Bridging Crisis and Care: Reforming Involuntary Civil Commitment Laws to Address Substance Use Disorder

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Executive Summary

Substance use disorder (SUD) remains a national health crisis, afflicting 48.5 million Americans in 2023 alone, with nearly half also experiencing a co-occurring serious mental illness (SMI). These dual challenges strain healthcare systems, overwhelm criminal justice resources, and impose an estimated societal cost exceeding $500 billion annually. Many states have either adopted or considered involuntary civil commitment (ICC) laws, which compel vulnerable individuals within the crisis into inpatient SUD treatment to reduce the loss of human life. ICC laws vary widely in their scope, legal thresholds, and effectiveness. States that have both reformed their ICC laws and invested in additional downstream resources should expect to see improvements among the most vulnerable individuals within the SUD crisis, although these measures alone are only the beginning in addressing the wider SUD crisis.

This Master's Project (MP) addresses the policy question: Which state-level reforms to involuntary civil commitment laws compelling individuals with substance use disorders into inpatient treatment are most effective in reducing substance use disorder, and what are the associated financial and cultural implications of implementing these state-level reforms?

Policy Recommendations

Insights from literature review, case studies supported by data analysis, and stakeholder interviews conducted for this MP indicate a clear framework for recommendations: addressing both "front-end" and "back-end" needs simultaneously. States must reform their ICC laws while in parallel investing in downstream resources, such as additional hospital beds, to enhance the effectiveness of these reforms. Implementing ICC law reforms without the accompanying investment in downstream resources, or vice versa, diminishes the effectiveness of these efforts. These recommendations underscore the importance of concurrently strengthening the "front-end" (i.e., legal and procedural mechanisms) and the "back-end" (i.e., clinical and community-based infrastructure) to ensure sustainable recovery outcomes and reduced societal costs.

Front-end: Enhance and Standardize the Legal Framework

1. <u>Redefine Eligibility & Commitment Thresholds:</u> Expand statutory language to explicitly include SUD as qualifying grounds for ICC and broaden criteria beyond the standard of "imminent danger" to permit ICC for individuals demonstrating clear patterns of SUD-related harm—such as repeated overdoses—even if they have not yet reached an immediately life-threatening crisis. The most vulnerable individuals affected by the SUD crisis often fall through the cracks due to high legal thresholds and bureaucratic barriers, leading to tragic outcomes.

2. <u>Broaden Petition Authority & Simplify Processes:</u> Permit family members, healthcare professionals, and law enforcement to initiate ICC petitions. Streamline court procedures and reduce filing costs, mirroring successes in Kentucky's "*Casey's Law*." Expanding who can petition and simplifying processes helps ensure timely intervention, preventing delays that could otherwise cost lives.

3. Protect Civil Liberties with Guardrails: States vary widely in their existing legal protections—ranging from minimal to extensive—making it essential that ICC reforms explicitly guarantee rights to legal counsel, due process, and transparent judicial review. Ensuring these safeguards promotes public trust and protects vulnerable populations from potential misuse or abuse of ICC statutes.

Back-end: Bolster the Healthcare Continuum

1. Bolster Treatment Capacity & Infrastructure: Increase funding for inpatient and outpatient services, psychiatric beds, and Certified Community Behavioral Health Clinics. Without sufficient treatment beds or mental health professionals, ICC orders displace other patients or leave individuals waiting for care.

2. Mandate a Continuum of Care: Require ICC interventions to include structured aftercare: step-down programs, outpatient counseling, Medication-assisted Treatment (MAT), and peer support. Involuntary stabilization alone often fails without sustained follow-up.

3. Advance Sustainable Financing & Workforce Development: Integrate ICC-related expenses into state budgets, expand Medicaid coverage for mandated treatment stays, and incentivize workforce growth through scholarships and loan forgiveness. States lacking a robust pipeline of psychiatrists, counselors, and social workers cannot fulfill expanded ICC mandates.

Methodology & Criteria

This analysis employed a mixed-methods approach spanning:

- **Literature Review:** An evaluation and synthesis of existing research on ICC laws, SUD treatment efficacy, legal history and implementation challenges, ethical considerations, and best practices to inform policy recommendations.

- **Case Studies Supported by Data Analysis:** A comparative analysis of seven states (Oregon, Alabama, Wisconsin, California, Kentucky, Massachusetts, and Ohio) reflecting diverse regional, political, and ICC law differences with an examination of state-level SUD statistics, recidivism, and SUD treatment outcomes.

- **Stakeholder Interviews:** Insights from judges, families of individuals with SUD, former patients, and mental health professionals. These interviews highlighted gaps between existing legal frameworks and practical realities on the ground.

The criteria guiding policy recommendations included effectiveness in reducing SUD rates, feasibility of legal implementation, resource availability, financial cost, and ethical considerations related to patient autonomy and civil rights.

Key Findings & Analysis

- Legal Barriers & Underuse: States with narrowly defined or outdated legal thresholds (e.g., those excluding SUD from ICC) often leave families and medical professionals powerless to intervene. Even when SUD qualifies, high burdens of proof or administrative hurdles frequently deter petitions.

- Combined Care & Co-occurring Conditions: SUD commonly coexists with SMI, yet ICC statutes and healthcare facilities typically address only one or the other. Integrated clinics offering mental health and SUD treatment under one roof improve patient outcomes.

- Insufficient Treatment Resources: A shortage of psychiatric beds, limited insurance coverage, and workforce deficits undermine the effectiveness of ICC across states. Where ICC expanded without parallel investments in inpatient capacity and outpatient services, real-world benefits were minimal.

- Costs & Return on Investment: Although court-mandated care can be expensive (an average of $12,500 for a 30-day inpatient program), investing in treatment yields a high return by preventing overdoses, curbing hospital readmissions, and reducing crime. Without further financing—especially as federal spending remains uncertain—states bear the primary responsibility to fund these programs.

- Unexpected Outcomes: Despite concerns that mandatory treatment might erode patient autonomy or prove ineffective, early reforms in Kentucky and Massachusetts suggest ICC can stabilize individuals with severe SUD long enough to connect them to extended care. However, reforms lacking robust aftercare or consistent oversight often return patients to high-risk environments.

Implications and Pathway Forward

States poised to reform their ICC laws must adopt a twofold strategy: modernize legal avenues for civil commitment and simultaneously strengthen healthcare infrastructure. Where these dual reforms have taken hold, early indicators—such as decreased overdose deaths and reduced homelessness—offer cautious optimism. Yet ICC alone is not a long-term cure; it is a strategic intervention that must be paired with voluntary treatment pathways, harm-reduction strategies, community-based support systems, and expanded funding streams.

By recalibrating ICC thresholds, augmenting treatment capacity, and safeguarding patient rights, state policymakers can more effectively mitigate SUD's profound social, economic, and human costs. This in tandem approach ensures that involuntary intervention serves as a bridge from crisis to sustained recovery, rather than a stopgap measure ultimately undermined by resource shortfalls.

Policy Background

Scope of the Issue and Origins

In 2023, 48.5 million Americans suffered from a SUD, of which 20.4 million Americans with SUD had a co-occurring SMI, contributing to a health epidemic severely straining healthcare resources, and impacting our economy and society at large.[1] SUD is recognized as a medical brain disorder and includes the misuse of substances such as marijuana, heroin, cocaine, alcohol, nicotine, and prescription drugs.[2] The societal costs of SUDs in the U.S. exceeds $532 billion annually.[3] The origins of ICC to address SUDs (and mental illness) can be traced back to the early 19th century in the U.S.[4] In the 19th century, during the temperance movement, American psychiatry focused on committing individuals with SUDs, such as alcoholism, to facilities known as "inebriate asylums."[5] These asylums emerged to reform individuals with SUDs since the movement started treating addiction as a medical disease rather than a moral failing.

By the early 20th century, the use of inebriate asylums declined due to changing treatment models and the prohibition era, which criminalized substance use, shifting the problem from the healthcare system to the criminal justice system.[6] At the start of the 20th century, the U.S. saw a rise of opioid and morphine addiction.[7] States began to create hospital institutions for involuntary commitment of drug users—permitting the involuntary commitment of individuals with SUDs if they posed a danger to themselves or others—such as the Lexington Narcotic Farm (opened in 1935), to rehabilitate individuals impacted by SUDs.[8] However, the focus eventually shifted to institutionalizing patients rather than rehabilitating patients, and patients treated for a SUD typically did not have a co-occurring illness addressed, and vice-versa.[9,10] These hospitals made up 50% of all hospital beds in the U.S. by 1955, and due to overcrowding, poor conditions, and unethical practices, the institutions became a stain on America's past.[11]

By the late 1950s, the deinstitutionalization movement started the closure of most psychiatric hospitals[12], sparking the current debate over ICC for SUDs (and mental illness). In 1963, President John F. Kennedy signed the *Community Mental Health Act*, accelerating America's deinstitutionalization with the promise of community-based treatment centers to address mental illness and SUDs.[13] Medical treatment costs were shifted to the taxpayer with Medicaid and the prison system bearing the largest costs, and nursing homes, jails, prisons, and community residences were put in charge of administering treatments, which were often ill-equipped to handle the demand.[14] California Governor Ronald Reagan then led the effort at the state-level to end the practice of committing individuals to state institutions, encouraging other states to follow suit.[15] The U.S. failed to allocate adequate resources to the subsequent community-based facilities.[16] This lack of resources, coupled with the flow of drugs in the late 20th century and the escalating opioid crisis, has fueled the debate today over ICC laws regarding SUD and mental illness.

Relevance of the Policy Question

In 2023 alone, deaths from alcohol, opioids, and other drugs were five times greater than the total number of U.S. soldiers lost during the entire Vietnam War, leaving a devastating impact on families and communities each year.[17] Reiterating from before, nearly 50 million Americans currently suffer from SUD, costing the U.S. over $500 billion annually—marking a severe public

health crisis.[18,19] In 2023, there were over 107,000 drug overdose deaths and 178,000 alcohol-related deaths, resulting in the premature loss of 285,000+ lives.[20,21] Alcohol-related emergency department visits surged by 47% between 2006 and 2014, and death certificates citing alcohol as a cause of death increased by 25.5% from 2019-2020 and another 10% from 2020-2021.[22] Meanwhile, opioid and drug-related deaths rose from under 20,000 annually in 1999 to over 105,000 in 2022.[23]

Currently, 38 states and the District of Columbia (D.C.) have ICC laws targeting SUDs; however, 40% of states with such provisions either never or rarely utilize them.[24,25] To help address the SUD crisis, states need a clear roadmap outlining which ICC reforms have been successful and an analysis of the cultural and financial costs involved. Recent reforms in states like California and Kentucky demonstrate approaches such as expanding civil commitment qualification to SUD, extending mandatory treatment periods from one to three months, broadening the list of eligible petitioners, increasing court accessibility, and enhancing funding for psychiatric and rehabilitation hospitals and additional treatment beds.[26]

Balancing Public Health and Civil Liberties

In parallel to the 1960s deinstitutionalization transition, most states revised their commitment laws addressing SUD and mental illness to require dangerousness as grounds for commitment to preserve civil liberties.[27] This made it more difficult to commit individuals since the process became more legalistic. 1970s state reforms focused on protecting civil liberties, developing therapeutic models for treatment, and shifting the culture of addiction from punishment to voluntary treatment.[28] Federal reforms also took place during the '70s due to U.S. Supreme Court rulings related to the 14th Amendment.[29] Wisconsin psychiatrist Daryl Treffert was an early critic of these reforms; in his 1973 letter, "Dying with Their Rights On," he argued that many individuals deemed uncommittable under these revised standards faced "sad ends."[30]

Despite the intent behind these reforms, the transition from institutionalization to community-based treatment struggled due to chronic underfunding and community resistance to establishing treatment centers near schools or churches.[31] Many individuals who were once housed in psychiatric hospitals became homeless or incarcerated.[32] Some psychiatrists argue that efforts to preserve individuals' rights to mental illness or substance abuse went too far, resulting in increased homelessness and imprisonment.[33] By the late 1970s, it was expected these state reforms would start reducing SUDs. However, the focus shifted with the onset of the "War on Drugs" targeting cocaine use, and later, the opioid crisis in the early 2000s highlighted the need for further policy intervention as opioid-related deaths surged.[34,35]

Kentucky's "*Casey's Law*," signed in 2004 by Republican Governor Ernie Fletcher and strengthened in 2022 by Democratic Governor Andy Beshear, was one of the first major modern reforms to ICC, in response to the growing opioid crisis catalyzed by Purdue Pharma and other actors. The Kentucky law enables families and friends to petition the court for treatment on behalf of a person impaired by SUD.[36] It was named in honor of Matthew Casey who died from a heroin overdose.[37] The Casey family lobbied for a change in the law after the family was denied by a Kentucky court to force Matthew into SUD treatment.

State approaches to ICC for SUD vary significantly. Of the 38 states with such laws, some permit only short-term commitments, while others allow longer durations.[38] States also differ in who is authorized to initiate the commitment process, ranging from family members and medical professionals to law enforcement officials.[39] California's recent reforms illustrate the contentious nature of these policies. Governor Gavin Newsom expanded CARE (Community Assistance, Recovery, and Empowerment) Courts and increased state funding to support involuntary commitment laws, arguing "civil liberties concerns have left far too many people without the care they need."[40] In contrast, organizations like Disability Rights California and the ACLU oppose these measures, arguing they infringe on civil rights.[41] Matthew Casey's mother in Kentucky argues it is the right of the family to protect their loved one's right to live.

Analysis

Research examining this policy question consists of a mixed-methods approach to conduct comprehensive due diligence, ensuring the policy question is answered effectively with multiple sources of data to enhance its validity. Three research methods are utilized in this research: 1) literature review; 2) case studies supported by data analysis; and 3) stakeholder interviews.

1. **Literature Review:** This MP leverages an extensive review of peer-reviewed journal articles, government reports, policy evaluations, and foundational texts related to ICC, SUD, mental health, and healthcare. The review establishes a historical context for ICC laws, highlighting their evolution, intended purposes, and public and political attitudes influencing their reforms. Scholarly consensus and debates regarding the ethical implications, efficacy, and unintended consequences of ICC laws form a critical component of this analysis. Key literature identifies essential metrics to evaluate ICC effectiveness, such as treatment outcomes, recidivism rates, and socio-economic impacts. The literature review identifies gaps in current research. It also emphasizes the importance of integrating lived experiences from patients and families, a perspective underrepresented in existing academic discourse. The literature review provides a robust theoretical and empirical foundation informing the subsequent analysis and recommendations within this MP.

2. **Case Studies Supported by Data Analysis:** This MP relies on publicly available state-level case studies and statistics to compare the impacts of reformed ICC laws with those of states having non-reformed or absent ICC laws. Given resource and time constraints of this project, a mixed-methods approach examines seven states—Oregon, Alabama, Wisconsin, California, Kentucky, Massachusetts, and Ohio—selected for their diverse political perspectives, urban-rural demographics, geographic distribution, and notably varied ICC frameworks. The evaluation is complemented with state-level SUD data, treatment outcomes, and recidivism rates, including metrics like repeat hospitalizations or continued substance abuse post-treatment.

3. **Stakeholder Interviews:** Interviews are leveraged with relevant stakeholders to supplement case studies. Stakeholders were narrowed to judges, former patients and families of those patients, and mental health and addiction professionals. Judges provide an understanding of the legalistic process in their state; former patients and their families provide a perspective of lived experiences and impact of the ICC laws; mental health and

addiction professionals provide a scientific understanding of SUD. A total of nine interviews took place and were anonymized to protect the interviewees' identities given the sensitivity of the research—interviewees will be referenced in the endnotes with generic descriptions due to confidentiality. Additional insights from the interviews are sited in **Appendix A – Interview Notes**—these are Duke Internal Review Board (IRB)-approved anonymous Zoom AI notes from each interview. The breadth of interviewees included judges (three people) from states like California and Oregon, patients and families of patients from Wisconsin and Oregon (four people), psychiatrists and economists from top universities and hospitals (three people). Dr. Bundorf and Dr. Zhang were granted access to the data collected from interviews adhering to IRB standards. The interview questions asked are sited in **Appendix B – Questions Asked**.

Common Themes from Literature Review Provide Context

ICC is a controversial tool with mixed perspectives among experts and practitioners regarding its effectiveness; three common themes emerge that provide context influencing the recommendations for this MP's policy question.

- **Involuntary Civil Commitment History in the U.S. Makes It a Painful Subject:** In the *Scope of the Issue and Origins* section it was briefly called out that "due to overcrowding, poor conditions, and unethical practices" ICC led to a "stain on America's past." ICC's history fuels part of the current-day opposition to ICC reforms, making it critical to understand the history of the subject before pursuing reforms. ICC in the 19th and 20th century meant patients were committed to asylum facilities often-times suffering from chronic overcrowding and patient abuse. A prime example of this overcrowding and patient abuse manifested itself within the Pennhurst State School and Hospital located in Pennsylvania. The asylum opened its doors to its first patient in 1908, but after numerous court cases, the asylum shut down in 1986.[42] The federal district court case *Halderman v. Pennhurst State School and Hospital*—argued in 1983 and decided in 1984 by the U.S. Supreme Court—exposed the chronic overcrowding and patient abuse. Examples of overcrowding included excrement and urine on ward floors due to lack of adequate space, beds were placed in aisles but did not meet the number of patients in each ward, and there was significant lack of activity areas for the patients to spend time in.[43] Examples of abuse included lack of psychologists during the weekend, physical restraints utilized for 500+ hours on patients, patients raped by a staff person, and patients experienced physical injuries likes bruises, cuts, and welts.[44] This example personified abuse rife across the American asylum system, and it was called out by an investigation published in Life Magazine in 1946.[45] The Life Magazine article helped catalyze the deinstitutionalization movement, but the issues faced by asylums back then are now faced by modern private and public hospitals, academia, mental healthcare systems, and prisons: chronic waitlists and demand of services, understaffing, and underfinancing.[46]

- **Lack of Involuntary Civil Commitment Case Studies Creates Confusion About Effectiveness:** ICC effectiveness is notoriously difficult to study and to understand its true impact, leading opponents of ICC reform to argue there is insufficient data to support its use.[47] Ethics is the driving force behind the lack of case studies examining the effectiveness

of ICC. It is not possible within ethical research guidelines in the U.S. to conduct randomized controlled trials (RCTs) to assess inpatient ICC outcomes. An RCT studying the outcome of inpatient ICC would violate the independent review principle published by the National Institutes of Health (NIH) Clinical Center and potentially violate other principles.[48] Forcing one group into treatment while denying it to another group that qualifies for inpatient involuntary commitment creates significant ethical risks. The risks include participants who may harm themselves or others—posing the possibility of malpractice liability or other legal claims resulting from the study.[49]

Of the case studies demonstrating results of ICC effectiveness, a lack of consensus exists about the validity of the studies' outcomes creating confusion across multiple stakeholders as to whether inpatient ICC works—and if it does, which process is the most effective. In an interview with an Academic Psychiatrist, they referred to a case study titled "Why the Evidence for Outpatient Commitment Is Good Enough" to prove outpatient commitment is an effective, life-saving tool. The interviewee described the case study as applicable to inpatient commitment, too. The case study describes issues with RCTs regarding civil commitment, and why observational, quasi-experimental, and naturalistic studies are "definitive enough" to demonstrate effectiveness.[50] The broader message from the interviewee was clear: despite lack of formal consensus about civil commitment effectiveness and limited implementation because of "flawed studies," it works when the legal landscape and the downstream resources (e.g., investments into healthcare resources, facilities, staffing, costs, etc.) behind it work together in tandem. When civil commitment laws were tightened in the 1970s, it created cause for concern that many who needed treatment were not receiving it.[51] Since then, select states have started to reform their laws to prevent the legal landscape from acting as a barrier to care (although these reforms have typically not been accompanied by investments into downstream resources, violating the tandem rule).

A perspective by the Substance Abuse and Mental Health Services Administration (SAMHSA) to ensure inpatient ICC works relies on four main ethical principles: respect for autonomy; non-maleficence; beneficence; and justice.[52] In an article published by Dr. Sullivan et al., it is argued that despite lack of data, inpatient ICC provides "potentially lifesaving care in situations where withholding care would endanger individuals by depriving them of necessary treatment."[53] Likewise, in the study titled "A Clinical Tool for Rating Response to Civil Commitment for Substance Abuse Treatment," the outcome determined that "civil commitment resulted in good to excellent outcome in many but not all committed patients."[54] In a survey result published in 2022 titled "Court Clinicians' Experiences Performing Civil Commitment Evaluations For Substance Use Disorders," 76.7% of respondents agreed that civil commitment "was the appropriate intervention for substance use and associated risks" after looking at the full history and details of a patient that meets the threshold for commitment, and 73.3% of respondents disagreed that civil commitments caused more harm than good.[55] The respondents were court clinicians from Massachusetts who were experienced in conducting civil commitment evaluations for SUDs. While the survey was small, the NIH indicated future studies may take place at a larger scale to look at clinicians across the U.S.

Statements from reputable organizations like RAND distort messaging regarding civil commitment effectiveness because their position heavily weights RCTs. RAND's position does not consider outside studies and methods mentioned later in this MP. In a research summary published by RAND in 2023, their stated position is based on two qualitative analyses from an online survey of selected experts.[56] The results from the surveys found there is lack of evidence to back civil commitment effectiveness—this conclusion did not consider non-RCT studies. In one of few RCT studies available—*specific to SMI* and conducted by Duke Medical School—the conclusion was "outpatient commitment can improve treatment outcomes when the court order is sustained and combined with relatively intensive community treatment."[57] A RCT on outpatient commitment specific to SMI is the closest gold-standard empirical study available for drawing inferences about inpatient commitment and SUD. In an interview with the Academic Psychiatrist, they stated that if an outpatient commitment RCT focused on SUD were conducted today, its results would likely align with this study's findings.[58] However, due to the increasingly stringent criteria in academia IRB standards over the past two decades since the Duke University study, such a study is unlikely to be conducted again.

When the Duke study was published, RAND challenged its findings, arguing that it did not account for the potential effects of court orders issued *without* intensive treatment.[59] However, this critique is flawed, as court-ordered civil commitment without intensive treatment would violate statutory requirements in most states (e.g., this is highlighted later in the MP with Kentucky's statutory requirements). When considered alongside interview data from this MP, the findings suggest that ICC is effective for SUD when paired with sustained healthcare resources and treatment.

- **Long-Term Investments in Involuntary Civil Commitment Are Misaligned with America's Current Priorities:** The current priorities of the Trump administration do not include long-term investments needed to address the SUD crisis. In all interviews conducted for this MP, a common thread connected every judge, family, and health expert: the critical need for investments in federal and state research grants, collaboration between public health and criminal justice systems, healthcare and hospital systems, philanthropic and private sector support, workforce training and development, and housing and social services. If long-term investments are not made into these categories, legal reforms alone on a state by state basis will have little impact on the effectiveness of inpatient ICC managing SUD, according to the interviewees. For example, the CARE Court[60] CA Superior Court Judge #1 discussed how some cases do not make it to their court because there are no available treatment beds, limiting the real-world impacts of California's ICC reforms. The optimal number of state psychiatric hospital beds range between 50-60 beds, but in 2023, the U.S. hit a historic low of 10.8 beds per 100,000 adults.[61] A December 2023 report by the Health Resources and Services Administration demonstrated more than half of the U.S. population lives in a Health Professional Shortage Area (HPSA).[62]

  In early 2025, President Trump's Administration and Republican members of Congress indicated their desire to cut spending, most likely from Medicaid, to help pay for tax cuts.[63] As of April 2025, Republican congressional leaders are considering cuts up to ~$880

billion from Medicaid over 10 years.[64] Likewise, President Trump's Administration has also tried to freeze federal grants funding local health clinics and other healthcare resources—the spending freeze is currently being litigated in federal court.[65]

While the federal government is most likely to either maintain or cut spending on categories impacting adults with SUD for the foreseeable future, states may choose to increase investments into SUD categories. In 2022, 32 states increased their investments addressing SUD and reported spending a collective $123 million from general state revenue funds.[66] Expenditures were reported on recovery community centers, recovery housing, peer recovery staff, workforce development, recovery support services, and other areas.[67] However, it is critical to note that more than $250 million derived from federal sources like SAMHSA and the Substance Abuse Prevention and Treatment Block Grant (SABG). During the Trump Administration era, it is likely states will need to increase spending from general state revenue funds to address potential gaps in federal funding.

Insights and Case Studies from the Seven Selected States

As mentioned earlier in this paper, 38 states and D.C. have enacted some sort of ICC laws, with the laws changing on a yearly basis.[68,69] The statutes governing each state vary, but many of the laws overlap each other with similar provisions. The similar ICC qualifying provisions include dangerousness to oneself or others, grave disability, lack of decision-making capacity or incapacitation, inability to manage personal affairs and take care of basic needs, and loss of control or succumbing to addiction. Additionally, rules around who can petition a court to commit someone and the process for commitment vary across states. The overlap typically seen between states include statutory requirements requiring a person with SUD be evaluated by a medical professional (or whether SUD even qualifies for ICC), differences in length of the ICC for treatment, and the follow up processes from the state and/or medical care provider(s). Lastly, each state considers a person's civil rights throughout the ICC process, and these statutes may include the right for the patient to have an attorney during the process, the right to petition a court for a writ of habeas corpus, receiving notice of the hearing date and being present at the hearing, communicating with family, and presenting and cross-examining witnesses, etc. For this MP's brevity, only high-level statutes with significant impact will be discussed within each state.

- **Oregon:** Rev. Stat. Ann. § 426.495 outlines that ICC is applied to a "person with a chronic mental illness" other than those caused by substance abuse who is diagnosed by a psychiatrist or licensed clinical psychologist.[70] The statute specifically excludes SUD as grounds for ICC. In Oregon, only 5.8% of SUD patients who died from drug overdose in 2021 were receiving treatment for mental health and substance use, and Oregon's SUD rate is ~28% higher than the national average.[71]

  In an interview with a clerk of an ICC judge in Oregon, they stated the statute governing civil commitments in Oregon—Chapter 426—is outdated and has not been revised through several editions of *Diagnostic and Statistical Manual of Mental Disorders (DSM)*.[72] Case law in Oregon reinforces the prohibition of civil commitment for SUDs, even though the current DSM includes SUD as a recognized condition. The clerk contributed to a recent report that was delivered to the Chief Justice of Oregon recommending updates to the

statute to advance Oregon's efforts addressing its SUD crisis. In *A Review of Oregon's Civil Commitment System*, the report dedicates 19 pages detailing concerns of the statute like "Oregon is one of a minority of states that does not consider substance use disorder as a condition that would allow for civil commitment."[73] In its recommendation section, most contributors to the report supported amending the statute to include SUD. As of this MP's submission, Oregon has not reformed its statute, nor has it adopted many of the report's recommendations. The clerk believed it would take Oregon a few years to adopt the report's recommendations and thought it was unlikely Oregon would include SUD as qualifying grounds for ICC.

- **Alabama:** Ala. Code § 22-52-1 states that ICC applies to individuals with a mental illness but explicitly excludes epilepsy, intellectual disability, SUDs (including alcoholism), and developmental disabilities.[74] Any person may file a petition for involuntary commitment, but the individual in question must pose a real and present threat of substantial harm to themselves or others. If deemed eligible for inpatient commitment, Alabama's initial commitment period lasts up to 150 days, with the state required to file a renewal petition within 30 days of the initial order.[75] The most recent state data related to SUD in Alabama is from 2019. According to the CDC, Alabama had the highest opioid prescribing rate in the country, with 85.8 prescriptions per 100 persons, compared to the national average of 46.7 per 100 persons.[76] Additionally, Alabama's drug overdose death rate was 32.4 per 100,000 people between 2011 and 2021, compared to the national rate of 30.1, according to KFF.[77] The most recent reforms to Alabama's ICC laws expanded the definition of "dangerousness to oneself" to include an inability to meet basic needs. The reforms also broadened the list of individuals who can petition for ICC to include family members.[78] However, these reforms did not extend ICC eligibility to individuals with SUD, nor did they introduce significant investments in healthcare infrastructure to support ICC patients. Alabama currently has 408 state hospital beds for adults with SMI, ranking 35th in the U.S.[79] The state has approximately 28,800 residents who have not received treatment through its public or private mental health systems and ranks 46th out of 50 states and D.C. in providing adequate access to mental health services.[80]

- **Wisconsin:** Wis. Stat. Ann. § 51 allows a person to petition the court for the involuntary commitment of an individual with a SMI or drug dependence, provided that "the person [is] a danger to him or herself or others as manifested by evidence of recent threats of, or attempts at, suicide."[81] Wisconsin law also requires a "strong probability" that the individual is at risk of death or serious injury. These stringent criteria make it particularly difficult to petition for a court-ordered commitment, as the petitioner must prove that the individual presents an imminent danger. In interviews with a Wisconsin family and a person with lived experience, the primary barrier to helping individuals with SUD was the "imminent danger" clause.[82,83] This legal standard shifted focus away from addressing prolonged mental instability and SUD, often resulting in individuals being denied appropriate treatment. The interviews also revealed frustration among Wisconsin law enforcement officers with the state's mental health and substance use system, leading them to frequently defer individuals to the criminal justice system instead. This practice places additional financial and logistical strain on taxpayers by incarcerating individuals with SUD and/or SMI, while also raising ethical concerns about how the system is structured.

As of 2021, Wisconsin's drug overdose death rate was 31.6 per 100,000 people, slightly below the U.S. average of 32.4.[84] Of these drug overdose deaths, 75% were opioid related. Additionally, 34.9% of adults in Wisconsin reported experiencing an "unmet need" for mental health treatment—defined as a person being recommended for treatment but not receiving care—compared to the U.S. average of 28.2%.[85] A 2017 report from Wisconsin's Department of Health Services found that 30% of offenders booked into Wisconsin jails and 60% of the state's prison population had a SUD.[86] Alcohol was identified as the most misused and addictive substance in the state.[87] Despite these challenges, there have been no recent efforts to reform Wisconsin's Chapter 51 framework.

- **California:** Cal. Welf. & Inst. Code Ann. § 5201 allows any person to file a petition requesting an evaluation of an individual who is a danger to themselves or others or is gravely disabled.[88] California's ICC law applies to individuals with a SMI or SMI with a co-occurring SUD. In 2022, Governor Gavin Newsom signed Senate Bill 1338, known as the CARE Act, into law.[89] This legislation established a court process for creating CARE plans for individuals suffering from SMI or SMI with a co-occurring SUD. In 2023, Governor Newsom signed Senate Bill 43, marking the first reform to the *Lanterman-Petris-Short Act* in more than 50 years.[90] The reform introduced new diagnostic criteria and expanded the definition of "grave disability." Previously, the law focused solely on mental health disorders; SB 43 broadened the definition to include individuals with "a severe substance use disorder, or a co-occurring mental health and severe substance use disorder, who are unable to provide for their basic needs for food, clothing, shelter, access to medical care, or personal safety."[91] Additionally, SB 43 empowered California to place individuals with severe SUDs under involuntary psychiatric holds, whereas the original ICC law only applied to those with SMI.[92] As of 2021, California's drug overdose death rate was 26.6 per 100,000 people, lower than the U.S. average of 32.4.[93] California has a higher "Percent of Need Met" compared to the U.S. average due to greater investment in mental health and substance use care.[94] However, the state currently has 34.9 inpatient psychiatric beds per 100,000 adults, falling short of the estimated need of 50.5 beds per 100,000 adults.[95] Nationally, the U.S. has only 10.8 inpatient psychiatric beds per 100,000 adults, far below the estimated need of 60 beds per 100,000 adults to meet optimal care standards.[96] The first judge interviewed noted that, due to California's shortage of treatment beds, doctors and loved ones sometimes refrain from filing commitment petitions—highlighting the importance of investing in downstream resources alongside legal reforms.[97] As discussed later in this MP, the first report evaluating the CARE Act's effectiveness will be released after the completion of this MP.[98] Therefore, it is currently too soon to assess its initial impact, but additional insights will become available soon.

- **Kentucky:** KY Rev. Stat. Ann. § 222 allows any person to file a petition for the involuntary treatment of an individual suffering from SMI or SUD. The definition of an imminent threat of danger includes a clause stating that the likelihood of such a threat occurring in the future, combined with the reasonable expectation that the individual would benefit from treatment, meets the threshold for ICC.[99] In 2004, Kentucky enacted the *Matthew Casey Wethington Act for Substance Abuse Intervention*, reforming the state's ICC laws.[100] Before the Act, family members and friends had no legal avenue to petition for the involuntary treatment of individuals based on SUD. The law was further reformed in 2022 with two

key provisions: (1) allowing healthcare professionals to be subpoenaed during ICC hearings and (2) mandating that treatment be ordered if the court finds that an individual meets the ICC criteria.[101] The ICC reforms in 2004 and 2022 were bipartisan, with both reforms signed by a Republican and then a Democratic governor. Kentucky's ICC reforms—including expanding who can petition the court, broadening the eligibility threshold, and explicitly including SUD—have made the state a model for ICC reform over the past two decades.[102] Ohio adopted *Casey's Law*, and more than 20 other states have since implemented similar versions, demonstrating the widespread impact of Kentucky's reforms. As of 2023, 37.4% of adults in Kentucky reported experiencing mental illness, compared to the U.S. average of 32.3%. In 2021, Kentucky's drug overdose death rate was 55.6 per 100,000 people, significantly higher than the U.S. average of 32.4 per 100,000.[103] Despite these challenges, Kentucky currently has only 9.1 inpatient psychiatric beds per 100,000 adults, highlighting a critical gap in mental health infrastructure.[104]

- **Massachusetts:** Mass. Gen. Laws Ann. ch. 123 § 35 allows police officers, physicians, spouses, blood relatives, guardians, or court officials to petition the court for an order of involuntary commitment if an individual is suffering from alcoholism or SUD.[105] Under Section 35, a judge may commit an individual for up to 90 days if they meet the threshold for SUD and pose a likelihood of serious harm to themselves or others as a result of their disorder.[106] Enacted in 2018, Section 35—also known as the CARE Act—was the most recent reform to Massachusetts' ICC law. The reform ended the practice of civilly committing men to correctional facilities (a practice that had already been halted for women in 2016), expanded the number of SUD treatment beds, and shifted care toward patient-centered treatment, emphasizing individualized treatment planning and aftercare.[107] In 2023, the Massachusetts Medical Society officially endorsed Section 35 due to its restrictions on involuntary commitment confinement to facilities approved by the Department of Public Health or Department of Mental Health and its requirement that treatment adhere to widely accepted medical guidelines.[108] The endorsement highlighted that Section 35 not only implemented legal reforms but also improved the patient experience and prioritized treatment effectiveness. An interview with the Academic Psychiatrist revealed that they had a nuanced perspective on ICC reform.[109] They stated that they could not support reforms that only altered the legal framework without expanding healthcare resources, as such reforms would be ineffective.[110] However, they would support reforms like Section 35, which both lowered the ICC threshold and increased investment in downstream resources. In Massachusetts, the rate of adults reporting mental illness is lower than the national average, but drug overdose deaths reached 36.8 per 100,000 people in 2023, compared to the national average of 32.4 per 100,000.[111] The state has been more successful than most in meeting the needs of its residents with health professionals, likely due to Section 35's 2018 investment in expanded healthcare resources.[112] The discussion with the Academic Psychiatrist significantly informed the recommendations section, indicating the need for downstream resource investments to occur in tandem with legal reforms.

- **Ohio:** Ohio Rev. Code Ann. §§ 5119.92 and 5119.93 allows a spouse, relative, or guardian to file a petition in court for the involuntary commitment of an individual suffering from alcohol and/or SUDs.[113] Like Kentucky's law, Ohio's definition of imminent threat of

danger includes a clause stating that a future likelihood of harm to oneself, combined with a reasonable expectation of benefiting from treatment, meets the threshold for ICC.[114] Ohio adopted *Casey's Law* in 2012, mirroring Kentucky's framework, and later reformed it in 2021 to simplify the process and improve its effectiveness.[115] The 2021 reform removed the requirement to pay treatment costs upfront, eliminated the filing fee, removed the requirement to provide proof of insurance or coverage for half the treatment cost upfront, and eliminated the requirement for a physical examination of the individual before seeking intervention.[116] Ohio judges hope that these streamlined processes will encourage families to use the law, shifting addiction treatment from the criminal justice system to the medical and mental health treatment system.[117] Ohio residents report higher rates of mental illness compared to the national average. In 2021, the state's drug overdose death rate reached 48.1 per 100,000 people, significantly higher than the national average of 32.4 per 100,000.[118] In 2023, the Treatment Advocacy Center found that Ohio had only 9.6 inpatient psychiatric beds per 100,000 people, far below the recommended 60 beds per 100,000.[119]

Common Themes from Interviews Informing Recommendations

In nine interviews conducted with judges[120,121,122], former patients[123], their families[124], and mental health and addiction professionals[125,126,127,128], key themes emerged. Understanding these key themes spotlights the urgent need for ICC reform to deliver more effective, humane, and financially sustainable solutions for vulnerable individuals with SUD (and co-occurring SMI if applicable) in the U.S. A breakdown of the key themes is below (Interview data is sited in **Appendix A – Interview Notes** and the consent statement is sited in **Appendix C – Consent Statement**):

- **Inefficiencies in Current Involuntary Civil Commitment Laws:** Many states, such as Oregon, do not permit ICC for SUD, thereby limiting intervention options for affected patients, a view shared in the interview with the clerk. Existing ICC laws are outdated and inadequate for effectively addressing the SUD crisis. Non-reformed state laws discourage families from securing appropriate care for loved ones unable to recognize their own need for treatment, a view shared by the family and the advocate for reform in their interviews. Common shortcomings include overly restrictive criteria determining who can petition for ICC, excessively high thresholds for qualifying individuals for commitment, and procedures no longer aligned with treatment needs. Additionally, many individuals with severe SUD experience anosognosia, a neurological condition characterized by an inability to recognize their psychiatric or neurological impairments, further complicating the effectiveness of current ICC processes.[129] This was emphasized in the interview with the advocate for reform. The standard threshold of "imminent danger" is excessively restrictive in most states, resulting in individuals being denied necessary treatment. In response, states like Kentucky and Massachusetts have reformed their ICC laws, expanding criteria beyond "imminent danger" to include thresholds such as "unable to meet basic needs" and "unable to provide adequate care for oneself." The family and person with lived experience interviewed share the view it would be beneficial to expand these reforms to states like Wisconsin, and to develop an updated national standard guiding ICC reform.

- **Treatment Gaps and Systemic Failures:** There is poor coordination between courts, crisis teams, and medical professionals, resulting in individuals frequently falling through systemic gaps—a common view held across all interviewees. These gaps include fragmented communication and inadequate coordination among stakeholders, insufficient psychiatric bed capacity leading to untreated cases (impacting judicial outcomes according to one judge interviewed), and overly restrictive legal criteria for ICC that narrowly emphasize "imminent danger" rather than broader medical needs. Furthermore, short inpatient care durations (typically around 30 days) are inadequate, and longer stays ranging from 90 to 180 days, coupled with step-down care, are necessary for effective treatment, according to the advocate for reform. Financial and insurance barriers further limit access to mandated care, while societal stigma and cultural misunderstandings contribute to the ongoing criminalization of mental health and SUDs, according to the health economist interviewed. Additionally, the option to file involuntary commitment petitions is often underutilized due to doctors' reluctance stemming from resource limitations, such as inadequate capacity at hospitals or treatment centers. These systemic failures compromise the provision of consistent, effective care.

- **Law Enforcement and Criminalization of Mental Illness and Addiction:** Many law enforcement officers criminalize mental illness and addiction rather than directing affected individuals toward appropriate treatment resources, a view held by the advocate for reform, the family, and person with lived experience in their interviews. Crisis Intervention Training (CIT) implementation varies considerably across state police departments, resulting in inconsistent responses to mental health crises. Additionally, law enforcement personnel frequently view the mental health system as ineffective, leading them to favor punitive measures over therapeutic solutions. While mental health courts and drug treatment courts have been established as alternatives to incarceration in some states, their availability remains limited and uneven across jurisdictions, further perpetuating the cycle of criminalization.

- **Financial and Operational Barriers:** Families and patients face significant financial burdens due to limited insurance coverage for court-ordered treatment. Even when insurance is available, restrictive provider payment structures can limit access to essential services, a view held by the advocate for reform. Additionally, severe shortages of psychiatric beds exacerbate treatment accessibility issues; for example, states like Wisconsin have only 8-9 beds per 100,000 people, far below the recommended benchmark of 60—a concern deeply expressed by the psychiatrists interviewed. Compounding these issues, workforce shortages and the lack of trained mental health professionals further constrain the system's capacity to provide timely and adequate treatment, a view emphasized by all interviewees.

- **Cultural, Societal, and Ethical Concerns:** Widespread stigma and societal ignorance about mental health and SUD create substantial resistance to necessary reforms, according to both psychiatrists, the family, and advocate for reform in their interviews. Marginalized populations, particularly people of color, disproportionately experience criminalization rather than treatment, further intensifying inequities—called out by the advocate for reform. Additionally, ICC laws are caught between competing interests of balancing

individual autonomy and civil liberties against the broader public health need for early and effective intervention. Without robust safeguards, ICC processes risk misuse and coercion, potentially institutionalizing individuals who do not meet legitimate clinical criteria, a point emphasized with critical importance from the crisis services psychiatrist.

- **Role of Family and Peer Support:** Family involvement plays a crucial role in treatment but often becomes adversarial due to ICC processes that frequently place families in opposition to their loved ones, according to the family and the person with lived experience interviewed. Conversely, integrating peer support into treatment has been demonstrated to significantly improve outcomes, particularly within Assertive Community Treatment (ACT) models, highlighting the importance of collaborative rather than confrontational approaches in care delivery. The advocate for reform emphasized the importance of ACT more than once in their interview.

Economic Case for Expanding Substance Use Disorder Treatment Investments

Investments in SUD treatment programs generate a significant return on investment (ROI) by reducing societal costs and increasing economic output. As highlighted earlier in this paper, the societal costs of tobacco, alcohol, and illicit drug use exceeds $500 billion annually.[130] These costs include disease, premature death, lost productivity, crime-related expenses (such as theft and violence), foster care and homeless shelters, lost economic growth, and expenditures on law enforcement, prosecution, incarceration, and probation.[131] Some estimates, including those from the Gateway Foundation and the U.S. Congress Joint Economic Committee, place the total costs of SUD at nearly $1 trillion per year.[132,133]

Despite these staggering costs, total annual spending on SUD treatment—including federal, state, and local government funding, as well as private insurance and out-of-pocket expenses—is estimated at only $50–$60 billion annually.[134,135,136] Historical analyses demonstrate that increasing investments in SUD prevention and treatment yields substantial savings.

- **2008 (Bush Administration – SAMHSA):** Every $1 spent on substance use prevention for youth aged 12–14 saved society $18.[137] The 1:18 ratio reflects the long-term savings from reduced social costs—such as SUD-related medical care, use of public resources, and lost productivity—as well as the preservation of quality of life. While not directly tied to this MP's central policy question, it offers important context on the value of prevention and the potential to reduce reliance on ICC. It also illustrates how broader, coordinated efforts can contribute to addressing the SUD crisis.

- **2012 (Obama Administration – Fact Sheet[138]):** According to estimates from the study *Benefit-Cost in the California Treatment Outcome Project* published in *Health Services Research*,[139] every $1 invested in substance abuse treatment yields $4 in healthcare savings and $7 in reduced law enforcement and criminal justice costs, as cited in the Fact Sheet.

- **2018 (Trump Administration – Council of Economic Advisers):** Investments in substance abuse programs within the criminal justice system have been shown to reduce crime and incarceration-related (e.g., healthcare) costs, yielding a return of $1.47 to $5.27

for every taxpayer dollar spent.[140] This study, published under the Trump Administration, reflects similar healthcare savings reported in the broader population by the Obama Administration's Fact Sheet.

The evidence is clear: increased investments in SUD prevention and treatment save far more money than they cost while also saving lives.

To effectively address SUD, the U.S. should invest slightly more than double the current spending on SUD treatment. This level of investment would close the treatment gap and significantly reduce the annual societal costs associated with SUD. The average cost of SUD treatment in the U.S. is $1,583, though this figure varies widely depending on the type and intensity of care.[141,142] Inpatient treatment for SUD ICC is particularly expensive. The average cost of a 30 day inpatient SUD treatment program is $12,500, and 60-90 day programs average $36,000.[143] According to the 2023 SAMHSA National Survey on Drug Use and Health, an estimated 54.2 million Americans needed substance use treatment in the past year, yet only 12.8 million (~23%) received it.[144] This leaves 41.4 million Americans untreated annually. A significant factor for adults who perceived an unmet need for SUD treatment was the belief treatment would cost too much.[145] A rough estimate of the additional investment required can be calculated by multiplying the average SUD treatment cost ($1,583) by the 41.4 million untreated individuals, totaling approximately $65.6 billion per year. Based on the Fact Sheet from the Obama Administration, this incremental investment could yield substantial returns, generating an estimated $262.4 billion in annual healthcare savings and $459.2 billion in annual law enforcement savings. In total, a $65.6 billion annual investment could result in $721.6 billion in savings—representing a notable 1,000% ROI. The average cost and benefits of inpatient treatment programs are not separated in this calculation because the Obama Administration's Fact Sheet uses an aggregate figure that already includes inpatient care within the $1,583 average treatment cost. Since only a small subset of the 41.4 million untreated individuals would require involuntary inpatient care, most investments would support voluntary treatment and involuntary assisted outpatient treatment (AOT). However, without reforming ICC laws—even if they apply to a limited portion of the SUD crisis—the human toll will continue to grow, remaining unaddressed.

Co-occurring Mental Illness + Substance Use Disorder Demonstrate Need for "Combined Care"

Interviews with both psychiatrists reveal that patients with SMI frequently have an unaddressed co-occurring SUD—and vice versa—highlighting the need for combined care within ICC laws and the healthcare system. The advocate for reform, who lost their adult child to suicide and attributes part of their child's death to absent ICC laws, emphasized that facilities typically treat either SMI or SUD, but not both.[146] Similarly, while ICC statutes recognize SMI as a qualifying factor, they sometimes overlook SUD, creating significant bottlenecks in both the ICC and healthcare systems and leaving families to struggle with navigation. NIH research shows that over 50% of SMI patients have a co-occurring SUD.[147] After four initial interviews revealed this consistent trend, it was decided SMI data should be examined within this MP's **Literature Review**. Although there is insufficient data to focus solely on SUD, this MP's **Analysis** maintains an emphasis on SUD while also considering its intrinsic link to SMI.

The professional term for combined care as it relates to ICC is called the Certified Community Behavioral Health Clinic (CCBHC) model. CCBHC is a specially designated clinic that provides a comprehensive range of mental health and substance use services.[148] This model, indicated by the advocate for reform and CA Superior Court Judge #1 in their interviews, provides an ideal model for integrated care.[149,150] The model's foundation is built on addressing both SMI and SUD, so if a patient has a co-occurring illness, the facility has the resources to provide holistic care to the patient that normal care centers may not be able to address. CCBHCs include 24/7 care and access to MAT. These facilities provide access to mental health and substance use care much faster than the average wait time of 48 days, and they provide communities the power to effectively address both the SMI and SUD crises simultaneously.[151] The CCBHC model began its journey in eight states as part of a 2017 demonstration program initiated by the *Excellence in Mental Health Care Act of 2014*. Since 2018, SAMHSA has provided grants to clinics across the U.S., supporting them as they adopt the full range of activities and services characteristic of a CCBHC. In October 2022, further expansion was announced: planning grants, funded by the *Bipartisan Safer Communities Act*, were created to help more states implement the CCBHC model nationwide.[152]

Involuntary Civil Commitment Reform Performance Indicates Further Research and Data Needed

States like California and Washington have recently reformed their ICC laws to include SUD as a qualifying criterion for commitment. While these reforms have led to increased utilization, their mixed results suggest that refinement is needed, and that not enough data is available to draw strong, empirical-based conclusions yet. In California, over 1,400 individuals were connected to CARE Courts or county services in the first year of the reform, including those suffering from SUD.[153] The first *Annual CARE Act Report* will be released in July 2025, after the completion of this MP.[154] In Washington State, the report *Involuntary Treatment for Substance Abuse: Client Outcomes* was published in June 2023—it is one of the few reports available detailing ICC performance after state-level reforms.[155] The findings were mixed—ICC patients were less likely than voluntary patients to continue SUD treatment post-ICC, but they were also less likely to experience homelessness and had reduced healthcare costs.[156] Both inpatient and outpatient treatment utilization increased between the pre- and post-treatment periods for both ICC and voluntary patients.[157] The cost-benefit analysis showed a positive return when considering detox centers alone but a negative return when including both detox centers and involuntary treatment. A separate study examining the period from 2010 to 2021 found no significant difference between states with and without ICC laws for SUD.[158] Overdose death rates were higher in states with ICC SUD laws compared to those without, but the study noted this as a limitation, as these laws were likely enacted in response to already high overdose death rates.[159] The study emphasized the need for further research to determine the actual effectiveness of ICC for SUD and cited preliminary findings from another study suggesting that ICC "may be a viable method for short-term overdose prevention for a subset of this vulnerable patient population."[160]

Initial case studies with data analysis and stakeholder interviews highlight the critical need for increased investment in aftercare within the continuum of care, as exemplified by Massachusetts' Section 35 reforms. A significant gap identified in many ICC laws for SUD is the absence of a structured transition from involuntary commitment to voluntary follow-up care. One proposed solution is the establishment of bridge clinics—low-barrier treatment programs directly connecting patients to ongoing care after ICC discharge.[161] These clinics could be effectively

integrated into the CCBHCs previously discussed. Ensuring that individuals have continued access to addiction medications, counseling, peer support services, and case management post-ICC could significantly improve treatment adherence during this vulnerable period. Additionally, it is essential to incorporate evidence-based treatments and harm reduction strategies. Massachusetts specifically revised its ICC protocols after recognizing that the lack of MAT negatively impacted outcomes.[162] As described earlier in the "*Insights and Case Studies from the Seven Selected States*" section, Massachusetts and California invested significantly in downstream resources alongside ICC reforms. In contrast, states that implemented ICC reforms without parallel investments in downstream services may face challenges due to the absence of these critical services. Moving forward, maintaining flexibility in ICC SUD laws will be crucial, enabling continuous refinement based on emerging empirical data to enhance the effectiveness of treatment for individuals with SUD.

Limitations and Risks of Involuntary Civil Commitment

ICC is one of many tools necessary to address the SUD crisis. However, if not implemented properly, its effectiveness can be significantly undermined by profound limitations and risks, potentially hindering its role in mitigating the crisis. A board-certified psychiatrist leading a crisis service in the Midwest described ICC as "primarily a life-saving intervention rather than a long-term solution."[163] They likened it to resuscitating a heart attack victim—while it stabilizes the patient in the moment, it does not necessarily lead to sustained health improvements.

As previously discussed in this MP, the Duke Medical School RCT demonstrated positive results with outpatient commitment for individuals with SMI because it was structured as a twofold intervention: a sustained court order paired with intensive community treatment.[164] The same principle applies to ICC for SUD—without a continuum of care, defined as the delivery of healthcare over an extended period, ICC risks becoming ineffectual.[165] A study published in *Psychiatry Journal* describes substance dependence as "a cyclic, chronic condition consisting of alternating episodes of treatment and subsequent relapse."[166] This underscores the necessity of lower-intensity, ongoing outpatient treatment to sustain reductions in substance dependence beyond the initial inpatient ICC intervention. For example, the study found that patients who attended Alcoholics Anonymous (AA) weekly during the first six months after treatment had a relapse rate of 27%, compared to 64% among those who did not attend.[167] This highlights the critical role of continued care following ICC.

Key limitations and risks to consider with ICC include:

- **Relapse:** In the U.S., 40-60% of individuals with SUD will experience relapse.[168] While SUD is a treatable condition, it is essential to recognize that it is a chronic disease—meaning treatment is not a cure but a means of long-term management.[169] This underscores that ICC is not a definitive solution for addressing SUD but rather a potential starting point in an individual's journey toward recovery. ICC can serve as an initial intervention to stabilize a person in crisis, but sustained progress depends on a comprehensive treatment plan, the commitment of the individual, and the ongoing support of medical professionals. Just as ICC may provide short-term safety, long-term success hinges on the quality of

follow-up care, access to resources, and the individual's engagement in managing their disorder over time.

- **Experience:** ICC can be a traumatic experience for patients, particularly when resources and evidence-based methods are insufficiently applied to their case. The Advocate interviewed highlighted the stigma, cultural barriers, and systemic disparities that affect individuals undergoing ICC for SMI, SUD, or both.[170] They described how stigma disproportionately impacts people of color, who are more likely to face incarceration or even fatal encounters with law enforcement rather than receive appropriate treatment. Cultural barriers, such as a lack of awareness about anosognosia—the condition in which patients lack insight into their illness—further complicate treatment, as traditional psychoeducation may be ineffective for these individuals. Additionally, disparities in care were noted, particularly in how patients exhibiting violent behavior due to their symptoms are often criminalized rather than treated, with racial disparities compounding these negative outcomes. The Advocate also pointed to biases within the healthcare system, where individuals perceived as "likable" and those with high-quality health insurance are more likely to receive extended treatment, while others may be prematurely discharged or denied care. Patients who are prematurely discharged or denied care are often diverted to homeless shelters or jails, environments that lack the necessary support for recovery. Providing safe housing, access to medication, and sustained follow-up care (i.e., continuum of care) significantly increases the likelihood of successful long-term management of SUD. Ensuring stability through these critical resources not only improves individual outcomes but also reduces the cycle of relapse, hospitalization, and incarceration.

  In the interviews with the family and the person with lived experience, they reinforced these concerns, emphasizing that the U.S. prison system has become the largest provider of mental health services, including SUD treatment. Their observation is supported by a 2014 *American Journal of Public Health* article, which confirmed that jails and prisons house more individuals with mental health conditions than psychiatric facilities.[171] Given law enforcement's role in ICC, the past experiences of SUD patients with police may make them more resistant to forced treatment. In the interview with the Crisis Services Psychiatrist, they stressed that additional resources and funding are needed to support dedicated crisis response officers within law enforcement.[172] A specialized crisis team could ensure that ICC is a patient-centered process, reducing the likelihood of negative, traumatizing encounters while also alleviating the workload of traditional police officers (enabling police officers to focus on broader public safety). The psychiatrist noted that many individuals refuse post-ICC treatment if their initial experience is traumatic, further emphasizing the need for a more compassionate and well-resourced approach to ICC.

- **Cost and Insurance:** The average seven-day cost for a SUD inpatient stay is ~$7,100, while hospitals typically charge between $8,300 and $22,000 for such stays.[173] After inpatient care, additional outpatient treatment expenses can place significant financial strain on patients. Involuntary care is funded through four main channels: public programs, private insurance, charity programs, and out-of-pocket spending.[174] Approximately 60% of inpatient stays are covered by Medicare and Medicaid, 27% by private insurance, and 10% by self-pay or charity care.[175] However, even when a patient is not the primary payer, they

may still be responsible for out-of-pocket costs such as deductibles, copayments, coinsurance, and other ICC expenses. This financial burden poses a significant risk, particularly for individuals with limited financial resources, potentially discouraging them from seeking continued care after the ICC process is initiated.

- **Trade-offs and Resources:** In an interview with a renowned Health Economist specializing in health policy, drug regulation, and payment systems, they highlighted critical trade-offs and resource challenges associated with ICC.[176] The discussion underscored how insurance coverage for SUD treatment has evolved since the 1970s—from minimal inpatient coverage to parity laws mandating equal coverage for substance use and mental health. However, despite expanded coverage, access remains a major barrier, creating a paradox: better insurance coverage does not necessarily translate to better access to SUD treatment. As noted earlier in this MP, the U.S. faces a severe shortage of psychiatric beds, as well as critical healthcare resources such as nurses, physicians, and treatment facilities.[177,178] An ICC order does not inherently create additional capacity, often leading to the displacement of voluntary patients. Every involuntary admission risk turning away a voluntary patient, raising ethical concerns about prioritization. The healthcare system must carefully balance whether it is more beneficial to prioritize involuntary patients over those actively seeking treatment. A holistic approach is essential—expanding ICC without addressing capacity constraints will be ineffective. The success of reforms relies not only on legal changes but also on resource allocation to ensure that treatment remains accessible for all patients in need.

Alleged Harms of Involuntary Civil Commitment

Despite the National Institute on Drug Abuse stating in Principle 11 that "treatment does not need to be voluntary to be effective," critics of ICC highlight alleged harms as reasons for their opposition.[179,180] These concerns include stigmatizing and punitive experiences, heightened family conflict and social isolation, erosion of patient self-determination, and increased long-term overdose risk.[181] Critics argue that forced treatment may diminish patient motivation to actively engage in recovery and point to the lack of consistent evidence demonstrating ICC's effectiveness in reducing long-term relapse rates—the gap in experience and research is discussed earlier in this MP.[182] Additionally, critics warn investments in ICC could divert resources away from community-based programs that prioritize voluntary engagement, harm reduction, and a continuum of care—the trade-offs and resource limitations are also examined earlier in this MP.[183] There is also concern that ICC may disproportionately impact marginalized populations while failing to address the underlying social determinants of addiction, such as poverty, housing instability, and limited access to comprehensive healthcare.[184] For this MP's brevity, these related topics are not explored in depth but it is acknowledged these external factors do play a role within SUD ICC.

State-Agnostic Recommendations

This MP's **Analysis** highlights critical considerations for states seeking to reform their inpatient ICC laws for SUDs. While each state faces unique legal, financial, and cultural contexts, there are overarching, state-agnostic strategies that can guide policymakers, healthcare providers, and communities toward more effective inpatient ICC frameworks. These recommendations

emphasize the necessity of simultaneously strengthening the "front-end" (legal and procedural mechanisms) and the "back-end" (clinical and community-based infrastructure), ensuring that interventions result in sustainable recovery and reduced societal costs. The recommendations outlined also include solutions to finance ICC reforms, augment workforce development to support downstream services, and an implementation plan to effectively enact these recommendations.

Front- + Back-end Solutions Must Work in Tandem

Front-end: Enhance and Standardize the Legal Framework

- Redefine Eligibility and Commitment Thresholds: States should expand statutory language to explicitly include SUD as qualifying grounds for ICC, addressing the current gap created by limitations that restrict eligibility to SMI in certain jurisdictions. Additionally, existing ICC statutes often require an individual to present an "imminent threat" to self or others—a standard that can prevent timely intervention for individuals with SUD who may not be in a state of acute crisis but are nonetheless in a deteriorating condition. To ensure more timely and effective intervention, states should adopt broader definitions of dangerousness or grave disability, accounting explicitly for the chronic, escalating nature of SUD, such as repeated overdoses, evident functional decline, or significant self-neglect risks. This expanded approach aligns with recent reforms in states like Kentucky, which now recognizes potential future harm as legitimate grounds for ICC, facilitating earlier, proactive care interventions.

- Expand Petition Authority and Simplify Procedures: As demonstrated by *Casey's Law* in Kentucky and similar legislation in Ohio, allowing a wider pool of petitioners—such as family members, physicians, and mental health professionals—to initiate ICC can facilitate earlier intervention. Simplified court procedures reduce bureaucratic hurdles, encourage families to seek help, and ensure that medical evaluations and hearing schedules move swiftly. States pursuing reform must also provide accessible legal guidance for families, especially those unfamiliar with the court system.

- Promote Judicial and Law Enforcement Training: Effective ICC implementation depends on a judiciary and law enforcement workforce trained in both the legal dimensions of ICC and the clinical realities of SUD. Evidence from interviews in Wisconsin and California reveals that judges may hesitate to commit individuals unless they are assured adequate treatment resources exist. Law enforcement officers, if properly trained in CIT and de-escalation techniques, can better distinguish between criminal behavior and health crises. Expanded, standardized training curricula should also address racial and cultural biases that disproportionately affect individuals of color.

- Ensure Safeguards for Civil Liberties: While states broaden ICC eligibility to include SUD, patient rights must remain foremost. ICC frameworks should guarantee a right to counsel, periodic judicial reviews, and a clear path to appeal. Written notifications of hearings, opportunities to cross-examine witnesses, and requirements for expert testimony protect against potential abuses of power. Codifying these measures in each state's statute preserves public trust and ensures the law remains grounded in due process.

Back-end: Bolster the Healthcare Continuum

- Invest in Treatment Capacity and Infrastructure: A critical shortcoming in many states is the mismatch between ICC eligibility expansions and the availability of inpatient beds, community treatment centers, and trained healthcare professionals. ICC reforms must be paired with funding for additional inpatient and outpatient services, ensuring that every court-ordered individual can be matched with a suitable program. As highlighted in the California CARE Act discussions, insufficient bed capacity risks displacing voluntary patients or leaving individuals on waitlists, nullifying ICC's immediate benefits.

- Adopt a Continuum of Care Model: ICC functions best when it serves as a catalyst for long-term recovery rather than a short-term solution. States should require that all individuals leaving court-mandated inpatient treatment transition to structured step-down services, such as outpatient counseling, ACT, or supportive housing. This model reduces the risk of relapse by ensuring care continuity. Establishing "bridge clinics," which integrate mental health services, MAT, and peer support, can significantly improve outcomes in the vulnerable post-discharge period.

- Expand Certified Community Behavioral Health Clinics (CCBHCs): Literature review from Kentucky, Massachusetts, and Ohio underscore the importance of facilities equipped to treat co-occurring mental illness and SUD in a single setting. The CCBHC model fulfills this need by offering 24/7 crisis care, MAT, and wraparound services that address psychosocial determinants of health (e.g., housing, employment training, and family counseling). States should leverage federal grants from SAMHSA and established planning grants to expand the CCBHC network.

- Integrate Peer Support and Family Engagement: ICC's effectiveness can be undermined if the individual perceives the process as coercive, adversarial, or isolating. Integrating peer specialists—people with lived experiences of SUD—into treatment plans can improve therapeutic alliance and adherence to recovery protocols. Family involvement, when framed as a supportive rather than adversarial element, can also lessen shame or distrust in legal proceedings. Structured family therapy, psychoeducation, and support groups should be incorporated into post-discharge requirements.

Advance Sustainable Financing and Workforce Investments

- Allocate State Budgets and Leverage Federal Programs: Reforming ICC laws and expanding treatment infrastructure requires substantial financial commitment. States must not rely solely on federal grants or block funding; rather, they should integrate ICC-related expenses and expanded treatment services into long-term budget plans. Initiatives such as Medicaid waivers, state innovation funds, or public-private partnerships can bolster financial stability for newly established clinics and inpatient facilities.

- Explore Cost-Sharing Mechanisms: Many families express concerns about prohibitive treatment costs. Policymakers should explore cost-sharing measures, such as sliding-scale fees, local levy supports, and philanthropic contributions, to reduce out-of-pocket burdens.

Additionally, states can collaborate with private insurers to create specialized ICC payment models, ensuring that coverage extends to mandated inpatient stays and continuous outpatient aftercare.

- Facilitate Workforce Development: Even if states invest in expanded bed capacity, the impact is limited without a robust workforce of psychiatrists, addiction specialists, social workers, and peer counselors. By offering scholarships, loan forgiveness programs, and competitive compensation packages, states can attract new providers to underserved regions. This strategy also includes ongoing training on evidence-based approaches to SUD treatment and cultural competency to address the nuanced needs of diverse communities.

Implementation and Interim Strategies

Successful implementation should begin with targeted investments in healthcare infrastructure and workforce capacity prior to or concurrently with legal reform efforts. States should adopt a phased approach, initially ensuring adequate psychiatric bed capacity, expanding outpatient services, and bolstering workforce training programs, followed by comprehensive updates to statutory language for ICC. If immediate infrastructure development is not feasible, states can introduce intermediary solutions like involuntary outpatient commitment (IOC) or AOT, which can serve as bridges to more robust treatment systems without exacerbating resource limitations or leaving patients worse off. IOC or AOT models provide mandated care in community-based settings, reducing the strain on inpatient facilities and enabling early intervention before patients reach acute crisis states.

As legal reforms proceed state-by-state, policymakers must continually assess implementation outcomes and resource availability, adjusting statutory language and infrastructure investment accordingly. Ongoing monitoring will allow for incremental adjustments, ensuring patients do not face deteriorating care due to premature legal changes without adequate service capacity. Temporary innovations, such as telehealth services, mobile crisis units, and bridge clinics, can also provide immediate relief and care continuity during transitional periods. This approach offers flexibility to ensure continuous refinement and responsiveness based on real-time data and emerging best practices.

Closing Statement

A state-agnostic approach to ICC reforms requires coordinated action across legislative, judicial, and healthcare systems. By modernizing legal frameworks to allow earlier, more flexible intervention and simultaneously strengthening the continuum of care to promote sustained recovery, states can better address the ongoing SUD crisis. These recommendations—drawn from the literature review, case studies with data analysis, and stakeholder interviews—serve as a flexible blueprint that can be adapted to varying political climates and resource capacities. Ultimately, the success of any ICC legislation hinges upon an enduring commitment to evidence-based practices and robust investments in public health and treatment infrastructure. When properly implemented, inpatient ICC can serve as a bridge from crisis to stability for SUD—an intervention that not only saves lives in the immediate term but also lays the groundwork for meaningful, long-term recovery.

Appendix A – Interview Notes

Interview Summaries Are Edited for Length and Clarity

Interview: Family Advocates (Interview with members of ADMIRE, an advocacy organization for mental illness treatment reform), interview by Travis Reese, January 17, 2025.

Interview Results:

The interview highlights the challenges and experiences of families navigating ICC laws for SUD treatment. The main themes include the inadequacies of current laws and processes, the burdens on families, and the limited efficacy of treatment.

Key insights:

- Inefficiencies in ICC Laws: ICC laws are outdated and fail to address the needs of individuals who cannot recognize their need for care. The current threshold for involuntary commitment often leaves families struggling to secure appropriate help.
- Treatment Gaps: Short durations of in-patient care (30 days) are insufficient, and quality of care is often poor. Longer mandatory periods and improved continuity of care are crucial.
- Financial and Emotional Burden: Families face significant financial strain, as insurance often fails to cover the costs of court-ordered programs. The lack of adequate resources in mental health facilities exacerbates the issue.
- Legal and Cultural Implications: Families reported difficulty navigating ICC laws, compounded by systemic inefficiencies and cultural stigma around mental illness and substance use.
- Recommendations: Proposed reforms include expanding ICC durations to 180 days, redefining "imminent danger," involving families in the legal process, and addressing systemic issues in mental healthcare funding and access.

Flaws in the Current System

A. Police and Legal System Issues

- Law enforcement frequently criminalizes mental health crises instead of directing individuals toward treatment.
- Officers often defer to the criminal justice system rather than the mental health system due to frustration with the process.
- Commitment laws focus on “imminent danger” rather than prolonged mental instability, which leads to individuals being denied necessary treatment.

B. Shortcomings of Treatment Programs

- Inadequate duration of care: 30-day rehabilitation programs were deemed too short; 90-day stays with step-down support were recommended.
- Failure to enforce long-term outpatient commitments: Individuals were often stable after hospitalization but relapsed once their case management ended.
- Lack of coordination between crisis teams, courts, and medical professionals: This breakdown often resulted in people falling through the cracks.

Proposed Policy Reforms

A. Legal Reforms

- Extend the look-back period for involuntary commitment petitions:
  - Current law requires documentation of a "recent act" (within 30 days), but advocates propose a 180-day period to account for long-term patterns of deterioration.
- Shift from "imminent danger" to a broader standard:
  - A new standard should focus on whether a person is in "severe psychosis" or a "dire need of crisis intervention."
- Reduce the number of required petitioners:
  - Wisconsin's three-party petition process is too difficult to meet. It should be reduced to two parties.
- Mandate private hospitals to accept involuntary patients:
  - Many hospitals have closed psychiatric units, reducing the number of available involuntary commitment beds.
- Ensure continued outpatient commitment enforcement:
  - Without consistent monitoring, individuals quickly relapse.

B. Criminal Justice & Law Enforcement Reforms

- Stop criminalizing mental illness:
  - Many officers divert individuals to jail rather than treatment due to systemic inefficiencies.
- Improve Crisis Intervention Training (CIT) for police:
  - While some officers want to help, others see the mental health system as a revolving door and prefer punitive solutions.
- Create specialized teams to handle mental health crises instead of relying on police.

Interview: Person with Lived Experience (Interview with an individual with severe mental illness and substance use disorder), interview by Travis Reese, January 20, 2025.

Interview Results: The interview provides insights into the respondent's perspective on the effectiveness, challenges, and necessary reforms for ICC laws addressing SUD. Key themes include the failures of current systems, the critical role of stigma reduction, and the need for a holistic, patient-centered approach.

Key Insights:

- State-Level Success and Current Gaps:
  - Current systems rely heavily on the criminal justice model, which exacerbates stigma and trauma for individuals with serious mental health and substance use disorders.
  - Punitive measures, such as incarceration in local jails, worsen outcomes and create additional barriers to recovery.

- Measuring Treatment Effectiveness:
  - Effectiveness should be assessed through medical evaluation, treatment adherence, and the individual's ability to manage their disorders post-treatment.

- The ACT (Assertive Community Treatment) model, originating in Wisconsin, is highlighted as a successful approach.

- Financial and Operational Challenges:
  - Financial burdens include inadequate insurance coverage, underfunded state programs, and lack of sufficient data to guide resource allocation.
  - Generational poverty and systemic inequities are key drivers of poor outcomes.

- Cultural Barriers and Stigma:
  - Widespread stigma and ignorance about mental health and substance use contribute to resistance to reforms and effective treatment.
  - Public education campaigns are necessary to shift perceptions and reduce blame placed on individuals.

- Best Practices and Support:
  - Peer support from the start of treatment and ongoing family involvement are vital.
  - A team-based approach, incorporating medical professionals, family, and peers, enhances outcomes.

- Ethical Considerations:
  - Clinically supported, patient-centered decisions are essential to protect individuals' rights while ensuring public safety.
  - Current systems often pit families against loved ones, creating adversarial dynamics.

- Recommended Reforms:
  - Extend federal, state, and local funding based on data-driven needs.
  - Shift focus from punishment to healing, ensuring ICC laws are led by medical professionals with legal support where necessary.
  - Address root causes such as poverty and systemic inequities that contribute to chronic mental health and substance use disorders.

- Role of Family and Community Support:
  - Family support systems are critical but must be complemented by peer support to reduce the adversarial nature of civil commitment.
  - Holistic approaches that involve families as allies, rather than adversaries, are key to success.

- Barriers to Reform:
  - The biggest obstacle is societal ignorance and resistance to change, coupled with the for-profit nature of the healthcare system.
  - Misaligned incentives and a lack of empathy for individuals in need of care perpetuate systemic failures.

- Unintended Consequences:

- Civil commitment often results in punitive outcomes that traumatize individuals further and create long-term barriers to recovery.

Highlights for Consideration:

- Peer and Family Support: Integrating these into treatment plans from the start improves outcomes and reduces stigma.
- Holistic Approaches: Emphasizing healing over punishment is essential to reforming ICC laws.
- Systemic Reform: Addressing funding gaps, cultural stigma, and systemic inequities will require comprehensive and collaborative solutions.
- Justice System Integration: Mental health and substance use courts presided over by medical experts, not solely legal professionals, are crucial.

Interview: CA Superior Court Judge #1 (Interview with a judge from a Superior Court), interview by Travis Reese, January 23, 2025.

Interview Results:

- Legal Criteria for Involuntary Civil Commitment
    - California law requires proving grave disability for involuntary commitment.
    - Previous criteria: Inability to provide for food, clothing, or shelter.
    - Recent reforms: Expanded criteria to include inability to provide for personal safety and inability to access healthcare.
    - The standard of proof is beyond a reasonable doubt, making it a high bar.

- Connection Between Substance Use Disorder and Mental Illness
    - Rarely sees individuals with only substance use disorder (SUD); usually, SUD is secondary to mental illness.
    - Common co-occurring conditions include schizophrenia, schizoaffective disorder, bipolar disorder, and PTSD.
    - Many individuals use substances as self-medication for underlying conditions.

- Decision-Making Considerations for Commitment
    - Judges assess cases based on the new criteria, particularly personal safety and healthcare access.
    - Common fact patterns justifying commitment:
        - Risky behaviors (e.g., running into traffic).
        - Severe medical neglect (e.g., repeated infections leading to amputations).
        - The urban setting of San Francisco exacerbates dangers.

- Impact of Recent State-Level Reforms
    - Broadening the criteria for grave disability led to an increase in filings for involuntary commitment.
    - Doctors now have stronger legal grounds to justify these filings.

    - Some cases do not make it to court because there are no available treatment beds, limiting real-world impact.

- Effectiveness and Limitations of Involuntary Commitment
    - Positive outcomes:
        - Individuals receive housing, medical treatment, and stability.
        - Some improve significantly, even agreeing to extend their commitment.
        - Better environments (away from drug-using areas) improve success rates.
    - Challenges and limitations:
        - Addiction is persistent and difficult to treat.
        - Even "successful" programs have low success rates (often around 10-20%).
        - Relapse rates remain high, and long-term effectiveness is uncertain.

- Financial and Resource Constraints
    - Severe shortage of treatment beds in California.
    - Doctors sometimes don't file commitment petitions due to lack of placement options.
    - The demand for treatment outpaces availability, leading to hidden crises.
    - Public frustration: Citizens want treatment on demand, but there's no infrastructure to support it.
    - Lack of political will to allocate necessary funding for beds, facilities, and staff.

- Civil Liberties vs. Public Safety
    - Strong resistance from civil liberties advocates against expanding involuntary commitment.
    - Judge argues that the current hands-off approach leads to tragic consequences, such as:
        - Repeated amputations due to untreated infections.
        - Deaths from overdoses and exposure.
        - Suggests a need to shift the legal threshold to intervene earlier.

- Cultural and Societal Influences
    - San Francisco's permissive drug culture makes intervention more challenging.
    - Some individuals relocate to SF for its lenient policies on drug use.
    - Historically, SF has had a more tolerant approach to drug use (dating back to the 1960s counterculture).

- Role of Family and Support Systems
    - Family support is rare in involuntary commitment cases.
    - When present, family involvement significantly improves outcomes.
    - Some individuals stabilized through commitment can return home and reintegrate.

- Proposed Reforms and Policy Considerations
    - Increase the number of treatment beds and resources.
    - Expand involuntary hold durations (e.g., a new category for SUD holds, like mental health holds).

        - (e.g., beyond the 72-hour threshold for mental health crises).
    - Create waitlists to expose system failures rather than allowing untreated cases to slip through the cracks.
    - Consider a "middle ground" approach where individuals are involuntarily stabilized before being released.

Interview: Academic Psychiatrist (Interview with a professor specializing in psychiatry and behavioral sciences), interview by Travis Reese, January 27, 2025.

Interview Results:

- Historical Context of Civil Commitment
    - Mid-20th century: Asylum-based care dominated, with approximately half a million individuals in state mental hospitals.
    - Deinstitutionalization began due to:
        - Development of pharmacotherapies.
        - Sociological critiques of institutions.
        - Emphasis on individual civil rights.
    - The expectation of community care systems to replace asylums was largely unmet due to lack of investment.

- Civil Commitment Reforms
    - 1970s reforms introduced stringent criteria for involuntary commitment, requiring imminent risk of harm to self or others and court oversight.
    - Some states, like New York, are expanding criteria to include "grave disablement," allowing commitment based on inability to meet basic needs.
    - Civil commitment systems vary significantly across states, influenced by local statutes, judicial discretion, and advocacy.

- Challenges in Addressing Substance Use Disorders (SUDs)
    - SUDs often coexist with mental illnesses, complicating treatment and policy implementation.
    - Public attitudes and stigma toward substance use and mental illness remain significant barriers.
    - The bifurcated treatment culture (mental health vs. substance abuse treatment) exacerbates service fragmentation.

- Effectiveness of Involuntary Civil Commitment
    - Can be effective if implemented within a well-funded, integrated system of care.
    - Key conditions for success include:
        - Adequate psychiatric beds.
        - Community-based intensive services.
        - Long-term follow-up and support.
    - Randomized trials, like those conducted in North Carolina, show positive outcomes for individuals receiving sustained outpatient treatment orders.

    - Approximately 27% of participants retrospectively endorsed their civil commitment experience as beneficial.

- Barriers to Reform
    - Workforce shortages limit treatment capacity, rendering court orders ineffective in under-resourced areas.
    - Ethical concerns around autonomy and potential trauma from coercive interventions.
    - Disparities in resource allocation can lead to unintended consequences, such as extended wait times for others needing care.

- Unintended Consequences
    - Individuals may experience trauma from the civil commitment process, especially if poorly handled (e.g., police transportation or physical restraints).
    - System-level effects include resource diversion during program rollouts, initially disadvantaging non-committed individuals.
    - Long-term systemic equilibrium may eventually improve overall capacity and access.

- Future Directions and Considerations
    - Significant investment in public behavioral health systems is critical.
    - Legal tools should target the small subset of individuals unlikely to access treatment otherwise.
    - Ethical debates around balancing public safety and individual rights must guide policy reforms.
    - Public education on mental illness and substance use is necessary to reduce stigma and align public attitudes with evidence-based practices.

Interview: Crisis Services Psychiatrist (Interview with a medical director for crisis services), interview by Travis Reese, February 10, 2025.

Interview Results:

The psychiatrist emphasizes that involuntary civil commitment is primarily a life-saving intervention rather than a long-term treatment solution. They liken it to resuscitating a heart attack victim—it stabilizes them in the moment but does not necessarily lead to long-term health improvements. There is limited data supporting the effectiveness of involuntary commitment in reducing long-term substance use, although some states have implemented involuntary outpatient treatment models that have shown promise in managing chronic mental illnesses. A major concern is that involuntary care may exacerbate feelings of helplessness and powerlessness in individuals with SUD, potentially leading to increased substance use rather than reduced use.

- Measuring Treatment Outcomes
    - Traditional metrics like readmission rates, self-harming behaviors, and suicidal ideation are commonly used to assess effectiveness.

- Reduction in substance use, rather than complete abstinence, is increasingly recognized as a meaningful success metric.
- A 50% to 75% reduction in usage can have significant public health benefits.
- Many treatment models have historically focused on binary abstinence goals (e.g., counting "days sober"), which can be discouraging for individuals who struggle with relapses.

- Best Practices for Involuntary Treatment
  - Restoring autonomy: Despite the involuntary nature of treatment, the doctor stresses that patients should feel in control of their care as much as possible.
  - A collaborative rather than punitive approach is key. Instead of treating involuntary commitment as a disciplinary action (e.g., "If you don't comply, you're going to jail"), it should be framed as an opportunity for stabilization and support.
  - The goal should always be to transition a patient from involuntary to voluntary treatment as quickly as possible.

- Ethical Considerations & Civil Liberties
  - Balancing patient rights with public health needs remains a major ethical challenge.
  - Involuntary treatment inherently involves a conflict between autonomy and beneficence (doing good for the patient).
  - A scarcity of resources exacerbates ethical dilemmas—forcing a patient into treatment may inadvertently take a bed away from someone who is voluntarily seeking care.
  - Systemic disparities in insurance coverage further complicate access to care, with voluntary treatment often being underfunded.

- Financial & Operational Challenges
  - Severe shortages in psychiatric beds: The Treatment Advocacy Center recommends 60 beds per 100,000 people, but some states, like Wisconsin, have as few as 8-9 beds per 100,000.
  - There is limited financial incentive for hospitals to provide inpatient psychiatric care, leading to a shift toward public sector and academic hospitals managing the burden.
  - Many private hospitals outsource psychiatric care, reinforcing a fragmented system where mental health and addiction treatment are disconnected from general healthcare services.
  - For-profit psychiatric hospitals (Institutes of Mental Disease – IMDs) are often the only available treatment option but may not be well-integrated with broader healthcare networks.

- Law Enforcement & Criminal Justice Intersection
  - Law enforcement is often unavoidably involved in involuntary civil commitment because they are the only profession trained, authorized, and legally protected to use force in these situations.
  - There has been a movement to reduce police involvement in mental health crises, but as long as involuntary holds exist, law enforcement will likely remain involved.

    - Potential for traumatization: Individuals with SUD, particularly from marginalized backgrounds, may have negative past experiences with police, making involuntary commitment even more distressing.
    - Even if law enforcement officers are well-trained, their mere presence can escalate situations and deter future engagement with healthcare providers.

- Policy Reforms to Improve Outcomes
    - Prioritizing investment in voluntary treatment options:
        - More outpatient, incentive-based, and integrated care models should be funded.
        - Address the lack of adolescent treatment programs, which often leads youth with substance use issues into the juvenile justice system rather than healthcare settings.
    - Link involuntary commitment to long-term care pathways:
        - If a state expands involuntary commitment laws, it must also invest in post-treatment services, including case management and housing support.
    - Shift the narrative on addiction treatment:
        - Addiction should be viewed as a chronic condition like diabetes or hypertension, requiring lifelong management, rather than an acute issue resolved through short-term inpatient stays.

- Unintended Consequences of Involuntary Commitment
    - Loss of trust in the healthcare system:
        - Even if legally justified, involuntary commitment can alienate patients from future care.
        - Many individuals refuse treatment for years following a negative involuntary commitment experience.
    - Strain on healthcare resources:
        - Forcing individuals into treatment may divert resources away from those actively seeking help.
        - Some hospitals prioritize involuntary patients because they have a guaranteed payer (e.g., Medicaid or court-ordered funding), creating access disparities for voluntary patients.
    - Criminalization of substance use:
        - Without adequate healthcare investment, many individuals end up in the criminal justice system rather than receiving appropriate treatment.
        - Juvenile offenders with SUD often never receive formal treatment, cycling in and out of detention instead.

- Final Thoughts
    - Family perspectives must be acknowledged, as loved ones often push for involuntary commitment out of desperation.
    - However, a purely coercive approach may not yield the best long-term outcomes.
    - The goal should be to create a continuum of care, where involuntary treatment is used sparingly and only as a bridge to sustainable, voluntary engagement in recovery.

- Conclusion
    - The doctor's insights highlight the complexity of involuntary civil commitment as a policy tool for addressing substance use disorder. While it serves an essential life-saving role, it is not a comprehensive solution. Instead, a balanced approach—one that prioritizes voluntary, long-term treatment and minimizes law enforcement involvement—is crucial for improving outcomes. Policymakers must ensure that any expansion of involuntary commitment laws is paired with substantial investments in community-based services to prevent unintended consequences.

Interview: Advocate for Psychiatric and Drug Reform (Interview with the founder of a grassroots mental health advocacy organization), interview by Travis Reese, January 28, 2025.

Interview Results:

- State-Level Reforms & Data Limitations
    - There is limited data on the effectiveness of involuntary commitment in treating substance use disorder due to poor tracking of post-commitment outcomes.
    - States often fail to collect data on individuals who need treatment but do not meet involuntary commitment criteria, leading to an incomplete understanding of system failures.

- Bed Capacity as a Core Issue
    - Success in treating individuals involuntarily committed depends on adequate bed capacity, which includes both physical space and proper staffing.
    - The U.S. has shifted resources away from civil commitment beds to forensic beds (jail/prison settings), exacerbating the crisis.
    - TAC's "Prevention Over Punishment" report provides a comprehensive review of national bed capacity and highlights the shift away from treatment facilities toward incarceration.

- Measuring Treatment Effectiveness
    - Success should be measured not only by tracking individuals who receive care but also by assessing the outcomes of those who are denied treatment due to legal or systemic barriers.
    - Unmet treatment needs lead to higher rates of homelessness, incarceration, suicide, and homicide.

- Financial & Operational Challenges
    - Many states bill individuals after involuntary commitment, creating an added burden.
    - A shortage of public defenders has resulted in individuals being released from hospitals without treatment because they cannot be legally represented.

    - Some hospitals deny care based on behaviors that qualify individuals for involuntary commitment, creating a contradictory system where the sickest are turned away.

- Stigma, Cultural Barriers & Disparities
    - Patients experiencing psychotic disorders with violent symptoms are often criminalized rather than treated, with racial disparities further exacerbating outcomes.
    - A person of color experiencing a psychiatric crisis is more likely to be incarcerated or killed rather than receive treatment.
    - There is a bias in the system, where patients who are "likable" and have good insurance are more likely to receive extended treatment.

- Best Practices for Involuntary Treatment
    - Motivational Interviewing: A technique that helps individuals recognize the benefits of treatment rather than forcing them to acknowledge their diagnosis.
    - Anosognosia Awareness: Many individuals with psychotic disorders lack insight into their condition, making traditional psychoeducation ineffective.
    - Thoughtful Discharge Planning: Ensuring patients have safe housing, medication, and follow-up care rather than being sent to homeless shelters or jails.
    - Family Engagement: HIPAA is often misapplied, preventing family members from being involved in care planning.
    - Adequate Staff Training: Many psychiatric facilities are ill-equipped to handle patients with severe psychotic symptoms, leading to unnecessary criminalization.

- Legal & Policy Reforms Needed
    - Shift from a "Dangerousness" Standard to a "Medical Need" Standard:
        - Current laws prioritize intervention only when someone is overtly dangerous, leading to delayed treatment.
        - A reformed system should intervene based on psychiatric deterioration rather than waiting for crises.
    - Expanded Psychiatric Advance Directives:
        - Many states do not honor psychiatric advance directives, which allow individuals to consent to future treatment while they are still well.
    - Investment in Outpatient & Community-Based Care:
        - Certified Community Behavioral Health Centers (CCBHCs) provide an ideal model for integrated care, but funding is uncertain.
    - Insurance Parity Enforcement:
        - Despite laws mandating equal insurance coverage for mental health care, enforcement remains weak.
    - Anti-NIMBYism Advocacy:
        - Resistance to mental health facilities in communities ("Not in My Backyard" attitudes) hinders access to essential services.

- Economic Justification for Reform

- The cost of doing nothing is estimated at $500 billion per year in the U.S. due to the economic impact of homelessness, incarceration, and emergency healthcare.
- Investing in mental health treatment is likely more cost-effective than continuing the current reactive system.

- Final Thoughts & Next Steps
  - Advocate emphasized the need for systemic reforms that prioritize treatment over punishment and eliminate the bureaucratic barriers that prevent individuals from accessing care.
  - They expressed interest in reviewing the final thesis, particularly the cost analysis on the economic impact of inaction, for use in advocacy efforts.
  - Future research should examine how legal reforms in states like California and New York impact treatment accessibility and patient outcomes.

Interview: Court Clerk (Interview with a court clerk assisting in mental health and drug court cases), interview by Travis Reese, January 28, 2025.

Interview Results:

- Legal Framework for Involuntary Commitment in Oregon
  - Oregon law does not allow involuntary civil commitment for substance use disorder (SUD). The commitment process is strictly for individuals with severe mental illness (SMI) who meet one of the three criteria:
    - Danger to self
    - Danger to others
    - Unable to meet basic needs
  - The statute governing civil commitments in Oregon is outdated and has not been revised through multiple editions of the *Diagnostic and Statistical Manual of Mental Disorders (DSM)*.
  - Case law in Oregon reinforces the prohibition of civil commitment for substance use disorder, even though the current DSM includes SUD as a recognized condition.

- Challenges and Limitations in Current System
  - Lack of State-Level Reforms:
    - Clerk is part of *Commitment to Change*, a workgroup drafting recommendations for reforming the civil commitment process. However, he acknowledges that legislative changes will take years and may not reflect stakeholder consensus.
  - Inconsistent Implementation:
    - Oregon's commitment process varies by county; some counties have only a few commitment hearings per year, while Multnomah County has approximately 10 per week.
    - Statutory requirements, such as mandated pre-hearing patient evaluations, are often not followed in practice.
  - Systemic Bottlenecks:

        - The commitment process allows only five days from mental health hold to court hearing, leaving little time for investigation or witness testimony.
        - The average length of stay after commitment is only 3-4 weeks, despite a formal commitment order lasting up to 180 days.

- Role of the Courts and Judges
    - Judicial Constraints:
        - Judges are bound by strict legal definitions, which often prevent commitment even for individuals who lack the capacity to make rational decisions about their treatment.
        - The current system prioritizes individual rights over public safety or long-term care, often leading to the release of individuals who remain highly vulnerable.
    - Alternative Pathways:
        - While civil commitment for SUD is not allowed, Oregon offers drug treatment courts where individuals facing criminal charges can opt for inpatient treatment instead of jail.
        - Clerk emphasized that courts try to steer individuals with dual diagnoses (SMI + SUD) into mental health courts or drug treatment courts based on severity.

- Stakeholder Perspectives and Conflicts
    - Divergent Interests:
        - *Disability Rights Oregon* (which represents patients) strongly opposes expanded commitment powers.
        - *Families of individuals with severe mental illness* advocate for more involuntary commitment options, often pushing for commitment based solely on family testimony.
        - *Law enforcement and district attorneys* focus on public safety concerns related to untreated mental illness.

- Impact of Family Involvement:
    - Some families provide crucial support, while others financially exploit or enable the individual's condition.
    - Families sometimes resist hospitalization due to stigma or cultural beliefs about mental illness.
    - Courts struggle with cases where families over-support individuals, preventing them from hitting crisis points necessary for intervention.

- Effectiveness of Involuntary Commitment
    - Mixed Results:
        - Clerk noted a high rate of recidivism, with many individuals cycling through the commitment system repeatedly.
        - Patients often resist medication due to severe side effects (e.g., tardive dyskinesia, diabetes, dementia), reducing long-term adherence.

        - Psychiatric wards are not therapeutic environments; the distressing conditions can exacerbate symptoms.
    - Lack of Resources:
        - Oregon lacks sufficient inpatient beds for those requiring long-term care.
        - The closure of multiple psychiatric wards in Portland to create *Unity*, a centralized psychiatric hospital, resulted in a net loss of 20 beds, worsening the mental health crisis.
        - Many individuals fail out of supportive housing due to severe behaviors, leaving them homeless.

- Proposed Reforms and Future Directions
    - Introduction of a "Middle Ground" Approach:
        - The *Commitment to Change* report recommends implementing court-ordered outpatient treatment as an intermediate step before full commitment.
        - This approach would require individuals to engage in community-based treatment, with commitment consequently for noncompliance.
    - Financial Considerations:
        - Involuntary commitment costs are typically covered by private insurance or state funding, so financial barriers are not a major legal consideration.
        - However, the system lacks funding to expand treatment programs, leading to bottlenecks.
    - Cultural and Societal Challenges:
        - Social stigma prevents individuals from acknowledging mental illness.
        - Patients are more willing to admit to having depression or anxiety but avoid diagnoses like schizophrenia due to fear of labeling.
        - Courts often work around this by negotiating alternative diagnoses with patients.

- Substance Use Disorder and Commitment Barriers
    - Definitional Challenge:
        - Defense attorneys frequently argue that symptoms of psychosis are drug-induced, making it difficult to distinguish between SUD and underlying mental illness.
        - Psychiatrists struggle to prove whether an individual's mental state is due to chronic mental illness or temporary drug effects.
    - Current Handling in Oregon:
        - SUD cases are redirected to drug treatment courts or mental health courts.
        - The judicial system does not recognize SUD as a stand-alone basis for commitment.
    - Potential for Reform:
        - Clerk suggests that steering individuals into specialized courts (drug treatment or mental health) based on their needs is currently the most effective approach.

Interview: CA Superior Court Judge #2 (Interview with a judge from a Superior Court), interview by Travis Reese, February 6, 2025.

Interview Results:

- Criteria for Involuntary Civil Commitment Decisions
    - Legal standard: Individuals can be conserved if they cannot provide for their own:
        - Food
        - Clothing
        - Shelter
        - Personal safety
        - Necessary medical care
    - Commitment must be due to mental health disorder or substance use disorder (SUD).
    - Primary consideration: Personal safety, followed by the inability to meet basic needs.

- California's Reforms and Legal Mechanisms
    - Recent reforms:
        - CARE Court: Not truly involuntary, requires participant agreement.
        - LPS Conservatorships: Primary legal mechanism for involuntary treatment, allowing individuals to be placed in locked facilities.
    - Key components of LPS Conservatorships:
        - No access to narcotics while in treatment.
        - Medication can be administered involuntarily if the individual lacks the capacity to consent.

- Effectiveness of Involuntary Commitment for SUD
    - Success is difficult to measure due to frequent relapse cycles:
        - Some individuals show improvement in self-care abilities (basic needs).
        - Many relapses after release.
        - Follow-up tracking is limited, making long-term effectiveness unclear.
        - Public health programs try to track individuals and continue treatment interventions.
        - Certain cases do not make it to court due to lack of resources

- Balancing Individual Rights vs. Need for Treatment
    - Difficult legal balance:
        - Court intervention is necessary when an individual is incapacitated and cannot ensure their safety.
        - Families often advocate for involuntary commitment, but many individuals lack family support.
        - Decisions rely heavily on medical reports and legal considerations.

- Patterns in Outcomes (Positive & Negative)
    - Negative Outcomes:

        - Individuals may physically resist treatment.
        - Some reject medication, including long-acting injections.
        - Forced administration of medication is sometimes required.
    - Positive Outcomes:
        - Some improvement in self-care ability.
        - A "victory" is when a conservatorship is not renewed because the individual is doing well.
        - No clear evidence of complete recovery due to lack of follow-up data.

- Challenges in Enforcing Involuntary Civil Commitment
    - Main Challenge: Convincing individuals they need treatment.
        - Many refuse to acknowledge their substance use disorder.
        - Ensuring continuation of treatment post-release (e.g., Suboxone, methadone).

- Financial Implications:
    - Not a major issue in San Francisco due to public funding.
    - Insurance (Medicaid/Medi-Cal) may affect treatment quality but not access.
    - Resources are generally available.

- Potential Policy Reforms
    - Increasing referrals into the system:
        - Many homeless individuals with SUD lack access to treatment.
        - Public education about conservatorships and CARE Courts could help.
    - Reevaluating the definition of "danger to self or others":
        - Current threshold: "Imminent danger" (72-hour hold)
    - Proposed reforms in other states:
        - Extending commitment periods beyond 30 days (e.g., 75-day holds).
        - Expanding who can petition for commitment (e.g., family members).
        - Including alcoholism and SUD in commitment criteria (not all states allow this).

- California's structure:
    - Maximum 30-day involuntary hold unless extended through temporary or general conservatorship.
    - General conservatorship can last a year but does not always require confinement.

- Accessibility of the Involuntary Commitment Process
    - Not easily navigable for the average person.
    - A lawyer is often necessary.
    - Hospitals and healthcare providers initiate most petitions.
    - Family members rarely initiate the process, although they technically can.

- Role of Family Support
    - Varies widely:
        - Supportive families help treatment outcomes.

        - Some individuals reject family involvement due to resentment.
        - Some families are too traumatized and cut ties to protect themselves financially and emotionally.

- Biggest Barrier to Reform
    - Strong advocacy groups protecting individual civil rights:
        - Legal and nonprofit organizations challenge involuntary treatment efforts.
        - Balancing constitutional rights vs. public safety and treatment necessity is a major policy conflict.
        - In California, this advocacy is especially strong compared to other states

- Final Reflections
    - Importance of treating co-occurring disorders:
        - Many individuals with severe mental illness (e.g., schizophrenia) self-medicate with drugs.
        - Effective SUD treatment must address mental illness simultaneously.

Interview: Health Economist (Interview with a professor specializing in health economics and mental health policy), interview by Travis Reese, February 4, 2025.

Interview Results:

- Background and Expertise
    - The doctor has worked extensively on health insurance coverage for substance abuse treatment.
    - Their knowledge primarily pertains to the financial and insurance aspects of involuntary civil commitment rather than direct policy evaluation.

- Financial Considerations and Insurance Challenges
    - Coverage and Payment Dynamics:
        - Health insurance plays a limited role in many involuntary civil commitment cases.
        - Insurance coverage for substance abuse treatment has evolved significantly:
            - 1970s-80s: Minimal coverage for inpatient mental health and substance abuse treatment.
            - Later years: Introduction of parity laws requiring equal coverage for substance abuse and mental health.
            - Present-day: While coverage has improved, access remains a major issue due to managed care restrictions.

- Economic Structure in Treatment:
    - The demand side (patient coverage and eligibility).
    - The supply side (provider compensation and resource availability).
    - Insurers often restrict access via managed care policies and unattractive provider payment structures.
    - This results in a paradox: better coverage does not always mean better access.

- Supply-Side Constraints: The Bed Capacity and Resource Problem
    - Involuntary Commitment as a Demand Generator:
        - Increases demand for substance abuse treatment.
        - Creates legal obligations on providers to accept patients.
    - Bed and Provider Shortages:
        - Many states face severe limitations in available treatment beds and professionals.
        - Commitment orders do not automatically create additional capacity, leading to displacement of voluntary patients.
    - Opportunity Cost of Commitment:
        - Every involuntary patient admitted may result in a voluntary patient being turned away.
        - The system must decide whether it is more beneficial to prioritize involuntary patients over those actively seeking treatment.

- Unintended Consequences of Involuntary Civil Commitment
    - Queue Jumping & Resource Displacement:
        - Those forced into treatment may displace voluntary patients who recognized their need for help.
        - Creates ethical and logistical dilemmas regarding how resources should be allocated.
    - Question of Effectiveness:
        - The long-term success of involuntary civil commitment remains uncertain.
        - Temporary removal from harmful situations is helpful, but does it lead to sustained recovery?
    - Cultural and Societal Challenges:
        - Many people oppose forced treatment on ethical and legal grounds.
        - However, some believe intervention is necessary for those who may not recognize their own need for treatment.

- Policy and Insurance Industry Resistance
    - Pushback from Insurance Providers:
        - Insurers resist government mandates requiring them to cover involuntary commitment services.
        - Mandated coverage increases overall healthcare costs, which insurers pass on via higher premiums.
    - State-Level Reforms and Challenges:
        - States like California and Kentucky have led in reform efforts.
        - Others, such as Wisconsin and Alabama, lag due to lack of investment in mental health infrastructure.
        - The effectiveness of reforms depends on both policy changes and resource allocation.

- Final Takeaways

- Effectiveness is key: If involuntary commitment does not improve long-term outcomes, then the resource cost may not be justified.
- The system must be holistic: Increasing involuntary commitments without addressing capacity constraints will not work.
- Financial realities matter: Policy must account for insurance coverage issues and provider compensation structures.
- Balance is critical: The decision to prioritize involuntary patients over voluntary patients has serious ethical and practical implications.

Appendix B – Questions Asked

Category	Interview Questions
Judges	What criteria do you consider most critical when deciding to order involuntary civil commitment for individuals with substance use disorders?
	Can you describe any state-level reforms in involuntary commitment laws that you believe have been effective in reducing substance use disorder in your jurisdiction?
	How do you assess the balance between individual rights and the need for treatment when making decisions about involuntary commitment?
	Have you observed any patterns in outcomes (positive or negative) when individuals are compelled into in-patient treatment under these laws?
	What are the financial implications you observe or anticipate from implementing and enforcing these state-level reforms?
	How do cultural factors, such as societal stigma or family involvement, influence your decision-making process regarding involuntary commitments?
	What are the main challenges you face when enforcing state-level reforms related to substance use disorder treatment through involuntary commitment?
	In your opinion, how could these reforms be improved to achieve better outcomes for individuals struggling with substance use disorders?
Previous Patiets and Families of Individuals with Substance Use Disorder	What were your or your family member's experiences with involuntary civil commitment laws and in-patient treatment for substance use disorder?
	Did you find the treatment effective, and what aspects of it were helpful or unhelpful?
	How did the involuntary nature of the commitment impact your (or your family member's) willingness to engage in treatment?
	Were you aware of the legal and cultural implications of the commitment before it occurred? How did they affect your decision-making and experience?
	What kind of support (emotional, financial, or informational) did you receive throughout the process?
	In your view, what changes could improve the effectiveness of involuntary commitment as a tool for addressing substance use disorders?
	How has the treatment or commitment affected your family dynamics or your relationship with the individual receiving treatment?
	What financial burdens, if any, did your family face due to the involuntary commitment process?
Mental Health & Addiction Professionals / Experts (e.g., Social Workers, Doctors, Researchers)	Based on your experience, what state-level reforms have shown the most success in reducing substance use disorder through involuntary civil commitment?
	How do you assess and measure the effectiveness of treatment outcomes for individuals compelled into in-patient care?
	What are the major financial and operational challenges associated with providing treatment under involuntary commitment laws? What have the overall costs been?
	How do you address the cultural barriers or stigma patients might face when they enter treatment involuntarily?
	What best practices have you found in working with patients who are mandated to receive in-patient treatment?
	Are there particular resources or support services that enhance the success of involuntary treatment programs?
	What are the ethical considerations you encounter when treating individuals who did not voluntarily choose to enter treatment?
	In your opinion, what reforms would improve the alignment between legal mandates and the healthcare system's ability to effectively treat individuals with substance use disorders?
Potential Generic Questions to be asked	In your experience, what are the key factors that determine the success or failure of involuntary civil commitment for substance use disorders?
	What changes or reforms do you believe could improve the effectiveness of involuntary civil commitment as a tool for addressing substance use disorders?
	How do financial considerations (e.g., costs of treatment, insurance coverage, state funding) impact the outcomes of involuntary commitments?
	What are the cultural or societal challenges you have observed when implementing or experiencing involuntary civil commitment laws?
	How effective do you believe current state-level laws are in addressing the needs of individuals with substance use disorders? Why or why not?
	From your perspective, what role do family support systems play in the effectiveness of involuntary in-patient treatment?
	What, if any, unintended consequences have you seen from involuntary civil commitment for substance use disorders?
	How do you think the stigma surrounding substance use and involuntary treatment affects the implementation and outcomes of these laws?
	Are there specific support services or programs that you believe enhance the success of involuntary commitment treatment?
	What do you think is the most significant barrier to implementing effective reforms for involuntary civil commitment related to substance use disorders?
	Is there anything else you would like to discuss or touch on that I did not ask or address?

Appendix C – Consent Statement

“Consent for Research Participation

Study Title: Reforming Involuntary Civil Commitment Laws for Individuals Suffering from SUD(s)

Researcher: Travis R. Reese
Affiliation: Duke University
Contact Information: travis.reese@duke.edu and 608-921-2661

Key Information
Purpose of the Study:
You are invited to participate in a research study aimed at understanding the potential impact of reforming involuntary civil commitment laws to compel individuals suffering from SUD(s) into in-patient treatment. The outcome goal of the study would be to develop state-agnostic policy reform recommendations to impact state by state policy making and reduce deaths caused by SUD(s).

Procedures:
If you agree to participate, you will take part in a one-on-one interview with me, lasting approximately 45 to 60 minutes. The interview will be conducted via Duke’s Zoom and AI transcription through Zoom will be utilized. You will be asked questions about your experiences and perspectives related to SUD(s), involuntary commitment, and treatment policies.

Confidentiality:
Your identity and the information you provide will remain confidential. I would like to audio-record the interviews to ensure transcription accuracy, but you may decline audio-recording, and I will take handwritten notes instead. I will remove all identifying information from the transcription, and only generalizations will be used in the final report. Your privacy will be protected throughout the research process by saving all research data in a protected Duke server.

Voluntary Participation:
Your participation is entirely voluntary. You may choose to skip any question or stop the interview at any time without any consequences. There will be no penalties for choosing not to participate, and you may withdraw from the study at any point.

Risks and Benefits:
Given the sensitive nature of the topics, you may feel emotional discomfort while discussing your experiences. Remember that your participation is completely voluntary. There are no direct benefits to you for participating in this research.

Contact Information:
If you have questions about the study or need further clarification, please contact me at travis.reese@duke.edu or 608-921-2661.

If you have any questions about your rights as a research participant, please contact the Duke University Campus Internal Review Board (IRB) at campusirb@duke.edu. If you contact the IRB, please reference protocol #2025-0204.

Consent Statement:
Do you consent to participate in this research interview?
Do you consent to me audio-recording this interview?”

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