

Involuntary Commitment for Substance Use Disorder: A Facade of Public Health

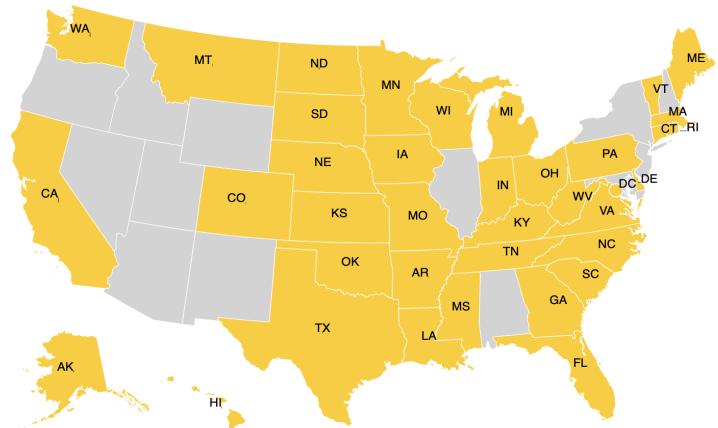
Key Points

- In recent years, statutes allowing involuntary commitment (IC) of individuals with a substance use disorder (SUD) have expanded in both number and scope, bringing the total to 37 states and the District of Columbia
- Although promoted as a “public health” response to the overdose crisis, IC is very problematic
- As implemented, IC programs are more characteristic of incarceration than treatment
- Involuntary commitment also raises grave ethical and legal concerns
- Empirical evidence suggests that IC for SUD is not an effective strategy for reducing addiction. Instead, it may reduce adherence to treatment and aggravate patients’ overdose risk upon re-entry
- States should instead focus resources on strategies that are both effective and ethical, such as voluntary treatment, medications for addiction treatment (MAT), harm reduction, and structural supports

Background

In the past two decades, over 800,000 individuals have died from a drug overdose and models predict that, without treatment expansion, another 400,000 people will die by 2025.¹ What originally began as a way to protect the community at large, a strategy adopted by [37 states and the District of Columbia](#) is to allow for the involuntary commitment of individuals with a substance use disorder. States differ in how often they utilize IC for SUD, with some states committing zero, some 1,000, and others 15,000 people per year.²

Source: [Health in Justice Action Lab](#)



Involuntary Commitment Is Carceral

Involuntary commitment is promoted as humane and as a means of avoiding the criminal justice system, but as actually implemented, IC programs operate like incarceration. Individuals are often processed like criminal defendants.³ Courts may issue warrants for the individuals’ arrest, and they may be brought to court in handcuffs --despite not being charged with a crime.⁴ In some facilities, patients are forced to wear traditional prison uniforms.⁵ Indeed, some IC programs are in jails, either under statutory policy or because there are not enough available public beds.⁶ Committed individuals describe the experience as “being ‘punitive,’ ‘degrading,’ and ‘humiliating,’”⁷ thereby removing any potential benefit of a “less carceral” system.⁸ The American Psychiatric Association takes the position that programs should be administered through health systems, rather than justice or correctional systems.⁹ Without substantial change, the criminalization of civil commitment cannot improve outcomes.¹⁰

Legal and Ethical Concerns

The carceral nature of involuntary commitment raises grave due process and ethical concerns. Because it is governed by civil rather than criminal law, the standard of proof for commitment criteria--(1) addiction to drugs or alcohol, (2) dangerousness to oneself or others, and (3) an inability to provide for one’s basic needs--is lower than the proof required in the criminal legal system.¹¹ Effective legal counsel is often not available to assist in challenging

commitment petitions. These petitions may be brought not just by healthcare providers but by many people uneducated in addiction medicine, from family members to police officers to, in some states, anyone.

IC also violates informed consent. The standards for the treatment of drug use disorders established by the World Health Organization and United Nations Office on Drugs and Crime clearly state that treatment “should not be forced or against the will and autonomy of the patient.”¹² Individuals who are civilly committed are not given an opportunity to fully contemplate and agree to such treatment.

Involuntary Commitment Is Ineffective at Treating Addiction

The majority of studies evaluating compulsory treatment did not find them to be more effective at reducing future drug use or crime than equivalent voluntary programs; some studies actually indicated potential negative effects.¹³

There are several reasons for their ineffectiveness:

1. For most people suffering with SUD, the coerciveness of IC impedes their internal motivation to pursue recovery.¹⁴
2. No states require IC settings to deliver evidence-based addiction treatment.¹⁵ In those that do not, by refusing to offer FDA-approved medications for MAT--the standard of care for treating opioid use disorder¹⁶--and only providing withdrawal management and/or mutual aid approaches, research predicts a failure rate 80 to 90%.^{17, 18}
3. Overdose rates are extremely high following discharge from IC contexts because tolerance to opioids falls rapidly, but cravings do not (unless individuals are prescribed and provided with MAT).¹⁹

Proposed Policy Solutions

There are many proven solutions that have far greater effectiveness at reducing addiction and overdose than involuntary commitment when adequately funded and bolstered. The fact that involuntary commitment is often the most accessible and streamlined option for a family seeking help for a loved one with a substance use disorder demonstrates the need to greatly expand effective programs. Resources should be increased and legal hurdles decreased in order to build out strategies such as:

- Expand effective voluntary programs;
- Expand harm reduction programs to “meet people where they are at” for more effective interventions;
- Invest in peer recovery coaches and treatment navigators;
- Provide resources to guide families supporting a loved one with SUD;
- Increase on-demand services in times of crisis;
- Create meaningful access to medications for addiction treatment such as methadone and buprenorphine.

Given its general ineffectiveness and ethical concerns, we recommend eliminating IC for SUD. If not eliminated, IC programs require significant overhaul to reduce their harms:

- Programs must be required to meet the established, evidence-based standard of addiction care;
- FDA-approved medications for opioid use disorder must be available to all patients;
- Treatment must take place in a healthcare setting and never a correctional environment;
- Limit who can petition to those educated in addiction medicine;
- Time spent in an IC setting should be as brief as possible.

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