Compulsory Treatment for Drug-dependent Persons: Justifications for a Public Health Approach to Drug Dependency

LAWRENCE O. GOSTIN

American Society of Law and Medicine

MY GOAL IS TO PROPOSE A PROGRAM FOR compulsory treatment for persons who are dependent on illicit drugs and who can benefit from services. Compulsory treatment involves a serious diminution in autonomy and liberty. Thus, a heavy burden rests on proponents to justify compulsory treatment by careful reasoning and specific evidence (Aronowitz 1967). I will seek to accomplish this by demonstrating benefits both to the individual and to society, and by showing the efficacy of compulsory treatment. I will then propose a specific program for effecting the policy of compulsory treatment.

In making these proposals, I am acutely sensitive to the historic failures of compulsory treatment,[1] and to the current beliefs of many, perhaps most, drug-treatment specialists that compulsory treatment makes little sense in a political environment where even those who want treatment cannot receive it (National Institute on Drug Abuse 1987). The need for, and the right to, drug treatment services therefore must be integrally connected to any mandatory program.

[1] Despite the creation of civil commitment statutes throughout the United States in the 1960s, no state is currently committing significant numbers of persons for drug treatment.

The Milbank Quarterly, Vol. 69, No. 4, 1991

I will describe and analyze two different forms of mandatory treatment: civil commitment and diversion from the criminal justice system. A clear theoretical distinction exists between these two forms of mandatory treatment, although in practice they overlap and the terms are often used interchangeably. Civil commitment authorizes the state to confine a person for treatment with due process, but without bringing a criminal charge. Diversion from the criminal justice system involves diverting a person already charged with, or convicted of, an offense from indictment, trial, or sentencing.

I am often encouraged by my colleagues to address the question of legalization in *any* article I write on the drug epidemic (Gostin 1991a,b). Civil libertarians, in particular, argue that the issue of mandatory treatment cannot arise unless what Joel Feinberg has termed the "clutchability" of the state to assert control over the drug user has first been determined (Feinberg 1970). Put another way, if the state does not have the constitutional authority to prohibit and criminalize the use of sale of drugs, then surely it has no authority to restrict the person's liberty for the purposes of mandatory treatment.

I am both a pragmatist and a realist. My convictions are as follows:

1. The academic debate on legalization of drugs, while conceptually useful, has so dominated discourse that it has actually impeded creative ideas for a public health approach within the extant legal system.
2. The critical data needed to come to a conclusion on legalization are unavailable and perhaps unknowable (e.g., whether drug use, morbidity, mortality, and criminality would increase, or decrease, and by how much).
3. In any event, the current academic discourse on legalization will not lead to decriminalization of drugs in the foreseeable future.

The constitutionality of imposing criminal sanctions against persons who use or sell drugs is so well established that successive Supreme Courts have dismissed constitutional challenges without argument and with a single phrase.[2] The Court's implicit reasoning is that drug use

[2] See, e.g., *Whipple v. Martinson*, 256 U.S. 41, 45 (1921). ("There can be no question of the authority of the state to regulate the . . . use of dangerous habit forming drugs. This power is so manifest in the interest of public health and

manifestly contributes to morbidity, mortality, and associated criminal behavior, rendering the state's power to control beyond question.[3]

Two separate, but important, questions are worthy of study. First, do the barely spoken assumptions of the Supreme Court about the constitutionality of criminal sanctions against drug use withstand jurisprudential analysis? Second, even if the state has the constitutional authority to criminalize drug use or sale, should the state exercise its criminal jurisdiction? This requires further policy assessment that carefully balances the health benefits of prohibition, with its economic and social costs, and the human rights burdens. Addressing either of these two important issues in this article would be distracting to the arguments on mandatory treatment in lieu of criminal punishment, and the allotted space would permit only superficial treatment of the weighty social problems raised by legalization.

The Advent and Demise of "Civil" Commitment

The Supreme Court in *Robinson v. California* held that a state statute making it an imprisonable offense to "be addicted to the use of narcotics" inflicts a cruel and unusual punishment in violation of the Eighth and Fourteenth Amendments.[4] The Court would not allow criminal punishment for the "status" or "chronic condition" of being a narcotics addict; a status offense would render an addict subject to prosecution "at any time before he reforms."[5] Any law that made it a criminal offense to have a disease such as a drug dependency, mental illness, or leprosy "would doubtless be uniformly thought to be [unconstitutional]." This strong statement, however, did not prevent the Court

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welfare, that it is unnecessary to enter a discussion of it."); *Robinson v. California*, 370 U.S. 660 (1962) (quoting *Whipple* with approval); *Powell v. Texas*, 392 U.S. 514 (1968) (upholding constitutionality of criminalizing public drunkenness); *Harmelin v. Michigan*, 1991 LEXIS 3816 (June 27, 1991), Kennedy J. concurring. (Harmelin's suggestion that simple possession of cocaine was nonviolent and victimless is "false to the point of absurdity.")

[3] Harmelin, op. cit. ("Studies demonstrate the grave threat that illegal drugs, particularly cocaine, pose to society in terms of violence, crime, and social displacement.")

[4] *Robinson v. California*, 370 U.S. 660 (1962).

[5] *Robinson v. California*, 370 U.S. at 666.

from ruling only six years later that it was constitutional for a state to convict an alcoholic for public drunkenness.[6] Although the Court argued that the person was convicted because of his *behavior* of appearing in public, not his *status* of alcoholism, this comes perilously close to punishing a person because of his physical dependence.

Oddly, the Supreme Court's rejection of punishment for addicts in *Robinson* paved the way for federal and state statutes designed to involuntarily confine drug-dependent persons. The purpose of this confinement was expressed as "therapeutic" and not "punitive." More than 40 years before *Robinson*, the Supreme Court ruled that "there can be no question of the authority of the state in the exercise of its police power to regulate the . . . use of dangerous habit forming drugs. . . . The right to exercise this power is so manifest in the interest of public health and welfare, that it is unnecessary to enter a discussion of it."[7] The Supreme Court in *Robinson* said that states could constitutionally establish "a program of compulsory treatment for those addicted to narcotics," including "periods of involuntary confinement" enforced through penal sanctions.[8]

Although the California commitment statute had already been adopted in 1961, the dicta in *Robinson* provided the impetus for the enactment of federal and state programs of mandatory treatment (Aronowitz 1967). Governor Nelson Rockefeller specifically referred to the *Robinson* decision in urging the adoption of New York's civil commitment statute (Rockefeller 1966). By the mid-1960s, the federal government,[9] California,[10] Massachusetts,[11] and New York[12] each had enacted major civil commitment statutes for "narcotics addicts."[13]

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[6] *Powell v. Texas*, 392 U.S. 514 (1968).
[7] *Whipple v. Martinson*, 256 U.S. 41, 45 (1921).
[8] *Robinson v. California*, 370 U.S. at 665.
[9] *Narcotic Addict Rehabilitation Act of 1966*, P. L. 89-793 (Nov. 8, 1966).
[10] Cal. Welfare and Institutions Code, paras. 3000–3005 (West 1966).
[11] Mass. Ann. Laws, ch. 111A, paras. 1–10 (Supp. 1965).
[12] N.Y. Mental Hygiene Law, paras, 200–17 (McKinney Supp. 1966).
[13] Earlier civil commitment statutes had been enacted in the 1950s in such states as Alabama, Arkansas, Delaware, Georgia, and Maryland. These statutes, however, were used very little, apparently because relatives refused to initiate commitment, and few specialized treatment facilities were established. At that time much of the "treatment" for drug dependency took place in the mental health system (Aronowitz 1967).

The statutes enacted in these four major jurisdictions were broadly similar in approach, but differed in their specific application. All the statutes used the term "civil commitment" (Abromovsky and McCarthy 1977; Aronowitz 1967). The courts held that confinement had "none of the attributes of a criminal or penal sanction,"[14] and was "not to be considered as a punishment for a crime" (Ginnow 1974).[15] Yet these "civil commitment" statutes actually encompassed at least three distinct forms of mandatory treatment, some of which were closely connected to the criminal process[16]:

1. *pure civil commitment*, where the person was detained for mandatory treatment not connected with any current arrest or charge for a criminal offense
2. *civil commitment in lieu of a criminal trial*, where eligible persons were detained for mandatory treatment after being arrested and charged with a criminal offense, and the treatment took place in lieu of continued prosecution of the offense, that is, mandatory treatment while a criminal charge was held in abeyance
3. *civil commitment following a criminal conviction*, where the person convicted received mandatory treatment in lieu of a prison sentence or other criminal disposition

True civil commitment, as used in the mental health context, would be confinement without any connection to an arrest, charge, or conviction for a criminal offense.

These mandatory treatment statutes applied to persons who, by reason of repeated use of illicit drugs, were addicted or in "imminent danger of becoming addicted." The statutes appeared, even then, to limit confinement to persons who were not merely casual users, but who were emotionally or physically dependent on drugs (Gulick and Kimbrough 1990).[17]

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[14] *Showers v. Lloyd*, 296 F. Supp. 441 (D.C. Cal. 1969); *ex parte De La O*, 28 Cal. Rptr. 489, 378 P.2d 793 (1963); *in re Whisaker*, 134 F. Supp. 864 (D.C. 1955).

[15] *People v. Reynoso*, 50 Cal. Rptr. 468, 412 P. 2d 812 (1966).

[16] All the statutes, except Massachusetts, also permitted addicts to be committed on their own petition.

[17] *People v. Victor*, 42 Cal. Rptr. 199, 398 P. 2d 391 (1965).

In order for a drug-dependent person to be eligible for mandatory treatment in lieu of a trial or sentencing, he or she had to come within the specifications of the statute. Typically, persons charged or convicted of violent offenses, or who had a record of such offenses, were ineligible for mandatory treatment.[18]

Eligibility for mandatory treatment for persons charged or convicted of an offense was determined in the criminal proceeding.[19] However, prior to mandatory treatment, the person had a right to a *civil* hearing when the sole issue was his dependency on drugs. The civil proceedings, however, had such an immediate effect upon his personal liberty that the person was entitled to a full due process hearing, including the right to counsel, notice, and the right to compel and question witnesses.[20]

Mandatory treatment meant that persons were confined in specialized drug-treatment facilities with the goal of attaining total abstinence from drugs. If a drug-dependent person was deemed ready for the next phase of treatment, he or she would be released from the facility as an outpatient. Once released, the person was subject to intensive supervision similar to that required of a person on parole. This might involve specified living arrangements such as a group home, periodic visits from supervisors, and drug testing. Breach of any condition would require the person to be readmitted to an inpatient facility.[21]

Persons were committed for mandatory treatment for indefinite periods of time, subject to a statutory maximum. The prescribed maximum periods depended upon whether the person was charged or convicted of an offense, and differed under each statute. Maximum detention for those charged with or convicted of an offense ranged from three to ten

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[18] *U.S. v. Taylor*, 689 F.2d 1107 (D.C. Cir. 1982); *Macias v. U.S.*, 484 F.2d 1292 (5th Cir. 1972); *Neria v. U.S.*, 493 F.2d 913 (5th Cir. 1974); *People v. Navarro*, 102 Cal. Rptr. 137, 497 P.2d 481 (1972); *U.S. v. Krehbiel*, 493 F.2d 497 (9th Cir. 1974).

[19] *People v. Strickland*, 52 Cal. Rptr. 215 (1966).

[20] *People v. Moore*, 76 Cal. Rptr. 150 (1969); *People v. Malins*, 101 Cal. Rptr. 270 (1972); *People ex rel. McNeill v. Morrow*, 302 N.Y.S. 2d 933 (1969); *People v. Fuller*, 300 N.Y.S. 2d 102, 248 N.E. 2d 17 (1969); *Pannell v. Jones*, 368 N.Y.S. 2d 467, 329 N.E. 2d 159 (1975).

[21] The person still had civil rights, however, and had *some* due process protections before he was compelled to be reinstitutionalized. *Re Bye*, 115 Cal. Rptr. 382, 524 P.2d 854, cert. denied, 420 U.S. 996 (1975). *Re Murillo*, 110 Cal. Rptr. 494, superseded 115 Cal. Rptr. 393, 524 P.2d 865 (1974).

years (Myers 1974). The duration of detention, within the statutory minimums or maximums, was a medical rather than a judicial decision.[22]

Successful termination of mandatory treatment meant a great deal to persons because it affected their liberty and determined whether any pending criminal charges would be dismissed. Persons were therefore entitled to a periodic hearing on termination, but it often involved a pro forma review of affidavits or depositions.[23]

Mandatory treatment statutes were widely upheld as constitutional whether[24] or not[25] the person had been charged with, or convicted of, a crime (Schopler et al. 1964). The courts upheld these statutes as a valid exercise of the police power because they were reasonably necessary to protect the public health and welfare.[26]

Encouraged by the courts' approval of existing laws, numerous states enacted mandatory treatment statutes in the years to follow (i.e., from the mid-1960s through the 1970s). Although a few states repealed their statutes,[27] today some 18 states and the federal government have mandatory drug-treatment laws.[28] However, the enthusiasm for mandatory treatment rapidly waned throughout the 1980s until now, where it is, for all intents and purposes, a relic of the past, never utilized. The National Conference of Commissioners on Uniform State Law (NCCUSL) published a lengthy model treatment statute in 1973.[29] The Uniform Act was coolly received by the states, and not one has adopted it in whole or in part (*American Jurisprudence 2d* 1990).

Remarkably little has been written about the reasons mandatory treatment was devised with such promise, used in such earnest, and then quietly allowed to wither—all in the space of a couple of decades. Were a post mortem to be written, undoubtedly it would mention sev-

[22] *Baughman v. U.S.*, 450 F.2d 1217 (8th Cir. 1971).
[23] *U.S. v. Thornton*, 344 F.Supp. 249 (D.C. Del. 1972).
[24] *In re Trummer*, 36 Cal. Rptr. 281, 388 P.2d 177 (1964); *Narcotic Addiction Control Commission v. James*, 285 N.Y.S. 2d 793, 29 A.D. 2d 72 (1967).
[25] *Ex parte Raner*, 30 Cal. Rptr. 814, 381 P.2d 638 (1963).
[26] *Blinder v. State Department of Justice*, 101 Cal. Rptr. 635 (1972).
[27] For example, Connecticut in 1990.
[28] AK, CA, GA, HI, IN, MA, MI, ND, NV, NY, RI, SC, SD, WV, WI (NJ, NM, and TX are for juveniles only). See also Anderson and Keilitz (1991).
[29] Uniform Drug Dependence Treatment and Rehabilitation Act, published by NCCUSL in 1973. See 25 Am. Jur. 2d. Supp. para 75 (April 1990).

eral factors responsible for the demise of mandatory treatment. Certainly, the advent of methadone maintenance enabled treatment to take place on a voluntary basis in the community, as opposed to compulsory admission to an institution. Many heroin addicts simply did not need to be forced to take methadone. Apart from methadone, adequate treatment facilities were never established. Authorities simply stopped using mandatory treatment because specialized treatment facilities were not available. Today, the U.S. Public Health Service has virtually abandoned any attempt to provide treatment as a diversion from the criminal justice system.

Connected to this reason was the growing belief in the 1970s that "treatment does not work." Well-publicized analyses of treatment outcomes declared that treatment was valueless both in stopping or even impeding drug use, and in stemming associated crime (Martinson 1974).

The hope of effective treatment began to turn sour, and drug dependence began to be viewed as a hopeless, chronically relapsing condition without any effective intervention. In addition, there was the pronounced shift in ideology from the 1960s through the 1980s. The ideology of social welfarism that emerged in the 1960s rested on the central belief that drug dependence was a disease amenable to public health interventions. David Musto (1989) characterized the period as follows: "Reform-minded lawyers, academics, and physicians found the harsh penalties toward addicts to be inhumane. Rather than depriving addicts of heroin, heroin should be provided them. Rather than jailing addicts, they should be hospitalized. . . ."

By the 1980s, drug users were beginning to be perceived as more bad than ill, and law enforcement and criminal punishment began to emerge as the predominant public strategy (U.S. Office of National Drug Policy 1990a). By the end of the 1980s, the policies then in vogue of user accountability and zero tolerance made it acceptable to direct the state's formidable powers toward drug-dependent persons themselves (Gostin 1991a). Indeed, this shift in political ideology can be traced in the expenditure of the federal budget devoted to treatment and prevention compared with law enforcement, interdiction, and eradication. Two decades ago, more than 50 percent of the total drug-abuse budget went to treatment and prevention; it was reduced to between 18 and 27 percent during the Reagan years in the 1980s, and is approximately 29 percent for Fiscal Year 1991 (Brecher 1989; Shenon 1990; U.S. Office of

National Drug Policies 1990b). Some policy makers today are calling for at least half of the drug budget to be spent on treatment and prevention (Majority Staffs of the Senate Judiciary Committee 1990; Pear 1990).

A final reason for the disuse of mandatory treatment probably rested with the fact that the laws themselves were out of touch with contemporary thinking about the legitimacy of the state's power to confine, which reflected the influence of the civil libertarian challenge to the agencies of social control. The premise of these laws was that it was acceptable to label mandatory treatment as "civil" and shelter the entire process from a hard-headed review of the philosophical purposes, public health efficacy, and human rights aspects of the confinement[30] (Abromovsky and McCarthy 1977).

Throughout the 1970s, the federal courts were making revolutionary changes in the analogous concept of civil commitment of the mentally ill (Brakel, Parry, and Weiner 1985; Perlin 1989; Note 1975). Courts required rigorous procedural due process prior to civil commitment of persons with mental illness or mental retardation;[31] extended the right to due process to adolescents voluntarily committed to institutions;[32] required recent dangerous overt behavior as a basis for commitment;[33] refused to allow purely custodial confinement in the absence of treatment for nondangerous persons;[34] and provided a limited right to refuse treatment for institutionalized persons.[35] Drug-dependency statutes were clearly deficient in the rights afforded to individuals when measured against the mental health decisions of the federal courts.

Whatever the real reasons for the demise of mandatory treatment, it is certain that many drug-dependent people charged or convicted of offenses preferred treatment to criminal punishment. (Some offenders charged with minor offenses, of course, preferred a noncustodial sen-

[30] Uniform Drug Dependence Treatment and Rehabilitation Act. 1973. Prefatory Note.

[31] *Lessard v. Schmidt*, 349 F.Supp. 1078 (E.D. Wisc. 1972).

[32] *Parham, Commissioner, Department of Human Resources of Georgia v. J.R.*, 442 U.S. 584 (1979) (the procedures afforded to adolescents voluntarily admitted, however, were far less rigorous than those afforded to those subject to compulsory civil commitment).

[33] *Lessard v. Schmidt*, 349 F. Supp. 1078 (E.D. Wisc. 1972).

[34] *O'Connor v. Donaldson*, 422 U.S. 563 (1975); *Pennhurst State School and Hospital v. Halderman*, 451 U.S. 1 (1981).

[35] *Mills v. Rodgers*, 457 U.S. 291 (1982).

tence or a short term of imprisonment to indeterminant periods of treatment.) Much of the litigation of the time was targeted at federal or state authorities who refused to divert them to treatment[36] or simply argued that no treatment facilities were available.[37] Drug-dependent people saw treatment as a constitutional entitlement, whereas the government and courts saw it as discretionary.[38]

The Advent and Demise of Diversion from Criminal Justice

The rehabilitative principle of diversion from the criminal justice system reached its high-water mark in the decade beginning in the mid-1960s. The impetus for the wider use of rehabilitative diversion was provided by the President's Commission on Law Enforcement and Administration of Justice (1967). The commission observed that "in the century we have built our drug control policies around the twin judgements that drug abuse was an evil to be suppressed and that this could most effectively be done by the application of criminal enforcement and penal sanctions" (1967, 134, 222). The premise of these policies had been that the more certain and severe the punishment (typically, minimum mandatory sentences and ineligibility for suspension of sentence, probation, and parole) the greater the impact on drug use and crime. However, the commission found the effects of mandatory minimum sentences to be inconclusive, and probably harmful to the public health and safety. It recommended explicit policies for early identification of drug users and

[36] *U.S. v. Palmer*, 369 F.Supp. 1030 (D.C. Cal. 1974); *U.S. v. Leazer*, 460 F.2d 864 (D.C. Cir. 1972).

[37] *U.S. v. Butler*, 676 F. Supp. 88 (W.D. Pa. 1988). This issue even made it to the Supreme Court, which upheld the constitutionality of the Narcotic Rehabilitation Act (NARA) even though it excluded violent offenders from the opportunity for treatment. *Marshall v. U.S.*, 414 U.S. 417 (1974). Justice Marshall filed a dissent in which he said: "It simply makes no sense to deem an addict a 'hardened criminal' unworthy or unsuited for treatment simply because he has engaged in criminal activity." 414 U.S. at 437. Justice Marshall quotes a Congressman in the debate on NARA arguing that it is like "building a sanitorium to treat tuberculosis, and then refusing admittance to patients with a contagious disease." 112 Cong. Rec. 11812 (1976).

[38] *U.S. v. Butler*, 676 F.Supp. 88 (W.D. Pa. 1988); *People v. Victor*, 42 Cal. Rptr. 199, 398 P.2d 391 (1965); *U.S. v. Barrow*, 540 F.2d 204 (4th Cir. 1976).

diversion to community resources for treatment. This could be accomplished through clearly stated criteria and procedures for diversion, greater prosecutorial and judicial discretion to opt for treatment, and a greatly expanded network of rehabilitative services.

The American Law Institute's Model Code of Pre-arraignment Procedure (para 320.5[d]) followed the commission's approach. Parties could agree to suspend prosecution for up to one year on condition that the defendant enter a rehabilitation program that may include treatment, counseling, training, or education. State statutes specifically authorizing diversion were almost uniformly held constitutional (Landis 1981).

Just as prosecutors began to reject the idea of civil commitment from the mid-1970s onward, so too did they turn against the rehabilitative ideal of diversion. Nelson Rockefeller's (1973) call for laws making punishment for drug users much more severe in order to "close all avenues for escaping the full force of this sentence" was symbolic of the change in heart. Only seven years earlier, Rockefeller (1966) had appeared before the U.S. Senate Committee on the Judiciary arguing for civil commitment as an alternative to punishment.

There followed a sustained effort by federal and state governments, reinforced through the Reagan years and up to the present, systematically to dismantle rehabilitation as a legitimate goal of criminal justice. This had the effect of virtually foreclosing opportunities for diversion for many drug law violators and other seriously drug-dependent persons. The so-called tough drug laws had two elements. First was the explicit prohibition or restriction on parole, probation, or suspension of sentence in cases of violent crimes (Smith 1980). The second required convicted drug offenders to be sentenced to a mandatory,[39] or a minimum,[40] prison term (Williams 1977). The courts uniformly upheld such statutes based upon the sovereign power of the state legislature to prescribe the penalty for commission of a crime.[41]

[39] E.g., *U.S. v. Holmes*, 838 F.2d 1175 (11th Cir. 1988); *U.S. v. Brady*, 680 F.Supp. (W.D. Ky 1988); *State v. Pacheco*, 588 P.2d 830 (Ariz. 1978).

[40] E.g., *State v. Benitez*, 395 So. 2d 514 (Fla. 1981); *Draughn v. State*, 539 P.2d 1389 (Okla Crim. 1975). In a mandatory minimum sentence, the legislature prescribes a sentence without the possibility of parole until the person serves the minimum term. The legislature divests judges and probation officials of discretion to forego incarceration or suspend sentences (Glick 1979; Lambiotte 1987).

[41] E.g., *State v. Johnson*, 206 N.J. Super. 341, 502 A.2d 1149 (1985); *Scott v. State*, 479 So. 2d 1343 (Ala. App. 1985); *People v. Smith*, 414 N.E. 2d 1281 (Ill. 1980); see *Harmelin v. Michigan*, 1991 LEXIS 3816 (June 27, 1991).

Even in some jurisdictions that did not formally adopt tough drug laws, prosecutors decided to exclude drug-law violators from diversion programs. One state supreme court upheld a district attorney's blanket policy of excluding all drug-law violators from diversion programs.[42] The court based its decision on the "seriousness of the drug problem in society today, particularly its devastating effect upon young people."[43]

The tough drug laws make it legally difficult or impossible to use creative alternative sentencing such as to an inpatient or outpatient treatment facility. They also provide a marked disincentive for plea bargaining because the judge has little discretion in sentencing. This does not prevent imaginative prosecutors from finding ways around these legal constraints, for example, by informally staying the charge in exchange for a promise to receive treatment. However, such informal approaches depend upon the flexibility of prosecutors and the availability of alternative services. In a political climate where treatment is seen as "coddling" drug users, district attorneys (many of whom are elected) and their political bosses will not countenance use of rehabilitation in circumventing tough minimum sentencing laws (U.S. Office of National Drug Policy 1990a).

Singling out all drug offenders, including minor offenders, for harsh minimum prison terms treats them less favorably than other offenders and also precludes their rehabilitation. One dissenting judge in the supreme court of Kansas could not understand why a 22-year-old first offender convicted of unlawful delivery of 11 ounces of marijuana should receive a mandatory prison term, while the court maintained discretion to suspend the sentence of a person convicted of murder, armed robbery, or rape, even after a previous felony conviction.[44] Nor was it possible to provide treatment for the drug offender to help him overcome his dependency.

Although courts were prepared to uphold most draconian antidrug laws, one state legislature went too far. The supreme court of Michigan held that a state law providing a mandatory minimum prison sentence of 20 years for selling or giving away any quantity of marijuana was so excessive that it inflicted cruel and unusual punishment.[45]

Challenges to tough drug laws premised on the Eighth Amendment's

[42] *State v. Greenlee*, 620 P.2d. 1132 (S.Ct. Kan. 1980).
[43] Id. at 1139.
[44] Id.
[45] *People v. Lorentzen*, 194 N.W. 2d 827 (Mich. S.Ct. 1972); *People v. Sinclair*, 194 N.W. 2d 878 (Mich. S.Ct. 1972) (overturning mandatory sentence for pos-

proscription against cruel and unusual punishment took a major setback with the Supreme Court's decision in *Harmelin v. Michigan*.[46] Harmelin was convicted of possessing more than 650 grams of cocaine and sentenced to a mandatory term of life in prison without the possibility of parole. Justice Scalia, delivering part of the opinion of the Court, rejected Harmelin's claim that his sentence is unconstitutional because of its mandatory nature, allowing no opportunity to consider "mitigating factors." Justice Scalia found no support in the text and history of the Eighth Amendment for the proposition that judges must maintain discretion in sentencing. Severe mandatory penalties may be cruel, but they are not unusual, having been employed throughout the nation's history.

Justice Kennedy, delivering another part of the Court's opinion, accepted a narrow proportionality principle in the Eighth Amendment—namely, that extreme sentences that are grossly disproportionate to the gravity of the offense are unconstitutional. Justice Kennedy recognized that a sentence of life imprisonment without parole is the second most severe penalty permitted by law. Nevertheless, the Court did not regard the sentence as disproportionate to Harmelin's crime of possessing more than 650 grams of cocaine. "His suggestion that the crime was nonviolent and victimless is false to the point of absurdity. Studies demonstrate the grave threat that illegal drugs, particularly cocaine, pose to society in terms of violence, crime, and social displacement."[47] The Court's decision suggests that it will grant "substantial deference" to state determinations imposing mandatory minimum sentences on drug offenders.

Justifications for Compulsory Treatment

The choice among the three most discussed options for a national drug strategy—criminal punishment, compulsory treatment, and legalization—should be based upon the method that would best achieve a re-

session of two marijuana cigarettes). Still, most courts upheld statutes providing stiff penalties for simple possession of marijuana (Williams 1979).

[46] 1991 U.S. LEXIS 3816 (June 27, 1991).

[47] Justice Kennedy said a clear nexus between drug use and crime exists: (1) drug-induced changes in physiology may lead to criminal behavior; (2) drug users commit crime to obtain money to buy drugs; and (3) violent crimes occur as part of the drug business or culture. 1991 U.S. LEXIS 3816, 77.

duction in morbidity and mortality caused by the drug epidemic and the associated needleborne HIV epidemic (Gostin 1991a,b). The justification for compulsory treatment can be centered between the two extremes of legalization (Nadelmann 1989) and criminal punishment (Wilson 1990). Compulsory treatment, unlike the other two options, faces the public health dimensions of drug dependency head on by providing interventions that demonstrably lower drug use and its associated morbidity, mortality, and criminality. A public health approach to drug dependency emerges as critically important.

Avoiding the Harms of the Criminal Justice System

The declared policy of a "Drug Free America by 1995,"[48] supported by an ever-widening net of detection through drug screening and law enforcement, is a fruitless, impractical endeavor destined to overwhelm the criminal justice system. It becomes virtually impossible to present a credible law-enforcement program with an estimated 28-million people having used illicit drugs in 1988 alone (National Institute of Drug Abuse 1989). The 850,000 people arrested each year for drug offenses represent only a fraction of current drug users; more than three-quarters of these arrests are for simple possession, typically marijuana, and not for manufacturing, importing, or selling (Bureau of Justice Statistics 1989).

The Fiscal Year 1991 federal budget projected a total of just over $10.6 billion for the National Drug Control Strategy, more than 70 percent of which was designated for law enforcement and interdiction (U.S. Office of National Drug Policy 1990b). Federal monies devoted to drug law enforcement have quadrupled within the last five years (National Drug Enforcement Policy Board 1987; Shenon 1990). Nationally, arrests for drug law violations increased from 162,177 in 1968, or 112 per 100,000 people, to 850,034 in 1989, or about 450 per 100,000 people (Reinhold 1989).

The organs of the criminal justice system (law enforcement, the courts, and corrections), designed to provide swift, sure punishment, have become so clogged by the weight of cases that they cease to function, and require increasing resources to provide an effective deterrence

[48] Drug Free America by 1995 Authorization Act, P.L. 100-690, § 7603.

and minimally humane conditions. Narcotic prosecutions in the federal courts have risen 229 percent in the past decade, with drug law cases representing 40 to 65 percent of all criminal trials (Bureau of Justice Statistics 1988; Labaton 1990). Fifty-eight percent of all drug cases filed in federal district courts, moreover, were for sale of possession of marijuana (Bureau of Justice Statistics 1989). The result is that courts cannot manage the drug caseload, which results in inordinate delays in the prosecution of other criminal offenses. The impact of delays on civil and family cases is compounded because such cases have lower priorities than criminal cases.

The number of prisoners in federal or state corrections systems at the end of 1989 reached a record 710,054. The net increase in 1989 of 13 percent also set a new record, which translates into 1,600 new bed spaces per week. The growth in prison population in the 1980s was 115 percent. During this period, the per capita incarceration rate rose more than 97 percent from 139 per 100,000 to 274 per 100,000 residents. The federal prison system is currently operating at 63 percent above full capacity, while the state systems are, on average, between 7 and 27 percent above capacity (Bureau of Justice Statistics 1990). Nearly 40 states are operating under court orders as a result of overcrowding (Malcolm 1991).

Overall, a massive growth in the criminal justice system has emerged over the last 15 years to the point where 3.3 million individuals were under criminal justice supervision on the designated census days in 1987, compared with 1.3 million in 1976 (Institute of Medicine 1990, 113–14). In some poor, urban communities, one out of every ten black males is under criminal justice supervision, the majority of whom are either drug law violators or drug abusers.

Mandatory treatment would significantly ease the pressure on the organs of the criminal justice system by avoiding the heavy costs of prosecution, trial, and imprisonment. Treatment in lieu of prosecution would also allow government to shift resources currently placed into expanding law enforcement, the judiciary, and corrections into treatment expansion.

A Public Health Approach to Drug Dependency

Mandatory treatment, as a diversion from the criminal justice system, stands the best chance of reducing the morbidity, mortality, and crimi-

nality associated with the drug epidemic. Diversion programs provide an ideal opportunity to identify cases of seriously drug-dependent people; to provide treatment for those who otherwise would not attend public health intervention programs; and to require attendance for a period of time that maximizes the opportunities for success.

The criminal justice system provides a key forum for an effective public health program (Anglin and Hser 1991a). Because of the clandestine nature of their conditions, drug dependent persons are exceedingly hard to reach (Feldman and Biernacki 1988). This creates an obstacle to providing them with education on risk reduction, counseling, and treatment. Yet because police, prosecutors, and the courts have significant contact with the drug-dependent population, they constitute a valuable resource for providing services. Voluntary anonymous urine specimens from a sample of male arrestees in 22 cities reveal that at least 50 percent have recently used cocaine (Centers for Disease Control 1989). This figure, moreover, is an underestimate because the screening program limits the participation of persons who are arrested on charges of possession or sale of drugs. The finding that at least 20 percent of drug injectors in this study reported sharing needles indicates a continuing risk for spread of HIV and other bloodborne infections. Between 75 and 83 percent of incarcerated persons reported that they had used drugs in the past, and between one-third and two-fifths reported that they were under the influence of an illegal drug at the time of the offense (Bureau of Justice Statistics 1988; Office of Justice Programs 1989; Office of Technology Assessment 1990, 92–3).

Many prisoners even take drugs after they are incarcerated and often share injection equipment with other prisoners (Institute of Medicine 1990, 17). One rural prison system reported that 27 percent of the inmate samples tested positive for illicit drugs. Although the prison system was able to lower this rate to 9 percent with routine drug screening and punishments, it indicates that drug use among incarcerated inmates can be substantial (Vigdal and Stadler 1989).

Despite the large number of drug-dependent persons who come into contact with the criminal justice system, there are few comprehensive treatment programs. One national survey found that only 4 percent of state prison inmates received any treatment, and almost half of the nation's state prisons were not served by any identifiable drug abuse treatment program (Tims 1986). Some report slightly higher provision of correctional treatment (Bureau of Prisons 1990), but at least two-thirds

of prison treatment involves nonintensive periodic group or individual talk sessions. This level of intervention is probably not intensive enough to effect any lasting behavioral changes (Institute of Medicine 1990, 119). For many in the criminal justice system, routine urine testing is the only "treatment" provided.

It makes little sense to process large numbers of drug-dependent persons, at exorbitant cost, through prosecution, trial, and imprisonment without systematic efforts to lessen their physical and psychological dependence on drugs. Drug-dependent persons are subject to the authority of the state. Yet many offenders are released early from overcrowded prisons, having learned nothing—except perhaps some criminal behaviors from other inmates (Malcolm 1991; Reinhold 1989). It is disturbing to observe that between one-half and three-fifths of those inmates who use major drugs did not do so until *after* their first arrest (Office of Justice Programs 1988).

"Treatment Works"

Criticism and calls for rejection of criminal diversion and correctional treatment programs peaked with a review article by Martinson (1974) concluding that treatment does not reduce drug use or recidivism and asking, "Does nothing work?" Five years later, Martinson (1979) renounced his position, stating that the benefits of treatment are "simply too overwhelming to ignore," but the severe retrenchment of treatment had already begun to occur.

Treatment outcome data, to be sure, are compromised by the lack of controlled clinical trials.[49] Much of the early research also focused on heroin rather than cocaine dependency. Despite the methodologic concerns, recent authoritative reviews of a large number of outcome studies conclude that treatment, including compulsory treatment, reduces the use of drugs, sharing of injection equipment, as well as criminal behavior (Institute of Medicine 1990; Office of Technology Assessment 1990; National Criminal Justice Association 1990; National Association of State Alcohol and Drug Abuse Directors 1990). Some studies have reported

[49] A wide array of factors complicates the assessment of treatment effectiveness: the chronic relapsing patterns of drug use, the heterogeneous composition of drug users, and the problem of patient self-selection of treatment and treatment modalities (Office of Technology Assessment 1990, 62–4).

similar levels of treatment efficacy for cocaine abuse (Simpson et al. 1986; Hubbard et al. 1989).

Much of the collective knowledge of treatment effectiveness derives from two large-scale, federally funded, longitudinal studies: Treatment Outcome Prospective Study (TOPS) (Hubbard et al. 1989) and the National Treatment System Based on the Drug Abuse Reporting Program (DARP) (Simpson and Sells 1990). A third large-scale national prospective study, the Drug Abuse Treatment Outcome Study (DATOS), is underway.

TOPS and DARP, together with numerous smaller studies (McLellan et al. 1982; National Institute on Drug Abuse 1983), demonstrated that each of the three primary treatment modalities were effective in causing significant and enduring declines in drug use and criminal behaviors—methadone maintenance, therapeutic communities (TCs), and outpatient drug-free (ODF) programs.

Methadone maintenance allows an "illicit short-acting opiate administered with needles to be replaced with a legal long-acting safe, and orally administered substance" (Zweben and Sorensen 1988). The Office of Technology Assessment (1990, 76) observes that the "consistency of the scientific literature regarding the safety, efficacy, and effectiveness of methadone is overwhelming, yet some still consider methadone a controversial treatment modality." In controlled clinical studies, heroin-dependent, heavily criminally involved populations who were randomly assigned to methadone or a control condition "demonstrated clinically important and statistically significant differences in favor of methadone on the gauges of drug use, criminality, and engagement in socially productive roles such as employment, education, or responsible child raising" (Institute of Medicine 1990, 143). Methadone has the highest retention rate of all treatment modalities, and lowers human immunodeficency virus (HIV) risk behavior by significantly reducing the number of injections and sharing of equipment (Cooper 1989). Although several pharmacotherapies such as buprenorphine are currently being evaluated (Mello et al. 1989; Office of Technology Assessment 1990, 78–9), the absence of any established efficacious agent is having dire consequences for cocaine-dependent persons and, if they are HIV infected, their sexual partners.

Therapeutic communities are "residential programs with expected stays of 9 to 12 months, phasing into independent residence" (Institute of Medicine 1990, 14). Therapeutic community clients end virtually all

illicit drug taking and other criminal behavior while in residence and perform better than those not in treatment (in terms of reduced drug use and criminal activity and increased social productivity) after discharge (Institute of Medicine 1990, 188–9). Studies that evaluate progress upon completing the program report that 30 percent achieve absolute success (no drugs, no crime), with improvement rates ranging from 50 to 60 percent (Office of Technology Assessment 1990, 83). Retention rates, however, were poor, and success is directly related to length of time in treatment, with a minimum stay of three to nine months being desirable (Institute of Medicine 1990, 156–63).

Outpatient drug-free (ODF) programs display a great deal of heterogeneity, and range from one-time assessments and drop-in, or "rap," centers to virtual outpatient therapeutic communities with daily psychotherapy and counseling. The TOPS and DARP studies suggest similarly favorable outcomes for drug users attending outpatient drug-free programs. Yet evaluation is significantly hampered by the lack of uniformity in ODF programs and the small number of clients served.

The quality of evidence and the cost effectiveness of the three major modalities suggest a priority ranking of methadone maintenance, TCs, and ODF. Yet the Institute of Medicine (1990, 186) points out that the order of expenditures for these modalities is exactly the reverse of the order of knowledge about their effectiveness. Well-designed research on therapeutic communities, particularly ODFs, is essential.

Compulsory Versus Voluntary Treatment

A striking research consensus exists that the single greatest predictor of favorable treatment outcomes is the length of time in treatment (Cooper 1989; Hubbard et al. 1989). This bodes well for mandating programs that require minimum stays. The Institute of Medicine (1990, 119) aptly observed:

> Contrary to earlier fears among clinicians, criminal justice pressure does not necessarily vitiate treatment effectiveness and probably improves retention. Yet, the most important reason to consider . . . [compulsory treatment] is not that coercion may improve the results of treatment but that treatment may improve the rather dismal record of plain coercion—particularly imprisonment. . .

The intuition that compulsory treatment will fail because drug-dependent people must be self-motivated in order to benefit (Schottenfeld 1989) simply is not borne out by the relevant data.[50] Indeed, state civil commitment programs died, not necessarily because of their lack of effectiveness, but because of a lack of political will to devote adequate resources to them.[51] In the California Civil Addict Program (CAP), which operated throughout the 1960s and early 1970s, daily narcotics use and property-related crime among program participants were reduced by 22 percent and 19 percent, respectively. This represented a threefold improvement in outcome measures over a comparison group of drug users who were admitted to the program but were discharged because of legal errors and who reduced their daily drug use and their criminal activities by only 7 percent (Anglin and Hser 1991a). Evaluations of clients in the federal and other civil commitment programs demonstrated that clients did as well, or better, than those who volunteered for treatment (Anglin 1988; Anglin, Brecht, and Maddahian 1987; Leukfeld and Tims 1988). Legal coercion did not appear to interfere with treatment effectiveness in any modality ranging from methadone maintenance (Anglin, Brecht, and Maddahian 1987) to therapeutic communities (DeLeon 1988).

Extensive research has also been undertaken concerning the success of mandatory treatment in the criminal justice system—treatment as a condition of release on bail, probation, parole, or treatment while in prison. Both TOPS and DARP report benefits to individuals who were in treatment under the criminal justice system. The major model for treatment in the federal criminal justice system is the Treatment Alternatives to Street Crime (TASC) program. TASC was established as a small experimental program in 1972, and by 1988 it was operating in 18 states. The goals of TASC are to identify drug users who come into contact with the criminal justice system, to refer them to clinically appropriate treatment, to monitor their progress, and to return violators to the criminal justice

[50] An annotated bibliography on compulsory treatment is published by the National Clearinghouse for Alcohol and Drug Information, Office of Substance Abuse and Prevention (18) 1290. See also the symposium issue on compulsory treatment in the *Journal of Drug Issues* 1988;18 (4): 503–661.

[51] James Inciardi (1988) concludes that New York's civil commitment program was doomed to failure because of mismanagement and misrepresentation; its treatment facilities were in former prisons whose environments were not conducive to behavioral change; facility directors were political appointees with little clinical experience; and its aftercare program was inadequate.

system (Hubbard et al. 1989). TASC employs creative strategies, including deferred prosecution, community sentencing, diversion to the voluntary treatment system, and pretrial intervention to help funnel drug users into treatment. TASC also utilizes traditional strategies, such as probation and parole supervision, for probable and proven crimes.

More than 40 evaluations of TASC have concluded that it has intervened effectively to reduce drug abuse and criminal activity and that it has identified previously unrecognized drug-dependent persons (National Criminal Justice Association 1990). Indeed, researchers have concluded that criminal justice treatment clients favorably alter their behavior as much as or more than clients in other drug abuse treatment programs. Successes of compulsory treatment include significantly reduced drug use and criminal activity, and increased employment and social coping skills.

The most recent and influential models of treatment in the state criminal justice systems are Stay'n Out (a New York program based upon the social organization of a major therapeutic community, Phoenix House, and adapted to the prison setting) and Cornerstone (a modified therapeutic community program for state prisoners in the last year prior to parole eligibility, located in Oregon State Hospital in Salem). Studies of Stay'n Out (Speckart and Anglin 1986) and Cornerstone (Field 1989) show that program participants were convicted significantly less often than comparable released prisoners (Institute of Medicine 1990, 177–80).

Outcome evaluation of prison-based programs also shows "reductions in criminal recidivism rates and that time in treatment is positively related to increased time until arrest" (Bureau of Prisons 1990). A note of caution is sounded by researchers who have studied far less intensive (Besteman 1990) or traditional (e.g., "boot camp" or "shock incarceration"; Parent 1989) prison treatment programs and have shown little long-term effect on behavior.

The results of mandatory treatment programs are not unequivocal, but they are encouraging. The best programs produced marked, enduring changes in drug use and arrest rates. Criminal justice clients are "hard cases," but even a modest rate of success yields substantial social benefits. The reduction in arrest records produces benefits that can only be fully understood in reference to expert opinion that, for every arrest, criminally inclined individuals have generally committed hundreds of crimes (Speckart and Anglin 1986).

Cost-benefit studies (Hubbard et al. 1989; Tabbush 1986) suggest

that every dollar spent on treatment will reap many more dollars because of reduced social costs stemming from fewer arrests, prosecutions, and incarcerations and because of reduced losses from theft and the economic benefits of an improved labor market and reduced medical costs (Institute of Medicine 1990, 102–4; Office of Technology Assessment 1990, 125–6). The Presidential Commission on the HIV Epidemic (1988) reported that the annual cost of keeping a person in prison is $14,500; as little as $3,000 is needed for drug treatment. The cost of treatment compares favorably with the estimated $50,000 lifetime cost of treating a person with AIDS (Fox 1990).

Compulsory treatment's demonstrated effectiveness may persuade even groups that are morally opposed to drug use to choose treatment over punitive measures. A mandatory treatment program could make a user's otherwise useless time in the criminal justice system productive. Because a clear nexus exists between duration and success, treatment in the criminal justice system could significantly increase the probability of positive outcomes. Despite the limits it places on personal autonomy, compulsory treatment promises a brighter future for drug-dependent persons than currently practiced punitive measures.

Mechanisms for Compulsory Treatment: A Proposal

The goals of compulsory treatment are to:

1. maximize the utility of treatment in order to reduce drug dependence and its associated criminal activity and dysfunctional behavior
2. reduce the costs of the criminal justice system
3. transfer resources to treatment programs

The mechanism of compulsory treatment best suited to meet these goals is a comprehensive pretrial diversion program. Linking compulsory treatment to the criminal justice system provides the best opportunity for identifying cases of individuals who are seriously drug dependent, criminally involved, and who could benefit from treatment. By emphasizing diversion before trial, the program would create an incentive to enter into treatment and avoid the inordinate costs of prosecution, trial,

and incarceration. At the same time, the ability of prosecutors to continue the criminal process if compliance is not forthcoming provides a tool for enforcement.

These proposals do not preclude "pure" civil commitment outside the criminal justice system, but such a position would significantly widen the net of compulsion and incur civil liberties concerns. The proposals also do not preclude treatment in prison or as a condition of probation or parole. These treatment programs are essential, but do not have the advantage of easing the pressure on the criminal justice system.

Devising an effective mechanism for compulsory treatment requires the accommodation of two diverse perspectives:

1. *Justice*. The program must provide fair standards and procedures for individuals and be consistent with constitutional standards already set in the comparable area of mental health confinement.
2. *Societal benefit*. The program must achieve the goals for compulsory treatment stated above, including protection of the public.

These two perspectives can be accommodated by incorporating the following elements into the diversion program.

Client Agreement

The libertarian value of "justice" requires that programs respect individual autonomy as much as possible. Full respect for autonomy in a compulsory program is impossible to achieve. The person's consent is offered within the context of a coercive criminal system. Yet entry into many well-regarded treatment programs has been subject to negotiation or multilateral agreement and performance expectations. In effect, a social contract is formed, which requires the client, the treatment program, and criminal justice authorities to fulfill their respective obligations (Institute of Medicine 1990, 184–5). Client agreement to enter the program therefore should be a requirement. Past experience suggests that many persons prefer the option of compulsory treatment to the punitive sanctions of the criminal justice system.

The fact that client agreement is sought does not render the program "voluntary." The fact that the alternative to "agreement" is a potentially severe prison sentence introduces a sure element of coercion into the program.

The Right to Procedural Due Process

Compulsory treatment restricts liberty; therefore, it must be subject to the rules of procedural due process. Courts, in the context of both mental health[52] and juvenile[53] confinement, have recognized that even though the ostensible goal of the confinement is labeled therapeutic or beneficent, the person is still deprived of liberty. The client therefore is constitutionally entitled to a hearing with many of the elements of a criminal trial: notice, a hearing by a court or tribunal, and the right to be present, to confront and cross-examine witnesses, and to appeal. The fact that the person is already being processed under the criminal justice system does not justify the denial of rigorous procedures.[54]

Drug Dependence and Susceptibility to Treatment

Compulsory treatment programs should give priority to those for whom treatment would provide the greatest benefit—to themselves and to society. Accordingly, eligibility criteria should focus on persons who are seriously dependent upon drugs and susceptible to treatment. Dependence is the most extreme pattern of drug consumption, defined as the persistent seeking and consumption of drugs in excessive amounts, despite high costs to health and social functioning (Institute of Medicine 1990, 5). Scarce treatment beds should not be allocated to casual or even regular drug users, but rather to those who are unable to control their drug use. The National Institute on Drug Abuse (1987) argues that because it is not possible to treat everyone identified as a drug user, it is necessary to examine drug abuse careers and choose persons with chronic and serious drug problems. Indeed, drug dependence may well be regarded as a constitutional prerequisite for confinement in the same way that "mental illness" is required for civil commitment (Perlin 1989, 48–9). It might be argued that this leaves casual users without treatment. Nothing in the proposal prevents casual users from seeking treatment voluntarily. It serves no public purpose, however, to compel treatment of all users, at public expense, unless the need for treatment and the probable success of treatment are clearly established.

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[52] *Lessard v. Schmidt*, 349 F. Supp. 1376 (E.D. Wis. 1974).
[53] *In re Gault*, 387 U.S. 1 (1967).
[54] *Baxtrom v. Herold*, 383 U.S. 107 (1966).

Dangerousness

Courts have concluded in mental health cases that the state's police powers can be exercised only where the person poses a significant danger based upon recent overt acts (Note 1977).[55] The police power cannot be invoked merely because the person is drug dependent or even because he or she is charged with an offense. Nor can the state rely on the statistical fact that some, even most, drug-dependent persons are criminally involved. The state must demonstrate that the specific individual has engaged in dangerous behavior.

The National Institute on Drug Abuse (1987) consensus meeting on compulsory treatment concluded that priority should be given to those who pose a serious public health danger, such as HIV-infected intravenous drug users or commercial sex workers who continue to share needles or have sexual intercourse.

Proportionality and Duration of Confinement

The Supreme Court in *Jackson v. Indiana* held, "At least, due process requires that the nature and duration of commitment bear some reasonable relation to the purpose for which the person is committed."[56] A person admitted for compulsory drug treatment should not be confined longer than necessary to reduce his dependence on drugs. Thus, the individual should have access to a periodic hearing, and should be released as soon as the criteria for the original admission are no longer met. The confinement, however, is not purely therapeutic but intertwined with the criminal process. To this end, the duration of confinement should be no longer than the person would have received had he or she been convicted of the offense. Once a person is released from drug treatment (whether because her dependence has been sufficiently ameliorated or because the maximum period of confinement is expired) the pending criminal charge should lapse. The time spent in drug treatment should be discounted from any criminal sentence in the event that she is tried and convicted on the original charge.

It could be argued that the public health goal served by treatment is not fully achieved if the drug user must be released from the program

[55] *Lessard v. Schmidt*, 349 F. Supp. 1978, 1093 (E.D. Wis. 1972).
[56] 406 U.S. 715, 738 (1972).

before he or she is ready. No doubt this is true, but a careful balance must be drawn for any policy between public health, public safety, and justice for the individual. Compulsory detention of individuals for a duration clearly disproportionate to the gravity of an offense needs a cogent justification, which goes beyond the carefully crafted proposal made in this article.

The Least Restrictive Alternative

Persons should receive compulsory treatment in the least restrictive setting necessary to serve the objective of client benefit and public safety. Thus, modern mandatory treatment programs should utilize the wide breadth of existing treatment modalities, ranging from inpatient drug-free to therapeutic communities and outpatient methadone maintenance and drug rehabilitation and counseling.

The Supreme Court developed the doctrine of the least restrictive alternative to prohibit the state from pursuing its goals by means that "broadly stifle fundamental personal liberties when the end can be more narrowly pursued."[57] The doctrine has been applied in mental health cases by placing the burden on the state to explore community-based alternatives to institutionalization.[58]

The Institute of Medicine (1990), Office of Technology Assessment (1990), and National Institute on Drug Abuse (1987) all urge the widest possible use of existing drug-treatment facilities in any compulsory program. Priority should be given to those facilities and modalities that have demonstrated successful outcomes through quality research.

The Right to Treatment

Persons who agree to enter compulsory treatment programs should have the right to receive high-quality, intensive treatment. In the 1970s, courts flirted with the idea that if the state had the power to detain a person for mental health treatment, then it had the constitutional obligation to provide minimally adequate treatment.[59] The Supreme Court

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[57] *Shelton v. Tucker*, 364 U.S. 479 (1960).

[58] *Lake v. Cameron*, 364 F.2d 657, 660 (D.C. Cir. 1966).

[59] *Wyatt v. Stickney*, 325 F. Supp. 781 (M.D. Ala. 1971), *aff'd sub nom, Wyatt v. Aderholt*, 503 f. 2d 1974; *New York State Ass'n for Retarded Children v. Rockefeller*, 357 F. Supp. 752 (E.D.N.Y. 1973).

never affirmed this doctrine, although it upheld a constitutional right of involuntary patients to adequate food, clothing, shelter, and medical care, as well as minimally adequate training to ensure safety and freedom from undue restraint.[60]

The legacy of compulsory treatment is that the state failed to provide adequate levels of service intensity, personnel quality and experience, and treatment capacity. The Institute of Medicine (1990, 230 et seq.) said that upgrading program performance, quality levels, and capacity should be the highest government priority in drug treatment. If individuals forgo their right to a criminal trial in exchange for the opportunity to enter treatment, then they should be entitled to minimally adequate levels of services appropriate to their needs. U.S. courts, of course, are reluctant to create treatment entitlements. The legislature could do so within compulsory drug-treatment statutes. Alternatively, federal or state governments could allocate adequate resources to ensure that program goals are met, benefitting both the individual and society through more enduring behavior change.

Conclusion

The idea of compulsory treatment is often roundly rejected by civil libertarians, government officials, and clinicians. However, their refusal to consider this idea is based largely on a misunderstanding of the goals of compulsory treatment and modern research findings. Civil libertarians are against any form of compulsion because they believe drug use is a voluntary behavior that, in itself, does not harm others. The proposal for compulsory treatment, to be sure, does not go as far as legalization. It does, however, respect a person's civil liberties more than the current punitive system. The compulsory treatment program proposed here would require the person's agreement, would not restrict freedom longer than if the person were convicted, and would allow a less restrictive, more humane and effective alternative to incarceration. The distinct advantage of pretrial diversion is that it avoids the substantial erosion of civil liberties inherent in the criminal justice system (Glasser 1990). Civil libertarians also fear that compulsory treatment would widen the net of compulsion, but a program devised as an alternative disposition to imprisonment should become attractive to civil libertarians.

[60] *Youngberg v. Romeo*, 451 U.S. 982 (1981).

Government officials, particularly those on the political right, reject pretrial diversion because they see it as a soft option for drug users, and because it will not adequately protect public safety. Whether pure retribution for the act of ingesting drugs is ever justified is a matter for debate, but one can argue that compulsory treatment does have a punitive component because the person is denied his liberty. A more important goal is public safety. Here, outcome studies suggest that, in the long run, the public is better protected by treatment than by incarceration.

The most telling argument against compulsory treatment is put forward by clinicians. They argue that it is inherently wrong to provide compulsory treatment to persons accused of crimes, while many thousands of drug users who are actively and voluntarily seeking treatment must cope with long waiting lists. This essay does not suggest that persons eligible to receive compulsory treatment should have priority over those in the voluntary system. Compulsory treatment should not replace treatment capacity available to other clients. Compulsory treatment offers an opportunity to shift some of the huge investment in the criminal justice system in order to expand the treatment system. The empirical evidence demonstrating the efficacy of treatment, the philosophical arguments explaining its humanity, and the economic studies showing its cost benefit all militate toward a fundamental reevaluation of current policies favoring criminal punishment over public health interventions in combatting the drug epidemic.

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Acknowledgments: The research assistance of Renée Solomon and Ann Gamertsfelder, and the technical assistance of San Juanita Rangel are gratefully acknowledged.

Address correspondence to: Lawrence O. Gostin, J.D., Office of the Executive Director, American Society of Law & Medicine, 765 Commonwealth Avenue, 16th floor, Boston, MA 02215.