REHABILITATION & COMMUNITY PROVIDERS ASSOCIATION

Position on SB 716: Involuntary Commitment for SUD
December 1, 2025

Senator Laughlin's SB 716 intends to amend Pennsylvania's Mental Health Procedures Act (MHPA) by defining substance use disorder (SUD) as a mental illness, thereby subjecting those with an SUD to the same procedures outlined in MHPA, including an involuntary commitment to a 120-hour hold in a psychiatric hospital, which is commonly referred to as a 302 (Section 302 of MHPA).

The Rehabilitation and Community Providers Association (RCPA) represents nearly 400 licensed substance use disorder (SUD) treatment facilities in Pennsylvania. Our SUD treatment providers represent the entire continuum of SUD treatment, from the outpatient level of care up to hospital-based residential services that employ addiction psychiatrists who work daily with those with SUD and mental illness. **Based on input from these varied levels of expertise and real-world experience, published research on the process, and experiences from other states with involuntary commitment laws, RCPA opposes SB 716.**

Consider:

- Research demonstrates that involuntary commitment is not effective. Among the many examples: in a 2018 study of nearly 300 people who had been involuntarily committed for SUD in their lifetime, the average time to relapse following commitment was 72 days, although 34 percent relapsed on the same day of their release. In Massachusetts (with a population of nearly six million fewer people than Pennsylvania), where more than 6,000 people annually are involuntarily committed for SUD, a group of physicians and clinicians followed a group of individuals who were involuntarily committed (abstract) from their hospital. Every patient relapsed within a year of being released from involuntary commitment and continued to have serious medical complications. Two patients died. The return on the massive resource investment in an involuntary commitment process for SUD simply does not support it.
- Although some proponents of SB 716 cite court-mandated SUD treatment as essentially the same as an involuntary commitment to treatment, there is a glaring difference between the two: those mandated to treatment by a specialty court (e.g., drug-treatment court) are either accused or convicted of a crime and ultimately do have a choice: treatment or jail. Further, drug-treatment courts include intensive, long-term judicial supervision, comprehensive substance use treatment, and a coordinated team approach, none of which is explicitly directed in MHPA nor adequately funded in the current SUD treatment system. Those individuals who would be subject to an involuntary commitment to treatment for SUD have not necessarily committed any crime, and, unlike those given the choice of treatment through specialty courts, would be forced into treatment. Therefore, SB 716 criminalizes people who use drugs, reinforcing existing stigma and adding traumatic experiences to many who already suffer from deep trauma.
- There has been no meaningful effort to quantify the financial cost to the system to implement involuntary commitment for SUD, although some estimates place the cost at approximately $800

million in Pennsylvania. Although statewide data on involuntary commitments are not available, a 2023 study of Allegheny County's involuntary commitment process reported that approximately 3,700 petitions are upheld annually. Enabling the involuntary commitment process for those with SUD will significantly increase the number of petitions, thereby commensurately increasing the cost to the system, including issuing warrants, dispatching police, hospital costs (including medical staff), and county and Medicaid behavioral health dollars. In a time of inadequate state funding for behavioral health Medicaid capitation and the potential for significantly reduced federal Medicaid funding, significant financial investments in a process proven to return little to nothing is wasteful spending — especially in rural counties, where resources to support an expanded involuntary commitment process are inadequate. Further, in many instances, psychiatric facilities cannot bill Medicaid to treat patients with only an SUD diagnosis, illustrating one of the many ways the current system is misaligned to manage SUD involuntary commitment. Financial resources would be much better invested in efforts to expand intervention and treatment initiatives that are proven to be effective.

- As MHPA works today, if a petition for involuntary commitment is upheld, the person is transferred from the emergency department to an inpatient psychiatric facility where they can be held involuntarily for up to 120 hours. In an age of fentanyl, xylazine, and medetomidine, inpatient psychiatric facilities are unlikely to be prepared to manage complex SUD-specific withdrawal protocols. Senator Laughlin's staff has suggested that the entire MHPA would simply be tailored to the SUD patient and system for the SUD involuntary commitment. However, involuntarily transferring an individual with an SUD to a Department of Drug and Alcohol Programs site is vastly different, as these facilities are not locked nor staffed to manage patients forced to be there. An individual who walks away from a 302 becomes subject to further legal action, which further criminalizes the disease of addiction. Expecting an already stretched workforce to manage a crisis in a facility not equipped to do so fails to consider or understand the current challenges of the treatment system.

Although well-intended, SB 716 fails to fully consider the complexities of the mental health and SUD systems, both historically and within the context of today's challenges. It also fails to consider the serious, wide-ranging consequences of this short-sighted approach. SB 716 not only risks further harming those it intends to help but will also significantly negatively affect an SUD treatment system that is already facing serious issues and threats. Therefore, RCPA opposes SB 716.