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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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outbreak in South Carolina⁴ began in September, drastically increased in January 2026, and continues.

Thirty states have had measles cases this year;⁵ 47 have seen cases since the start of 2025. Health officials across the U.S. have confirmed 1,300 infections already this year⁶ as of March 6, putting the country on track to surpass 2025's numbers, which were the highest in 35 years.

We study outbreak preparedness and response at Brown University's Pandemic Center, and we view the return of measles in the U.S. as a grim signal of what's to come.

Low levels of vaccination across the country mean measles outbreaks will continue to occur, needlessly hospitalizing and killing the unvaccinated. But beyond these harms, the disease's resurgence serves as a serious warning about the country's capacity to manage infectious disease threats of all kinds.

An Eliminated Disease Returns

Measles' return is no mystery: At its root is the falling vaccination rate.

Around 90% of the U.S. population has received the MMR vaccine⁷, which protects against measles, mumps and rubella, and in some regions of the country, the rate is below 60% (Zhou). Since about 2019-2020, that overall number has dropped below the 95% needed for herd immunity. It is necessary to keep that rate nationally, but maintaining herd immunity at the local level is equally important in order to prevent measles from finding pockets of unvaccinated communities.

Countries that remain free of continuous transmission for 12 months⁸ are

deemed to have eliminated measles—a designation the U.S. achieved in 2000. The Pan American Health Organization was scheduled to decide in April whether the U.S. should lose that designation, but the organization postponed its meeting until November.

Current trends suggest that both the U.S. and Mexico, which has also been battling the disease, may lose this status—as Canada did in November 2025. All three countries have seen their vaccination rates fall below the 95% threshold, and their outbreaks may share epidemiological links.

A Serious, Long-Term Threat to US Health

By any measure, the ongoing U.S. measles outbreaks signal that the disease has returned in a way that will have serious adverse health consequences. In 2025, three people died from measles in the U.S. That is more than in any year since the disease's elimination 25 years ago.

Of the country's 2,283 confirmed measles cases in 2025, 11% were sick enough to be hospitalized.⁹ In South Carolina, where most measles cases have been reported in 2026, hospitals don't have to report when patients are admitted due to measles complications, so the actual number of hospitalizations due to measles could be much higher.

People who recover from measles can experience complications such as pneumonia, which can lead to death, or encephalitis, which can later lead to deafness or intellectual disabilities from the brain swelling. The virus can also affect the immune system, making people more susceptible to other infections over the long term, even ones they've had before (Mina).

In rare instances—though more likely if someone is infected as a child—measles patients can develop a progressive dementia known as subacute sclerosing panencephalitis, or SSPE, anywhere from two to 10 years after their infection. SSPE always leads to death. This past year, a school-age child in Los Angeles died of this condition years after being infected with measles as an infant, before they were old enough to be vaccinated.

⁹ <https://www.cdc.gov/measles/data-research/index.html>

Measles Is an Economic Scourge

Recurring outbreaks of measles in the U.S. will mean high economic costs. Countries have pursued measles elimination in part because of the clear economic benefits of stopping domestic transmission of the virus.

Studies have found that the cost of containing measles outbreaks (Sriudomporn) is often as much as tens of thousands of dollars per case. One outbreak in Washington state in 2018-2019 (Pike), which involved 72 cases—a small outbreak compared with what states are reporting now—cost US\$3.2 million for the public health response, medical expenses and productivity losses. The Common Health Coalition found that a sustained 1% drop in MMR coverage would cost the U.S. billions across health care systems and the economy.

An Opening For Infectious Disease

As concerning as recent outbreaks of measles have been, they herald a larger systemic problem.

How a country controls measles can be viewed as a proxy for how well it would control many other diseases. That's because the steps for stopping the spread are the same: deploying vaccines to prevent infections, detecting and isolating cases when they occur, identifying exposed contacts of infected people and making sure they stay home if they're likely to be contagious, and treating sick people safely.

But besides measles, we've already seen infections that were once controlled, like whooping cough,¹⁰ that rose sharply in 2024 and remained high in 2025 compared with before the COVID-19 pandemic.

That's because controlling the spread of many infectious diseases depends on the public's trust in the basic components of public health. Declining MMR vaccine coverage reveals underlying challenges in public support for vaccines. Public confidence in the current Centers for Disease Control and Prevention is also eroding, according to polling from 2023 to early 2026 by the health

¹⁰ <https://www.cdc.gov/pertussis/php/surveillance/index.html>

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⁴ <https://dph.sc.gov/diseases-conditions/infectious-diseases/measles-rubeola/measles-dashboard>

⁵ <https://www.cdc.gov/measles/data-research/index.html>

⁶ <https://www.cidrap.umn.edu/measles/us-measles-total-approaches-1300-infections>

⁷ <https://www.cdc.gov/nchs/fastats/immunize.htm>

⁸ <https://www.kff.org/other-health/measles-elimination-status-what-it-is-and-how-the-u-s-could-lose-it/>

policy organization KFF. Less than half of the people polled trust the government even “a fair amount” to provide reliable vaccine information.

These growing cracks in the country’s public health armor will complicate efforts to protect Americans from future disease threats—whether an outbreak, a pandemic or a biological attack.

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