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PERSPECTIVE

What's Old Is New Again in Addiction Treatment: The Expansion of Involuntary Commitment in the United States

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Introduction

The recent confirmation of Robert F. Kennedy Jr. as the secretary of the Department of Health and Human Services has raised numerous concerns regarding the future shape of the United States' medical and public health systems. Among his controversial opinions is support for involuntary commitment at abstinence- and faith-based "healing farms" for people struggling with addiction.[1] Some of Kennedy's beliefs stem from his own experience with addiction and recovery, which involved a variety of abstinence-based programs.[2] He is far from the first politician to advocate for forced addiction treatment, which is growing in popularity as a central feature of the overdose crisis response. Upward of 25 states added new—or expanded existing—involuntary commitment statutes between 2015 and 2018 alone, a trend that invokes the United States' grim history of institutionalization as a dominant approach to addiction and mental health problems.[3]

While state-level laws allowing for forced addiction treatment are becoming commonplace, their implementation has been limited in most jurisdictions. Lack of funding, human rights concerns, and logistical constraints have thus far rendered existing legal mechanisms largely dormant. For example, California became one of the most recent adopters of forced addiction treatment through the passage of Senate Bill 43, which expanded the criteria for psychiatric involuntary commitment to include substance use disorder in isolation as a qualifying diagnosis.[4] However, the use of this law is exceedingly rare because most patients fail to meet the criteria for involuntary commitment once they are no longer acutely intoxicated from substances, and those who do are unable to be placed because residential addiction treatment facilities do not have the infrastructural capacity to enact involuntary holds. One study from 2015 found that of the 33 states

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with laws permitting involuntary commitment for substance use disorder, fewer than half regularly adopted this approach.[5]

As it stands, the United States is sitting on a sleeping giant where nearly every state has the capability to forcibly treat people for substance use disorders provided that the political climate allows for the expansion of funding to establish treatment facilities designated for this use. While the severity of the ongoing overdose crisis warrants swift and definitive intervention, we must be wary of the use of involuntary commitment for substance use disorder given the dearth of evidence supporting its use either domestically or abroad. Furthermore, the research that does exist on this subject is often not generalizable because ethical concerns limit the ability to conduct randomized controlled trials. One international review from 2009 synthesizing 30 years of research on coerced addiction treatments found that studies were generally inconsistent and of low quality.[6] A more recent study from Sweden found that individuals released from compulsory addiction treatment had a threefold increased risk of dying immediately following their release.[7]

The state of the research in the United States is even more abysmal: as noted by a 2015 study, of the twenty states implementing involuntary commitment for substance use disorder, only seven were able to consistently report utilization data.[8] For years, compulsory treatment programs have functioned with little scrutiny—facilities providing care to those involuntarily committed for addiction release little information regarding the treatments they provide, and rarely (if ever) release data regarding patient outcomes.

Massachusetts as a cautionary tale

To illustrate the risks of wide involuntary commitment deployment, we need to look no further than the Commonwealth of Massachusetts, which, along with Florida and North Carolina, is one of the country's highest utilizers of these laws. Each year, Massachusetts forces upward of 6,000 people into addiction treatment at great cost to its taxpayers.[9] This system is promulgated under a law referred to as Section 35, which allows for the forceful detention and placement of individuals into dedicated involuntary addiction treatment facilities for up to 90 days at a time.[10] Despite Section 35's widespread deployment, and repeated efforts to increase transparency, the nature of its implementation and efficacy has remained shrouded in mystery.[11] Until now, the most comprehensive reports on outcomes of involuntary commitment for substance use disorders in Massachusetts have been limited to data from 2011–2015.[12]

Recently, however, the Massachusetts Department of Public Health (DPH) was forced to shed more light on this system. In late 2024, it released a statutorily mandated report comparing outcomes of voluntary versus involuntary addiction treatment.[13] In this study, those subjected to involuntary commitment were younger (more than 80% were under the age of 45) and more often white (82%) compared to those receiving voluntary treatment.[14] The vast majority of participants receiving any addiction treatment, voluntary or involuntary, were insured through Medicaid.[15] To compare outcomes between different forms of addiction treatment, the report looked specifically at individuals who had both received voluntary treatment and undergone involuntary commitment between 2015 and 2021, comparing numerous health-related outcomes at 30 and 90 days after each treatment episode. Most notably, the report found that after release from involuntary treatment, individuals had a 1.4-fold increased risk of non-fatal overdose and possibly an increased risk of death from any cause.[16]

While these findings may come as a surprise, they serve as further proof of the concerns that we and many others have raised for years and warrant a deeper dive to fully understand their significance.[17] What happens to people subjected to involuntary commitment for substance use disorders? How might this lead to an increased risk of overdose and death? Moving forward, what should the United States do to ensure that involuntary commitment for substance use disorders does not continue to harm those it seeks to help?

Although the exact details of involuntary commitment for substance use disorders will vary state

by state, it is worth examining the existing system in Massachusetts to better contextualize findings from this most recent DPH report. In Massachusetts, all involuntary commitment episodes start with a petition filed to a court requesting that an individual be forced into treatment for addiction. While many different people (e.g., health care providers, law enforcement officers, court officials, and so on) may submit these petitions, most are filed by an individual's family member. In many cases, courts will then grant a warrant that allows the police to locate and physically detain the individual in question for a hearing to determine whether they qualify for involuntary commitment.[18] It is important to note that an individual need not have been charged with or found guilty of a crime in order to be forcibly committed. Once sentenced to involuntary commitment, the individual is then sent to one of several treatment facilities across the state. Most facilities are run by the DPH or the Department of Mental Health, but the largest and most notorious is owned and operated by the Department of Corrections and staffed by prison guards.[19] Although involuntary commitment for substance use disorders is branded as "treatment," one can see how many parts of this process more closely approximate the process of incarceration than that of medical care.

Once at a treatment facility, the patient is monitored while they undergo withdrawal—for patients with opioid use disorder, this process is excruciating and may last days, with only minimal relief provided from adjunctive medications. The exact details of treatment beyond this point are murky. One study investigating the experiences of individuals released from forced addiction treatment in Massachusetts found that fewer than one in five participants were offered medications for substance use disorder or scheduled for community-based follow-up, raising concerns about the standard of care in involuntary commitment facilities.[20] The outcomes for these patients were perhaps even more worrisome—fewer than one in ten participants actually attended their scheduled follow-up, and more than one-third reported relapsing on the day of their release.[21] While relapse is an expected part of the process for patients struggling with addiction, it becomes particularly dangerous for people whose tolerance for drugs has been reduced by being in an institutionalized setting. This is not simply a theoretical risk—this phenomenon has been studied extensively for people released from prisons, with studies showing a dramatically increased risk of overdose death, particularly in the first two weeks following release.[22] We believe it is this same underlying process that may be driving the increased rates of overdose detected in the most recent data from the Massachusetts DPH.

Implications for the US response and beyond

With the shift in the federal administration, there is now a risk that dormant involuntary commitment mechanisms will become more actively deployed across the United States. Policy makers who support the expansion of involuntary commitment for substance use disorders as a solution to the ongoing overdose crisis must reconcile mounting evidence that this approach may increase the number of deaths among people who use drugs.

In Massachusetts and elsewhere, shutting the system down is not a realistic option in the short term—thousands of people receive treatment through involuntary commitment each year, and the practice remains politically popular. However, we must start the process of dramatically redistributing budgetary funds toward evidence-based voluntary treatment options and away from involuntary commitment. In 2023, the Massachusetts governor's budget allocated more than US$22 million to the Massachusetts Alcohol and Substance Abuse Center, the involuntary treatment facility housed alongside a state prison, while providing less than US$7 million to harm reduction services across the state.[23] This imbalance of resources has led to overreliance on involuntary commitment for substance use disorders as a first-line intervention.[24] For instance, there have been numerous anecdotes from those treating addiction in the community that people are volunteering themselves for involuntary commitment because they are otherwise

unable to access treatment. Additionally, the recent DPH report found that areas with access to more robust voluntary treatment services had proportionately lower rates of involuntary commitment for substance use disorders.[25] Nationally, we must ensure that states seeking to implement involuntary commitment for substance use disorders have first taken care to allot sufficient resources to voluntary treatment options.

In cases where involuntary commitment is still needed, we must aim to use the least restrictive measures possible and guarantee the provision of evidence-based treatments to mitigate the risk of overdose. Courts evaluating patients for involuntary commitment for substance use disorders should consider alternative, less restrictive measures such as mandated outpatient or intensive outpatient programs, depending on the severity of an individual's addiction. Those who do not meet the criteria for involuntary commitment should be directed to voluntary treatment options. We must also work to set treatment standards for involuntary commitment for substance use disorders, such as guaranteed provision of medications for substance use disorders for patients who are interested. The importance of these interventions cannot be understated—buprenorphine and methadone used in the treatment of opioid use disorder are the most effective treatments available for addiction, leading to a more than 50% reduction in all-cause mortality.[26] Additionally, facilities must guarantee community-based follow-up for all individuals being discharged from treatment. Finally, we must ensure that treatment is provided in health care settings by trained medical and psychiatric providers. Although a Massachusetts bill passed in 2017 required that facilities for women be operated by the DPH or the Department of Mental Health, state house and senate bills providing the same protection for men have not been passed despite several attempts.[27]

Given that drug overdose remains a leading cause of death for US residents under 45, we must do all that we can to protect the lives of those experiencing addiction.[28] Although involuntary commitment for substance use disorders has been proposed as a desperate measure to prevent overdose, it has backfired. In Massachusetts, the magnitude of the system of involuntary commitment for substance use disorders will make change difficult. However, if we resort to this as the primary means of addressing the overdose crisis, we do so at the cost of the lives of those forced into treatment for addiction.

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