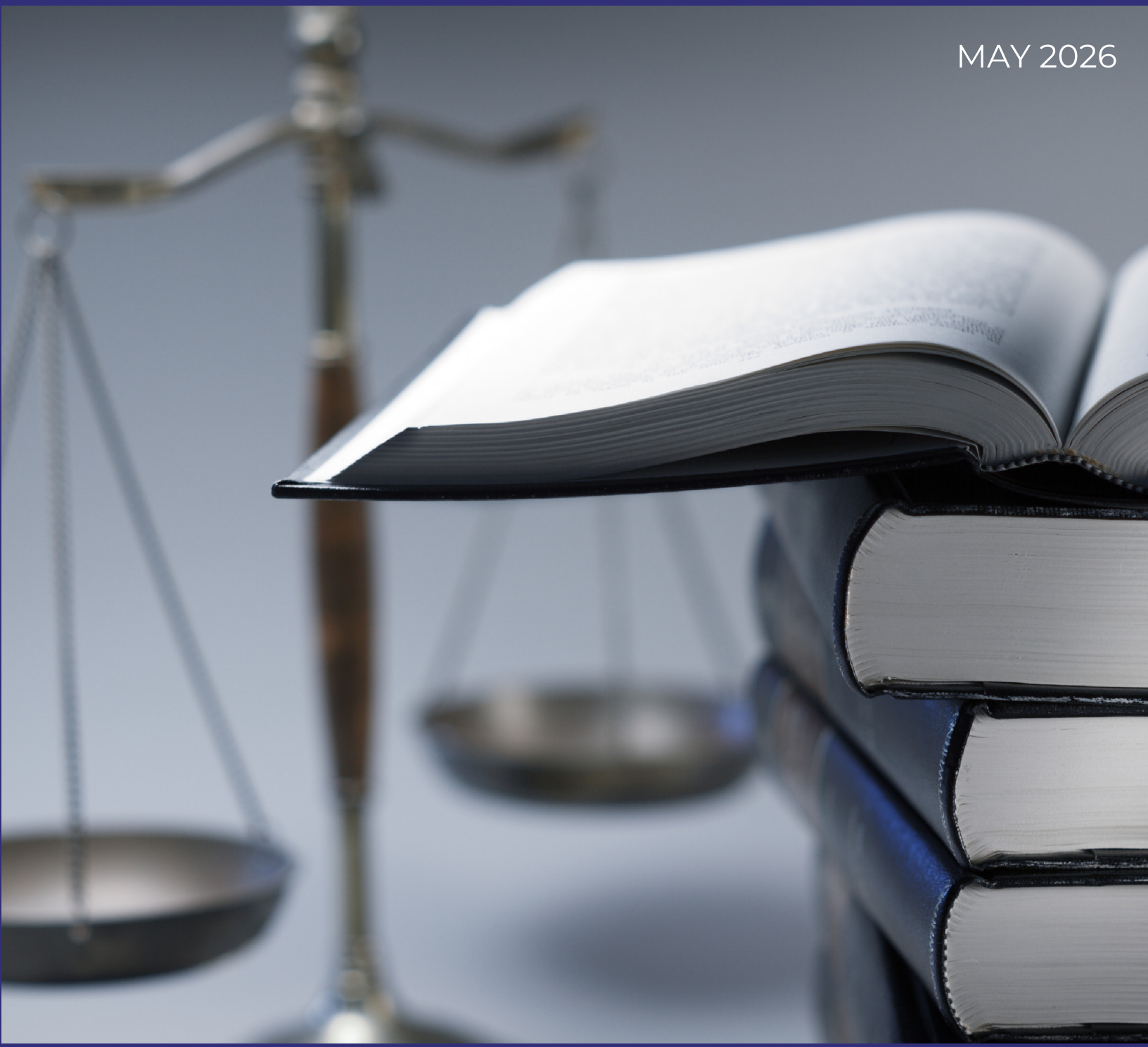
LEGISLATIVE ANALYSIS AND PUBLIC POLICY ASSOCIATION

MODEL INVOLUNTARY COMMITMENT FOR SUBSTANCE USE DISORDER ACT

MAY 2026



LAPPA
LEGISLATIVE ANALYSIS AND PUBLIC POLICY ASSOCIATION

This project was supported by the Model Acts Program, funded by the Office of National Drug Control Policy, Executive Office of the President. Points of view or opinions in this document are those of the author and do not necessarily represent the official position or policies of the Office of National Drug Control Policy or the United States Government. Research is Current as of February 2026.

MODEL INVOLUNTARY COMMITMENT FOR SUBSTANCE USE DISORDER ACT

ACKNOWLEDGMENTS

The Legislative Analysis and Public Policy Association (LAPPA) is grateful to the Office of National Drug Control Policy for its support in funding, enabling, and contributing to this Model Act.

This Model Act was developed with invaluable input from a host of individuals from civil rights activists to law enforcement officials to addiction and mental health specialists. Readers should note that some working group members expressed concerns that the practice of involuntary commitment is antithetical to the fundamental medical principle of patient consent and autonomy and believe that any model legislation concerning involuntary commitment should restrict, rather than expand, its use. We encourage states to adopt this Model Act, which seeks to provide individuals subject to involuntary commitment with as much autonomy as possible, in whole or in part, as is appropriate for the jurisdiction.

Due to the many divergent views on the topic, some in the Model Involuntary Commitment for Substance Use Disorder Act working group requested not to have their names listed in the acknowledgements. LAPPA made attempts to include all working group members' opinions in the commentary throughout the Model Act. LAPPA wishes to thank the group's distinguished members, including those listed below, for providing their expertise, guidance, and suggestions that contributed to the model's development. Please note, however, that those listed below do not necessarily endorse the Model Act.

Camille Cioffi, PhD
University of Oregon
Oregon Research Institute
Influents Innovations

Richard Gordon
Court Consultant

Libby Reekers
Tama County (IA)
Judicial Mental Health Advocate

Carol Stojinski, MD
Geisinger Health System

Terrence D. Walton
NAADAC
the Association for Addiction Professionals

MODEL INVOLUNTARY COMMITMENT FOR SUBSTANCE USE DISORDER ACT

TABLE OF CONTENTS

SECTION I. SHORT TITLE.

This Act may be referred to as the "Model Involuntary Commitment for Substance Use Disorder Act," "the Act," or "Model Act."

Commentary

The drafters have chosen to use the term "involuntary commitment" within this Act, but states may choose to use the interchangeable terms "civil commitment" or "involuntary civil commitment." This Act focuses on involuntary commitment for substance use disorder (SUD), which is distinct from involuntary commitment for mental illness. Involuntary commitment for SUD is also distinct from legally mandated treatment ordered by a drug court in an effort to deflect an individual from incarceration.

SECTION II. LEGISLATIVE FINDINGS AND PURPOSE.

(a) Legislative findings.—The [legislature][1] finds that:

(1) In 2024, more than 46 million Americans aged eighteen (18) years of age or older had substance use disorder, including [x] individuals in [state].[2]

(2) For that same year, the Substance Abuse and Mental Health Services Administration estimated that over 10 million Americans aged twelve (12) or older had substance use disorder, categorized as severe, based on criteria established by the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition.[3]

(3) In 2024, the Centers for Disease Control and Prevention reported that 79,384 individuals died of a drug overdose, including [x] individuals in [state].[4]

[1] This Act contains certain bracketed words and phrases (*e.g.*, "[legislature]"). Brackets indicate instances where state lawmakers may need to insert state-specific terminology or facts.

[2] *Results from the 2024 National Survey on Drug Use and Health: Detailed Tables*, U.S. DEP'T OF HEALTH & HUM. SERVS., SUBSTANCE ABUSE & MENTAL HEALTH SERVS. ADMIN., Table 5.1A (2025).

[3] *Id.* at Table 5.2A. The Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition categories SUD as mild, moderate, or severe based on the assessment of 11 criteria. The presence of two or three criteria in an individual is considered mild SUD, the presence of four or five criteria is considered moderate SUD, and the presence of six or more criteria is considered severe SUD. *See Substance Use Disorders vs. Substance Abuse and Dependance: DSM-5 Changes*, UNIV. OF FLA. DEP'T OF PSYCHIATRY (last visited Jan. 6 2025), https://addiction-certificate.psychiatry.ufl.edu/about-the-program/articles/substance-use-disorders-vs-substance-abuse-and-dependence-dsm-5-changes/.

[4] Matthew F. Garnett and Arialdi M. Miniño, *Drug Overdose Deaths in the United States, 2023-2024*, 549 NAT'L CTR. FOR HEALTH STATISTICS DATA BRIEF (Jan. 2026), https://www.cdc.gov/nchs/products/databriefs/db549.htm.

Return to Table of Contents

(4) Individuals with severe substance use disorder may have difficulty reducing or stopping their substance use,[5] neglect responsibilities and relationships, give up activities about which they used to care, have difficultly completing tasks,[6] and exhibit dangerous and risky substance use,[7] such as using substances in unclean environments and using shared drug supplies. They may also become physically dependent on the drug and experience withdrawal symptoms when a substance is not used.[8]

(5) Several individuals with substance use disorder also have a co-occurring mental illness. In 2024, an estimated 21 million individuals aged eighteen (18) years of age and older had a co-occurring substance use disorder and any mental illness,[9] and an estimated 6.9 million individuals aged eighteen (18) years of age and older had a co-occurring substance use disorder and serious mental illness.[10]

(6) In 2024, an estimated nine million individuals aged eighteen (18) years of age and older received treatment for substance use disorder, including [x] individuals in [state].[11] Of those, an estimated 2.3 million individuals received inpatient treatment,[12] while an estimated 6.6 million individuals received outpatient treatment.[13]

(7) With respect to individuals eighteen (18) years of age and older with substance use disorder categorized as severe, an estimated 2.7 million individuals received

[5] AMERICAN PSYCHIATRIC ASSOCIATION, DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS (5th ed. 2022). (DSM-5 category one (impaired control over substance use) of the symptoms of SUD (criteria 1-4)).
[6] *Id.* (DSM-5 category two (social impairment) of the symptoms of SUD (criteria 5-7)).
[7] *Id.* (DSM-5 category three (risky use) of the symptoms of SUD (criteria 8-9)).
[8] *Id.* (DSM-5 category four (pharmacology) of the symptoms of SUD (criteria 10-11)). *See also DSM-5 Criteria for Addiction Simplified*, ADDICTION POLICY FORUM (Aug. 17, 2020), https://www.addictionpolicy.org/post/dsm-5-facts-and-figures.
[9] *Results from the 2024 National Survey on Drug Use and Health: Detailed Tables*, *supra* note 2, at Table 6.10A.
[10] *Id.* at Table 6.13A. According to the NSDUH, serious mental illness (SMI) aligns with DSM-IV criteria and is defined as having a diagnosable mental, behavioral, or emotional disorder, other than a developmental or substance use disorder. SMI is a subset of any mental illness (AMI) because SMI is limited to people with AMI that resulted in serious functional impairment.
[11] *Id.* at Table 5.14A.
[12] *Id.* at Table 5.19A.
[13] *Id.* at Table 5.20A.

Return to Table of Contents

treatment for their substance use disorder, while an estimated seven million did not receive treatment.[14]

(8) In the United States, there is a gap between the need for and the utilization of substance use disorder treatment that stems from a variety of factors, including the lack of accessible, evidence-based treatment services and the inability or unwillingness of some individuals with substance use disorder to seek treatment voluntarily.[15]

(9) Voluntary substance use disorder treatment is always preferred over involuntary substance use disorder treatment because it provides the patient with full autonomy; however, when voluntary treatment options have been offered, declined, or exhausted, the involuntary commitment of an individual with severe substance use disorder to treatment may be necessary in order to safeguard the individual and/or the public from physical harm.[16]

(10) Due to the deprivation of liberty and freedom, involuntary commitment must only be used in situations involving severe substance use disorder in which recent overt acts indicate that an individual poses a grave risk of imminent physical harm to him or herself or others.[17]

(11) Research shows that treating individuals with severe substance use disorder with dignity, respect, and empathy during the involuntary commitment process increases the likelihood that the individual will not return to use and will voluntarily follow up with additional care upon release.[18]

(b) Purpose.—The purpose of this Act is to:

---

[14] *Id.* at Table 5.31A.
[15] *Involuntary Commitment for Substance Use Disorders*, HAZELDEN BETTY FORD FOUNDATION (July 2017), https://www.hazeldenbettyford.org/research-studies/addiction-research/involuntary-commitment.
[16] *See* Alan A. Cavaiola and David Dolan, *Considerations in Civil Commitment of Individuals with Substance Use Disorders*, 37 SUBSTANCE USE & ADDICTION J. 181 (Jan. 2016), https://doi.org/10.1080/08897077.2015.1029207.
[17] *See Id.*
[18] Cynthia M.A. Geppert, *Civil Commitment for Substance Use Disorders: Coercion or Compassion?*, 39 PSYCHIATRIC TIMES 20, 22 (June 2022), https://www.psychiatrictimes.com/view/civil-commitment-for-substance-use-disorders-coercion-or-compassion.

Return to Table of Contents

(1) Establish protocols and procedures for the involuntary commitment of individuals with substance use disorder that is separate and distinct from the procedure for the involuntary commitment of individuals with mental illness;

(2) Ensure that the due process rights of individuals with substance use disorder who are subject to involuntary commitment proceedings are respected and protected and that all individuals are treated with dignity, respect, and empathy throughout the process;

(3) Enumerate the rights of individuals involuntarily committed for substance use disorder treatment;

(4) Establish discharge planning requirements to prevent harm upon discharge from involuntary commitment and reduce the risk of overdose upon reentry into the community;

(5) Establish an involuntary commitment review board to review the admission and retention of individuals ordered to undergo involuntary commitment for the treatment of substance use disorder in a clinical setting;

(6) Establish training and education materials on the process of involuntary commitment for courts, the medical community, and the general public; and

(7) Establish a reporting requirement for treatment facilities to ensure the collection and analysis of data related to involuntary commitment and its outcomes, including admission and retention data.

Commentary

According to the U.S. Department of Health and Human Services' Substance Abuse and Mental Health Services Administration's National Survey on Drug Use and Health (NSDUH), over 46 million Americans aged 18 or older had SUD in 2024.[19] The American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition, (DSM-5) categorizes the severity of SUD as either mild, moderate, or severe based on 11 established criteria, or symptoms.[20] The DSM-5 groups the symptoms of SUD into four categories: (1) impaired control; (2) social problems; (3) dangerous use; and (4) physical dependence.[21] An individual who exhibits six or more of the 11 stated symptoms is considered to have severe

[19] *Results from the 2024 National Survey on Drug Use and Health: Detailed Tables*, *supra* note 2.
[20] AMERICAN PSYCHIATRIC ASSOCIATION, *supra* note 4. *See also DSM-5 Criteria for Addiction Simplified, supra* note 8.
[21] AMERICAN PSYCHIATRIC ASSOCIATION, *supra* note 4. *See also DSM-5 Criteria for Addiction Simplified, supra* note 8.

Return to Table of Contents

SUD.[22] The 2024 NSDUH estimated that over 10 million Americans aged 12 and older had severe SUD.[23]

If an individual's SUD is severe, not receiving or continuing evidenced-based treatment places him or her at a high risk of overdose,[24] adverse medical events,[25] homelessness,[26] suicide,[27] involvement in the criminal justice system,[28] being a victim of a crime,[29] or physically harming another individual.[30] While severe SUD can affect the physical, mental, and social aspects of an individual's life, there are evidence-based treatments available that can lead to sustained recovery.[31] Treatment for SUD varies based on the substance involved but may consist of the following practices including medication for addiction treatment, behavioral therapy and counseling, peer support, and contingency management, all of which can be provided on an inpatient or outpatient basis.[32] Even when evidence-based treatment for SUD is available, it is not always accessible, and many individuals with SUD are unable or unwilling to receive treatment. There are a variety of reasons why such is the case, including lack of or insufficient funds and/or health insurance, or a lack of evidence-based treatment programs or options within the individual's geographic area.[33] There are also instances in which evidence-based treatment may be available and accessible, but the individual refuses it while presenting a grave risk of imminent physical harm to him or herself or others.

An individual's continued substance use and unwillingness or inability to seek treatment despite negative life consequences can be a frustrating and frightening situation for family members, close friends, and others who care about the individual.[34] Members of the individual's

---

[22] AMERICAN PSYCHIATRIC ASSOCIATION, *supra* note 4. *See also DSM-5 Criteria for Addiction Simplified, supra* note 8.
[23] *Results from the 2024 National Survey on Drug Use and Health: Detailed Tables*, *supra* note 2, at Table 5.2A.
[24] *See Drug Overdose Deaths: Facts and Figures*, NAT'L INST. ON DRUG ABUSE (Aug. 2024), https://nida.nih.gov/research-topics/trends-statistics/overdose-death-rates.
[25] *See What are the Other Health Consequences of Drug Addiction?*, NAT'L INST. ON DRUG ABUSE (July 2011), https://nida.nih.gov/publications/drugs-brains-behavior-science-addiction/addiction-health.
[26] *See Opioid Abuse and Homelessness*, NAT'L ALLIANCE TO END HOMELESSNESS (Apr. 2016), https://endhomelessness.org/resource/opioid-abuse-and-homelessness/.
[27] *See* Alison Athey, et al., *Association of Substance Use with Suicide Mortality: An Updated Systematic Review and Meta-analysis*, 14 DRUG & ALCOHOL DEPENDANCE REPORTS (2024), https://doi.org/10.1016/j.dadr.2024.100310.
[28] *See Alcohol, Drugs, and Crime*, NAT'L COUNCIL ON ALCOHOLISM AND DRUG DEPENDENCE, INC. (last visited Jan. 8, 2025), https://ncaddnational.org/addiction_articles/alcohol-drugs-and-crime/.
[29] Michael G. Vaughn, et al., *Criminal Victimization and Comorbid Substance Use and Psychiatric Disorders in the United States: Results from the NESARC*, 20 ANNALS OF EPIDEMIOLOGY 281 (2010), https://doi.org/10.1016/j.annepidem.2009.11.011.
[30] Shaoling Zhong, et al., *Drug Use Disorders and Violence: Associated with Individual Drug Categories* 42 EPIDEMIOLOGIC REV. 103 (2020), https://doi.org/10.1093/epirev/mxaa006.
[31] *See What Is a Substance Use Disorder?* AM. PSYCHIATRIC ASS'N (Apr. 2024), https://www.psychiatry.org/patients-families/addiction-substance-use-disorders/what-is-a-substance-use-disorder.
[32] *Types of Treatment*, SUBSTANCE ABUSE AND MENTAL HEALTH SERV. ADMIN. (Apr. 2023), https://www.samhsa.gov/find-support/learn-about-treatment/types-of-treatment.
[33] *See Results from the 2024 National Survey on Drug Use and Health: Detailed Tables*, *supra* note 2, Table 5.36A.
[34] Matthew T. Walton and Martin T. Hall, *Involuntary Civil Commitment for Substance Use Disorders: Legal Precedents and Ethical Considerations for Social Workers*, 32 SOCIAL WORK IN PUBLIC HEALTH 382, 382 (2017), https://doi.org/10.1080/19371918.2017.1327388.

Return to Table of Contents

social network may fear that without intervention, the individual may end up in jail or dead.[35] To alleviate some of these fears, an individual's social network, if he or she has one, may assist and encourage the individual to voluntarily participate in treatment, connect with peer support services, and carry naloxone. The social network may also connect the individual to social services, including housing and Medicaid, which may help improve the individual's health and safety and place him or her in a situation in which he or she is more amenable to voluntary treatment. However, in certain circumstances with an adult who has severe SUD, the only option to prevent imminent physical harm to him or herself or others may be involuntary commitment.[36]

Involuntary commitment is a legal process by which a judge may order an individual with symptoms of a serious mental illness or SUD to undergo treatment against the individual's wishes.[37] Traditionally, involuntary commitment laws were reserved only for the treatment of individuals with severe mental illness, but over time, jurisdictions have expanded their laws to apply to individuals with severe SUD.[38] As of December 2024, 34 states, the District of Columbia, Puerto Rico, and the U.S. Virgin Islands, have involuntary commitment laws that can be used to involuntarily commit an individual with a primary diagnosis of SUD.[39] In Rhode Island, the involuntary commitment law may only be used to involuntarily commit an individual with alcohol use disorder.[40] In comparison, in 15 states, American Samoa, Guam, and the Northern Mariana Islands, individuals with a primary diagnosis of SUD cannot be involuntarily committed.[41] This does not mean that individuals with SUD are prohibited from being involuntarily committed in those jurisdictions but rather that the individual must have a co-occurring mental illness in order to satisfy the criteria for involuntary commitment. According to the 2024 NSDUH, 46 percent of individuals with an SUD have any mental illness and 15 percent of individuals with an SUD have a serious mental illness.[42] While more than half of the states already have laws concerning the involuntary commitment for SUD in place, a model law on the topic is necessary to reduce variability among the states and ensure that respondents are provided with the same rights and opportunities throughout the involuntary commitment process regardless of where they reside. This Model Act creates a pathway for involuntary commitment for SUD that is separate and distinct from the pathway for involuntary commitment for mental illness. The drafters have chosen not to combine the two pathways because individuals with a primary diagnosis of SUD have different treatment needs and requirements than those with a primary diagnosis of mental illness.

---

[35] Elizabeth A. Evans, et al., *Perceived Benefits and Harms of Involuntary Civil Commitment for Opioid Use Disorder*, 48 J. OF L., MED., & ETHICS 718, 721 (2020), https://doi.org/10.1177/1073110520979382.
[36] *Id.*
[37] *See* Cavaiola, *supra* note 16.
[38] *See Involuntary Commitment of Those with Substance Use Disorders: Summary of State Laws*, LEGIS. ANALYSIS & PUB. POL'Y ASS'N (Dec. 2024), https://legislativeanalysis.org/involuntary-commitment-of-those-with-substance-use-disordersnvoluntary-commitment-and-guardianship-laws-pdf/.
[39] *Id.* at 5.
[40] *Id.*
[41] *Id.*
[42] SUBSTANCE ABUSE AND MENTAL HEALTH SERVICES ADMINISTRATION, KEY SUBSTANCE USE AND MENTAL HEALTH INDICATORS IN THE UNITED STATES: RESULTS FROM THE 2024 NATIONAL SURVEY ON DRUG USE AND HEALTH 35, Figure 57 (2025), https://www.samhsa.gov/data/sites/default/files/reports/rpt56287/2024-nsduh-annual-national-report.pdf.

Return to Table of Contents

The temporary state intrusion on an individual's civil liberties by involuntary commitment is justified through the principles of *parens patriae* and a state's police power.[43] *Parens patriae* is a legal doctrine that allows a state to act *in loco parentis* ("in the place of a parent") on behalf of its citizens when they are incapable of acting on their own behalf.[44] A state's police power provides it with the authority to limit an individual's autonomy to the extent that it is necessary to protect its citizens from harm and ensure public safety.[45] Thus, to protect the safety of the individual and those in his or her community, a court may suspend that individual's right to liberty and compel him or her into treatment. However, the mere presence of SUD or a co-occurring mental illness is not a valid justification for involuntary commitment. In order to constitutionally confine an individual through involuntary commitment, there must be a showing that, as a result of the SUD or co-occurring mental illness, the individual is dangerous to him or herself or others.[46] In the 1975 U.S. Supreme Court case of *O'Connor v. Donaldson*, the Court ruled that it is unconstitutional to confine a non-dangerous individual who is capable of surviving safely independently or with the help of a willing and responsible adult.[47] The Court also ruled that it is unconstitutional to keep an individual involuntarily committed once he or she is no longer at risk of danger to him or herself or others.[48]

While involuntary commitment is legal under certain circumstances, the practice is controversial. Proponents of involuntary commitment for SUD argue that the practice is a tool for families to handle urgent and immediate life-threatening situations without the involvement of the criminal justice system and places individuals on the path toward recovery.[49] For example, the mother of Matthew "Casey" Wethington, for whom Kentucky's involuntary commitment for SUD law is named,[50] argues that involuntary commitment provides a means of intervention that allows parents, relatives, and friends to petition the court for evidence-based treatment on behalf of an adult individual who is unable to recognize his or her need for treatment due to his or her impairment.[51] In contrast, opponents of involuntary commitment for SUD argue that the practice may exacerbate trauma, foster a mistrust of healthcare systems, and make individuals less willing to seek treatment in the future.[52] There were also some working group members who expressed concerns that the practice of involuntary commitment is antithetical to the fundamental medical principle of patient consent and autonomy and believe that any model legislation concerning involuntary commitment should restrict, rather than expand, its use. In an American Society of Addiction Medicine survey of 165 addiction medicine physicians on involuntary commitment for SUD, 60.7 percent favored the practice, 21.5 percent opposed the practice, and 17.8 percent were

[43] Walton, *supra* note 34, at 383.
[44] *Id.*
[45] Geppert, *supra* note 18, at 21.
[46] *See* O'Connor v. Donaldson, 422 U.S. 563, 576 (1975).
[47] *Id.*
[48] *Id.* at 575.
[49] Evans, *supra* note 35.
[50] KY. REV. STAT. ANN. §§ 222.430 through 222.437 (West 2024).
[51] *About Casey's Law*, CASEY'S LAW (last visited Jan. 8, 2025), https://caseyslaw.org/caseys-law/.
[52] Michael S. Sinha, et al., *Neither Ethical Nor Effective: The False Promise of Involuntary Commitment to Address the Overdose Crisis*, 48 J. OF L., MED., & ETHICS 741, 742 (2020), https://doi.org/10.1177/1073110520979384.

Return to Table of Contents

unsure of how they felt about the practice.[53] Those surveyed who opposed the practice were more likely to believe that involuntary commitment for SUD would jeopardize patient rapport, would be ineffective for unmotivated individuals, or that the practice should only be permitted for certain types of substances (*i.e.*, opioids) due to their perceived dangerousness and heightened risk of overdose.[54] A majority of survey respondents believed that there is a need for more clinician education (91.5 percent) and research (87.1 percent) on the practice of involuntary commitment for SUDs.[55] Data on the effectiveness of involuntary commitment for SUD laws has been limited and difficult to generalize in part due to the variability among state laws.[56] The utilization of these laws also varies greatly among states and many states do not collect data on the practice.[57]

Although involuntary commitment for SUD has generated important debate about the practice, various stakeholders agree that more research is needed to fully understand its effectiveness.[58] Involuntary commitment for SUD may achieve the immediate goal of minimizing or preventing imminent physical harm to an individual or others, but whether the practice leads to a sustained recognition of treatment needs by the affected individual, engagement in voluntary care, and improved decision making remains unclear.[59] There are various frameworks and recommendations available that have been developed by researchers, including those involved in law, bioethics, and addiction medicine, that can be implemented to better ensure that involuntary commitment for SUD protocols that are currently in place are beneficial, patient-centered, and fair.[60] Bioethicists Thomas Beauchamp and James Childress developed a framework of four ethical principles that can be used to guide health-related policies, practices, and decisions: (1) respect for autonomy; (2) non-maleficence; (3) beneficence; and (4) justice.[61] Any intervention that restricts the liberty of individuals must be implemented in a way that carefully balances the rights of the individual and the safety of the community.[62] When a court issues an order for involuntary commitment for SUD, "every effort must be taken to minimize harm to the patient, including not only providing safe and effective care but promoting the patient's autonomy to the greatest extent possible and assuring services in the least restrictive setting, with an eye toward release at the earliest opportunity."[63]

---

[53] Abhishek Jain, et al., *Civil Commitment for Substance Use Disorders: A National Survey of Addiction Medicine Physicians*, 15 J. OF ADDICTION MED. 285 (Aug. 2021), https://doi.org/10.1097/ADM.0000000000000847.
[54] *Id.*
[55] *Id.*
[56] Abhishek Jain, et al., *Civil Commitment for Opioid and Other Substance Use Disorders: Does it Work?*, 69 PSYCHIATRIC SERVICES 374, 374-75 (Apr. 2018), https://doi.org/10.1176/appi.ps.201800066.
[57] *Id.*
[58] Walton, *supra* note 34, at 391.
[59] Jain, *supra* note 56, at 375.
[60] SUBSTANCE ABUSE AND MENTAL HEALTH SERVICES ADMINISTRATION, CIVIL COMMITMENT AND THE MENTAL HEALTH CARE CONTINUUM: HISTORICAL TRENDS AND PRINCIPLES FOR LAW AND PRACTICE 23 (2019), https://www.samhsa.gov/resource/ebp/civil-commitment-mental-health-care-continuum-historical-trends-principles-law.
[61] *Id.*
[62] *Id.* at 25.
[63] *Id.*

Return to Table of Contents

To allow for a practice that better suits the needs of individuals with SUD, this Model Act establishes policies and procedures for the implementation and evaluation of involuntary commitment for SUD that is separate and distinct from involuntary commitment for mental illness. The Act incorporates recommendations and best practices from various researchers involved in the practice of law, medicine, and ethics to create an involuntary commitment procedure that addresses ethical concerns and balances the needs of the individual and the community. A few members of the working group were concerned with the sparse research on the effectiveness of using involuntary commitment to treat individuals with SUD and declined to affix their names to this Model Act. Some agreed to have their names acknowledged to support collaboration with states seeking guidance but wished to state that authorship does not indicate endorsement of this Act. However, the goal of this Model Act is to provide jurisdictions with a framework for the involuntary commitment of individuals with SUD that restricts the use of involuntary commitment to specific circumstances and includes protective policies and procedures for the individual. Additionally, the Model Act seeks to provide consistency among involuntary commitment for SUD laws across jurisdictions to allow for standardized research and data on the practice in an effort to gain more insight on the efficacy of involuntary commitment for SUD.

SECTION III. DEFINITIONS.

[States may already have definitions in place for some or all of the following terms. In such case, states may use the existing definitions in place of those listed below.]

For purposes of this Act, unless the context clearly indicates otherwise, the words and phrases listed below have the meanings given to them in this section:[64]

(a) Co-occurring disorder.—"Co-occurring disorder" means the existence of both substance use disorder and mental illness;[65]

(b) Correctional facility.—"Correctional facility" means a jail, prison, adult or juvenile detention center, immigration detention center, or other environment used to house individuals accused of, charged with, or convicted of a criminal offense and in which an individual is confined by a federal, state, or local government entity;[66]

[64] Where a definition is based on, adapted from, or directly pulled from, language from enacted statute, proposed legislation, or other research material, the footnote referenced at the end of the definition provides that source. Additional information about the reasoning for certain definitions is included in the Section III commentary.
[65] *See Co-occurring Disorders and Health Conditions*, NAT'L INST. ON DRUG ABUSE (Sept. 2024), https://nida.nih.gov/research-topics/co-occurring-disorders-health-conditions#mental.
[66] Taken in part from *Model Access to Medication for Addiction Treatment in Correctional Settings Act*, LEGIS. ANALYSIS & PUB. POL'Y ASS'N (Sept. 2024), https://legislativeanalysis.org/model-access-to-medication-for-addiction-treatment-in-correctional-settings-act-2/.

Return to Table of Contents

(c) Court.—"Court" means the [probate] court for the district in which the respondent resides or, if the respondent's residence is out of state or unknown, for the district in which he or she is located at the time the petition is filed;[67]

(d) Grave disability.—"Grave disability" means a condition evidenced by behavior in which an individual, as a result of a substance use disorder or co-occurring disorder, is likely to come to serious physical harm or serious illness because he or she is unable to provide for his or her own basic physical needs;[68]

(e) Grave risk.—"Grave risk" means an extremely high possibility of harm or danger to self or others, often implying a high likelihood of negative consequences, potentially even death, requiring immediate attention and action;[69]

(f) Healthcare practitioner.—"Healthcare practitioner" means a physician, physician assistant, or advanced practice nurse practitioner that is credentialed and licensed by the state and who is authorized to conduct a substance use disorder assessment and diagnosis;[70]

(g) Inpatient treatment.—"Inpatient treatment" means medically managed, twenty-four (24) hour-a-day care that occurs within a hospital or residential treatment setting for individuals who have substance use disorder or a co-occurring disorder;[71]

(h) Involuntary commitment.—"Involuntary commitment" means a legal process by which a judge may order an individual with symptoms of severe substance use disorder, with or without a co-occurring disorder, to undergo evidence-based treatment for a period of time against the individual's wishes;[72]

(i) Law enforcement official.—"Law enforcement official" means a paid or volunteer employee of a police department or sheriff's office, which is a part of or administered by the state or any political subdivision thereof, or any full-time or part-time employee of a private police department, and who is responsible for the prevention and detection of

---

[67] Adapted from CONN. GEN. STAT. ANN. § 17a-685 (West 2024).
[68] ARIZ. REV. STAT. ANN. § 36-501(16) (West 2025).
[69] Adapted from the definitions of *Grave*, CAMBRIDGE DICTIONARY (2025) and *Risk*, CAMBRIDGE DICTIONARY (2025).
[70] Adapted from OHIO REV. CODE ANN. § 5119.90 (West 2024).
[71] *See Levels of Care in Addiction Treatment*, PYRAMID HEALTHCARE, INC. (last accessed Jan. 23, 2025), https://www.pyramid-healthcare.com/service/levels-of-care/.
[72] *See* Cavaiola, *supra* note 16.

Return to Table of Contents

crime and the enforcement of the penal, traffic, or highway laws of the state. Law enforcement officials include law enforcement officers and other high-ranking staff members within the law enforcement agency;[73]

(j) Medication for addiction treatment.—"Medication for addiction treatment" means drugs approved by the U.S. Food and Drug Administration for the treatment of substance use disorder;[74]

(k) Behavioral health professional.—"Behavioral health professional" means a psychologist, clinical social worker, professional clinical counselor, marriage and family therapist, [certified alcohol and drug counselor], or any other individual licensed, registered, certified, or otherwise authorized to provide mental health services in the state;[75]

(l) Outpatient treatment.—"Outpatient treatment" means direct services provided in a community-based setting for individuals with substance use disorder, with or without a co-occurring disorder;[76]

(m) Overdose reversal medication.—"Overdose reversal medication" means a medication approved by the U.S. Food and Drug Administration to reverse an overdose;[77]

(n) Peer support services.—"Peer support services" means assistance that encompasses a range of activities and interactions between individuals who share similar experiences of navigating substance use disorder or co-occurring disorder in an effort to help individuals get and stay connected to services and the community, gain stability, and maintain recovery;[78]

---

[73] Taken in part from *Model Overdose Mapping and Response Act*, LEGIS. ANALYSIS & PUB. POL'Y ASS'N (Mar. 2020), https://legislativeanalysis.org/http-legislativeanalysis-org-wp-content-uploads-2020-03-odmap-model-final-3-2020-pdf/.

[74] *See Medications for Substance Use Disorders*, SUBSTANCE ABUSE AND MENTAL HEALTH SERVICES ADMINISTRATION (last updated Apr. 11, 2024), www.samhsa.gov/medication-assisted-treatment.

[75] Taken in part from *Model Substance Use During Pregnancy and Family Care Plans Act*, LEGIS. ANALYSIS & PUB. POL'Y ASS'N (Mar. 2023), https://legislativeanalysis.org/model-substance-use-during-pregnancy-and-family-care-plans-act/.

[76] *See* Dennis McCarty, et al., *Substance Abuse Intensive Outpatient Programs: Assessing the Evidence*, 65 PSYCHIATRIC SERV. 718 (June 2014), https://doi.org/10.1176/appi.ps.201300249.

[77] *Opioid Overdose Reversal Medications*, SUBSTANCE ABUSE AND MENTAL HEALTH SERVICES ADMINISTRATION (last updated Mar. 26, 2024), https://www.samhsa.gov/medications-substance-use-disorders/medicationscounseling-related-conditions/opioid-overdose-reversal-medications.

[78] Taken in part from *Model Substance Use Disorder Treatment in Emergency Settings Act*, LEGIS. ANALYSIS & PUB. POL'Y ASS'N (Mar. 2023), https://legislativeanalysis.org/model-substance-use-disorder-treatment-in-emergency-settings-act/.

Return to Table of Contents

(o) Petitioner.—"Petitioner" means an individual who initiates an involuntary commitment proceeding under this Act;[79]

(p) Remote hearing.—"Remote hearing" means a court hearing that takes place through a video conferencing system or platform;[80]

(q) Respondent.—"Respondent" means an individual alleged in a petition to have severe substance use disorder, with or without a co-occurring disorder, and who the petitioner seeks to have ordered to undergo involuntary commitment;[81]

(r) Severe substance use disorder.—"Severe substance use disorder" means a substance use disorder that displays six or more of the eleven 11 stated symptoms of substance use disorder impairment in accordance with the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition.[82]

(s) Substance use disorder.—"Substance use disorder" means a pattern of use of a substance leading to clinical or functional impairment, in accordance with the definition in the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition, or in any subsequent editions, and includes, but is not limited to, alcohol use disorder, opioid use disorder, and stimulant use disorder;[83]

(t) Telemedicine.—"Telemedicine" means the delivery of healthcare services, including diagnosis, consultation, treatment, and prescribing, through the use of interactive remote conferencing technology, such as audio, video, or other electronic media;[84]

(u) Treatment.—"Treatment" means the management of, and care for, individuals with substance use disorder, with or without a co-occurring disorder, delivered by healthcare practitioners and/or behavioral health professionals, in accordance with an individualized assessment and clinical placement criteria, with care that includes assessment, diagnosis,

[79] Adapted from OHIO REV. CODE ANN. § 5119.90 (West 2024).
[80] *Virtual Hearings*, WOMENSLAW.ORG (last accessed Jan. 23, 2025), https://www.womenslaw.org/preparing-for-court/virtual-hearings/basic-info-and-definitions/what-remote-or-virtual-hearing.
[81] Adapted from OHIO REV. CODE ANN. § 5119.90 (West 2024).
[82] *See* AMERICAN PSYCHIATRIC ASSOCIATION, supra note 5.
[83] Taken in part from *Model Access to Medication for Addiction Treatment in Correctional Settings Act*, LEGIS. ANALYSIS & PUB. POL'Y ASS'N (Sept. 2024), https://legislativeanalysis.org/model-access-to-medication-for-addiction-treatment-in-correctional-settings-act-2/.
[84] *Id.*

Return to Table of Contents

case management, medical, psychiatric, behavioral and social services, medication for addiction treatment, counseling, and recovery support services;[85]

(v) Treatment facility.—"Treatment facility" or "facility" means a public or private hospital, a detoxification facility, opioid treatment program, a primary care facility, an intensive care facility, a long-term care facility, an outpatient care facility, a community mental health center, a health maintenance organization, a recovery center, a halfway house, or ambulatory care facility, that is licensed by the state and provides substance use disorder or co-occurring disorder treatment services. Wilderness treatment programs shall not be used as a treatment facility for involuntary commitment;[86] and

(w) Withdrawal management.—"Withdrawal management" refers to the medical and psychological care of patients who are experiencing withdrawal symptoms as a result of ceasing or reducing the use of a drug on which they are physically dependent.[87]

Commentary

The terms defined in this section may already be defined under state law, and states are free to use those definitions in lieu of the definitions provided in this section. However, the definitions included in this section may have been revised to better fit the needs and circumstances of this Act. States should note that the definitions in this Model Act have been crafted in a way to provide the utmost protection for respondents and restrict the use of involuntary commitment to only specific situations involving severe SUD. Modifying a definition or using a definition that a state already has in place may inadvertently weaken those protections or broaden the use of involuntary commitment for SUD.

The drafters have chosen to give probate courts jurisdiction over involuntary commitment proceedings. These courts oversee the execution of wills as well as the handling of estates, conservatorships, and guardianships.[88] Some jurisdictions use the terms "surrogate's court," "orphan's court," or "chancery court" in place of "probate court."[89] Fourteen states currently

[85] Taken in part from *Model Law Enforcement and Other First Responder Deflection Act*, LEGIS. ANALYSIS & PUB. POL'Y ASS'N (Sept. 2021), https://legislativeanalysis.org/model-law-enforcement-and-other-first-responder-deflection-act/.
[86] Adapted from TEX. HEALTH & SAFETY CODE § 462.001 (West 2024).
[87] Based in part on WORLD HEALTH ORGANIZATION, CLINICAL GUIDELINES FOR WITHDRAWAL MANAGEMENT AND TREATMENT OF DRUG DEPENDENCE IN CLOSED SETTINGS 31 (2009), https://www.ncbi.nlm.nih.gov/books/NBK310652/. *See also Model Withdrawal Management Protocol in Correctional Settings Act*, LEGIS. ANALYSIS & PUB. POL'Y ASS'N (June 2021), https://legislativeanalysis.org/modelwithdrawal-management-protocol-in-correctional-settings-act/.
[88] *See* Julia Kagan, *Probate Court: Definition and What Goes Through Probate*, INVESTOPEDIA (July 30, 2024), https://www.investopedia.com/terms/p/probate-court.asp.
[89] *Id.*

Return to Table of Contents

give probate courts jurisdiction over involuntary commitment proceedings.[90] An alternative for states that do not have dedicated probate courts would be to give family courts or district courts jurisdiction over involuntary commitment proceedings. When determining what court over which to assign jurisdiction in involuntary commitment proceedings, states should consider whether the court has the appropriate staff and facilities to ensure the safety of all parties involved. Ultimately, a state may decide that the judicial body it is currently using for involuntary commitment is the most appropriate and can default to that court.

The Model Act uses the term "medication for addiction treatment" (MAT) but other commonly used terms include "medication-assisted treatment" and "medication-based treatment." Additionally, individuals and entities sometimes use the more specific terms of "medication for opioid use disorder" or "medication for alcohol use disorder."

The term "behavioral health professional" includes a "[certified alcohol and drug counselor]." The drafters have included this professional title in brackets as names for certified alcohol and drug counselors vary by jurisdiction, and include titles such as SUD counselor, addiction counselor, and chemical dependency counselor.[91] Additionally, a state certification body may provide for multiple certification tiers for an alcohol and drug counselor based on education and experience level.[92]

SECTION IV. CRITERIA FOR INVOLUNTARY COMMITMENT FOR SUBSTANCE USE DISORDER.

(a) Criteria for involuntary commitment.—A petitioner who meets the requirements set forth in Section V, subsection (a) may file a petition with the court requesting the involuntary commitment of an individual eighteen (18) years of age and older if the petitioner has probable cause to believe that the respondent has severe substance use disorder and because of such disorder:[93]

(1) Is in need of substance use disorder treatment services and would reasonably benefit from such services but is not capable of:

(A) Appreciating his or her need for such services; and

(B) Making a rational decision in that regard;

---

[90] *See Involuntary Commitment of Those with Substance Use Disorders: Summary of State Laws, supra* note 38. The fourteen states are Alabama, Arkansas, Connecticut, Georgia, Indiana, Kansas, Michigan, Missouri, Mississippi, New Hampshire, Ohio, South Carolina, Texas, and Wisconsin.

[91] *See Behavioral Health Careers by State*, SUBSTANCE ABUSE & MENTAL HEALTH SERV. ADMIN. (last updated Oct. 18, 2024), https://www.samhsa.gov/about/careers/behavioral-health-workforce/careers-by-state.

[92] *See Id.*

[93] Adapted from FLA. STAT. ANN. § 397.675 (West 2024) and OHIO REV. CODE ANN. § 5119.92 (West 2024).

Return to Table of Contents

(2) Has a grave disability that results in the respondent being unable to provide for his or her own basic physical needs; and

(3) Without immediate care or treatment there is a grave risk of imminent physical harm to the individual respondent or others.

(b) Refusal to undergo treatment.—The mere refusal to undergo treatment for substance use disorder does not constitute evidence of an inability to make a rational decision as to the need for treatment as required under subsection (a)(1) of this Section.[94]

Commentary

As stated in the commentary for Section II, voluntary participation in evidence-based SUD treatment is preferable, as it provides an individual with complete autonomy, but in certain situations, involuntary commitment may be necessary. Because involuntary commitment involves the limitation of an individual's civil liberties, its use should be limited to cases involving individuals with severe SUD who are at grave risk of imminent physical harm to him or herself or others. The use of substances or the diagnosis of SUD alone is not a justification for involuntary commitment, nor is the risk of overdose alone. Additionally, involuntary commitment should never be used as a punishment for individuals who refuse to undergo voluntary treatment for SUD.

In order to constitutionally involuntarily commit an individual, the U.S. Supreme Court has ruled that there must be a threat of harm to self or others; this is referred to as the dangerousness standard.[95] Based on input from working group subject matter experts, the drafters have limited the use of involuntary commitment to situations involving a grave risk of imminent physical harm toward self or others. Originally, the drafters included a risk of serious emotional injury as well, but the members of the working group expressed concerns that allowing involuntary commitment for a risk of serious emotional injury would result in expansive and unnecessary use of involuntary commitment due to the indistinct and subjective nature of emotional injuries. In addition to dangerousness, involuntary commitment laws have increasingly considered the presence of a "grave disability" or "serious deterioration" in determining the appropriateness of involuntary commitment.[96] The drafters have added a grave disability requirement based on the definition of grave disability in Arizona law.[97] An individual with a grave disability may be at a grave risk for imminent physical harm without intervention. One member of the working group suggested adding a clause that would allow involuntary commitment when a respondent's substance use substantially interferes with his or her social or economic functioning, which is a clause included in the definition of "alcohol use disorder" and "substance use disorder" in Massachusetts law.[98] The drafters declined to incorporate this clause

[94] Adapted from FLA. STAT. ANN. § 397.675 (West 2024).
[95] *See* O'Connor v. Donaldson, 422 U.S. 563, 576 (1975).
[96] *Id.*
[97] ARIZ. REV. STAT. ANN. § 36-501(16) (West 2025).
[98] *See* MASS. GEN. LAWS ANN. ch. 123 § 35 (West 2025).

Return to Table of Contents

within the criteria for involuntary commitment for SUD over concerns that the standard was too broad and would be subject to subjective interpretation. The drafters believe that the grave disability requirement gets at the intent of the "substantial interference with social or economic functioning" suggestion but provides a much narrower, objective standard that does not greatly expand the use of involuntary commitment for SUD.

SECTION V. PETITION FOR INVOLUNTARY COMMITMENT FOR SUBSTANCE USE DISORDER.

(a) Who may petition.—A petition for involuntary commitment may be filed with the court by:[99]

(1) The spouse, parent, adult sibling, adult child, or legal guardian or conservator of the respondent;

(2) An individual who is at least eighteen (18) years of age and resides with the respondent;

(3) A healthcare practitioner or behavioral health professional who provides care to the respondent and whose license or credential permits the diagnosis of substance use disorder; or

(4) A law enforcement official.

(b) Representation of petitioners.—A petitioner who is a healthcare practitioner, behavioral health professional, or law enforcement official and is filing a petition within the scope of his or her professional duties, shall be represented by the county or district attorney, or his or her designee.

(c) Elements of the petition.—The petition shall be in writing, sworn to under oath, and shall include the following information:[100]

(1) The petitioner's name and address;

(2) The petitioner's relationship to the respondent;

(3) The respondent's name, address (if applicable), and current location;

(4) An assertion that the respondent is over the age of eighteen (18);

[99] Adapted from NEV. REV. STAT. § 433A.335 (West 2024).
[100] Adapted from MICH. COMP. LAWS ANN. § 330.1281a (West 2024).

Return to Table of Contents

(5) A description of the facts and overt acts that lead the petitioner to believe that the respondent has severe substance use disorder, is experiencing a grave disability, and presents a grave risk of imminent physical harm to him or herself, or others;

(6) Documentation that the respondent has refused accessible and appropriate voluntary treatment. The documentation may include, but is not limited to, notations in the respondent's medical or law enforcement records or sworn, written statements by a healthcare practitioner or behavioral health professional that are attached to the petition;[101]

(7) The names and addresses of other individuals with knowledge of the respondent's substance use disorder and of the allegations contained in the petition who may be called as witnesses; and

(8) A statement that the petitioner does not have a financial interest in, and will not receive any financial gain from, having the respondent involuntarily committed.

(d) Medical certification.—The petition shall be accompanied by a signed certificate of a healthcare practitioner who has examined the respondent within five (5) days before the filing of the petition, unless the respondent has refused to submit to a medical examination, in which case the fact of refusal shall be alleged in the petition. The signed certificate shall set forth the healthcare practitioner's findings, including clinical observations or information in support of the allegations of the petition, a finding of whether the respondent currently needs and is likely to benefit from treatment, and a recommendation as to the type of treatment .[102]

(e) Motion for temporary protective custody.—A petition for involuntary commitment filed with the court may include a motion for an order of temporary protective custody. Such motion shall state that the petitioner has reason to believe that the respondent presents a grave risk of imminent physical harm to him or herself or others if he or she remains at liberty prior to the commitment hearing, and such motion shall be supported by evidence, in the form of notations in the respondent's medical or law enforcement records, or sworn

[101] Adapted from COLO. REV. STAT. ANN. § 27-81-112 (West 2024).
[102] Adapted from COLO. REV. STAT. ANN. § 27-81-112 (West 2024) and CONN. GEN. STAT. ANN. § 17a-689 (West 2024).

Return to Table of Contents

written statements by a healthcare practitioner, behavioral health professional, or witness.[103]

(f) Issuance of an order for temporary protective custody.—If the court issues an order for temporary protective custody, the order shall direct a law enforcement official or a non-emergency medical transportation service to transport the respondent immediately to a treatment facility for protective custody pending the outcome of the probable cause hearing outlined in Section VI of this Act. Restraints shall not be used while transporting the respondent unless they are necessary to protect his or her safety or that of the transporters. At no time shall the respondent be held for protective custody in a correctional facility.[104]

(g) Care of respondent in temporary protective custody.—If a respondent is ordered into temporary protective custody, the treatment facility in which he or she has been placed shall provide the respondent with medically supervised withdrawal management services and supportive care, as determined to be necessary by the treatment facility, to stabilize him or her. The treatment facility should always offer initiation of medication for addiction treatment when clinically appropriate.

(h) Rights of respondent.—The petition shall include or contain as an attachment the following statement of rights:[105]

(1) The respondent has the right to effective assistance of counsel, including the right to a court-appointed attorney, throughout the involuntary commitment process, including during any applicable recommitment procedures outlined in Section IX;

(2) The respondent and his or her attorney have the right to be present at all significant stages of the proceedings and at all hearings, except that no attorney shall be entitled to be present upon medical examination of the respondent, unless the respondent determines that he or she wants his or her attorney to be present during the examination;

[103] Adapted from TEX. HEALTH & SAFETY CODE § 462.065 (West 2024).
[104] Adapted from TEX. HEALTH & SAFETY CODE § 462.065 (West 2024).
[105] Adapted from ARK. CODE ANN. § 20-64-801 (West 2024).

Return to Table of Contents

(3) The respondent has the right to present evidence on his or her own behalf and cross-examine witnesses who testify against him or her;

(4) The respondent has the right to remain silent, and the refusal to testify shall not result in an adverse inference nor be used as evidence that involuntary commitment is appropriate or necessary;

(5) The respondent has the right to view and copy all petitions, reports, and documents contained in the court file; and

(6) The respondent has the right to request to speak with a peer support worker or advocate at any time throughout the involuntary commitment process. Requests to speak with a peer support worker or advocate shall not postpone or delay any previously scheduled hearing. If a peer support worker or advocate is available, he or she may meet with the respondent in person or via a telemedicine platform. The peer support worker or advocate shall be compensated for his or her time by the respondent or his or her health insurance, if insured.

(i) Establishment of probable cause.—Upon the filing of a petition for involuntary commitment, the court shall review the petition and accompanying documents within forty-eight (48) hours to determine whether it complies with the requirements set forth in this section and whether it establishes probable cause to believe that the respondent is an individual with a severe substance use disorder requiring treatment who has a grave disability and is at a grave risk of causing imminent physical harm to self or others. If probable cause has not been established, the petition shall be dismissed unless an amendment would cure the defect.[106]

(j) Notice and summons procedure.—The respondent shall be served with a copy of the petition and a summons to appear for the commitment hearing pursuant to the [rules of civil procedure].

(k) Duties of counsel.—The attorney for the respondent shall:[107]

(1) Consult with the respondent prior to any hearing;

(2) Be given adequate time and access to prepare for all hearings;

[106] Adapted from N.D. CENT. CODE ANN. § 25-03.1-09 (West 2024).
[107] Adapted from MINN. STAT. ANN. § 253B.07 (West 2024).

Return to Table of Contents

(3) Continue to represent the respondent throughout any involuntary commitment proceedings unless released as counsel by the court or the respondent; and

(4) Be a vigorous advocate on behalf of the respondent.

(l) Compensation of court-appointed attorney.—If the respondent has a court appointed attorney, the attorney shall be paid by the county where the hearing and commitment proceedings are taking place at a rate determined by [reference to state or local law regarding compensation of court appointed attorneys].[108]

(m) Cost of treatment.—The cost of any and all treatment and other services associated with the temporary protective custody and involuntary commitment of the respondent shall be paid as follows:

(1) By the respondent's health insurance, if he or she is insured and if such services are covered;

(2) By the petitioner, who shall sign a guarantee which shall be filed with the petition obligating him or her to pay such costs only if the respondent does not have health insurance or if any services are not covered by the respondent's insurance; or

(3) By the state if the petitioner is filing the petition within his or her role as a law enforcement official, a healthcare practitioner, or a behavioral health professional, or if the petitioner is indigent.

(n) Penalty for false petition.—Any individual who willfully makes, joins in, or advises the making of any false petition or report, or knowingly or willfully makes any false representation for the purpose of causing the petition or report to be made, or for the purpose of causing an individual to be improperly committed under this chapter is guilty of a [misdemeanor].[109]

Commentary

Involuntary commitment cases are adjudicated in the civil court system, and the process is initiated when a concerned individual files a petition with the court. The petition provides supporting information and documentation to justify why a respondent's severe SUD requires involuntary commitment to prevent a grave risk of imminent physical harm to the respondent or others.[110] Among existing involuntary commitment laws, jurisdictions vary in who can file a

[108] Adapted from S.D. CODIFIED LAWS § 34-20A-70.1 (West 2024).
[109] Adapted from MINN. CODE. ANN. § 253B.23 (West 2024).
[110] Walton, *supra* note 34, at 384.

Return to Table of Contents

petition.[111] In 26 states and four territories, any adult can file a petition for involuntary commitment.[112] The drafters have limited who can file a petition for involuntary commitment for SUD to only certain family members of the respondent, a legal guardian or conservator of the respondent, an individual who lives with the respondent, a healthcare practitioner or behavioral health professional treating the respondent, or a law enforcement official. The drafters have chosen to limit who can file a petition only to the above-mentioned individuals because they are the individuals who would likely be the most knowledgeable about the respondent's behavior, risk level, and need for treatment. Limiting petitions only to these individuals helps to reduce the filing of petitions that are based only on a single or limited interaction with the respondent that may not have been reflective of the respondent's overall behavioral state.

The drafters have chosen to include law enforcement officials within the list of individuals that are eligible to file a petition in an effort to address situations in which an individual has little or no family or is not regularly seeking health care. However, some members of the working group expressed concerns about the inclusion of law enforcement officials on the list of eligible petitioners because they did not believe that law enforcement officials possess the qualifications or knowledge to assess an individual's SUD or co-occurring disorders. Some members of the working group also expressed concerns that allowing law enforcement officials to file petitions for involuntary commitment could make involuntary commitment a tool for police to deprive individuals of their rights without criminal process, worsen bias in policing, and increase law enforcement surveillance of individuals who use drugs. The drafters sought to include every option within the limited list of eligible petitioners, but a jurisdiction may further narrow the list to better suit its needs. An option to address concerns associated with law enforcement officials involuntarily committing individuals is to tie their ability to do so through deflection programs, whenever possible. Deflection is any collaborative intervention connecting law enforcement, other first responders, and community responders with public health systems to create pathways to evidence-based treatment and services for individuals—with low to moderate criminogenic risk—who have a substance use disorder, mental health disorder, or co-occurring disorders and who often have other service needs.[113] In active outreach deflection, law enforcement, alone or as part of a team with behavioral health professionals, proactively seeks to initiate contact with individuals or groups that are repeatedly showing signs of SUD in an effort to provide them with a referral to treatment or other services without that individual fearing arrest.[114] While deflection is meant to be voluntary, there may be a situation in which an individual refuses services and his or her refusal places him or her at a grave risk for imminent physical harm. In such a situation, the law enforcement officer may consider filing a petition for involuntary commitment of the individual. Jurisdictions that do not have deflection programs in

[111] *See Involuntary Commitment of Those with Substance Use Disorders: Summary of State Laws, supra* note 38.
[112] *Id.* The jurisdictions are Alabama, Arkansas, California, Colorado, Connecticut, Delaware, George, Hawaii, Illinois, Iowa, Kansas, Louisiana, Maine, Maryland, Missouri, New Hampshire, North Carolina, North Dakota, Pennsylvania, South Carolina, South Dakota, Texas, Vermont, Virginia, West Virginia, Wyoming, American Samoa, Guam, Northern Mariana Islands, and Puerto Rico.
[113] *Deflection and the Deflection Pathways*, LEGIS. ANALYSIS & PUB. POL'Y ASS'N (July 2023), https://legislativeanalysis.org/deflection-and-the-deflection-pathways/.
[114] *Id.*

Return to Table of Contents

place should refer to LAPPA's Model Law Enforcement and Other First Responder Deflection Act, drafted in collaboration with the Police, Treatment, and Community Collaborative.

Subsection (c) details the elements of the petition. As part of the petition, the petitioner is required to provide documentation that the respondent has refused accessible and appropriate voluntary treatment. One member of the working group suggested requiring petitioners to submit at least three separate documents detailing the respondent's refusal to accept voluntary treatment. While the drafters believe that the petitioner should ensure that voluntary treatment options have been exhausted or refused prior to filing a petition for involuntary commitment, other working group members were concerned that specifying a required number of documents would place too large a barrier on involuntary commitment. If the respondent is unwilling or unable to voluntarily participate in treatment, it would likely be difficult for the petitioner to get the respondent to meet with multiple treatment providers in order to obtain a specific number of records documenting his or her refusal to enter into treatment. The petitioner is also required to provide the names and addresses of other individuals with knowledge of the respondent's SUD and of the allegations contained in the petition who may be called as witnesses. The drafters did not include a minimum number of witnesses due to concerns that it would place too high a burden on the petitioner. Depending on the situation, it may be difficult for the petitioner to secure individuals who are able to commit to being witnesses, even if a potential witness believes that the respondent is in need of involuntary commitment, because a witness must be available for court hearings. Potential witnesses may ask not to be listed in the petition because they know that they are unable to participate in court hearings due to an inability to take time off from work, obtain childcare, or secure transportation. Potential witnesses might also be limited in number due to family or friends losing contact with the respondent.

In subsection (d), the drafters require the petition to be accompanied by a signed certificate from a healthcare practitioner who has examined the respondent within five (5) days before the filing of the petition. Existing involuntary commitment laws requiring a medical certificate as part of the petition vary on the timeframe in which the healthcare practitioner must have examined the respondent before the filing of the petition, ranging from two days to 45 days.[115] The drafters chose a five-day time frame believing that it would be close enough to the filing of the petition to reflect the current health of the petitioner, while also providing the healthcare practitioner enough time to draft a thorough report and the petitioner enough time to complete and submit the petition. Subsection (d) also states that if the respondent has refused to submit to a medical examination, the fact of refusal shall be alleged in the petition. One working group member commented that only a healthcare practitioner, not the petitioner or any other witness, should be able to allege that the respondent refused to submit to a medical examination. The drafters chose not to specify that a healthcare practitioner must allege, if applicable, in the petition that the respondent refused to submit to a medical examination because it would be difficult for a healthcare practitioner to allege such a thing if the respondent refuses to visit the healthcare practitioner's office to participate in an examination. In such a case, a petitioner cannot simply ask a healthcare practitioner to submit an affidavit stating that the respondent would not submit to an examination because the court would likely consider such a statement to

[115] *See Involuntary Commitment of Those with Substance Use Disorders: Summary of State Laws, supra* note 38.

Return to Table of Contents

be hearsay. The petitioner in that situation would be in the best position to allege that the respondent has refused to submit to a medical examination.

A difficult aspect of involuntary commitment laws is determining who is responsible for paying for the respondent's treatment. Based on feedback from members of the working group, the drafters have established a tiered system of financial responsibility. First, all costs associated with evidence-based treatment and other services provided to the respondent during temporary protective custody and involuntary commitment are to be paid by the respondent's health insurance, if he or she is insured. Any co-pays, deductibles, and co-insurance associated with the covered services are the responsibility of the respondent. Note that what services are covered may depend on the type of insurance that the respondent has. If the respondent is not insured, or if certain services are not covered by the respondent's insurance, then the petitioner is financially responsible for such costs. The drafters chose to make the petitioner financially responsible as opposed to the respondent absent any health insurance coverage because forcing the respondent into treatment that he or she does not want or request and requiring him or her to be responsible for paying for it is patently unfair. Additionally, placing financial responsibility on the petitioner can help reduce the risk of frivolous petitions being filed and better ensure that involuntary commitment is only used in severe situations as a last resort. Petitioners that are filing a petition within their role as a law enforcement official, healthcare practitioner, or behavioral health professional are exempt from financial responsibility because these petitioners should not be personally responsible for actions taken within the scope of their professional responsibility. If the petitioner is indigent or is subject to the professional exemption, then the financial responsibility for the respondent's treatment and other services falls to the state. Despite having an exception for petitioners that are indigent, some working group members expressed concerns that placing financial responsibility on the petitioner could still limit access to involuntary commitment only to individuals that are above a certain income level. An option to address this concern would be for a state to implement a sliding scale payment model in which the petitioner would pay a percentage of the treatment costs based on his or her income and the remaining costs would be paid by the state.

In further efforts to reduce the risk of frivolous or ill-intentioned petitions, the drafters included a penalty for the filing of a false petition. Twenty-four states' involuntary commitment laws set forth a penalty for filing a false petition for involuntary commitment.[116] Of those, nine states consider the filing of a false petition to be perjury, nine states categorize the filing of a false petition as a misdemeanor, and three states categorize the filing of a false petition as a felony.[117] Maryland's involuntary commitment law states that an individual who files a false petition can be held civilly or criminally liable.[118] Moreover, the drafters have required the petitioner to attest to a statement in the petition that states that he or she does not have a financial interest in, and will not receive any financial gain from, having the respondent involuntarily committed. This requirement will safeguard against ill-intentioned petitions and help prevent

[116] *Id.* The states are Alabama, Alaska Arkansas, California, Connecticut, Delaware, Georgia, Hawaii, Illinois, Kansas, Kentucky, Maryland, Michigan, Minnesota, New Jersey, New York, Oklahoma, Oregon, South Carolina, Utah, Vermont, West Virginia, and Wyoming.
[117] *Id.*
[118] *Id.*

Return to Table of Contents

petitions filed by individuals, especially healthcare practitioners or behavioral health professionals, from seeking to have a respondent involuntarily committed to a treatment facility that he or she operates or in which he or she has a financial interest.

One working group member suggested that petitioners, excluding those that are law enforcement officials, healthcare practitioners, and behavioral health professionals, be required to complete mandatory therapy or programing as a condition of filing a petition for involuntary commitment. The working group member argued that having such requirement would further safeguard against frivolous or unnecessary petitions because it would limit petitioners to only those who are seriously invested in participating in the respondent's recovery. While the drafters agree that petitioners, especially those who are family or friends of the respondent, should be invested in and supportive of the respondent's recovery, requiring the petitioner to participate in therapy in order to file a petition for involuntary commitment goes beyond the scope of this Model Act. Choosing to file a petition to involuntarily commit a loved one is an emotional decision, and petitioners should be encouraged to seek out and participate in individual or family therapy or support groups. However, it would be logistically difficult for the Model Act to require such participation due to issues and questions related to financial responsibility, the timeline in which the requirement would need to be completed, and consequences of non-compliance.

All respondents have the right to counsel throughout the involuntary commitment process. To ensure that attorneys zealously advocate for their clients in involuntary commitment proceedings, the drafters have included a set of requirements in subsection (k) for attorneys preparing for and participating in involuntary commitment proceedings. In the interest of justice, respondents benefit from an adversarial proceeding where their attorneys represent their desires and advocate ardently on their behalf.[119] The respondent's attorney is required by the rules of professional conduct to advocate for the respondent's desired outcome in the proceeding even if the attorney believes that involuntary commitment is in the best interest of the respondent.[120] The respondent's attorney, as always, should ensure that the respondent understands his or her rights throughout the proceeding. When a court appointed attorney is necessary, courts should, if feasible, give preference to attorneys that have experience representing individuals with severe SUD, with or without a co-occurring disorder.[121] While not specifically addressed in the Model Act, the petitioner has the right to have an attorney of his or her choice. A limited number of states, including Montana, Nebraska, New Mexico, and Oklahoma, require that the county or district attorney, or his or her designee, represent the petitioner in an involuntary commitment proceeding.[122] With the exception of petitioners who are healthcare practitioners, behavioral health professionals, and law enforcement officials that are filing a petition within the scope of their professional duties, the drafters chose not to have the county or district attorney represent the petitioner because involuntary commitment is a civil rather than criminal issue. Additionally, requiring the county or district attorney to represent the petitioner could place a financial burden

[119] Margaret J. Lederer, *Not So Civil Commitment: A Proposal for Statutory Reform Grounded in Procedural Justice*, 72 DUKE L. J. 903, 929 (2022), https://scholarship.law.duke.edu/dlj/vol72/iss4/4/.
[120] MODEL RULES OF PROF'L CONDUCT r. 1.2 (AM. BAR ASS'N 1983).
[121] *Id.* at 937.
[122] *See Involuntary Commitment of Those with Substance Use Disorders: Summary of State Laws, supra* note 38.

Return to Table of Contents

on the office and result in delays to other non-involuntary commitment cases due to the strain on staffing and other resources. However, if a jurisdiction has the means to allow the county or district attorney to represent all petitioners or if it has the county or district attorney represent the petitioner in involuntary commitment for mental illness cases, it can make the decision to allow the district or county attorney to be appointed to represent all petitioners in involuntary commitment for SUD cases.

A member of the working group also recommended that a court-appointed peer support worker or advocate be assigned to the respondent to provide support to the respondent prior to, during, and following involuntary commitment. Because a peer support worker or advocate may not be immediately available due to a nationwide shortage of such professionals and also due to the cost of retaining such individuals by courts, the drafters have provided the respondent with the right to request to speak with a peer support worker or advocate rather than automatically assigning such a person to every respondent. However, the court, the respondent's attorney, or the treatment facility should make a good faith effort to connect the respondent with a peer support worker or advocate either in person or via a secure electronic platform as soon as reasonably possible after the request is made if such service is available. Having access to such individuals provides the respondent with another individual to whom he or she can ask questions, especially questions that he or she might not be comfortable asking an attorney, and seek support and guidance. If a respondent requests to speak with a peer support worker or advocate, and such individual is available, then the respondent or the respondent's health insurance, if insured and covered by his or her insurance, must bear the financial responsibility of paying for such service. The respondent, or his or her insurance plan, is solely responsible for the costs associated with speaking to a peer support worker or advocate because electing to speak with such individual is optional and not a required aspect of the involuntary commitment process or proceeding.

A petitioner may include a motion for an order of temporary protective custody as part of the petition for involuntary commitment if he or she believes that the respondent presents a grave risk of imminent physical harm to him or herself or others if he or she remains at liberty prior to the commitment hearing. The drafters have established a protocol that allows a judge to grant the motion for temporary protective custody based on a reading of the petition and the motion and a finding of probable cause. Subsequently, within 72 hours, the court must hold a hearing as described in Section VI to determine if there is probable cause to continue to hold the respondent in temporary protective custody until the final disposition hearing. If the respondent is ordered to undergo temporary protective custody, the use of restraints and physically coercive measures should be limited while transporting the respondent to the treatment facility.[123] While the respondent is in temporary protective custody, the treatment facility must provide the respondent with withdrawal management and supportive care as necessary. During a temporary protective custody order, the intent is not to provide SUD treatment to the respondent but to stabilize him or her because, at this point, the respondent has not been ordered to receive involuntary treatment. However, the treatment facility may offer the respondent MAT or other evidence-based

[123] AM. PSYCHIATRIC ASS'N, POSITION STATEMENT ON VOLUNTARY AND INVOLUNTARY HOSPITALIZATION OF ADULTS WITH MENTAL ILLNESS (2020), https://www.psychiatry.org/about-apa/policy-finder/position-statement-on-voluntary-and-involuntary-ho.

Return to Table of Contents

treatment when clinically appropriate. In addition to withdrawal management services, other services that the treatment facility may provide to a respondent in temporary protective custody include comfort care and symptom management, treatment for acute infections, and wound care.

Multiple working group members expressed concern about what would happen if a court ordered a respondent into temporary protective custody or involuntary commitment and no treatment facilities with beds were immediately available to accept the individual. Due to the lack of treatment facilities in some areas, this is a situation that may occur and something for which jurisdictions should be prepared with a contingency plan. Even when no treatment facility beds are immediately available, jurisdictions must not hold respondents in correctional facilities. A possible option in such a situation would be to transport the respondent to a hospital or a behavioral health crisis center to be held until a bed at an appropriate treatment facility becomes available. This option, however, comes with its own challenges as hospitals and crisis centers may be unwilling to hold respondents beyond a certain length of time. Additionally, there would be a question of who would bear the cost of such a stay should it be necessary. One member of the working group also recommended that treatment facilities not designate or hold a certain number of beds only for involuntary commitment patients because it would limit the number of available treatment spots for individuals seeking voluntary treatment. The long-term solution for this issue is for jurisdictions to invest in SUD treatment infrastructure and workforce to better ensure that everyone who needs SUD treatment can immediately access it.[124]

Additionally, a member of the working group suggested that the drafters include a provision to permit respondents with minor children to designate an individual to assign temporary custody of their children prior to the involvement of child protective services if the respondents are placed in temporary protective custody or are subsequently involuntarily committed. While the need to determine who will have custody of the respondent's children is an important concern, it goes beyond the scope of this Model Act. Jurisdictions likely already have laws in place that address such situations in which a parent needs to temporarily assign custody of a child to another individual.

SECTION VI. PROBABLE CAUSE HEARING FOR TEMPORARY PROTECTIVE CUSTODY.

(a) Probable cause hearing.—If the court issued an order for temporary protective custody under Section V, subsection (e), then it shall hold a hearing no later than seventy-two (72) hours after the temporary protective custody order is signed to review the petition and motion for protective custody to determine if there is probable cause to continue to hold the respondent in temporary protective custody until the final disposition hearing. If

[124] *See Model Building the Substance Use Disorder Workforce of the Future Act*, LEGIS. ANALYSIS & PUB. POL'Y ASS'N (Dec. 2024), https://legislativeanalysis.org/model-building-the-substance-use-disorder-workforce-of-the-future-act/.

Return to Table of Contents

the period ends on a Saturday, Sunday, or legal holiday, the hearing shall be held on the next day that is not a Saturday, Sunday, or legal holiday.[125]

(b) Postponement of hearing.—The court may postpone the hearing each day for an additional twenty-four (24) hours if it declares that an extreme emergency exists because of hazardous weather conditions or a natural disaster or the respondent or another essential party to the hearing is experiencing a medical or family emergency.[126] A petition for involuntary commitment shall not be dismissed solely because the probable cause hearing is not completed within the time period required by this section if there is good cause for the delay.[127]

(c) Opportunity to appear.—The respondent and the respondent's attorney are entitled to appear at the hearing and present evidence.[128]

(d) Burden of proof.—The burden shall be on the petitioner to show that probable cause for continued protective custody exists.[129]

(e) Remote hearing.—This hearing may be held remotely if doing so would be in the best interest of the respondent.

(f) Probable cause established.—If the court determines after the hearing that probable cause exists for the continued protective custody of the respondent due to him or her presenting a grave risk of imminent physical harm to him or herself or others, the court shall order the respondent to continue to be detained in the treatment facility until the final disposition hearing.[130] The provisions of Section V, subsection (f) apply to the respondent's continued protective custody.

(g) Lack of probable cause.—If the court determines after the hearing that probable cause does not exist for the continued protective custody of the respondent, it shall order the immediate release of the respondent.

[125] Adapted from TEX. HEALTH & SAFETY CODE § 462.066 (West 2024).
[126] Adapted from TEX. HEALTH & SAFETY CODE § 462.066 (West 2024).
[127] Adapted from VT. STAT. ANN. tit. 18 § 7612a (West 2024).
[128] Adapted from TEX. HEALTH & SAFETY CODE § 462.066 (West 2024).
[129] Adapted from N.H. REV. STAT. ANN. § 135-C:31 (West 2024).
[130] Adapted from TEX. HEALTH & SAFETY CODE § 462.066 (West 2024).

Return to Table of Contents

(h) Discharge from temporary protective custody.—If the respondent is discharged from temporary protective custody, the treatment facility shall provide him or her with the following upon release:[131]

(1) Information about options for voluntary substance use disorder treatment, mental health treatment and support, peer support services, recovery support services, and social services;

(2) Consistent with state and federal laws, a prescription for a sufficient supply of medication for addiction treatment to last until the final disposition hearing described in Section VII of this Act for respondents that chose to initiate medication for addiction treatment. If the respondent has been initiated on methadone, the treatment facility shall also provide him or her with instructions on how to fill his or her prescription at the nearest opioid treatment program, if the treatment facility is not itself certified as an opioid treatment program, and information on transportation; and

(3) At least two doses of overdose reversal medication and instructions on its use.

Commentary

Within 72 hours of the issuance of an order for temporary protective custody, the court is required to hold a hearing to determine whether probable cause to continue the order for temporary protective custody until the final disposition hearing exists. One member of the working group suggested that the hearing occur within 24 to 48 hours of the issuance of the order for temporary custody. The drafters agree that holding the hearing as soon as possible is in the best interest of justice but want to ensure that the attorneys have enough time to properly prepare for the hearing, which may not be possible in such a short timeframe. The 72-hour timeframe allows the respondent to get the care that he or she needs, while also providing the parties with enough time to prepare for the hearing.[132] Additionally, the National Center for State Courts identifies 72 hours as sufficient time to permit the parties to prepare themselves and present their cases at a hearing.[133]

This hearing uses the evidentiary standard of probable cause, which is a lower burden of proof than the clear and convincing standard used in the final disposition hearing in Section VII. The probable cause hearing is more informal than the final disposition hearing, and the hearing

[131] Adapted from Section IV of the *Model Substance Use Disorder Treatment in Emergency Settings Act*, LEGIS. ANALYSIS & PUB. POL'Y ASS'N (Mar. 2023), https://legislativeanalysis.org/model-substance-use-disorder-treatment-in-emergency-settings-act/.
[132] Lederer, *supra* note 119, at 932.
[133] *Id.*

Return to Table of Contents

does not provide the respondent with the full array of rights that the final disposition hearing allows. Nonetheless, the respondent should be present and represented by counsel during the probable cause hearing, as procedural justice is increased when the respondent has the opportunity to interact with the court and participate in the proceedings.[134] This hearing may be held remotely if it is in the best interest of the respondent. Information and details about remote hearings is best left for regulation or policy, and many courts likely already have established protocols for remote hearings.

If the respondent is ordered into continued temporary protective custody at the conclusion of the hearing, he or she is to remain at the treatment facility, continuing to receive supportive services and MAT, if initiated, until the final disposition hearing in Section VII. A member of the working group suggested that the court hold an additional hearing every 48 to 72 hours up until the final disposition hearing in order for the court to reevaluate the respondent's need for temporary protective custody. The expedited timeline for involuntary commitment cases, which involves both a temporary protective custody hearing and a final disposition hearing, is a lot for a court to handle in a system that is already overwhelmed. The drafters believe that requiring additional temporary protective custody hearings would place an even greater burden on the courts. However, should a jurisdiction believe that it could manage additional hearings, it may consider including them as part of its involuntary commitment procedure.

Subsection (h) establishes discharge requirements to reduce the risk of overdose in respondents that have been released from temporary protective custody and are allowed to remain at liberty until the final disposition hearing. There is an increased risk of overdose after a period of abstinence from drugs due to a reduction in an individual's tolerance.[135] When an individual experiences a reduction in tolerance, a previously tolerated dose of a substance may potentially be fatal if the individual returns to use.[136] Loss of tolerance commonly occurs after incarceration, hospitalization, and medically supervised withdrawal.[137] To reduce the respondent's risk of overdose upon release, the treatment facility is required to provide him or her with referrals to peer support services. Additionally, if the respondent chooses to initiate MAT while in temporary protective custody, the treatment facility, in accordance with federal and state law, is required to supply him or her with a prescription for enough medication to last until the final disposition hearing. Due to federal regulations, the treatment facility must make special considerations for individuals that are initiated on methadone, as prescriptions for methadone for the treatment of SUD cannot be filled at a standard pharmacy. If the respondent is initiated on methadone, the treatment facility must provide the respondent with instructions on how to obtain that medication from an opioid treatment program (OTP) and information on transportation to and from the OTP, if necessary. The risk of overdose, suicide, and death can be significantly reduced by allowing individuals who previously initiated MAT to continue using

[134] *Id.*
[135] Derek C. Chang, et al., *A Case of Opioid Overdose and Subsequent Death After Medically Supervised Withdrawal: The Problematic Role of Rapid Tapers for Opioid Use Disorder*, 12 J. OF ADDICTION MED. 80 (Jan./Feb. 2018), https://doi.org/10.1097/ADM.0000000000000359.
[136] *Id.*
[137] *Id.*

Return to Table of Contents

the medications.[138] Finally, because of the prevalence of synthetic opioids, including fentanyl, in the illegal drug supply, and the frequency of polysubstance use, the treatment facility is required to provide all individuals released from temporary protective custody with overdose reversal medications, such as naloxone.

SECTION VII. FINAL DISPOSITION HEARING.

(a) Final disposition hearing.—The court shall fix a date for the final disposition hearing no later than ten (10) days, excluding Saturday, Sunday, and legal holidays, after the date that the petition was filed.

(b) Postponement of hearing.—At the request of the respondent or the respondent's attorney, the hearing may be postponed, but in no case may the postponement exceed seven (7) calendar days from the date established by the court in subsection (a).[139]

(c) Failure to appear.—In the event that the respondent is not in protective custody and fails to appear for the hearing, the respondent may be found in contempt of court, and the court may take action pursuant to the [rules of civil procedure].

(d) Location of hearing.—The hearing may be held at any convenient place within the county. The respondent or the court on its own motion may request that the hearing occur in another county because of convenience to the parties or the court or because of the respondent's mental or physical condition.[140] The hearing may be held remotely if it is in the best interest of the respondent.

(e) Closed hearings.—Every hearing that is held under this section shall be closed to the public, unless the respondent or the respondent's attorney moves to open the hearing.[141] If the hearing is closed, only the petitioner, respondent, their attorneys and witnesses, and anyone specially requested by the respondent or the court shall be permitted to be present.

(f) Respondent's presence at hearing.—The respondent shall be present at the hearing unless he or she waives the right to be present on the record or in writing filed with the court. A

[138] *See* NAT'L COMM'N ON CORR. HEALTH CARE, JAIL-BASED MEDICATION-ASSISTED TREATMENT (2018), https://www.sheriffs.org/publications/Jail-Based-MAT-PPG.pdf.
[139] Adapted from WIS. STAT. ANN. § 51.20 (West 2024).
[140] Adapted from HAWAII REV. STAT. ANN. § 334-60.5 (West 2024).
[141] Adapted from NEB. REV. STAT. § 71-951 (West 2024).

Return to Table of Contents

waiver is valid only upon acceptance by the court following a judicial determination that the respondent understands his or her rights and is competent to make such a waiver.[142]

(g) Exclusion of respondent by court.—The court, on its own motion or on the motion of any party, may exclude a respondent from the hearing who is seriously disruptive to the point that the hearing cannot continue. In such instances, the court shall specify on the record the behavior of the respondent or the other circumstances justifying proceeding in the absence of the respondent. If a respondent is excluded from a hearing by the court, the respondent's attorney shall be present for the entirety of the hearing.[143]

(h) Testimony and witnesses.—During the hearing, the petitioner and the respondent shall be afforded the opportunity to testify and to present and cross-examine witnesses.[144]

(i) Medical examination.—A respondent shall not be subject to an order of involuntary commitment unless at least one healthcare practitioner who has personally examined the respondent for the purpose of the involuntary commitment proceeding testifies at the hearing. If the petition did not include a medical certification due to the refusal of the respondent to be examined, the court shall provide the respondent with an opportunity to be examined by a court-appointed healthcare practitioner chosen by the respondent from a list of qualified healthcare practitioners prior to the final disposition hearing. If the respondent refuses to submit to an examination and there is sufficient evidence to believe that the allegations of the petition are true, the court may issue a temporary order committing the respondent to a treatment facility for a period of not more than five (5) days to conduct a diagnostic examination.[145]

(j) Independent medical examination.—The respondent shall have the right to secure his or her own independent medical examination by a healthcare practitioner of his or her choice prior to the final disposition hearing and have the healthcare practitioner testify on his or her behalf.[146]

---

[142] Adapted from HAWAII REV. STAT. ANN. § 334-60.5 (West 2024).
[143] Adapted from MINN. STAT. ANN. § 253B.08 (West 2024).
[144] Adapted from N.D. CENT. CODE ANN. § 25-03.1-19 (West 2024).
[145] Adapted from HAWAII REV. STAT. ANN. § 334-60.5 (West 2024) and S.D. CODIFIED LAWS § 34-20A-76 (West 2024).
[146] Adapted from HAWAII REV. STAT. ANN. § 334-60.5 (West 2024).

Return to Table of Contents

(k) Compensation of healthcare practitioner.—A healthcare practitioner that examines a respondent pursuant to subsection (i) or (j) shall be compensated through the respondent's health insurance, if the respondent is insured. If the respondent is not insured, the healthcare practitioner shall be paid by the county where the involuntary commitment proceedings take place. The county shall be reimbursed for such expense by the petitioner if he or she is financially able to do so.[147]

(l) Telemedicine.—For the purpose of a medical evaluation, the healthcare practitioner may use telemedicine to conduct the examination of the respondent.[148]

(m) Evidence.—The court shall admit all relevant evidence at the hearing. The court shall make its determination upon the entire record pursuant to the Rules of Evidence.[149]

(n) Burden of proof.—There is a presumption against involuntary commitment in favor of the respondent. The burden of proof is on the petitioner to show by clear and convincing evidence that the petition should be granted.[150]

(o) Dismissal of petition.—If, upon completion of the hearing, the court finds that the petition has not been sustained by clear and convincing evidence, the court shall deny the petition, terminate the proceedings, and order the respondent to be immediately discharged from protective custody, if applicable.[151]

(p) Order of involuntary commitment.—If, upon completion of the hearing, the court finds by clear and convincing evidence that the respondent is in need of involuntary commitment for the treatment of substance use disorder and finds that there are no alternatives to involuntary commitment, the court shall commit the respondent to the least restrictive inpatient treatment program that can meet his or her needs.[152]

(q) Length of initial commitment period.—The initial court order for inpatient involuntary commitment shall not exceed a treatment period of ninety (90) days. Time that the respondent has spent in temporary protective custody prior to the order for involuntary commitment shall not count toward the respondent's time in treatment.

---

[147] Adapted from S.D. CODIFIED LAWS § 34-20A-76.1 (West 2024).
[148] Adapted from N.D. CENT. CODE ANN. § 25-03.1-10.1 (West 2024)
[149] Adapted from MINN. STAT. ANN. § 253B.08 (West 2024).
[150] Adapted from N.D. CENT. CODE ANN. § 25-03.1-19 (West 2024).
[151] Adapted from N.D. CENT. CODE ANN. § 25-03.1-19 (West 2024).
[152] Adapted from MINN. STAT. ANN. § 253B.08 (West 2024) and S.C. CODE ANN. § 44-52-110 (West 2024).

Return to Table of Contents

(r) List of treatment facilities.—Annually, the [state department of substance use and mental health services] shall provide to the clerk of the [probate] court in each county a list of all the treatment facilities in the state that are able, willing, and qualified to provide treatment for substance use disorder pursuant to an order for involuntary commitment.[153]

(s) Medication for addiction treatment.—A treatment facility used for involuntary commitment under this Act shall maintain or provide for the capacity to process, dispense, and administer all U.S. Food and Drug Administration-approved medication for addiction treatment options and shall make such treatment available to any individual for whom such treatment is medically appropriate.[154]

(t) Selection of treatment facility.—A court shall not commit a respondent to a treatment facility unless it determines that the proposed facility is able to provide the respondent with adequate and appropriate treatment, including medical treatment, and the treatment is likely to be beneficial.[155] Preference between available, appropriate treatment facilities shall be given to the treatment facility that is located nearest to the respondent's residence or last known location except when the respondent requests otherwise or there are other compelling reasons.[156] The respondent shall never be committed to a correctional facility.

(u) Transportation to treatment facility.—Upon order of the court, a law enforcement official or a non-emergency medical transportation service shall transport the respondent to the treatment facility or, if the respondent is already at the treatment facility for protective custody, authorize the facility to retain the patient for the required treatment period.[157] Restraints shall not be used while transporting the respondent unless they are necessary to protect his or her safety or that of the transporters. If a non-emergency medical transportation service is used to transport the respondent to the treatment facility, the cost associated with such service shall be paid for in accordance with the tiered payment system established in Section V, subsection (m).

[153] Adapted from OHIO REV. CODE ANN. § 5119.97 (West 2024).
[154] Adapted from MASS. GEN. LAWS ANN. ch. 123 § 35 (West 2024).
[155] Adapted from S.D. CODIFIED LAWS § 34-20A-77 (West 2024).
[156] Adapted from VT. STAT. ANN. tit. 18 § 7617 (West 2024).
[157] Adapted from S.C. CODE ANN. § 44-52-110 (West 2024).

Return to Table of Contents

(v) Treatment plan.—Every individual subject to involuntary commitment by court order shall be evaluated and have an individualized treatment plan developed by the treatment facility within twenty-four (24) hours after admission.[158] The facility shall provide a copy of the treatment plan to the respondent, the respondent's attorney, and the court.

(w) Record required.—The court shall cause an accurate stenographic record or tape recording of the proceedings to be made.[159]

(x) Appeal.—All orders for involuntary commitment shall be considered final and appealable under [state rule for civil appeals].[160]

(y) Liability.—The following individuals shall not be held civilly or criminally liable for committing or failing to commit a respondent under this Act or for releasing a respondent at or before the end of the involuntary commitment order if the individuals have performed their duties in good faith and without gross negligence:[161]

(1) The administrator and medical director of the treatment facility;

(2) A judge or other public official performing the functions necessary for the administration of this Act; and

(3) A law enforcement official or other individual responsible for detaining or transporting a respondent under the terms of this Act.

Commentary

In the 1979 U.S. Supreme Court Case of *Addington v. Texas*, the Court ruled that "clear and convincing evidence" is the required legal standard for involuntary commitment cases.[162] The clear and convincing evidence standard is a higher burden of proof than the "preponderance of the evidence" standard used in civil proceedings but not as high as the "beyond a reasonable doubt" standard used in criminal proceedings.[163] The Supreme Court determined that the clear and convincing evidence standard would properly balance the rights of the respondent against the rights of the state to protect its citizens.[164] Forty-five states, the District of Columbia, American Samoa, the Northern Mariana Islands, Puerto Rico, and the U.S. Virgin Islands specifically mention the clear and convincing evidence standard within their involuntary commitment laws.[165] Kentucky uses the higher standard of beyond a reasonable doubt for

[158] Adapted from S.C. CODE ANN. § 44-52-110 (West 2024).
[159] Adapted from MINN. STAT. ANN. § 253B.08 (West 2024).
[160] Adapted from ARK. CODE ANN. § 0-64-827 (West 2024).
[161] Adapted from ALASKA STAT. § 47.37.235 (West 2024).
[162] 441 U.S. 418, 431 (1979).
[163] *Id.* at 431-32.
[164] *Id.*
[165] *See Involuntary Commitment of Those with Substance Use Disorders: Summary of State Laws, supra* note 38.

Return to Table of Contents

involuntary commitment proceedings.[166] Montana uses the beyond a reasonable doubt standard for physical facts and the clear and convincing standard for all other matters within the involuntary commitment proceeding.[167] Three states and Guam do not specify within their involuntary commitment statutes what the legal standard is for those proceedings, but based on the *Addington* ruling, legal scholars assume that they use the standard of clear and convincing evidence or higher.[168] The drafters chose to explicitly set the evidentiary standard for the final disposition hearing as clear and convincing evidence.

The length of time between the filing of the petition and the final disposition hearing varies greatly among states, ranging from five days to 30 days.[169] The American Psychiatric Association (APA) identifies prompt hearings as crucial for those facing involuntary commitment in order to reduce feelings of malfeasance.[170] The drafters have chosen to set the time between the filing of the petition and the final disposition hearing to no more than 10 days, excluding weekends and legal holidays, as a middle ground. The drafters, however, acknowledge that the timeframe may need to be made shorter or longer by a jurisdiction depending on the caseload and resources of the courts assigned to handle involuntary commitment cases, but states should make an effort to establish a timeframe that is prompt and reasonably practical.

The drafters chose to have the hearing closed to the public with the option for the respondent or the respondent's attorney to move to open the hearing. While closed hearings provide the respondent with privacy and protection, there are some benefits to public hearings of which the respondents might want to take advantage, including providing a check on the court system and enhancing public confidence in courts.[171] Public hearings can be observed by court monitors who are volunteers that observe hearings in an effort to keep courts accountable, identify issues in the court system, and advocate for court reform.[172] For example, National Family Court Watch Project volunteers attend hearings to address issues such as litigants without legal representation, procedural and due process concerns, and language and hearing barriers.[173] In addition to family court hearings, court monitoring occurs often in criminal and immigration hearings that are open to the public. Should a respondent choose to have an open involuntary commitment hearing, he or she might benefit from having a court monitor observe the hearing.

The drafters provided the courts with flexibility in determining where the final disposition hearing is held. For respondents that are being detained via an order for temporary

---

[166] *Id.*
[167] *Id.*
[168] *Id.*
[169] *Id.*
[170] AM. PSYCHIATRIC ASS'N, *supra* note 123.
[171] *ABA Court Watching*, AM. BAR ASS'N (Sept. 6, 2023), https://www.americanbar.org/groups/legal_aid_indigent_defense/indigent_defense_systems_improvement/court-watching0/aba-court-watching/.
[172] *See* Kristie Puckett Williams, *Court Watching 101*, AM. C.L. UNION OF N.C. (last accessed May 9, 2025), https://static1.squarespace.com/static/5daf53015bc9a966f3ea3674/t/5e4c57233eaf09036282683d/1582061352208/Fees+and+Fine+General+Court+Watch+Presentation+%281%29.pdf.
[173] *Learn about the National Family Court Watch Project*, NAT'L FAM. CT. WATCH PROJECT (last accessed May 9, 2025), https://nationalfamilycourtwatchproject.org/about-us.

Return to Table of Contents

protective custody, holding a hearing in a standard courtroom requires a law enforcement official or non-emergency medical transportation service to transport the respondent to the courthouse, which can be a stressful process. To minimize any adverse impacts associated with the transportation of a respondent from a treatment facility to a courthouse, the APA recommends that hearings be held in an appropriate location within the treatment facility.[174] For jurisdictions where holding a hearing within the treatment facility is unrealistic due to the time and cost required for travel by necessary court personnel, remote hearings provide an acceptable and cost-effective alternative that protects the respondent's welfare without compromising his or her due process rights.[175] Protocols associated with remote hearings go beyond the scope of this Model Act and are better suited for regulation or policy.

If a respondent is not in protective custody and fails to appear for the final disposition hearing, as with other types of civil cases, the respondent may be found in contempt of court, and the court may take appropriate action pursuant to the state or local rules of civil procedure. One member of the working group had concerns about the possibility of a respondent facing jail time if he or she fails to appear for the hearing and mentioned that any possible jail time would be inappropriate, and potentially dangerous, for an individual with severe SUD. The respondent is required to receive a copy of the petition and a summons to appear at the hearing pursuant to Section V, subsection (j). The drafters have made efforts to make it easier for the respondent to appear and participate in the hearing, such as allowing for flexible hearing locations and remote hearings, but ultimately it is the responsibility of the respondent to appear. Should the respondent fail to appear, the court has the option, pursuant to its rules of civil procedure, to simply reschedule the hearing and provide notice of the new hearing date to the respondent and/or the respondent's attorney or to find the respondent to be in civil or criminal contempt. If it finds the respondent in contempt, the court has the discretion to issue an appropriate punishment, which may include a fine or jail time or entry of an order for temporary custody in a treatment facility. Jail time for contempt in involuntary commitment cases should be used sparingly, and the respondent should be released from jail as soon as possible. Note that if a respondent is ordered to jail for contempt, the jail should provide him or her with any medically necessary withdrawal management services and the opportunity to initiate MAT in compliance with Title II of the Americans with Disabilities Act.[176]

Subsection (i) requires at least one healthcare practitioner who has personally examined the respondent to testify at the final disposition hearing. States should note that this provision may not be feasible in their jurisdiction if they prohibit healthcare practitioners from being compelled to testify. For example, Tennessee law exempts physicians, physician assistants, advanced practice registered nurses, psychologists, senior psychological examiners, chiropractors, and dentists from being subject to subpoenas to testify at civil trial.[177] The

---

[174] AM. PSYCHIATRIC ASS'N, POSITION STATEMENT ON LOCATION OF CIVIL COMMITMENT HEARINGS (2021), https://www.psychiatry.org/about-apa/policy-finder/position-statement-on-location-of-civil-commitment.
[175] *Id.*
[176] *See* 42 U.S.C.A. § 12132 (Westlaw through Pub. L. No. 119-18); *see also Model Access to Medication for Addiction Treatment in Correctional Settings Act*, LEGIS. ANALYSIS & PUB. POL'Y ASS'N (Sept. 2024), https://legislativeanalysis.org/model-access-to-medication-for-addiction-treatment-in-correctional-settings-act-2/.
[177] TENN. CODE ANN. § 24-9-101 (West 2025).

Return to Table of Contents

rationale behind this exemption is to avoid the disruption to the healthcare practices of those exempted, as it would require them to close their offices in order to testify. An alternative to having a healthcare practitioner testify at the hearing would be to have the practitioner submit a written report and/or testify via deposition.

If the court finds, by clear and convincing evidence, that the respondent is in need of involuntary commitment for the treatment of SUD, it may order the respondent to be committed at an appropriate treatment facility. When determining whether to commit the respondent, the court should consider the least restrictive inpatient treatment environment that can meet the respondent's needs and be the most beneficial to him or her. Every treatment facility that receives individuals via an involuntary commitment order should do the following:

- Prioritize patient-centered care: A treatment facility should provide care that emphasizes the individual needs of the patient and helps to foster trust and collaboration, which in turn can enhance the patient's experience and engagement in treatment;
- Validate the experience of being subject to involuntary commitment: The patient may not have voluntarily chosen to receive treatment, but offering him or her opportunities for choice, control, and privacy, while addressing his or her physical and emotional needs, throughout the treatment period can improve the patient's experience;
- Protect patients from harm: Creating a safe, supportive, and comfortable environment is crucial to minimizing distress and promoting well-being;
- Involve the patient in his or her treatment plan: A treatment facility should provide the patient with clear and concise information about his or her treatment plan, address his or her concerns or fears, and involve the patient in the decision-making process as much as possible;
- Address long-term adverse impacts: A treatment facility should take care to rebuild the patient's trust in healthcare practitioners and systems; and
- Utilize evidence-based practices: Incorporating evidence-based practices ensures the effectiveness and appropriateness of treatment interventions.[178]

For the initial order of involuntary commitment for SUD, the court may only order the respondent to inpatient treatment. The drafters have limited the initial order to inpatient treatment because an individual with a severe SUD that displays a grave risk of imminent physical harm to him or herself or others needs a level of care that goes beyond the capabilities of outpatient treatment. However, a court may recommit a respondent to either inpatient or outpatient treatment after the initial order of involuntary inpatient treatment pursuant to Section IX. The American Society of Addiction Medicine (ASAM) has developed a set of criteria to determine the set of standards for placement, continued service, and transfer of patients with SUD or co-occurring disorders.[179] The ASAM criteria describes five levels of SUD treatment (Levels 0.5 to

[178] Helen M. Stallman and Vikas Gupta, *Involuntary Commitment*, STATPEARLS (Jan. 20, 2025), https://www.ncbi.nlm.nih.gov/books/NBK557377/.

[179] MEDICAID INNOVATION ACCELERATOR PROGRAM, OVERVIEW OF SUBSTANCE USE DISORDER CARE CLINICAL GUIDELINES: A RESOURCE FOR STATES DEVELOPING SUD DELIVERY SYSTEM REFORMS 3 (Apr. 2017), https://www.medicaid.gov/state-resource-center/innovation-accelerator-program/iap-downloads/reducing-substance-use-disorders/asam-resource-guide.pdf.

Return to Table of Contents

4) that span a continuum of care.[180] According to these criteria, for the initial order of involuntary commitment, the court should only order the respondent to a treatment facility that is able to provide Level 4 or Level 3 programming. Level 4 treatment facilities provide medically managed intensive inpatient services.[181] ASAM defines "medically managed" services as those in which a physician provides diagnosis and treatment services directly to the patient, manages the provision of those services, or both.[182] This level of care is appropriate for respondents with medical, emotional, behavioral and/or cognitive conditions severe enough to warrant primary medical care and nursing care.[183] Level 4 services are provided in a hospital-based setting and include medically directed evaluation and treatment by an interdisciplinary team composed of appropriately credentialed clinical staff, including addiction medicine physicians, who are available 24 hours a day.[184]

A step below Level 4, is Level 3, which includes four sublevels with the uniting feature being that the treatment services are provided in a structured residential setting that is staffed 24 hours a day and are clinically managed.[185] ASAM defines "clinically managed" services as those directed by non-physician addiction specialist rather than medical personnel.[186] The four sublevels of Level 3 are: Level 3.1 clinically managed low-intensity residential programs; Level 3.3 clinically managed population specific high-intensity residential programs; Level 3.5 clinically managed residential programs; and Level 3.7 medically monitored inpatient programs.[187] Level 3.5 and Level 3.7 would likely be the most appropriate Level 3 sublevels for a respondent's initial order of involuntary commitment. Level 3.5 is appropriate for individuals in some imminent danger with functional limitations who cannot safely be treated outside of a 24-hour stable living environment.[188] The interdisciplinary team for Level 3.5 services is composed of drug and alcohol counselors, social workers, and licensed professional counselors who provide residential oversight; telephone or in-person consultations with a physician is a required support, but an on-site physician is not a requirement at this level of care.[189] Level 3.7 is appropriate for respondents with medical, emotional, behavioral, and/or cognitive conditions that require highly structured 24 hour care, including direct evaluation, observation, and medically monitored SUD treatment.[190] ASAM defines "medically monitored" services as those provided by an interdisciplinary staff of nurses, licensed professional counselors, social workers, and drug and alcohol counselors, under the direction of a licensed physician.[191] Level 3.7 differs from Level 4 in that the population served does not have conditions severe enough to warrant

[180] *Id.*
[181] *Id.* at 11.
[182] *Id.* at 5.
[183] *Id.* at 1.
[184] *Id.*
[185] *Id.* at 8.
[186] *Id.* at 5.
[187] *Id.* at 8-11.
[188] *Id.* at 10.
[189] *Id.*
[190] *Id.*
[191] *Id.* at 5.

Return to Table of Contents

medically managed inpatient services or acute care in a hospital where daily treatment decisions are managed by a physician.[192]

The utilization of evidence-based practices is particularly important, and for that reason, the drafters have required all treatment facilities used for involuntary commitment to provide all U.S. Food and Drug Administration approved forms of MAT. Currently, MAT only exists for opioid use disorder and alcohol use disorder; however, medications for other substances are currently in development.[193] Research shows that MAT can successfully treat substance use disorder and help sustain recovery.[194] Studies have shown that MAT improves patient survival, increases retention in treatment, decreases criminal activity among individuals with substance use disorder, increases a patient's ability to gain and maintain employment, and improves birth outcomes among pregnant women with substance use disorder.[195] Other evidence-based practices that treatment facilities may incorporate into treatment protocols when appropriate include contingency management[196] and motivational interviewing.[197]

The maximum length of an initial involuntary commitment period among jurisdictions varies greatly, ranging from up to 15 days to one year.[198] Ninety days was the most commonly implemented maximum length of commitment for inpatient treatment, so the drafters have chosen to implement a 90-day maximum length for inpatient treatment. Note that the drafters only designate a maximum length of an involuntary commitment order. The respondent is not required to remain in the treatment facility for the maximum commitment length and may be discharged early pursuant to the provisions in Section IX. This Act does not establish a minimum commitment length because all individuals should receive individualized care and be released from commitment as soon as they no longer meet the criteria for commitment. How long a respondent remains under commitment should be based only on the treatment needs of the individuals and the recommendations of his or her care team.

SECTION VIII. RIGHTS OF INDIVIDUALS INVOLUNTARILY COMMITTED FOR SUBSTANCE USE DISORDER TREATMENT.

(a) Rights of individuals involuntarily committed.—All individuals who are involuntarily committed for the treatment of substance use disorder retain the following rights, subject only to the limitations and restrictions authorized by subsection (d):

---

[192] *Id.*
[193] *Medications for Substance Use Disorders*, SUBSTANCE ABUSE AND MENTAL HEALTH SERV. ADMIN. (Apr. 11, 2024), https://www.samhsa.gov/medications-substance-use-disorders.
[194] *Id.*
[195] *Id.*
[196] *See Contingency Management*, LEGIS. ANALYSIS & PUB. POL'Y ASS'N (Oct. 30, 2023), https://legislativeanalysis.org/contingency-management/.
[197] *See Using Motivational Interviewing in Substance Use Disorder Treatment*, SUBSTANCE ABUSE AND MENTAL HEALTH SERV. ADMIN. (2021), https://library.samhsa.gov/sites/default/files/PEP20-02-02-014.pdf.
[198] *See Involuntary Commitment of Those with Substance Use Disorders: Summary of State Laws, supra* note 38.

Return to Table of Contents

(1) To receive timely medical and behavioral health care and treatment based on the individual's needs and that is delivered in the least restrictive treatment setting possible;

(2) To be treated fairly, with dignity and respect, and to receive the same consideration and access to appropriate services as others;

(3) To be free from unnecessary restraint and isolation;

(4) To have access to appropriate and adequate food, water, and hygiene products;

(5) To have physical privacy in showering, changing, and using the restroom;

(6) To visitation and telephone communications;

(7) To send and receive sealed mail;

(8) To keep and use personal clothing and possessions;

(9) To be afforded regular opportunities for outdoor physical exercise;

(10) To be free to exercise religious faith of choice or to abstain from religious practices;

(11) To manage personal financial affairs, unless a court issues an order stating otherwise;

(12) To have the right to refuse medication in accordance with subsection (b) below;

(13) To have access to his or her own medical records;

(14) To have his or her treatment records remain confidential, except as required by law;

(15) To present grievances and complaints to the treatment facility's staff or administrator;

(16) To seek to be discharged from commitment at any time by an order in the nature of habeas corpus;

(17) To be free from experimental research without the express and informed written consent of the patient. The patient shall only be asked to participate in experimental research studies focused on substance use disorder, co-occurring disorders, or the experience of involuntary commitment;

(18) To continue to receive previously prescribed medications, as long as the medications are not contraindicated by any new medication prescribed by the

treatment facility. The treatment facility shall be required to consult with the patient's prescribing healthcare practitioner before discontinuing any previously prescribed medications; and

(19) To be free from the requirement of performing non-compensated work or labor, except for duties associated with the cleaning and upkeep of the patient's personal space and belongings.

(b) Right of refusal.—With the exception of emergency situations in which the patient's life is at risk, the patient has the right to refuse medication, including medication for addiction treatment, and medical treatment unless a hearing is held and a judge determines that the patient does not have the capacity to consent to or refuse the treatment and/or medication.[199]

(c) Additional rights.—The rights enumerated in subsection (a) are in addition to, and not in derogation of, any other state or federal constitutional, statutory, or regulatory right.[200]

(d) Informing patients of rights.—All individuals involuntarily committed shall be fully informed both verbally and in writing, in a language and reading comprehension level that they can understand, of their rights, all rules and regulations governing patient conduct, and their responsibilities during their stay at the treatment facility. A current list of patient rights shall be posted in the treatment facility in a prominent location that is accessible to all patients.[201]

(e) Limitation and restriction of rights.—

(1) The rights enumerated in subsection (a), paragraphs (1), (2), (4), (10), (13), (14), (15), (16), (17), (18), and (19) shall not be restricted or limited absent a court order.

(2) The remaining rights enumerated in subsection (a) shall only be limited or restricted if a committee composed of the medical director of the treatment facility, or the director's designee, the patient safety officer, and the patient's treating healthcare practitioner, determine, based on their professional judgment,

[199] CALIFORNIA DEPARTMENT OF HEALTH CARE SERVICES, RIGHTS FOR INDIVIDUALS IN MENTAL HEALTH FACILITIES 15 (May 2014), https://www.dhcs.ca.gov/services/Documents/DHCS_Handbook_English.pdf.
[200] Adapted from DEL. CODE ANN. tit. 16 § 2220 (West 2024).
[201] Adapted from DEL. CODE ANN. tit. 16 § 2220 (West 2024).

Return to Table of Contents

that doing so would be necessary to preserve the patient's health and safety. When the committee imposes a special restriction on the rights of the patient, a written order specifying the restriction and the reasons for the restriction must be signed by the medical director, or the director's designee, and attached to the patient's chart. Any restriction or limitation of a patient's rights must be reviewed and reevaluated every seven (7) days. The patient's rights shall be immediately restored as soon as the committee determines that the patient's health and safety are no longer clearly endangered.[202]

(f) Incompetency.—An order of involuntary commitment for the treatment of substance use disorder is not a judicial determination of legal incompetency.[203]

(g) Criminality.—Any individual subject to an order of involuntary commitment for the treatment of substance use disorder shall not be deemed a criminal. The order shall not be deemed a conviction and shall not appear on the individual's criminal record.[204]

(h) Guardianship and conservatorship.—An order of involuntary commitment for the treatment of substance use disorder shall not be used as an implication or presumption that an individual is in need of a guardian, a conservator, or both.[205]

(i) Health insurance coverage.—A health insurance provider may not deny an insured the benefits of the insured's policy solely because the health care that the insured receives is provided pursuant to a court order for involuntary commitment.[206]

Commentary

By definition, involuntary commitment limits an individual's liberty. However, an individual who is involuntarily committed should not be devoid of all of his or her rights. All individuals subject to an order of involuntary commitment should be treated with respect and dignity.[207] To show respect for an individual's autonomy and preferences, the treatment facility should offer the individual opportunities for choice and shared decision-making, within the limits of involuntary treatment, whenever possible.[208] The drafters acknowledge that some of the rights enumerated in this section may be dependent on the logistics and infrastructure of the treatment facility. For example, subsection (a)(9) states that the patient should have regular access to

[202] Adapted from COLO. REV. STAT. ANN. § 27-81-114 and N.D. CENT. CODE ANN. § 25-03.1-41 (West 2024).
[203] Adapted from MINN. STAT. ANN. § 253B.23 (West 2024).
[204] Adapted from D.C. Code Ann. § 24-711 (West 2024).
[205] Adapted from KAN. STAT. ANN. § 59-29b48 (West 2024).
[206] Adapted from UTAH CODE ANN. § 26B-5-351 (West 2024).
[207] Stallman, *supra* note 178.
[208] *Id.*

Return to Table of Contents

opportunities for outdoor physical exercise. How often the individual will be able to go outside (*i.e.*, daily or weekly) will depend on the treatment facility's outdoor recreational capabilities and security protocols. Additionally, how much physical privacy the patient has while showering, changing, and using the restroom will depend on if the treatment facility has individual or communal bathroom facilities.

Subsection (a), paragraph (19) prohibits a treatment facility from requiring a patient to perform certain acts of non-compensated work or labor as part of his or her involuntary treatment plan. A member of the working group had specific concerns about involuntary commitment patients having to work on farms, in shops, or as full-time custodians, or perform other revenue-generating tasks under the guise of doing service or completing other treatment plan goals or activities. However, the working group member believed that patients should be able to participate in certain tasks for no compensation as long as the tasks resemble household chores more than a job and only occupy a small percentage of the patient's day. Under the therapeutic community model for SUD and mental illness recovery, chores play a therapeutic function by providing patients with structure and routine and fostering a sense of personal responsibility and community.[209] Jurisdictions may elect to specifically exclude or allow certain types of work or tasks in their adoption of this Model Act.

There may be times during an order for involuntary commitment when an individual's autonomy or rights must be limited in order to protect the health and safety of the individual. For example, an individual subject to an involuntary commitment order should be free from isolation and restraints whenever possible, but the use of isolation and restraints may be necessary in some situations in order to stabilize the individual or ensure his or her safety or that of others.[210] Whenever an individual's autonomy and rights are limited, the treatment facility should take care to restore the individual's autonomy and rights as soon as the health and safety of the individual, and the safety of others, is no longer endangered.

SUD treatment records are protected under the Health Insurance Portability and Accountability Act (HIPAA) and 42 C.F.R. Part 2.[211] 42 C.F.R. Part 2 regulations "impose restrictions upon the disclosure and use of alcohol and drug patient records which are maintained in connection with the performance of any federally assisted alcohol and drug abuse program."[212] The restrictions on disclosure apply to any information held by a federally assisted substance use disorder program (known as a Part 2 program), as defined in the regulation, that would identify a patient as having a substance use disorder.[213] HIPAA and 42 C.F.R. Part 2 only apply to treatment records, so while SUD treatment information is protected from disclosure unless an exception applies, the question of whether the existence of an involuntary commitment order is protected by privacy laws is more complicated.

---

[209] Hannah Friedman, *Mutual Support in Therapeutic Communities*, RECOVERY.COM, (Nov. 30, 2021), https://recovery.com/resources/therapeutic-communities/.
[210] *Id*. Types of restraints include physical (using physical force to limit movement), mechanical (applying devices such as straps or belts), or chemical (administering medication to calm or sedate the individual).
[211] 42 U.S.C.A. § 1320d *et seq*. (Westlaw through Pub L. No. 119-18).
[212] 42 C.F.R. § 2.3(a) (2024).
[213] 42 C.F.R. § 2.12(a) (1) (2024).

Return to Table of Contents

One member of the working group posed the question of whether a record of involuntary commitment would appear on a background check. The answer to that question depends on the confidentiality laws of the state and the type of background check performed. For example, under Virginia law, involuntary commitment records sent by the court to the state's Central Criminal Records Exchange are required to be kept confidential and used only to determine an individual's eligibility to possess, purchase, or transfer a firearm.[214] Background checks for general employment purposes will likely not include involuntary commitment records due to their being civil court records rather than criminal, but background checks for employment involving certain security clearances may include such records. Additionally, any background check performed prior to purchasing a firearm may also include involuntary commitment records.[215]

SECTION IX. REASSESSMENT, MODIFICATION OF ORDER, DISCHARGE, AND RECOMMITMENT.

(a) Reassessment of treatment plan.—The treatment facility shall reassess and modify the respondent's treatment plan at least every thirty (30) days while he or she is committed. If changes are made to the respondent's treatment plan, the treatment facility shall immediately provide a copy of the new treatment plan to the respondent, the respondent's attorney, and the court.

(b) Modification of inpatient services order.—The administrative director, or his or her designee, of the facility to which the respondent is committed for inpatient treatment, or the respondent on his or her own behalf, may request that the court modify an initial or recommitment order requiring the respondent to submit to inpatient treatment to one requiring the respondent to participate in outpatient treatment or services. The request shall explain in detail the reason for the request and be accompanied by a certificate of medical examination.[216] If the court grants the request modifying the initial involuntary inpatient treatment to one requiring involuntary outpatient treatment, the maximum commitment period shall change from ninety (90) days to six (6) months and include the time that the respondent spent in involuntary inpatient treatment.

---

[214] VA. CODE ANN. § 37.2-819 (West 2025).
[215] *See* Brady Handgun Violence Act, 18 U.S.C.A. § 922 (Westlaw through Pub L. No. 119-18); *see also Firearm-related Challenge and Voluntary Appeal File*, FEDERAL BUREAU OF INVESTIGATION (last accessed June 25, 2025), https://www.fbi.gov/how-we-can-help-you/more-fbi-services-and-information/nics/national-instant-criminal-background-check-system-nics-appeals-vaf.
[216] Adapted from TEX. HEALTH & SAFETY CODE § 462.073 (West 2024).

Return to Table of Contents

(c) Change to voluntary status.—A respondent subject to an involuntary commitment order shall be entitled to request that the court change his or her status to that of a voluntary patient if the medical director of the treatment facility certifies that:

(1) The respondent has been receiving involuntary treatment for at least thirty (30) calendar days;

(2) The respondent is reasonably capable of understanding the nature of the decision to change status;

(3) The respondent acknowledges that he or she has a severe substance use disorder, with or without a co-occurring disorder, and recognizes his or her need for treatment; and

(4) There has been a material change in the respondent's circumstances.[217]

(d) Notice of change to voluntary status.—The administrator of the treatment facility shall file a notice of intent to change to voluntary status with the court and serve a copy of the notice on the petitioner and the respondent or their attorneys pursuant to the [rules of civil procedure] within five (5) days.

(e) Limitations of voluntary status.—A respondent that has been transferred to voluntary treatment status shall remain subject to the initial court order for the duration of the commitment period. Respondents that leave treatment against medical advice or violate the terms of the treatment plan shall be subject to the contempt powers of the court pursuant to the [rules of civil procedure], and his or her status shall revert to involuntary for the remainder of the commitment period.

(f) Recommitment motion.—If the administrator of the treatment facility, on the advice of the medical director, believes that continued involuntary treatment is necessary or appropriate, the administrator, no later than fifteen (15) days before the expiration of the court order, shall file with the court a motion for continued involuntary treatment that alleges the basis for recommitment and further treatment.[218]

(g) Recommitment hearing.—Upon the receipt of a motion for recommitment under subsection (f), the court shall assign a time for a hearing no later than ten (10) business

[217] Adapted from DEL. CODE. ANN. tit. 16 § 2217 (West 2024).
[218] Adapted from ARIZ. REV. STAT. ANN. § 36-543 (West 2024).

Return to Table of Contents

days after the date the recommitment petition was filed. The administrator or his or her designee shall serve a copy of the motion and notice of the hearing on the petitioner and the respondent or their attorneys.[219]

(h) Recommitment order.—If, after hearing all of the relevant evidence, the court finds by clear and convincing evidence that without additional treatment the respondent continues to be at a grave risk of causing imminent physical harm to self or others, it shall make an order of recommitment for either continued involuntary inpatient treatment or, if recommended or requested by the facility administrator, involuntary outpatient treatment. The order shall be for no more than ninety (90) days for inpatient treatment and no more than six (6) months for outpatient treatment.[220] The court shall not issue more than two (2) recommitment orders per respondent.[221] At the conclusion of a second recommitment order, the commitment shall not be continued unless a new involuntary commitment petition, as outlined in Section V, is filed and a hearing and determination on such petition is made.[222]

(i) Modification of outpatient services order.—The court may modify a recommitment order for involuntary outpatient treatment to involuntary inpatient treatment upon request of the administrative director of the facility, or designee, at a modification hearing if evidence supports that:

(1) The respondent has not substantially complied with the court's order in good faith; or

(2) The respondent's condition has deteriorated to the extent that outpatient care or services are no longer appropriate.[223]

(j) Early discharge.—The administrator of the treatment facility, on the advice of the medical director, may discharge an individual committed or recommitted for treatment at any time prior to the expiration of the involuntary commitment order if the grounds for commitment no longer exist, further treatment will not be likely to bring about significant

[219] Adapted from CONN. GEN. STAT. ANN. § 17a-685 (West 2024).
[220] Adapted from CONN. GEN. STAT. ANN. § 17a-685 (West 2024).
[221] Adapted from S.D. CODIFIED LAWS § 34-20A-83 (West 2024).
[222] Adapted from MINN. STAT. ANN. § 253B.13 (West 2024).
[223] Adapted from TEX. HEALTH & SAFETY CODE § 462.072 (West 2024).

Return to Table of Contents

improvement in the individual's condition, or treatment is no longer adequate or appropriate. The administrator of the treatment facility shall file with the court a notice of intent to discharge and serve a copy of the intent notice on the petitioner, the respondent, and their attorneys. If no objection is received within five (5) days of proof of service, the court shall issue an order of discharge. If a written objection is filed with the court, the court shall review the objection to determine whether a hearing must be conducted prior to issuing an order of discharge.[224]

(k) Expiration of order.—At the conclusion of the commitment or recommitment order period, if the individual involuntarily committed has not been discharged early pursuant to subsection (h), he or she shall be automatically discharged from the facility.[225]

(l) Termination of order.—A discharge terminates the court order, and the individual discharged shall not be compelled to submit to involuntary treatment unless a new order is issued in accordance with this Act.[226]

(m) Discharge plan.—Fifteen (15) days prior to the individual's discharge date, the individual's treatment team at the facility shall develop a discharge plan in collaboration with local social service entities. The treatment team shall give the individual an opportunity to participate in the formulation of the discharge plan. A copy of the discharge plan shall be provided to the court. The discharge plan shall include and document the respondent's needs and actions to address such needs for, at a minimum:[227]

(1) Appointments to follow up on physical and behavioral health issues;

(2) Information on how to obtain prescribed medications including medication for addiction treatment, if applicable;

(3) Information on available social services and public benefits including housing, employment, and transportation and referrals to such services as necessary;

(4) Information on how to obtain health insurance if the individual is uninsured;

(5) Referral to recovery support opportunities including, but not limited to, peer support services; and

[224] Adapted from CONN. GEN. STAT. ANN. § 17a-685 (West 2024) and S.C. CODE ANN. § 44-52-120 (West 2024).
[225] Adapted from FLA. STAT. ANN. § 397.6977 (West 2024).
[226] Adapted from TEX. HEALTH & SAFETY CODE § 462.080 (West 2024).
[227] Adapted from FLA. STAT. ANN. § 397.6977 (West 2024) and UTAH CODE ANN. § 26B-5-331 (West 2024).

Return to Table of Contents

(6) A safety plan for the individual and the number of a crisis services hotline.

(n) Peer support services.—If available, the discharge plan shall ensure that the patient is directly connected to an individual within the geographic area in which he or she will reside upon discharge who is authorized by the state to provide peer support services.

(o) Overdose reversal medication.—Upon discharge, the treatment facility shall provide the individual with at least two doses of an overdose reversal medication and education on its use.

Commentary

The needs of a patient subject to an involuntary commitment order may change over time and, as a result, his or her level of care may need to be modified to ensure that he or she is receiving beneficial treatment in the least restrictive setting. Additionally, there may be a situation in which the patient needs additional treatment beyond the initial involuntary commitment order. In such cases, the administrator of the treatment facility, on the advice of the medical director, may file a motion for recommitment. It is the administrator of the treatment facility, not the original petitioner, who bears the burden of proving that the patient needs continued involuntary commitment after the initial commitment period.[228] Unlike with the initial involuntary commitment order, the recommitment order issued by the court may be for inpatient or outpatient treatment. Because outpatient treatment, as compared to inpatient treatment, is a less intense form of treatment, the drafters have set the maximum treatment length for outpatient treatment as six months (*i.e.*, twice the maximum length as for inpatient treatment). Fifteen states and Guam have different maximum commitment lengths for inpatient and outpatient treatment; the maximum length of commitment for outpatient treatment in these jurisdictions is longer than those for inpatient treatment. For the purposes of involuntary commitment for SUD, Level 2 services, which ASAM categorizes as intensive outpatient and partial hospitalization programs, are the outpatient treatment types most appropriate for a respondent's needs.[229] Any services below Level 2 would likely not provide enough support for an individual whose SUD is severe enough to warrant involuntary commitment. Level 2.1 intensive outpatient programs provide nine to 19 hours of weekly structured programming, including individual and group counseling, motivational interviewing, MAT services, occupational therapy, and other skilled treatment services.[230] Level 2.5 partial hospitalization programs are able to provide 20 hours or more of clinical intensive programming each week to support patients who need daily monitoring and management in a structured outpatient setting.[231] If a respondent is not substantially complying in good faith with a recommitment order for involuntary outpatient treatment or if the respondent's condition has deteriorated to the extent that outpatient care or services are no longer appropriate, the court may modify the order to involuntary inpatient treatment upon request of the administrative director of the facility.

[228] *See* AM. PSYCHIATRIC ASS'N, *supra* note 123.
[229] MEDICAID INNOVATION ACCELERATOR PROGRAM, supra note 179, at 6.
[230] *Id.*
[231] *Id.* at 7.

Return to Table of Contents

After a respondent has spent at least 30 days in involuntary commitment, he or she may request that the court change his or her status to that of a voluntary patient. To be eligible for a change to voluntary status, the medical director of the treatment facility must be able to certify that there has been a material change in the respondent's circumstances. This material change may be demonstrated by the respondent's regular use of MAT or compliance with all treatment modalities. Some of the working group members expressed concerns about a respondent's ability to switch to voluntary status, fearing that some respondents would request a change to voluntary status to simply accelerate their discharge and leave treatment. However, a respondent under voluntary status remains subject to the requirements outlined in the involuntary commitment order, including the length of the commitment period and the provisions governing early discharge, but he or she now has the psychological mindset that he or she is not being forced to be at the facility. Respondents that leave treatment against medical advice or violate the terms of the treatment plan will be subject to contempt of court proceedings and have his or her status changed back to involuntary for the remainder of the commitment period.

Patients subject to an order for involuntary commitment are not required to be committed for the entire length of the commitment or recommitment order and may be discharged at any time prior to the expiration of the order. A patient should be discharged from an involuntary commitment order when the grounds for commitment no longer exist, further treatment will not likely bring about significant improvement in the individual's condition, or treatment is no longer adequate or appropriate. One working group member was concerned that treatment facilities would be financially invested in keeping respondents committed for the entirety of the commitment period and, thus, whether a respondent should be discharged from commitment early should be determined by a third-party healthcare practitioner instead of the treatment facility's medical director. The drafters chose not to require a third-party healthcare practitioner to make an early discharge determination because it would be difficult for the respondent to find an outside healthcare practitioner that would be able to regularly come into the treatment facility to evaluate him or her. This would also affix an additional cost on top of the costs associated with receiving treatment at the facility.

Critics of involuntary commitment for SUD view it as a "short-term solution that's going to lead to long-term problems."[232] Of particular concern among critics is that individuals released from involuntary commitment face a higher risk of overdose due to a reduction in tolerance and a lack of community support for continued treatment, comparable to formerly incarcerated individuals upon reentry.[233] To address these concerns, healthcare practitioners recommend the integration of involuntary commitment with existing healthcare systems to better prepare involuntary commitment patients for reentry into their communities.[234] A well-structured discharge plan is essential for ensuring a smooth transition from involuntary commitment to community-based care and reducing the risk of overdose upon release.[235] A discharge plan should provide for a continuum of care that supports the individual's recovery and helps prevent

[232] Evans, *supra* note 35, at 729.
[233] *Id. See also* Sinha, *supra* note 52, at 742.
[234] Evans, *supra* note 35, at 730.
[235] Stallman, *supra* note 178.

Return to Table of Contents

return to use,[236] and the treatment facility should work with the patient to develop a personalized discharge plan.[237] A proper discharge plan should provide the patient with scheduled follow-up appointments for continuing treatment and MAT, if applicable, connections to social services and public benefits, a safety plan, and coping strategies. Additionally, providing the patient with access to peer support services upon discharge can help lessen feelings of isolation upon reentry and further support the individual's recovery.[238] One of the working group members stated that the discharge plan is the most critical factor in achieving long-term success post-involuntary commitment and advised that states should invest resources into the discharge process in order to strengthen discharge planning and post-treatment support.

SECTION X. INVOLUNTARY COMMITMENT REVIEW BOARD.

(a) Establishment.—Within one (1) year of the effective date of this Act, the [state department of substance use and mental health services] shall establish an involuntary commitment review board composed of three or more individuals to review the admission, retention, and post-commitment care of individuals ordered to undergo involuntary commitment for the treatment of substance use disorder under this Act. One member shall be a healthcare practitioner with a specialty in addiction medicine, one member shall be a behavioral health professional, and one member shall be an attorney practicing civil rights or disability law.[239]

(b) Review.—The review board shall review the admission, retention, and post-commitment care of involuntarily committed individuals at treatment facilities within the state on at least a quarterly basis. The review board may examine the court and treatment records of all involuntarily committed individuals in order to identify any cases of unjustified or excessive involuntary commitment. The review board shall report any findings and concerns to the administrator of the treatment facility, the clerk of the probate court of the county where the involuntary commitment proceedings occurred, and the [state department of substance use and mental health services] within forty-eight (48) hours of discovery. The entities and individuals receiving a report from the review board shall take any corrective action necessary to address the issue(s) identified in the report.

[236] *Id.*
[237] *Id.*
[238] Evans, *supra* note 35, at 730.
[239] Section adapted from MINN. STAT. ANN. § 253B.22 (West 2024).

Return to Table of Contents

(c) Receipt of concerns and complaints.—The review board shall receive concerns or complaints from patients, interested individuals, and treatment facility staff.

(d) Notice.—Upon admission to a treatment facility for involuntary commitment for substance use disorder, the treatment facility shall notify the patient through a simple written statement of his or her right to file a concern or complaint with the review board.

(e) Compensation.—Each member of the review board shall receive compensation and reimbursement as established by the [commissioner of the state department of substance use and mental health services].

(f) Post-commitment interviews.—The review board shall provide all respondents, upon discharge from an order of involuntary commitment and at three (3) and six (6) months post-release, with the opportunity to participate in a post-commitment interview with the involuntary commitment review board to discuss his or her involuntary commitment and post-commitment experience. Participation in an exit interview is voluntary, and declining to participate shall not result in any negative consequences. All of the information collected by the review board through the post-commitment interviews shall be de-identified and analyzed and included within the review board's report required in Section XII of this Act.

Commentary

Individuals eligible for involuntary commitment for SUD are part of a group whose status warrants added protection to guard against potential harms.[240] This need for extra protection may be compounded by additional factors, including having limited financial resources, a co-occurring disorder, or other type of impairment.[241] To better ensure that the rights of this group are being protected, the drafters have established the creation of an involuntary commitment review board based on the novel review board section in Minnesota's involuntary commitment law. The review board is comprised of multi-disciplinary members and is tasked with reviewing the admission and retention of individuals ordered to undergo involuntary commitment for SUD to identify any cases of unjustified or excessive involuntary commitment. The review board may also receive concerns or complaints from patients, interested individuals, and treatment facility staff.

In an effort to gain qualitative evidence on involuntary commitment for SUD, the drafters established a voluntary post-commitment interview process for discharged respondents who wish

[240] Evans, *supra* note 35, at 732.
[241] Laura Joszt, *5 Vulnerable Populations in Healthcare*, AJMC (July 20, 2018), https://www.ajmc.com/view/5-vulnerable-populations-in-healthcare.

Return to Table of Contents

to provide the involuntary commitment review board with information about their experience with involuntary commitment. Respondents participating in the interview upon discharge should be asked questions about their perceived procedural justice during the involuntary commitment hearing process, attitudes toward involuntary commitment, and motivation to continue to receive treatment voluntarily.[242] The follow up interviews conducted by the review board at three and six months post release should focus on whether the respondent is receiving continued treatment; whether he or she has returned to use for any period of time; the status of his or her housing, employment, and health insurance; whether he or she has had any new involvement with the criminal justice system; and whether he or she has a continued relationship with the petitioner. To protect the privacy of the respondent, all information provided by the respondent to the review board during these interviews must be de-identified. Information collected by the review board from these interviews will be analyzed by the board and included in the board's annual report as required by Section XII of this Act.

SECTION XI. EDUCATION AND TRAINING.

(a) Training materials.—Within one (1) year of the effective date of this Act, the [state department of substance use and mental health services] shall develop and make available training materials concerning involuntary commitment for substance use disorder treatment and update those materials as necessary.

(b) Training requirement.—The following individuals are hereby required to undergo annual training on the practice of involuntary commitment for substance use disorders:

(1) [Probate] court judges and court staff;

(2) Law enforcement officials;

(3) District or county attorneys, and their designees;

(4) Healthcare practitioners practicing within the specialties of addiction medicine, psychiatry, family medicine, and internal medicine; and

(5) Behavioral health professionals.

The [relevant state agencies] for the individuals identified above shall develop continuing education and training modules using the information created in subsection (a) and shall promulgate regulations and/or policies consistent with the requirements of this section. Additionally, the [relevant state agencies] shall establish penalties for failure to comply with the training requirement.

[242] Paul P. Christopher, et al., *Civil Commitment Experiences Among Opioid Users*, 193 DRUG AND ALCOHOL DEPENDENCE 137, 138 (Dec. 2018), https://doi.org/10.1016/j.drugalcdep.2018.10.001.

Return to Table of Contents

(c) Training topics.—The training required by subsection (b) shall include, but not be limited to:

(1) Information on the legal requirements for involuntarily committing an individual for substance use disorder treatment;

(2) Principles of autonomy and non-maleficence in relation to working with or treating individuals with substance use disorder;

(3) Methods for ensuring that decisions regarding involuntary commitment direct individuals toward the most effective treatment;

(4) Safeguards to minimize potential harm during the involuntary commitment order and upon reentry into the community; and

(5) Examples of positive and negative experiences with involuntary commitment from individuals who have experienced involuntary commitment.[243]

(d) Medical examination guidance.—The state boards of medicine and nursing shall promulgate rules establishing uniform requirements for conducting medical examinations and evaluations for the purpose of determining an individual's involuntary commitment eligibility.

(e) Involuntary commitment guide.—The [state department of substance use and mental health services] shall develop a written guide no later than [date], providing information regarding involuntary commitment and the legal process for involuntarily committing an individual for the treatment of substance use disorder. The guide shall include, but not be limited to:

(1) Alternatives to involuntary commitment, including resources about voluntary treatment options available in the area;

(2) The types of treatment available through involuntary commitment and the duration of the commitment period;

(3) Expected outcomes and impacts of involuntary commitment;

(4) Steps of the involuntary commitment process from the filing of the petition to commitment, written in easily understandable language;

[243] Adapted from CAL. WELF. & INST. CODE § 5349.1 (West 2024). *See also* Evans, *supra* note 35, at 732.

Return to Table of Contents

(5) An explanation of the costs associated with the filing of an involuntary commitment petition and who may be legally responsible for such costs;

(6) The eligibility requirements for filing an involuntary commitment petition;

(7) Instructions for completing the involuntary commitment petition; and

(8) The process of community reentry upon discharge from an order of involuntary commitment[244]

(f) Guide availability.—The guide shall be provided by the clerk of the [probate] court to any individual seeking an involuntary commitment order under this Act and be made publicly available on the [state department of substance use and mental health services] website.[245] Individuals may request to speak with a court advocate either in person or through a toll-free phone number in order to ask questions about the information contained in the guide.

Commentary

Research indicates that more education and training about involuntary commitment and the ethical issues surrounding the practice is needed for healthcare practitioners, behavioral health professionals, law enforcement officials, judges, and court staff.[246] To address this gap, the drafters established state mandated education and training for healthcare practitioners practicing within certain specialties, behavioral health professionals, law enforcement officials, judges, and court staff on involuntary commitment for SUD policies and procedures and how to address ethical concerns and reduce harm. Penalties for not completing the required training go beyond the scope of this Model Act but would likely be governed by the appropriate professional licensing or governing board, professional society, or the administrative office of the courts, and include some sort of administrative action. Additionally, to better ensure that examinations and evaluations performed by healthcare practitioners to determine whether an individual is eligible for involuntary commitment for SUD are based on uniform criteria, the drafters have required the state medical and nursing boards to promulgate rules establishing uniform requirements for conducting such medical examinations and evaluations. Such rules and guidelines can establish best practice standards for involuntary commitment evaluations and help prevent healthcare practitioners from considering a broader range of behaviors that go beyond the scope of the established eligibility criteria for involuntary commitment for SUD that is outlined in Section III of this Model Act.[247]

---

[244] Adapted from MISS. CODE ANN. § 41-31-3 (West 2024). *See also* Evans, *supra* note 35, at 732.
[245] Adapted from MISS. CODE ANN. § 41-31-3 (West 2024).
[246] Evans, *supra* note 35, at 732.
[247] *See* Paul P. Christopher, et al., *Court Clinicians' Experiences Performing Civil Commitment Evaluations for Substance Use Disorders*, 49 J. AM. ACAD. OF PSYCHIATRY & THE L. 187 (Feb. 2021), https://doi.org/10.29158/JAAPL.200061-20.

Return to Table of Contents

Another area where education about involuntary commitment is lacking is among potential petitioners, especially family members of individuals with severe SUD.[248] Petitions for involuntary commitment are most often filed by family members of the respondent.[249] When family members are considering involuntary commitment for SUD, they are likely having feelings of helplessness, frustration, fear, and desperation, and they may feel that involuntary commitment is the only option to protect their loved one.[250] The decision to involuntarily commit an individual for SUD treatment requires full consideration of the potential harms and benefits associated with involuntary commitment. To better allow potential petitioners to make informed decisions, the drafters have required the state to develop an involuntary commitment guide. The guide, which is to be offered to any individual seeking an involuntary commitment order and made publicly available on-line, provides the reader with information about alternatives to involuntary commitment, the involuntary commitment and hearing process, the petitioner's financial responsibility, and the expected outcome and impact of involuntary commitment for SUD on the petitioner and the respondent. This information will help potential petitioners realize that involuntary commitment should only be used as a tool of last resort and allow them to assess the legal, ethical, and social considerations associated with involuntary commitment. Because initiating involuntary commitment proceedings may be complex, the court should make court advocates available to answer questions and offer guidance about the process.

SECTION XII. REPORTING.

(a) Annual report.—Within one (1) year of the effective date of this Act and annually by that date thereafter, the following entities shall submit a de-identified, aggregate report to the [state department of substance use and mental health services]:

(1) Each [probate] court within the state that conducts involuntary commitment for substance use disorder proceedings;

(2) Each treatment facility within the state that accepts individuals subject to an order of involuntary commitment for the treatment of substance use disorder; and

(3) The involuntary commitment review board.

(b) Data analysis.—The [state department of substance use and mental health services] shall analyze each annual report submitted pursuant to subsection (a). It shall create a single report containing an aggregate of the data submitted and shall submit that report to the governor and the [appropriate committees] of the state legislature.

---

[248] *Id.*

[249] Emily R. Cummins, et al., *Use and Perceptions of Involuntary Civil Commitment Among Post-overdose Outreach Staff in Massachusetts, United States: A Mixed-methods Study,* 120 ADDICTION 327, 331 (Oct. 2024), https://doi.org/10.1111/add.16690.

[250] *Id*. *See also* Stallman, *supra* note 178.

Return to Table of Contents

(c) Contents of annual report for [probate] courts.—The annual report required in subsection (a)(1) shall include, but not be limited to, the following information:

(1) The number of petitions for involuntary commitment for substance use disorder that were filed with the court;

(2) The relationships between the petitioners and the respondents;

(3) The number of respondents ordered into temporary protective custody;

(4) The average length of time between the filing of the petition and the final disposition hearing;

(5) The number of individuals who were ordered to be involuntarily committed;

(6) The number of respondents that required or requested a court appointed attorney;

(7) The number of respondents ordered to involuntary treatment;

(8) The number of respondents who transitioned to involuntary outpatient treatment during his or her initial commitment order;

(9) The number of individuals who were ordered to be recommitted after the initial commitment order and whether they were ordered to inpatient or outpatient treatment;

(10) The number of respondents who transitioned to voluntary status;

(11) The number of respondents who filed an appeal and the outcomes of such appeals; and

(12) The number of new involuntary commitment petitions; and

(13) The number of new involuntary commitment orders involving formerly involuntarily committed individuals.

(d) Contents of annual report for treatment facilities.—The annual report required in subsection (a)(2) shall include, but not be limited to, the following information:

(1) The number of individuals subject to an involuntary commitment order who received substance use disorder treatment at the facility;

(2) The demographics of the individuals involuntarily committed, including age, sex, race, ethnicity, and type of substance use disorder;

(3) The number of individuals involuntarily committed with a co-occurring disorder;

(4) The number of individuals involuntarily committed who received medication for addiction treatment;

(5) The average length of treatment for individuals involuntarily committed;

(6) The number of individuals who were discharged prior to the expiration of the involuntary commitment order;

(7) The average length of treatment for a recommitment order; and

(8) The number of individuals involuntarily committed who are insured through Medicaid or private insurance.

(e) Contents of annual report for the involuntary review board.—The involuntary commitment review board shall be responsible for monitoring and reporting the following post-commitment information about respondents that were subject to an order of involuntary commitment for substance use disorder:

(1) Encounters with the criminal justice system, including any new arrests;

(2) The number of formerly involuntarily committed individuals who remain on medication for addiction treatment;

(3) The number of formerly involuntarily committed individuals who transitioned to a voluntary treatment program post-commitment;

(4) The number of fatal and non-fatal overdoses experienced by formerly involuntarily committed individuals;

(5) The number of formerly involuntarily committed individuals who are currently employed;

(6) The number of formerly involuntarily committed individuals who are unhoused;

(7) Information from post-commitment interviews of involuntarily committed individuals, including how many formerly involuntarily committed individuals chose to participate in the interviews and any anecdotes from interviewees about their experience with involuntary commitment for substance use disorder treatment and life post-commitment; and

(8) Any recommendations for state and local agencies or the state legislature to improve or change the process of involuntary commitment for substance use disorder treatment.

Return to Table of Contents

(d) De-identified data.—All data and metrics contained within the reports shall be de-identified.

(e) Public access to reports.—Reports submitted pursuant to this section are not confidential and shall be made publicly available on the [state department of substance use and mental health services]'s website.

Commentary

There is limited research available on the long-term effects of involuntary commitment for SUD.[251] The absence of this research leads to further questions about the ethical implications of the practice.[252] To help researchers and to develop a better understanding of the outcomes associated with involuntary commitment for SUD, the drafters have established a reporting requirement for courts, treatment facilities, and the involuntary commitment review board. The data collected from these reports can help researchers better understand who is filing these petitions, how often the petitions are granted, the types of patients for whom involuntary commitment for SUD is most effective, whether involuntary commitment for SUD has better outcomes than alternative treatment measures, and the cumulative effect of involuntary commitment for SUD over the short- and long-term.[253]

Information provided in these reports can be used to study the effectiveness of involuntary commitment for SUD and how the process should or should not be used. Well-crafted studies can provide guidance on the appropriate length of involuntary commitment, which treatment modalities and enforcement mechanisms are most effective for such individuals, and whether effectiveness varies by individual characteristics.[254] Research can also look at how involuntary commitment outcomes are influenced by pre-commitment factors, such as the relationship of the petitioner to the respondent and the respondent's previous interactions with the civil and criminal court systems.[255] Moreover, research is needed to understand the transition from involuntary commitment to community care, and what barriers (*e.g.,* transportation, financial/insurance issues, having a criminal record, or lack of accessible treatment options in the area) exist for individuals who do not follow through with voluntary post-commitment treatment.[256] Finally, research is needed on the degree to which the use of involuntary commitment for SUD is driven by a limited availability of voluntary, evidence-based treatment in a community.[257]

[251] Evans, *supra* note 35, at 732.
[252] *Id.*
[253] *Id.*
[254] Jain, et al., *supra* note 56, at 375.
[255] Christopher, et al., *supra* note 242, at 140.
[256] *Id.*
[257] *Id.*

Return to Table of Contents

SECTION XIII. FUNDING.

(a) Budget allocation.—Unless otherwise fully funded through another source, the legislature shall appropriate sufficient funds for each fiscal year to the [state department of substance use and mental health services] and the [state judicial system] for the purpose of establishing, implementing, operating, and overseeing involuntary commitment proceedings and involuntary commitment orders.

(b) Pursuit of funding.—The [state department of substance use and mental health services] and the [state judicial system] may pursue all federal funding, matching funds, and foundation or other charitable funding for the initial start-up and ongoing activities required under this Act as allowable under [state] law.

(c) Opioid settlement funds.—Funds available from an opioid-related litigation settlement or damage award may be used to fund the expenses incurred by this Act.

(d) Acceptance of gifts.—The [state department of substance use and mental health services] and the [state judicial system] and any public or private agency or organization acting under contract of such departments may accept such gifts, grants, and endowments from public or private sources, as may be made from time to time, in trust or otherwise, for the use and benefit of the purposes of this Act and expend the same or any income derived from it according to the terms of the gift, grant, or endowment, as allowed by state and federal law.

Commentary

Funding sections in model laws can be complicated, as states fund projects through legislation in a variety of ways, and there is no "one size fits all" approach. However, if the Model Act omits the funding discussion altogether, the legislation could give the appearance of an unfunded mandate. Funds should not be reallocated from voluntary SUD treatment initiatives in order to fund involuntary commitment proceedings. State funding should always prioritize voluntary treatment options and services over involuntary commitment for SUD. States should consult with their Opioid Settlement Fund Advisory Board, or equivalent state or local entity, to determine whether opioid settlement funds may be used to pay for expenses associated with involuntary commitment. Some members of the working group noted that using opioid settlement funds to pay for expenses associated with involuntary commitment would allow involuntary commitment to be available as a treatment tool without placing an additional financial burden on families, taxpayers, or public health programs. However, others stated that a better use of opioid settlement funds would be to expand SUD treatment facilities and infrastructure for voluntary treatment services and establish and expand other resources, such as

Return to Table of Contents

MAT, behavioral health services, and social services, for individuals who use drugs and their families in an effort to eliminate the need for involuntary commitment for those with SUD.

SECTION XIV. RULES AND REGULATIONS.

The department shall promulgate such rules and regulations as are necessary to effectuate this Act.

SECTION XV. SEVERABILITY.

If any provision of this Act or application thereof to any individual or circumstance is held invalid, the invalidity does not affect other provisions or applications of the Act that can be given effect without the invalid provisions or applications, and to this end, the provisions of this Act are severable.

SECTION XVI. EFFECTIVE DATE.

This Act shall be effective on [specific date or reference to normal state method of determination of the effective date].

Return to Table of Contents

ABOUT THE LEGISLATIVE ANALYSIS AND PUBLIC POLICY ASSOCIATION

The Legislative Analysis and Public Policy Association (LAPPA) is a 501(c)(3) nonprofit organization whose mission is to conduct legal and legislative research and analysis and draft legislation on effective law and policy in the areas of public safety and health, substance use disorder, and the criminal justice system.

LAPPA produces up-to-the-minute comparative analyses, publications, educational brochures, and other tools ranging from podcasts to model laws and policies that can be used by national, state, and local criminal justice and substance use disorder practitioners who want the latest comprehensive information on law and policy. Examples of topics on which LAPPA has assisted stakeholders include naloxone laws, law enforcement/community engagement, alternatives to incarceration for those with substance use disorder, medication for addiction treatment in correctional settings, and the involuntary commitment of individuals with alcohol or substance use disorder.

For more information about LAPPA, please visit: https://legislativeanalysis.org/.


LAPPA
LEGISLATIVE ANALYSIS AND PUBLIC POLICY ASSOCIATION