

HaRRT Center Narrative Review of the Literature on Involuntary Treatment for Substance Use Disorder

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For years, we have been asked by colleagues, community members and journalists about our Center’s stance on “coerced,” “mandated,” and/or “involuntary” treatment and the evidence base for these approaches. These requests have become more frequent as mainstream and social media have picked up [lay assertions](#) (and sometimes [professionals’ claims](#)) that involuntary treatment is a novel and/or effective strategy that should be widely implemented to “[force addicted](#)” people to stop using substances.

None of this is new to the field. The topic of coerced treatment, including involuntary treatment, and its efficacy have been studied and hotly debated for decades ([Klag et al 2005](#)). Various types of coerced treatment already exist in all 50 US states, with 34 states offering “involuntary treatment” (i.e., involuntary civil commitment) for substance use disorder (SUD), specifically. Although it is not at all a novel approach, the topic of involuntary treatment does entail new twists and consequences following the rise of synthetic, more potent drugs and the resulting heightened risks of overdose.

About three years ago, I put together a brief position paper to synthesize the scientific literature on involuntary treatment and touch briefly on other, more researched forms of formal coercion in treatment for SUD. In light of the rekindling of this perennial debate and a new systematic review, I have refreshed and built out our Center’s synthesis of the existing research.

I will note that this paper is intended for lay audiences and is not intended to provide a *systematic review* or *meta-analysis* of the literature. Instead, it is an overview of key findings, ethical considerations, and our Center’s conclusions, given the current state-of-the-science and clinical best practices.

TL;DR. Involuntary treatment for SUD entails civil (in the US specifically), military, or police commitment. It is “forced treatment,” which is different from court-mandated treatment. The literature spanning the past four decades shows that involuntary treatment is ethically fraught and should remain an intervention of last resort. Systematic reviews report no sustained positive outcomes and instead point to null and negative results, including elevated risk of overdose and death. As it stands, more US-based evaluation and research are needed because the mostly worldwide findings to date indicate that involuntary treatment is not an effective solution for broad implementation.

Secondarily, systematic reviews of court-mandated treatments show mixed evidence, with positive findings mostly reflecting increased compliance with treatment and not improved substance use outcomes. Some studies of court-mandated treatment show iatrogenic (that is negative) effects on patients.

Definitions

When it comes to understanding research on involuntary treatment, we first have to address the definitions involved: What does “coerced,” “mandated,” or “involuntary” treatment even mean? Studies show even physicians are often confused about these definitions ([Jain et al, 2021](#)). In the US, there are different ways coercion is involved in treatment, and we review them here.

- Informal forms of coercion, like family or employment pressure, are very common in substance use treatment referrals and self-referrals. This kind of informal coercion even forms the basis of some substance use interventions, such as the Johnson model.
- There are more formal means of coercion:
 - **“Mandated treatment”** is ordered by criminal courts, drug courts, or family courts. In mandated treatment, a person is legally or institutionally required to enter treatment if they want to avoid a penalty (e.g., losing child custody, probation revocation, jail time). Unlike involuntary treatment, which is described below, mandated treatment generally involves a person’s consent and occurs in community-based or residential programs. This category has historically also included employer mandates, although these are less common in the present day in the US outside of specific, high-risk professions (e.g., physicians, pilots).
 - **“Involuntary treatment”** is known as “involuntary civil commitment” in the US; in other countries it may entail civil, military or police commitment. It is the most coercive form of SUD treatment. Involuntary treatment in the US occurs when a person is hospitalized for SUD after a (typically) 72-hour hold for evaluation and then treated in a locked facility for a physician- or court-determined amount of time. As of late 2024, [34 states](#) (plus Washington DC, Puerto Rico, and the US Virgin Islands) allow civil commitment when SUD is the primary diagnosis; other jurisdictions require co-occurring psychiatric diagnoses. However, many of these statutes are not active for various reasons, including not having facilities that are adequate to support civil commitment and its extraordinary costs.

Challenges in parsing out how coercion works (or doesn’t) in substance use treatment

In the broader substance-use treatment literature, the body of research on coercion and coercive treatments is relatively small. Coercion is also difficult to study because there are often multiple, overlapping layers of coercion, which makes it challenging to know what exactly contributes to outcomes ([Klag et al 2005](#)). In studying coercive treatments, there are a host of methodological challenges that are reflected in the research literature. For example, in some evaluations, there's no control group because the study is following a real-world rollout of involuntary treatment and not a research trial. For other studies, they are only able to measure certain outcomes (e.g., retention in a specific program) or can only measure outcomes over a limited amount of time, often due to funding limitations.

Another layer of complexity lies in the terminology. Research has shown that many physicians and counselors are unfamiliar with the precise terminology and legal details around these types of interventions ([Jain et al, 2021](#)). Similarly, scientists reviewing the literature sometimes use imprecise language in describing an intervention or face complications synthesizing findings across jurisdictions with very different laws and approaches. As a result, some reviews (e.g., Bahji et al., 2023) misclassify studies of, say, “mandated” treatment as “involuntary” treatment. These kinds of operationalization errors blur important distinctions. In doing so, they can fuel misunderstanding among professionals and create confusion in communication to the public (e.g., high-exposure [op eds](#)).

What is the reasoning for and hypothesized benefit of involuntary treatment for people who use drugs and alcohol?

The reasoning behind involuntary treatment stems from a) the state's *parens patriae* authority, which refers to its power to intervene on behalf of individuals who cannot care for or protect themselves, and b) its police powers to protect public safety. The argument is that the state is called to avoid the risk of extreme harm to its citizens due to its own inaction and that short-term involuntary treatment can save lives when individuals with severe SUD are at acute and high risk of harming themselves or others.

Involuntary treatment is meant to be a means of avoiding serious harm in the short term as well as an entry point for longer-term recovery ([Carter & Hall, 2013](#)). Professional organizations such as the [American Psychiatric Association](#) and the [Substance Abuse and Mental Health Services Administration](#) emphasize that involuntary treatment should be used as a last resort, delivered in the least restrictive setting and with a focus on recovery. In their [statutes](#), however, only a handful of states explicitly include this standard, and its application varies widely.

Even as it is well-intentioned, involuntary treatment carries extreme risk and thus requires strong evidence to tip the risk-to-benefit ratio

Involuntary treatment involves stripping an individual of their civil liberties, which can only be justified if the potential benefits clearly outweigh the known harms. Among serious proponents and critics, there is broad agreement that involuntary treatment should be grounded in evidence that it delivers effective, lifesaving care. Let's review that evidence.

Systematic reviews of research show involuntary treatment does not impact substance use outcomes in a positive and sustained way. A systematic review is an evaluation of the existing research that uses structured, transparent methods to identify, screen, and evaluate all relevant studies on a topic, thereby reducing bias and providing the clearest possible picture of the evidence. There are 2 recent systematic reviews conducted in the past decade that summarize the worldwide evidence on involuntary treatment, with some overlap between the reviewed studies.

Werb et al. (2016) screened 430 articles and identified 9 eligible studies conducted worldwide, 5 of which examined true involuntary treatment (i.e., civil, military or police commitment). Of these 5 studies, none showed sustained positive outcomes on substance use. Two studies in China found no long-term benefit, with relapse rates exceeding 90% in some cohorts. Three studies (Thailand, Taiwan, Sweden) found negative or equivocal results, with involuntary treatment linked to relapse, continued recidivism, or worse outcomes compared to voluntary treatment. In short, involuntary treatment was ineffective at best and harmful at worst.

Bahji et al., 2023 screened over 3,500 articles and included 42 studies of coerced treatment, 8 of which involved involuntary treatment. This systematic review, which was published after our initial 2022 position paper, reinforces our prior position that involuntary treatment lacks adequate positive evidence to date. Across 8 studies of involuntary treatment for SUD, the authors found no models that produced clearly positive effects on substance use outcomes.

Aligned with earlier narrative reviews and ethical analyses (e.g., Wild et al., 2002; Klag et al., 2005), the more recent Werb et al (2016) and Bahji et al (2023) findings continue underscore that involuntary treatments into the present day do not improve substance use outcomes.

Of note, none of the above studies were conducted in the US, and the featured programs reviewed operate under different health and justice systems. This underscores the need for rigorous, US-based research on involuntary treatment, which in the US, currently entails involuntary civil commitment. At the same time, institutions providing civil

commitment in the US rarely deliver gold-standard SUD treatment (e.g., opioid agonist therapy, cognitive behavioral therapy; [Evans et al., 2021](#)); thus, there is little reason to assume better outcomes here in the US without positive evidence to indicate it.

Involuntary treatment is associated with increased probability of overdose and death. Large registry and administrative studies now confirm elevated post-discharge risk for overdose and death. In Sweden, a national registry study found the risk of death is 2.6–3.7 times higher in the first two weeks after release from involuntary treatment than in later periods, with excess deaths driven by external causes such as overdose ([Ledberg & Reitan, 2022](#)). A separate Swedish registry analysis likewise found involuntary treatment was associated with higher substance-related mortality overall compared with matched controls not entered into involuntary treatment ([Scarpa et al., 2023](#)).

In the US, Massachusetts conducted a statewide analysis using its Chapter 55 linked data system to evaluate outcomes for people civilly committed under Section 35, the state’s involuntary treatment law. Findings showed that people with an involuntary-treatment history had a higher risk of fatal overdose compared to those without ([Massachusetts DPH, 2019](#)). They also reported significantly greater odds of non-fatal overdose in the 30 to 90 days after release compared with equivalent voluntary treatment periods ([DPH Section 35 Commission presentation, 2019](#)).

Smaller US cohorts converge on this pattern. One such study showed that, among individuals in involuntary treatment, one-third relapsed on the day of release (average time to relapse \approx 72 days). These findings underscore the impact of reduced opioid tolerance and lack of consistent medication provision during and after commitment ([Christopher et al., 2018](#)).

These early documented trends in the US have carried into the fentanyl era: A 50-state ecological study found that, while overdose death rates did not differ before 2020, in 2020–2021, states with involuntary treatment laws saw significantly greater increases in opioid overdose deaths than those without ([Cochran et al., 2024](#)).

Closer to home in Washington State, the state’s involuntary treatment program for SUD (Ricky’s Law), has shown mixed 6-month impacts (i.e., less ER use and homelessness balanced with high cost, no change in arrests, less likelihood of attending follow-up treatment). Crucially, analyses are not published documenting overdose or mortality outcomes, leaving the biggest safety question unanswered ([WSIPP, 2023](#)), especially as both the medically supervised withdrawal control group and the involuntary treatment at the time did not require MOUD delivery, the accepted gold standard of care.

What is the cost of involuntary treatment? Systematic reviews of involuntary treatment (Werb et al., 2016; Bahji et al., 2023) report on effectiveness but contain no economic evaluations. Given the formal research trials of involuntary treatment have been primarily conducted abroad in the context of very different economic systems, it is also unclear how such findings might translate if they existed. However, common sense about the relative costs of more intensive versus less intensive treatment paired with the available cost studies (e.g., Washington’s WSIPP report, Sweden’s registry analyses) indicate that involuntary treatment is substantially more expensive than voluntary care, with poor or uncertain returns on investment.

Involuntary treatment opens the door to significant trauma and abuses in an already vulnerable population. Involuntary treatment comes with good intentions and can feel emotionally pressing from the perspective of impacted families, communities and the law makers that represent them. However, the stripping of civil liberties that involuntary treatment involves leaves people vulnerable to intentional and unintentional harm. The potential for abuses to contribute to negative sequelae is compounded in a population already known to be severely impacted by childhood trauma (approx. one-third; [Reddy et al., 2020](#)), and a posttraumatic stress disorder prevalence estimated at 51% ([Gusy et al., 2022](#)). In fact, reviews have shown traumatic themes reported by other mental health populations following inpatient hospitalization, including overuse of restraints and abuse committed by staff and other patients ([Paksarian et al., 2014](#)). Reviews of involuntary treatment indicate lower patient satisfaction, decreased compliance with treatment and increased suicidality following involuntary mental health treatment ([Corderoy et al., 2024](#); [Cossu et al., 2022](#)). Internationally, the [WHO](#) has called for involuntary treatment facilities to be closed due to their lack of effectiveness, their human rights abuses, lack of evidence-based practices (medications) in the facilities, and their ability to spread illness among detainees ([Lunze et al., 2016](#)). Bottom line is that when you strip a person of their civil liberties, abuses and traumatic sequelae can easily follow.

In the absence of adequate data on involuntary treatment, let’s briefly consider findings for coercive treatment for SUD more generally. Because there are not yet adequate data for involuntary treatment in the US specifically, let’s take a step down and look at treatment that is coerced with varying levels of intensity through the justice system (not civil commitment). There is some evidence that abstinence-based interventions ensconced in the legal system, like drug court, have modest effects on recidivism (e.g., rearrest; [Trood et al., 2021](#)). But one review of the literature that actually took into account other important outcomes as well –namely actual drug use — indicated either poor or no changes outcomes in response to compulsory treatment in 7 of 9 studies, with clear

iatrogenic effects in 2 of them ([Werb et al 2016](#)). Bahji et al (2023) noted that 6 studies yielded positive findings, but likewise primarily for retention in programming.

This is a low bar considering that substance use treatment researchers typically consider interventions acceptable for broad use if they show consistent *positive* findings, not mixed and even iatrogenic findings. This means even with coerced treatment more generally, which is a step down or two from the intensity of involuntary treatment, we are regularly submitting the most vulnerable and severely impacted people to treatment in such a way that is often ineffective and even harmful.

Conclusions

In the US, involuntary treatment for SUD entails civil commitment deemed necessary by the state to manage the risk for acute substance-related harm. Although it is meant to be restorative, it is widely acknowledged to be the most restrictive, last-resort intervention in our system because it requires stripping individuals of their civil liberties. Such facilities in the US often lack evidence-based treatments (e.g., opioid agonist treatments), further heightening the risk for post-release overdose.

Because involuntary treatment is an extreme measure that carries high risk for harm, it requires rigorous evaluation and compelling evidence to support a strong benefit-to-risk ratio. **Systematic reviews to date show no sustained positive outcomes for involuntary treatment and instead point to iatrogenic effects and heightened risks for abuse. Involuntary treatment therefore does not meet the most basic evidence-based standards of care in the US.**

Normally, even minimal-risk treatments require rigorous trials before recommendation for broader use; the need for evidence is far greater for such a high-risk, limited benefit intervention. US states and researcher should work together to systematically collect, analyze and publish data –including severe harms such as overdose – on existing involuntary treatment programs. Until rigorous US-based research demonstrates benefits that clearly outweigh harms, it is our Center’s position that involuntary treatment cannot be recommended for broad or routine use. It should remain a measure of last resort, used only in rare and exceptional circumstances, and only with strong safeguards and utmost data transparency.