Incarceration, Rebranded: Misinformation about Involuntary Commitment for Substance Use Disorder in the Age of the Overdose Crisis

By Leo Beletsky, Sunyou Kang, Sean McCormick, Katelyn McCreedy, Norrie Osgood, Sarah Yates[*]

* Beletsky is Professor of Law and Health Sciences at Northeastern University and the faculty director at The Action Lab, Center for Health Policy and Law, Northeastern University School of Law, where Kang is Director of Operations. McCormick was Civil Rights Legal Fellow. McCreedy is a Doctoral Researcher in Epidemiology. Osgood was a Legal Research Assistant. Yates was a Research Lead. The authors thank Fatimah Al-Najjar, Sophia Cassim, and Julia Winett of the Action Lab. The authors also thank Mehreen Butt, Director of the Center for Health Policy and Law. Special thanks to the *Northeastern University Law Review* for their guidance, especially to Maureen Greason, Articles Editor.

Table of Contents

Abstract 507

Introduction 509

I. Involuntary Commitment in Context 512

A. *Institutionalization of Deviance: An American Legacy* 513

B. *Evolution of Involuntary Commitment for Substance Use Disorder* 516

II. Efficacy of Involuntary Commitments for SUD 517

A. *Public Health Dimensions* 519

B. *Systematic Review* 520

III. Misinformation 521

A. *MediaCloud Misinformation Analysis* 524

B. *Physician Attitudes Towards Involuntary Commitment* 526

IV. In Practice: Involuntary Commitment for Substance Use Disorder as a Response to the Overdose Crisis 529

A. *Dynamics of Involuntary Commitment for Substance Use Disorder in Massachusetts: A Case Study* 529

B. *Dynamics of Involuntary Commitment for Substance Use Disorder Implementation Across Key States* 533

V. Law as an Instrument to Reduce the Harms of Involuntary Confinement 536

A. *Constitutional Considerations and Potential Solutions* 539

1. Involuntary Commitment and the Due Process Clause of the Fourteenth Amendment 541

a. Substantive Due Process 543

b. Procedural Due Process 545

2. Involuntary Commitment and the Equal Protection Clause of the Fourteenth Amendment 547

3. The Eighth Amendment 548

B. *Statutory Considerations* 550

1. The Americans with Disabilities and Rehabilitation Acts 551

2. Civil Rights of Institutionalized Persons Act of 1980 551

VI. Ethical Dimensions 553

VII. Next Steps 556

A. *Changing the Media Narrative* 558

B. *Proposed Policy Changes* 560

Conclusion 561

Appendix A 562

Abstract

Substance Use Disorder (SUD) remains a critical public health challenge in the United States. Involuntary commitment is a legal mechanism authorizing mandated detention for substance use or mental health treatment. In response to the ongoing overdose crisis, states have embraced involuntary commitment for substance use. This approach has grown in popularity under the banner of treatment as a more humane alternative to incarceration and other forms of criminal legal intervention. This article challenges cavalier investment in involuntary commitment as incarceration by another name. In addition to highlighting close involvement of correctional systems and practices in involuntary commitment systems, we review empirical evidence documenting increased risks of overdose and relapse as a result of mandated treatment. This is partly because involuntary commitment programs often deploy outdated interventions that prioritize institutionalization over science-based approaches.

While broader statutory reform is needed, this Article articulates ways to reduce the harms of the current involuntary commitment in the immediate term. Public health efforts should prioritize reducing institutionalization, improving access to science-driven interventions, and boosting investment in voluntary outpatient alternatives.

INTRODUCTION

During his 2020 presidential campaign, President Joe Biden repeatedly invoked the use of "mandatory rehabilitation" as a method by which he would address the ever-burgeoning addiction crisis in America. Undeniably, Substance Use Disorder ("SUD") is a significant tragedy and public health challenge in the United States that affects approximately 46.3 million Americans age twelve or older in 2021.[1] It is impossible to ignore the impact of this crisis. SUD can lead to negative mental and physical health outcomes including overdose and infectious disease transmission that affect not just individuals with SUD but their loved ones and their fellow community members as well.[2] As drug-related deaths surge and the drug overdose crisis continues unabated, the demand for efficient and effective responses grows in turn—often from family members, who find themselves without accessible or adequate treatment options for their loved one with SUD, as well as experts who highlight the dangers of existing policies and the need to user in meaningful change.[3]

1 *See* AM. PSYCHIATRIC ASS'N, DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS 483–85 (5th ed. 2013); Candice T. Player, *Involuntary Civil Commitment: A Solution to the Opioid Crisis?*, 71 RUTGERS U. L. REV. 589, 595 (2019) ("[T]he American Psychiatric Association replaced the diagnostic criteria for substance abuse and substance dependence with a new diagnostic category—substance use disorder [(SUD) in 2013] . . . key criteria for diagnosing a [SUD] in the DSM-5 include: consuming the drug in larger and larger quantities, over a longer period of time than intended; continued use of the substance despite persistent social or interpersonal problems; and tolerance, i.e. 'requiring a markedly increased dose of the substance to achieve the desired effect.'"); SUBSTANCE ABUSE & MENTAL HEALTH SERVS. ADMIN., KEY SUBSTANCE USE AND MENTAL HEALTH INDICATORS IN THE UNITED STATES: RESULTS FROM THE 2021 NATIONAL SURVEY ON DRUG USE AND HEALTH (2021), https://www.samhsa.gov/data/sites/default/files/reports/rpt39443/2021NSDUHFFRRev010323.pdf.

2 *Harm Reduction*, SUBSTANCE ABUSE & MENTAL HEALTH SERVICES ADMIN. (updated Apr. 24, 2023), https://www.samhsa.gov/find-help/harm-reduction; *Infectious Diseases, Opioids and Injection Drug Use*, CTR. FOR DISEASE CONTROL & PREVENTION (Aug. 31, 2021), https://www.cdc.gov/pwid/opioid-use.html.

3 *Mayor Adams Announces Plan to Provide Care for Individuals Suffering From Untreated Severe Mental Illness Across NYC*, N.Y.C. OFF. OF THE MAYOR, (Nov. 29, 2022), https://www.nyc.gov/office-of-the-mayor/news/870-22/mayor-adams-plan-provide-care-individuals-suffering-untreated-severe-mental#/0 (Mayor Eric Adams has proposed increased court-ordered treatment for people with severe mental illness who are not "meeting their own basic human needs to the extent that they are a danger to themselves," insisting on "dispel[ling] a persistent myth that the legal standard for involuntary intervention requires an 'overt act' demonstrating that the person is violent, suicidal, or engaging in outrageously dangerous behavior

In contrast to historically favored criminal legal interventions, Biden's invocation of treatment rather than criminalization implicitly concludes that promotion of mandatory rehabilitation is a humane approach through which governments may address SUD. Congruently, as the overdose crisis continues to unfold, and the impact of the punitive "War on Drugs" is harshly criticized, policymakers and healthcare providers call for expanded access to evidence-based treatment and supportive services in place of arrest and incarceration.[4] As a result, the deployment of involuntary commitment as an alternative treatment to the overdose crisis becomes increasingly prevalent—with states expanding policy avenues to allow SUD as a condition for commitment, and most jurisdictions currently allow for the involuntary commitment of individuals with SUD.[5]

It is necessary to note that this much-overdue shift in rhetoric (away from criminalization and toward civil remedies) was at least in part driven by the "changing face" of drug-related policy challenges—namely, the growing impact on wealthier, whiter people.[6] In further contrast to the Black-targeted crack cocaine crisis of the 1980s and 1990s and other drug-related crises, the role of pharmaceutical companies in the opioid crisis as perpetrators of harm to unwitting patients sets a

likely to result in imminent harm."); Alex Kennedy, *Angry Families Confront N.L. Government, Demand Action on Drug Deaths*, CBC (Aug. 23, 2023), https://www.cbc.ca/news/canada/newfoundland-labrador/drug-overdose-death-rally-1.6945042; David Sheff, *My Son Was Addicted and Refused Treatment. We Needed More Options*, N.Y. Times (Apr. 19, 2023), https://www.davidsheff.com/news/2023/4/19/my-son-was-addicted-and-refused-treatment-we-need-more-options-opinion-new-york-times; Leo Beletsky & Denise Tomasini-Joshi, *'Treatment Facilities' Aren't What You Think They Are*, N.Y. Times (Sept. 3, 2019), https://www.nytimes.com/2019/09/03/opinion/opioid-jails-treatment-facilities.html.

4 *See* The Action Lab & Ctr. for Pub. Health L. Rsch., *Involuntary Commitment for Substance Use*, Prescription Drug Abuse Pol'y Sys. (May 1, 2021), https://pdaps.org/datasets/civil-commitment-for-substance-users-1562936854; John C. Messinger & Jacqueline Garza, *Patients with Substance Use Disorder Need Care, Not Coercion*, Harv. Pub. Health (July 18, 2023), https://harvardpublichealth.org/policy-practice/involuntary-commitment-not-solution-to-addiction-housing-instability/.

5 *See* The Action Lab & Ctr. for Pub. Health L. Rsch., *Involuntary Commitment for Substance Use*, Prescription Drug Abuse Pol'y Sys. (May 1, 2021), https://pdaps.org/datasets/civil-commitment-for-substance-users-1562936854; John C. Messinger & Jacqueline Garza, *Patients with Substance Use Disorder Need Care, Not Coercion*, Harv. Pub. Health (July 18, 2023), https://harvardpublichealth.org/policy-practice/involuntary-commitment-not-solution-to-addiction-housing-instability/.

6 Theodore J. Cicero et. al., *The Changing Face of Heroin Use in the United States: A Retrospective Analysis of the Past 50 Years*, 71 JAMA Psychiatry 821, 821–26 (2014).

gentler tone for more humanistic policymaking narratives.[7]

However, this shift in approach is insufficient to resolve the multifaceted, complex nature of what it means to live with SUD. These narratives ignore the true complexity of the opioid crisis, effectively ignoring Indigenous and other minoritized groups that have been hardest hit by this national tragedy from its inception.[8] Observers also rightly point out that the change in tone and language has not been backed up by a true shift in approach—without underlying social change and evidence-based solutions, a purported shift away from punitive action is insufficient to support people with SUD and the communities around them.[9] Mandated or "involuntary commitment" precisely encapsulates this change in tone without a meaningful change in the substance of policies.

Involuntary commitment (also known as civil commitment) for individuals with SUD is a legal intervention by which a person can be detained against their will without invoking criminal law, thereby diverting them away from criminal justice system involvement.[10] While options for evidence-based and cost-effective measures exist, access to and investment in these responses lag, while involuntary commitment for SUD has become the norm (in part by acting as a stand-in measure for more effective voluntary treatment options). Despite limited evidence supporting the use of involuntary commitment for SUD, an increasing number of state legislatures have amended laws related to involuntary commitment of people who use drugs as a means of reducing problematic substance use and overdoses.[11] In addition to

7 *See* Taleed El-Sabawi, *Defining the Opioid Epidemic: Congress, Pressure Groups, and Problem Definition*, 48 U. Mem. L. Rev. 29–31 (2018); Julie Netherland & Helena Hansen, *The War on Drugs That Wasn't: Wasted Whiteness, "Dirty Doctors," and Race in Media Coverage of Prescription Opioid Misuse*, 40 Culture, Med., & Psychiatry 664, 666 (2016).

8 Netherland & Hansen, *supra* note 6; *see Advancing Racial Justice in Health Care Through Addiction Medicine*, Am. Soc'y of Addiction Med. (2021), https://www.asam.org/advocacy/national-advocacy/justice.

9 Leo Beletsky, *America's Favorite Antidote: Drug-Induced Homicide in the Age of the Overdose Crisis*, 4 Utah L. Rev. 833, 883–84 (2019); Ju Nyeong Park et al., *Situating the Continuum of Overdose Risk in the Social Determinants of Health: A New Conceptual Framework*, 98 Milbank Q. 700, 702, 704, 726 (2020).

10 Abhishek Jain et al., *Civil Commitment for Opioid and Other Substance Use Disorders: Does it Work?*, 69 Psychiatric Servs. 374 (2018).

11 *Involuntary Commitment for Substance Use*, The Action Lab, https://www.healthinjustice.org/involuntary-commitment-for-substanc (last visited Apr. 27, 2023); Mass. Dep't of Pub. Health, An Assessment of Fatal and Nonfatal Opioid Overdoses in Massachusetts 29, 49–50 (2011-2015) (2017) (report based on data

being violative of individual rights, critics argue that the treatment is reactionary, failing to address the root causes of addiction. There is also a lack of empirical evidence supporting the treatment's effectiveness, as well as growing evidence that the practice, in fact, increases health risks.[12]

Involuntary commitment is a symptom of, not a cure for, the dismal state of SUD care and treatment in the United States. This proliferation of involuntary commitment for SUD raises significant legal, ethical, and public health questions, but many key issues remain under-examined.[13]

In this Article, we fill several knowledge gaps. We begin by examining the empirical evidence base behind involuntary commitment for SUD to assess its purported public health impact. We continue by analyzing the current legal landscape surrounding and underlying involuntary commitment policies throughout the United States. To better understand the landscape driving the ever-burgeoning nationwide investment in involuntary commitment, we examine the ways in which prevailing media narratives surrounding involuntary commitment for SUD may promote its use. Finally, we advocate against the proliferation of involuntary commitment for SUD, discussing several promising legal and public health interventions to halt its growing deployment in the United States.

I. Involuntary Commitment Context

Involuntary commitment is not a new mental health intervention; it has existed for decades in various forms in the United States.[14] In fact, preceding the creation of the American asylum, people with mental illnesses were involuntarily isolated in prisons and shelters under the

from 2012-2016).

12 John Messinger & Leo Beletsky, *Involuntary Commitment for Substance Use: Addiction Care Professionals Must Reject Enabling Coercion and Patient Harm*, 15 J. Addiction Med. 280, 280–282 (2021); John Messinger et al., *Outcomes for Patients Discharged to Involuntary Commitment for Substance Use Disorder Directly from the Hospital*, 59 Cmty. Mental Health J. 1300 (2023); Galya Walt et al., *Clinician's Experiences with Involuntary Commitment for Substance Use Disorder: A Qualitative Study of Moral Distress*, 99 Int'l J. of Drug Pol'y, Jan 2022, at 2.

13 It is necessary to note that laws are social remedies. Policies are essentially problem-solving instruments. However, without the backing of data, their efficacy is tested in real-time upon incorporation into effective law. As a result, policy remedies often either produce no effect or adverse events that are unintended or ignored.

14 Zachary Groendyk, *"It Takes a lot to get into Bellevue": A Pro-rights Critique of New York's Involuntary Commitment Law*, 40 Fordham Urb. L.J. 549, 572 (2013).

assumption that they lacked decision-making capacity over their care.[15] Later on, asylums served to house people indefinitely and for various, uncorroborated reasons. Rather infamously, Elizabeth Packard was committed to an asylum in 1860 by her husband, who asserted that she had an "unclean spirit."[16] Upon her subsequent diagnosis of "moral insanity," Mrs. Packard was held involuntarily in a hospital for three years before being released upon a declaration of sanity.[17] Today, clearly, these are not conditions under which a person may be involuntarily committed for lack of decision-making capacity. As observed in Mrs. Packard's case, a lack of established standards and criteria provided courts with little ability to oversee or regulate a party's decision to civilly commit another.[18] The legacy of these nebulous standards lives on in involuntary commitment policy and practice today.

A. *Institutionalization of Deviance: An American Legacy*

As elucidated through Mrs. Packard's case, involuntary and coerced treatment, as well as other forms of civil detention, were historically deployed in the United States under the pretext of protection to suppress perceived deviance and enforce social norms.[19] This approach to suppressing perceived deviance resulted in the growth of asylums, mental hospitals, and other forms of institutional control over people who were deemed outside the norm, including people who used certain substances.[20]

In the 1960s, in a de-institutionalization effort and an attempt to create clearer standards for this deprivation of liberty explicit to the

15 Stuart A. Anfang & Paul S. Appelbaum, *Civil Commitment – The American Experience*, 43 Isr. J. Psychiatry & Related Sci. 209, 210 (2009).

16 Megan Testa & Sara G. West, *Civil Commitment in the United States*, 7 Psychiatry 30, 32 (2010).

17 *Id.*

18 Christyne E. Ferris, *The Search for Due Process in Civil Commitment Hearings: How Procedural Realities Have Altered Substantive Standards*, 61 Vand. L. Rev 959, 963 (2008) (Further, no distinction was drawn between "voluntary" and "involuntary" psychiatric interventions. Lacking procedural safeguards, people often did not appear before a judge, were not provided counsel, or were provided insufficient counsel "characterized by mutual expectations of perfunctory performance").

19 *See* Stephen J. Morse, *A Preference for Liberty: The Case Against Involuntary Commitment of the Mentally Disordered*, 70 Cal. L. Rev. 54, 67–69 (1982) (substance use included under the larger umbrella of "deviant behavior").

20 Bernadette Dallaire et al., *Civil Commitment Due to Mental Illness and Dangerousness: The Union of Law and Psychiatry Within a Treatment-Control System*, 22 Socio. Health & Illness 679, 679–699 (2000).

determination that a person should be isolated in an institution without their consent, Washington, D.C., became the first jurisdiction to institute a standard of "dangerousness" for civil commitment procedures, followed by California.[21] Under this standard, to be involuntarily committed, a person must pose an imminent danger to themselves or others or be "gravely disabled" such that they cannot provide themselves with the necessities for survival.[22]

This standard endures, though it remains ill defined and its application is often inconsistent, especially across states.[23] Generally, "dangerousness" is indicated by establishing imminent physical harm to self or others.[24] Differences emerge when observing how the standard is applied: for example, in some states, an evaluator's judgment may suffice to establish the required presence of a mental illness to initiate commitment;[25] however, the legal definitions of the risks that evaluators are asked to testify to are murky.[26]

Further, the scope of what involuntary commitment means in practice may vary by state. In most states, civil commitment laws authorize any of three modes of confinement and treatment: (1) emergency "psychiatric holds" for evaluation purposes; (2) inpatient civil commitment until the court determines that the patient no longer meets civil commitment criteria; and (3) outpatient civil commitment,

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21 Anfang & Appelbaum, *supra* note 13, at 211 (Prior to the 1970s, civil commitment merely required "findings" from two physicians that the patient was "ill and a proper subject for treatment in a psychiatric hospital," with no definition of "ill" or "proper subject").

22 *Id.* at 211.

23 *See* The Action Lab & Ctr. for Pub. Health L. Rsch., *supra* note 4.

24 Ferris, *supra* note 16, at 966 (noting no consensus among states but typical consideration of "three criteria: the type of danger, the immediacy of the danger, and the likelihood of the danger."); Anfang & Appelbaum, *supra* note 13, at 211–23 (under dangerousness standards, commitment of an individual cannot be initiated without a demonstrated risk to oneself or others); Substance Abuse & Mental Health Servs. Admin., *Civil Commitment and the Mental Health Care Continuum: Historical Trends and Principles for Law and Practice* 1, 4 (2019), https://www.samhsa.gov/sites/default/files/civil-commitment-continuum-of-care.pdf.

25 Ethical concerns around the suitability of these authorizations for SUD treatment have been raised, particularly with regard to poor outcomes and abusive practices noted in some facilities, highly individualized needs and preferences for treatment options, and the possibility, in some states, of an unqualified individual petitioning to initiate commitment. For expanded discussion, *see* Part III; *see also* Shoba Sreenivasan et al., *Expert Testimony in Sexually Violent Predator Commitments: Conceptualizing Legal Standards of "Mental Disorder" and "Likely to Reoffend,"* 31 J. Am. Acad. Psychiatry & L. 471 (2003).

26 Sreenivasan et al. *supra* note 23, at 471–85.

involving court-ordered mental health treatment.[27]

Despite interstate variability, each state's civil commitment processes are held to the baseline standard established by the Supreme Court in *O'Connor v. Donaldson* in 1975: an individual who, firstly, does not pose a danger to themselves or others, and secondly, is able to provide for themselves without state supervision, may not be involuntarily committed.[28] Further, before admission into a facility, a person has the right to a trial with attorney representation.[29] Patients are generally allowed the opportunity to stand before a court to determine whether they should remain committed,[30] and most jurisdictions require a timely opportunity for a hearing once commitment has been initiated.[31] All involuntarily committed patients possess the right to petition for a writ of habeas corpus.[32] Many states also specify that commitment should not be initiated if less restrictive approaches are available or appropriate for an individual's needs.[33] As such, psychiatrists are required to recommend the least restrictive means of care appropriate for a non-dangerous person.

The lower burden of proof required in civil suits as opposed to criminal suits presents an easier pathway to civilly commit another person. *Addington v. Texas* attempted to determine a sufficient standard of proof to hold a petitioner for the involuntary commitment of another individual.[34] The Supreme Court held that "because psychiatry was a field dealing with the inexact science of predicting future risk, the standard of beyond a reasonable doubt was so burdensome that it would serve as a barrier to the hospitalization of many patients who were in clear

27 Involuntary outpatient commitment statutes also exist in most states to provide psychiatric care under supervision with the goal of limiting the impact upon individual liberties. If criteria are met, a person may be mandated to psychiatric treatment, though not necessarily to take prescribed medications. Lisa Dailey et al., *Grading the States: An Analysis of U.S. Psychiatric Treatment Laws*, Treatment Advoc. Ctr. 1, 9, 10, 22–23 (2018), https://www.treatmentadvocacycenter.org/wp-content/uploads/2023/10/grading-the-states.pdf.

28 *See* O'Connor v. Donaldson, 422 U.S. 563, 573, 576 (1975).

29 Substance Abuse & Mental Health Servs. Admin, *supra* note 22, at 12.

30 *Id.*

31 *Involuntary Commitment and Forced Mental Health Treatment Violate Human Rights*, Citizens Comm'n on Hum. Rts. Int'l, (Jan. 23, 2023), https://www.cchrint.org/2023/01/23/involuntary-commitment-forced-mental-health-treatment-violate-human-rights/.

32 *Involuntary Commitment for Substance Use Disorders*, Hazelden Betty Ford Found. (July 2017), https://www.hazeldenbettyford.org/research-studies/addiction-research/involuntary-commitment.

33 Substance Abuse & Mental Health Servs. Admin, *supra* note 22, at 4, 12.

34 Addington v. Texas, 441 U.S. 418, 432–33 (1979).

need of care," and rested upon the "clear and convincing" standard.[35] This standard, when compared to the standard applied in criminal cases ("beyond a reasonable doubt"), is a less stringent method through which a person may be civilly deprived of liberties.[36]

B. *Evolution of Involuntary Commitment for Substance Use Disorder*

Tens of thousands of people across the United States have been forced to undergo addiction treatment in substandard treatment facilities under jail-like conditions. Some treatment facilities are, in fact, housed on the grounds of correctional complexes or run by departments of correction—resulting in incarceration by another name. While some emphasize the benefits of involuntary commitment, reports indicate that these interventions can do more harm than good.[37]

Doling out diminished autonomy and liberty under the banner of "treatment" has a sordid legacy in the United States. In the late nineteenth century, states began enacting laws allowing for the involuntary confinement of individuals with mental illnesses. The United States Supreme Court has upheld the constitutionality of involuntary commitment in several cases.[38] In 1997, the Court held that states may commit individuals with a "mental abnormality" that makes them likely to engage in sexually violent behavior.[39]

People with SUD are at a high risk of mortality.[40] The complex

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35 *See* Testa & West, *supra* note 14, at 34.

36 *Id.* One of three standards of proof may apply, the most stringent being "beyond a reasonable doubt," which requires the court decision to be made "without any reservations that would be expected of a reasonable person." This standard applies in criminal cases. "The lowest standard of proof is by a 'preponderance of the evidence,' and it requires only that the trier of fact be certain that [their] decision is more likely to be correct than incorrect." This standard applies in civil suits. "The third standard of proof allows decisions to be made based on 'clear and convincing evidence,' which is defined as being greater than a preponderance of evidence, but less than beyond a reasonable doubt." *Id.*

37 Ruth Sangree, *I Was Hospitalized Against My Will. I Know Firsthand the Harm It Can Cause.* The Guardian (Dec. 23, 2022), https://www.theguardian.com/society/2022/dec/23/involuntary-hospitalization-policy-new-york-city-eric-adams; Sarah E. Wakeman, *Why Involuntary Treatment for Addiction Is a Dangerous Idea,* Stat (Apr. 25, 2023), https://www.statnews.com/2023/04/25/involuntary-treatment-for-addiction-research/; Messinger & Garza, *supra* note 4.

38 *See, e.g.*, *Addington*, 441 U.S. at 432–33.

39 Kansas v. Hendricks, 521 U.S. 346, 350, 371 (1997).

40 Jakob Svensson et al., *Patterns of Mortality Risk Among Patients with Substance Use Disorder: An Opportunity for Proactive Patient Safety*?, BMC Psychiatry, Dec. 2022, at 1, 7,.

relationship between American culture and substance use almost universally labels people who use drugs as deviant, putting them in the crosshairs of institutionalization. "In 1961, California passed legislation allowing for involuntary hospitalization of [people with SUD] . . . who had been arrested for drug-related crimes."[41] The following year, New York passed a law allowing "civil commitment of persons with opioid dependence."[42] In 1966, Congress passed the Narcotic Addict Rehabilitation Act ("NARA"), allowing compulsory commitment and treatment of people who had not been convicted or charged with legal offenses, but who experienced addictions to narcotics.[43] While many states allow persons convicted of criminal drug offenses to accept treatment as an alternative to going to jail,[44] these policies do not often relate to civil commitment (which occurs prior to or instead of contact with the criminal justice system). Because legal precedent primarily contemplates the commitment of people with severe mental illnesses and not SUD, many states have crafted statutes specifically designed to allow the involuntary commitment of people with SUDs, as we discuss in Part III.[45]

II. EFFICACY OF INVOLUNTARY COMMITMENT FOR SUD

A history of involuntary treatment is associated with a 1.4x higher likelihood of fatal opioid overdose.[46]

The following is well established: The toll of the overdose crisis

41 Testa & West, *supra* note 14, at 37.

42 *Id.*

43 *Id.*

44 Off. of Nat'l Drug Control Pol'y, *A Smart Approach to Criminal Justice*, The White House: President Barack Obama (May 2011), https://obamawhitehouse.archives.gov/ondcp/ondcp-fact-sheets/drug-courts-smart-approach-to-criminal-justice.

45 *See* Nat'l Jud. Opioid Task Force, *Involuntary Commitment and Guardianship Laws for Persons with a Substance Use Disorder*, Nat'l Ctr. for State Cts. 1–10 (2019), https://www.ncsc.org/__data/assets/pdf_file/0028/18478/inv-comm-and-guard-laws-for-sud-final.pdf; The Action Lab, *Laws Authorizing Involuntary Commitment for Substance Use*, LawAtlas 1 (updated Mar. 1, 2018), https://www.lawatlas.org/datasets/civil-commitment-for-substance-users; The Action Lab, *Involuntary Commitment for Substance Use*, Prescription Drug Abuse Pol'y Sys. (updated May 1, 2021), https://pdaps.org/datasets/civil-commitment-for-substance-users-1562936854.

46 Mass. Dep't of Pub. Health, *Section 35 Commission Treatment Statistics from BSAS Programs*, Mass.Gov, at 1, 27, https://www.mass.gov/doc/presentation-on-dph-opioid-and-civil-commitment-data/download.

has been astronomical, with fatal overdose rates over double those of motor vehicle accident and firearm-related deaths.[47] In response, policymakers continue to search for ways to effectively turn the tide on this public health emergency.[48] However, built upon the moralistic foundation of a long history of prohibitionist attitudes against drug use in the United States, these policy approaches have not been public health-minded but rather carceral and punitive.[49]

Medications for opioid use disorder ("MOUD"), including buprenorphine and methadone as opioid agonist therapy ("OAT"), are unequivocally safe, cost-effective, and successful in not only treating SUD but also in reducing crime and improving public health and safety.[50] OAT is considered the gold standard in pharmacotherapy approaches to SUD; however, only 21% of treatment facilities offer OAT,[51] and of facilities that do provide MOUD, many do not accept insurance. A maze of additional barriers and risks (including transportation to treatment centers, prescriber stigma and lack of training or awareness, and prescription surveillance) interconnects to create a frustrating and near-impossible treatment landscape. As with many other healthcare and social issues, these challenges are only amplified for formerly incarcerated people and people of color.[52]

Given the proven benefits of MOUD for people who use drugs ("PWUD") and overall public health, why has access faltered? The SUD treatment gap (and societal treatment of PWUD more broadly) has deep roots in moralism, racism, stigma, and misinformation. Recovery and abstinence are frequently conflated with forced (unsafe) detoxification without MOUD, which remains a mainstay in many treatment and correctional settings.[53] Similarly, harm reduction services also suffer this impact. Pushback against syringe services programs and supervised consumption sites feature false narratives—that these facilities

47 Nat'l Ctr. for Health Stat., *Drug Overdoses*, Ctr. for Disease Control & Prevention (updated Dec. 29, 2023), https://www.cdc.gov/nchs/fastats/drug-overdoses.htm.

48 *See* Taleed El-Sabawi, *The Role of Pressure Groups and Problem Definition in Crafting Legislative Solutions to the Opioid Crisis*, 11 Ne. U. L.R. 372, 374 (2019).

49 *Id.*

50 Leo Beletsky, *21st Century Cures for the Opioid Crisis: Promise, Impact, and Missed Opportunities*, 44 Am. J.L. & Med. 359 (2018).

51 *Id.*

52 *Id.*

53 Maia Szalavitz, *Why Forced Addiction Treatment Fails*, N.Y. Times (Apr. 30, 2022), https://www.nytimes.com/2022/04/30/opinion/forced-addiction-treatment.html.

encourage drug use, worsen addiction, or attract crime—narratives that are too often successful in preventing or shutting down evidence-based harm reduction programs.[54]

A. *Public Health Dimensions*

Four major characteristics of involuntary commitment for SUD warrant concern. First, despite its prominence and endurance as a mental health intervention, research indicates that involuntary commitment may not be an effective method with which to address SUD (and in fact can be counterproductive, increasing risk of overdose and relapse).[55] Research on the benefits of involuntary commitment has been inconsistent and of poor quality.[56] Involuntary commitment is a deeply problematic and punitive framework with demonstrated harms, eliminating autonomy and positive support from the process of treatment and recovery.[57] Second, forcing withdrawal only enforces sobriety for the length of the commitment, thereby reducing drug tolerance.[58] Treatment facilities in jails are particularly dangerous given the lack of MOUD treatment options available that may ease detox and reduce cravings.[59] Considering the harsh nature of reentry

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54 Sunyou Kang et al., *The Other Infodemic: Media Misinformation About Involuntary Commitment for Substance Use*, 2 J. Addiction Med. 396, 397 (2023); Ana B. Ibarra, *California Governor Vetoes Supervised Drug Injection Sites*, Cal. Matters (updated Aug. 23, 2022), https://calmatters.org/health/2022/08/supervised-injection-sites/; Krista Kafer, *Opinion: Safe Injection Sites Don't Treat Addiction, They Enable It*, Denver Post (Mar. 2, 2023), https://www.denverpost.com/2023/03/02/opinion-safe-injection-sites-colorado/.

55 The Lab has hosted a significant portion of this research, gathering multiple perspectives on involuntary commitment for SUD, including from those with lived experience, healthcare providers, and public discourse. *See Involuntary Commitment for Substance Use*, *supra* note 9.

56 Messinger & Beletsky, *supra* note 10, at 281.

57 Aditya Sareen et al., *Trauma from Involuntary Hospitalization and Impact on Mental Illness Management*, The Primary Care Companion For CNS Disorders (Aug. 9, 2022), https://www.psychiatrist.com/pcc/trauma-from-involuntary-hospitalization-impact-mental-illness-management/.

58 Vivek Kumar, *Former Opioid Users Are at a Greater Risk of Overdosing Than the Newly Addicted*, The Jackson Lab'y (June 6, 2016), https://www.jax.org/news-and-insights/jax-blog/2016/june/former-opioid-users-at-greater-risk-of-overdose-than-newly-addicted; Claudia Rafful et al., *Increased Non-Fatal Overdose Risk Associated with Involuntary Drug Treatment in a Longitudinal Study with People Who Inject Drugs*, 113 Addiction 1056, 1064 (2018).

59 *See* Noa Krawczyk et al., *Jail-Based Treatment for Opioid Use Disorder in the Era of Bail Reform: A Qualitative Study of Barriers and Facilitators to Implementation of a State-Wide Medication Treatment Initiative*, 17 Addiction Sci. & Clinical Prac. 1, 2 (2022).

from any carceral or otherwise isolating environment in addition to the aforementioned factors, the risk of overdose (fatal or non-fatal) upon reentry is extremely high and serves to show that involuntary commitment is a stopgap at best. This, in addition to larger global risk factors such as COVID-19 and its proliferation within secure settings such as jails, prisons, or commitment facilities, demonstrates significant harms that outweigh any potential benefits of involuntary commitment. Third, the detrimental effects of involuntary commitment on social well-being and self-regard also warrant consideration. Reports of "humiliating" practices and longer-term harms are not to be ignored.[60] Finally, involuntary commitment works at direct cross-purposes with evidence-based and harm-reductive treatment methods, relying on external definitions and validation of recovery rather than recognizing its nonlinear nature. It employs degrading and dehumanizing tactics with longer-term effects on sobriety, recovery, or even life or death.[61] Despite these dangerous atrocities, involuntary commitment practices have garnered growing attention, funds, and public and policy support, sapping precious resources that could instead go toward evidence-based, high-quality treatment and social services such as housing.

B. Systematic Review

A 2021 systematic review update conducted by the Action Lab expands upon our understanding of the evidence base on involuntary treatment for substance (including alcohol) use.[62] Overall, the quality of the empirical evidence leaves much to be desired.[63] The review of the

60 *See, e.g.*, Szalavitz, *supra* note 52; Leo Beletsky et al., *Involuntary Treatment for Substance Use Disorder: A Misguided Response to the Opioid Crisis*, Harv. Health Blog (Jan. 28, 2018), https://www.health.harvard.edu/blog/involuntary-treatment-sud-misguided-response-2018012413180.

61 Maia Szalavitz, *supra* note 52; *see supra* notes 57–59.

62 A search of multiple databases (EBSCOhost/Academic Search Complete, APA PsychInfo, Cochrane Central, Embase, PAIS International/Proquest, PubMed, Sociological Abstracts/Proquest, Web of Science) supplemented by web and article reference list searches, was conducted to gather all relevant peer-reviewed, quantitative academic literature on involuntary treatment. Analysis extracted information including study period and design, sample size, participant characteristics, changes in substance use, intervention modalities, and summarized outcomes. Methodological quality assessments were also performed to evaluate the validity of selected studies. The Downs & Black scoring scale (ranging from 0 to 18, lowest to highest quality) was applied to 16 eligible studies, finding a median score of 14.

63 *See infra* Appendix A.

extant peer-reviewed literature found that the majority (n=14, 87.5%) of studies analyzed did not find significant positive impacts of involuntary commitment on substance use-related outcomes. Among the studies that showed any positive relationship, relapse was still widespread and the studies themselves relied on weak methodological designs.[64] Despite the continued lack of evidence for the effectiveness of involuntary treatment, there remains a persistent emphasis on its use.[65]

Given this evidence of limited utility and the ethical concerns regarding involuntary treatment, there must be a shift toward voluntary, safe, and evidence-based SUD treatment that prioritizes autonomy, dignity, and respect. While we note that treatment is employed in an attempt to help the patient eliminate or reduce substance use and to mitigate associated adverse health effects (infectious diseases, overdose, organ damage), several ethical standards are violated when treatment is initiated under involuntary or coercive auspices. For PWUD who do not meet the criteria for substance dependence and have not committed any crimes, treatment can be considered a form of punishment for a non-treatable condition, thus causing harm to the individual and violating their individual freedom.[66] For PWUD who meet SUD diagnostic criteria, the use of involuntary commitment violates the principle of informed consent guaranteed by codes of medical ethics as well as Article 7 of the International Covenant on Civil and Political Rights.[67] Policymakers are thus tasked with shifting the treatment landscape to better reflect the evidence base, while closely watching for and swiftly addressing human rights violations within the existing system.

III. Misinformation

The integrity of public health-related information has become increasingly compromised over recent years but is by no means a new phenomenon. Fearmongering around vaccine safety, as just one example, has been joined by misinformation around fentanyl safety.[68] Despite endemic levels of misinformation in op-eds, news media, and

64 *See infra* Appendix A.

65 *Involuntary Commitment for Substance Use*, *supra* note 9.

66 Alex Stevens, *The Ethics and Effectiveness of Coerced Treatment of People Who Use Drugs*, 2 Hum. Rts. & Drugs Network, 7, 11 (2012)..

67 *Id.*; G.A. Res. 2200A (XXI), International Covenant on Civil and Political Rights (Dec. 16, 1966).

68 Leo Beletsky et al., *Fentanyl Panic Goes Viral: The Spread of Misinformation About Overdose Risk from Casual Contact with Fentanyl in Mainstream and Social Media*, Int'l J. Drug Pol'y, Dec. 2020, at 1.

governmental publications,[69] responses to correct this trend remain few and generally ineffective.

One of the key drivers behind ineffective and harmful drug policies is misinformation. Misinformation on involuntary commitment for SUD is no exception. Despite the aforementioned doubts about the legal, ethical, and public health bases of involuntary commitment for people with SUD, the prevailing discussion is predominantly represented within a positive frame. Specifically, narratives favorable to involuntary commitment generally feature praise for its "tough love" approach, framing commitment as a protective rather than paternalistic effort, wholly neglecting to acknowledge the harms associated with coercive treatment and forced drug withdrawal. Others justify those harms by claiming that involuntary commitment is preferred to incarceration as a response to mental health or substance use concerns.

Involuntary commitment is an area in which incorrect narratives on the merits find purchase among the public, journalists, policymakers, and healthcare professionals. Notably, people with lived experience with coercive treatment are rarely included in these discussions. Efforts to include first-hand accounts are needed to guide corrective measures, along with support from credible community figures such as clinicians, governmental authorities, and law enforcement.

Policy is dependent upon social context. Media discourse, specifically the ways in which an issue is framed, contributes to the public's understanding of a topic, in turn influencing policymakers.[70] Framing is the implicit cognitive process by which people package previously stored information to better understand an issue and its context.[71] It is through this process that we determine what is important.[72] Framing in news media, as described by reporter and political commentator Walter Lippman, creates "pictures in our heads."[73] Depending upon how a

69 *Id.* at 2.

70 Maxwell E. McCombs & Donald L. Shaw, *The Agenda-Setting Function of Mass Media*, 36 Pub. Op. Q. 176, 180 (1972).

71 Charlotte Ryan, Prime Time Activism: Media Strategies for Grassroots Organizing 53 (1991).

72 Lori Dorfman et al., Communicating for Change Module 3: Shaping Public Debate with Framing and Messages 4 (2007) (quoting communications scholar Frank Gilliam, frames are "labels the mind uses to find what it knows. Frames . . . signal what to pay attention to— and what not to, they allow us to fill in or infer missing information, and they set up a pattern of reasoning that influences decision outcomes. Framing, therefore, is a translation process between incoming information and the pictures in our heads").

73 Walter Lippmann, Public Opinion xviii (1922).

journalist frames an issue, they may completely change one's perception of its importance and its meaning.[74] Lori Dorfman, Director of Berkeley Media Studies Group, succinctly notes that "the news media largely determine what issues we collectively think about, how we think about them, and what kinds of alternatives are considered viable; the news media set the agenda and terms of debate for policy makers and the public."[75] For example, media narratives surrounding poor women and children drove the legislative debate in Aid for Families and Dependent Children ("AFDC") public policy issues. Specifically, Professor Lucy Williams argues that media narratives—in framing poor, Black and brown women and children as a selfish and irresponsible monolith—drives public perception and the "short-sighted legislative assumption that a welfare mother should not expect a job with dignity, a career ladder, adequate benefits, or flexibility for family obligations."[76]

The drug law and policy spheres are rife with strong rhetoric as a result of societal factors, influencing policy in turn. For example, discourse on the "crack epidemic" in the 1980s centered around drug use and social issues including "poverty, violent crime, overcrowded prisons, overcrowded hospitals, . . . homelessness, and sexually transmitted diseases."[77] In so doing, the "War on Drugs" framed PWUD as moral failures. Policy followed. By 2002, federal spending on drug control had increased nearly $18 billion since 1981.[78] Though people from all races and income brackets use drugs and experience SUD, increased policing and ensuing criminal action are predominantly taken against low-income people of color.[79]

Similarly, misinformation that posits involuntary commitment as an effective strategy to combat SUD carries broad implications for

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74 Dietram A. Scheufele & David Tewksbury, *Framing, Agenda Setting, and Priming: The Evolution of Three Media Effects Models*, 57 J. Commc'n 4, 15 (2007).

75 Lori Dorfman & Ingrid Daffner Krasnow, *Public Health and Media Advocacy*, 35 Ann. Rev. Pub. Health, 293, 296 (2014).

76 Lucy A. Williams, *Race, Rat Bites and Unfit Mothers: How Media Discourse Informs Welfare Legislation Debate*, 22 Fordham Urb. L.J. 1159, 1195 (2011) ("Thus policymakers are able to apply the collective guilt of the socially marginalized image and endorse collective punishment by denying welfare to all in order to pay for the sins of the image."); *see* Ryan, *supra* note 70, at 54 (stating media frames "operate as underlying mind sets that prompt one to notice elements that are familiar and ignore those that are different").

77 Barry M. Lester et al., *Substance Use During Pregnancy: Time for Policy to Catch Up with Research*, 2004 Harm Reduction J., Apr. 2004, at 1, 2.

78 *Id.* at 3.

79 Keturah James & Ayana Jordan, *The Opioid Crisis in Black Communities*, 46 J.L. Med. & Ethics, 404, 409–10 (2018).

policymaking. Narratives that present involuntary commitment as a valid approach for people with SUD place the "pictures in our heads"[80] that people with SUD are failing morally, that they should be removed from their decision-making positions, and that isolating them from society is the best option. Accordingly, these pictures set the "short-sighted legislative assumption" that people with SUD "should not expect" compassionate, data-driven care.[81]

A. MediaCloud Misinformation Analysis

Our team recently assessed misinformation embedded within news media discourse on involuntary commitment for SUD.[82] We used the MediaCloud platform, which tracks media ecosystems to develop a sample of news stories about involuntary commitment published in U.S.-based mainstream media between 2015 and 2020.[83] This analysis discovered that approximately half of the sampled articles on involuntary commitment for SUD unquestionably and favorably covered involuntary commitment and received extensive Facebook shares. Nearly half (48%)[84] of articles were definitively supportive of involuntary commitment, 30% featured mixed narratives, and 22% were critical of involuntary commitment. The publication of articles supportive of involuntary commitment grew over our study's time period; however, critical narratives were shared nearly twice as often (with 199,909 Facebook shares) as supportive and mixed articles, which received a combined 112,429 Facebook shares. Of the articles that compared involuntary commitment and incarceration for SUD, only 7% spoke unfavorably of involuntary commitment as an alternative to incarceration. Most articles did not specify the type of drug use that initiated involuntary commitment.

Also striking was the lack of lived experiences with substance

80 Lipmann, *supra* note 72, at xvii.

81 Williams, *supra* note 75, at 1192.

82 Kang et al., *supra* note 53, at E396.

83 Using MediaCloud, a web-scraping tool, media content published between January 2015 and October 2020 on involuntary commitment for SUD was collected. After cleaning the initial results for duplicates and irrelevant articles, the resulting 505 articles were qualitatively categorized (or "coded") for critical, mixed, or supportive narratives on involuntary commitment, perspectives included (such as law enforcement, community members, healthcare professionals), comparisons drawn between incarceration and involuntary commitment, and mentions of specific drug classes (such as opioids, alcohol, or stimulants). The research team assessed the content of these articles, identified patterns, and analyzed the proliferation in shares of these articles on Facebook.

84 *See infra* Appendix A for detailed results of this study.

use featured in these articles: only a minority of articles included the perspectives of people who experienced involuntary commitment for SUD. In the sample, 7% of stories presented the perspectives of those who had personally experienced involuntary commitment. Instead, these figures were eclipsed by those of law enforcement/legal entities (38%), families/friends/community members (11%), and healthcare professionals (18%). Law enforcement and legal entities, most prominently featured in our sample, held largely (62%) favorable views of involuntary commitment for SUD. Contrastingly, of healthcare professionals interviewed, only 23% spoke in support of involuntary commitment, and only 16% of families, friends, or community members held positive views of involuntary commitment.

Our media sample serves as a biopsy of a larger, troubling malignancy in U.S. news media: concerns for the health and well-being of those subjected to involuntary commitment for SUD are not given due coverage. The media analysis project was limited to articles published between 2015 and 2020. While this time frame allows for an analysis of recent coverage on the topic, it may not capture changes in attitudes or policies that have occurred since then. The lack of weight given to the ethical and humanitarian concerns around involuntary commitment mirrors—and may in fact be conducive to—a similarly misguided legal and policy landscape. Examples of misinformation giving rise to harmful attitudes towards PWUD are plenty, and instances of such narratives influencing decisions to prevent the establishment or continued operation of harm reduction services are well noted.[85] Supervised consumption sites, embraced abroad, continue to face pushback in the United States in large part due to the false messaging around harm reduction services "encouraging" drug use and inviting crime into communities.[86]

85 Kang et al., *supra* note 53, at 2; Joe Atmonavage, *Atlantic City Votes to Close State's Largest Needle Exchange Program, Drawing Outrage*. NJ.COM (July 22, 2021), https://www.nj.com/news/2021/07/atlantic-city-votes-to-close-states-largest-needle-exchange-program-drawing-outrage.html; Nina Feldman & Jake Blumgart, *Safehouse Hits Pause on Plan to Open Supervised Injection Site in South Philly*, WHYY (Feb. 27, 2020), https://whyy.org/articles/safehouse-hits-pause-on-plan-to-open-supervised-injection-site-in-south-philly/; Szalaitz *supra* note 52.

86 Feldman & Blumgart, *supra* note 84; *Summary of Information on The Safety and Effectiveness of Syringe Services Programs (SSPs)*, CTR. FOR DISEASE CONTROL & PREVENTION (Jan. 11, 2023), https://www.cdc.gov/ssp/syringe-services-programs-summary.html; Merlinsbeard999, *City Hall Wants to Put a Heroin Injection Facility in Davis Square*, REDDIT, https://www.reddit.com/r/Somerville/comments/w9gwls/city_hall_wants_to_put_a_heroin_injection/ (last visited Mar. 31, 2024).

However, our study also yielded potentially promising findings. While we cannot determine the sentiment behind social media sharing of certain articles, we did find that articles critical of involuntary commitment were highly shared on Facebook. At the very least, within our sample, data show that informed messaging was circulated more often than misinformation and may indicate a growing public awareness of the troubling nature of coercive treatment for SUD. A turning of the tide against misinformation is still likely a distant achievement. However, consistent corrective efforts, particularly those aimed towards and carried by actors such as law enforcement and healthcare professionals who receive high media attention and hold credibility with their peers and clients, may prove a highly effective approach.

B. Physician Attitudes Towards Involuntary Commitment

Commentary for the Journal of Addiction Medicine (published 2021) authored by Action Lab ("Lab") members also highlights physician attitudes towards involuntary commitment for SUD and a larger pattern of stigmatizing attitudes and practices towards PWUD. In this effort to replace health misinformation with evidence-based policies and discourse, we look to those in positions of authority and high standing within the legislative and healthcare systems of the United States. However, when said authorities are carriers of stigma and misinformation, little change can be made.

As it relates to involuntary commitment for SUD, this commentary collected insights from addiction medicine physicians across multiple studies and surveys.[87] One such study found that the majority (60.7%) of addiction medicine physicians within the American Society of Addiction Medicine indicated support for involuntary commitment for SUD, with only 21.5% in opposition. The number of physicians in support has nearly tripled (60.7% versus 22%) since a similar survey in 2007 of American psychiatrists. This is in line with the infiltration of favorable portrayals of involuntary commitment into public discourse and policy but only emphasizes how out of step these fields, in addition to healthcare, are with the evidence on involuntary commitment.

Said evidence includes data from 2011 to 2015 showing that clients of Massachusetts-run commitment programs "with a history of involuntary [commitment are] 1.4 times as likely to [experience fatal] opioid overdoses" than those without any history of involuntary

87 Messinger & Beletsky, *supra* note 10, at 280–81.

commitment.[88] Fatal overdose rates following release from secure settings such as jails or prisons also eclipse those in the general population.[89] A study in Washington state found that overdose death is 129 times more likely for those in the two weeks following release from state prison than for those in the general public.[90] In addition to inflated overdose rates, reports of trauma, discriminatory and cruel practices, escape attempts, and suicide have been tied to experiences with involuntary commitment.[91] This is in part a product of and akin to the lack of evidence-based, FDA-approved treatment options, namely MOUD, offered within these facilities. Over 50% of physicians surveyed stated that MOUD is necessary for treatment success, while nearly all (over 90%) of addiction medicine physicians surveyed believe that "'clearly outlined consequences for failure to comply' were either very or absolutely necessary for treatment success."[92] These physicians support a system that (1) is inconsistent with their clinical knowledge of what effective SUD treatment entails, and (2) introduces a punitive element into healthcare.

Why do healthcare providers support involuntary commitment despite these clear indications that involuntary commitment as it currently exists is substandard and harmful? Moralism and stigma are deeply embedded in perceptions of drug use and, by extension, PWUD. Even as a population with resources such as implicit bias training (mandated in some states) and exposure to different modes of thought, healthcare providers are not resistant to stigmatizing attitudes or practices towards PWUD.[93] A study finds that less than 10% of emergency medicine providers reported utilizing harm reduction resources in practice despite reporting willingness to do so.[94] Another

88 Mass. Dep't of Pub. Health, *supra* note 45, at 27.

89 *Overdose Deaths and Jail Incarceration: National Trends and Racial Disparities*, Vera Inst. of Just. https://www.vera.org/publications/overdose-deaths-and-jail-incarceration/national-trends-and-racial-disparities (last visited Mar. 31, 2024).

90 *Id.*

91 Deborah Becker, *Civil Commitment for Addiction Treatment Led to Loved One's Suicide, Family Says*, WBUR (Mar. 26, 2019), https://www.wbur.org/news/2019/03/26/section-35-suicide-sean-wallace; Peter Simons, *Involuntary Hospitalization Increases Risk of Suicide, Study Finds*, Mad in Am. (June 24, 2019), https://www.madinamerica.com/2019/06/involuntary-hospitalization-increases-risk-suicide-study-finds/.

92 Messinger & Beletsky, *supra* note 10, at 281.

93 Lisa A. Cooper et al., *Mandated Implicit Bias Training for Health Professionals—A Step Toward Equity in Health Care*, JAMA Health F. (2022), https://jamanetwork.com/journals/jama-health-forum/fullarticle/2795358.

94 Messinger & Beletsky, *supra* note 10, at 281.

study finds that the majority of physicians surveyed were reluctant to prescribe naloxone.[95] The evidence supporting the use of these methods is clear: harm reduction saves lives.[96] The hesitance behind aligning this evidence with attitudes and practice may lie instead in workplace or community culture, public discourse, or overarching policy and governmental communiques to the contrary.[97] Given the influence that providers have within their patient networks to create a supporting, collaborative care plan (or to instead alienate and stigmatize patients), targeting the provider population of the United States as both recipients and carriers of anti-stigma material is key.

A final point that many arguments arrive at in this debate over involuntary commitment is its utility as a "last resort."[98] Those in support claim that involuntary commitment works when nothing else does, or that despite its shortcomings, "it is better to have a traumatized patient than a dead or incarcerated one."[99] Besides barreling past key evidence and ethical considerations, these claims fail to recognize the relative lack of consistent, positive, and sustainable first-line approaches to SUD treatment as well as the lack of harm reduction services that can help prevent a person's recovery or substance use process from devolving to the point where there is imminent risk to that individual or others. The SUD treatment net in the United States is a patchwork with immense gaps that, along with clinging to outdated punitive and coercive models, continues to fail PWUD at a figure of 106,699 overdose deaths in 2021[100] and allows related, *preventable* harms such as infectious disease to remain a risk.[101] A system meant to introduce humane alternatives for

95 *Harm Reduction*, *supra* note 2.

96 *Id.*; Studies of various harm reduction programs have shown reductions in infectious disease transmission of over two-thirds and nearly 50% reductions in opioid overdose mortality. Substance Abuse & Mental Health Servs. Admin., *Harm Reduction Framework*, 7 (2023) https://www.samhsa.gov/sites/default/files/harm-reduction-framework.pdf.

97 Beletsky et al., *supra* note 67, at 1.

98 Dinah Miller & Annette Hanson, *Violent Behavior and Involuntary Commitment: Ethical and Clinical Considerations*, Psychiatric Times, Feb. 2020, at 18.

99 *Id.*

100 *Drug Overdose Death Rates*, Nat'l Inst. on Drug Abuse (June 30, 2023), https://nida.nih.gov/research-topics/trends-statistics/overdose-death-rates; Milena Stanojlović & Larry Davidson, *Targeting the Barriers in the Substance Use Disorder Continuum of Care With Peer Recovery Support*, 15 Substance Abuse: Rsch. & Treatment, June 2021, at 1.

101 Mitch Legan, *Indiana Needle Exchange That Helped Contain a Historic HIV Outbreak To Be Shut Down*, NPR (June 3, 2021), https://www.npr.org/sections/health-shots/2021/06/01/1001278712/indiana-needle-exchange-that-helped-contain-an-hiv-outbreak-may-be-forced-to-clo.

SUD must employ thought that is not only different from, but explicitly against, incarceration and punishment, acknowledging and embracing opportunities to save lives and enact change.

IV. In Practice: Involuntary Commitment for Substance Use Disorder as a Response to the Overdose Crisis

A key consideration in the argument against involuntary commitment for SUD is the lack of standardization of its regulation across state lines.[102] As of 2018, SUD is grounds for involuntary commitment in thirty-five states. Thirty-two of those states allow a maximum involuntary commitment duration of thirty days or longer (up to two years or unspecified). Furthermore, in twenty-one states, compulsory commitment can be initiated by "any interested person" as opposed to medical professionals, mental health professionals, or treatment facility staff.[103] By neglecting to resolve the wide variability across state involuntary commitment practices and opening the door for non-medical professionals to deem involuntary commitment an appropriate response, these states uphold a flawed, inconsistent, and subjective system.

A. *Dynamics of Involuntary Commitment for Substance Use Disorder in Massachusetts: A Case Study*

Despite relatively progressive drug policies,[104] Massachusetts remains an example of how involuntary commitment for SUD seems to masquerade as a public health measure. For years, Massachusetts' drug overdose fatalities have spiraled in concert with an aggressive program of involuntary commitment for substance use;[105] the Commonwealth's

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102 *See* The Action Lab & Ctr. For Pub. Health L. Rsch., *supra* note 4 (mapping state laws on involuntary commitment for SUD between March 2018 and May 2021 and analyzing scope, initiation, and duration of commitment).

103 The Action Lab, *supra* note 44.

104 Ethan Nadelmann & Lindsay LaSalle, *Two Steps Forward, One Step Back: Current Harm Reduction Policy and Politics in the United States*, June 2017, at 3; *see* Kade Crockford, *What's Said Is Not What's Done: How Reagan-era Drug Warrior Politics Dominate in Progressive Massachusetts – and What We Can Do About It.*, The Appeal (Nov. 13, 2019), https://theappeal.org/whats-said-is-not-whats-done-how-reagan-era-drug-warrior-politics-dominate-in-progressive-massachusetts.

105 A case study by the Action Lab explored the following metrics in Massachusetts between 2010 and 2018: the numbers of filed versus authorized petitions for involuntary commitment for SUD, the breakdown of petitions for alcohol use versus other drug use, and adult versus juvenile petitions. Notably, Massachusetts

Section 35 program detained 10,642 petitions for involuntary commitment for SUD in 2018 alone.[106]

In Massachusetts, authority for a qualified person to request a court order to civilly commit an individual for mental health purposes is designated by Chapter 123 of Section 35 of the Massachusetts General Laws.[107] The Section 35 process is as follows: "A spouse, immediate family member, police officer, physician, or court official" may petition for involuntary commitment for SUD if a risk to self or others is suspected.[108] The petition is reviewed by a judge and a decision is made to either issue a summons or a warrant depending on the urgency of the situation and whether an immediate danger is indicated. An evaluation is conducted by a Department of Mental Health court clinician.[109] Two criteria are considered along with any testimony, clinical evaluation, or "clear and convincing evidence": (1) that the "person has an alcohol or substance use disorder" and (2) that as a result of this SUD, the person presents a risk of "serious harm to self or others."[110]

However, the link between civil commitment and the carceral system in Massachusetts is explicit.[111] As of March 16, 2023, Massachusetts reports nine Section 35 facilities (five female-designated and four male-designated).[112] A 2019 report named a collective capacity of 655 beds

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eliminated the distinction between alcohol and other/unspecified drug commitments at the beginning of Q3 of FY2016, marking a conscious shift in the framing and societal acceptance of alcohol use as well as the acknowledgment of polysubstance use as a major, but overlooked driving factor of the U.S. drug overdose crisis. *Involuntary Commitment for Substance Use*, *supra* note 9; *see also* Jordan Michael Smith, *The Jailing of Jesse Harvey,* The Intercept (Mar. 23, 2022) https://theintercept.com/2022/03/23/opioid-addiction-treatment-civil-commitment/.

106 *Involuntary Commitment for Substance Use*, *supra* note 9.

107 Mass. Gen. Laws ch. 123 § 35 (2023).

108 *Id.*

109 *Id.*

110 *Section 35: The Process*, Mass.gov, https://www.mass.gov/service-details/section-35-the-process (last visited Apr. 28, 2023).

111 Thorough, accessible, clear, and current information on these facilities' operations remains limited. In fact, several government sources present conflicting and outdated information. For example, Mass.gov reports five female-designated Section 35 facilities, including MCI Framingham. This source was last updated in March of 2023. However, a 2016 law ceased the practice of sending Section 35 patients to Framingham. *Facilities and Resources for Section 35 Treatment*, Mass.gov (updated Mar. 16, 2023), https://www.mass.gov/info-details/facilities-and-resources-for-section-35-treatment; Shira Schoenberg, *Massachusetts Stops Sending Women Civilly Committed For Drug Abuse To Prison,* MassLive (Jan. 25, 2016), https://www.masslive.com/politics/2016/01/massachusetts_stops_sending_wo.html.

112 *Facilities and Resources for Section 35 Treatment*, *supra* note 110.

for both Acute Treatment Services and Clinical Stabilization Services.[113] Two of the four facilities approved for the involuntary commitment of men are operated by the Massachusetts Department of Correction.[114] Arrest warrants are issued and patients may be held or handcuffed without distinction or separation from criminal defendants.[115] These facilities can hold residents to strict, structured schedules with little free time, utilize isolation as a tactic, and enforce uniforms (sometimes jail or prison uniforms).[116] These practices, employed by facilities that claim to provide medical treatment, have clearly documented harms and remove patients' autonomy from the process of receiving "treatment"—and thus are not in line with key tenets of medical ethics.[117] In fact, they do not follow recommendations put forth by the American Psychiatric Association to operate under "applicable medical standards" and exist within health (rather than correctional) systems, nor do they follow the standards set by the World Health Organization and United Nations Office on Drugs and Crime that state SUD treatment should not violate patient autonomy or will.[118]

In Massachusetts, in line with reports from other states,[119]

113 Commonwealth of Mass., Section 35 Commission 14 (July 1, 2019), https://www.mass.gov/files/documents/2019/07/01/Section%2035%20Commission%20Report%207-1-2019.pdf.

114 *Facilities and Resources for Section 35 Treatment*, *supra* note 110; *Section 35: The Process*, *supra* note 109.

115 *Involuntary Commitment for Substance Use Disorder: A Facade of Public Health*, The Action Lab, https://www.healthinjustice.org/_files/ugd/3bbb1a_176ac7ce4a2546df8cbf44eb522f9bce.pdf (last visited Apr. 14, 2024).

116 *Stonybrook Stabilization & Treatment Centers*, Mass.gov 13–14 (Apr. 25, 2019), https://www.mass.gov/doc/stonybrook-stabilization-and-treatment-centers-presentation/download; Wakeman, *supra* note 36; Deborah Becker, *Advocates Press Lawsuit Despite DOC Claims of Improved Involuntary Addiction Treatment*, WBUR (Oct. 20, 2020), https://www.wbur.org/news/2020/10/20/section-35-lawsuit-amended-addiction-state-prisons; *see also* Lawrence H. Yang et al., *Stigma and Substance Use Disorders: An International Phenomenon*, 30 Current Op. in Psychiatry 378 (2018).

117 Wakeman, *supra* note 36; Thomas R. McCormick, *Principles of Bioethics*, U.W. Med., https://depts.washington.edu/bhdept/ethics-medicine/bioethics-topics/articles/principles-bioethics (last visited March 31, 2024).

118 Am. Psychiatric Ass'n, *Position Statement on Civil Commitment for Adults with Substance Use Disorders*, Psychiatry.org (2019), https://www.psychiatry.org/getattachment/00976942-2f44-4f6d-9a19-edc9a344bd8e/Position-Civil-Commitment-for-Adults-with-SUD.pdf; World Health Org. & United Nations Off. on Drugs & Crime, International Standard For the Treatment of Drug Use Disorders 9 (2020).

119 Gi Lee & David Cohen, *Incidences of Involuntary Psychiatric Detentions in 25 U.S. States*, 72 Psychiatric Servs., 61, 65 (2021).

involuntary commitment for SUD became more prevalent—in fact, nearly doubling—from 2010 to 2018 in petitioned commitments, with a 38% increase in authorized commitments from 2011 to 2018.[120] In 2018, of 10,770 petitions, 7,267 individuals were evaluated, and 6,048 were committed as a result (an 83% authorization rate).[121] Between 2010 and 2018, petitions for involuntary commitment increased by 82.5% (from 5,903 to 10,770 commitments).[122] Prior to 2016 when the distinction between commitment for alcohol versus other drug use was removed, commitments for adult drug use represented roughly double the number of commitments for adult alcohol use each year.[123] Petitions for juvenile commitments were a small fraction of total commitments (less than 1.25% of total commitments in any given year) but followed the same trend as other commitments, increasing from 0.05% to 1.2% of total commitments across 2010-2018.[124]

Massachusetts has taken steps to move towards a harm-reduction policy environment in recent years, establishing a Harm Reduction Coalition in 2018 and noting on its Section 35 website that involuntary commitment should not be used as a first-line treatment for SUD.[125] However, fundamental deviations from true harm reduction theory remain evident. The same Section 35 site notes that oftentimes, "just the threat of being committed will influence an individual to enter treatment voluntarily"—in direct contradiction of the previous sentence, which states that "[treatment o]utcomes are often better if an individual is motivated and willing to engage in treatment, in the least restrictive environment."[126] The process of recovery from SUD does not necessitate sobriety. The process is difficult, non-linear, and lifelong. To ensure a sustainable, effective, and safe recovery process, individualized treatment options that truly prioritize autonomy, dignity, and well-being must be made accessible in addition to a range of other harm reduction measures.

120 *Section 35 Commission*, *supra* note 112, at 2.

121 *Id.* at 18.

122 *Id.*

123 *Id. at 19.*

124 *Involuntary Commitment for Substance Abuse*, *supra* note 9.

125 *Harm Reduction Commission*, Mass.gov, https://www.mass.gov/orgs/harm-reduction-commission (last visited Mar. 31, 2024); *Section 35: The Process*, *supra* note 109.

126 *Section 35: The Process*, *supra* note 109.

B. Dynamics of Involuntary Commitment for Substance Use Disorder Implementation Across Key States

To evaluate state-run involuntary commitment program practices, the Lab submitted Freedom of Information Act ("FOIA") requests to 15 states, chosen for legal markers of leniency with regard to involuntary commitment for SUD. The requests asked for data concerning individuals civilly committed to substance use and addiction treatment. These data include state-wide volume, demographic information, facility information, and financial information. Despite the broadly cast net, the requests produced full and partial data for only five states: Massachusetts, North Carolina, South Carolina, Florida, and Minnesota.[127]

First, the results indicate that these five states either do not collect or are reticent to disclose data on overdose rates within their facilities or post-discharge. Drug overdose data can serve as a clear indication of the efficacy of involuntary commitment in the short and long term, and without it or another marker of public health outcomes, there is no way to assess involuntary commitment as a treatment method. This follows a broader trend of a lack of data on other indicators of interest such as the involuntarily committed pregnant population and financial information.

Second, at least 40% of the involuntarily committed population in the five states surveyed is women.[128] Again in comparison with carceral population statistics, which show that women constitute 6.7% of the population of persons incarcerated,[129] these data suggest that women are disproportionately committed for SUD. Considering that involuntary commitment in practice, compared to incarceration, can be similarly

127 *Involuntary Commitment for Substance Abuse*, *supra* note 9 (To analyze the FOIA data, the research team aggregated involuntary commitment data received from the five responsive states. No states provided data on overdose rates during or after involuntary commitment in their facilities or indicated tracking this data. The use of involuntary commitment varied by intake volume, with programs housing anywhere from 1,000 to 15,000 people in involuntary commitment each year. "Women make up at least 40% of people experiencing [involuntary commitment] in each of these states, despite women making up [only 18%] of the total people incarcerated in the U.S." The data also demonstrated the unproportionate dearth of Black, indigenous, and other people of color ("BIPOC") subjected to involuntary commitment, despite it being regarded as a more humane alternative to incarceration).

128 *Id.*

129 E. Ann Carson, U.S. Dep't of Just., Prisoners in 2020 – Statistical Tables 10 (Dec. 2021), https://bjs.ojp.gov/content/pub/pdf/p20st.pdf.

punitive, instill shame, and reduce self-efficacy,[130] the data demonstrate an urgent need to reevaluate commitment practices for inherent biases.

Third, Florida's involuntarily committed population stands at an average of 9,426 people per year versus Massachusetts's second-highest average of 5,147 people per year.[131] Keeping in mind that this analysis only took into consideration public, state-run facilities and does not include data from private facilities regarding involuntary commitment for SUD, these counts are likely higher across all states.

Fourth, Black, indigenous, and other people of color are underrepresented in the involuntary commitment population. While this may seem a promising figure at first glance given the carceral nature of this approach, involuntary commitment is often considered a more humane and compassionate measure for SUD than incarceration. However, we must take into account the racial disparities evident within the criminal justice system and the incarcerated population.[132] Data (per 100,000) from 2019 shows 525 Hispanic, 547 American Indian/Alaska Native, and 1,096 Black individuals incarcerated in state and federal prisons, compared to 214 white Americans.[133] Given the inflated number of BIPOC individuals who are incarcerated and the lower proportion of BIPOC individuals who are committed (and vice versa with regards to white individuals),[134] we conclude that in line with broader sentencing trends, BIPOC Americans are subject to harsher, more punitive responses to mental health and substance use than are white Americans.

Finally, there exists a lack of accessible data on involuntary commitment practices and health outcomes across not just these studied five states, but all 50 states. In our efforts to gather this information, several realities became clear: (1) not all states collect data on involuntary commitment outcomes; (2) of those states that do record data, many state offices are disinclined to release that data despite receiving written FOIA requests, implementing various legal, financial,

130 *See* Z. Xu et al., *Involuntary Psychiatric Hospitalisation, Stigma Stress and Recovery: A 2-Year Study*, 28 Epidemiology & Psychiatric Scis. 458, 458 (2018); *Involuntary Commitment for Substance Abuse*, *supra* note 9.

131 *Involuntary Commitment for Substance Abuse*, *supra* note 9.

132 Wendy Sawyer, *Racial Disparities in Prison Incarceration Rates*, 2019, Prison Pol'y Initiative (2022), https://www.prisonpolicy.org/graphs/prison_rates_by_race_2019.html.

133 *Id.*

134 *Involuntary Commitment for Substance Abuse*, *supra* note 9; Wendy Sawyer, *Black People Are Disproportionately Serving Sentences of Life, Life Without Parole, or "Virtual Life,"* Prison Pol'y Initiative (2020), https://www.prisonpolicy.org/graphs/lifesentencesbyrace2016.html.

or communication barriers; (3) the data that our team received varied widely and was inconsistent in maintenance and organization, turning the collection phase into a massive time sink.

While this is a highly specific case study of state-run involuntary commitment practices, the results (or lack thereof) are telling. Markers necessary to evaluate the short- or long-term success of these programs as SUD treatment—or even simply as healthcare—are missing or withheld from the body of research. Instead, anecdotal evidence of the toll of commitment on individuals' physical and mental health fills that gap. Alongside these anecdotes are calls by healthcare professionals, advocates, and academics for the elimination, or at the very least restructuring, of involuntary commitment for SUD, along with support for harm reduction measures instead.[135]

Nevertheless, it is important to acknowledge the limitations of this study. The FOIA project was limited to the fifteen states with the broadest laws allowing involuntary commitment. This means that the findings may not be generalizable to other states with different laws and policies. Additionally, not all states were able to provide data, which limits the scope of the analysis. The varying data collection and reporting practices of each state rendered state-by-state data comparison more difficult and may have led to missing or incomplete information. Furthermore, the FOIA requests only sought data related to individuals who were civilly committed to substance use and addiction treatment, which may not capture all instances of involuntary commitment for SUD. While the research provides important insights into the use of involuntary commitment for SUD, it does not address the experiences of individuals who have undergone involuntary commitment. Future research could include interviews or surveys with individuals who have experienced involuntary commitment to gain a more comprehensive understanding of the impact of this practice on individuals and communities.

In sum, there is broad variability in the nature and application of involuntary commitment for SUD, including in the number of people forced into this treatment system, the policies governing entry into this system, and the level of clinically sound treatment (e.g., MOUD) within these facilities. Data that has been made available, generally on state-run operations, demonstrates these inconsistencies. However, there is a troubling lack of data on private facilities, and a general nationwide reluctance to collect or make available any data. This presents challenges

135 Maria Szalavitz, *supra* note 52; Wakeman, *supra* note 36.

in assessing the utility or effectiveness of involuntary commitment. However, first-hand reports speak to the carceral, often traumatic nature of coercive treatment, and the dangers of forced abstinence are well established.[136]

V. Law as an Instrument to Reduce the Harms of Involuntary Confinement

"For the rational study of the law the lack-luster man may be the man of the present, but the man of the future is the man of statistics and the master of economics." – Oliver Wendell Holmes

Authority for effective, ethical public health policy is built into our existing legal structures. Nevertheless, as the Lab's analyses suggest, involuntary commitment impinges upon various constitutional and statutory protections. Beyond the lack of data to indicate the efficacy of involuntary commitment as an effective approach to address SUD, involuntary commitment deprives individuals of medical decision-making authority and amalgamates SUD treatment within the stigmatizing carceral system.[137] Involuntary commitment for SUD results in people being detained, frequently within penal facilities, for extended periods of time, absent any crime or victim. Therein lies significant ethical concern—is it appropriate to involuntarily subject people to a system that not only consistently fails at providing adequate treatment but may worsen that person's medical condition?

Traditionally, public health and its relationship to law receives little attention.[138] One of the hallmarks of public health policy, that "upstream" preventative measures aim to stop harm before it

136 Leo Beletsky et al., *Fatal Re-Entry: Legal and Programmatic Opportunities to Curb Opioid Overdose Among Individuals Newly Released from Incarceration*, 7 Ne. U. L.J. 155, 159, 172 (2015); Rachel Poser, *Does Forced Rehab Work?*, Mother Jones (July-Aug. 2018), https://www.motherjones.com/politics/2018/06/does-forced-rehab-work/; Shoshana Walter, *At Hundreds of Rehabs, Recovery Means Work Without Pay*, Reveal News (July 7, 2020), https://revealnews.org/article/at-hundreds-of-rehabs-recovery-means-work-without-pay/.

137 *See* John Messinger & Leo Beletsky, *Forced Addiction Treatment Could Be a Death Sentence During COVID-19*, CommonWealth Beacon (Jan. 20, 2021), https://commonwealthbeacon.org/criminal-justice/forced-addiction-treatment-could-be-death-sentence-during-covid-19/; James K. Rustad et al., *Civil Commitment Among Patients with Alcohol and Drug Abuse: Practical, Conceptual, and Ethical Issues*, 11 Addictive Disorders & Their Treatment 136, 137 (2012).

138 Wendy E. Parmet, Populations, Public Health, and the Law 5 (2009).

is perceived, is also one of its greatest challenges.[139] Though "the protection of population health may be viewed as one of the motivating justifications for a legal system,"[140] convincing the public to approve of the creation or implementation of a potentially imperceptible public health policy can be a difficult task. When achieved, the law can serve as a beneficial social and structural determinant of health.[141] If wielded improperly, the law can also create unethical, unjust structures harmful to the public health and welfare.

Although the prominent role that the promotion of public health through law and policy has played over the past few years may seem novel, it is true that the understanding and use of law as a determinant of health has a long and storied history. The maxim *salus populi est suprema lex* is attributed to Cicero's *De Legibus*.[142] Related texts and court cases implicate questions of responsibility, community, and individual rights.[143] The same questions come into play in regard to the methods by which law, policy, and society treat people with SUD.

Building upon these ethical frameworks, the Constitution is a critical tool for the promotion of public health.[144] Public health powers belong to the state as "police powers," which rest with natural sovereign governments to regulate private interests for the public good.[145] The term "police" refers to the state's civil authority to further the public good.[146]

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139 Wendy E. Parmet, *Population-Based Legal Analysis: Bridging the Interdisciplinary Chasm Through Public Health in Law*, 66 J. Legal Educ. 100, 108 (2016).

140 *Id.* at 105.

141 Parmet, *supra* note 140, at 28–50, 33–34.

142 "Let the welfare of the people be the supreme law." *Salus populi suprema lex esto*, Merriam-Webster Dictionary, https://www.merriam-webster.com/dictionary/salus%20populi%20suprema%20lex%20esto (last visited Apr. 15, 2024); *Salus populi suprema lex esto*, Latin is Simple, https://www.latin-is-simple.com/en/vocabulary/phrase/1684/ (last visited Apr. 15, 2024).

143 John Fabian Witt, *The Law of Salus Populi: Epidemics and the Law*, Yale Rev. (Mar. 30, 2020), https://yalereview.org/article/law-salus-populi; *see* Wendy E. Parmet, *Health Care and the Constitution: Public Health and the Role of the State in the Framing Era*, 20 Hastings Const. L.Q., 267, 268–335, 312–19 (1993); *see also Social Contract*, Britannica Encyclopedia, https://www.britannica.com/topic/social-contract (last visited Apr. 15, 2024) (describing historical invocations of public health and its relationship to law that may be observed as a form of John Locke's social contract theory: moral and political obligations are for the benefit of society and are dependent upon a contract among individuals, indicating a community-wide implied sacrifice of the rights which burden the well-being of the masses).

144 Lawrence O. Gostin, & Lindsay F. Wiley, Public Health Law in the Constitutional Design 73, 87 (3d ed. 2016).

145 *Id.*

146 Wendy E. Parmet, *From Slaughter-House to Lochner: The Rise and Fall of the*

Through plenary powers, limited by constitutional safeguards, states retain sovereignty to protect the health of their citizens.[147] Although limited, the federal government's jurisdiction over health policy stems from these powers, which include the powers to tax and spend as well as control interstate commerce.[148] The Constitution also places limits upon a government's power to interfere with the individual.[149] At the heart of this tension is the concept of "federalism," which keeps state and federal government authorities distinct.[150] In the realm of public health, this creates an interesting push and pull between seemingly diametric constitutional interests.[151]

In the nineteenth century, little jurisprudence existed to clarify the scope of government power in the protection of public health.[152] The language of the Fourteenth Amendment allowed the Court to better define "the limits and scope of a broad range of governmental authorit[ies]."[153] In doing so, individual rights became better protected "against assertions of state authority" under the Constitution.[154] The Amendment may be used to prevent the state from exceeding its police power. As a result, the Amendment has been sued to prevent the state from exceeding its police power.

A significantly influential public health case from this era is the 1905 case, *Jacobson v. Massachusetts.*[155] Here, the Supreme Court rejected a constitutional challenge to a state statute authorizing health departments to require smallpox vaccination.[156] In upholding the ordinance allowing

Constitutionalization of Public Health, 40 Am. J. Legal Hist. 476, 478 (1996) (citing James Tobey in 1927: "[G]overnment is organized for the purpose, among others, of preserving the public health and the public morals, it cannot divest itself of the power..."; the rights of states to regulate its citizens under police power was not limited to the realm of health: other common law maxims used frequently in nineteenth-century police power cases was "*sic utere tuo ut alienum non laedas*" (use your own not to injure another) and *parens patriae* (parent of the nation), which belongs primarily to state and local governments)).

147 Gostin & Wiley, *supra* note 146, at 74–77.

148 *Id.* at 77.

149 *Id.* at 74.

150 *Id.*

151 *Id.*

152 Parmet, *supra* note 148, at 479.

153 *Id.* at 480.

154 *Id.*

155 Mark A. Hall et al., *The Legal Authority for States' Stay-at-Home Orders*, New Eng. J. Med. e29(1), e29(3) (2020); Petition for Writ of Mandamus to the United States District Court for the Western District of Texas at 10, In re Abbott, 954 F.3d 772 (5th Cir. 2020) (No. 20-50264).

156 Jacobson v. Massachusetts, 197 U.S. 11, 39 (1905); Wendy E. Parmet, *Valuing the*

vaccine mandates, Justice Harlan stated that:

> [I]n every well-ordered society charged with the duty of conserving the safety of its members the rights of the individual in respect of his liberty may at times, under the pressure of great dangers, be subjected to such restraint, to be enforced by reasonable regulations, as the safety of the general public may demand."[157]

Using epidemiological principles, the Court affirmed that state governments may use police power to limit individual liberties in the interest of protecting the public from harm.[158] While Justice Harlan asserted that "the mere possibility that the legislature might abuse its police power does not 'disprove its existence,'" the Court did acknowledge the need to carefully balance the pursuit of public protection with the preservation of individual liberties, upholding the evidentiary requirement that police power may not be "arbitrary and oppressive."[159]

A. *Constitutional Considerations and Potential Solutions*

The Supreme Court has repeatedly affirmed the constitutionality of involuntary commitment, so long as the statute at issue includes certain procedural and evidentiary safeguards.[160] As an exercise of the state's police power, involuntary commitment statutes have been repeatedly affirmed as constitutional, while the Court has acknowledged the liberty interest at stake. "[F]reedom from physical restraint 'has always been at the core of the liberty protected by the Due Process Clause from arbitrary governmental action . . . .'"[161] Despite its centrality, this freedom is not limitless:

> [T]he liberty secured by the Constitution of the United

Unidentified: The Potential of Public Health Law, 53 Jurimetrics 255, 265 (2013).

157 *Jacobson*, 197 U.S. at 29.

158 Parmet, *supra* note 158, at 265.

159 Powell v. Pennsylvania, 127 U.S. 678 (1888); *Jacobson*, 197 U.S. at 38 (1905) (asserting that "[t]he safety and the health of the people of Massachusetts are, in the first instance, for that commonwealth to guard and protect. They are matters that do not ordinarily concern the national government").

160 Kansas v. Hendricks, 521 U.S. 346, 346–47 (1997).

161 *Id.* at 356 (quoting Foucha v. Louisiana, 504 U.S. 71, 80 (1992)).

> States to every person within its jurisdiction does not import an absolute right in each person to be, at all times and in all circumstances, wholly freed from restraint. There are manifold restraints to which every person is necessarily subject for the common good. On any other basis organized society could not exist with safety to its members.[162]

Without having directly ruled on the matter, the Supreme Court has implied in related cases that involuntary commitment for SUD may not be unconstitutional.[163] In *Whipple v. Martinson*, the Court determined "[t]he broad power of a State to regulate the narcotic drugs traffic within its borders,"[164] and with that, established that related regulations "could take a veriety [sic] of valid forms."[165] The Court specifically named "compulsory treatment" (including "periods of involuntary confinement") as a potential way to discourage drug law violations and suggested that noncompliance with such treatment may be met with penal consequences, looking to similar models of confinement for psychiatric conditions or infectious disease as precedent.[166]

While the general standard for initiating involuntary commitment for SUD requires a petitioner to prove that an individual poses a danger to themselves or others, some states' grounds for commitment include "grave [disability] as a result of [SUD]" or an inability to provide for one's own basic needs for survival such as shelter or sustenance.[167] Relatedly, most states stipulate that commitment cannot be initiated (with related restrictions on the in/outpatient setting) if an individual's "needs can be met in a less restrictive setting."[168] However, while some states require discharge after thirty days of commitment (barring petitions to recommit), others allow for longer-term commitment of up to two years[169] or simply decline to specify any

162 *Jacobson*, 197 U.S. at 26.

163 Robinson v. California, 370 U.S. 660, 676 (1962) (holding that a narcotic addict may be subject to therapeutic confinement or confinement for public safety, but criminalization of the addiction constitutes cruel and unusual punishment within the meaning of the Eighth Amendment); Lawrence O. Gostin, *Compulsory Treatment for Drug-dependent Persons: Justifications for a Public Health Approach to Drug Dependency*, 69 Milbank Q. 561, 564–65 (1991); Player, *supra* note 1, at 597.

164 *Robinson*, 370 U.S. at 676 (quoting Whipple v. Martinson, 256 U.S. 41 (1921)).

165 *Id.* at 664.

166 *Id.* at 664–65.

167 Player, *supra* note 1, at 596–97.

168 Rockville, MD: Off. of the Chief Med. Officer, *supra* note 22, at 12.

169 The Action Lab, *Laws Authorizing Involuntary Commitment For Substance Use*, The Policy Surveillance Program (Mar. 1, 2018), https://lawatlas.org/datasets/

particular duration.[170]

In sum, "the person sought to be committed [must be] mentally ill and [require] hospitalization for his own welfare and protection of others."[171] While recognizing that the state has an interest in "providing care and assistance to the unfortunate," the Court in *O'Connor v. Donaldson* held that "a state cannot constitutionally confine without more a nondangerous individual who is capable of surviving safely in freedom by himself or with the help of willing and responsible family members or friends."[172] Moreover, the definition of "mental illness" is not restricted to diagnosable medical conditions.[173] The inclusion of legally significant medical conditions "serve[s] to limit involuntary civil confinement to those who suffer from a volitional impairment rendering them dangerous beyond their control."[174]

By noting a distinction in the law's text delineating those with SUD versus those "in imminent danger" of developing SUD, *People v. Victor* effectively recognized the nature of SUD as a spectrum and "not so much an event as a process."[175] Though the California Supreme Court in *People v. Victor* acknowledged that non-regular use for recreational or experimental purposes does not indicate SUD, the Court did allow that such use "could be a step in [the process of developing SUD]."[176] In doing so, the Court established that the legal authorization of proactive or preventative involuntary commitment for the use of addictive substances or SUD is "neither un-constitutionally vague nor beyond the police power of the state."[177]

1. Involuntary Commitment and the Due Process Clause of the Fourteenth Amendment

The Due Process Clause of the Fourteenth Amendment

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civil-commitment-for-substance-users (select filter #3).

170 *Id.*

171 Foucha v. Louisiana, 504 U.S. 71, 75–76 (1992) (citing Addington v. Texas, 441 U.S. 418 (1979)).

172 O'Connor v. Donaldson, 422 U.S. 563, 575–76 (1975) (finding unconstitutional state action to hold plaintiff O'Connor in a hospital for 14 years though he requested release and was neither suicidal nor likely to inflict injury upon another person).

173 *See* Kansas v. Hendricks, 521 U.S. 346, 359 (1997).

174 *Id.* at 358.

175 People v. Victor, 398 P.2d 391, 404 (Cal. 1965); Player, *supra* note 1, at 599.

176 *Victor*, 398 P.2d at 404; Player, *supra* note 1 at 599.

177 Player, *supra* note 1, at 599; *see Victor*, 398 P.2d at 394.

guarantees that no person shall be deprived "of life, liberty, or property, without due process of law."[178] Compulsory treatment must comply with these liberty and autonomy guarantees.[179]

Per the Supreme Court, due process "protects individuals against two types of government action" and has two forms: (1) "substantive due process" and (2) "procedural due process."[180] Substantive due process limits governmental conduct that "infringes upon certain fundamental rights" or "shocks the conscience;" while "procedural due process" prohibits the deprivation by the government of "life, liberty, or property without adequate procedural safeguards."[181]

The Court "repeatedly has recognized that civil commitment for any purpose constitutes a significant deprivation of liberty that requires due process protection."[182] Moreover, in *Addington v. Texas*, the Court acknowledged the additional social consequences that may result from commitment under these statutes.[183] The Court stated, "[w]hether we label this phenomena 'stigma' or choose to call it something else is less important than that we recognize that it can occur and that it can have a very significant impact on the individual."[184] Due process necessitates, at a minimum, "that the nature and duration of commitment bear some reasonable relation to the purpose for which the individual is committed."[185] Accordingly, the conditions and restrictions must reasonably relate to a legitimate non-punitive governmental objective.[186]

In regard to the deprivation of life, liberty, or property, the State may argue that there is no constitutional cause of action for potential litigation because people who are subject to involuntary commitment as treatment for SUD have a post-deprivation remedy—people subject to civil commitment could file a grievance to challenge this issue. However,

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178 U.S. Const. amends. V, XIV ("No State shall make or enforce any law which shall abridge the privileges or immunities of citizens of the United States; nor shall any state deprive any person of life, liberty, or property, without due process of law; nor deny to any person within its jurisdiction the equal protection of the laws.").

179 Addington v. Texas, 441 U.S. 418, 418–19 (1979) (noting mother's petition for the "indefinite" civil commitment of her son under Texas law).

180 United States v. Salerno, 481 U.S. 739, 746 (1987).

181 Christyne E. Ferris, *The Search for Due Process in Civil Commitment Hearings: How Procedural Realities Have Altered Substantive Standards*, 61 Vand. L. Rev. 959, 960–61, n.9; *see* Rochin v. California, 342 U.S. 165, 172 (1952) (holding that "forcible extraction" of "stomach[] contents" violates due process).

182 *Addington*, 441 U.S. at 425.

183 *Id.* at 425–26.

184 *Id.* at 426.

185 Jackson v. Indiana, 406 U.S. 715, 738 (1972).

186 *See* Seling v. Young, 531 U.S. 250, 265 (2001).

a post-deprivation remedy is not enough when an act is not random or unauthorized.[187] Civil commitment is a foreseeable act, and the state could have had a system for pre-deprivation remedy in place.[188] A person can sue for compensatory damages if they can demonstrate that the wrong done to them was caused by an official municipal policy or custom.[189]An act constitutes official policy if it was taken pursuant to an established city policy or custom.[190] Assuming that there is a problem showing an established city policy or custom on these issues, a single act made by a policymaking officer could be enough to be a policy or custom.[191] The court would look to state law to decide whether the person has policymaking authority.

a. Substantive Due Process

The procedural safeguards that became a part of the civil commitment framework during the 1960s and 1970s remain an invaluable tool to protect the individual rights of a person who is involuntarily committed. The right to freedom from restraint is fundamental and deeply rooted in the history and tradition of "liberty." Any infringement upon liberty rights must be reasonably tailored to achieve a constitutional and legitimate government interest.[192] Involuntary commitment may infringe upon the liberty interest in freedom from restraint. However, under its police powers, a state may pass laws to promote the health, safety, and general welfare of its citizens. To counteract these police powers, substantive due process requires the government to show a

187 *See* Zinermon v. Burch, 494 U.S. 113, 113–14 (1990).

188 *Id.*

189 Monell v. N.Y.C. Dep't of Soc. Servs., 436 U.S. 658, 690–91 (1978).

190 Pembaur v. City of Cincinnati, 475 U.S. 469, 481 (1986); *see also* Oklahoma City v. Tuttle, 471 U.S. 808, 822–824 (1985).

191 *See Pembaur*, 475 U.S. at 481.

192 One of such rights is the freedom of contract. *See* Lochner v. New York, 198 U.S. 45 n.1, 53 (1905) (holding that a New York statute providing that no employee "shall . . . work in a biscuit, bread, or cake bakery or confectionery establishment more than sixty hours in any one week, or more than ten hours in any one day" is unconstitutional on the grounds that it "interfere[s] with the right of contract between the employer and employees," reasoning that the "general right to make a contract in relation to [a person's] business is part of the liberty of the individual as protected by the Fourteenth Amendment"). *But see* West Coast Hotel v. Parrish 300 U.S. 379, 391 (1937) (upholding a state law establishing minimum wage for women was a reasonable exercise of the state's power to exercise their police powers over property and the liberty right to freedom of contract based upon the reasoning that "regulation which is reasonable in relation to its subject and is adopted in the interests of the community is due process").

compelling need to terminate fundamental rights related to life, liberty, or property.

In *Youngberg v. Romeo*, the Supreme Court acknowledged that people who are involuntarily committed maintain liberty interests in freedom from unsafe conditions and freedom from bodily restraints as ensured by the Due Process Clause of the Fourteenth Amendment.[193] Section 1983 of the Civil Rights Act of 1871 ("§ 1983") allows a plaintiff to express a cause of action against a state actor for: (1) state action that is (2) in violation of federal law.[194] Pursuant to 42 U.S.C. § 1983, Respondent, who was involuntarily committed to a state institution, filed an action against Petitioner institution administrators. The case alleged a violation of Respondent's "constitutionally protected liberty interest in safety, freedom of movement, and training within the institution."[195] Respondent alleged that Petitioner institution administrators infringed upon these rights by failing to provide constitutionally required conditions of confinement. The Court ruled for Respondent, finding that "the State [was] under a duty to provide [R]espondent with such training as an appropriate professional would consider reasonable to ensure his safety and to facilitate his ability to function free from bodily restraints."[196]

To avoid infringement of these rights, "liberty interests require the State to provide minimally adequate or reasonable training" for State officials.[197] In determining whether the training is adequate, the decision of medical professionals is presumptively valid; "liability may be imposed only when the decision by the professional is such a substantial departure from accepted professional judgment, practice, or standards as to demonstrate that the person responsible actually did not base the decision on such a judgment."[198] Many facilities used to house people involuntarily committed, in particular correctional facilities, fall short of these minimal standards for medical care, especially care for SUD. Specifically, access to MOUD, a core component of the standard of care for OUD is exceedingly limited in prisons.[199] The widespread nature

193 Youngberg v. Romeo, 457 U.S. 307, 315–16 (1982).

194 42 U.S.C. § 1983.

195 *Id.* at 319 (finding that people who are involuntarily committed for reasons due to mental health are entitled to receive "minimally adequate or reasonable training to ensure safety and freedom from undue restraint".

196 *Id.* at 324.

197 *Id.* at 319.

198 *Id.* at 314, 323.

199 Amy Nunn et al., *Methadone and Buprenorphine Prescribing and Referral Practices in U.S. Prison Systems: Results from a Nationwide Survey*, 105 Drug & Alcohol

of these shortcomings does not excuse the fact that the care provided to people involuntarily committed departs from the overwhelming medical consensus regarding the standard of care for people with OUD. Moreover, without access to effective methods to manage their SUD, people who are involuntarily committed in these facilities lack a vital tool to be released from confinement. Thus, the shortcomings in treatment raise additional, significant questions.

In many cases, the thresholds used to involuntarily commit individuals are not reasonably related to the legislative aims of these statutes. Many legislative definitions extend far beyond harm to self or others; specifically, statutes allow for the commitment of people with mental illnesses who have a "grave disability" or "need for treatment."[200] These overinclusive statutes allow for the involuntary commitment of people who do not pose any threat to the safety of themselves or others, which runs contrary to *O'Connor* and needlessly subjects people to the harms of commitment.

b. Procedural Due Process

Procedural due process claims contain a "mistaken or unjustified deprivation" without due process.[201] To find a violation of due process, a plaintiff must demonstrate a deprivation of a covered right in which the deprivation was intentional, not random or unauthorized, but under a scheme in which the state broadly delegates state authority to the defendants without providing pre-deprivation safeguards. As Justice Field wrote in his dissenting opinion in *Powell v. Pennsylvania*, a state law:

> [M]ust have in its provisions some relation to the end to be

DEPENDENCE, Nov. 2009, at 83, 85; *see also* Ashish P. Thakrar, *Trends in Buprenorphine Use in US Jails and Prisons From 2016 to 2021*, JAMA NETWORK OPEN, Dec. 2021, at 2 ("An estimated 3.6% of the 270 000 incarcerated individuals with OUD in the US received buprenorphine").

200 Daniel H. Stone, *There Are Cracks in the Civil Commitment Process: A Practitioner's Recommendations to Patch the System,* 43 FORDHAM URB. L.J. 789, 792 n.10 (2016) (citing *Improved Treatment Standards*, TREATMENT ADVOCACY CTR., http://www.treatmentadvocacycenter.org/solutions/improved-treatment-standards) ("Only eight states still define dangerousness solely as a 'danger to self or others.' Forty-two states provide criteria broader than dangerousness that often include either a 'grave disability' or a 'need for treatment' provision.").

201 Erwin Chemerinsky, *Procedural Due Process Claims*, 16 TOURO L. REV. 871, [pincite] (2016); U.S. CONST. amend. XIV, § 1; *Procedural Due Process Civil,* JUSTIA, https://law.justia.com/constitution/us/amendment-14/05-procedural-due-process-civil.html (last visited Apr. 15, 2024).

> accomplished. If that which is forbidden is not injurious to the health or morals of the people, if it does not disturb their peace or menace their safety, it derives no validity by calling it a police or health law. Whatever name it may receive, it is nothing less than an unwarranted interference with the rights and the liberties of the citizen.[202]

Taking these definitions into account, the civil commitment process raises a number of legal questions in regard to procedural due process.[203] For example, is there an adequate opportunity to be heard? What are the evidentiary and procedural requirements for these statutes?[204] What would additional protections provide? What are the "fiscal and administrative burdens" of these protections? [205]

Although § 1983 actions are usually brought against municipalities or city or state officials, private actors can be defendants if they are conspiring with officials acting under the color of state law (such as through contracts with the state).[206] The defendant in a § 1983 action must be a person acting under the color of state law, violating federal law.[207] State action does not have to be authorized by state law to be state action under the Fourteenth Amendment or in a § 1983 action.[208]

However, a series of cases cut back on the availability of § 1983 actions through the Fourteenth Amendment. *Paul v. Davis* established that "the procedural guarantees of the Fourteenth Amendment apply whenever the State seeks to remove or significantly alter [interests comprehended within the meaning of either 'liberty' or 'property']."[209]

202 Parmet, *supra* note 148, at 496 (citing Powell v. Pennsylvania, 127 U.S. 678, 695 (1888) (Field, J., dissenting)).

203 Ferris, *supra* note 16, at 960.

204 Stone, *supra* note 201, at 795, 807.

205 Youngberg v. Romeo, 457 U.S 307, 321 (1982) (citing Parham v. J. R., 442 U.S. 584, 599–600 (1979)).

206 U.S. Ct. of Appeals for the Ninth Circuit Off. of Staff Att'ys, Section 1983 Outline 11, 13, 72 (2011), https://cdn.ca9.uscourts.gov/datastore/uploads/guides/Section_1983_Outline_2012.pdf.

207 *See generally* Monroe v. Pape, 365 U.S. 167 (1961).

208 *See generally Id.* at 167.

209 Paul v. Davis, 424 U.S. 693, 710–11 (1976) ("It is apparent from our decisions that there exists a variety of interests which are difficult of definition but are nevertheless comprehended within the meaning of either 'liberty' or 'property' as meant in the Due Process Clause. These interests attain this constitutional status by virtue of the fact that they have been initially recognized and protected by state law, and we have repeatedly ruled that the procedural guarantees of the Fourteenth Amendment apply whenever the State seeks to remove or significantly alter that protected status.").

The characteristics of what constitutes a "deprivation" were narrowed in *Parratt v. Taylor*, in which the Court found that the negligent deprivation of property was covered by the Fourteenth Amendment, but a post-deprivation remedy adequately addressed the deprivation such that it did not constitute a violation of the Fourteenth Amendment.[210] Further, *Daniels v. Williams* overturned the first *Parratt* holding, finding that a negligent action by an officer was not a deprivation.[211]

However, the Court in *Zinermon v. Burch* found a violation of due process when mental health hospital staff let plaintiff Burch sign into the facility even though he was declared incompetent, keeping him there for five months without a hearing. Had Burch been admitted involuntarily, he would have received a hearing.[212] In *Zinermon*, the Court found that post-deprivation remedies are insufficient for due process after an unauthorized but foreseeable deprivation of a covered right.[213]

2. Involuntary Commitment and the Equal Protection Clause of the Fourteenth Amendment

United States citizens also enjoy protection under the Equal Protection Clause of the Fourteenth Amendment.[214] Under this framework, citizens are protected from discrimination based on classifications in their exercise of fundamental rights.[215] The Supreme Court has established a high bar to governments' classification-based attempts to impinge fundamental rights, allowing such measures only when "narrowly tailored to serve a compelling state interest."[216] In

210 Parratt v. Taylor, 451 U.S. 527, 541 (1981) (pre-deprivation hearing *not* constitutionally required).

211 Daniels v. Williams, 474 U.S. 327 (1986).

212 Zinermon v. Burch, 494 U.S. 113, 123 (1990) (The assertion that Burch, if admitted involuntarily, would have received a hearing is based upon the understanding that the Constitution ensures the right to a hearing "before the State deprives a person of liberty or property").

213 *Id.* at 138.

214 *See* Gomillion v. Lightfoot, 364 U.S. 339, 132 (1960) (wherein a classifications (race)-based violation of the Equal Protection Clause was identified).

215 *See, e.g.*, Reynolds v. Sims, 377 U.S. 533 (1964); *see* Bolling v. Sharpe, 347 U.S. 497 (1954) (The Equal Protection clause only appears in the Fourteenth Amendment which only applies to states and local governments. But through reverse incorporation, the Fifth Amendment encompasses equal protection because the due process clause of the Fifth Amendment says that the federal government can't apply laws in a non-equal way).

216 Buckley v. Am. Const. L., 525 U.S. 182, 192 n.12 (1999); O'Connor v. Donaldson, 422 U.S. 563, 580 (1975).

regard to involuntary commitment, the fundamental right at risk of infringement is "every [person's] constitutional right to liberty."[217]

3. The Eighth Amendment

The Supreme Court affirmed, in *Estelle v. Gamble*, that denying individuals who are incarcerated basic healthcare constitutes cruel and unusual punishment under the Eighth Amendment.[218] Though this care is largely not sufficient, is oftentimes nonexistent,[219] and is also complicated by statutes like the Medicaid Inmate Exclusion Policy,[220] on paper, the right to care is consistently affirmed. Unfortunately, *Estelle v. Gamble* does not clarify what constitutes reasonably adequate care in carceral settings.[221]

Although involuntarily committed patients' "liberty interests require the State to provide minimally adequate or reasonable training to ensure safety and freedom from undue restraint,"[222] there are no requirements that treatment must be provided and there are no requirements that the treatment must be effective. The Supreme Court distinguishes this discrepancy based upon the notion that involuntary commitment is not punishment but rather detainment for public safety purposes,[223] allowing states to involuntarily commit individuals.[224]

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217 *O'Connor*, 422 U.S. at 573.

218 Estelle v. Gamble, 429 U.S. 97, 104–05 (1976); United States v. DeCologero, 821 F.2d 39, 43 (1st Cir. 1987) (stating that the Bureau of Prisons is obligated to provide incarcerated individuals with adequate "services at a level reasonably commensurate with modern medical science and of a quality acceptable within prudent professional standards").

219 Andrew P. Wilper et. al., *The Health and Health Care of US Prisoners: Results of a Nationwide Survey*, 99 Am. J. Pub. Health 666 (2009); Danya Ziazadeh, *Inadequate Health Care: A Significant Problem Affecting Incarcerated Women*, Univ. of Mich. Sch, of Pub. Health (May 30, 2019), https://sph.umich.edu/pursuit/2019posts/inadequate-healthcare-a-significant-problem-affecting-incarcerated-women.html.

220 42 U.S.C. § 1396d (prohibiting the use of federal funds for medical care provided to "an inmate of a public institution").

221 Marin G. Olson et. al., *Aligning Correctional Health Standards with Medicaid-Covered Benefits*, JAMA Health F. (July 27, 2020), https://jamanetwork.com/journals/jama-health-forum/fullarticle/2768932.

222 Youngberg v. Romeo, 457 U.S. 307, 319 (1982).

223 *See* Kansas v. Hendricks, 521 U.S. 346, 361 (1997) (concurring opinion discusses that the involuntary commitment statute did not establish criminal proceedings and did not implicate the Ex Post Facto or Double Jeopardy Clauses because involuntary commitment is not a punishment).

224 Testa & West, *supra* note 14, at 33; *Hendricks*, 521 U.S. at 361–63.

Because the Court denies that these statutes punish, criminal protections do not apply.[225]

The Court looks to several factors to determine whether an involuntary commitment statute is criminal. In *Seling v. Young*, the Court upheld a Washington statute that allowed for "the civil commitment of sexually violent predators" who had a mental abnormality that made them a danger to themselves or others.[226] The Court noted the earlier decision in *Hendricks*, which upheld a similar statute and looked to several factors:

> The Act did not implicate retribution or deterrence; prior criminal convictions were used as evidence in the commitment proceedings, but were not a prerequisite to confinement; the Act required no finding of scienter to commit a person; the Act was not intended to function as a deterrent; and although the procedural safeguards were similar to those in the criminal context, they did not alter the character of the scheme.[227]

Despite the Court's continued focus on retribution and deterrence, these are not the only penological aims of criminalization. Criminal laws also may aim to incapacitate.[228] The aim of many involuntary commitment statutes is to incapacitate.[229] Indeed, in upholding the constitutionality of the statute despite the lack of effective treatment, the Court recognized the incapacitation aim of the statute involved in *Hendricks*.[230] Thus, involuntary commitment statutes that aim to incapacitate people with SUD are actually advancing a penological aim in a method that treats people with SUD as criminals.

The conditions within involuntary commitment settings may also tend to demonstrate its punitive nature.[231] As observed in practice,

225 *Hendricks*, 521 U.S. at 361.

226 Seling v. Young, 531 U.S. 250, 253 (2001).

227 *Id.* at 261 (2001) (citing *Hendricks*, 521 U.S. at 361).

228 *See* Ken Pease & Joyce Wolfson, *Incapacitation Studies: A Review and Commentary*, 18 Howard J. 160, 167 (1979) (describing the use of imprisonment to incapacitate and distinguishing incapacitation from other penological aims); 4 Jeremy Bentham, *Panopticon vs. New South Wales*, *in* The Works Of Jeremy Bentham 173, 174 (John Bowring ed., 1843) ("*Incapacitation* - prevention of similar offences on the part of the same individual, by depriving him of the *power* to do the like.").

229 Rockville, MD: Off. of the Chief Med. Officer, *supra* note 22; Justin Engel, *Constitutional Limitations on the Expansion of Involuntary Civil Commitment for Violent and Dangerous Offenders*, 8 U. Pa. J. Const. L. 841, 847 (2006).

230 *See Hendricks*, 521 U.S. at 366.

231 Rustad et al., *supra* note 139, at 137.

for lack of available beds or resources, many people with SUD who are involuntarily committed are placed within penal settings. The involuntary placement of a person in a penal setting inherently raises the question of whether such commitment is essentially equivalent criminal punishment. Furthermore, it may be argued that the detainment of a person with SUD without providing access to the evidence-based standard of care for OUD is also punishment. Inadequate medical care that does not utilize effective treatments allows for the indefinite, or at least unnecessarily prolonged, confinement of people who lack access to the tools to facilitate their release.[232] Given inferior access to MOUD and other SUD care in many carceral settings, many people with SUD do not have the effective tools for sustained recovery and may ultimately be detained for an indefinite period. In effect, the sustained confinement may result in an unconstitutional punishment for SUD.[233]

When involuntary commitment statutes cause punishments, the Court's jurisprudence regarding criminal protections should apply.[234] Among these protections, due process requires certain procedural safeguards, such as the right to counsel and the right to a trial. Moreover, the criminal designation would offer protection through the Ex Post Facto Clause and the Double Jeopardy Clause.[235]

B. Statutory Considerations

Beyond the aforementioned constitutional bases upon which involuntary commitment may be challenged, below are three statutes which may, or have been, interpreted to provide authority for a person, class of people, or government body to challenge a person's deprivation of liberties upon being involuntarily committed to a treatment facility for SUD.

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232 *See* Samantha M. Caspar & Artem M. Joukov, *Worse Than Punishment: How the Involuntary Commitment of Persons with Mental Illness Violates the United States Constitution*, 47 Hastings Const. L.Q. 499, 502–503 (2020) (arguing that the conditions of involuntary commitment of people with mental illnesses often constitutes a greater deprivation of liberty due to medical providers having such power over the length of commitment).

233 Robinson v. California, 370 U.S. 660, 667 (1962) (holding that punishment for the status of being a person addicted to narcotics was unconstitutional).

234 Hannah Alise-Rogers, Cong. Rsch. Serv., R47571, Involuntary Civil Commitment: Fourteenth Amendment Due Process Protections 7 (May 24, 2023), https://crsreports.congress.gov/product/pdf/R/R47571; Newton E. Kendig, et al., *Health Care During Incarceration: A Policy Position Paper From the American College of Physicians*, 175 Annals Internal Med. 1742–45 (2022).

235 *See Hendricks*, 521 U.S. at 369 (contemplating these protections).

1. The Americans with Disabilities and Rehabilitation Acts

The Americans with Disabilities Act is the landmark legislation that protects people with SUD and other disabilities from discrimination based on their status.[236] This law states that "no qualified individual with a disability shall, by reason of such disability, be excluded from participation in or be denied the benefits of the services, programs, or activities of a public entity, or be subjected to discrimination by any such entity."[237] Although it does not directly address the isolation of people with disabilities, the statute's legislative history and application are highly relevant to the institutionalization of people with mental and physical health challenges.[238] Since the law's passage, the judiciary has grappled with the applicability of the law to a "statutory right to treatment in the 'least restrictive environment,' or at least some right for the civilly committed to be free from unnecessary segregation from the rest of the population."[239]

Similarly, the Rehabilitation Act of 1973 "prohibit[s] discrimination against an otherwise qualified individual based on [their] disability."[240] This law applies to entities receiving federal funding, which applies to many entities engaged in involuntary commitment for SUD. Together, these statutory provisions and interpretive court decisions can provide important additional instruments to challenge institutionalization of people with SUD.

2. Civil Rights of Institutionalized Persons Act of 1980

The Civil Rights of Institutionalized Persons Act ("CRIPA") was created to provide the United States Attorney General specific authority to enforce constitutional rights of institutionalized persons by initiating and intervening in litigation. Under the Act, institutions are state-run

236 *See* 42 U.S.C. §§ 12131–32 (note that § 12210 excludes those using illegal substances: "for purposes of this chapter, the term 'individual with a disability' does not include an individual who is currently engaging in the illegal use of drugs, when the covered entity acts on the basis of such use").

237 *Id.* § 12132.

238 Neil S. Butler, *"In The Most Appropriate Setting": The Rights of Mentally Disabled Individuals Under the Americans with Disabilities Act in the Wake of* Olmstead v. L.C., 49 Cath. U. L. Rev. 1021, 1035 (2000).

239 *Id.* at 1036.

240 Calero-Cerezo v. U.S. Dep't. of Just., 355 F.3d 6, 19 (1st Cir. 2004).

facilities, including mental health facilities.[241] The Act excludes from its scope all private facilities unless they fall under certain exceptions.[242] Further, CRIPA explicitly includes as "persons" in state institutions people who are "mentally ill, disabled, or retarded, or chronically ill or handicapped" or are residents of facilities that provide "skilled nursing, intermediate or long-term care, or custodial or residential care."[243]

To bring a civil action on behalf of an institutionalized person under CRIPA, the Attorney General makes the discretionary determination that there is reasonable cause based on two essential elements.[244] First, they should have reasonable cause to believe the residents are being subjected "to egregious or flagrant conditions which deprive such persons" of a constitutional or federally protected right "causing such persons to suffer grievous harm."[245] Second, the Attorney General must also have reasonable cause to believe "a pattern or practice of resistance to the full enjoyment of . . . rights, privileges, or immunities . . . secured or protected by the Constitution of the United States" has occurred.[246] The Attorney General may then file an action that is intended to provide the "minimum corrective measures necessary to insure the full enjoyment of such rights, privileges, or immunities."[247]

In practice, cases brought on CRIPA grounds can refer to the standards set in *Youngberg* to determine adherence to minimum constitutional requirements for care.[248] Cases can also be brought under § 1983 of the Civil Rights Act, the ADA, or § 504 of the Rehabilitation Act.[249]

241 *See* 42 U.S.C. § 1997.

242 *See id.* § 1997(2).

243 *Id.* §§ 1997(1)(B)(i), (v).

244 *See id.* § 1997a(a); United States v. Pennsylvania, 902 F. Supp. 565, 579 (W.D. Pa. 1995), *aff'd sub nom.* United States v. Ridge, 96 F.3d 1436 (3d Cir. 1996).

245 42 U.S.C. § 1997a(a).

246 *Id.*

247 *Id.*

248 *See* U.S. Dep't of Just., Opinion Letter on the Commonwealth of Virginia's Compliance with the Americans with Disabilities Act and of Central Virginia Training Center (Feb. 10, 2011), https://dlcv.org/wp-content/uploads/2015/01/DDS-110210DOJFindings.pdf; U.S. Dep't of Just., Opinion Letter on CRIPA Investigation of Kings County Hospital Center (Jan. 30, 2009), https://graphics8.nytimes.com/packages/pdf/nyregion/2009/2009130KCHC.pdf; John Kip Cornwell, *CRIPA: The Failure of Federal Intervention for Mentally Retarded People*, 97 Yale L.J. 845, 847–48 (1988); Youngberg v. Romeo, 457 U.S. 307, 324 (1982).

249 ACLU, *Know Your Rights: Legal Rights of Disabled Prisoners* (Nov. 19, 2012), https://www.aclu.org/sites/default/files/images/asset_upload_file735_25737.pdf; U.S. Dep't of Just., The Law of Prisoners Rights: A Summary for Masters 5 (Sept.

VI. Ethical Dimensions

Involuntary commitment exists in a unique overlap of multiple systems (and simultaneously, in a legal realm all its own). While it is considered a civil process, it takes many of its practices from criminal law and corrections, as demonstrated above. However, due to its governance by civil rather than criminal law, the standard of proof for meeting the criteria to initiate involuntary commitment is lower.[250] Rules on who may submit a petition to initiate involuntary commitment vary across states and range from healthcare providers, law enforcement, family, or any interested party.[251] Not all states explicitly uphold the right to counsel during commitment proceedings.[252] Involuntary commitment also walks the line between medicine and the law, intended and recommended to live under the umbrella of public health and medical treatment, but at the same time serving as another branch of the criminal justice system. As such, involuntary commitment is effectively an exception to all of the systems above and thus finds an intersection between these otherwise highly regulated worlds where little governance of standard operations and practitioner performance exists.

Involuntary commitment can be perceived by patients as an unjustified infringement upon their civil liberties.[253] By eliminating people who are involuntarily committed from the treatment decision-making process,[254] involuntary treatment programs create an environment of disempowerment where the loss of agency feeds even greater harms.[255] Negative experiences with involuntary commitment can break trust in treatment providers and chill future care-seeking.[256]

1983), https://www.ojp.gov/pdffiles1/Digitization/95053NCJRS.pdf.

250 *See* Addington v. Texas, 441 U.S. 418, 431 (1979).

251 *See* The Action Lab & CPHLR, *supra* note 44 (choose "4. Who can initiate involuntary commitment?" on left side of map).

252 *Id.* (choose "8. Does the individual have a right to counsel at the commitment hearing?" on left side of map).

253 *See* Marianne Wyder et al., *The Experiences of the Legal Processes of Involuntary Treatment Orders: Tension Between the Legal and Medical Frameworks*, 35 Int'l J.L. & Psychiatry 44, 49 (2015).

254 *See* Emanuele Valenti et al., *Which Values Are Important for Patients During Involuntary Treatment? A Qualitative Study with Psychiatric Inpatients*, 40 J. Med. & Ethics 832, 833 (2014).

255 *See* John Monahan et al., *Coercion and Commitment: Understanding Involuntary Mental Hospital Admission*, 18 Int'l J.L. & Psychiatry 249, 258 (1995).

256 Graham Danzer & Asha Wilkus-Stone, *The Give and Take of Freedom: The Role of Involuntary Hospitalization and Treatment in Recovery from Mental Illness*, 79 Bull

Some people who are involuntarily committed also experience "loss of self-esteem, identity, self-control, and self-efficacy, as well as diminished hope in the possibility of recovery."[257] Socially, involuntary commitment can also result in devastating enduring consequences after release such as an increased risk of losing child custody, issues securing housing, difficulty accessing education, and even exclusion from certain professions.[258] Poorly maintained operations in involuntary treatment facilities make for uncomfortable conditions at best and deadly ones at worst, with complaints against these facilities and their staff going unaddressed.[259] This system sets people up to fail. Satisfaction with treatment, which is often associated with fewer feelings of coercion, leads to less compulsory readmission.[260] However, the current standard of care in involuntary treatment settings makes survival, not recovery, the priority.

It is impossible to consider today's role of involuntary commitment without considering the broader context of the War on Drugs. Declared by President Nixon in 1971, the War "cracked down" on drug use and trafficking through harsher sentencing and growing the law enforcement footprint, feeding into an increasingly bloated carceral system.[261] These and subsequent policy changes continue to be disproportionately enforced and impactful across racial and socioeconomic lines,[262] with an outsized effect on Black and Latinx

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Menninger Clinic 255, 262–64 (2015).

257 *Id.* at 263.

258 Jerry Iannelli, *Adams' Forced Hospitalization Plan Will Have Lifelong Consequences*, The Appeal (Dec. 7, 2022), https://theappeal.org/nyc-mayor-eric-adams-involuntary-commitment/.

259 *See* John Messinger & Leo Beletsky, *Forced Addiction Treatment Could Be Death Sentence During COVID-19*, Commonwealth Beacon, (Jan. 20, 2021), https://commonwealthbeacon.org/criminal-justice/forced-addiction-treatment-could-be-death-sentence-during-covid-19/; Poser, *supra* note 136.

260 Szalavitz, *supra* note 52.

261 *See* Brian Mann, *After 50 Years of the War on Drugs, 'What Good Is It Doing For Us?,'* NPR (June 17, 2021), https://www.npr.org/2021/06/17/1006495476/after-50-years-of-the-war-on-drugs-what-good-is-it-doing-for-us; Drug Policy Alliance, *The Drug War, Mass Incarceration and Race*, Drug Pol'y All. (June 2015), https://www.unodc.org/documents/ungass2016/Contributions/Civil/DrugPolicyAlliance/DPA_Fact_Sheet_Drug_War_Mass_Incarceration_and_Race_June2015.pdf; Mathew D. Lassiter, *America's War on Drugs Has Always Been Bipartisan—and Unwinnable*, Time (Dec. 7, 2023), https://time.com/6340590/drug-war-politics-history/.

262 Graham Boyd, *The Drug War Is the New Jim Crow*, ACLU (July 31, 2001), https://www.aclu.org/documents/drug-war-new-jim-crow; Mass. Cannabis Control Comm'n, Report on Identifying Disproportionately Impacted Areas by Cannabis

populations.[263]

Addressing SUD through a public health rather than a punitive approach creates more successful outcomes.[264] Dr. Nora Volkow of the National Institute of Drug Abuse states that, through the punitive approach, the structurally racist system underlying the War on Drugs is further reinforced.[265] Racial disparities, however, develop differently in the context of involuntary commitment than in the War on Drugs. Because involuntary commitment is seen as the more humane approach, in many jurisdictions people who are involuntarily committed are

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and Drug Prohibition: Commissioner Questions & Research Team Answers 6 (2022), https://masscannabiscontrol.com/wp-content/uploads/2022/02/Report-on-Identifying-Disproportionately-Impacted-Areas-by-Cannabis-and-Drug-Prohibition.pdf.

263 *See* Dan Baum, *Legalize It All: How to Win the War on Drugs*, Harper's Mag. (Apr. 2016), https://harpers.org/archive/2016/04/legalize-it-all/ (In a 1994 interview, Nixon adviser John Ehrlichman explicitly stated that the "War on Drugs" was intended to promulgate racial animus for political gain: "We knew we couldn't make it illegal to be either against the [Vietnam W]ar or [B]lack," Ehrlichman said. "[B]ut by getting the public to associate the hippies with marijuana and [B]lacks with heroin, and then criminalizing both heavily, we could disrupt those communities"); *See* Report: The War on Marijuana in Black & White, ACLU (June 3, 2013), https://www.aclu.org/report/report-war-marijuana-black-and-white (Racist and violent from their very conception, these policies proved to be massively harmful– not only by feeding the Era of Mass Incarceration, but also by framing substance use as a moral failure rather than a symptom of larger systemic issues); *see also* Boyd, *supra* note 264.

264 Nora D. Volkow et al., *Drug Use Disorders: Impact of a Public Health Rather Than a Criminal Justice Approach*, 16 World Psychiatry 213, 213–14 (2017).

265 Boyd, *supra* note 264; *see also* Nora D. Volkow, *Addiction Should be Treated, Not Penalized*, 46 Neuropsychopharmacology 2048, 2048–49 (2021); Lisa D. Moore & Amy Elkavich, *Who's Using and Who's Doing Time: Incarceration, the War on Drugs, and Public Health*, 98 Am. J. Pub. Health S176 (2008); *Policing as a Social Determinant of Health: Addressing the Public Health Crisis of Systemic Racism*, Network for Pub. Health L. (June 18, 2020), https://www.networkforphl.org/news-insights/policing-as-a-social-determinant-of-health-addressing-the-public-health-crisis-of-systemic-racism/; Liam Knox, *New Study Shows Racism May Shorten Black Americans' Lifespans*, NBC News (Feb. 5, 2020), https://www.nbcnews.com/news/nbcblk/new-study-shows-racism-may-shorten-black-americans-lifespans-n1128351 (Disproportionate policing decreases autonomy and freedom in the short- and long-term and is one social determinant of health. Police stops are associated with increased incidence of anxiety, depression, and PTSD, and chronic exposure to over-policing is associated with lower life expectancy. Massive hurdles prevent formerly incarcerated people from securing employment, housing, and financial stability. To state the disproportional effect of policing upon people of color through epidemiological or statistical terms feels overwhelmingly obvious and excessively disconnected from the devastation that too many continue to experience).

disproportionately white, while Black and brown people continue to be relegated to the criminal legal system. Involuntary commitment, however, is still a product of racism—rather than deploying actual scientific approaches, it has clouded the entire system of thinking to focus on coercion.[266] As data are uncovered about how it is being deployed, additional disparities may become apparent.

In sum, involuntary commitment for SUD is a controversial practice that violates individual rights and lacks empirical evidence supporting its effectiveness.[267] While the practice has a long history in the United States, its use in cases of SUD remains highly debated.[268] Many states have amended their involuntary commitment laws to include SUD, and the practice has become increasingly prevalent in the wake of the opioid epidemic.[269] However, the use of involuntary commitment for SUD raises significant legal, ethical, and public health questions that require further examination. The harm reduction principles used in responding to the overdose crisis suggest that involuntary commitment is not an effective response and may in fact harm individuals living with substance use disorder.[270] Thus, it is crucial to examine the legal and ethical considerations surrounding involuntary commitment and advocate for harm reduction strategies that prioritize individualized treatment and reducing harm.

VII. Next Steps

The road to involuntary commitment reform proceeds through harm reduction. Involuntary commitment runs counter to the central tenets of harm reduction, which excludes criminal punishment as a means to reduce the harms of substance use.[271] Evidence affirms that

266 Rafik Wahbi & Leo Beletsky, *Involuntary Commitment as "Carceral-Health Service": From Healthcare-to-Prison Pipeline to a Public Health Abolition Praxis*, 50 J.L. Med. & Ethics 23 (2022).

267 John C. Messinger et al., *Outcomes for Patients Discharged to Involuntary Commitment for Substance Use Disorder Directly From the Hospital*, 59 Cmty. Mental Health J. 1300 (2023).

268 Abhishek Jain et al., *Civil Commitment for Opioid and Other Substance Use Disorders: Does It Work?*, 69 Psychiatric Serv. 374, 375 (2018).

269 The Action Lab, *Laws Authorizing Involuntary Commitment for Substance Use*, The Pol'y Surveillance Program, https://lawatlas.org/datasets/civil-commitment-for-substance-users (last updated Mar. 1, 2018).

270 Beletsky & Tomasini-Joshi, *supra* note 3.

271 *Principles of Harm Reduction*, Nati'l Harm Reduction Coal., https://harmreduction.org/about-us/principles-of-harm-reduction/ (last visited April 1, 2024).

involvement in the judicial system complicates care and worsens health outcomes for people with SUD.[272] Though packaged with different names, involuntary commitment is comparable to incarceration; indeed, in some states, civil commitment is operated through departments of correction.[273] There is limited evidence that involuntary commitment for SUD effectively prevents overdoses.[274] In fact, in Massachusetts's 2017 review of opioid-related deaths, persons who had been subjected to involuntary commitment for SUD had higher mortality rates than those receiving treatment and any incarceration made the risk for overdose following release 50 times higher.[275] These outcomes may be tied to limited treatment within involuntary commitment settings. No states require access to evidence-based treatment for SUD within involuntary commitment settings.[276] In a survey of people with SUD who were previously involuntarily committed, fewer than 20% received medication for their SUD during their involuntary commitment.[277]

In addition to the lack of public health evidence, significant legal and ethical considerations problematize the use of involuntary commitment for people with SUD. Glaringly, these compulsory treatments can be viewed as conflicting with the liberty and autonomy guarantees of the Fourteenth Amendment, which protects against deprivation of liberty without due process.[278] Moreover, involuntary commitment for SUD results in people being detained, frequently within penal facilities, for extended periods of time, absent any crime or victim. Beyond the black-letter law, involuntary commitment as a treatment

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272 Leo Beletsky et al., *Expanding Coercive Treatment Is the Wrong Solution for the Opioid Crisis (Updated)*, HealthAffairs (Feb. 11, 2016), https://www.healthaffairs.org/do/10.1377/forefront.20160211.053127.

273 Wahbi & Beletsky, *supra* note 268.

274 Paul P. Christopher et al., *Criminalization of Opioid Civil Commitment*, 77 Jama Psychiatry 111 (2020); Paul P. Christopher et al., *Nature and Utilization of Civil Commitment for Substance Abuse in the United States*, 43 J. Am. Acad. Psychiatry & L. 313, 318 (2015).

275 Mass. Dep't of Pub. Health, An Assessment of Fatal and Nonfatal Opioid Overdoses in Massachusetts 29, 49–50 (2011-2015) (2017) (report based on data from 2012-2016).

276 The Action Lab, *supra* note 54.

277 Paul P. Christopher et al., *Civil Commitment Experiences Among Opioid Users*, Drug & Alcohol Dependence 137 (2018).

278 Cong. Rsch. Serv., Involuntary Civil Commitment: Fourteenth Amendment Due Process Protections, 7 (May 24, 2023); U.S. Const. amends. V, XIV ("[n]o state shall make or enforce any law which shall abridge the privileges or immunities of citizens of the United States; nor shall any state deprive any person of life, liberty, or property, without due process of law; nor deny to any person within its jurisdiction the equal protection of the laws.").

is ethically questionable because it deprives individuals of medical decision-making authority and amalgamates substance use with the stigmatizing carceral system.[279] Given inadequate treatment, there is an additional ethical question of whether it is appropriate to involuntarily subject people to a system that not only consistently fails at providing adequate treatment but may worsen that person's medical condition. These legal, ethical, and philosophical concerns further elevate doubts about involuntary commitment as an appropriate strategy for dealing with SUD.

With an SUD treatment system that underperforms in measures of accessibility and sustainability, other systems (which tend to be authoritarian in nature) have filled the gaps in response despite concerns about their effectiveness, suitability, or preparedness to do so.[280] For example, law enforcement has few non-carceral options when responding to mental health crises.[281] Of those few options, involuntary commitment has garnered support in the absence of widely accessible evidence-based care.[282] In consideration of the concerns that surround the safety of involuntary commitment (and carceral approaches to SUD or other mental health crises), growing the capacity of recovery support systems to take the place of current responders to the overdose crisis is imperative.

A. *Changing the Media Narrative*

As discussed, misinformed narratives frequently promulgated and replicated within our political and social zeitgeist often result in similarly misinformed policies. Misinformation regarding the effectiveness of involuntary commitment as a strategy to address SUD follows a similar pattern. Media misinformation distorts the legal debate

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279 Rustad et al., *supra* note 139, at 137, 140–43 (concerns around involuntary commitment may include the absence of informed consent to treatment, resentment towards the petitioner for involuntary commitment (potentially family, loved ones), and the power dynamic between the provider and the committed patient potentially further limiting the patient's ability to communicate their preferences for (or against) and consent to treatment options).

280 Beletsky et al., *supra* note 274; Christopher, et al., *Criminalization of Opioid Civil Commitment*, *supra* note 276; Christopher et al., *Nature and Utilization of Civil Commitment for Substance Abuse in the United States*, *supra* note 276.

281 Linda A. Teplin, *Keeping the Peace: Police Discretion and Mentally Ill Persons*, Nat'l Inst. of Just. J., July 2000, at 8, 9–10.

282 Alexander R. Bazazi, *Commentary on Rafful et al. (2018): Unpacking Involuntary Interventions for People Who Use Drugs*, 113 Addiction 985 (2018).

around the use of involuntary commitment for SUD, setting the stage for the promulgation of laws that regard the intervention as an effective treatment despite widespread data and first-hand accounts providing that laws allowing involuntary commitment for SUD are misaligned with harm reduction and raise significant legal, ethical, and philosophical questions.

Changing the Narrative ("CTN") is a project supported by the Action Lab which creates and disseminates resources for journalists to encourage the use of science-based rhetoric in covering the overdose crisis.[283] CTN includes an expert directory with contact information for a network of harm reduction advocates, academic researchers, journalists, persons with lived experience, and other subject matter experts for journalists to contact. The utilization of CTN resources and strategies, notably foregrounding people who themselves have experienced involuntary commitment, will begin to outline the shapes of a more realistic and productive conversation about the merits and harms of involuntary commitment and ways to reorient the treatment landscape.

The use of data, such as that which has been analyzed and compiled by the Lab, will further clarify this picture. One such method may be through the dissemination of cost-savings data. Strategies include publicly funding psychiatric medication and bolstering mental health service systems, thereby potentially reducing arrest rates and the corresponding criminal justice and corrections costs.[284] Relatedly, knowing the utility and value of medications for opioid use disorder and other recovery supports, similar approaches to improve support systems prior to contact with the criminal justice system or involuntary treatment system are promising in cost-saving potential and provide evidence-based care.[285]

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283 *Changing the Narrative*, THE ACTION LAB, https://www.changingthenarrative.news/ (last visited April 1, 2024).

284 Jolynn Tumolo, *Mental Health Services Save Taxpayers Money*, PSYCH CONG. NETWORK (June 18, 2013), https://www.hmpgloballearningnetwork.com/site/pcn/article/mental-health-services-save-taxpayers-money; Nina Fainman-Adelman, *Involuntary Hospitalization or Incarceration: Why Our Choices Are So Limited*, WASH. COLL. L.: HEALTH L. & POL'Y BRIEF (Feb. 27, 2020) https://www.healthlawpolicy.org/2020/02/27/involuntary-hospitalization-or-incarceration-why-our-choices-are-so-limited/.

285 Tumolo, *supra* note 286; Fainman-Adelman, *supra* note 286; *Making the Investment Case for Harm Reduction*, HARM REDUCTION INT'L (Apr. 21, 2020), https://hri.global/publications/making-the-investment-case-cost-effectiveness-evidence-for-harm-reduction/.

A general lack of understanding of the interconnectedness of the social determinants of health and their effect on public health lends to a misplaced view that people are in control of and are responsible for their own health outcomes. As Gostin explains, social circumstances, such as the various social determinants of health, inevitably color personal decision-making and produce complex behaviors and outcomes.[286] Shifting to a more fact-based, jurisprudential lens of the role of government in preserving health requires a shift back to collective responsibility. Individualistic, behavior-based interventions are not effective.[287]

B. Proposed Policy Changes

Involuntary commitment should be used sparingly and as a last resort, if ever. Access to voluntary treatment must be expanded. Several alternative methods supporting recovery and overdose prevention exist and have proven more successful and cost-effective than involuntary commitment. [288] Harm reduction services are an obvious, more sustainable substitute. Syringe exchange programs, safe consumption facilities, MOUD prescriptions, and naloxone distribution save lives with few contraindications.[289] These services themselves can be gateways to voluntary treatment.[290] Improving access to safe crisis-response services as well as longer-term support such as MOUD is also critical to a stable and safe environment for recovery and safe substance use. Finally, improved guidance for support figures (loved ones, clinicians, or community, school, or workplace advocates) to establish and maintain healthy and respectful relationships is key to pursuing and maintaining recovery.

Harm reduction is a critical framework in responding to the

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286 Peter D. Jacobson & Wendy E. Parmet, *Defending Public Health Regulations: The Message Is the Medium*, 44 Hastings Ctr. Rep. 4, Jan.–Feb. 2014, at 4–6. ("[L]aws that are paternalistic are not inappropriate simply because they are paternalistic (consider the Food, Drug, and Cosmetic Act's requirement that drugs be proven safe and effective.").

287 Gostin & Wiley, *supra* note 146, at 547.

288 Fair & Just Prosecution, Harm Reduction Responses to Drug Use 9–11 (2019), https://www.fairandjustprosecution.org/staging/wp-content/uploads/2019/08/FJP_Brief_HarmReduction.pdf.

289 *Harm Reduction*, Ctrs. Disease Control & Prevention, https://www.cdc.gov/drugoverdose/od2a/case-studies/harm-reduction.html (last visited Apr. 1, 2024).

290 *Id.*; Ctrs. Disease Control & Prevention, Syringe Services Programs (SSPs) Fact Sheet (2019), https://www.cdc.gov/ssp/docs/SSP-FactSheet.pdf.

overdose crisis in the United States—indeed it is recognized as a pillar of the U.S. Department of Health and Human Services' approach to addressing the overdose crisis.[291] The approach recognizes the social determinants and frameworks that drive substance use behavior and advocates for meeting people where they are to reduce harm. This perspective contrasts with the traditional carceral and medical responses that do not prioritize addressing the social determinants at the root of the issue.[292] The social-epidemiological lens used in harm reduction theory highlights the importance of analyzing the social context of substance use and leveraging social networks as tools to prevent overdose.[293] Harm reduction strategies, such as supervised consumption sites and drug decriminalization, have been shown to be effective in reducing overdose deaths and improving the health outcomes of PWUD.[294] Thus, it is critical to prioritize harm reduction strategies in responding to the overdose crisis and to recognize the social context in which substance use occurs.

Conclusion

We recognize that advocating for and implementing harm reduction-centric policy, particularly in more politically and socially conservative landscapes, may be a long and uphill battle. As a first step, involuntary commitment as it currently exists must be changed. Following recommendations of scholars and medical societies, involuntary commitment programs should shift to a medical framework, employing licensed clinicians to support residents, using non-correctional facilities, and offering comprehensive treatment options (including and especially MOUD). Further, departments of correction should be disallowed from running involuntary commitment facilities. Offering longer-term support services, minimizing the length of commitment, and placing standardized and limited guidelines on who can petition to initiate

291 *Overdose Prevention Strategy*, U.S. Dep't of Health & Hum. Servs., https://www.hhs.gov/overdose-prevention/ (last visited Apr. 1, 2024).

292 Sandra Galea & David Vlahov, *Social Determinants and the Health of Drug Users: Socioeconomic Status, Homelessness, and Incarceration*, 117 Pub. Health Reps. S135, S135–36, S139 (2002).

293 Tim Rhodes, *The 'Risk Environment': A Framework for Understanding and Reducing Drug-Related Harm*, 13 Int'l J. Drug Pol'y, June 2002, at 85, 88–89.

294 Mary Clare Kennedy et al., *Public Health and Public Order Outcomes Associated with Supervised Drug Consumption Facilities: a Systematic Review*, 14 Current HIV/AIDS Reps., Sept. 2017, at 161.

involuntary commitment will place autonomy back into the hands of those impacted. We must ensure that entry and exit from involuntary commitment emphasizes the empowerment of individuals to return to their communities and lives as safely as possible.

Appendix A

[n. 62]:

In applying the Downs & Black scoring scale which has a scoring range of 0 to 18, with 18 signifying highest quality studies, we found the median score of our sample of 16 studies to be 14 (interquartile range: 13-15). Weaknesses in methodology and/or documentation included failures to report all relevant study characteristics (including objectives, participant characteristics, outcomes to be measured, and main findings) and failures to mitigate risk of bias and/or confounding.

[n. 63]:

The review of the extant peer-reviewed literature found that the majority (n=14, 87.5%) of studies analyzed did not find significant positive impacts of involuntary commitment on substance use-related outcomes.

Action Lab & Ctr. for Pub. Health L. Rsch., *Involuntary Commitment for Substance Use*, Prescription Drug Abuse Pol'y Sys. (May 1, 2021), https://pdaps.org/datasets/civil-commitment-for-substance-users-1562936854.

Adeeba Kamarulzaman & John L. McBrayer, *Compulsory Drug Detention Centers in East and Southeast Asia,* 26 Int'l J. Drug Pol'y, 26, Feb. 1, 2015, S33–S37.

Adrian R. Pasareanu, et al., *Improved Drug-Use Patterns at 6 Months Post-Discharge From Inpatient Substance Use Disorder Treatment: Results from Compulsorily and Voluntarily Admitted Patients*, 16 BMC health servs. rsch, 291 (2016).

Alex Stevens, *The Ethics and Effectiveness of Coerced Treatment of People*

Who Use Drugs, 2 HUM. RTS. & DRUGS, 2012.

AM. PUB. HEALTH ASS'N, *Defining and Implementing a Public Health Response to Drug Use and Misuse,* (Nov. 5, 2013), https://www.apha.org/policies-and-advocacy/public-health-policy-statements/policy-database/2014/07/08/08/04/defining-and-implementing-a-public-health-response-to-drug-use-and-misuse.

Andreas Pilarinos et al., *Coercion into Addiction Treatment and Subsequent Substance Use Patterns Among People who use Illicit Drugs in Vancouver, Canada*, 115(1) ADDICTION, Jan. 2020, 97–106.

Anh T. Vo et al. (2021*). Assessing HIV And Overdose Risks For People Who Use Drugs Exposed To Compulsory Drug Abstinence Programs (CDAP)*: *A Systematic Review and Meta-Analysis.* 96 INT'L J. DRUG POL'Y, 103401 (2021).

Claudia Raffulet al., *Increased Non-Fatal Overdose Risk Associated With Involuntary Drug Treatment in a Longitudinal Study with People who Inject Drugs* 113(6) ADDICTION, 1056–1063 (2018).

Dan Werb et al., *The Effectiveness of Compulsory Drug Treatment: A Systematic Review,* 28 INT'L J. DRUG POL'Y, 28, 1– (2016).

David Moher, et al., *Preferred Reporting Items for Systematic Reviews and Meta-Analyses: The PRISMA Statement*, 339 PLOS MED., July 21, 2009, b2535.

Downs & Black, *The Feasibility of Creating a Checklist for the Assessment of the Methodological Quality Both ff Randomised and Non-Randomised Studies of Health Care Interventions*, 52(6), J. EPIDEMIOLOGY & CMTY. HEALTH, 1998, 377–384.

Felice J. Freyer, *State Crime Bills Would Expand Inmates' Access to Addiction Treatment*, THE BOSTON GLOBE (Nov. 20, 2017). https://www.bostonglobe.com/metro/2017/11/20/state-crime-bills-would-expand-inmates-access-addiction-treatment/7TI2SCOz5FNEZgmrEnIl2O/story.html.

G.A. Res 2200A (XXI) International Covenant on Civil and Political Rights, at 171 (Dec. 16, 1966).

Global Burden of Disease Collaborative Network, *Global Burden of Disease Study 2017 (GBD 2017) Results*, https://www.healthdata.org/sites/default/files/files/policy_report/2019/GBD_2017_Booklet.pdf (last accessed Apr. 3, 2024).

Haiyan Xiong & Jidong Jia, (2019) *Situational Social Support and Relapse: An Exploration of Compulsory Drug Abuse Treatment Effect in China*, 63(8) Int'l J. Offender Therapy & Comparative Criminology, 1202–1219 (2019).

Hellen Boit, et al. *A Comparison Between the Involuntary and Voluntary Treatment of Patients With Alcohol Use Disorder in a Residential Rehabilitation Treatment Program,* Journal of Addictions Nursing 30(1) 57-60 (2019).

Ian C. Lamoureux et al., *Petitioning for Involuntary Commitment for Chemical Dependency by Medical Services, 45*(3), J. Am. Acad. Psychiatry & L., 2017, 332–338.

Jiang Haifeng et al., *Gender Differences in Recovery Consequences Among Heroin Dependent Patients After Compulsory Treatment Programs*, 5 Scientific Reports, Dec. 8, 2015, 17974.

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Leo Beletsky et al., *Involuntary Treatment for Substance Use Disorder: A Misguided Response to the Opioid Crisis*, Harv. Health Blog (Jan. 28, 2018), https://www.health.harvard.edu/blog/involuntary-treatment-sud-misguided-response-2018012413180.

Magnus Israelsson et al., *European Laws on Compulsory Commitment to Care of Persons Suffering From Substance Use Disorders or Misuse Problems- A Comparative Review From a Human and Civil Rights Perspective*,10 Substance Abuse Treatment Prevention & Pol'y Aug. 28, 2015.

Martin P. Wegman, et al., (2017). *Relapse to Opioid Use in Opioid-Dependent Individuals Released from Compulsory Drug Detention Centres Compared with Those from Voluntary Methadone Treatment Centres in Malaysia: A Two-Arm, Prospective Observational Study*, 5(2) The Lancet. Global Health, DEC. 7, 2016, e198–e207.

Mourad Ouzzani, et al., *Rayyan – A Web and Mobile App for Systematic Reviews*, 5 Systematic Revs. 210 (2016).

Parhar, K., Wormith, J., Derkzen, D., & Beauregard, A. (2008), *Offender Coercion in Treatment: A Meta-Analysis of Effectiveness*. 35 Crim Just. & Behavior, Sept. 1, 2008, 1109–1135.

Paul P. Christopher et al., *Civil Commitment Experiences Among Opioid Users*, Drug & Alcohol Dependence, 2018, at 137–141.

Paul P. Christopher et al., *Nature and Utilization of Civil Commitment for Substance Abuse in the United States*, 43(3), J. Am. Acad. Psychiatry & L. Online, 2015, at 313.

Stefanie Klag et al., *The Use of Legal Coercion in the Treatment of Substance Abusers: An Overview and Critical Analysis of Thirty Years of Research*, 40(12), 2005, 1777–1795.

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org/documents/drug-prevention-and-treatment/UNODC-WHO_International_Standards_Treatment_Drug_Use_Disorders_April_2020.pdf.

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Y. Zhou et al., *Overdose of Heroin and Influencing Factors in Intravenous Drug Users in Parts of Yunnan*, 37 5 Zhonghua liu xing bing xue za zhi = Zhonghua liuxingbingxue zazhi, , 648-52 (2016).

Zunyou Wu, *Arguments in Favour of Compulsory Treatment of Opioid Dependence*, 91 (2) Bulletin of the WHO, 142-145 (2013).

[n. 83]:

n = 242 articles supportive of involuntary commitment.

n = 152 articles with mixed narratives on involuntary commitment.

n = 111 articles critical of involuntary commitment.

n = 96 total articles that compared involuntary commitment for SUD to incarceration.

n = 7 articles critical of involuntary commitment as an alternative to incarceration.

n = 68 articles that featured perspectives of those with lived experience with involuntary commitment.

n = 395 stories that featured the perspectives of law enforcement.

n = 118 stories that featured the perspectives of family, friends, and/or community members.

n = 184 stories that featured the perspectives of healthcare professionals.

Of n = 395 articles that featured the perspectives of law enforcement.

n = 24 articles with favorable views of involuntary commitment from healthcare professionals.

n = 26 articles with favorable views of involuntary commitment from family, friends, and/or community members.