EDUCATIONAL BRIEF
JULY 2025

Policy Rounds

Exploring Policies Shaping Addiction Medicine

ASAM American Society of Addiction Medicine

Involuntary Civil Commitment of People with Substance Use Disorders

Jurisdictions are increasingly legalizing involuntary civil commitment (ICC) for substance use disorders (SUD), allowing courts to order people with SUD to medically supervised treatment when certain criteria are met, such as being "gravely disabled" or at risk of harming themselves or others.[1,2] As of 2024, 34 US states and the District of Columbia allow ICC for a primary diagnosis of SUD.[1] Rates of utilization of ICC for SUD are particularly high in Florida and Massachusetts.[2]

In states that have legalized ICC for SUD, family members, healthcare professionals, or justice professionals can file a petition with a court to initiate the ICC process. A judge then assesses whether the legal requirements of the state for ICC are met and whether the evidence substantiates the request. Details of this ICC process, including how quickly the judge must make a decision about a petition, vary by state.[1] States also vary with respect to treatment requirements for people with SUD ordered to ICC, including whether such treatment can be outpatient or must be inpatient/residential and the maximum duration of ICC (i.e., 15 days to one year).[1,2] ICC for SUD is controversial,[3] with a recent survey showing wide variation in attitudes toward ICC among addiction medicine physicians.[4]

Arguments Against ICC

Arguments against ICC include that it violates autonomy and civil liberties.[3,5] ICC is often implemented in a dehumanizing manner – more akin to a criminal process than a civil process for a healthcare condition.[6] For example, in Massachusetts, people subjected to an ICC petition are arrested and held in custody with people arrested for crimes; and many ICC facilities are located in jails.[6] Some scholars argue that ICC's coercive nature makes it unlikely to facilitate long-term recovery, because motivation for treatment is a key determinant of recovery.[2,7] At worst, ICC could increase harm by decreasing willingness to participate in treatment[5] or by heightening overdose risk after loss of tolerance for opioids.[8,9] ICC is sometimes used in an abusive manner by family members to "punish" loved ones.[5] It has also been argued that the "gravely disabled" legal criteria for ICC are no longer met once intoxication is treated or stabilized.[10] Finally, without widespread access to voluntary, evidence-based SUD treatment, it is unclear whether ICC for SUD is really being used as a "last resort" or "least restrictive" alternative, as ethics and legal principles require when autonomy is severely restricted.[8]

SOME SCHOLARS ARGUE THAT ICC'S COERCIVE NATURE MAKES IT UNLIKELY TO FACILITATE LONG-TERM RECOVERY, BECAUSE MOTIVATION FOR TREATMENT IS A KEY DETERMINANT OF RECOVERY.

Arguments for ICC

Arguments for ICC include that it could save lives by preventing overdose or other severe harm, especially in the immediate short term.[5] ICC could also serve as a "turning point" where patients realize they would benefit from treatment

or abstinence after experiencing stability in the ICC facility, potentially resulting in motivation for treatment.[5] ICC could have a positive effect on the family or community of the person with SUD, if the treatment is successful.[5] Finally, the government has a legal and ethical duty to care for individuals who cannot care for themselves and to protect the public from harm.[11]

ICC Outcomes

Much of the controversy around ICC for SUD hinges on its outcomes. For example, if the health outcomes of ICC for SUD are overwhelmingly negative, then from an ethical and legal perspective the removal of autonomy is no longer justifiable. Unfortunately, very few studies have rigorously examined outcomes of ICC for SUD in the US,[2,5] with some researchers noting that "documentation of post-commitment outcomes in particular is nearly nonexistent."[12]

One systematic review from 2021 specifically examined the risk of overdose after ICC for SUD, finding a generally heightened risk, but the review only included one US study.[13] Since 2021, only a handful of additional studies have examined outcomes of ICC for SUD in the US – mostly in Massachusetts. One of these studies found overdose death rates were twice as high among people with SUD who had an ICC history as compared to people with SUD without an ICC history; but no randomization occurred, and social vulnerabilities and comorbidities between the two groups differed, limiting conclusions.[9] Two other studies found high rates of return to drug use following ICC, including immediately upon release.[14,15] In contrast, one study found fewer than 50% of patients with opioid use disorder returned to opioid use twelve weeks after ICC, with lower rates predicted by use of medications for opioid use disorder (MOUD).[12] While that study found more than half of patients had at least some MOUD treatment after ICC,[12] another study in the same state found low MOUD treatment rates after ICC.[15] Finally, a qualitative study in Massachusetts found both perceived benefits and harms related to ICC for SUD among patients, family members, and clinicians.[5] All these studies have significant methodological limitations, including small sample sizes, lack of control groups, and heterogeneity in populations, environments, and treatments provided.[5,9,12,14-16] Some patients repeatedly experience ICC for SUD, suggesting it may become a revolving door.[15,17] In summary, it is not clear from existing research whether the potential benefits of ICC for SUD outweigh the risks.[2,5,15] If ICC is beneficial, it is unknown at what duration.[15] Therefore, scholars note that caution should prevail in expanding ICC for SUD.[3] More data collection and reporting from states related to ICC for SUD could facilitate rigorous research on this topic.[18]

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Looking Ahead

While much more work is needed, existing research does point to factors that could improve the ICC process and its outcomes for SUD. First, when patients are offered MOUD during ICC and continue it upon release, they are less likely to be recommitted or return to drug use.[12,19] Unfortunately, in some studies of ICC for SUD, MOUD provision was rare.[5,15] Second, patients, clinicians, and family members feel jail is a harmful and stigmatizing setting for ICC.[5] Third, SUD is a chronic health condition, so ICC is unlikely to be successful long-term without follow-up care and wrap-around services.[20] Fourth, even patients deemed gravely disabled by their SUD have some decisional capacity, and clinicians can promote dignity and autonomy of patients by assessing and seeking to implement patient preferences during the ICC process.[3] An ICC implementation plan in which patient choices are ignored may be unethical. Additionally, a fair and respectful ICC process may predict more positive SUD outcomes.[15] Section 1.3 of ASAM's Public Policy Statement on Medical Ethics in Addiction Medicine provides guidance to healthcare professionals on ICC for SUD.

SUD IS A CHRONIC HEALTH CONDITION, SO ICC IS UNLIKELY TO BE SUCCESSFUL LONG-TERM WITHOUT FOLLOW-UP CARE AND WRAP-AROUND SERVICES.

Acknowledgements and Disclaimer

As part of the American Society of Addiction Medicine (ASAM) Advocacy Department's "Policy Rounds" series, this educational brief was prepared in coordination with ASAM's Legislative and Public Policy Committee. ASAM appreciates the review and contributions of those members in preparation of this educational brief.

This educational brief does not reflect the official public policy of ASAM. The information herein is provided for educational purposes only.

"Policy Rounds" Educational Brief #3, dated July 10, 2025.

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