, 36 ANN. REV. PUB. HEALTH 559, 562–63 (2015).

fraudulent marketing, combined with a new focus on patient satisfaction and the elimination of pain, sharply increased the availability of pharmaceutical narcotics.”¹⁵ Opioid prescription drug sales have quadrupled since 1999, along with deaths from prescription opioids.¹⁶ Between 1999 and 2015, more than 183,000 people in the United States died from an opioid prescription overdose.¹⁷

The opioid epidemic began during the late 1990s with prescription opioids, but since 2011, overdose deaths involving a prescription opioid have leveled off, while deaths involving heroin and fentanyl are on the rise.¹⁸ According to the CDC, three out of four new heroin users report abusing prescription opioids before using heroin.¹⁹ Between 2010 and 2015, heroin-related deaths tripled, driven in large part by the appearance of fentanyl in the drug supply.²⁰ Fentanyl is similar to heroin and morphine, “but 50 to 100 times more potent.”²¹ Increasingly dealers are mixing fentanyl with heroin or cocaine in order to increase the potency of the drug, sometimes with or without the user’s knowledge.²²

The social and economic costs of the opioid crisis are staggering. Between 2005 and 2014, “the rate of opioid-related ED visits increased 99.4 percent, from 89.1 per 100,000 population in 2005 to 177.7 per 100,000 population in 2014.”²³ During the same time period, the rate of opioid-related inpatient stays increased 64.1%, from 136.8 per 100,000

15. Katz, *supra* note 8. In 2007, Purdue Pharma, the manufacturer of OxyContin, pled guilty to charges of misleading doctors, regulators and patients about the risk of becoming addicted to OxyContin. Barry Meier, *In Guilty Plea, OxyContin Maker to Pay \$600 Million*, N.Y. TIMES (May 10, 2007), <http://www.nytimes.com/2007/05/10/business/11drug-web.html>.

16. *Community and Outpatient Use and Abuse of Opioids*, PREMIER SAFETY INST., <http://www.premiersafetyinstitute.org/safety-topics-az/opioids/community/> (last visited Mar. 9, 2019).

17. *Id.*

18. Andrew Kolodny, *The Opioid Epidemic in 6 Charts*, THE CONVERSATION (Oct. 4, 2017, 8:56 PM), <http://theconversation.com/the-opioid-epidemic-in-6-charts-81601>.

19. *Heroin Overdose Data*, CTRS. FOR DISEASE CONTROL AND PREVENTION, <https://www.cdc.gov/drugoverdose/data/heroin.html> (last updated Dec. 19, 2018).

20. Rose A. Rudd et al., *Increases in Drug and Opioid Overdose Deaths—United States, 2000–2014*, CTRS. FOR DISEASE CONTROL AND PREVENTION (Jan. 1, 2016), <https://www.cdc.gov/mmwr/preview/mmwrhtml/mm6450a3.htm>.

21. *Fentanyl*, CTRS. FOR DISEASE CONTROL AND PREVENTION, <https://www.cdc.gov/niosh/topics/fentanyl/> (last updated Nov. 15, 2016).

22. Julie K. O’Donnell et al., *Deaths Involving Fentanyl, Fentanyl Analogs, and U-47700—10 States, July–December 2016*, MORBIDITY & MORTALITY WKLY. REP. 1197, 1199 (2017), <https://www.cdc.gov/mmwr/volumes/66/wr/mm6643e1.htm>.

23. Audrey J. Weiss et al., *Opioid-Related Inpatient Stays and Emergency Department Visits by State, 2009–2014*, HEALTHCARE COST AND UTILIZATION PROJECT, <https://www.hcup-us.ahrq.gov/reports/statbriefs/sb219-Opioid-Hospital-Stays-ED-Visits-by-State.jsp> (last modified Feb. 6, 2017).

population in 2005 to 224.6 per 100,000 population in 2014.²⁴ According to the Department of Health and Human Services, prescription drug abuse accounts for \$55 billion dollars in health and social costs each year.²⁵ Drug addiction also imposes a considerable burden on children and families, who struggle to cope with a substance-abusing parent. Between 2012 and 2015, the number of children in foster care rose by 8% nationally.²⁶ In Ohio, the number of children in foster care has increased by nearly 10%, and more than 60% of children in the Ohio foster care system were removed from their families due to parental drug abuse.²⁷

Despite the anguish that people with drug addictions experience, most people who are addicted to drugs do not seek treatment voluntarily, and those who do usually drop out after a few weeks.²⁸ As parents wait for their children to “hit bottom” and enter treatment voluntarily, many report a constant fear that for their son or daughter, rock bottom will be a fatal overdose.²⁹ To that end, families and addiction advocates are urging lawmakers to expand access to involuntary civil commitment.³⁰ Civil commitment is a legal process that allows family members and others to seek court ordered treatment for a person with a substance use disorder.³¹ Most states already have laws that allow medical professionals and families to petition a court for involuntary commitment, if the petitioner can establish that the person has a

24. *Id.*

25. U.S. DEP'T. OF HEALTH & HUMAN SERVS., *THE OPIOID EPIDEMIC: BY THE NUMBERS* (2016), <https://nmhealth.org/data/view/substance/1914/>.

26. See ADMIN. FOR CHILDREN AND FAMILIES (Oct. 27, 2016), <https://www.acf.hhs.gov/archive/media/press/2016-number-of-children-in-foster-care-increases-for-the-third-consecutive-year>.

27. Perry Stein & Lindsey Bever, *The Opioid Crisis Is Straining the Nation's Foster-Care Systems*, WASH. POST (July 1, 2017), https://www.washingtonpost.com/national/the-opioid-crisis-is-straining-the-nations-foster-care-systems/2017/06/30/97759fb2-52a1-11e7-91eb-9611861a988f_story.html?utm_term=.0e86afe0d84f.

28. Sally Satel, *Compelled Drug Addiction Treatment Works Because of Retention*, N.Y. TIMES (May 4, 2016, 1:23 PM), <https://www.nytimes.com/roomfordebate/2015/11/11/should-drug-addicts-be-forced-into-treatment/compelled-drug-addiction-treatment-works-because-of-retention>.

29. Alan A. Cavaola & David Dolan, *Considerations in Civil Commitment of Individuals with Substance Use Disorders*, 37 *SUBSTANCE ABUSE* 181, 182 (2016).

30. See Deirdre Shesgreen, *Families Seek Involuntary Commitment Laws as Key Tool in Saving Opioid Addicts*, USA TODAY (Aug. 23, 2017, 5:14 PM), <https://www.usatoday.com/story/news/politics/2017/08/23/families-seek-involuntary-commitment-laws-key-tool-saving-opioid-addicts/594423001/>; see also Christine Vestal, *Lawmakers Move to Involuntarily Commit Opioid Users*, THE INQUIRER (June 15, 2017, 12:31 PM), <https://www.philly.com/philly/health/addiction/lawmakers-move-to-involuntarily-commit-opioid-users-20170615.html>.

31. Abhishek Jain et al., *Civil Commitment for Opioid and Other Substance Use Disorders: Does It Work?*, 69 *PSYCHIATRIC SERVS.* 374, 374 (2018).

substance use disorder and the person is dangerous to himself or others.³² While some states rarely use their civil commitment statutes for substance abuse, others have been more aggressive.³³ According to the Massachusetts Department of Health, approximately 6,500 people were involuntarily committed to addiction treatment in 2016.³⁴

Part II of this Article explains how substance abuse civil commitment statutes work and how courts have responded to the legal challenges they present. States have broad authority to confine people with substance use disorders when they are dangerous to themselves or others.³⁵ Nonetheless, some of the proposals cropping up in state legislatures fall beyond even the broad boundaries established by the Supreme Court's civil commitment jurisprudence.³⁶ Part III turns to the empirical evidence. Surprisingly, many studies have shown that a person who is struggling with an addiction need not "hit rock bottom" for treatment to be effective.³⁷ Indeed, much of the research in this area suggests that people who are required to participate in drug treatment under a court order do as well or better than their voluntary counterparts.³⁸

The fact that civil commitment probably works forces us to grapple with a difficult ethical question—under what circumstances is it morally permissible to force someone like John Carter into treatment over his objection? Prominent bioethicists have argued that compulsory drug treatment is morally permissible because "[p]eople who are addicted really do not have the full capacity to be self-determining" in large part "because they are caught up in the behavioral vice that is addiction."³⁹ Part IV argues that while people with substance use disorders suffer from impairments in their capacity to be self-determining or autonomous, most addicts retain at least some degree of control over their behavior,

32. See *infra* Part II.A.

33. See Paul P. Christopher et al., *Nature and Utilization of Civil Commitment for Substance Abuse in the United States*, 43 J. AM. ACAD. PSYCHIATRY & L. 313, 315 (2015) reporting wide variability in the extent to which civil commitment statutes are used each year). The authors found there were more than 9,000 substance abuse civil commitments each year in Florida; more than 4,500 in Massachusetts in 2011; 260 in Wisconsin and 166 in Missouri. *Id.*

34. Deborah Becker, *Is It Addiction Treatment or Prison? A Look Inside A State Center for Involuntary Commitments*, WBUR: COMMONHEALTH (Sept. 13, 2017), <https://www.wbur.org/commonhealth/2017/09/13/civil-commitment-substance-treatment>.

35. See *infra* Part II.B.

36. See *infra* Part II.B.

37. See *infra* Part III.C.

38. See *infra* Part III.C.

39. See Arthur L. Caplan, *Ethical Issues Surrounding Forced, Mandated, or Coerced Treatment*, 31 J. SUBSTANCE ABUSE TREATMENT 117, 118 (2006).

thereby undermining arguments in favor of compulsory treatment based on the brain disease model of addiction.

In recent years, the brain disease model of addiction has come under attack from many quarters.⁴⁰ Much of this argument has been dedicated toward showing that addiction is not a disease at all, merely a “choice”⁴¹ or “a bad habit that can be learned and unlearned.”⁴² Whether addiction is or is not a disease is not my concern. In contrast to many of these scholars, I am willing to assume for the sake of argument that a drug addiction is indeed a serious mental disorder. In Part V, I argue that what should matter in civil commitment cases is whether the person retains the capacity to make a competent treatment decision, whether the person has a disease or not. In doing so, my approach takes its cues from soft paternalism. Soft paternalism is the view that government intervention into self-regarding harm is justified when, and only when, intervention is necessary to determine whether the person’s conduct is knowledgeable and voluntary.⁴³ When they are not intoxicated, most addicts are competent to make treatment decisions.⁴⁴ Part V, contends that a person who is competent to refuse treatment should be permitted to do so.

Finally, a note on terminology. In common parlance, terms such as “addiction,” “substance abuse” and “substance dependence” are used interchangeably. However, in 2013, the American Psychiatric Association replaced the diagnostic criteria for substance abuse and substance dependence with a new diagnostic category—substance use disorder. The fifth edition of *The Diagnostic and Statistical Manual of Mental Disorders* (DSM-5) now recognizes a variety of substance use disorders (SUDs) with varying levels of severity. Some of the key criteria for diagnosing a substance use disorder in the DSM-5 include: consuming the drug in larger and larger quantities, over a longer period of time than intended; continued use of the substance despite persistent social or interpersonal problems; and tolerance, i.e. “requiring a markedly increased dose of the substance to achieve the desired effect.”⁴⁵

40. See *infra* Part IV.B.

41. E.g., GENE M. HEYMAN, ADDICTION: A DISORDER OF CHOICE 94–98 (2009).

42. Marc Lewis, Opinion, *Addiction Is a Bad Habit That Can Be Learned and Unlearned*, N.Y. TIMES (Feb. 17, 2014, 11:52 PM), <https://www.nytimes.com/roomfordebate/2014/02/10/what-is-addiction/addiction-is-a-bad-habit-that-can-be-learned-and-unlearned>.

43. See 3 JOEL FEINBERG, THE MORAL LIMITS OF THE CRIMINAL LAW: HARM TO SELF 12 (1986).

44. See *infra* Part V.

45. AM. PSYCHIATRIC ASS’N, DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS 483–85 (5th ed. 2013) [hereinafter DSM-5]. In order to be diagnosed with a substance use disorder, pursuant to the DSM-5, a person must have a problematic pattern

“Addiction” is not a diagnostic category in the DSM-5; however, mental health professionals, along with the National Institute on Drug Abuse, use the term “addiction” to refer to severe substance use disorders.⁴⁶ According to the DSM-5, a severe substance use disorder is one suggested by the presence of six or more symptoms.⁴⁷ I will use the same definition of addiction here.

II. LEGAL RESTRICTIONS ON THE USE OF CIVIL COMMITMENT TO CONFIN PEOPLE WITH SUBSTANCE USE DISORDERS

A. *Constitutional Challenges*

Thirty-five states and the District of Columbia have statutes that authorize involuntary civil commitment for someone who has been diagnosed with a substance use disorder.⁴⁸ Typically, the petitioner must

of substance use, leading to clinically significant impairment or distressed, as demonstrated by at least two of the following signs, within a 12-month period: (1) taking the substance in “larger amounts or over a longer period than was originally intended;” (2) “a persistent desire to cut down or regulate substance use” and “multiple unsuccessful efforts to decrease or discontinue use;” (3) spending a great deal of time “obtaining the substance, using the substance, or recovering from its effects;” (4) craving as “manifested by an intense desire or urge for the drug;” (5) “failure to fulfill major role obligations at work, school, or home;” (6) continued use of the substance “despite having persistent or recurrent social or interpersonal problems caused or exacerbated by the effects of the substance;” (7) giving up “[i]mportant social, occupational, or recreation activities . . . because of substance use;” (8) “recurrent substance use in situations in which it is physically hazardous;” (9) continuing to use the substance despite knowledge of physical or psychological problems that are “likely to have been caused or exacerbated by” substance use; (10) tolerance, “signaled by requiring a markedly increased dose of the substance to achieve the desired effect or a markedly reduced effect when the usual dose is consumed;” and (11) withdrawal as demonstrated by consuming the substance to relieve symptoms. *Id.*

46. NAT’L INST. ON DRUG ABUSE, DRUGS, BRAINS AND BEHAVIOR: THE SCIENCE OF ADDICTION, 5 n.† (2014).

47. DSM-5, *supra* note 45, at 484.

48. Five states include substance abuse or alcoholism in their statutory definition of a mental disorder. In those states, the process for civilly committing a person with a substance use disorder is the same as the process for committing a person with a mental disorder. IND. CODE ANN. § 12-26-1-1.5 (West 2018); ME. REV. STAT. tit. 34-B, § 3801 (West 2018); Nebraska Mental Health Commitment Act, NEB. REV. STAT. ANN. § 71-908 (West 2018); TENN. CODE ANN. § 33-1-101 (West 2018); and VA. CODE ANN. § 37.2-800 (West 2018). In most states, however, there are separate provisions for committing someone who has been diagnosed with a substance use disorder. ALASKA STAT. ANN. § 47.37.190 (West 2018); ARK. CODE ANN. § 20-64-815 (West 2018); CONN. GEN. STAT. ANN. § 17a-502 (West 2018); DEL. CODE ANN. tit. 16, § 2212 (West 2018); D.C. CODE ANN. § 24-607 (West 2018); FLA. STAT. ANN. § 397.675 (West 2018); GA. CODE ANN. § 37-7-81 (West 2018); HAW. REV. STAT. ANN. § 334-60.2 (West 2018); IOWA CODE ANN. § 229.6 (West 2018); MASS. GEN. LAWS ANN. ch. 123, § 35 (West 2018); MICH. COMP. LAWS ANN. § 330.1281a (West 2018); MINN. STAT. ANN. § 253B.05 (West 2018); MISS. CODE ANN. § 41-31-3 (West 2018); MO. ANN. STAT. §

establish by clear and convincing evidence that the person has a substance use disorder and the person is dangerous to himself or others.⁴⁹ In some states, petitioners can obtain civil commitment orders if they can establish that the respondent is “gravely disabled,” as a result of his or her substance use disorder, and therefore unable to provide for his or her basic needs for food, clothing and shelter.⁵⁰ In every state, civil commitment must be the least restrictive alternative.⁵¹ Ordinarily, without a petition for recommitment, the subject of an inpatient civil commitment order must be discharged after thirty days,⁵² but in some states, the subject of an inpatient commitment order may be held for up to six months⁵³ or a year.⁵⁴

The Supreme Court has yet to address the constitutionality of civil commitment for people with substance use disorders. However, in *Robinson v. California*, the Court suggested that such a program might not be unconstitutional.⁵⁵ In dicta, Justice Stewart underscored “[t]he broad power of a State to regulate the narcotic drugs traffic within its borders.”⁵⁶ The Court reasoned that “[s]uch [a] regulation . . . could take a vereity [sic] of valid forms.”⁵⁷ In order to discourage inhabitants from violating drug laws: “[A] State might establish a program of compulsory

631.145 (West 2018); MONT. CODE ANN. § 53-24-302 (West 2017) (alcoholism only); N.D. CENT. CODE ANN. § 25-03.1-11 (West 2018); OHIO REV. CODE ANN. § 5119.92 (West 2018); OKLA. STAT. ANN. tit. 43a, §1-103 (West 2018); 23 R.I. GEN. LAWS ANN. § 23-1.10-12. (West 2018) (alcohol only); S.C. CODE ANN. § 44-52-10 (West 2018); S.D. CODIFIED LAWS § 34-20A-70 (West 2018); TEX. HEALTH & SAFETY CODE ANN. § 462.062 (West 2017); VT. STAT. ANN. tit. 18, § 7612 (West 2018); WASH. REV. CODE ANN. § 71.05.020 (West 2018); W. VA. CODE ANN. § 27-5-2 (West 2018); WIS. STAT. ANN. § 51.45 (West 2018). For a comprehensive summary of substance abuse civil commitment laws, see Heather Gray, *Involuntary Commitment for Individuals with Substance Use Disorder or Alcoholism*, NAT’L ALLIANCE FOR MODEL ST. DRUG LAWS (Oct. 19, 2016), <http://namsdl.dynamicwebware.com/News%20Tab/NAMSDL%20News/NAMSDL%20News%20October%2019%202016.pdf>.

49. *E.g.*, COLO. REV. STAT. ANN. § 27-81-112 (West 2018); FLA. STAT. ANN. § 397.675 (West 2018).

50. *E.g.*, CAL. WELF. & INST. CODE § 5008 (West 2018); IND. CODE ANN. § 12-26-6-2 (West 2018); LA. STAT. ANN. § 28:54 (2018); WASH. REV. CODE ANN. § 71.05.040 (West 2018).

51. Megan Testa & Sara G. West, *Civil Commitment in the United States*, 7 PSYCHIATRY 30, 33 (2010), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3392176/pdf/PE_7_10_30.pdf (citing *Lake v. Cameron*, 364 F.2d 657 (1966)). *See also* In the Interest of L.B., 858 N.W.2d 322, 325 (N.D. 2015).

52. *See, e.g.*, COLO. REV. STAT. ANN. § 27-81-112(7) (West 2018).

53. GA. CODE ANN. § 37-7-81.1(c) (West 2018); N.C. GEN. STAT. ANN. § 122C-287(1) (West 2018).

54. *See, e.g.*, D.C. CODE ANN. § 24-709 (West 2018).

55. 370 U.S. 660, 676–77 (1962). In *Robinson*, the Supreme Court held that a state law, which made it a criminal offense to be a “narcotic addict,” inflicted cruel and unusual punishment within the meaning of the Eighth Amendment. *Id.* at 676.

56. *Id.* at 664.

57. *Id.*

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.”⁵⁸ The Court analogized the power to commit persons who are addicted to narcotics to the firmly established power of a state to confine people with mental illnesses and others who are afflicted with various forms of infectious disease.⁵⁹ To lower courts and state legislatures, the *Robinson* dicta suggested that using involuntary civil commitment to target people who were addicted to narcotics would survive constitutional scrutiny.⁶⁰

By the mid-1960s, the federal government,⁶¹ New York⁶² and California⁶³ had each established compulsory drug treatment programs, primarily for people with heroin addictions.⁶⁴ All three programs included civil commitment procedures for people who violated federal or state drug laws, as well as people who had never been charged with a crime.⁶⁵ Patients who were committed to these programs routinely argued that civil commitment was punitive,⁶⁶ or no more than a “sham,” or “a veneer for an extended jail term.”⁶⁷ However, those arguments were dismissed by courts, which tended to view addiction as a “disease,” and civil commitment as a compassionate rehabilitative response to the “addict as a sick person.”⁶⁸

In New York and California, civil commitment laws applied not only to people who were addicted to narcotics, but also to people who were “in

58. *Id.* at 665.

59. *Id.* at 666.

60. Lawrence O. Gostin, *Compulsory Treatment for Drug-dependent Persons: Justifications for a Public Health Approach to Drug Dependency*, 69 MILBANK Q. 561, 564–65 (1991).

61. Narcotic Addict Rehabilitation Act of 1966, Pub. L. No. 89-793, 80 Stat. 1438 (1966).

62. 1966 N.Y. Laws 758.

63. See Gostin, *supra* note 60, at 564.

64. See Gostin, *supra* note 60, at 568.

65. 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).

66. *In re David De La O*, 378 P.2d 793, 796–98 (Cal. 1963).

67. *People v. Fuller*, 248 N.E.2d 17, 21 (N.Y. 1969).

68. *People v. Reynoso*, 412 P.2d 812, 813–14 (Cal. 1966) (denying that defendant was entitled to credit on his criminal sentence for time spent in the rehabilitation center); *Fuller*, 248 N.E.2d at 20 (indicating that “[by] its [own] terms New York’s Narcotic Control Act of 1966 recognizes that drug addiction is a ‘disease’ and that an addict is a sick person in need of treatment.”); *Blinder v. Division of Narcotic Enforcement*, 101 Cal. Rptr. 635, 641 (Cal. Ct. App. 1972) (concluding that statutes providing for the civil confinement of narcotic addicts “are enactments which have for their purpose the interest of public health and welfare and are reasonably necessary for the accomplishment of that purpose.”).

imminent danger of becoming addicted to narcotics.”⁶⁹ In *People v. Victor*, the California Supreme Court observed that by creating a distinct category of persons who are “in imminent danger of ‘becoming’ addicted, the Legislature has in effect recognized the fundamental medical fact that narcotics addiction is not so much an event as a *process*.”⁷⁰ Although “mere sampling or experimentation does not make an addict,” the court indicated that sampling and experimentation “could be a step” in that process.⁷¹ To that end, a statute, authorizing a form of preventive inpatient commitment for people who were merely in danger of becoming addicted to narcotics, was neither un-constitutionally vague, nor beyond the police power of the state.⁷²

In the same way, courts have held that former inpatients may be required to remain under supervision as outpatients for a reasonable period of time. In *In re Trummer*, the petitioner challenged the civil commitment order against him on the ground that he was no longer addicted to narcotics and therefore entitled to be released from the California Civil Addict Program.⁷³ However, according to the California Supreme Court, the purpose of the program was “not only to treat and ‘cure’ addicts,” but also to “rehabilitate them.”⁷⁴ “[A]lthough the petitioner currently may give every appearance of being ‘cured’ of his addiction, it is within the constitutional power of the Legislature to require that a person once committed as a narcotics addict remain under supervision for a period sufficient to give reasonable assurance against relapse.”⁷⁵ Given the risk that Trummer might lapse into opioid use once again, three years of parole was not unreasonable.⁷⁶

B. Expanding State Power

In a series of decisions throughout the 1960s, courts upheld civil commitment laws against a variety of constitutional challenges, and in doing so, created broad authority for states to force people with substance use disorders into treatment through civil commitment. However, as part of their ongoing efforts to combat the opioid crisis, legislators are drafting

69. See Gostin, *supra* note 60, at 564; 1966 N.Y. Laws 758 (defining a “narcotic addict” as any person “who is at the time of examination dependent upon opium, heroin, morphine” or “in imminent danger of becoming dependent upon opium, heroin, morphine, or any derivative or synthetic drug of that group.”).

70. 62 Cal. 2d 280, 301 (1965) (emphasis added).

71. *Id.*

72. *Id.* at 306.

73. *In re Trummer*, 388 P.2d 177, 178 (Cal. 1964).

74. *Id.* at 179.

75. *Id.*

76. *Id.*

statutes that would make it even easier to commit people who are addicted to drugs.

In New Hampshire, Senate Bill 220-FN would expand the definition of a mental illness in the state's civil commitment statute to include a person who has "ingested opioid substances" and whose behavior "demonstrates that he or she lacks the capacity to care for his or her own welfare."⁷⁷ Although the U.S. Supreme Court has said that a civil commitment order requires clear and convincing evidence of both mental illness and dangerousness to self or others, in *Kansas v. Hendricks*, Justice Thomas indicated that "the term 'mental illness' is devoid of any talismanic significance."⁷⁸ "Indeed, we have never required state legislatures to adopt any particular nomenclature in drafting civil commitment statutes. Rather, we have traditionally left to legislators the task of defining terms of a medical nature that have legal significance."⁷⁹ For the *Hendricks* majority, it was enough that Hendricks had been diagnosed with "pedophilia, a condition the psychiatric profession itself classifies as a serious mental disorder."⁸⁰

Lower courts have embraced the flexibility handed to them in *Kansas v. Hendricks*. In *Mercer v. Commonwealth of Virginia*, the Virginia Supreme Court held that an insanity acquittee, who had been diagnosed with antisocial personality disorder and polysubstance dependence, was mentally ill within the meaning of the state's civil commitment statute, permitting her continued confinement.⁸¹ The Virginia Court alluded to Justice Thomas's declaration that the Supreme Court has never required state legislatures to adopt any particular definition of mental illness for the purposes of civil commitment.⁸² Therefore, whether polysubstance abuse qualifies as a mental illness for the purpose of confining an insanity acquittee was a question of fact to be resolved by the lower

77. S.B. 220-FN, 2017 Sess. (N.H. 2017). New Hampshire is one of 24 states that specifically excludes substance use disorders and alcoholism from the statutory definition of a mental illness. It is also one of 8 states that does not have a separate provision for civilly committing people with substance use disorders. The absence of a strong civil commitment statute has also been a challenge in a state that has been called "ground zero" in the opioids epidemic. See Kyle Plantz, *What Factors Led New Hampshire to be Ground Zero for the Opioid Crisis?*, INSIDESOURCES (June 11, 2017), <https://www.insidesources.com/nh-fentanyl-opioid-crisis-study/>. New Hampshire has the second highest drug overdose death rate in the country and the highest death rate from synthetic opioids, primarily fentanyl. *Synthetic Opioid Data*, CTRS. FOR DISEASE CONTROL AND PREVENTION, <https://www.cdc.gov/drugoverdose/data/fentanyl.html> (last updated Dec. 19, 2018).

78. 521 U.S. 346, 359 (1997).

79. *Id.*

80. *Id.* at 360.

81. 523 S.E.2d 213, 217 (Va. 2000).

82. *Id.* at 216.

courts.⁸³ Indeed, in *Mercer*, the Virginia Supreme Court found that there was evidence in the record to support the trial court's finding that Mercer had a mental illness and presented a serious risk of bodily harm to others "because of her long history of drug abuse, drug addiction, and violence."⁸⁴

Hendricks and *Mercer* suggest that states may define the term "mental illness" broadly, and indeed broadly enough to include merely ingesting "opioid substances." What remains to be seen, however, is how broadly states can define terms such as "dangerousness" or "grave disability" in their civil commitment statutes. A controversial bill in the Washington State Legislature would expand the state's civil commitment statute by bringing heroin and opioid users within the definition of persons who are gravely disabled.⁸⁵ Under Senate Bill 5811, "[a] person is gravely disabled due to a substance use disorder when the person has an opioid use disorder characterized by active use of heroin and, within the" last twelve months, the person has had three or more arrests related to substance use; one or more hospitalizations connected to substance use; or "three or more visible track marks indicating intravenous drug use."⁸⁶

States have broad authority to confine people with substance use disorders, but Senate Bill 5811 would be a bridge too far. Track marks provide strong evidence of a serious drug problem, but courts have consistently required clear and convincing evidence of harm beyond the substance use disorder itself.⁸⁷ Without evidence of harm, the petitioner must at least establish that the respondent is unable to care for his or her basic needs. For example, in *Matter of Stephen O.*, the respondent's family petitioned for civil commitment when Stephen O. claimed to hear the voice of Jesus, telling him to "get on a path of repentance."⁸⁸ The Alaska Supreme Court held that Stephen O. was not gravely disabled within the meaning of the state's civil commitment statute.⁸⁹ Alluding to the U.S. Supreme Court's decision in *O'Connor v. Donaldson*, the Alaska

83. *Id.*

84. *Id.* at 217.

85. S.B. 5811, 65th Leg., 2017 Reg. Sess. Laws (Wash. 2017).

86. *Id.*

87. *In re G.P.*, 40 N.E.3d 989, 1001 (Mass. 2015) ("Both parties agree that proof that the respondent is a chronic alcoholic or substance abuser, by itself, is insufficient to establish a 'very substantial risk' of harm."); *see, e.g., In re J.G.*, 834 N.W.2d 870 (Table), 2013 WL 2107462, (Iowa Ct. App. 2013) (finding that "[o]ngoing alcohol use, without more" was insufficient to establish a likelihood of serious danger); *see also In re E.J.H.*, 493 N.W.2d 841, 843 (Iowa 1992) ("The fact that the respondent remains an untreated substance abuser alone is not sufficient reason to find that she is dangerous to herself or others.").

88. *In re Stephen O.*, 314 P.3d 1185, 1187 (Alaska 2013).

89. *Id.* at 1195.

court observed that “mental illness, without more, ‘does not disqualify a person from preferring his home to the comforts of an institution.’”⁹⁰ Nor is it sufficient to establish that inpatient commitment would be “beneficial,” or in the person’s “best interests.”⁹¹ Track marks—like hearing the voice of Jesus—probably provide strong evidence that the person has a serious illness. But “without more” than track marks indicating recent intravenous drug use, it cannot be established that the person is unable to survive safely in freedom within the meaning of *Donaldson*.

III. THE EFFECTIVENESS OF CIVIL COMMITMENT FOR PEOPLE WITH SUBSTANCE USE DISORDERS

The use of civil commitment to confine people with substance use disorders is not unlawful when they are dangerous to themselves or others, but is it effective? In contrast to the voluminous empirical literature on the use of both inpatient and outpatient civil commitment for people with mental illnesses, remarkably, there has been very little empirical research on the use of civil commitment to confine people with substance use disorders. Instead, much of what we know about the effectiveness of civil commitment for this population comes from inpatient civil commitment programs implemented by New York, California, and the federal government during the mid-20th century.

Part II.A. begins by explaining how these early programs worked, along with the empirical evidence suggesting that people under involuntary civil commitment orders usually had better outcomes than their voluntary counterparts. Nonetheless, whether a civil commitment program is likely to be effective depends in large part on the quality of the underlying treatment program. To that end, Part II.B. describes contemporary evidence-based approaches to addiction treatment. Part II.C. turns to the empirical literature on drug courts, much of which suggests that a person need not “hit rock bottom” for treatment to be effective.

A. *Early Civil Commitment Programs: 1933—1970*

Compulsory substance abuse treatment has been a feature of the U.S. landscape since at least the mid-1930s, when the U.S. Public Health

90. *Id.*

91. *Id.*

Service established the U.S. Narcotic Farm in Lexington, Kentucky.⁹² Located on 1,100 acres of farmland, the Narcotic Farm was both a “hospital-prison-sanitarium” and a working farm where patients were encouraged to engage in “sewing, printing, [and] woodworking.”⁹³ The idea was that “serenity and respite care” would enable people with drug addictions to return to their lives as productive citizens.⁹⁴ A few years later, the Public Health Service opened a second farm in Fort Worth, Texas.⁹⁵

The farms were established primarily to rehabilitate people who violated federal drugs laws, many of whom were sent to the farms in lieu of a prison sentence.⁹⁶ Others, who had neither been charged with nor convicted of a crime, went to the farms voluntarily.⁹⁷ The recommended course of treatment was detox and withdrawal, followed by four to six months group therapy, remedial education, vocational training, farm work, recreation, and religious services.⁹⁸ But because there was no mechanism for holding voluntary patients, 70% of all voluntary patients signed out against medical advice before completing the program.⁹⁹ Within a few years, 90% of those patients relapsed.¹⁰⁰ When patients remained in treatment, they usually did so under the threat of a court order.¹⁰¹

A small number of longitudinal studies found that people who were committed to the farms in Lexington or Fort Worth under a court order usually had better outcomes than voluntary patients. For example, a 1943 study of more than 4,700 Lexington patients found that 27% of probationers and 31% of paroled prisoners maintained continuous abstinence from opioids for six months after being discharged from the Lexington PHS hospital, compared to only 12% of their voluntary

92. Sally L. Satel & David J. Farabee, *The Role of Coercion In Drug Treatment*, in *SUBSTANCE ABUSE: A COMPREHENSIVE TEXTBOOK* 690, 692 (Joyce H. Lowinson et al. eds., 2005).

93. JILL JONNES, HEP-CATS, NARCS, AND PIPE DREAMS: A HISTORY OF AMERICA'S ROMANCE WITH ILLEGAL DRUGS 111–12 (1995).

94. Faye S. Taxman & Nena P. Messina, *Civil Commitment: One of Many Coerced Treatment Models*, in *CLINICAL AND POLICY RESPONSES TO DRUG OFFENDERS 2* (Carl G. Leukefeld, Frank Tims & David Farabee eds., 2002).

95. Satel & Farabee, *supra* note 92, at 692.

96. James Maddux, *Clinical Experience with Civil Commitment*, in *COMPULSORY TREATMENT OF DRUG ABUSE: RESEARCH AND CLINICAL PRACTICE* 35, 36 (Carl G. Leukefeld & Frank M. Tims eds., 1988).

97. *Id.*

98. *Id.*

99. Satel & Farabee, *supra* note 92, at 692.

100. *Id.*

101. *See* Maddux, *supra* note 96, at 36.

counterparts.¹⁰² In contrast to voluntary patients, who were frequently discharged without a plan for aftercare,¹⁰³ probationers and parolees were required to remain under the supervision of a law enforcement officer. Twenty years later, a second study followed 100 male heroin addicts who had been discharged from the Lexington PHS hospital during the early 1950s.¹⁰⁴ The study compared three categories of patients—(i) prisoners who were hospitalized for at least nine months and spent at least one year on parole; (ii) prisoners who were hospitalized for less than nine months with no parole; and (iii) voluntary patients.¹⁰⁵ The study found that 67% of the prisoners who were hospitalized for at least nine months with one year of parole abstained from drugs for at least one year or more, compared to only 4% of prisoners who were hospitalized for less than nine months, and only 4% of voluntary patients.¹⁰⁶

Not all studies found that civil commitment was associated with long-term abstinence. A 1962 study followed 1,881 patients who had been discharged from the Lexington PHS hospital between 1952 and 1955.¹⁰⁷ Researchers concluded that 87.3% of those patients were readdicted to drugs within twelve months of being discharged.¹⁰⁸ Nonetheless, the same study found significantly lower rates of re-addiction among three groups of patients—(i) nonvoluntary patients, age thirty and older, compared to their voluntary counterparts; (ii) white nonvoluntary patients compared to their African American counterparts; and (iii) patients under thirty, who remained in the hospital for thirty-one days or more, compared to patients who remained in the hospital for thirty days or less.¹⁰⁹

102. MICHAEL J. PESCOR, U.S. PUB. HEALTH SERV., FOLLOW-UP STUDY OF TREATED NARCOTIC DRUG ADDICTS: SUPPLEMENT NO. 170 TO THE PUBLIC HEALTH REPORTS, 1, 3–4 (1943).

103. See Bernard J. Langenauer & Charles L. Bowden, *A Follow-Up Study of Narcotic Addicts in the NARA Program*, 128 AM. J. PSYCHIATRY 41, 41 (1971) (explaining that “[m]ost volunteers only stayed long enough to be detoxified[and] [t]hose who elected to stay for the ‘cure,’ four and half months,” usually left without a plan for aftercare).

104. George E. Vaillant & Robert W. Rasor, *The Role of Compulsory Supervision in the Treatment of Addiction*, 30 FED. PROB. 53, 53–54 (1966).

105. *Id.*

106. *Id.* at 54; see also George E. Vaillant, *A 20-Year Follow-Up of New York Narcotic Addicts*, 29 ARCHIVES GEN. PSYCHIATRY 237, 238–40 (1973) (finding that community supervision and methadone maintenance were more likely to lead to abstinence than voluntary hospitalization and court ordered inpatient addiction treatment).

107. G. Halsey Hunt & Maurice E. Odoroff, *Followup Study of Narcotic Drug Addicts After Hospitalization*, 77 PUB. HEALTH REP. 41, 43–44 (1962).

108. *Id.* at 43.

109. *Id.* at 48.

A similar lesson emerged from the California Civil Addict Program (CAP). The enabling legislation permitted involuntary civil commitment to the California Rehabilitation Center if after a hearing, the court determined that a person either had a drug addiction or was in “imminent danger of becoming addicted” to narcotics.¹¹⁰ In theory, anyone with a drug addiction could be admitted to the program, but in practice, most of the people who were committed to CAP were diverted from the criminal justice system.¹¹¹ The defining feature of the CAP was its seven year civil commitment order divided into two parts.¹¹² During the institutional phase of the order, patients were confined to the California Rehab Center for a statutory minimum of at least six months.¹¹³ Reminiscent of the narcotics farms, inpatient treatment usually consisted of “self-help groups,” “vocational and academic education,” and “work assignments.”¹¹⁴ After six months of inpatient treatment (or more often eighteen to twenty-four months) patients were discharged under a five-year outpatient civil commitment order.¹¹⁵

During the early years of the program, patients who were released from the California Rehab Center were carefully monitored.¹¹⁶ Parole agents were required to contact “parolees” (i.e. patients) at least twice a month and a collateral informant such as an employer or family member at least once a month.¹¹⁷ Parolees were required to submit to urinalysis three times per month and weekly group counseling was required.¹¹⁸ Parolees who tested positive for drugs (or violated some other condition of their parole) were returned to the CRC, and “the median stay on return was around eight months.”¹¹⁹

In contrast to the equivocal evaluations of the federal civil commitment program, the California Civil Addict Program has generally been viewed as a success.¹²⁰ An important study by W. H. McGlothlin and M. D. Anglin compared patients who were admitted to the program and released into the community under supervision, with people who were admitted to the program but discharged shortly thereafter, owing to an

110. See Gostin, *supra* note 60, at 565.

111. Anglin & Hser, *supra* note 65, at 152.

112. NARCOTIC ADDICT EVALUATION AUTH., STATE OF CAL. DEP’T OF CORR., ALL ABOUT THE CIVIL ADDICT PROGRAM 1 (1988).

113. Note, *Civil Commitment of Narcotic Addicts*, 76 YALE L.J. 1160, 1161 n.10 (1967).

114. *Id.*

115. See WILLIAM H. MCGLOTHLIN ET AL., AN EVALUATION OF THE CALIFORNIA CIVIL ADDICT PROGRAM 6 n.4 (1977).

116. *Id.* at 9–10.

117. *Id.* at 9.

118. *Id.* at 9 n.9.

119. See *id.* at 9–10.

120. *Id.* at 1.

administrative mistake.¹²¹ McGlothlin and Anglin compared the treatment group and the comparison group, across various outcomes of interest, including self-reported daily narcotic use and criminal behavior.¹²² Among parolees who remained under CAP supervision for seven years, self-reported daily narcotics use declined by 22%, while self-reported drug use among parolees who were prematurely discharged only declined by 7%.¹²³ Similarly, self-reported criminal activity declined by 19% among CAP enrollees.¹²⁴ Among the comparison group, however, self-reported criminal activity only declined by 7%.¹²⁵ Undoubtedly, reliance on self-reported drug use and self-reported criminal activity is a weakness of the study. Nonetheless, McGlothlin and Anglin corroborated self-reports using arrest records and drug tests, and only a small fraction of respondents who denied drug use actually tested positive for narcotics.¹²⁶

Other civil commitment programs were less successful than the California Civil Addict Program for a variety of reasons. In 1966, Congress passed the Narcotic Addict Rehabilitation Act (NARA).¹²⁷ Under Title III of the NARA, a person could be committed to inpatient treatment for up to six months.¹²⁸ The NARA also authorized up to thirty-six months of posthospital treatment and supervision in the community,

121. *Id.* at 1–2.

122. *Id.* at 14–15.

123. Anglin & Hser, *supra* note 65, at 153.

124. *Id.*

125. *Id.*

126. William H. McGlothlin et al., *An Evaluation of the California Civil Addict Program* 60 (1977) (noting that of the 309 respondents who provided a urine sample and denied drug use, only 12% tested positive for drugs). There was also some evidence that sustained participation in the CAP program was associated with a lasting benefit, even after parolees were discharged from the program. Seven years post discharge, parolees who underwent a full seven-year commitment order, reported that they spent somewhat less time using drugs than parolees who were prematurely discharged (57% v. 46%). *Id.* at 1. *But see* John C. Kramer et al., *Civil Commitment for Addicts: The California Program*, 125 AM. J. PSYCHIATRY 128, 133 (1968) (finding that 50% of CAP parolees returned to opiate use during their first year on outpatient supervision). Moreover, while participation in the CAP program might have been associated with some successes, it should not be seen as a panacea. In a long-term study of 242 male heroin addicts who had been committed to the California Civil Addict program, 21% tested positive for heroin, 22% were daily alcohol drinkers and many reported “high rates of health problems, mental health problems, and criminal justice system involvement.” Yih-Ing Hser et al., *A 33-Year Follow-up of Narcotics Addicts*, 58 ARCHIVES GEN. PSYCHIATRY 503, 503 (2001).

127. Narcotic Addict Rehabilitation Act of 1966, Pub. L. No. 89-793, 80 Stat. 1438 (1966).

128. *Id.* Like the California Civil Addict Program, Title I of the NARA authorized civil commitment for drug users who had been charged with a federal offense and agreed to civil commitment in lieu of prosecution. Title II of the NARA authorized civil commitment for people with substance use disorders, who had been convicted of a federal offense. Maddux, *supra* note 96, at 40–41.

with the possibility of being recommitted to the hospital for another six months.¹²⁹ Only two empirical studies of NARA patients were completed and both of them found that most NARA patients continued to use drugs after they were discharged from a hospital, and in both studies, 80 to 90% of patients reported at least some opioid use by the end of their six months in aftercare.¹³⁰

Inspired by the success of the California Civil Addict Program, New York created its own civil commitment program in 1966.¹³¹ As in California, New York law provided for the civil commitment of people who were addicted to narcotics, primarily opium, heroin and morphine.¹³² The average duration of a civil commitment order was a little more than two years, including ten months of residential treatment.¹³³ A study of people who had been enrolled in the New York Civil Commitment Program (CCP) for up to three years and discharged found that self-reported heroin use declined dramatically.¹³⁴ Nonetheless, the program was thought to be too expensive and insufficiently effective to justify its cost.¹³⁵ Within a few years the program was abolished.¹³⁶

B. Evidence-Based Approaches to Addiction Treatment

Addiction treatment has changed dramatically since the heyday of the civil commitment programs in New York and California. Today, effective addiction treatment usually incorporates a few key principles. First, researchers and clinicians have found that addiction treatment must be tailored to the needs of the individual, beyond his or her drug use, to be effective. According to the National Institute for Drug Abuse, effective addiction treatment must “address the individual’s drug abuse and any associated medical, psychological, social, vocational, and legal

129. Narcotic Addict Rehabilitation Act § 2902(a); Maddux, *supra* note 96, at 41.

130. Langenauer & Bowden, *supra* note 103, at 76; Richard Stephens & Emily Cottrell, *A Follow-Up Study of 200 Narcotic Addicts Committed for Treatment Under the Narcotic Addict Rehabilitation Act (NARA)*, 67 BRIT. J. ADDICTION 45, 46 (1972). For a thoughtful discussion of the strengths and weaknesses of the NARA, see Richard Lindblad, *Civil Commitment Under the Federal Narcotic Addict Rehabilitation Act*, 18 J. DRUG ISSUES 595 (1988).

131. James A. Inciardi, *Some Considerations on the Clinical Efficacy of Compulsory Treatment: Reviewing the New York Experience*, in COMPULSORY TREATMENT OF DRUG ABUSE: RESEARCH AND CLINICAL PRACTICE, *supra* note 96, at 126, 128.

132. 1966 N.Y. Laws 760. And, as in California, New York law authorized civil commitment for drug users who never been charged with a crime, as well as those who been charged with or convicted of a crime. *Id.* at 759–60.

133. See Anglin & Hser, *supra* note 65, at 158.

134. *Id.* at 159.

135. *Id.*

136. *Id.*

problems.”¹³⁷ Because mental illnesses and substance use disorders often co-occur, a person who has been diagnosed with either condition should also be evaluated for the other.¹³⁸

Second, effective addiction treatment usually involves a combination of behavioral therapy and medication. Behavioral therapies vary in their approach, but the most common form of behavioral therapy is cognitive behavioral therapy, in which individuals learn to identify situations that might put them at risk for drug use, while also developing alternative strategies for coping with their cravings.¹³⁹ For people who are addicted to opioids, medications such as methadone, buprenorphine and naltrexone have also been shown to reduce illicit drug use.¹⁴⁰

Third, research has shown that most people with drug addictions need at least three months in treatment in order to reduce their drug use.¹⁴¹ In the Drug Abuse Treatment Outcome Study (DATOS) researchers followed 2,966 people who participated in four different kinds of drug treatment programs—outpatient methadone maintenance clinics (OMT); long-term residential placement (LTR); outpatient drug-free treatment (ODF), and short-term inpatient treatment (STI).¹⁴² One year after treatment, LTR, STI and ODF patients reported 50% less weekly or daily cocaine use, when compared to the year before they entered treatment.¹⁴³ Among patients who remained in treatment for

137. NAT'L INST. ON DRUG ABUSE, U.S. DEP'T OF HEALTH & HUMAN SERVS., PRINCIPLES OF DRUG ADDICTION TREATMENT: A RESEARCH-BASED GUIDE 2 (3d ed. 2012) [hereinafter PRINCIPLES OF DRUG ADDICTION TREATMENT].

138. *Id.* at 4.

139. *Id.* at 48–49.

140. Nora D. Volkow et al., *Medication-Assisted Therapies—Tackling the Opioid-Overdose Epidemic*, 370 NEW ENG. J. MED. 2063, 2064 (2014). Methadone and buprenorphine work by “trick[ing] the brain into thinking that it is still getting the problem opioid.” SUBSTANCE ABUSE & MENTAL HEALTH SERVS. ADMIN., U.S. DEP'T OF HEALTH & HUMAN SERVS., MEDICATION ASSISTED TREATMENT FOR OPIOID ADDICTION: FACTS FOR FRIENDS AND FAMILIES 5 (2011). The person feels “normal, not high” and experiences fewer cravings. *Id.* Naltrexone is slightly different. It works by blocking opioids and preventing them from binding to receptors in the brain, thereby by preventing their euphoric effects. *Id.*

141. Robert L. Hubbard et al., *Overview of 1-Year Follow-Up Outcomes in the Drug Abuse Treatment Outcome Study (DATOS)*, 11 PSYCHOL. ADDICTIVE BEHAVIORS 261, 276 (1997).

142. *Id.* at 261. DATOS, like many studies before it, collected data on self-reported drug use. *Id.* at 264. Researchers then verified self-reports through a combination of urine and hair toxicology tests. D. Dwayne Simpson et al., *A National 5-Year Follow-Up of Treatment Outcomes for Cocaine Dependence*, 59 ARCHIVES GEN. PSYCHIATRY 538, 539 (2002). Researchers found a remarkably high level of correspondence between self-reported drug use and the toxicology analysis. *Id.* at 540. For example, “Of patients who denied using cocaine in the past year, only 5% had positive urine or hair assay results.” *Id.*

143. Hubbard et al., *supra* note 141, at 261.

three months or more the effect was even stronger.¹⁴⁴ The percentage of patients who reported weekly cocaine use dropped to 35.5% among patients with three months or less of treatment, and 13.9% among patients with three months or more of treatment.¹⁴⁵ A five-year follow-up study of 1,393 DATOS patients found that among those in long-term residential treatment, better outcomes—including reductions in criminal activity and increases in full time employment—were associated with remaining in treatment for six months or more.¹⁴⁶

C. Coercion Works

Most people enter addiction treatment under some degree of informal coercion, be it pressure from friends and family, or pressure from an employer.¹⁴⁷ However, since the 1970s, the use of legal coercion to force people with drug addictions into treatment has been exerted through the criminal justice system, primarily through drug courts.¹⁴⁸ In a deferred prosecution drug court, defendants waive their right to a trial and enter treatment after being charged; those who fail to complete the program are prosecuted, while defendants who complete the program have their charges dismissed.¹⁴⁹ In a post-adjudication model, defendants are required to plead guilty to the charges against them, but their sentences are suspended while they participate in the program.¹⁵⁰ Defendants who complete the program are entitled to have their sentences waived or the charges against them expunged.¹⁵¹ Participants who are non-compliant can be sanctioned with jail time, more frequent status hearings, or more drug tests.¹⁵²

Studies have shown that participation in a drug court is associated with statistically significant reductions in drug use. In 2002, the National Institute of Justice commissioned the Multi-Site Drug Court Evaluation (MADCE) of twenty-three drug courts and 1,781 offenders across the

144. *Id.*

145. *Id.* at 268.

146. Robert L. Hubbard et al., *Overview of 5-Year Follow-Up Outcomes in the Drug Abuse Treatment Outcome Study (DATOS)*, 25 *J. SUBSTANCE ABUSE TREATMENT* 125, 127, 133 (2003).

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

148. See U.S. GOV'T ACCOUNTABILITY OFFICE, GAO-12-53, *ADULT DRUG COURTS: STUDIES SHOW COURTS REDUCE RECIDIVISM BUT DOJ COULD ENHANCE FUTURE PERFORMANCE MEASURE REVISION EFFORTS* 1 (2011).

149. See *id.*

150. See *id.*

151. See *id.*

152. RYAN S. KING & JILL PASQUARELLA, *THE SENTENCING PROJECT, DRUG COURTS: A REVIEW OF THE EVIDENCE* 4 (2009).

country.¹⁵³ Researchers collected information on substance use through self-reports and drug tests. After six months, drug court participants were less likely than members of the comparison group to report using drugs (40% vs. 55%).¹⁵⁴ After eighteen months, drug court participants continued to report less drug use than the comparison group (56% v. 76%).¹⁵⁵ As the researchers note, after 18 months, there was a small increase in drug use among offenders from both groups, “but the overall magnitude of the difference between the [groups] did not change.”¹⁵⁶ In short, “the gains made by those receiving the drug court intervention appeared to have been retained over time.”¹⁵⁷ Moreover, after eighteen months, fewer drug court participants tested positive for drugs (29% v. 46%) and among those who tested positive for drugs or self-reported drug use, drug court participants used drugs less often than members of the comparison group.¹⁵⁸

Further investigations into substance use among drug court participants have generally reached the same conclusion. A 2007 study of an Indiana Drug Court found that drug court participants had fewer positive drug tests than a comparison group three months, nine months, and twelve months after starting the program.¹⁵⁹ Similarly, a 2008 study of methamphetamine dependent adults who participated in a drug court program found “that drug court participants were significantly more likely” to provide clean urine samples than a comparison group.¹⁶⁰

The fact that participation in a drug court has been associated with statistically significant reductions in drug use tends to undercut the

153. SHELLI B. ROSSMAN ET AL., URBAN INST. JUSTICE POLICY CTR., THE MULTI-SITE DRUG COURT EVALUATION: EXECUTIVE SUMMARY 3 (2011).

154. SHELLI B. ROSSMAN ET AL., URBAN INST. JUSTICE POLICY CTR., THE MULTI-SITE ADULT DRUG COURT EVALUATION: THE IMPACT OF DRUG COURTS 33 (2011).

155. *Id.* at 35.

156. *Id.* at 39.

157. *Id.*

158. *Id.* at 37; *see also* GWEN MARCHAND ET AL., BARRY COUNTY ADULT DRUG COURT OUTCOME AND COST EVALUATION: FINAL REPORT 26–27 (2006) http://npcresearch.com/wp-content/uploads/Barry-Final-Report_10063.pdf (showing that drug court recipients had fewer positive drug tests than their counterparts in a comparison group at all times during a 12-month observation period); M. Douglas Anglin et al., *Pretreatment Characteristics and Treatment Performance of Legally Coerced Versus Voluntary Methadone Maintenance Admissions*, 27 CRIMINOLOGY 537, 551–52 tbl. 7 (1989) (showing drug court recipients showed substantial improvement in levels of narcotics use).

159. KATHARINA L. WIEST ET AL., INDIANA DRUG COURTS: ST. JOSEPH COUNTY DRUG COURT PROGRAM, PROCESS, OUTCOME AND COST EVALUATION: FINAL REPORT 35 (2007), http://npcresearch.com/wp-content/uploads/St._Joseph_Adult_Eval_Final1.pdf.

160. Patricia Marinelli-Casey et al., *Drug Court Treatment for Methamphetamine Dependence: Treatment Response and Posttreatment Outcomes*, 34 J. SUBSTANCE ABUSE TREATMENT 242, 246 (2008).

“rock bottom” hypothesis, but it only tells half of the story. Not all drug court participants perceive themselves as being coerced.¹⁶¹ Drug court participants choose whether to enter treatment or proceed through the criminal justice system and, to that end, at least some drug court participants may be motivated to participate in treatment, either to escape a jail sentence, or because they really believe they have a problem.¹⁶² Presumably at least some (perhaps even many) people who enter substance use treatment under an involuntary civil commitment order are not ready to change. Will court-ordered treatment work for them as well?

Perhaps. The work of James Prochaska and Carlo DiClemente on how people modify problem behaviors has become the dominant model of analyzing how people recover from addictions.¹⁶³ The model posits five stages of change.¹⁶⁴ In the precontemplation stage, the person is “unaware or underaware” of his or her problems and has no intention to change their behavior.¹⁶⁵ As Prochaska and DiClemente note: “When precontemplators present for psychotherapy, they often do so because of pressure from others . . . They may even demonstrate change as long as the pressure is on. Once the pressure is off, however, they often quickly return to their old ways.”¹⁶⁶ In the contemplation stage, the person is “aware that a problem exists” and they are weighing both “the pros and cons of the problem and the solution to the problem.”¹⁶⁷ Individuals in the preparation stage have begun to make “some small behavioral changes,” such as consuming less of their drug of choice or delaying use during the day.¹⁶⁸ In the action stage, individuals often “modify their behavior” by modifying their environment.¹⁶⁹ Finally, in the maintenance stage, individuals work to maintain the gains they have made during the action

161. See Michael Prendergast et al., *Influence of Perceived Coercion and Motivation on Treatment Completion and Re-Arrest Among Substance-Abusing Offenders*, 36 J. BEHAV. HEALTH SERVICES & RES. 159, 161 (2009) (“Analysis of the DATOS data indicates that 40% of clients who were referred to treatment by the criminal justice system said that they ‘think [they] would have entered drug treatment without pressure from the criminal justice system.’”).

162. See Anna C. Burke & Thomas K. Gregoire, *Substance Abuse Treatment Outcomes for Coerced and Noncoerced Clients*, 32 HEALTH & SOC. WORK 7, 11–13 (2007).

163. Prendergast et al., *supra* note 161, at 162; see also James O. Prochaska, Carlo C. DiClemente & John C. Norcross, *In Search of How People Change: Applications to Addictive Behaviors*, 47 AM. PSYCHOLOGIST 1102 (1992).

164. Prochaska, DiClemente & Norcross, *supra* note 163, at 1103.

165. *Id.*

166. *Id.*

167. *Id.*

168. *Id.* at 1104.

169. *Id.*

stage and prevent relapse.¹⁷⁰ “Because relapse is the rule rather than the exception,” Prochaska and DiClemente posit a spiral model of change, in which people progress through the stages of change, but sometimes relapse to an earlier stage.¹⁷¹

Drawing on Prochaska and DiClemente’s model, a small number of empirical studies have examined the relationship between motivation or readiness to change and treatment outcomes among substance-dependent offenders. Some of this research suggests that intrinsic motivation might not be necessary for beneficial changes to occur. For example, a large prospective study of 2,095 veterans with substance use disorders by John Kelly and his colleagues found that people who were mandated to treatment through the criminal justice system were less motivated to change, but had outcomes that were similar to, and in some cases, better than people who entered into treatment voluntarily.¹⁷² Researchers collected information on drug use through a combination of self-report and drug tests. After one year, offenders who were under a court order to participate in treatment were more likely to abstain from drug use than offenders who were not mandated to treatment (53.9% vs. 45.3%).¹⁷³

What accounts for these counterintuitive findings? Kelly and colleagues assessed treatment motivation upon entry.¹⁷⁴ It may be that by participating in treatment and interacting with other patients, mandated patients (who might or might not recognize that they have a problem) become engaged in treatment and over time manage to do as well or better than their voluntary counterparts, owing in part to the force of the court order.¹⁷⁵

170. *Id.*

171. *Id.*

172. John F. Kelly et al., *Substance Use Disorder Patients Who Are Mandated to Treatment: Characteristics, Treatment Process, and 1- and 5-Year Outcomes*, 28 J. SUBSTANCE ABUSE TREATMENT 213, 221 (2005). *But see* Thomas K. Gregoire & Anna Celeste Burke, *The Relationship of Legal Coercion to Readiness to Change Among Adults with Alcohol and Other Drug Problems*, 26 J. SUBSTANCE ABUSE TREATMENT 35, 38 (2004) (finding that people who entered treatment under some form of legal coercion were far more likely to be in the action stage of change than their noncoerced counterparts).

173. Kelly et al., *supra* note 172, at 218–19. Note that these figures represent the *adjusted* rates for abstinence; *see also* Burke & Gregoire, *supra* note 162, at 7, 11 (finding that legally coerced participants were 2.8 times more likely to report abstaining from drugs and alcohol prior to the six-month follow-up interview).

174. Kelly et al., *supra* note 172, at 215.

175. Prendergast et al., *supra* note 161, at 160 (“[C]oerced clients and those who may not recognize or acknowledge that they have a drug problem can, through treatment participation and interaction with other clients, become engaged in treatment and do as well as voluntary clients.”).

Nonetheless, further research is needed on the relationship between motivation, treatment compliance and outcomes. Although the study found that people who were required to participate in treatment by the justice system were less motivated to change than their voluntary counterparts, the authors did not determine whether mandated patients were more likely to be in the “contemplation,” or “precontemplation” stage of Prochaska and DiClemente’s model.¹⁷⁶ It may be that the patients under investigation in the Kelly study were successful because they were more likely than their counterparts to be in the “contemplation” stage of change. If, by contrast, people who enter addiction treatment through a civil commitment order are more likely to be in the precontemplation stage of change (and thus “unaware or underaware” of their problem) civil commitment might be a less effective way to reduce their drug use.

D. Summary

There is ample evidence that substance abuse treatment works, but the person must remain in treatment long enough to reap its benefits, preferably for at least three months.¹⁷⁷ Second, the empirical research on drug courts suggests that coercion is compatible with effectiveness. It is possible for someone to enter drug treatment under a court order, remain in treatment under a court order, and still reduce their drug use. Finally, effective substance abuse treatment will often require a plan for aftercare, which might also require some degree of coercion.

IV. THE BRAIN DISEASE MODEL OF ADDICTION

Courts have broad authority to confine people with substance use disorders when they are dangerous to themselves or others, and doing so might be associated with positive outcomes, including reductions in drug use.¹⁷⁸ Still, using civil commitment to force people who are addicted to drugs into treatment presents an ethical dilemma. Most people with substance use disorders are competent to make treatment decisions when they are not intoxicated or experiencing the symptoms of withdrawal.¹⁷⁹ Nonetheless, some bioethicists argue that compulsory addiction treatment is justified because people with substance use disorders “suffer

176. Kelly et al., *supra* note 172, at 220.

177. PRINCIPLES OF DRUG ADDICTION TREATMENT, *supra* note 137, at 14.

178. See, e.g., James K. Rustad et al., *Civil Commitment Among Patients with Alcohol and Drug Abuse: Practical, Conceptual, and Ethical Issues*, 11 ADDICTIVE DISORDERS & THEIR TREATMENT 136, 138–39 (2012).

179. *Id.* at 140–41.

from a brain disease” that robs them of their autonomy and impairs their capacity to make treatment decisions.¹⁸⁰ For example, Arthur Caplan writes:

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 their capacity for autonomy.¹⁸¹

Caplan is careful to add that “a drug-addicted individual, even a heroin-addicted individual” is not completely incompetent.¹⁸² Such a person, he concedes, would likely retain the capacity to ride the bus, select a song on the radio or pass a mini-mental status exam.¹⁸³ Still he argues that “addiction can in fact be a form of coercion.”¹⁸⁴ “If medicine could create more competency by blocking the coercion that results from these addictive, nearly irresistible cravings and physiological forces that, in fact, completely shape behavior, then this would be restoring autonomy, and not interfering with it.”¹⁸⁵

Others reject (or are at least highly skeptical of) the brain disease model of addiction.¹⁸⁶ These scholars argue that coercion is justified because substance abuse treatment is effective,¹⁸⁷ but in order for it to work, patients must remain in treatment, and retention sometimes requires coercion. In Parts III and IV, I argue that both of these viewpoints are mistaken.

180. ADRIAN CARTER & WAYNE HALL, ADDICTION NEUROETHICS: THE PROMISES AND PERILS OF NEUROSCIENCE RESEARCH ON ADDICTION 139 (Griffith Edwards ed., 2012).

181. See Caplan, *supra* note 39, at 118. The notion that addiction hijacks the brains of users is widely shared. See also Charles Dackis & Charles O’Brien, *Neurobiology of Addiction: Treatment and Public Policy Ramifications*, 8 NATURE NEUROSCIENCE 1431, 1431, 1434 (2005).

182. Caplan, *supra* note 39, at 119.

183. *Id.*

184. *Id.*

185. *Id.*

186. Wayne Hall, Adrian Carter & Cynthia Forlini, *The Brain Disease Model of Addiction: Is It Supported by the Evidence and Has It Delivered on Its Promises?* 2 LANCET PSYCHIATRY 105, 105–10 (2015).

187. PRINCIPLES OF DRUG ADDICTION TREATMENT, *supra* note 137, at 37.

A. *The Phenomenology of Addiction*

Neuroimaging technologies have provided critical insights into the impact of chronic drug-use on the brain.¹⁸⁸ Most addictive drugs appear to work by directly or indirectly targeting the brain's reward system and "flooding the circuit with dopamine."¹⁸⁹ Dopamine is a neurotransmitter, responsible for transmitting signals between neurons in the brain.¹⁹⁰ Dopaminergic neurons in an area of the brain called the ventral tegmental area (VTA) project into the brain's reward system (the nucleus accumbens) and into areas of the brain responsible for making decisions (i.e. the prefrontal cortex).¹⁹¹ Amphetamine, cocaine and other stimulants work by producing large rapid increases of dopamine in the synapses of the nucleus accumbens.¹⁹² Neuroimaging studies have shown that rapid increases in accumbal dopamine are associated with the subjective experience of euphoria.¹⁹³

The neural circuitry formed by the ventral tegmental area (VTA) and the nucleus accumbens is a key component of reward related learning.¹⁹⁴ "Whenever this reward circuit is activated, the brain notes that something important is happening that needs to be remembered, and teaches us to do it again and again without thinking about it."¹⁹⁵ The neurons of the VTA release dopamine in response to activities that are essential for survival, such as obtaining food, forming relationships, and sex.¹⁹⁶ These activities are experienced as pleasurable and rewarding, thereby motivating our behavior. However, these everyday activities produce much smaller increases in dopamine than addictive drugs.¹⁹⁷ When drugs are smoked or injected, surges in dopamine occur almost immediately and last much longer than the dopamine increases

188. See generally NAT'L INST. ON DRUG ABUSE, DRUGS, BRAINS AND BEHAVIOR: THE SCIENCE OF ADDICTION, *supra* note 46.

189. *Id.* at 17.

190. Wolfram Schultz, *Dopamine Reward Prediction Error Coding*, 18 DIALOGUES IN CLINICAL NEUROSCIENCE 23, 25 (2016).

191. CARTER & HALL, *supra* note 180, at 37.

192. *Id.* at 40.

193. Nora D. Volkow et al., *The Addicted Human Brain: Insights from Imaging Studies*, 111 J. CLINICAL INVESTIGATION 1444, 1447 (2003).

194. Steven E. Hyman, *Addiction: A Disease of Learning and Memory*, 162 AM. J. PSYCHIATRY 1414, 1415 (2005).

195. NAT'L INST. ON DRUG ABUSE, DRUGS, BRAINS AND BEHAVIOR: THE SCIENCE OF ADDICTION, *supra* note 46, at 18.

196. See *id.*

197. See, e.g., Ann E. Kelley & Kent C. Berridge, *The Neuroscience of Natural Rewards: Relevance to Addictive Drugs*, 22 J. NEUROSCIENCE 3306 (2002).

associated with natural rewards.¹⁹⁸ “The effect of such a powerful reward” is to motivate users “to take drugs again and again.”¹⁹⁹

Other parts of the brain associate these pleasurable feelings with the circumstances in which they occur.²⁰⁰ For many years, researchers believed that dopamine acts as a hedonic signal (signaling pleasure or euphoria)²⁰¹ but more recent evidence suggests that increases in dopamine are not directly related to the reward itself, but rather to the prediction of a reward.²⁰² “With repeated exposure to the same reward, dopamine cells stop firing in response to the reward,” and instead begin to fire in response to the environmental stimuli or “cues” that predict the reward.²⁰³ The “environmental stimuli that are repeatedly paired with drug use”—the place where drugs were taken, the person with whom drugs were taken, and the mental state of the user—can all trigger rapid surges of dopamine, which in turn trigger powerful cravings for the user’s drug of choice.²⁰⁴ These conditioned associations are deeply ingrained and trigger cravings long after the person has stopped using drugs, whether the person continues to perceive the drug as pleasurable or not.²⁰⁵ Over time, the brain adjusts to surges in dopamine by either producing less dopamine or reducing the number of dopamine receptors,²⁰⁶ and as a result, the person begins to feel lifeless, dull, and flat, and unable to enjoy activities that were once pleasurable.²⁰⁷

Dopamine-induced changes to the mesolimbic reward system occur alongside changes to the prefrontal cortex, an area of the brain implicated in judgment, decision-making, planning and other executive functions.²⁰⁸ The prefrontal cortex restrains our impulses and redirects us toward more important long-term goals by sending inhibitory signals to the dopamine neurons in the reward system.²⁰⁹ However, stimulants such as cocaine and amphetamine appear to damage the prefrontal

198. NAT’L. INST. ON DRUG ABUSE, DRUGS, BRAINS AND BEHAVIOR: THE SCIENCE OF ADDICTION, *supra* note 46, at 18.

199. *Id.*

200. Thomas R. Kosten & Tony P. George, *The Neurobiology of Opioid Dependence: Implications for Treatment*, 1 SCI. & PRAC. PERSP. 13, 14 (2002).

201. Hyman, *supra* note 194, at 1416.

202. Nora D. Volkow & Ting-Kai Li, *Drug Addiction: The Neurobiology of Behaviour Gone Awry*, 5 NATURE REVIEWS NEUROSCIENCE 963, 964 (2004).

203. Nora D. Volkow et al., *Neurobiologic Advances from the Brain Disease Model of Addiction*, 374 NEW ENG. J. MED. 363, 364 (2016).

204. *Id.* at 366.

205. *Id.* at 366–67.

206. CARTER & HALL, *supra* note 180, at 43–44.

207. NAT’L. INST. ON DRUG ABUSE, DRUGS, BRAINS AND BEHAVIOR: THE SCIENCE OF ADDICTION, *supra* note 46, at 19.

208. Kosten & George, *supra* note 200, at 15–18.

209. *Id.* at 16.

cortex, thereby weakening the person's ability to resist cravings and undermining their resolve to stop using drugs.²¹⁰

Many people drink alcohol and experiment with drugs, but only a small minority of them (approximately 10%) become addicted.²¹¹ "Evidence from twin and adoption studies suggests that 40-60% of the risk for developing" an addiction is attributable to genetic factors.²¹² Genes are thought to influence how drugs are metabolized, absorbed and excreted, along with a person's willingness to try drugs, and "how rewarding they find the effects of drugs."²¹³ Social and environmental factors also increase the risk of addiction. They include "exposure to parental drug use, peer drug use . . . physical or sexual abuse," and exposure to high stress environments, with poor social supports and easy access to drugs.²¹⁴ Certain mental disorders—including depression, anxiety disorders and attention-deficit disorder—are also thought to increase the risk of developing a substance use disorder.²¹⁵

B. Problems with the Brain Disease Model of Addiction

By emphasizing the neural substrates of addiction, proponents of the brain disease model have succeeded in reducing the stigma of substance abuse, but as a critic of the brain disease model writes: "neurobiology is not destiny."²¹⁶ The neurobiological changes associated with addiction "constrain a person's capacity for choice, but they do not destroy it."²¹⁷ Arthur Caplan's claim that people who are addicted to drugs lack the capacity to be self-determining because "they are caught up in the behavioral vice that is addiction"²¹⁸ echoes a common misconception about the phenomenology of addiction. We tend to think of people with substance abuse disorders "at their worst,"²¹⁹ driven by a nearly irresistible impulse or a "cue-induced craving" for their drug of choice.²²⁰ Neuroscientists have amassed ample evidence of drug-induced changes in the brain, and how those changes can trigger produce powerful desires.

210. *Id.*

211. Volkow et al., *supra* note 203, at 367–68.

212. CARTER & HALL, *supra* note 180, at 55; *see also* Ming D. Li & Margit Burmeister, *New Insights into the Genetics of Addiction*, 10 NATURE REVIEWS GENETICS 225, 225 (2009).

213. CARTER & HALL, *supra* note 180, at 55.

214. *Id.* at 57.

215. *Id.*

216. Sally Satel & Scott O. Lilienfeld, *Addiction and the Brain-Disease Fallacy*, 4 FRONTIERS IN PSYCHIATRY 1, 2 (2014).

217. *Id.*

218. Caplan, *supra* note 39, at 118.

219. Satel & Lilienfeld, *supra* note 216, at 3.

220. *Id.*

However, it does not follow from this research that people with addictive disorders are “coerced” by a brain disease over which they have no control.

1. Remission from Addiction

First, most people who are addicted to drugs recover. Indeed, many of them do so, without treatment.²²¹ In the Epidemiological Catchment Area Study, researchers recruited nearly 20,000 people to assess the incidence and prevalence of mental disorders in the United States.²²² By age twenty-four, more than half (58%) of those who had ever met the criteria for drug abuse or dependence no longer reported even a single symptom of drug addiction at the time of their interview.²²³ By age thirty-seven, roughly 75% of respondents who met the lifetime criteria for drug dependence no longer reported any symptoms of drug abuse at the time of their interview.²²⁴

Is it possible that some respondents simply lied to researchers about their drug use? Perhaps. But a seminal study of Vietnam Veterans by Lee Robins and colleagues also reported surprisingly high rates of remission from heroin addiction, and in the Vietnam Veterans study, self-reported drug use was corroborated by drug tests and official reports. Robins randomly sampled about 900 enlisted men who were scheduled to return to the United States from Vietnam in September 1971, including 495 men who tested positive for drugs during the same month.²²⁵ Eight to twelve months after returning to the United States, researchers interviewed the men about their drug use before, during, and after their service in Vietnam.²²⁶ Interviewers obtained urine samples from 92% of the men and military records for 99% of the men at the end of each interview.²²⁷ Approximately, 20% of the sample reported using heroin often enough to experience the physiological symptoms of withdrawal in Vietnam.²²⁸ Yet, “only 1% of [the] sample reported addiction to heroin during their first year back” in the United States, “and only 2% reported

221. Lewis, *supra* note 42 (noting that “many, perhaps most, addicts recover without treatment of any kind.”).

222. Gene M. Heyman, *Quitting Drugs: Quantitative and Qualitative Features*, 9 ANN. REV. CLINICAL PSYCHOL. 29, 35 (2013).

223. HEYMAN, *supra* note 41, at 70.

224. *Id.*

225. LEE N. ROBINS, *THE VIETNAM DRUG USER RETURNS: FINAL REPORT* vii (1974).

226. *Id.*

227. *Id.*

228. Lee N. Robins et al., *Vietnam Veterans Three Years After Vietnam: How Our Study Changed Our View of Heroin*, 19 AM. J. ON ADDICTIONS 203, 206 (2010).

addiction in the second or third year after Vietnam.”²²⁹ When asked why they did not continue to use heroin, veterans explained that it was not for lack of opportunity; most reported that heroin was easy to obtain. Instead their main reasons for no longer using heroin were the expense, the fear of arrest, and the disapproval of friends and family.²³⁰

2. Responding to Incentives

Moreover, there is ample evidence that people who are addicted to drugs change their behavior in response to financial rewards and professional penalties. For example, studies have shown that vouchers can help reduce illicit drug use among people with substance use disorders. Vouchers employ a strategy known as contingency management.²³¹ Patients provide urine samples several times a week, and in exchange, they receive vouchers when their samples test negative for drugs.²³² The vouchers can be exchanged for goods and services, such as gift certificates, movie tickets, sporting goods and clothing.²³³ The value of the voucher increases with each negative urine sample, along with bonuses for continuous periods of abstinence.²³⁴ Urine samples that test positive for drugs (or failing to submit a urine sample) reset the value of the voucher to its lowest level.²³⁵

In a 1994 study, Stephen Higgins and colleagues provided intensive behavioral therapy to a sample of cocaine-dependent adults; one group received vouchers contingent upon abstinence, while the other group did not.²³⁶ Seventy-five percent of the patients in the voucher group completed twenty-four weeks of treatment, compared to only forty

229. *Id.* Researchers confirmed self-reports of heroin use by collecting urine samples at the end of each interview and found a high degree of fidelity. See Lee N. Robins, *Vietnam Veterans' Rapid Recovery from Heroin Addiction: A Fluke or Normal Expectation?*, 88 ADDICTION 1041, 1042 (1993) (“[T]ests of urine samples collected at the end of the interview showed no higher rates positive for current use than did their self-reports given before they knew they would be asked for a urine sample.”).

230. ROBINS, *supra* note 226, at 58.

231. Stephen T. Higgins & Nancy M. Petry, *Contingency Management: Incentives for Sobriety*, 23 ALCOHOL RES. & HEALTH 122, 122 (1999).

232. *Id.* at 125.

233. *Accentuate the Positive: Vouchers Help Drug Abusers Stay in Treatment*, AM. PSYCHOL. ASS'N. (Dec. 10, 2003), <http://www.apa.org/research/action/vouchers.aspx>.

234. Stephen T. Higgins et al., *Contingent Reinforcement Increases Cocaine Abstinence During Outpatient Treatment and 1 Year of Follow-Up*, 68 J. CONSULTING & CLINICAL PSYCHOL. 64, 65 (2000).

235. *Id.*

236. Stephen T. Higgins et al., *Incentives Improve Outcome in Outpatient Behavioral Treatment of Cocaine Dependence*, 51 ARCHIVES GEN. PSYCHIATRY 568, 568 (1994).

percent of the patients in the control group.²³⁷ The duration of continuous cocaine abstinence was also significantly longer in the voucher group (approximately twelve weeks in the voucher group, compared to six weeks in the group without vouchers).²³⁸ Researchers have also shown that increasing the value of the voucher can increase the likelihood that patients abstain from cocaine both during and after treatment.²³⁹ Other studies have shown that even relatively inexpensive vouchers (ranging from \$1 to \$100) have a moderating effect on drug use.²⁴⁰

Researchers have also investigated the use of penalties to encourage sobriety among physicians who are struggling with addiction.²⁴¹ A 2009 study examined substance abuse outcomes among 904 physicians who were admitted to Physician Health Programs (PHPs) in sixteen states over a five year period.²⁴² The PHPs required physicians to abstain from drugs and alcohol during the study period and participants were subject to frequent random drug tests.²⁴³ Physicians who tested positive for drugs risked losing their jobs and their licenses to practice medicine.²⁴⁴ Researchers found that the vast majority of physicians who participated in the program (78%) never tested positive for either drugs or alcohol during the study period.²⁴⁵

Taken together, the data strongly suggest that people with substance use disorders are capable of responding to incentives to refrain from

237. *Id.*

238. *Id.* at 572.

239. Steven T. Higgins et al., *Effects of Varying the Monetary Value of Voucher-Based Incentives on Abstinence Achieved During and Following Treatment Among Cocaine-Dependent Outpatients*, 102 *ADDICTION* 271, 274 (2006).

240. *See, e.g.*, Nancy M. Petry & Bonnie Martin, *Low-Cost Contingency Management for Treating Cocaine-and Opioid-Abusing Methadone Patients*, 70 *J. CONSULTING & CLINICAL PSYCHOL.* 398, 403 (2002) (finding that low-cost contingency vouchers, ranging from \$1 to \$100, were associated with longer periods of continuous abstinence among cocaine-using methadone patients than daily methadone doses and counseling alone).

241. *See* George M. Bohigian et al., *The Impaired and Disruptive Physician: The Missouri Physicians' Health Program—An Update (1995–2002)*, 24 *J. ADDICTIVE DISEASES* 13, 13 (2005) (finding a recovery rate of 90% among 197 physician participants); Karen B. Domino et al., *Risk Factors for Relapse in Health Care Professionals with Substance Use Disorders*, 293 *JAMA* 1453, 1458–59 (2005) (discussing that, for certain physicians, stricter monitoring programs may be needed); Oswald H. Ganley et al., *Outcome Study of Substance Impaired Physicians and Physician Assistants Under Contract with North Carolina Physicians Health Program for the Period 1995-2000*, 24 *J. ADDICTIVE DISEASES* 1, 9 (2005) (explaining the escalating levels of monitoring and treatment under North Carolina's Physician Health Program).

242. Robert L. DuPont et al., *Setting the Standard for Recovery: Physicians' Health Programs*, 36 *J. SUBSTANCE ABUSE TREATMENT* 159, 159 (2009).

243. *Id.* at 161.

244. *Id.*

245. *Id.* at 166.

drugs, whether those incentives are the positive rewards of a voucher program, the threat of losing one's license, or the threat of arrest, or the disapproval of friends and family. While people with substance use disorders suffer from impairments in their capacity to be self-determining or autonomous, most addicts retain at least some degree of control over their behavior, thereby undermining arguments in favor of compulsory treatment based on the brain disease model of addiction. Nonetheless, Arthur Caplan's intuition that compulsory addiction treatment may be justified when a person lacks the capacity to safeguard her own interests is the right one.

V. THE MORAL JUSTIFICATIONS FOR CIVIL COMMITMENT

Having debunked the myth that people with drug addictions lack the capacity to be self-determining, Part IV turns to the central question in this Article—under what circumstances is it morally permissible to force someone like John Carter into treatment over his objection? Part IV defends an approach to civil commitment that takes its cues from soft paternalism. It argues that in their current form most civil commitment statutes suffer from an over-inclusiveness problem insofar as they reach people with substance use disorders who are competent to make treatment decisions on their own.

A. *The View from Soft Paternalism*

Soft paternalism is the view that government intervention into self-regarding harm is justified, when and only when, intervention is necessary to determine whether the person concerned is acting knowledgeably and voluntarily.²⁴⁶ John Stuart Mill offers a classic example: suppose you are hiking through the woods when you see a man approaching a bridge over a raging river.²⁴⁷ If you know the bridge to be unsafe, and you are unable to warn him, then according to Mill, you may “seize him and turn him back, without any real infringement of his liberty; for liberty consists in doing what one desires” and you may presume that “he does not desire to fall into the river.”²⁴⁸ If, however, you inform him of the risk, and he chooses to proceed anyway, you must let him pass, for as Mill writes, the possibility that he might harm himself supplies good reason for “remonstrating with him,” but not for

246. See FEINBERG, *supra* note 43, at 12.

247. JOHN STUART MILL, ON LIBERTY 88 (1859).

248. *Id.*

“compelling him, or visiting him with any evil in case he do[es] otherwise.”²⁴⁹

In the same way, soft paternalists—foremost among them philosopher Joel Feinberg—argue that when an agent’s choices are primarily self-regarding, “the law’s concern should not be with the wisdom, prudence or dangerousness” of the person’s choice, “but rather with whether or not the choice is truly his” or her own.²⁵⁰ But when is an agent’s choice primarily “self-regarding?” And why, as between the agent’s right and her good, do soft paternalists privilege the individual interest in autonomy? According to Mill, self-regarding harms are those which “chiefly,” “primarily,” or “directly” affect the interests of the decision-maker.²⁵¹ Beyond the personal domain are other-regarding harms which directly or primarily affect the interests of others.²⁵²

For soft paternalists, the right to self-determination has both instrumental and non-instrumental value.²⁵³ Consider the right to self-determination in the context of medical decision-making. If one assumes a subjective theory of wellbeing, then according robust protection to the interest in self-determination may be “instrumentally valuable in the promotion of a person’s wellbeing,” as the person conceives it.²⁵⁴ Health is valuable, but as Alan Buchanan and Dan Brock write “health is only one value among many, and different aspects of it are assigned different importance by different persons.”²⁵⁵ Therefore, whether a particular medical intervention is likely to promote a person’s wellbeing will often depend on the unique constellation of that particular person’s aims and values.²⁵⁶

Second, even when others are in a better position to make choices for us, most people want to make important decisions about their own lives for themselves, in part because our choices have both instrumental and non-instrumental value.²⁵⁷ Most people who are competent to make decisions about their own medical treatment are permitted to do so.²⁵⁸ Therefore, I might value choice because without it, I will feel that the absence of choice is degrading. In the same way, Gerald Dworkin has said

249. *Id.* at 13.

250. FEINBERG, *supra* note 43, at 12.

251. *Id.* at 56.

252. *Id.*

253. See ALLEN E. BUCHANAN & DAN W. BROCK, DECIDING FOR OTHERS: THE ETHICS OF SURROGATE DECISION MAKING 36–41 (1989) (discussing how the right of self-determination implicates both instrumental and non-instrumental values).

254. *Id.* at 38.

255. *Id.* at 30.

256. See *id.* at 30, 37.

257. See *id.* at 38–40.

258. See *id.* at 39.

that one might value autonomy because he or she derives self-respect from being recognized as “the kind of creature” who is capable of exercising autonomy.²⁵⁹ For all of those reasons, the law ordinarily permits adults to make their own medical decisions when they are competent to do so, even if refusing treatment poses a threat to their wellbeing.²⁶⁰

The law as it pertains to people with substance use disorders is somewhat different. In Kentucky, for example, an inpatient civil commitment order requires no more than clear and convincing evidence that the person has a drug or alcohol problem and “[p]resents an imminent threat of danger to self, family, or others as a result of alcohol or other drug abuse” and the person “[c]an reasonably benefit from treatment.”²⁶¹ In California, a successful petitioner need only establish that the person is dangerous to himself or others, or gravely disabled, as a result of controlled substances, and the person has a need for, but is unwilling or unable to accept treatment voluntarily.²⁶² Yet, a great many people, with a great variety of ailments, would benefit from medical treatment and many of them are unwilling to accept treatment voluntarily. Ordinarily, however, courts do not order them into inpatient treatment, over their objections, unless they are incompetent to make treatment decisions on their own.²⁶³

While states have the *parens patriae* authority to care for people who are unable to care for themselves, without a judicial determination of incompetence, medical interventions undertaken pursuant to the *parens patriae* power risk over-inclusiveness.²⁶⁴ Courts have recognized this problem in other contexts. For example, in *Rivers v. Katz*, a case concerning antipsychotic medication, the New York Court of Appeals held that while the State of New York has the *parens patriae* power to provide treatment to people who are unable to care for themselves due to mental illness: “For the State to invoke this interest ‘the individual himself must be incapable of making a competent decision concerning treatment on his own. Otherwise, the very justification for the state’s purposed exercise of its *parens patriae* power—its citizen’s inability to care for himself [. . .] would be missing.”²⁶⁵ The logic of *Rivers v. Katz*

259. GERALD DWORKIN, *THE THEORY AND PRACTICE OF AUTONOMY* 112 (1988).

260. *See id.* at 113.

261. KY. REV. STAT. ANN. § 222.431 (West 2018).

262. CAL. WELF. & INST. CODE §§ 5250, 5343 (West 2018).

263. *See Rivers v. Katz*, 495 N.E.2d 337, 344 (N.Y. 1986) (involving whether a state can order a mentally ill patient to take an antipsychotic drug after being involuntarily confined to a facility).

264. *See id.* at 343.

265. *Id.* at 343.

applies to civil commitment orders more broadly. In order for a court to issue an inpatient civil commitment order pursuant to the *parens patriae* power, it should be the case that the person is incapable of making a competent treatment decision on his own.²⁶⁶

B. Competence

A civil commitment order may be an appropriate exercise of the *parens patriae* power, but it requires a judicial determination of incompetence.²⁶⁷ There are several models of competence, but undoubtedly, the most influential is the MacArthur model, developed by Paul Appelbaum and Thomas Grisso.²⁶⁸ In the MacArthur model, competence consists of four abilities—(i) understanding; (ii) appreciation (iii) reasoning; and (iv) the ability to communicate a choice.²⁶⁹ The first element of competence is the ability to understand information that is relevant to the treatment decision.²⁷⁰ The relevant body of information generally includes the patient's diagnosis, the nature of the treatment plan, the risks and benefits of treatment and the likely consequences of refusing treatment.²⁷¹ In addition to understanding, competence requires the ability to appreciate the meaning of the information that has been disclosed.²⁷² As a general matter, appreciation concerns the patient's ability to "form accurate beliefs" about the information that has been disclosed to him, as well as the patient's ability to apply those facts to the treatment decision at hand.²⁷³ Third, competence requires the ability to reason or manipulate information rationally.²⁷⁴ The standard does not require perfect rationality, but rather at least a basic ability to weigh the risks and benefits of treatment against one's values.²⁷⁵ Fourth and

266. See *id.* at 345.

267. See *id.* at 343.

268. Paul S. Appelbaum & Thomas Grisso, *The MacArthur Treatment Competence Study. I: Mental Illness and Competence to Consent to Treatment*, 19 LAW & HUM. BEHAV. 105, 106 (1995); see also Samantha Weyrauch, *Decision Making for Incompetent Patients: Who Decides and by What Standards?* 35 TULSA L. J. 765, 765, 780 (2000) (discussing the most common tests used to determine whether a person is competent to make a medical treatment decision).

269. Appelbaum & Grisso, *supra* note 268, at 109.

270. *Id.*

271. *Id.* at 109–10; see also Weyrauch, *supra* note 268, at 770.

272. Appelbaum & Grisso, *supra* note 268, at 110.

273. SCOTT Y.H. KIM, EVALUATION OF CAPACITY TO CONSENT TO TREATMENT AND RESEARCH 22 (2010).

274. Appelbaum & Grisso, *supra* note 268, at 110.

275. See *id.*

finally, competence requires the ability to communicate a choice, either in writing or through a surrogate.²⁷⁶

Three basic assumptions permeate the literature on competence. The first is that competence is decision-specific.²⁷⁷ As Alan Buchanan and Dan Brock have observed, competence is always competence “*to do something . . . at a particular time, under certain circumstances.*”²⁷⁸ A person may be competent to perform one task, but incompetent to perform another.²⁷⁹ Second, competence is a threshold concept.²⁸⁰ Although the various capacities that comprise competence admit of degrees, the purpose of a competence assessment is to make an “all-or-nothing” judgment about whether a person will be permitted to make their own decisions or whether their decision will be set aside.²⁸¹ Third, courts and bioethicists generally agree that patients should be free to “make unpopular decisions, even ones that are considered highly irrational by others.”²⁸² Therefore, an inquiry into competence should “focus primarily not on the content of the patient’s decision but on the *process* of the reasoning that leads up to that decision.”²⁸³

C. Addiction and Competence

In contrast to the extensive literature on mental illness and competence, we know relatively little about the impact of chronic substance use on decisional capacity.²⁸⁴ Nonetheless, a few studies have found significant impairments in decision-making capacity among people with substance use disorders. For example, a study by Steven Grant and colleagues found that people with substance use disorders performed more poorly on the Iowa Gambling Task than people who did not use drugs, even though both groups performed equally well on a test of intelligence.²⁸⁵ The Iowa Gambling Task (IGT) is a card game in which participants are instructed to accumulate as much play money as

276. *See id.* at 109.

277. BUCHANAN & BROCK, *supra* note 253, at 18.

278. *Id.*

279. *Id.*

280. *Id.* at 27.

281. *Id.*

282. Louis C. Charland, *Decision-Making Capacity*, STAN. ENCYCLOPEDIA OF PHIL., <https://plato.stanford.edu/entries/decision-capacity/> (last updated June 20, 2011).

283. BUCHANAN & BROCK, *supra* note 253, at 50.

284. For a discussion of the literature on substance abuse and decisional capacity, see Dilip V. Jeste & Elyn Saks, *Decisional Capacity in Mental Illness and Substance Use Disorders: Empirical Database and Policy Implications*, 24 BEHAV. SCI. & L. 607, 621–23 (2006).

285. Steven Grant et al., *Drug Abusers Show Impaired Performance in a Laboratory Test of Decision Making*, 38 NEUROPSYCHOLOGIA 1180, 1182–84 (2000).

possible by selecting one card at a time from four decks (A, B, C and D) until 100 cards have been selected.²⁸⁶ The cards in Decks A and B yield larger short-term payoffs (\$100) while the cards in Decks C and D yield smaller short-term payoffs (\$50).²⁸⁷ Some of the cards in each deck include a penalty, and the penalties in Decks A and B are larger than the penalties in Decks C and D.²⁸⁸ Researchers have found that healthy adults learn to avoid the decks with larger short-term gains and higher long-term losses.²⁸⁹ By contrast, studies have found that people with substance use disorders continue to make choices that result in their long-term losses exceeding their short term gains.²⁹⁰

In this respect, researchers believe that people with substance use disorders resemble patients who have sustained damage to an area of the brain known as the ventromedial (VM) prefrontal cortex.²⁹¹ The ventromedial cortex plays a role in processing risk and inhibiting emotional responses.²⁹² When this area of the brain is damaged, VM patients tend to make choices that result in immediate benefits, even though those choices often lead to negative future consequences, such as the loss of a job, family, or friends.²⁹³ Antoine Bechara has argued that, in this respect, people with substance use disorders and people with VM damage are similar, insofar as both groups display a “myopia for the future,” namely a tendency to prefer large immediate gains, despite larger long-term losses.²⁹⁴

Nonetheless, this research has some limitations. Ventromedial dysfunction might explain some of the decision-making impairments observed in people with substance use disorders; however, researchers do not know whether VM damage develops as a consequence of drug use, or whether it is a pre-existing vulnerability that makes some people more

286. Monique Ernst et al., *Decision Making in Adolescents with Behavior Disorders and Adults with Substance Abuse*, 160 AM. J. PSYCHIATRY 33, 34 (2003).

287. *Id.*

288. *Id.*

289. *Id.* at 36–38.

290. See, e.g., Antoine Bechara et al., *Decision-Making and Addiction (Part II): Myopia for the Future or Hypersensitivity to Reward?*, 40 NEUROPSYCHOLOGIA 1690, 1690 (2002); Antoine Bechara & Hanna Damasio, *Decision-Making and Addiction (Part I): Impaired Activation of Somatic States in Substance Dependent Individuals When Pondering Decisions with Negative Future Consequences*, 40 NEUROPSYCHOLOGIA 1675, 1687 (2002); Grant et al., *supra* note 286; Nancy M. Petry, *Substance Abuse, Pathological Gambling, and Impulsiveness*, 63 DRUG & ALCOHOL DEPENDENCE 29, 35 (2001).

291. Xavier Noël et al., *The Neurocognitive Mechanisms of Decision-Making, Impulse Control, and Loss of Willpower to Resist Drugs*, 3 PSYCHIATRY 30, 30–31 (2006).

292. *Id.* at 31.

293. *Id.* at 31–2.

294. *Id.* at 32.

vulnerable to addiction than others.²⁹⁵ Moreover, studies using the Iowa Gambling Task to detect decision-making impairments among people with substance use disorders have reported mixed results. While some studies have found decision-making impairments among people with substance use disorders using the IGT, others have not.²⁹⁶ Although a 2003 study found reduced blood flow to the orbitofrontal cortex in the brains of cocaine-dependent adults—a region of the brain implicated in decision-making—those differences were not associated with poorer performance on the Iowa Gambling Task.²⁹⁷

A disadvantage of the Iowa Gambling Task is that participants must learn which decks are more likely to lead to rewards than others as they complete the task.²⁹⁸ It might be that poorer learners develop less successful decision-making strategies over the course of the task, and as a result, scores on the IGT might reflect the impact of learning, more so than substance use.²⁹⁹ Researchers have used the Cambridge Risk Task to isolate the decision-making abilities of participants apart from learning.³⁰⁰ In the Cambridge Risk Task, participants are shown six boxes and a proportion of them are either red or blue (e.g., 3:3 or 5:1).³⁰¹ Participants are told that the computer has “hidden a yellow token at random behind one of the six boxes,” and they must decide whether the

295. Bechara & Damasio, *supra* note 290, at 1686.

296. See, e.g., Bryon Adinoff et al., *Resting Regional Cerebral Blood Flow and Gambling Task Performance in Cocaine-Dependent Subjects and Healthy Comparison Subjects*, 160 AM. J. PSYCHIATRY 1892, 1893 (2003) (finding that performance on the Iowa Gambling Task did not differ significantly between cocaine-dependent adults and the control group); K.I. Bolla et al., *Orbitofrontal Cortex Dysfunction in Abstinent Cocaine Abusers Performing a Decision-Making Task*, 19 NEUROIMAGE 1085, 1089 (2003) (reporting that cocaine-dependent adults performed more poorly on the Iowa Gambling Task, but the results were not statistically significant); Ernst et al., *supra* note 286, at 37 (finding that performance on the Iowa Gambling Task did not differ significantly between adults with substance abuse disorders and healthy controls); Miriam Z. Mintzer et al., *Opioid Abuse and Cognitive Performance*, 78 DRUG & ALCOHOL DEPENDENCE 225, 228 (2005) (finding that abstinent opioid abusers did not differ significantly from methadone maintenance patients or controls on tests of recognition memory, free recall or the gambling task).

297. Bolla et al., *supra* note 297, at 1085; see also Adinoff et al., *supra* note 296, at 1892 (finding lower resting blood flow to the orbitofrontal cortex of cocaine-dependent adults, but no relationship between orbitofrontal cortex blood flow and performance on the Iowa Gambling Task); R. Pirastu et al., *Impaired Decision-Making in Opiate-Dependent Subjects: Effect of Pharmacological Therapies*, 83 DRUG & ALCOHOL DEPENDENCE 163 (2006).

298. R. Pirastu et al., *supra* note 297, at 164.

299. Karen D. Ersche & Barbara J. Sahakian, *The Neuropsychology of Amphetamine and Opiate Dependence: Implications for Treatment*, 17 NEUROPSYCHOLOGY REV. 317, 325 (2007).

300. *Id.*

301. K.D. Ersche et al., *Abnormal Frontal Activations Related to Decision-Making in Current and Former Amphetamine and Opiate Dependent Individuals*, 180 PSYCHOPHARMACOLOGY 612, 615 (2005).

token is underneath a red or blue box.³⁰² Larger bets are usually associated with the less abundant color.³⁰³ For example, if there were “two blue boxes and four red boxes, choosing” a blue box might entail a 70-point gamble, while choosing a red box would equal a 30-point gamble.³⁰⁴ If the participant were to select the correct box, she would win the points; if not, she would lose the points.³⁰⁵

Studies using the Cambridge Risk Task to investigate the decision-making abilities of people with substance use disorders have also reported mixed results. A 1999 study found that chronic amphetamine users, particularly those with long histories of substance abuse, were more likely to make disadvantageous choices on the Cambridge Risk Task (CRT) than healthy controls.³⁰⁶ In this respect, chronic amphetamine users were similar to patients with orbital prefrontal damage.³⁰⁷ Still, not all studies have found a relationship between substance use and suboptimal decision-making on the CRT.³⁰⁸ A 2005 study by Dr. Karen Ersche and colleagues found that current and former amphetamine and opiate users were no more likely to make disadvantageous decisions on the Cambridge Risk Task than healthy controls.³⁰⁹

Although there is some evidence that chronic substance abuse is associated with impaired decision-making, for a few reasons, it would be premature to conclude that people with drug addictions are necessarily incapable of making treatment decisions that are consistent with their aims and values. First, the Iowa Gambling Task and the Cambridge Risk Task are gambling tasks, and performance on a gambling task might—or might not—be predictive of competence to refuse treatment.³¹⁰ Second, even if people with substance-use disorders are more likely than others to manifest impairments in a decision-making capacity, whether such a person is competent (or incompetent) to refuse treatment must be assessed on a case-by-case basis. Third, competence is a threshold

302. *Id.* at 615–16.

303. *Id.* at 616.

304. *Id.*

305. *Id.*

306. See R. D. Rogers et al., *Dissociable Deficits in the Decision-Making Cognition of Chronic Amphetamine Abusers, Opiate Abusers, Patients with Focal Damage to Prefrontal Cortex, and Tryptophan-Depleted Normal Volunteers: Evidence for Monoaminergic Mechanisms*, 20 *NEUROPSYCHOPHARMACOLOGY* 322, 330 (1999).

307. *Id.* at 330–31.

308. See Ersche et al., *supra* note 302, at 618.

309. *Id.*

310. T. Cameron Wild, Jody Wolfe & Elaine Hyshka, *Consent and Coercion in Addiction Treatment*, in *ADDICTION NEUROETHICS: THE ETHICS OF ADDICTION NEUROSCIENCE RESEARCH AND TREATMENT* 153, 155–57 (Adrian Carter et al. eds., 2012).

concept. It requires neither perfect comprehension, nor perfect reasoning. In the MacArthur model, a person is competent to refuse treatment if she understands her diagnosis, and the risks and benefits of treatment as well as the consequences of refusing treatment.³¹¹ When sober, most people with addictions will be able to meet that standard and should be permitted to refuse unwanted medical treatment if they choose to do so.

One might wonder whether the MacArthur model is the right one. Professor Louis Charland has argued that cognitive models of competence, such as the MacArthur model, “fail to get to the real causal roots of addiction.”³¹² Instead, according to Charland, “the roots of addiction lie primarily in the area of affectivity.”³¹³ Charland’s primary contention is that because “the brain of a heroin addict has almost literally been hijacked by the drug[, t]he set of values that governs their daily decisions and behavior is no longer really theirs.”³¹⁴ Addiction involves a pathological set of values, but the values of heroin users have not been displaced in the way Charland suggests. If Charland’s depiction were accurate, no one would stop using drugs, but they do. A common theme in the biographies of ex-addicts is that drug use typically declines when using is no longer compatible with something of value—i.e., a license to practice medicine, freedom from arrest, or regaining custody of a child. Although quitting is extremely difficult, and most people relapse several times before they stop using, most people who develop an addiction to drugs recover, and many of them do so without treatment.³¹⁵

An approach of this kind—with its emphasis on competence and the autonomy interests of people with substance use disorders—is likely to provoke a few objections. Hard paternalists will argue that autonomy matters, but it is not the only interest that matters. As Satel and Farabee note: “addicts are notoriously poor self-disciplinarians. They are also extremely ambivalent about giving up drugs, in spite of all the damage that drugs have caused them.”³¹⁶ According to Satel and Farabee, “[a]ddicts’ problems of self-governance demand a rehabilitative regime for them include limit-setting, consistency, and sometimes physical containment.”³¹⁷ The problem, of course, is that many of us are poor self-disciplinarians. According to some estimates, nearly half of all Americans

311. Louis C. Charland, *Decision-Making Capacity and Responsibility in Addiction*, in ADDICTION AND RESPONSIBILITY 139, 147–49 (Jeffrey Poland & George Graham eds., 2011).

312. *Id.* at 144.

313. *Id.* (italics omitted).

314. Louis C. Charland, *Cynthia’s Dilemma: Consenting to Heroin Prescription*, 2 AM. J. BIOETHICS 37, 43 (2002).

315. Hall, Carter & Forlini, *supra* note 186, at 106.

316. Satel & Farabee, *supra* note 92, at 701.

317. *Id.*

with chronic diseases do not take their medications as prescribed.³¹⁸ Yet courts do not force effective medical treatments upon competent patients. Nor should they.

VI. CONCLUSION

Civil commitment saves lives, but it is not a solution for America's opioid crisis. In their current form, most civil commitment statutes reach people with substance-use disorders who are competent to make treatment decisions.³¹⁹ It may be that until now, states have simply presumed that drug users are incompetent to make treatment decisions, but such a presumption would be mistaken. A few studies have assessed the decisional capacities of people with substance use disorders, and although the findings in this area are mixed, they do not conclusively establish that drug users are incapable of making competent treatment decisions on their own.³²⁰ There is a place for civil commitment, but without a judicial determination of incompetence, using civil commitment to confine drug users is a dangerous exercise of the *parens patriae* power.

There are many steps states can take to reduce the number of opioid-related deaths—foremost among them, increasing access to naloxone.³²¹ Naloxone (also known as Narcan) quickly reverses the effects of an opioid overdose, but the price has skyrocketed, along with the number of opioid deaths.³²² In twenty-eight states, law enforcement agencies have established diversion programs, in which drug users are given the opportunity to enter treatment, without fear of arrest.³²³ During the first year of a diversion program in Lake County, Illinois, police officers transported 130 people to treatment facilities, and “75 percent [of them] completed treatment.”³²⁴ States have also experimented with

318. *Overcoming Barriers to Medication Adherence for Chronic Diseases*, CTNS. DISEASE CONTROL & PREVENTION (Feb. 21, 2017), <https://www.cdc.gov/grand-rounds/pp/2017/20170221-medication-adherence.html>.

319. *See supra* note 48 and accompanying text.

320. *See supra* Part V.C.

321. The Editorial Board, *America's 8-Step Program for Opioid Addiction*, N.Y. TIMES (Sept. 30, 2017), <https://www.nytimes.com/2017/09/30/opinion/opioid-addiction-treatment-program.html>.

322. Ravi Gupta et al., *The Rising Price of Naloxone—Risks to Efforts to Stem Overdose Deaths*, 375 NEW ENG. J. MED. 2213, 2213–14 (2016).

323. Davida M. Schiff et al., Letter to the Editor, *A Police-Led Addiction Treatment Referral Program in Massachusetts*, 375 NEW ENG. J. MED. 2502, 2502–03 (2016).

324. Rick Kambic, *A Year In, Mundelein Police Chief Says Opioid Program Showing Signs of Success*, CHI. TRIB. (July 17, 2017, 12:57 PM), <http://www.chicagotribune.com/>

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prescription drug monitoring programs in which physicians check electronic databases to learn more about the prescribing histories of their patients.³²⁵ Although the evidence is inconclusive, studies have shown that prescription drug monitoring programs are associated with statistically significant reductions in “doctor shopping” among opioid abusers.³²⁶ Each year, opioid overdoses kill more people than gun violence and car accidents, but states can solve this problem without burdening the liberty interests of drug users who are competent to make treatment decisions on their own.

suburbs/mundelein/news/ct-mun-way-out-opiod-conference-sessions-pence-tl-0713-20170717-story.html.

325. Rebecca L. Haffajee, *Preventing Opioid Misuse with Prescription Drug Monitoring Programs: A Framework for Evaluating the Success of State Public Health Laws*, 67 HASTINGS L.J. 1621, 1624–25 (2016).

326. Mir M. Ali et al., *Prescription Drug Monitoring Programs, Nonmedical Use of Prescription Drugs, and Heroin Use: Evidence from the National Survey of Drug Use and Health*, 69 ADDICTIVE BEHAVIORS 65, 69 (2017).