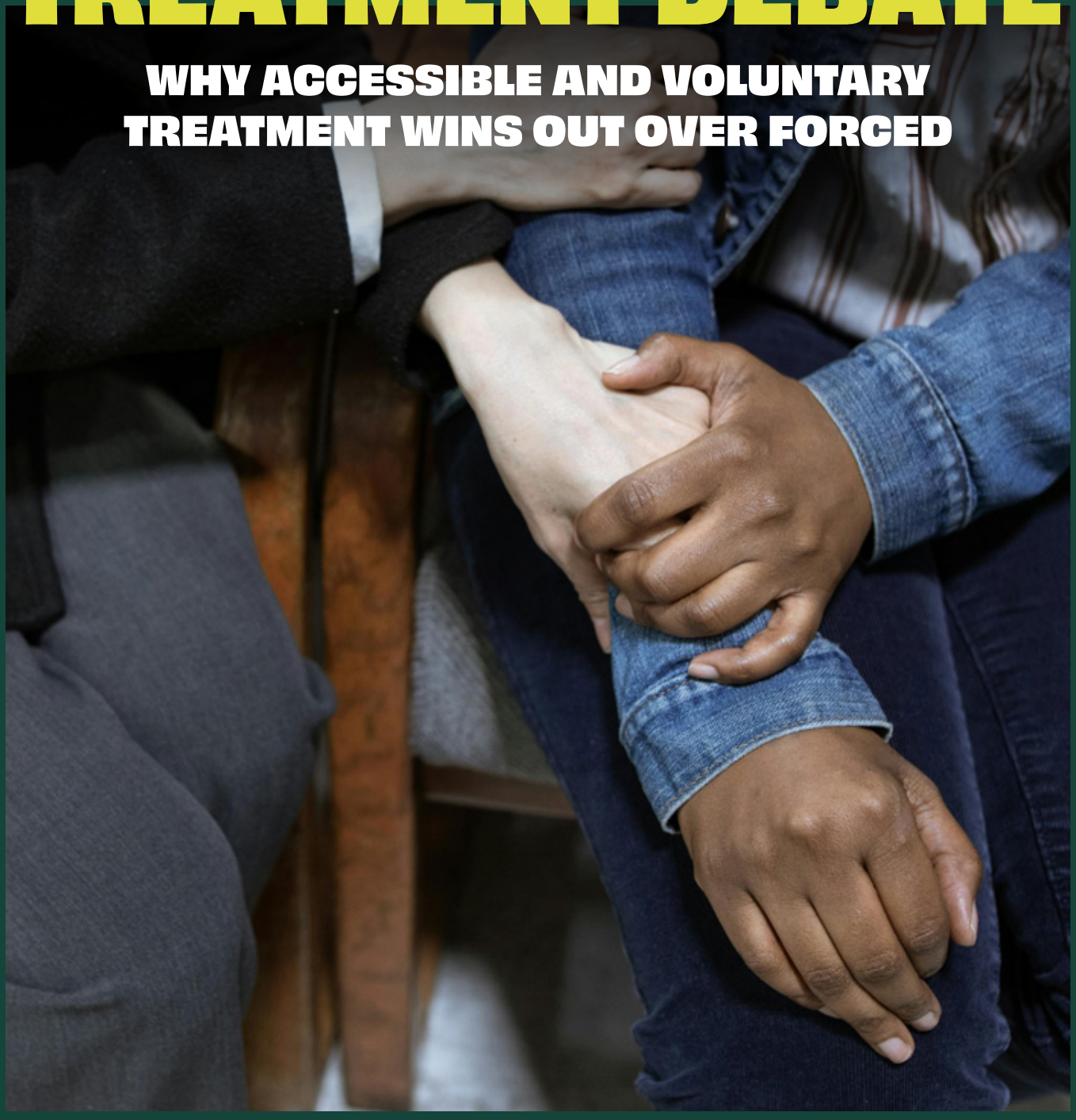
THE DRUG TREATMENT DEBATE

WHY ACCESSIBLE AND VOLUNTARY TREATMENT WINS OUT OVER FORCED



DRUG POLICY ALLIANCE.

THE DRUG TREATMENT DEBATE

WHY ACCESSIBLE AND VOLUNTARY TREATMENT WINS OUT OVER FORCED

SEPTEMBER 2024

DRUG POLICY ALLIANCE.

TABLE OF CONTENTS

EXECUTIVE SUMMARY

We all want people living with addiction to get the help they need. At the Drug Policy Alliance, we believe that everyone should have access to the substance use disorder (SUD) supports that they choose to improve their physical and mental health — and that effective services should be available when and where people are ready for them, without hurdles like cost or preconditions to get help. In short, SUD supports should be voluntary, effective, affordable, accessible, and appealing.

Unfortunately, the United States has neither prioritized on-demand care nor ensured that available SUD supports are effective or beneficial. Having failed to provide even remotely sufficient access to the kinds of health-centered approaches that research shows are most effective (e.g., medications for opioid use disorder, or MOUD, and contingency management for stimulant use disorder, or CM), some ill-informed policymakers are advocating for expanding the power of courts to force people into existing SUD services, against their will and not of their choosing.

This is not entirely new. Forced treatment has been a familiar practice in criminal courts for decades — where criminal defendants have had the "choice" to opt for court-ordered SUD services or face traditional sentencing, often including incarceration.

FORCED TREATMENT HAS PRODUCED:

- Doubling down on a punitive approach to drug use, while failing to provide meaningful SUD treatment or improved personal or systemic outcomes.
- Increased low-level drug arrests by law enforcement who expect that people arrested will be sent to a new drug court in their jurisdiction, when, in reality, only a tiny fraction of people arrested for an eligible offense will actually enter a small local drug court.
- Increased racial disparities in low-level drug arrest incarceration, because people of color are generally less likely than white people to be offered participation in a local drug court.
- Increased incarceration of people in the drug court program, where participants may actually serve more time behind bars than if they had accepted traditional sentencing in the first place — due to drug courts' widespread use of incarceration for failing a drug test, missing an appointment, or being a "knucklehead."
- Drug courts' tendency to "cherry pick" participants; those likely to have the best outcomes are those who do not have SUD but who may be recreational consumers.

Despite the robust evidence against court-mandated treatment, states are increasingly expanding forced SUD services through courts outside the criminal system, a procedure called "involuntary commitment". In this process, the individual is not accused of a crime. Instead, a third

party asks the court to find the individual to be a danger to themselves (e.g., because they might die of an overdose) and to order their participation in SUD services of the court's choosing.

For some, support for forced treatment may be founded in a disdain for people who use drugs. For others, it comes from a place of compassion and, often, sheer desperation. Regardless of intention, commitment for SUD is a tool of control — and threatens to do much more harm than good. As this report shows, it already has. More of the same will only compound the harm done. This is especially true given the likelihood that forced service programs will be poorly designed, badly implemented, and/or underfunded — as has been the case in mental health commitment.

This report challenges the erroneous belief that forcing individuals to participate in externally-imposed SUD services is an acceptable or beneficial response to substance use. Fortunately, ethical and effective alternativesare available.

Substance use disorder supports should be voluntary, effective, affordable, accessible, and appealing. This means that SUD services must:

- Reduce cost, increase the number/variety of providers, improve programmatic flexibility, reduce stigma, and create individualized approaches.
- Be made available on demand; when people need and want them people are more likely to make change when they are motivated.
- Be based on the best available evidence, constantly monitored, and evaluated.
- Address the whole person and their needs, and be integrated with health and social services.
- Be culturally sensitive and responsive to the needs of specific populations.
- Be provided by trained and credentialed health professionals.
- Ensure that people involved in the criminal legal system have access to the full range of SUD service options available in the community.

Making quality, on-demand services available to people with SUD will require significant public investments in a full range of health-centered supports, including harm reduction[i] approaches. It will also require substantial stigma-busting efforts targeting everyone, including people with SUD themselves, their families, healthcare professionals entrusted to provide services, and elected representatives at all levels of government. Ending stigma also means expanding our shared understanding of "recovery" so that each person is free to define it for themselves, whether that definition includes complete abstinence from drug use or not.

We deserve a world where people struggling with addiction can get quality care quickly and compassionately.

Forced treatment will not accomplish this.

But, together, we can advocate for the urgently-needed range of voluntary, effective, affordable, accessible, and appealing SUD service options that can empower people to make decisions about their own care.

INTRODUCTION

PEOPLE WHO USE DRUGS DESERVE ACCESS TO VOLUNTARY, EFFECTIVE, AFFORDABLE, ACCESSIBLE, AND APPEALING SUBSTANCE USE DISORDER (SUD) SUPPORTS THEY CHOOSE THAT CAN IMPROVE THEIR PHYSICAL AND MENTAL HEALTH.

SUD supports can be a critical service for people struggling with addiction, helping to reduce the harm of problematic drug use or offering a path towards sobriety. However, it is important to note that most people who use alcohol or other substances do not need or want treatment.[2]

For those interested in receiving SUD services, the Drug Policy Alliance is dedicated to ensuring access to effective supports based on evidence, health, equity, and human rights. To be effective, SUD supports must be voluntary, effective, affordable, accessible, and appealing to the people who need them. They must never be forced.

However, there exists a belief by some that SUD supports should be forced in certain circumstances. Sometimes it is out of a desire to control people who use drugs. Other times, it is out of desperation to help someone and keep them alive.

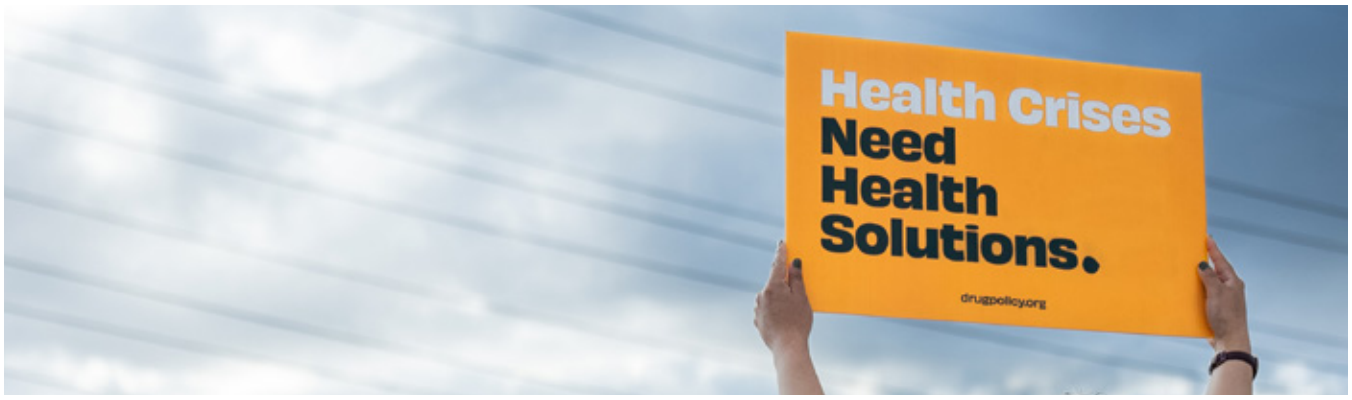
But the evidence is clear: forced treatment is harmful and ineffective. It can lead to undesirable health outcomes, including a substantially-increased risk of overdose death. In countries where forced treatment is common, research consistently shows higher rates of relapse (compared to voluntary community-based treatment services), avoidance of healthcare in response to stigma and shame, higher rates of infectious disease and bloodborne virus transmission, and inadequate medication and staffing.

COERCION TAKES MANY FORMS:

- The family regulation system[3] requiring treatment to maintain or regain child custody
- A criminal court ordering participation in SUD services under the threat of incarceration
- A civil court detaining a person against their will and ordering them to participate in SUD services not of their choosing

The criminal legal system has long been used to coerce people accused of a crime, often low-level drug possession, into court-selected SUD services of questionable quality.

Notwithstanding some much-touted anecdotal success stories, the proliferation of court-mandated treatment has done tremendous, well-documented harm on both individual and systemic levels.[4] Nonetheless, states are increasingly expanding legal authority to force people into SUD services through a strategy called "involuntary commitment."[5]



INVOLUNTARY COMMITMENT (ALSO CALLED "CIVIL COMMITMENT") LEGALLY EMPOWERS OTHERS — TYPICALLY MEDICAL PROVIDERS, FAMILIES AND/OR LAW ENFORCEMENT OFFICERS — TO PETITION A COURT TO FORCIBLY DETAIN AN INDIVIDUAL WHO USES DRUGS OR ALCOHOL ABSENT ANY CRIMINAL CHARGE.[6]

Between 2015 and 2018 alone, states passed 25 laws addressing involuntary SUD commitment — more than triple the number passed over the previous decade.[7] As of 2018, at least 38 states had adopted statutes enabling involuntary SUD commitment, and thousands of people are detained under these statutes annually.[8] The period of commitment varies substantially by state, ranging from three days in Michigan to two years in West Virginia.[9] In many states, committed persons are routinely confined in jails or jail-like settings — with poor treatment options, or none at all.[10]

Despite anecdotal success stories, research does not support involuntary commitment for SUD.[11] As Dr. Nora Volkow, director of the National Institute on Drug Abuse, stated in 2022,

> **"The data does not show that it's beneficial to put someone in jail or prison or force them against their will to go to treatment. There are absolutely instances where people may have had a positive outcome. But it's the minority." [12]**

In one particularly alarming finding, commitment of people with opioid use disorder (OUD) dramatically increases their chances of dying from opioid overdose after their release from confinement.[13]

> The reality is that there are very real problems to solve — including a woeful lack of access to effective SUD services and a worsening overdose crisis — *and forced treatment is not the answer.*

It is understandable that families that support involuntary commitment want to do something — *anything* — to save the lives of their loved ones. But policymakers who sell struggling families on involuntary commitment are doing them a disservice and may be putting those families' loved ones in danger.

Real, effective solutions to substance use disorder and overdose mortality must include creating more SUD services that are voluntary, effective, affordable, accessible, and appealing, as well as rooting out the stigma that has so thoroughly saturated existing SUD services.

THE ARGUMENTS AGAINST FORCED TREATMENT

THE ARGUMENTS AGAINST FORCED TREATMENT
THE ARGUMENTS AGAINST FORCED TREATMENT
THE ARGUMENTS AGAINST FORCED TREATMENT
THE ARGUMENTS AGAINST FORCED TREATMENT
THE ARGUMENTS AGAINST FORCED TREATMENT
THE ARGUMENTS AGAINST FORCED TREATMENT

THE ARGUMENTS AGAINST FORCED TREATMENT

Forced treatment advocates may genuinely want to help people with substance use disorder (SUD) and hope that imposing court-ordered services will improve their lives and the lives of those around them.

Unfortunately, compelling people into SUD services not of their choosing, whether through criminal or civil courts, does not achieve this laudable aim. In many ways, it does the opposite.

THE ARGUMENT AGAINST FORCED TREATMENT HAS FIVE MAIN PARTS:

1. **It is deadly, increasing overdose risk.**
2. **It is often harmful in other ways even when it doesn't kill.**
3. **It amounts to a rebranding of criminal incarceration.**
4. **It is not supported by research.**
5. **It is fundamentally unethical.**

FORCED TREATMENT IS DEADLY, INCREASING OVERDOSE RISK.

The risk of dying after discharge from compulsory SUD treatment is high.[14] People with opioid use disorder (OUD) are especially at-risk following commitment.[15] Even if civil commitment may succeed in providing short-term protection from overdose, it worsens outcomes post-commitment.[16] People, especially those who use opioids, are very susceptible to overdose after release. [17] Even short periods of detention contribute to increased overdose risk upon release, as a person loses tolerance during periods of abstinence during commitment. Additionally, while detained, a person is unlikely to have access to the most effective treatment, medications for opioid use disorder (MOUD), specifically, the opioid antagonists methadone and buprenorphine. This gold-standard approach[18], also called medication-assisted treatment (MAT), is available to only a small minority of individuals during SUD commitment.[19]

SO FAR, NO STATES REQUIRE INVOLUNTARY COMMITMENT PROGRAMS TO PROVIDE MOUD FOR OPIOID USE DISORDER, ALTHOUGH IT IS THE MOST EFFECTIVE TREATMENT AVAILABLE AND HAS THE STRONGEST EVIDENCE BASE.[20]

As mentioned, recently-released individuals have reduced tolerance for opioids, increasing their risk of overdose.

Previous systems have failed to engage people in community-based supports following exit from commitment.[21] In the case of involuntary commitment for SUD, this means that people are unlikely to be meaningfully connected to effective treatments within their communities following release, including to life-saving naloxone, which reverses opioid overdose. In Massachusetts, for example, a whopping one-third of people who are civilly committed for OUD relapse the same day they are released.[22] Post-release opioid-related overdose mortality is also the leading cause of death among people released from jails or prisons.[23] Far from reducing drug-related harms, increasing reliance on incarceration has coincided with rising deaths from overdose, as well as suicide and infectious disease, over the last three decades.[24]

1 IN 3

1 in 3 people in Massachusets who are civilly committed for OUD relapse **the same day they are released.**[22]

RESEARCH SHOWS DEFINITIVELY THAT DETENTION LEADS TO INCREASED RISK OF OPIOID OVERDOSE DEATH.

A recent review of 45 studies that linked incarceration records with overdose deaths found that:

- At two weeks after release, opioid overdose deaths were 27 times higher than expected in the general population.
- At three to four weeks post-release, overdose deaths were 10 times higher than expected.
- At one year after release, they were 15 times higher than expected.
- And, at any time after release, overdose deaths were almost seven times higher than expected.[25]

One striking study on incarcerated people detained without reliable access to MOUD — similar to people who have been involuntarily committed for OUD — found that they have a 43-fold greater risk of dying from an overdose for three months following their release compared to the general population.[26]

DRUG COURTS DO NOT PREVENT DRUG-RELATED MORTALITY EITHER.

In specialized criminal courts that are supposed to connect defendants with SUD treatment, participation is legally considered a choice for defendants who otherwise face traditional sentencing, which might include a lengthy period of incarceration.[27] Though these programs vary tremendously from courtroom to courtroom, they have generally produced problematic outcomes both on the individual and systemic levels. Given that the current overdose crisis is overwhelmingly related to opioid use, it is significantly noteworthy that opioid users have shown the least success in these criminal court-mandated treatment programs, compared to consumers of other illicit substances.

An Indiana study found that **people who use opioids were 80% less likely to complete drug court programs** than others, probably because the programs did not offer MOUD, the highest-quality treatment for OUD.[28]

A Massachusetts study found that **one-third of drug court participants with OUD relapsed on the day of program completion,** and 50% by two months after completion.[29]

A Baltimore study found that **20% of people who successfully completed a drug court program died from a drug-related cause within 15 years after completing in the program** — no lower than criminal defendants with SUD who did not go through a drug court.[30]

FORCED TREATMENT IS OFTEN HARMFUL IN OTHER WAYS, EVEN WHEN IT DOESN'T KILL.

Beyond increasing risk of death, forced treatment causes individuals harm in a multitude of other ways. Forced treatment perpetuates systemic racism, disrupts lives, fosters alienation from intended support services, compounds the vulnerability of individuals with substance use disorders, and leaves those detained powerless in the face of potentially harmful treatments. These unsettling facets of forced treatment emphasize the need for a compassionate and equitable approach to SUD services that respects individual autonomy and dignity.

FORCED TREATMENT REINFORCES SYSTEMIC RACISM.

People of color, particularly Black people, are especially impacted by civil commitment.[31] For instance, Black people are overrepresented in involuntary commitment. One reason for this is that they are especially unlikely to receive treatment for opioid use disorder in the community.[32] Racial disparities in access to OUD treatment is a long-standing public health issue.[33] This is due, at least in part, to the fact that a Black person with SUD is more likely to be treated as a "criminal" rather than as a "patient" by *healthcare personnel.*[34]

Racially disparate rates of civil commitment fit a pattern of government systems focusing on controlling — rather than supporting — communities of color. It is likely that racial disparities in involuntary commitment mirror those in the criminal legal system, where disparate outcomes exist at every stage.[35] Rather than turning to involuntary commitment, policymakers should address the many removable barriers to SUD services in the community, including disparate access across racial/ethnic groups. Access to services that people are willing and able to accept voluntarily, including culturally specific services, should be the policy priority.[36]

FORCED TREATMENT TEARS PEOPLE AWAY FROM THEIR SUPPORT SYSTEMS.

When detained, people are often separated from the essential services they rely on to maintain their health and well-being.[37] Access to regular medical check-ups, addiction services, and mental health services becomes severely limited, exacerbating existing health issues and potentially leading to the development of new ones. Whether held through the criminal or civil system, confined people lose any stability they may have had, from housing, to employment, to health insurance. Detained individuals also lose contact with friends, family members, and community organizations that may have been their primary sources of support. Isolation deepens a sense of alienation and despair, and worsens outcomes.[38]

In a diary that he kept while involuntarily committed for SUD in Massachusetts, Jesse Harvey, who sadly died of an overdose following his release, wrote:

> "I can't believe how powerless I am here.
>
> They have sufficiently beaten me down into dirt.
>
> All I feel is worthless.
>
> All I see is metal bars.
>
> All I hear is lies and dogma and broken promises. ...
>
> The power differential that is inherent in a situation like this is glaring and dangerous.
>
> They are taking away the supports they say you need." [39]

FORCED TREATMENT CAN REQUIRE HEALTH PROVIDERS TO REPORT CLIENT INFORMATION, ERODING TRUST BETWEEN PROVIDER AND CLIENT.

Court orders give government actors power over those who are committed, undermining the therapeutic relationship between health providers and participants. In legally-forced treatment, health providers become an arm of the legal system and may be required to report treatment progress and outcomes, including results of drug tests, to the legal system. People who rightfully feel violated when private health information is shared with courts or law enforcement, are unlikely to be fully transparent with their service provider. Where people feel stigmatized and mistreated, they are also less likely to seek support in the future.[40] In fact, people report that the way services are delivered is more important than the type of services provided.[41]

> **"Involuntary civil commitment is the opposite of treatment. In a therapeutic relationship, patients have autonomy and must provide informed consent prior to commencing any treatment or procedure. In a coercive setting such as involuntary civil commitment, patients have no autonomy to affirmatively choose treatment."**
>
> *- Michael Sinha, associate professor at the Center for Health Law Studies at Saint Louis University School of Law*

PEOPLE WITH SUD ARE OFTEN VULNERABLE AND TRAUMATIZED, WHICH DETENTION CAN WORSEN.

Research suggests that most people who develop SUD have other mental health diagnoses, traumatic childhoods, or both; just 7% report no history of mental illness.[43]

One peer-reviewed study found that almost 75% of women who described using heroin problematically were sexually abused as children.[44] Unfortunately, as reported by the federal Substance Abuse and Mental Health Services Administration, seclusion and restraint are still used in inpatient commitment settings.[45] This can be highly traumatic for anyone, but especially for patients who have experienced sexual assault or other violence in the past.[46]

DETAINED PEOPLE HAVE NO POWER TO REJECT SO-CALLED TREATMENTS THAT MAY BE HARMFUL.

The lengthy and well-documented history of mental health "treatments" is a chilling reminder of what happens when experts, confident they know better than their patients, make treatment decisions for those patients. As Andrew Scull, professor of sociology and science studies at University of California at San Diego and an expert on the history of mental illness, succinctly lays out:

> "It is true many treatments added to the suffering of the mentally ill.
>
> Compulsory sterilization; removal of teeth, tonsils and internal organs to eliminate the infections that were allegedly poisoning their brains;
>
> inducing life-threatening comas with injections of insulin;
>
> subjecting them to multiple episodes of electroshock treatments day after day till they were dazed, incontinent, and unable to walk or feed themselves;
>
> damaging the frontal lobes of the brain, either with an instrument resembling a butter-knife or by using a hammer to insert an icepick through the eye socket and sever brain tissue:
>
> these were unambiguously, horrendous interventions." [47]

Similarly uninformed and harmful approaches have also been used as so-called cures for addiction.[48]

THESE SO-CALLED ADDICTION TREATMENTS HAVE BEEN REJECTED BY SCIENTIFIC AND HEALTH RESEARCHERS:

MORAL AND RELIGIOUS APPROACHES:
Assuming that addiction is a moral failing, strict religious or moral re-education can be used to instill discipline and self-control.

FORCED COLD-TURKEY DETOXIFICATION:
Rapid detoxification, where individuals were abruptly withdrawn from addictive substances, was once common but is now understood to be an unsafe and unethical approach.

ELECTROCONVULSIVE THERAPY (ECT):
In the mid-20th century, ECT was sometimes used as a treatment for addiction, particularly for alcoholism.

AVERSION THERAPY:
This controversial approach involved pairing drug use with unpleasant stimuli — such as electric shocks or medications that induce vomiting — to create a negative association.

EXCESSIVE USE OF ANTABUSE:
Antabuse (disulfiram) can cause nausea, vomiting, and other adverse reactions when alcohol is consumed. While it can be effective medication for some with alcohol use disorder, the medication has been overused, often without patient consent.

WORK THERAPY:
Motivated by either a belief that labor is healing, or because it is profitable, some so-called treatment providers offer only unpaid or minimally paid labor.[49]

The above "treatments" have all been discredited. Experts today recognize addiction as a complex medical condition rather than a moral failing.

AND MODERN RESEARCH IS CLEAR:

PEOPLE NEED EFFECTIVE TREATMENT AND SUPPORT, NOT PUNISHMENT OR ABUSE.

FORCED TREATMENT IS CRIMINALIZATION REBRANDED.

Criminalization is a failed response to substance use, not an approach we should be expanding.[50]

Forced treatment is the same punitive approach as criminalization, repackaged as benevolent and for the good of people who use drugs. But involuntary commitment relies on criminalization's same tactics of detention and forced compliance.

Committed people are confined, cut off from loved ones, employment (often their source of health insurance), healthcare, and supportive services, and may be subjected to so-called treatments that ignore evidence-based practices.[51] Criminalization, including forced treatment, has failed to reduce drug use, supply, or demand.[52]

INVOLUNTARY COMMITMENT IS HEAVILY INTERTWINED WITH CRIMINAL DETENTION SYSTEMS.

Despite being generally understood as distinct from incarceration, civil commitment is often nearly indistinguishable from incarceration for a criminal conviction. Whether a person is criminally sentenced to incarceration or is civilly committed for SUD, they lose all freedom while locked up. Facilities holding people committed for SUD are often housed on the grounds of jail complexes, providing incarceration by another name. Tens of thousands of people across the country have been forced into jails or jail-like conditions, where they must endure treatment of questionable value.[53] In Massachusetts, which has among the most civil commitments for SUD in the country, the Department of Correction runs the state's largest SUD program.[54] In other states, people committed to SUD services wind up held in jails while waiting for an available treatment slot in the overcrowded, underfunded treatment systems.[55]

> **"There is an increasing recognition that incarceration may not be the appropriate response to addiction, but at the same time, the rapid growth of civil commitment laws and programs is an indicator that we're not moving away from negative, coercive programs—we're just rebranding them."**
>
> *– Leo Beletsky, professor of law & health sciences at Northeastern University*[56]

INVOLUNTARILY COMMITTED PEOPLE ARE TREATED LIKE CRIMINALS.

Individuals who have been civilly committed are routinely handcuffed or restrained during courtroom proceedings, provided little medical attention for withdrawal symptoms, and housed with prisoners.[57] While some people may find some benefit during their civil commitment, others find that they have no access to treatment at all — or that the so-called treatment is actually harmful.[58]

Treating people with SUD as criminals perpetuates stigma by falsely equating addiction with criminality. This might help explain why people who have been committed are *less likely to abstain from opioids* following their release than those who were never committed.[59]

People in need of help should be able to get it.

As shown below, too often, forced "treatment" looks and feels like prison or jail. Some of these "treatment" facilities are prison-like environments where healing is impossible.

FORCED "TREATMENT"

Robin Lubbock for WBUR

INCARCERATION

Meredith Nierman for WGBH

Jesse Costa for WBUR

MetroWest Daily News

Kayana Szymczak for the Intercept

Jesse Dearing for the Boston Global via Getty Images

FORCED TREATMENT IS NOT EVIDENCE-BASED.

Given all the problems identified in the previous sections of this report, it is unsurprising to find that the research on forced treatment is, to be generous, inconclusive — in contrast to other treatment approaches that have shown clear and substantial positive benefit. A commission appointed by Massachusetts Gov. Charlie Baker charitably reported in 2019: "There is limited quality, peer-reviewed research on the efficacy of involuntary treatment for alcohol and substance use disorders."[60] A 2022 review of the research found that "civil commitment may be associated with long-term harms, including a heightened risk of severe withdrawal, relapse and opioid-involved mortality."[61]

> **"Evidence does not, overall, suggest improved outcomes related to compulsory treatment approaches, with some studies suggesting potential harms. Given the potential for human rights abuses within compulsory treatment settings, non-compulsory treatment modalities should be prioritized by policymakers seeking to reduce drug-related harms."**
>
> *- Excerpt from a systematic review of compulsory drug treatment*[62]

LEGALLY-MANDATED TREATMENT DOES NOT IMPROVE OUTCOMES.

In countries where compulsory treatment is common, research consistently shows: higher rates of relapse compared to voluntary community-based treatment services, avoidance of healthcare in response to stigma and shame, higher rates of infectious disease and bloodborne virus transmission, and inadequate medication and staffing.[63] Research on court-ordered treatment in the U.S., too, suggests no improved outcomes over voluntary engagement, and some studies suggest potential harms.[64]

In a 2005 review of thirty years' worth of research into compulsory SUD treatment, the authors found a "mixed, inconsistent, and inconclusive pattern of results" that called into question "the evidence-based claims made by numerous researchers that compulsory treatment is effective in the rehabilitation of substance users." [65]

Of the 9 studies included in a 2016 systematic review of compulsory SUD services:

- **5 found no significant reductions in drug use or crime among people who underwent required treatment.**
- **2 studies found that compulsory services actually had negative impacts on those same measures.**
- **Only 2 studies found a small benefit in short-term recovery.[66]**

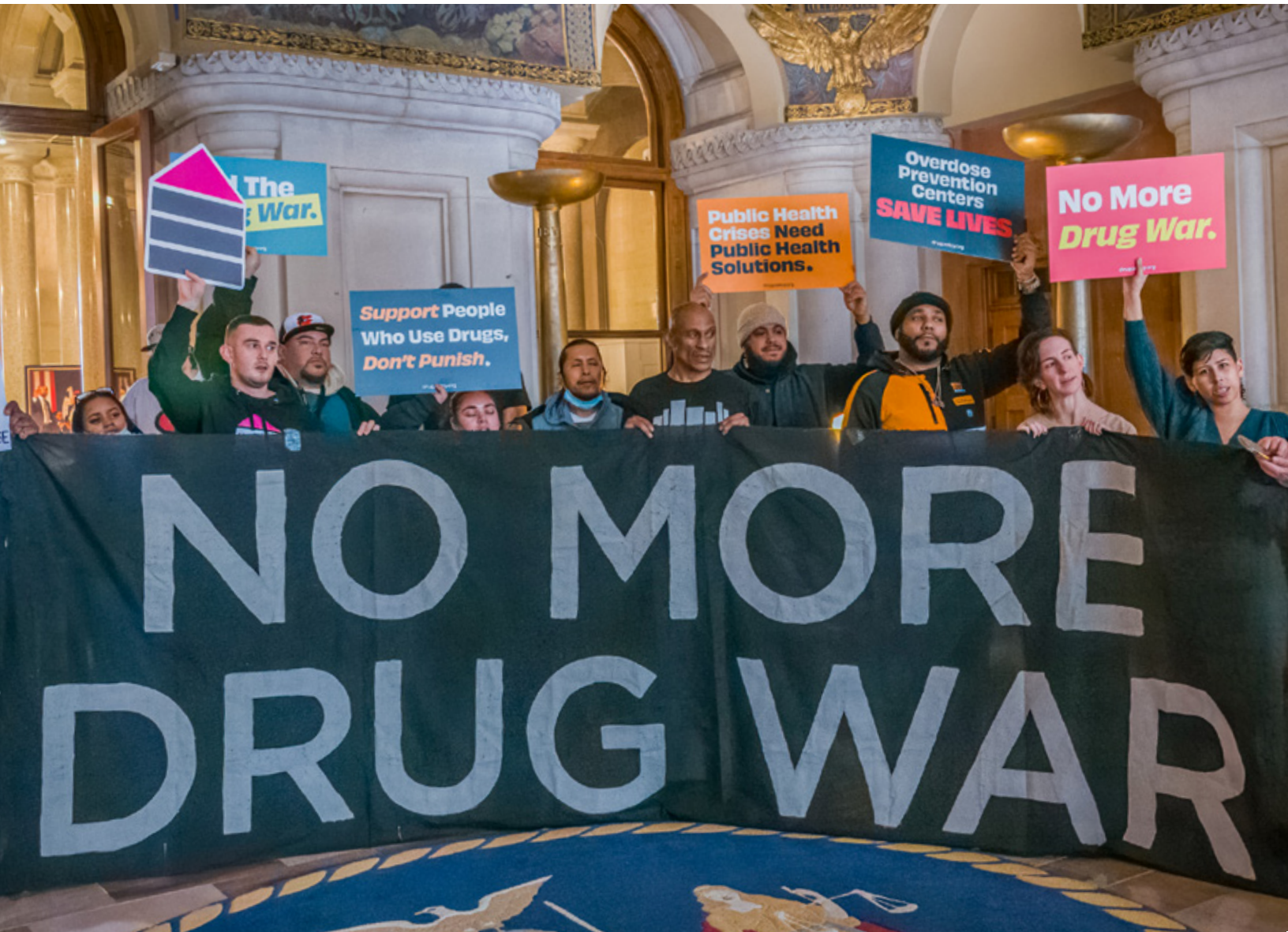
But, as noted above, outcomes immediately post-release as well as over the long term are often worse.

THERE ARE BETTER, PROVEN APPROACHES TO ADDICTION TREATMENT.

The findings on compulsory SUD services represent a poor showing in contrast to the consistent, substantial research that shows immense positive impact from voluntary MOUD, which can reduce mortality by more than 50%.[67] While there are currently no medications shown to address stimulant use disorders, contingency management (CM) — which consists of behavioral health interventions that positively reinforce desired outcomes — is a proven non-medication approach.[68]

SUPPORTERS OF FORCED TREATMENT APPEAR UNINTERESTED IN EXISTING OR FUTURE RESEARCH.

In their design and implementation of involuntary SUD commitment systems, most states do not bother to collect data or otherwise track civil commitment for SUD. When states do collect data, many keep it secret. Of 20 states that claim to consistently apply involuntary commitment statutes for SUD, only seven reported utilization data.[69] That is, we do not even know the number of people who have been civilly committed for SUD — let alone what kinds of environments and treatments they are subjected to or their collective outcomes.[70] This is unacceptable given the high stakes of involuntary commitment, including the infringement on people's autonomy and the known risks of forced treatment.



FORCED TREATMENT IS UNETHICAL.

Forcing people who use substances into SUD services by court-order flies in the face of public health principles because it strips individuals of agency over their own bodies and lives.[71] It encourages resistance, rather than cooperation, from the manipulated party (those forced into treatment). People who use drugs can and should control their own treatment decisions, including choosing not to receive it.

ADDICTION DOES NOT ELIMINATE ONE'S RIGHT TO, OR ABILITY FOR, SELF-DETERMINATION.

While addiction is characterized by compulsive and relapsing drug use, addiction also involves voluntary, intentional behavior that is motivated by the decision-making processes of people who use drugs.[72] That is, people with SUD may not feel totally free to make choices, but they have also not totally lost their ability to resist impulses. [73]

They can delay drug use when in police presence, for example. And they can choose another incentive over drug consumption, as shown in CM, a highly effective treatment for stimulant use disorder.[74] In CM, participants are incentivized, often by gift cards, to reduce consumption of substances (e.g., as evidenced by a drug-free urinalysis). All of this suggests that people with SUD can make choices for themselves, and in many cases have simply not had access to effective services that are appealing to them.

LEGAL PROCESSES FAIL TO PROTECT INDIVIDUALS FACING COMMITMENT.

Despite claims that civil commitment procedures protect the rights of the committed, there are reasons to be skeptical. For example, only four states require the court's commitment decision to reflect the results of an assessment of an individual's eligibility and appropriateness for SUD commitment.[75] That is, courts are generally not barred from subjecting non-problematic drug users to civil commitment and forced SUD services. Courts have previously been known to run roughshod over procedures intended to protect the rights of the committed. In the psychiatric system in California, for example, one practitioner estimated that the average court hearing for committing a person to a psychiatric institution lasted just five minutes.[76]

Even those empowered in court process to protect the rights of the committed acknowledge putting their own beliefs above the law: One peer-reviewed study found that 19 out of 33 court clinicians in Massachusetts who evaluated people for substance use disorders admitted to recommending that an individual be committed *even though they did not meet the statutory criteria for it.* [77] These practitioners based at least some recommendations not on the law and the legal rights of the person facing commitment, but on their own gut feelings which could very well be influenced by the stigma around both drug use and people who use drugs — as well as other personal biases, including racism.

NON-HEALTHCARE PROFESSIONALS ARE MAKING UNINFORMED MEDICAL DECISIONS.

Despite what may be extensive exposure to people with SUD, court officials are rarely trained in or aware of the research or best practices in SUD services. Those in a position to petition for another person's civil commitment — such as medical providers, families and/or law enforcement officers — may be similarly inadequately informed. Researchers have found that the evidence of long-term harms associated with civil commitment for SUD "is not well-known to either courts or petitioners." [78] In fact, some hold quite simplistic views of SUD and recovery.

According to Dr. David Fiellin, an addiction physician at the Yale School of Medicine, "There's often a misunderstanding of what treatment actually looks like and what it is — people often look to a quick fix. Effective treatment tends to be much more long term." [79] Courts may also fail to appreciate the limitations of the civil commitment system's design, implementation, or funding, as has been documented in mental health commitment systems. [80]

EFFECTIVE, AFFORDABLE,
ACCESSIBLE, AND
APPEALING SUBSTANCE
USE DISORDER SUPPORTS

PRIORITIZE INCREASING ACCESS TO VOLUNTARY, EFFECTIVE, AFFORDABLE, ACCESSIBLE, AND APPEALING SUBSTANCE USE DISORDER SUPPORTS

PRIORITIZE INCREASING
ACCESS TO VOLUNTARY,
EFFECTIVE, AFFORDABLE,
ACCESSIBLE, AND
APPEALING SUBSTANCE
USE DISORDER SUPPORTS
PRIORITIZE INCREASING
ACCESS TO VOLUNTARY,
EFFECTIVE, AFFORDABLE,
ACCESSIBLE, AND
APPEALING SUBSTANCE
USE DISORDER SUPPORTS
PRIORITIZE INCREASING
ACCESS TO VOLUNTARY,

PRIORITIZE INCREASING ACCESS TO VOLUNTARY, EFFECTIVE, AFFORDABLE, ACCESSIBLE, AND APPEALING SUBSTANCE USE DISORDER SUPPORTS.

Every person, whether or not they use drugs, has the right to control their own life. What substance use disorder (SUD) supports a person accesses — whether harm reduction, abstinence-based treatment, safe shelter, or healthcare — should be up to them. Forced treatment advocates hold the persistent, erroneous belief that people who use drugs cannot make choices for themselves and that others can make better choices for them.

Force does not heal.

Data show that the best treatment is compassionate and inviting.[81] Rather than turning to courts, policymakers and concerned family members must work together to ensure that SUD services are voluntary, effective, affordable, accessible, and appealing.

As one client told the Hartford Courant:

"People recover when they have a choice among alternative treatments and services, when they are empowered to make their own decisions and take responsibility for their lives, and when they are offered hope." [82]

SUBSTANCE USE DISORDER TREATMENT SHOULD BE VOLUNTARY.

Everyone, including SUD clients, have the right to autonomy.

Treatment must be grounded in respect for the human rights and dignity of all clients. It should be provided in a voluntary, ethical, and client-centered manner in the least restrictive setting possible. All SUD treatment providers must recognize and support the inherent dignity of the clients they serve. Providers must respect that clients are the authorities and experts of their own minds, bodies, and narratives. Clients should have final authority over any treatment decisions.

SUBSTANCE USE DISORDER TREATMENT SHOULD BE AFFORDABLE AND ACCESSIBLE (AND POLICYMAKERS MUST REMOVE BARRIERS).

The majority of people with substance use disorders do not seek treatment, and many will overcome any negative consequences of drug use without treatment. Around 10% of American adults report ever having had an SUD, with about 75% of them in recovery.[83]

50%

About half of people who have overcome a substance use disorder did so without accessing treatment or self-help recovery supports.[84]

Unfortunately, far too many people who desire SUD supports face challenges that stop them from accessing the services they want. The more barriers people face, the less likely they are to access services.

TO ADDRESS THE MOST COMMON OBSTACLES, POLICYMAKERS SHOULD FOCUS ON THE FOLLOWING:

- **REDUCING COST AND EXPANDING INSURANCE COVERAGE**

  SUD services are often not affordable or fully covered by health insurance. Other times, what is covered is inaccessible due to insurance requirements and limitations. Insurance coverage for treatment should be comprehensive.

  Many people in this country are uninsured or underinsured; they too should have access to services. Ability to pay should never be a barrier to care.

- **INCREASING AND DIVERSIFYING PROVIDERS**

  In many parts of the country, especially rural communities, there are too few providers nearby and long waitlists at existing providers. This can also include long distances to travel for treatment, which can be challenging for those with busy schedules, caretaking responsibilities, or without reliable transportation. Special efforts to increase providers of culturally-specific services are direly needed.

- **IMPROVING PROGRAMMATIC FLEXIBILITY**

  Many treatment providers have strict attendance requirements or limited treatment hours. This can be challenging for people who work, attend school, or have family/caretaking responsibilities. Treatment may not be appealing to potential clients due to restrictions on drug use (such as in abstinence-only programs) and visitation, and limited access to other services.

- **CREATING INDIVIDUALIZED APPROACHES**

  Treatment should be tailored to the specific needs or preferences of individuals, including their personal treatment and recovery goals. It can also include the needs of special populations including those with co-occurring mental health diagnoses, people of color, immigrants, sex workers, and queer and trans people.

- **FIGHTING STIGMA**

  The taboo associated with substance use often makes it difficult for people to seek help for fear of getting in trouble or being judged. Ending stigma will require substantial educational efforts targeting the public as well as the medical field [85], law enforcement [86], and elected officials.[87]

TO BE ACCESSIBLE, EFFECTIVE SUBSTANCE USE DISORDER SERVICES MUST BE AVAILABLE ON DEMAND.

People should have easy access to evidence-based treatment when they are most motivated for change. Treatment should meet people where they are at. It should be designed to encourage engagement and retention, and include no thresholds for enrollment. For example, programs should not require abstinence as a condition for starting, continuing, or completing care.

SUBSTANCE USE DIORDER TREATMENT SHOULD BE EFFECTIVE AND APPEALING.

Even when treatment is accessible, it is often not evidence-based, provided by highly trained professionals, or subject to adequate oversight.[88] Client engagement is correspondingly low and drop-out rates are high.[89] Rather than force people into a broken system, policymakers should fix the system of care and make it more appealing, transforming it into one that more people are able and willing to engage — and one that offers treatments actually shown to be effective.

SUBSTANCE USE DISORDER SERVICES MUST BE BASED ON THE BEST EVIDENCE, CONSTANTLY MONITORED, AND EVALUATED.

Treatment should be based on the best available current evidence to improve client engagement, retention, and outcomes. Providers should track outcomes beyond abstinence, including client satisfaction, quality of life, and other indicators of well-being. If a strong evidence base does not exist for specific aspects of treatment, new models should incorporate best practices. They should also include rigorous evaluation to monitor implementation and outcomes. Funding should be driven by what has proven to be effective and/or promising.

SUBSTANCE USE DISORDER SERVICES MUST ADDRESS THE WHOLE PERSON AND BE INTEGRATED WITH HEALTH AND SOCIAL SERVICES.

Treatment providers should work closely with other providers to address health or social service needs beyond substance use. In some cases, these needs — such as housing, food, health, or income — may be more urgent than SUD treatment. Clients should be able to decide whether these needs take precedence over SUD treatment.

SUBSTANCE USE DISORDER SERVICES MUST BE CULTURALLY SENSITIVE AND RESPONSIVE TO THE NEEDS OF SPECIFIC POPULATIONS.

Providers should understand that cultural sensitivity is essential and not optional in SUD treatment settings. Program administrators, supervisors, and providers must make ongoing efforts to understand how stigma, discrimination, criminalization, and marginalization impact certain groups and their treatment needs. SUD treatment settings may need to change so they are more accessible. This may include changes to language and translation services, materials, approaches, hours, and modalities.

While all treatment should be individualized, different client populations have unique strengths, vulnerabilities, and needs. Populations requiring special consideration and treatment can include adolescents, aging populations, women, pregnant and parenting people, sex workers, LGBTQ+ people, disabled people, people of color, ethnic and religious minorities, individuals involved in the criminal legal system, people experiencing homelessness, and individuals who are socially marginalized for other reasons.

SUD SERVICES SHOULD BE PROVIDED BY TRAINED AND CREDENTIALED HEALTH PROFESSIONALS.

Service providers should engage in transparent governance practices and be adequately monitored by licensing bodies. SUD treatment should be delivered by trained professionals and peers in approved treatment settings. Federal and state agencies should establish standards for training, credentialing, and/or licensing for SUD treatment providers. Providers should also receive adequate supervision, professional development, continuing education, and reasonable compensation to ensure they are providing appropriate care informed by best practices. Clients should also be able to seek recourse through licensing bodies, when needed.

PEOPLE INVOLVED IN THE CRIMINAL LEGAL SYSTEM SHOULD HAVE ACCESS TO THE FULL RANGE OF SUD SERVICE OPTIONS AVAILABLE IN THE COMMUNITY.

Effective treatment should always be available to those who want and need it, whether they are involved in the criminal legal system or not. Judges and other legal professionals should not decide the level or type of care clients receive in court-mandated SUD treatment. This is a decision that clients should make with their SUD treatment provider. People in court-ordered treatment or in correctional settings should have access to the full range of treatment services that are available in the community. This includes MOUD as well as harm reduction services. This treatment should be held to the same quality and ethical standards as treatment in the community.

CONCLUSION

A responsible policy approach to addiction must ensure that everyone has access to effective substance use disorder (SUD) supports that align with their personal choices and needs. The Drug Policy Alliance is steadfast in its commitment to ensuring that individuals have access to services based in evidence, health, equity, and human rights. SUD supports should always be voluntary, effective, affordable, accessible, and appealing and never imposed by legal force.

This report has specifically addressed involuntary commitment, where individuals are compelled to undergo SUD treatment against their will and not of their choosing. For decades, the criminal legal system has coerced individuals into these services, resulting in substantial and well-documented harm on a systemic scale.

Despite this painful history, many states have expanded courts' legal authority to force people into SUD services beyond the criminal system, utilizing what is known as civil or involuntary commitment. Civil commitment carries significant systemic risks. Positive outcomes are the exception rather than the rule. Notably, evidence does not support involuntary commitment for SUD supports, and, in fact, it has been found to substantially increase the risk of opioid overdose deaths after release from confinement.

Forced treatment is not the solution to the very real challenges of limited access to effective SUD services and a worsening overdose crisis. Advocates for this approach are unwittingly jeopardizing the very lives they claim to be trying to save.

Families seeking to save their loved ones' lives deserve real solutions. Genuine resolutions to SUD and overdose mortality require expanding access to proven, appealing SUD services and eradicating the pervasive stigma that has plagued existing support systems.

IT IS OUR COLLECTIVE RESPONSIBILITY TO PURSUE A PATH THAT RESPECTS INDIVIDUAL AUTONOMY AND PROVIDES THE HELP AND SUPPORT PEOPLE AND FAMILIES TRULY NEED TO OVERCOME SUBSTANCE USE DISORDERS AND GAIN OVERALL WELL-BEING.

REFERENCES

1. Harm reduction accepts that drug use is, and has always been, part of our world and focuses on minimizing its potential harmful effects. Harm reduction strategies measure success according to health, social, and economic outcomes, as opposed to only measuring success as complete cessation of drug use. Harm reductionists support drug users in meeting their own goals while helping them identify and overcome barriers to meeting those goals.

2. Substance Abuse and Mental Health Services Administration. Highlights for the 2021 National Survey on Drug Use and Health. Rockville, MD: SAMHSA, December 2022. Available at: https://www.samhsa.gov/data/sites/default/files/2022-12/2021NSDUHFFRHighlights092722.pdf

3. Drug Policy Alliance uses the term "Family Regulation System," coined by Emma Williams and used by other scholars, instead of the more commonly used term "Child Welfare System", to reflect the fact that, particularly for low-income families and families of color, state intervention often occurs in order to regulate their families rather than to prioritize the welfare of the entire family unit, of which the child is a part.

4. Drug Policy Alliance. Drug Courts Are Not the Answer. (New York: DPA, March 2011), Available at: https://www.prisonlegalnews.org/media/publications/drug_policy_alliance_drug_courts_are_not_the_answer_2011.pdf

5. Wakeman, Sarah E. "Why involuntary treatment for addiction is a dangerous idea." STAT News, April 25, 2023. Available at: https://www.statnews.com/2023/04/25/involuntary-treatment-for-addiction-research/; Sheff, David. "My Son Was Addicted and Refused Treatment. We Needed More Options." The New York Times. April 12, 2023. Available at: https://www.nytimes.com/2023/04/12/opinion/addiction-treatment.html

6. Messinger, John C., Daniel J. Ikeda, and Ameet Sarpatwari. "Civil commitment for opioid misuse: do short-term benefits outweigh long-term harms?" Journal of medical ethics 48, no. 9 (2022): 608-610. Available at: https://jme.bmj.com/content/48/9/608.abstract

7. Smith, Jordan M. "The Jailing of Jesse Harvey." The Intercept. March 23, 2022. Available at: https://theintercept.com/2022/03/23/opioid-addiction-treatment-civil-commitment/

8. Health in Justice Action Lab. Laws Authorizing involuntary commitment for substance use, 2018. Available at: https://lawatlas.org/datasets/civil-commitment-for-substance-users. [Accessed August 20, 2023]

9. Messinger, John C., Daniel J. Ikeda, and Ameet Sarpatwari. "Civil commitment for opioid misuse: do short-term benefits outweigh long-term harms?" Journal of medical ethics 48, no. 9 (2022): 608-610. Available at: https://jme.bmj.com/content/48/9/608.abstract

10. Poser, Rachel. "Does Forced Rehab Work? Desperate families are locking up their opioid-addicted relatives for treatment. But the lifeline can be a nightmare." Mother Jones. July/August 2018. Available at: https://www.motherjones.com/politics/2018/06/does-forced-rehab-work/

11. Ledberg, Anders, and Therese Reitan. "Increased risk of death immediately after discharge from compulsory care for substance abuse." Drug and alcohol dependence 236 (2022): 109492. Available at: https://www.sciencedirect.com/science/article/pii/S0376871622002290; Also see: Rafful, Claudia, Ricardo Orozco, Gudelia Rangel, Peter Davidson, Dan Werb, Leo Beletsky, and Steffanie A. Strathdee. "Increased non-fatal overdose risk associated with involuntary drug treatment in a longitudinal study with people who inject drugs." Addiction 113, no. 6 (2018): 1056-1063. Available at: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5938130/

12. Szalavitz, Maia. "Why Forced Addiction Treatment Fails." The New York Times. April 30, 2022. Available at: https://www.nytimes.com/2022/04/30/opinion/forced-addiction-treatment.html

13. Ledberg, Anders, and Therese Reitan. "Increased risk of death immediately after discharge from compulsory care for substance abuse." Drug and alcohol dependence 236 (2022): 109492. Available at: https://www.sciencedirect.com/science/article/pii/S0376871622002290; Also see: Paul J. Joudrey, Maria R. Khan, Emily A. Wang, et al., "A Conceptual Model for Understanding Post-Release Opioid-Related Overdose Risk." Addiction Science & Clinical Practice 14 (2019), 17, https://link.springer.com/article/10.1186/s13722-019-0145-5; Brinkley-Rubinstein, Lauren, Nickolas Zaller, Sarah Martino, David H. Cloud, Erin McCauley, Andrew Heise, and David Seal. "Criminal justice continuum for opioid users at risk of overdose." Addictive behaviors 86 (2018): 104-110. Available at: https://www.sciencedirect.com/science/article/abs/pii/S0306460318300893

14. Ledberg, Anders, and Therese Reitan. "Increased risk of death immediately after discharge from compulsory care for substance abuse." Drug and alcohol dependence 236 (2022): 109492. Available at: https://www.sciencedirect.com/science/article/pii/S0376871622002290

15. Christopher, Paul P., Bradley Anderson, and Michael D. Stein. "Civil commitment experiences among opioid users." Drug and alcohol dependence 193 (2018): 137-141. Available at: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6239959/

16. Messinger, John C., Daniel J. Ikeda, and Ameet Sarpatwari. "Civil commitment for opioid misuse: do short-term benefits outweigh long-term harms?" Journal of medical ethics 48, no. 9 (2022): 608-610. Available at: https://jme.bmj.com/content/48/9/608.abstract

17. Paul J. Joudrey, Maria R. Khan, Emily A. Wang, et al., "A Conceptual Model for Understanding Post-Release Opioid-Related Overdose Risk." Addiction Science & Clinical Practice 14 (2019), 17, https://link.springer.com/article/10.1186/s13722-019-0145-5. Also see: Brinkley-Rubinstein, Lauren, Nickolas Zaller, Sarah Martino, David H. Cloud, Erin McCauley, Andrew Heise, and David Seal. "Criminal justice continuum for opioid users at risk of overdose." Addictive behaviors 86 (2018): 104-110. Available at: https://www.sciencedirect.com/science/article/abs/pii/S0306460318300893

18. Karen Crotty, Kenneth Freedman, and Kyle Kampman, "Executive Summary of the Focused Update of the ASAM National Practice Guideline for the Treatment of Opioid Use Disorder," Journal of Addiction Medicine 14(2):p 99-112, March/April 2020. Available at: https://doi.org/10.1097/ADM.0000000000000635

19. Christopher, Paul P., Bradley Anderson, and Michael D. Stein. "Civil commitment experiences among opioid users." Drug and alcohol dependence 193 (2018): 137-141. Available at: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6239959/

20. Health in Justice Action Lab. Laws Authorizing involuntary commitment for substance use, 2018. Available at: https://lawatlas.org/datasets/civil-commitment-for-substance-users. [Accessed August 20, 2023]

21. Howle, Elaine M. Lanterman-Petris-Short Act: California Has Not Ensured That Individuals With Serious Mental Illnesses Receive Adequate Ongoing Care. Sacramento: Auditor of the State of California. July 2020. Available at: http://auditor.ca.gov/pdfs/reports/2019-119.pdf

22. Christopher, Paul P., Bradley Anderson, and Michael D. Stein. "Civil commitment experiences among opioid users." Drug and alcohol dependence 193 (2018): 137-141. Available at: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6239959/

23. Joudrey, Paul J., Maria R. Khan, Emily A. Wang, Joy D. Scheidell, E. Jennifer Edelman, D. Keith McInnes, and Aaron D. Fox. "A conceptual model for understanding post-release opioid-related overdose risk." Addiction science & clinical practice 14 (2019): 1-14. Available at: https://link.springer.com/article/10.1186/s13722-019-0145-5

24. Kajeepeta, Sandhya, Pia M. Mauro, Katherine M. Keyes, Abdulrahman M. El-Sayed, Caroline G. Rutherford, and Seth J. Prins. "Association between county jail incarceration and cause-specific county mortality in the USA, 1987–2017: a retrospective, longitudinal study." The Lancet Public Health 6, no. 4 (2021): e240-e248. Available at: https://www.thelancet.com/journals/lanpub/article/PIIS2468-2667(20)30283-8/fulltext

25. Cooper, Janine A., Ifeoma Onyeka, Christopher Cardwell, Euan Paterson, Richard Kirk, Dermot O'Reilly, and Michael Donnelly. "Record linkage studies of drug-related deaths among adults who were released from prison to the community: a scoping review." BMC public health 23, no. 1 (2023): 1-28. Available at: https://bmcpublichealth.biomedcentral.com/articles/10.1186/s12889-023-15673-0

26. Larochelle, Marc R., Ryan Bernstein, Dana Bernson, Thomas Land, Thomas J. Stopka, Adam J. Rose, Monica Bharel, Jane M. Liebschutz, and Alexander Y. Walley. "Touchpoints—opportunities to predict and prevent opioid overdose: a cohort study." Drug and alcohol dependence 204 (2019): 107537. Available at: https://doi.org/10.1016/j.drugalcdep.2019.06.039

27. Drug Policy Alliance. Drug Courts Are Not the Answer. (New York: DPA, March 2011), Available at: https://www.prisonlegalnews.org/media/publications/drug_policy_alliance_drug_courts_are_not_the_answer_2011.pdf

28. Gallagher, John Robert, Elizabeth A. Wahler, Elyse Lefebvre, Tara Paiano, Jesse Carlton, and Jane Woodward Miller. "Improving graduation rates in drug court through employment and schooling opportunities and medication-assisted treatment (MAT)." Journal of Social Service Research 44, no. 3 (2018): 343-349. Available at: https://www.tandfonline.com/doi/full/10.1080/01488376.2018.1472173

29. Christopher, Paul P., Bradley Anderson, and Michael D. Stein. "Civil commitment experiences among opioid users." Drug and alcohol dependence 193 (2018): 137-141. Available at: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6239959/

30. Kearley, Brook W., John A. Cosgrove, Alexandra S. Wimberly, and Denise C. Gottfredson. "The impact of drug court participation on mortality: 15-year outcomes from a randomized controlled trial." Journal of substance abuse treatment 105 (2019): 12-18. Available at: https://pubmed.ncbi.nlm.nih.gov/31443886/

31. Swanson, Jeffrey, Marvin Swartz, Richard A. Van Dorn, John Monahan, Thomas G. McGuire, Henry J. Steadman, and Pamela Clark Robbins. "Racial disparities in involuntary outpatient commitment: are they real?." Health Affairs 28, no. 3 (2009): 816-826. Available at: https://www.healthaffairs.org/doi/abs/10.1377/hlthaff.28.3.816

32. Substance Abuse and Mental Health Services Administration. Civil Commitment and the Mental Health Care Continuum: Historical Trends and Principles for Law and Practice. Rockville, MD: Office of the Chief Medical Officer, SAMHSA, 2019. Available at: https://www.samhsa.gov/sites/default/files/civil-commitment-continuum-of-care_041919_508.pdf

33. Chang, Ji Eun, Berkeley Franz, Cory E. Cronin, Zoe Lindenfeld, Alden Yuanhong Lai, and José A. Pagán. "Racial/ethnic disparities in the availability of hospital based opioid use disorder treatment." Journal of Substance Abuse Treatment 138 (2022): 108719. Available at: https://doi.org/10.1016/j.jsat.2022.108719

34. Ghoshal, Malini. "Race and addiction: how bias and stigma affect treatment access and outcomes," November 1, 2021, t.

35. Kovera, Margaret Bull. "Racial disparities in the criminal justice system: Prevalence, causes, and a search for solutions." Journal of Social Issues 75, no. 4 (2019): 1139-1164. Available at: https://doi.org/10.1111/josi.12355; Kurlychek, Megan C., and Brian D. Johnson. "Cumulative disadvantage in the American criminal justice system." Annual Review of Criminology 2 (2019): 291-319. Available at: https://www.annualreviews.org/doi/abs/10.1146/annurev-criminol-011518-024815

36. Substance Abuse and Mental Health Services Administration. Civil Commitment and the Mental Health Care Continuum: Historical Trends and Principles for Law and Practice. Rockville, MD: Office of the Chief Medical Officer, SAMHSA, 2019. Available at: https://www.samhsa.gov/sites/default/files/civil-commitment-continuum-of-care_041919_508.pdf

37. Vera Institute. Overdose Deaths and Jail Incarceration: National trends and racial disparities. Available at: https://www.vera.org/publications/overdose-deaths-and-jail-incarceration/national-trends-and-racial-disparities. Accessed on July 22, 2023.

38. Heilig, Markus, David H. Epstein, Michael A. Nader, and Yavin Shaham. "Time to connect: bringing social context into addiction neuroscience." Evaluating the Brain Disease Model of Addiction (2022): 35-49. Available at: https://www.taylorfrancis.com/chapters/edit/10.4324/9781003032762-6/time-connect-markus-heilig-david-epstein-michael-nader-yavin-shaham; Christie, Nina C. "The role of social isolation in opioid addiction." Social cognitive and affective neuroscience 16, no. 7 (2021): 645-656. Available at: https://doi.org/10.1093/scan/nsab029; Day, Brendan F., and Geoffrey L. Rosenthal. "Social isolation proxy variables and prescription opioid and benzodiazepine misuse among older adults in the US: A cross-sectional analysis of data from the National Survey on Drug Use and Health, 2015–2017." Drug and alcohol dependence 204 (2019): 107518. Available at: https://doi.org/10.1016/j.drugalcdep.2019.06.020

39. Smith, Jordan M. "The Jailing of Jesse Harvey." The Intercept. March 23, 2022. Available at: https://theintercept.com/2022/03/23/opioid-addiction-treatment-civil-commitment/

40. Volkow, Nora D. "Stigma and the toll of addiction." New England Journal of Medicine 382, no. 14 (2020): 1289-1290. Available at: https://www.nejm.org/doi/full/10.1056/NEJMp1917360. Also see: Stringer, Kristi L., and Elizabeth H. Baker. "Stigma as a barrier to substance abuse treatment among those with unmet need: an analysis of parenthood and marital status." Journal of family issues 39, no. 1 (2018): 3-27. Available at: https://doi.org/10.1177/0192513X15581659

41. Hannah Carver, Nicola Ring, Joanna Miler, "What constitutes effective problematic substance use treatment from the perspective of people who are homeless? A systematic review and meta-ethnography," Harm Reduction Journal 17(10), 2020, https://doi.org/10.1186/s12954-020-0356-9

42. Smith, Jordan M. "The Jailing of Jesse Harvey." The Intercept. March 23, 2022. Available at: https://theintercept.com/2022/03/23/opioid-addiction-treatment-civil-commitment/

43. Jones, Christopher M., Rita K. Noonan, and Wilson M. Compton. "Prevalence and correlates of ever having a substance use problem and substance use recovery status among adults in the United States, 2018." Drug and alcohol dependence 214 (2020): 108169. Available at: https://www.sciencedirect.com/science/article/abs/pii/S0376871620303343

44. Conroy, Elizabeth, Louisa Degenhardt, Richard P. Mattick, and Elliot C. Nelson. "Child maltreatment as a risk factor for opioid dependence: Comparison of family characteristics and type and severity of child maltreatment with a matched control group." Child Abuse & Neglect 33, no. 6 (2009): 343-352. Available at: https://doi.org/10.1016/j.chiabu.2008.09.009

45. Substance Abuse and Mental Health Services Administration. Civil Commitment and the Mental Health Care Continuum: Historical Trends and Principles for Law and Practice. Rockville, MD: Office of the Chief Medical Officer, SAMHSA, 2019. Available at: https://www.samhsa.gov/sites/default/files/civil-commitment-continuum-of-care_041919_508.pdf

46. Zervakis, Jennifer, Karen M. Stechuchak, Maren K. Olsen, Jeffrey W. Swanson, Eugene Z. Oddone, Morris Weinberger, Elena R. Bryce, Marian I. Butterfield, Marvin S. Swartz, and Jennifer L. Strauss. "Previous involuntary commitment is associated with current perceptions of coercion in voluntarily hospitalized patients." International Journal of Forensic Mental Health 6, no. 2 (2007): 105-112. Available at: https://doi.org/10.1080/14999013.2007.10471255

47. Curwen, Thomas. "Q&A: He's studied mental illness for 50 years. Here are all the things we're doing wrong." Los Angeles Times. May 10, 2022. Available at: https://www.latimes.com/california/story/2022-05-10/q-a-andrew-scull-severe-mental-illness

48. White, William L. Slaying the dragon: The history of addiction treatment and recovery in America. Bloomington, IL: Chestnut Health Systems, 1998. Available here: www.chestnut.org/store/products/5/slaying-the-dragon-the-history-of-addiction-treatment-and-recovery-in-america-second-edition/product-details/

49. Walter, Shoshana. "At hundreds of rehabs, recovery means work without pay." Reveal News. July 7, 2020. Available at: https://revealnews.org/article/at-hundreds-of-rehabs-recovery-means-work-without-pay/

50. Szalavitz, Maia. "Portugal Has Succeeded Where We've Failed With Addiction." The New York Times. August 29, 2023. Available at: https://www.nytimes.com/2023/08/29/opinion/arrest-drug-treatment-addiction.html

51. American Civil Liberties Union. Every 25 Seconds: The Human Toll of Criminalizing Drug Use in the United States. New York: ACLU & Human Rights Watch (HRW), 2016. Available at: https://www.hrw.org/news/2016/10/12/us-disastrous-toll-criminalizing-drug-use

52. Farber, David. The War on Drugs: A History. New York: University Press, 2021. Available at: https://doi.org/10.18574/nyu/9781479811397.001.0001. See also: Schultz, David. "Rethinking Drug Criminalization Policies." Tex. Tech L. Rev. 25 (1993): 151. Available at: https://heinonline.org/hol-cgi-bin/get_pdf.cgi?handle=hein.journals/text25&section=14

53. Smith, Jordan M. "The Jailing of Jesse Harvey." The Intercept. March 23, 2022. Available at: https://theintercept.com/2022/03/23/opioid-addiction-treatment-civil-commitment/

54. Becker, Deborah. "What To Know About Section 35 Civil Commitments in Mass." WBUR. July 3, 2019. Available at: https://www.wbur.org/news/2019/07/01/section-35-substance-addiction-treatment-commitments

55. Graulau, Bianca. "Floridians with addiction are going to jail instead of rehab in Pinellas County." WTSP. July 19, 2018. Available at: https://www.wtsp.com/article/news/local/floridians-with-addiction-are-going-to-jail-instead-of-rehab-in-pinellas-county/67-575443050

56. Smith, Jordan M. "The Jailing of Jesse Harvey." The Intercept. March 23, 2022. Available at: https://theintercept.com/2022/03/23/opioid-addiction-treatment-civil-commitment/

57. Christopher, Paul P., Paul S. Appelbaum, and Michael D. Stein. "Criminalization of opioid civil commitment." JAMA psychiatry 77, no. 2 (2020): 111-112. Available at: https://jamanetwork.com/journals/jamapsychiatry/article-abstract/2751926

58. Poser, Rachel. "Does Forced Rehab Work? Desperate families are locking up their opioid-addicted relatives for treatment. But the lifeline can be a nightmare." Mother Jones. July/August 2018. Available at: https://www.motherjones.com/politics/2018/06/does-forced-rehab-work/; Graulau, Bianca. "Floridians with addiction are going to jail instead of rehab in Pinellas County." WTSP. July 19, 2018. Available at: https://www.wtsp.com/article/news/local/floridians-with-addiction-are-going-to-jail-instead-of-rehab-in-pinellas-county/67-575443050; Smith, Jordan M. "The Jailing of Jesse Harvey." The Intercept. March 23, 2022. Available at: https://theintercept.com/2022/03/23/opioid-addiction-treatment-civil-commitment/.

59. Christopher, Paul P., Bradley Anderson, and Michael D. Stein. "Civil commitment experiences among opioid users." Drug and alcohol dependence 193 (2018): 137-141. Available at: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6239959/

60. Massachusetts Department of Public Health. Section 35 Commission Treatment Statistics from BSAS Programs [Internet], 2019. Available at: https://www.mass.gov/doc/presentation-on-dph-opioid-and-civil-commitment-data/download [Accessed August 20, 2023].

61. Messinger, John C., Daniel J. Ikeda, and Ameet Sarpatwari. "Civil commitment for opioid misuse: do short-term benefits outweigh long-term harms?" Journal of medical ethics 48, no. 9 (2022): 608-610. Available at: https://jme.bmj.com/content/48/9/608.abstract

62. Werb, Dan, Adeeba Kamarulzaman, Meredith C. Meacham, Claudia Rafful, Benedikt Fischer, Steffabie A. Strathdee, and Evan Wood. "The effectiveness of compulsory drug treatment: a systematic review." International Journal of Drug Policy 28 (2016): 1-9. Available at: https://doi.org/10.1016/j.drugpo.2015.12.005

63. Ali, Robert, and Matthew Stevens. "Moving toward Voluntary Community-Based Treatment for Drug Use and Dependence." Health and Human Rights 24, no. 1 (2022): 183. Available at: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC9212818/; Vo, Anh T., Christopher Magana, Matthew Hickman, Annick Borquez, Leo Beletsky, Natasha K. Martin, and Javier A. Cepeda. "Assessing HIV and overdose risks for people who use drugs exposed to compulsory drug abstinence programs (CDAP): A systematic review and meta-analysis." International Journal of Drug Policy 96 (2021): 103401. Available at: https://doi.org/10.1016/j.drugpo.2021.103401

64. Werb, Dan, Adeeba Kamarulzaman, Meredith C. Meacham, Claudia Rafful, Benedikt Fischer, Steffabie A. Strathdee, and Evan Wood. "The effectiveness of compulsory drug treatment: a systematic review." International Journal of Drug Policy 28 (2016): 1-9. Available at: https://doi.org/10.1016/j.drugpo.2015.12.005

65. Klag, Stefanie, Frances O'Callaghan, and Peter Creed. "The use of legal coercion in the treatment of substance abusers:

An overview and critical analysis of thirty years of research." Substance use & misuse 40, no. 12 (2005): 1777-1795. Available at: https://doi.org/10.1080/10826080500260891

66. Szalavitz, Maia. "Why Forced Addiction Treatment Fails." The New York Times. April 30, 2022. Available at: https://www.nytimes.com/2022/04/30/opinion/forced-addiction-treatment.html

67. Long, Brit, and Michael Gottlieb. "Is Opioid Agonist Treatment Associated With Reduced Risk of Overall and Cause-Specific Mortality in Opioid-Dependent People?" Annals of Emergency Medicine 78, no. 6 (2021): 776-778. Available at: https://www.annemergmed.com/article/S0196-0644(21)00700-9/fulltext

68. Ginley, Meredith K., Rory A. Pfund, Carla J. Rash, and Kristyn Zajac. "Long-term efficacy of contingency management treatment based on objective indicators of abstinence from illicit substance use up to 1 year following treatment: A meta-analysis." Journal of Consulting and Clinical Psychology 89, no. 1 (2021): 58. Available at: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC8034391/

69. Christopher, Paul P., Debra A. Pinals, Taylor Stayton, Kellie Sanders, and Lester Blumberg. "Nature and utilization of civil commitment for substance abuse in the United States." Journal of the American Academy of Psychiatry and the Law Online 43, no. 3 (2015): 313-320. Available at: https://facesandvoicesofrecovery.org/wp-content/uploads/2019/06/Nature-and-Utilization-of-Civil-Commitment-for-Substance-Abuse-in-the-United-States.pdf

70. Nathaniel P. Morris, "Detention without Date: Public Tracking of Civil Commitment," Psychiatric Services. May 22, 2020. Available at: https://doi.org/10.1176/appi.ps.202000212

71. Felicella, Guy and Dr. S. Monty Ghosh, "Incentivizing treatment for addiction could be more effective than mandating," The Globe and Mail, January 18, 2023, https://www.theglobeandmail.com/opinion/article-incentivizing-treatment-for-addiction-could-be-more-effective-than/

72. Henden, Edmund, Hans Olav Melberg, and Ole Jørgen Røgeberg. "Addiction: choice or compulsion?" Frontiers in psychiatry 4 (2013): 77. Available at: https://www.frontiersin.org/articles/10.3389/fpsyt.2013.00077/full

73. Szalavitz, Maia. "This Is What Neuroscientists and Philosophers Understand About Addiction." The New York Times. April 24, 2023. Available at: https://www.nytimes.com/2023/04/24/opinion/addiction-free-will.html

74. Ginley, Meredith K., Rory A. Pfund, Carla J. Rash, and Kristyn Zajac. "Long-term efficacy of contingency management treatment based on objective indicators of abstinence from illicit substance use up to 1 year following treatment: A meta-analysis." Journal of Consulting and Clinical Psychology 89, no. 1 (2021): 58. Available at: https://psycnet.apa.org/doi/10.1037/ccp0000552

75. Christopher, Paul P., Bailey Pridgen, and Ekaterina Pivovarova. "Court Clinicians' Experiences Performing Civil Commitment Evaluations for Substance Use Disorders." The journal of the American Academy of Psychiatry and the Law 49, no. 2 (2021): 187. Available at: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC9009061/

76. Grabar, Henry. "California Is Fighting to Make It Easier to Put People Under Conservatorships." Slate. February 2, 2022. Available at: https://slate.com/technology/2022/02/conservatorship-california-psychiatric-holds-mental-illness-homeless-rights.html

77. Christopher, Paul P., Bailey Pridgen, and Ekaterina Pivovarova. "Court Clinicians' Experiences Performing Civil Commitment Evaluations for Substance Use Disorders." The journal of the American Academy of Psychiatry and the Law 49, no. 2 (2021): 187. Available at: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC9009061/

78. Messinger, John C., Daniel J. Ikeda, and Ameet Sarpatwari. "Civil commitment for opioid misuse: do short-term benefits outweigh long-term harms?" Journal of medical ethics 48, no. 9 (2022): 608-610. Available at: https://jme.bmj.com/content/48/9/608.abstract

79. Weiland, Noah. "Addiction Treatment Eludes More Than Half of Americans in Need." The New York Times. August 15, 2023. Available at: https://www.nytimes.com/2023/08/15/health/addiction-treatment-opioids.html

80. Howle, Elaine M. Lanterman-Petris-Short Act: California Has Not Ensured That Individuals With Serious Mental Illnesses Receive Adequate Ongoing Care. Sacramento: Auditor of the State of California. July 2020. Available at: http://auditor.ca.gov/pdfs/reports/2019-119.pdf

81. Moyers, Theresa B., and William R. Miller. "Is low therapist empathy toxic?" Psychology of Addictive Behaviors 27, no. 3 (2013): 878. Available at: https://pubmed.ncbi.nlm.nih.gov/23025709/

82. Substance Abuse and Mental Health Services Administration. Civil Commitment and the Mental Health Care Continuum: Historical Trends and Principles for Law and Practice. Rockville, MD: Office of the Chief Medical Officer, SAMHSA, 2019. Available at: https://www.samhsa.gov/sites/default/files/civil-commitment-continuum-of-care_041919_508.pdf

83. Christopher M. Jones, Rita K. Noonan, and Wilson M. Compton, "Prevalence and correlates of ever having a substance use problem and substance use recovery status among adults in the United States, 2018," Drug and Alcohol Dependence, Vol 214 (2020), https://doi.org/10.1016/j.drugalcdep.2020.108169; John F. Kelly, Brandon G. Bergman, Bettina B. Hoeppner, et al., "Prevalence and pathways of recovery from drug and alcohol problems in the United States population: Implications for practice, research, and policy," Drug and Alcohol Dependence, Vol 181, 2017, https://doi.org/10.1016/j.drugalcdep.2017.09.028

84. John F. Kelly, Brandon G. Bergman, Bettina B. Hoeppner, et al., "Prevalence and pathways of recovery from drug and alcohol problems in the United States population: Implications for practice, research, and policy," Drug and Alcohol Dependence, Volume 181, 2017, https://doi.org/10.1016/j.drugalcdep.2017.09.028

85. Sean Fogler, "As a physician and a patient, I've seen the damage caused by the stigma of addiction. It must end," Stat, December 8, 2020, https://www.statnews.com/2020/12/08/stigma-weaponized-helps-fuel-addiction-crisis/

86. Nathan E Kruis, Jaeyong Choi, and Richard H Donohue, "Police officers, stigma, and the opioid epidemic," International Journal of Police Science & Management, Vol 22(4), 2020, https://doi.org/10.1177/1461355720962524

87. Kristin E. Schneider, Deborah Wilson, Lauren Dayton, et al., "Political partisanship and stigma against people who use drugs in opinions about allocating COVID-19 prevention resources to vulnerable populations," International Journal of Drug Policy, Vol 95, 2021, https://doi.org/10.1016/j.drugpo.2021.103301

88. Mark, Tami, William N. Dowd, and Carol L. Council. "Tracking the quality of addiction treatment over time and across states." (2020). Available at: https://www.ncbi.nlm.nih.gov/books/NBK559647/

89. Lappan, Sara N., Andrew W. Brown, and Peter S. Hendricks. "Dropout rates of in-person psychosocial substance use disorder treatments: a systematic review and meta-analysis." Addiction 115, no. 2 (2020): 201-217. Available at: https://doi.org/10.1111/add.14793

DRUG POLICY ALLIANCE.

131 West 33rd Street, 15th Floor
New York, NY 10001

drugpolicy.org