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What Decades of Research Reveal About Involuntary Substance Use Treatment—And Why Evidence Points Elsewhere

By Susan E. Collins

Since President Donald Trump issued a July 2025 executive order¹ aimed at “ending crime and disorder on America’s streets,” national attention has increasingly focused on involuntary treatment as a response to visible homelessness and drug use.

A few months later, in September 2025, officials in Utah announced plans for a 16-acre facility on the edge of Salt Lake City that would hold up to 1,300 people experiencing homelessness after they are removed from public spaces and offered a choice: the facility’s abstinence-based shelter or jail time. The facility also plans to include 300 to 400 beds reserved for involuntary treatment, for adults who have psychiatric and substance use disorders.

Supporters of this facility describe it as a humane alternative to the streets, while detractors liken it to prison.

Since the release of the executive order, other proposals for expanding involuntary treatment for adults with substance use disorder have been cropping up across the U.S., including in New Jersey, Washington state and New York state.

I am a licensed clinical psychologist, substance-use treatment professional and researcher at the University of Washington. Throughout my three decades in

the field, my research has focused on what works when it comes to substance use treatment, including among people experiencing homelessness.

I started reading research on involuntary treatment in 2018, when Ricky’s law—Washington’s version of involuntary treatment—was implemented where I live and work.

What I have learned is that involuntary treatment for adults with substance use disorders is necessary in extreme cases, but it does not outperform voluntary care and raises serious concerns about patient safety.

‘Involuntary’ or ‘Forced’ Treatment

People who have substance use disorder often experience pressure to enter treatment and stop using alcohol and drugs. This pressure ranges from informal coercion, like family pleas or providers leveraging housing or other services, to formal coercion, like treatment mandated by the court system (Sullivan).

Involuntary treatment, referred to in the U.S. as “involuntary civil commitment,”² is distinct from these approaches and is the most restrictive means of formal coercion. Civil commitment authorizes a court, often based on

² <https://www.congress.gov/crs-product/R47571>

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We Study Pandemics, and the Resurgence of Measles Is a Grim Sign of What’s Coming

By Jennifer B. Nuzzo and
Andrea Uhlig

In the three decades between 1993 and 2024, measles in the U.S. was relatively rare—a few hundred cases each year, at most. But suddenly, the disease has become so entrenched in American life that it sometimes fails to make headlines when a new outbreak erupts.

As of March 2026, measles has been continuously circulating around the U.S. for more than a year, starting with an outbreak in Texas that lasted from January to August 2025.¹ Before that outbreak was declared over, an outbreak on the Utah² and Arizona border³ began in August and is ongoing. An

¹ <https://www.dshs.texas.gov/news-alerts/measles-outbreak-2025>

² [https://files.epi.utah.gov/Utah measles dashboard.html](https://files.epi.utah.gov/Utah%20measles%20dashboard.html)

³ <https://www.azdhs.gov/preparedness/epidemiology-disease-control/measles/index.php>

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a health care professional's assessment, to order the involuntary deprivation of liberty, usually by confining a person to a locked treatment facility.

Unlike court-mandated treatment, which involves consent and choice, albeit limited, involuntary treatment does not involve consent and is often administered against a person's will, with the length of treatment determined by court order and state law.

Such treatment is typically considered when a person poses an imminent risk of serious physical harm to themselves or others—for example, expressing suicidal or homicidal intent with a plan and means to carry it out. It may also be considered in cases of grave disability, such that an adult is unable to care for themselves without assistance.

A History of Abuse

There is a reason involuntary treatment is reserved for these extreme cases. In the 19th and early 20th centuries, institutional abuses were rampant in state psychiatric hospitals, where patients were often confined and stripped of their civil rights for years, sometimes indefinitely. Through reforms in the 1960s, civil commitment law was applied in fewer cases, and legal protections for patients were strengthened.

But recent decades have seen a renewed interest in involuntary treatment

specifically for substance use disorder. As of early 2026, 37 states and the District of Columbia have laws allowing involuntary treatment for substance use disorder, with most having added new and expanded civil commitment statutes in just the past 10 years.

In practice, these statutes vary widely in criteria, duration and utilization, reflecting a lack of consensus about their proper role (Christopher).

Heightened Risk of Relapse, Rearrest and Death

Yet even as involuntary treatment for substance use disorder is being expanded, there is no clear scientific evidence that it is effective.

Three systematic reviews—wide-ranging analyses of the peer-reviewed, scientific literature—published in 2005 (Klag), 2016 (Verb), and 2023 (Bahji) have summarized the research on coercive substance use treatment in adults.

Within these reviews, some studies that are labeled as “involuntary treatment” actually refer to mandated but voluntary treatment, not civil commitment. When limited to studies of true involuntary treatment for substance use disorder, the literature indicates no measurable benefit and in some cases clear harm.

The most commonly cited harms are higher risk of relapse, rearrest and even death after release from treatment. In fact, one international research study showed that risk of death increases two- to nearly

fourfold (Ledberg) in the weeks following release, primarily due to overdose.

Unfortunately, there is no consistent and transparent program evaluation and reporting framework for involuntary substance use treatment in the U.S. To date, Massachusetts and Washington appear to be the only states to have published outcome evaluations of their involuntary substance use treatment programs.

Data from Massachusetts echoes the pattern reflected in the larger research literature: Adults with a history of involuntary treatment experienced 40% higher risk of death from overdose than people with no involuntary treatment history.³

In its eight years of operation, Washington's involuntary treatment program has published only one program evaluation.⁴ Findings showed mixed short-term results: There were modest reductions in emergency department use and homelessness, but lower rates of follow-up treatment for substance use and no change in arrests or employment. Most important, there has been no analysis of subsequent substance use outcomes or post-release mortality.

More data and more frequent reporting are needed to determine the effectiveness

³ <https://www.mass.gov/doc/presentation-on-dph-opioid-and-civil-commitment-data>

⁴ https://wsipp.wa.gov/ReportFile/1766/WSipp_Involuntary-Treatment-for-Substance-Abuse-Client-Outcomes_Report.pdf

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and safety of involuntary treatment for substance use disorder in the U.S.

In addition to documenting quantitative outcomes, documenting patients' own subjective experiences of involuntary treatment for substance use disorder, as has been done for patients in involuntary treatment for psychiatric disorders (Silva), may help improve its delivery, even as it remains a last resort.

Calculating the Cost

While patient health and civil liberties are top priorities, states also have to consider costs. It has been long documented that voluntary inpatient substance use treatment is substantially more expensive than lower-intensity, lower-barrier treatment and service settings. However, involuntary treatment layers on further costs of secured, statutorily designated placement with formal court proceedings and ongoing legal oversight.

Involuntary treatment under Massachusetts Section 35 law costs an estimated US\$76,819 per male patient annually.⁵ In Washington, the average 11-day stay costs \$7,298.⁶ Washington's program yielded a low benefit-to-cost ratio, with the program losing approximately 81 cents for every dollar spent within the first year after treatment.

The few U.S. evaluations of involuntary treatment conducted to date have thus not indicated that involuntary treatment reduces publicly funded service costs sufficiently to offset its expense.

Other Solutions

Meanwhile, the evidence consistently points to lower-barrier and voluntary

approaches as more effective, less costly and less risky than involuntary treatment.

For people with substance use disorder who also experience homelessness, this includes a range of affordable and supportive housing options, from abstinence-based recovery housing to low-barrier permanent supportive housing paired with services, such as Housing First. Research shows Housing First effectively increases housing stability and reduces use of publicly funded services (Baxter).

Evidence also supports implementing harm-reduction programs, including street-based engagement, syringe service programs and providing naloxone kits for overdose reversal. Collectively, these programs have been shown to prevent overdose, reduce transmission of blood-borne illness and connect people to voluntary services and treatment.

Effective behavioral treatments (Witkiewitz) and medications that reduce craving and overdose risk, such as buprenorphine, methadone, naloxone and naltrexone, represent the gold standards in substance use treatment and overdose prevention.

Justice system diversion programs have been shown to be effective in keeping those convicted of low-level drug use and possession crimes out of jail. Case managers for these programs help participants find housing and vocational services, improving their stability. These programs reduce recidivism and relieve an already overloaded legal system.

Given the lack of existing evidence supporting involuntary treatment, I believe expanding it beyond acute, life-threatening crises is unwarranted. It is not a substitute for investing in and delivering lower-barrier, voluntary services that already have been shown to save lives, reduce harm and foster sustainable recovery.

References

- Bahji, Anees, et al. "Effectiveness of Involuntary Treatment for Individuals With Substance Use Disorders: A Systematic Review." *The Canadian Journal of Addiction* 14(4):p 6–18, December 2023. | DOI: 10.1097/CXA.0000000000000188
- Baxter AJ, Tweed EJ, Katikireddi SV, et al. "Effects of Housing First approaches on health and well-being of adults who are homeless or at risk of homelessness: systematic review and meta-analysis of randomised controlled trials." *J Epidemiol Community Health* 2019;73:379–387.
- Christopher, Paul P. et al. "Nature and Utilization of Civil Commitment for Substance Abuse in the United States." *Journal of the American Academy of Psychiatry and the Law Online*, Sep 2015, 43 (3) 313–320.
- Klag, S., O'Callaghan, F., & Creed, P. "The Use of Legal Coercion in the Treatment of Substance Abusers: An Overview and Critical Analysis of Thirty Years of Research." *Substance Use & Misuse*, (2005), 40(12), 1777–1795. <https://doi.org/10.1080/10826080500260891>
- Ledberg, Anders & Reitan, Therese. "Increased risk of death immediately after discharge from compulsory care for substance abuse." *Drug and Alcohol Dependence*, Volume 236, 1 July 2022, 109492.
- Silva B, et al. "Feeling coerced during voluntary and involuntary psychiatric hospitalisation: A review and meta-aggregation of qualitative studies." *Heliyon*, Volume 9, Issue 2e13420, February 2023.
- Sullivan, M.A., et al. "Uses of Coercion in Addiction Treatment: Clinical Aspects." *The American Journal on Addictions*, (2008), 17: 36–47. <https://doi.org/10.1080/10550490701756369>
- Werb, D. et al. "The effectiveness of compulsory drug treatment: A systematic review." (2016) *International Journal of Drug Policy*, Volume 28, February 2016, Pages 1–9. <https://doi.org/10.1016/j.drugpo.2015.12.005>
- Witkiewitz, K. et al. "Advances in the science and treatment of alcohol use disorder." *Sci. Adv.* 5, eaax4043(2019). DOI:10.1126/sciadv.aax4043

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⁵ <https://www.wbur.org/news/2019/04/10/civil-commitments-massachusetts-treatment>

⁶ https://wsipp.wa.gov/ReportFile/1766/Wsipp_Involuntary-Treatment-for-Substance-Abuse-Client-Outcomes_Report.pdf