HHS Public Access

Author manuscript

Addiction. Author manuscript; available in PMC 2020 February 07.

Published in final edited form as:

Addiction. 2018 June ; 113(6): 1064–1065. doi:10.1111/add.14202.

Unpacking involuntary interventions for people who use drugs

Alexander R. Bazazi[1,2]

[1.]Yale School of Public Health, Department of Epidemiology of Microbial Diseases, New Haven, CT, USA.

[2.]Yale School of Medicine, Section of Infectious Diseases, AIDS Program, New Haven, CT, USA.

Concise Statement

Involuntary interventions for substance use disorders are less effective and potentially more harmful than voluntary treatment, and involuntary centers often serve as venues for abuse. Scaling up voluntary, evidence-based, low-barrier treatment options might invalidate the perceived necessity of involuntary interventions, and could go a long way toward reducing overdose risk.

Keywords

Involuntary drug treatment; compulsory drug detention centers; people who inject drugs; human rights; evidence-based treatment; overdose

Commentary

Worldwide, involuntary interventions for substance use are common, ranging in their approach, efficacy, and risk of harm to people who use drugs (PWUD). While legally coerced treatment, such as that offered by drug courts as an alternative to incarceration, has mixed evidence (1), compulsory treatment has not been shown to improve health (2, 3). Prior research on involuntary interventions has generally neglected risks to individuals after release from periods of forced abstinence. An important new study by Rafful and colleagues is among the first to examine the link between involuntary drug treatment centers and overdose (4). Among people who inject drugs in Tijuana, they found that past involuntary treatment was associated with a nearly two-fold increase in the odds of non-fatal overdose. Their finding makes sense in the context of extensive evidence that forced abstinence during incarceration places individuals at extremely high risk of overdose after release by decreasing tolerance without treating substance use disorders (5). This risk of overdose further tips the scales against involuntary treatment. But beyond weighing efficacy and risk, it is worth unpacking the concept of involuntary interventions for PWUD and what drives this approach.

What exactly do we mean by “involuntary drug treatment?” In Mexico, an estimated 38,000 people are in non-governmental drug treatment centers operating outside of legal supervision

Statement of competing interest:
I have no competing interests to declare.

(6). PWUD can be sent to centers involuntarily by a judge or forcefully detained by center staff at the request of family. The approach to treatment in these settings is heterogeneous but typically is based on a mutual aid model and can include physical violence, sometimes conceived as part of the treatment; human rights reports highlight harrowing accounts of deprivation and abuse in centers in Mexico and other Latin American countries (6–8). Involuntary interventions are not unique to Latin America. Several national governments in East and Southeast Asia operate "rehabilitation centers," where PWUD can be sent, typically by law enforcement, often without due process (9). These centers also employ widely varying approaches, at best offering counseling and education of unproven efficacy and at worst subjecting detainees to forced labor and other human rights violations (10). Unfortunately, what most involuntary centers do have in common is the failure to provide evidence-based treatment for substance use disorders.

It is worth being careful with our language to distinguish approaches like time-limited civil commitment to treatment from those involving human rights abuses and indefinite internment without due process. To highlight the absence of treatment and their functionally punitive nature, human rights advocates more appropriately call the "rehabilitation centers" in East and Southeast Asia "compulsory drug detention centers" (10). "Involuntary drug treatment centers," such as those experienced by participants in Rafful et al.'s Tijuana study, where maltreatment may be more commonplace than evidence-based treatment, might more appropriately be labeled involuntary "intervention" centers. At a minimum, the nature of the "treatment" provided within them should be elaborated.

Even absent maltreatment, involuntary interventions lack the efficacy of voluntary treatment. So what drives the continued use of involuntary approaches? In Mexico, use of involuntary centers, which are numerous and cheap, can reflect desperation by families given the enormous gap between the need for substance use disorder treatment and scant availability of public services (8). Additionally, two potential misconceptions may be at play: that PWUD lack capacity to make meaningful decisions about their health and that the primary barrier to treatment uptake is a lack of interest. These misconceptions undergird paternalistic justifications for intervening with PWUD against their will and, in the U.S., may be behind growing interest at the state level in policies facilitating involuntary interventions for PWUD (11, 12). What is often overlooked in arguments promoting involuntary interventions is the way that structural factors, such as lack of access to evidence-based treatment, limit the choices available to PWUD, perhaps to a greater extent than the influence of substance use itself. It makes little sense to consider the merits of involuntary interventions until voluntary, evidence-based treatment is widely available, accessible, and responsive to the needs of PWUD.

Detaining individuals in the name of drug treatment frequently occurs in settings that fail to provide appropriate treatment and can serve as venues for abuse. Critical research like that of Rafful et al., tracing health consequences of forced interventions, builds evidence against harmful practices. Ultimately, however, the continued existence of these practices may be driven less by evidence than by ideology, stigma, and limited access to voluntary treatment. Scaling up voluntary, evidence-based, low-barrier treatment options might invalidate the perceived necessity of involuntary interventions, and could go a long way toward reducing

the risk of overdose associated with untreated or inappropriately treated substance use disorders.

Acknowledgements:

This work was supported by the following grants from the National Institutes of Health: F30DA039716, T32GM07205, P30MH062294.

References:

1. Bright DA, Martire KA. Does Coerced Treatment of Substance-Using Offenders Lead to Improvements in Substance Use and Recidivism? A Review of the Treatment Efficacy Literature. Aust Psychol. 2013;48(1):69–81.
2. Werb D, Kamarulzaman A, Meacham MC, Rafful C, Fischer B, Strathdee SA, et al. The effectiveness of compulsory drug treatment: A systematic review. International Journal of Drug Policy. 2016;28:1–9. [PubMed: 26790691]
3. Wegman MP, Altice FL, Kaur S, Rajandaran V, Osornprasop S, Wilson D, et al. Relapse to opioid use in opioid-dependent individuals released from compulsory drug detention centres compared with those from voluntary methadone treatment centres in Malaysia: a two-arm, prospective observational study. Lancet Glob Health. 2017;5(2):e198–e207. [PubMed: 27964869]
4. Rafful C, Orozco R, Rangel G, Davidson P, Werb D, Beletsky L, et al. Increased non-fatal overdose risk associated with involuntary drug treatment in a longitudinal study with people who inject drugs. Addiction. 2018;[Epub ahead of print].
5. Merrall ELC, Kariminia A, Binswanger IA, Hobbs MS, Farrell M, Marsden J, et al. Meta-analysis of drug-related deaths soon after release from prison. Addiction. 2010;105(9):1545–54. [PubMed: 20579009]
6. Zamudio C, Chávez P, Zafra E. Abusos en centros de tratamiento con internamiento para usuarios de drogas en México. CUADERNOS CUPIHD [Internet]. 2015; Año 4, núm. 8. Available from: http://fileserver.idpc.net/library/abusos-en-centros-de-tratamiento-con-internamiento-para-usuarios-de-drogas-en-mexico.pdf.
7. Open Society Foundations. No Health, No Help: Abuse as drug treatment in Latin America & the Caribbean2016. Available from: osf.to/nohealthnohelp.
8. Garcia A Serenity: Violence, Inequality, and Recovery on the Edge of Mexico City. Med Anthropol Q. 2015;29(4):455–72. [PubMed: 25808246]
9. Kamarulzaman A, McBrayer JL. Compulsory drug detention centers in East and Southeast Asia. Int J Drug Policy. 2015;26 Suppl 1:S33–7. [PubMed: 25727259]
10. Csete J, Pearshouse R. Detention and punishment in the name of drug treatment. New York: Open Society Foundations 2016.
11. Vestal C Support grows for civil commitment of opioid users. The Pew Charitable Trusts [Internet]. 2017 Available from: http://www.pewtrusts.org/en/research-and-analysis/blogs/stateline/2017/06/15/support-grows-for-civil-commitment-of-opioid-users.
12. Hazelden Betty Ford Foundation. Involuntary commitment for substance use disorders. Emerging Drug Trends Report [Internet]. 2017 Available from: http://www.hazeldenbettyford.org/education/bcr/addiction-research/involuntary-commitment-edt-717.