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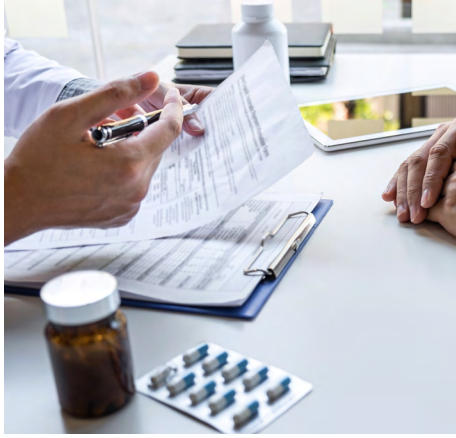


R Sheet On
Coercive Treatment for Drug Use

Background

About 40.3 million Americans have a substance use disorder (SUD). While treatment is not the only tool available to improve the health and well-being of people who use drugs (PWUD), it is the focus of many discussions on this topic. Treatment options differ depending on which drug(s) a person uses. For opioids, the primary driver of overdose deaths in recent years, treatment options include medically supervised withdrawal, 12-step programs, and medications for opioid use disorder (MOUD).

Medically supervised withdrawal and 12-step programs typically require strict abstinence, and evidence on their effectiveness is lacking compared to MOUD. MOUD, which includes methadone and buprenorphine, is an evidence-based, Food and Drug Administration-approved treatment for opioid use disorder. Compared to non-medication and abstinence-based treatment, MOUD improves retention, reduces illicit drug use, and lowers overdose risk.

Regardless of modality, accessing treatment is often challenging. Overall, the United States lacks sufficient drug treatment infrastructure. Treatment facilities often have insufficient capacity, and a person's insurance coverage can further limit their options. Regulatory and geographic factors can also limit access to MOUD. These factors, combined with individual readiness to enter treatment, result in only 13 percent of Americans with SUD receiving treatment each year. Because of the insufficient drug treatment infrastructure, people who are ready to enter treatment may not be able to access it.

Current Debate

Robert F. Kennedy Jr.'s confirmation as leader of the Department of Health and Human Services has sparked interest in involuntary or coercive forms of treatment. Kennedy has suggested implementing treatment "farms," described as camps or places where PWUD can go to recover either voluntarily or under pressure. Similarly, some argue that PWUD need external motivation to enter treatment. That external motivation can come from incarceration (or threat thereof) or civil commitment by medical professionals, family, friends, or law enforcement.

Presently, diversion programs offering treatment as an alternative to criminal charges are the most common form of coercive treatment. However, the evidence supporting long-term treatment and health outcomes is lacking.

Laws that allow civil commitment for SUDs have become more common in the past 25 years. Proponents argue that states have a moral imperative to aid people who are unable to help themselves and that civil commitment can save

Summary

- **Of people with substance use disorder, only 13 percent report receiving treatment each year.**
- **Recent statements by government officials highlight growing interest in more coercive mechanisms of getting people into treatment.**
- **Evidence supporting the effectiveness of coercive treatment mechanisms is lacking, and many proposed programs rely on treatment methods that are not evidence-based.**
- **The United States already lacks sufficient treatment resources for people accessing treatment voluntarily without adding people who enter treatment involuntarily.**
- **State and federal policymakers can increase treatment opportunities by modifying regulations on treatment providers and programs and decreasing insurance barriers.**

a person's life. But the evaluation of outcomes from involuntary treatment through civil commitment is limited, mixed, and not generalizable.

Those opposed to coercive treatment cite limited evidence as well as practical and ideological justifications. Arguments against the use of civil commitment for SUD treatment include the fact that it violates individuals' civil liberties and contradicts protections guaranteed by the 14th Amendment.

Another argument against civil commitment is that treatment infrastructure already lacks sufficient resources for people entering treatment voluntarily—meaning that an influx of involuntary entries would only overwhelm the system further. There are also state budgetary concerns about civil commitment. Finally, opponents raise concerns that the state or family and friends could abuse the power to commit someone involuntarily.

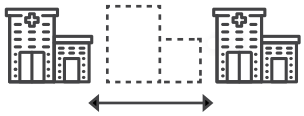
Action Items

While coercive treatment modalities intend to help PWUD in a humane way, the evidence for their effectiveness is lacking, and widespread implementation is impractical due to limited capacity. Above all, people who seek treatment for drug use should be able to access it—whether they choose medication-assisted treatment or 12-step programs. Expanding the treatment infrastructure by modifying regulations should be the first policy priority in addressing the treatment gap.

The most promising intervention to close the chasm involves increasing access to evidence-based treatments, specifically MOUD. The Modernizing Opioid Treatment Access Act is a federal bill that would expand access to methadone by allowing addiction specialist physicians to prescribe and dispense the drug. The current access structure requires patients to obtain methadone through an opioid treatment program (OTP). However, OTPs are not optimally distributed across the country, leaving large areas without access.

Another federal bill that can help expand access to SUD treatment is the Telehealth Response for E-prescribing Addiction Treatment Services Act, which would amend the Controlled Substances Act to allow the use of telehealth for SUD treatment.

State legislators can ensure that opioid settlement funds are appropriated to evidence-based interventions designed to directly improve the lives of PWUD. Additionally, states can expand the ability for providers licensed in other states to treat patients within their borders through cross-state licensure programs. Most states also impose regulations on OTPs that are stricter than federal guidelines recommend. Aligning state policies with federal OTP guidelines can expand access to evidence-based treatment options. Changes to health insurance requirements, such as ensuring that prior authorization is not required to start MOUD, can also lower barriers to access.



Expanding the treatment infrastructure by modifying regulations should be the first policy priority in addressing the treatment gap.

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