JOURNAL OF SUBSTANCE USE
https://doi.org/10.1080/14659891.2025.2609967

Taylor & Francis
Taylor & Francis Group

EDITORIAL

Drug overdose and suicidal intentionality among youth: consideration of commitment for treatment

Introduction

Suicidal behavior among youth has risen sharply over the past decade – making suicide the second leading cause of death among individuals aged 15–24 years (Han et al., 2018). Epidemiologic data indicate that up to 20% of adolescents experience suicidal thoughts and approximately 8–10% of adolescents report a suicide attempt annually (Centers for Disease Control and Prevention [CDC], 2021). Along with the suicide epidemic, the United States has been experiencing an unprecedented and escalating epidemic of fatal opioid overdose, with more than 111,000 fatalities across all age groups – including youth ages 15–24 years – reported between April 2022 and March 2023 (CDC, 2021). Population-level postmortem data from Connecticut indicate that an increasing proportion of the overdoses are intentional – with a nearly a doubling (3.8% to 7.7%) between 2016–2018 to 2019–2021 among youth aged 10–26 years old (Kaminer et al., 2024). Studies have identified risk factors common to both suicide and overdose, including depression, trauma exposure, family dysfunction, and substance use (Goldston et al., 2021; Kaminer et al., 2020). These data suggest a growing overlap between suicidality and overdose, which highlights the importance of recognizing intentionality and addressing comorbid mental illness in efforts at prevention and treatment.

Intersection of opioid use and suicidality

Against this backdrop of rising deaths, it is critical to understand why opioid use and suicidality intersect. Substance use disorders (SUDs) and suicidal behavior share common risk factors, including co-occurring psychiatric disorders (Goldston et al., 2021; Kaminer et al., 2020) and high rates of adverse childhood events (Stein et al., 2017). Although the manner of death for most decedents by overdose is classified as accidental, the use of natural, semisynthetic (e.g., heroin), and synthetic (e.g., fentanyl, tramadol) opioids has been linked to increased suicide risk and cases determined to be intentional overdose (Bohnert & Ilgen, 2019; Oquendo & Volkow, 2018). Therefore, the manner of death by suicide leading to fatal intentional overdose – is a grave concern that cannot be overlooked (Connery et al., 2021). Studies of opioid use disorder (OUD) report suicidal intent in approximately 10% of non-fatal opioid overdoses among adults admitted for OUD detoxification/stabilization (Connery et al., 2019). Like suicidal behavior, the intentionality of fatal overdose may be multidimensional and fluctuating rather than categorical. Among opioid overdose adult survivors, approximately 45% report some desire to die prior to the event, while about 20% endorse clear suicidal intent (Connery et al., 2022). Similarly, among individuals treated for non-fatal overdose, nearly half reported suicidal thoughts before the episode, and qualitative findings emphasized that intent was often ambivalent rather than a definitive wish to die (Neale, 2000). As a whole, these findings suggest that partial or fluctuating intent is common in overdose behavior, though precise rates among youth remain underexplored.

The reliability of adult survivors' reports of intent may be compromised by one or more of the following factors: (1) retrospective changes in perceived intent; (2) memory loss following loss of consciousness; (3) cognitive impairment due to brain hypoxia; (4) difficulty determining whether the overdose was intentional or unintentional; and (5) concealing future plans for intentional overdose (Britton et al., 2012). Moreover, individuals who experience an overdose often refuse further treatment and may ask to be discharged or elope against medical advice from emergency departments. Finally, youth with SUDs – the majority of whom also have co-occurring psychiatric diagnoses – are difficult to recruit, engage, retain, and monitor for compliance with research and treatment protocols (Kaminer et al., 2022). These are characteristic limitations and barriers to treatment and research involving drug overdose survivors.

Empirical evidence

The shared vulnerabilities between opioid use and suicidality are borne out in recent cohort data. Our team studied youth with a history of overdose and reported that many individuals experienced multiple overdose events, increasing the risk for morbidity and mortality if not addressed (Kaminer & Zhornitsky, 2025). More specifically, forty-two percent of the sample had a history of a suicide attempt. Of those, 78% reported > 1 episode of intentional overdose. Participants with suicide attempt history had a significantly higher depression severity, were significantly younger at the onset of opioid use and were significantly less likely to be Hispanic relative to those without suicide attempt history. The magnitude of desire to die before the most recent overdose was significantly predicted by a) number of lifetime suicide attempts, b) likelihood that participant thought they would overdose before their most recent overdose, and c) number of days using illicit opioids in the last 30 days, despite being on methadone. These findings indicate a high prevalence of intentional overdose among young adults enrolled in methadone maintenance programs. Awareness of suicidal intent as a predictor of overdose would improve prevention-intervention methods for the reduction of morbidity and mortality among them. These data raise the question of whether stronger, even involuntary, treatment

levers could avert repeat overdoses. Although our findings highlight suicidal intent as a potential predictor of overdose risk, it is also important to recognize the plausibility of a bidirectional relationship. Experiencing a non-fatal overdose may itself heighten suicidal ideation or intent by exacerbating hopelessness, social isolation, or physiological dysregulation. Future longitudinal research is needed to clarify the temporal sequencing of suicidal intent and overdose, as well as to identify dynamic factors that may mediate or moderate this relationship.

Civil commitment: rationale and challenges

Recognizing this high-risk profile, we next consider whether involuntary treatment can avert repeated overdoses. In terms of potential prevention measures, there has been discussion in the adult literature regarding the use of civil commitment for individuals with repeated episodes of severe health and life-threatening consequences due to substance use, including drug overdose (Cavaiola & Dolan, 2016). This is similar to the common practice of commitment for self-injurious or suicidal behavior. When suicidal intent is clearly established, existing civil commitment statutes already allow for involuntary hospitalization to prevent self-harm. However, many youth who experience repeated overdoses present with fluctuating or ambiguous intent, often denying suicidality despite engaging in life-threatening behavior. For these individuals, overdose itself may signal imminent danger even in the absence of explicit suicidal ideation. Developing a commitment framework that accounts for this clinical ambiguity could extend protections to individuals at high risk of mortality who might otherwise fall outside the scope of current suicide-based commitment criteria. Such a discussion is also necessary when considering the value and limitations of establishing specific preconditions and criteria for civil commitment of youth at risk for drug overdose, particularly when suicidal intent has been present as well as repeated episodes of overdose. Any such commitment scheme must grapple with two thorny questions – how long is enough and who pays.

Length of commitment

When deciding whether to impose involuntary treatment through civil commitment, it is crucial to balance an individual's right to personal autonomy with the danger posed by their life-threatening risky behavior. Determining the length and scope of involuntary hospitalization for an opioid-using youth at risk of suicide by overdose is not straightforward. Under U.S. law, allowable commitment periods for SUDs vary wildly by jurisdiction – from as short as 15 days to as long as one year, with around 90 days being the most common maximum for an initial commitment (Legislative Analysis and Public Policy Association [LAPPA], 2024). For instance, Florida's Marchman Act allows an initial treatment order up to 60 days, while Connecticut permits commitments that can extend to 180 days (American Addiction Centers, 2025). This variability reflects the unsettled question of how long is "enough" to protect the youth and effect meaningful change. A brief hold (e.g., a detoxification stay of a week or two) might stabilize the immediate crisis and clear opioids from the body, but it is likely to fail to address underlying drivers of the suicidal overdose risk. An optimal commitment period would ideally extend long enough to initiate and stabilize both psychiatric and addiction treatment – typically around 60 to 90 days – while allowing for individualized reassessment of risk, engagement, and readiness for outpatient transition. Most young people with opioid use disorder have co-occurring mental health issues such as depression or trauma-related disorders (Goldston et al., 2021; Kaminer et al., 2020; Stein et al., 2017). These underlying psychiatric issues, along with acute psychosocial stressors like homelessness or family conflict, cannot be resolved overnight. Effective intervention may require weeks or months of treatment to initiate therapy, start medication for depression or addiction (e.g., buprenorphine or naltrexone), and connect the youth to social supports. Proponents of longer commitments note that research shows better outcomes when addiction treatment lasts at least around 3 months, in line with standard rehab recommendations (National Institute on Drug Abuse [NIDA], 2018).

Who pays?

One critical issue is the financial burden of involuntary treatment and who will cover it. Available research in treatment populations indicates that only a minority of individuals who experience overdose report clear suicidal intent, whereas a considerably larger proportion experience repeated overdoses requiring medical intervention (Connery et al., 2019, 2022; Kaminer & Zhornitsky, 2025; Neale, 2000). Research studies seldom document intentionality in non-fatal overdoses, leaving the true prevalence of youth with recurrent, ambiguous-intent overdoses uncertain. However, given estimates of roughly 15,000– 20,000 annual overdose deaths among youth and young adults in the United States, even a small fraction meeting potential criteria for civil commitment would represent a significant clinical and policy challenge.

In the U.S., civil commitment for SUDs is legally permitted in most states (37 states and D.C. as of the early 2020's), but these laws often implicitly or explicitly place the cost of care on the patient or their family (Appel, 2023). Some state statutes even make a third party's ability to pay a precondition for commitment. For example, Kentucky's "Casey's Law" requires the petitioning family member to guarantee and often pre-pay the costs of treatment as a condition of the court order (LAPPA, 2024). Legislatures in several states have considered or enacted similar provisions tying involuntary commitment to the family's financial commitment (Appel, 2023). This raises serious equity concerns: only youths from families with resources can benefit, while those who are uninsured or indigent may be left behind. Indeed, fear of exorbitant costs has deterred many families from using these laws – in Ohio, only 7 out of 81 probate judges reported any SUD commitment petitions in the first three years after its Casey's Law – style statute passed, a shortfall attributed to the economic burdens on petitioners (Appel, 2023). Even when the law does not formally require a prepaid pledge, the

reality is that involuntary hospitalization and rehab entail high expenses (ambulance transport, hospital charges, treatment program fees) which someone must pay. If the young person is a minor, parents or guardians are typically held responsible for treatment costs, and some states have limited indigent-care funds to reimburse hospitals when families cannot pay (Fairfax-Falls Church Community Services Board, 2019). In many cases, however, there is no clear funding mechanism – raising the question of whether the state, insurers, or families should shoulder the enormous costs of potentially life-saving involuntary treatment.

The financial implications of implementing such measures would be considerable. Inpatient commitment for SUDs typically costs between $20,000 and $60,000 per treatment episode (King et al., 2024). Extended commitments lasting 90–180 days would proportionally increase these costs, and if even a modest proportion of high-risk youth required such care, the aggregate financial burden to state systems and families could be substantial. National data further indicate that community-based and outpatient treatment programs can achieve comparable outcomes at significantly lower cost (NIDA, 2018). These considerations underscore the need for less resource-intensive, community-based alternatives (such as court-monitored outpatient treatment) to reduce recurrence risk, while balancing fiscal and ethical responsibilities. Indeed, for youths who are medically stable after detox, a court-monitored course of extended-release naltrexone delivered in an outpatient setting can provide opioid blockade for 28 days at a time without requiring inpatient confinement (Alkermes, 2024; NIDA, 2018). Because each injection entails only the price of the medication and a brief clinic visit, the financial outlay is a fraction of what accrues during even a short civil-commitment stay (GoodrRX, 2025; King et al., 2024). In that sense, extended-release naltrexone offers a fiscally sustainable bridge between safety and autonomy – an option that avoids shifting a large, unexpected bill onto families or state systems. Clinical trial evidence indicates that relapse prevention with extended-release naltrexone is similar to buprenorphine-naloxone among those who successfully initiate treatment, but a substantial induction hurdle means fewer patients manage to start extended-release naltrexone in practice (Lee et al., 2018).

Policymakers must balance the immediate safety benefits of getting a suicidal, opioid-addicted youth out of harm's way via commitment against the limitations of what can be accomplished during a forced hospitalization, all while respecting the youth's rights. Deciding whether to hold someone just long enough to detox and avert an imminent overdose, or to prolong the commitment until co-occurring mental health issues and acute life stressors are meaningfully addressed, remains a challenging question with no one-size-fits-all answer. Each of these considerations – who pays for care, and how long and intensive that care should be – highlights the complex legal and ethical landscape surrounding civil commitment for at-risk youth with OUDs. The development of any such involuntary treatment framework in the U.S. will need to carefully navigate these issues of cost, coverage, and appropriate duration to ensure both effectiveness and fairness.

Limitations and ethical concerns of civil commitment

Despite potential benefits, the possible harms of civil commitment for individuals with OUD are substantial. Evans et al. (2020) applied the Kass Public Health Ethics Framework to evaluate the balance of benefits and harms of civil commitment for SUDs. They identified potential advantages, including protection of vulnerable patients, reduction of legal consequences, improved access to treatment, and support for families. However, they also emphasized serious potential harms – stigmatizing or punitive treatment experiences, increased family conflict and social isolation, erosion of patient autonomy, limited access to medications for OUD, and heightened overdose risk due to reduced tolerance after release. The authors concluded that individuals subject to civil commitment represent a particularly vulnerable population requiring enhanced ethical safeguards. They recommended that civil commitment be used only as a last-resort intervention, implemented through consensual and humane processes, ensure access to evidence-based medications, and demonstrate proven effectiveness prior to wider adoption.

Empirical evidence on effectiveness of involuntary commitment for SUDs remains mixed and methodologically weak. A systematic review found that out of 42 studies among SUD patients, only 7 studies comparing involuntary to voluntary intervention reported improved outcomes in the involuntary group, with most for retention in treatment and only one showing a reduction in substance use (Bahji et al., 2023). No studies compared involuntary treatment to no treatment. Most studies involved mixed drug-use populations rather than OUD specifically, limiting generalizability given the unique withdrawal, relapse, and tolerance dynamics associated with opioid dependence. Comparisons between involuntary and voluntary treatment groups are vulnerable to self-selection bias, as involuntarily committed individuals are often less motivated to cease opioid use at baseline, yielding poorer outcomes. Moreover, many compulsory programs exclude evidence-based pharmacotherapies and lack continuity-of-care mechanisms post-discharge (e.g., see Sun et al., 2001; Vuong et al., 2016, 2018; Wegman et al., 2016). Collectively, this limits any conclusion about the effectiveness of involuntary treatment in OUD.

Few studies have examined post-treatment outcomes specifically among individuals with non-suicidal overdose, as most available data do not distinguish intentional from unintentional events. Nonetheless, findings from mixed or unspecified samples indicate persistently high rates of relapse and re-overdose after release from involuntary care. For instance, Christopher et al. (2018) found that among individuals with OUD who had undergone civil commitment in Massachusetts motivation for recovery increased during the commitment period, but 34% relapsed on the day of discharge and the average relapse-free period was only 72 days. However, only 19.5% received any medication for OUD while committed. These outcomes underscore the limited long-term benefit of brief or medication-free commitment stays and highlight the urgent need for studies that prospectively evaluate outcomes as a function of overdose intentionality and treatment duration.

These findings underscore that while civil commitment may offer opportunities for engagement and safety in acute crises, its ethical justification and effectiveness remain uncertain without guaranteed access to evidence-based medication treatment, procedural fairness, and post-release continuity of care. Policy approaches should therefore prioritize voluntary, evidence-based, and recovery-oriented interventions before considering expansion of civil commitment as a preventive or rehabilitative measure.

Conclusion and research agenda

Clinical evidence and policy realities point to several priority areas for future research. First, longitudinal and mixed-methods studies are needed to clarify the bidirectional relationship between suicidal intent and overdose among youth with OUD, as well as to identify acute and modifiable risk factors for both behaviors. Second, research should distinguish between intentional and non-intentional overdoses to determine how psychiatric status, treatment engagement, and relapse risk differ across these groups. Third, prospective evaluation of treatment outcomes by length of stay and access to medications for OUD is needed to establish evidence-based parameters for involuntary and voluntary care. Fourth, policy-oriented studies should examine equity and cost-effectiveness implications of extended or mandated treatment, including the impact of insurance coverage, family financial responsibility, and continuity of care after discharge. Finally, research exploring youth and family perspectives on involuntary treatment could guide development of ethically sound, recovery-oriented models that balance safety, autonomy, and long-term outcomes. Addressing these gaps will be essential for designing targeted, evidence-based interventions that reduce both intentional and unintentional overdose deaths among youth with OUD.

While this commentary does not propose a definitive solution, our intent is to open a meaningful and multidisciplinary discussion on an underexamined but pressing issue – whether civil commitment can play a role, alongside voluntary and community-based interventions, in reducing the growing burden of youth overdose. As emphasized by Humphreys (2025) in a recent *New York Times* essay, mandatory treatment, when properly resourced and ethically implemented, can restore autonomy rather than violate it by helping individuals regain the capacity for sound judgment and self-control. Humphreys further notes that addiction erodes autonomy, and that mandated care can protect both individuals and communities when voluntary options fail. Although his commentary focused on adults and not overdose specifically, it underscores a broader public health principle: rejecting involuntary treatment categorically may overlook opportunities for compassionate, well-designed interventions that preserve life and dignity. Our aim is to stimulate empirical and ethical inquiry into how such approaches – alone or integrated with others – might reduce overdose mortality among vulnerable youth populations

Disclosure statement

No potential conflict of interestwas reported by the author(s).

References

Alkermes, Inc. (2024). *Vivitrol (naltrexone for extended-release injectable suspension) - U.S. prescribing information.*

American Addiction Centers. (2025). Involuntary rehab: Can you force someone into rehab? https://americanaddictioncenters.org/rehab-guide/involuntary-rehab-forced. Accessed 2025.

Appel, J. M. (2023). Financial equity in involuntary treatment for substance use disorders. *Journal of the American Academy of Psychiatry and the Law, 51*(3), 357–366. https://doi.org/10.29158/JAAPL.220098-22.

Bahji, A., Leger, P., Nidumolu, A., Watts, B., Dama, S., Hamilton, A., & Tanguay, R. (2023). Effectiveness of involuntary treatment for individuals with substance use disorders: A systematic review. *Canadian Journal of Addiction, 14*(4), 6–18. https://doi.org/10.1097/CXA.0000000000000188

Bohnert, A. S. B., & Ilgen, M. A. (2019). Understanding links among opioid use, overdose, and suicide. *New England Journal of Medicine, 380*(1), 71–79. https://doi.org/10.1056/NEJMra1802148.

Britton, P. C., Bohnert, A. S. B., Wines, J. D., & Conner, K. R. (2012). A procedure that differentiates unintentional from intentional overdose in opioid abusers. *Addictive Behaviors, 37*(1), 127–130. https://doi.org/10.1016/j.addbeh.2011.08.006

Cavaiola, A. A., & Dolan, D. (2016). Considerations in civil commitment of individuals with substance use disorders. *Substance Abuse, 37*(1), 181–187. https://doi.org/10.1080/08897077.2015.1029207.

Centers for Disease Control and Prevention. (2021). Synthetic opioid overdose data | Drug overdose. CDC Injury Center. Accessed 23 June 2025.

Christopher, P. P., Anderson, B., & Stein, M. D. (2018). Civil commitment experiences among opioid users. *Drug and Alcohol Dependence, 193*, 137–141. https://doi.org/10.1016/j.drugalcdep.2018.10.001.

Connery, H. S., McHugh, R. K., & Welsh, J. W. (2021). Commentary on Monico, et al.: The urgent need for developmental competency and effective policy to prevent youth opioid overdose. *Addiction, 116*(4), 874–875. https://doi.org/10.1111/add.15493.

Connery, H. S., Taghian, N., Kim, J., Griffin, M., Rockett, I. R. H., Weiss, R. D., & McHugh, R. K. (2019). Suicidal motivations reported by opioid overdose survivors: A cross-sectional study of adults with opioid use disorder. *Drug and Alcohol Dependence, 205*, 107612. https://doi.org/10.1016/j.drugalcdep.2019.107612.

Connery, H. S., Weiss, R. D., Griffin, M. L., Trinh, C. D., Kim, J., Rockett, I. R. H., & McHugh, R. K. (2022). Suicidal motivations among opioid overdose survivors: Replication and extension. *Drug and Alcohol Dependence, 235*, 109437–000. https://doi.org/10.1016/j.drugalcdep.2022.109437.

Evans, E. A., Harrington, C., Roose, R., Lemere, S., & Buchanan, D. (2020). Perceived benefits and harms of involuntary civil commitment for opioid use disorder. *The Journal of Law, Medicine & Ethics, 48*(4), 718–734. https://doi.org/10.1177/1073110520979382.

Fairfax-Falls Church Community Services Board. (2019). *Guidebook to the involuntary psychiatric hospitalization process for youth (Virginia).* Fairfax-Falls Church CSB.

Goldston, D. B., Curry, J. F., Wells, K. C., Kaminer, Y., Daniel, S. S., Esposito-Smythers, C., Doyle, O., Sapyta, J., Tunno, A. M., Heilbron, N. C., & Roley-Roberts, M. (2021). Feasibility of an integrated treatment approach for youth with depression, suicide attempts, and substance use problems. *Evidence-Based Practice in Child and Adolescent Mental Health, 6*(2), 155–172. https://doi.org/10.1080/23794925.2021.1888664.

GoodRx. (2025). Naltrexone (Vivitrol) 380-mg intramuscular kit, average retail price. Accessed 25 July 2025 https://www.goodrx.com/vivitrol?srsltid=AfmBOorfp0VK0KDrXDR_RmlB3N2rJdLhzNxqrCb4w4Djz4dwH57bEhoV.

Han, B., Compton, W. M., Blanco, C., Colpe, L., Huang, L., & McKeon, R. (2018). National trends in the prevalence of suicidal ideation and behavior among young adults and receipt of mental health care among suicidal young adults. *Journal of the American Academy of Child & Adolescent Psychiatry, 57*(1), 20–27.e2. https://doi.org/10.1016/j.jaac.2017.10.013.

Humphreys, K. (2025). September 2). Forced drug treatment isn't horrific. it's a relief. The New York Times. https://www.nytimes.com/2025/09/02/opinion/forced-drug-treatment.html

Kaminer, Y., Burke, R., Zhornitsky, S., Gill, J., Zajac, K., & Hesselbrock, V. (2024). Youth intentional fatal drug overdose: Trends in Connecticut 2019–2021. *American Journal of Addiction*, *33*(3), 327–334. https://doi.org/10.1111/ajad.13506.

Kaminer, Y., Chan, G., & Burke, R. (2022). Barriers for recruitment to treatment of youths with co-occurring substance use disorders and depression. *American Journal of Addiction*, *31*(5), 463–469. https://doi.org/10.1111/ajad.13223.

Kaminer, Y., Zajac, K., & Winters, K. C. (2020). Assessment and treatment of co-occurring internalizing disorders: Depression, anxiety disorders and PTSD. In Y. Kaminer & K. Winters (Eds.), *Clinical manual of youth addictive disorders* (pp. 255–276). American Psychiatric Association Publishing.

Kaminer, Y., & Zhornitsky, S. (2025). Drug overdose and suicidal intentionality among young adults in methadone treatment. *American Journal of Addiction*, *34*(4), 433–439. https://doi.org/10.1111/ajad.70026.

King, C. A., Beetham, T., Smith, N., Englander, H., Button, D., Brown, P. C. M., Hadland, S. E., Bagley, S. M., Wright, O. R., Korthuis, P. T., & Cook, R. (2024). Adolescent residential addiction treatment in the US: Uneven access, waitlists, and high costs. *Health Affairs (Millwood)*, *43*(1), 64–71. https://doi.org/10.1377/hlthaff.2023.00777.

Lee, J. D., Nunes, E. V., Jr., Novo, P., Bachrach, K., Bailey, G. L., Bhatt, S., Farkas, S., Fishman, M., Gauthier, P., Hodgkins, C. C., King, J., Lindblad, R., Liu, D., Matthews, A. G., May, J., Peavy, K. M., Ross, S., Salazar, D.Schkolnik, P. . . . Rotrosen, J. (2018). Comparative effectiveness of extended-release naltrexone versus buprenorphine-naloxone for opioid relapse prevention (x: Bot): A multicentre, open-label, randomised controlled trial. *Lancet*, *391*(10118), 309–318. https://doi.org/10.1016/S0140-6736(17)32812-X.

Legislative Analysis and Public Policy Association. (2024). *Involuntary commitment of those with substance use disorders: Summary of state laws*. LAPPA.

National Institute on Drug Abuse. (2018). *Principles of drug addiction treatment: A research-based guide* (3rd ed.). National Institutes of Health.

Neale, J. (2000). Suicidal intent in non-fatal illicit drug overdose. *Addiction*, *95*(1), 85–93. https://doi.org/10.1046/j.1360-0443.2000.951859.x

Oquendo, M. A., & Volkow, N. D. (2018). Suicide: A silent contributor to opioid-overdose deaths. *New England Journal of Medicine*, *378*(17), 1567–1569. https://doi.org/10.1056/NEJMp1801417.

Stein, M. D., Conti, M. T., Kenney, S., Anderson, B. J., Flori, J. N., Risi, M. M., & Bailey, G. L. (2017). Adverse childhood experience effects on opioid use initiation, injection drug use, and overdose among persons with opioid use disorder. *Drug and Alcohol Dependence*, *179*, 325–329. https://doi.org/10.1016/j.drugalcdep.2017.07.007.

Sun, B., Ye, Y., & Qin, L. (2001). An analysis of relapse factors of 615 heroin addicts. *Chinese Journal of Drug Dependence*, *10*, 214–216.

Vuong, T., Ritter, A., Shanahan, M., Ali, R., Nguyen, N., Pham, K., Vuong, T. T. A., & Le, G. M. (2018). Outcomes of compulsory detention compared to community-based voluntary methadone maintenance treatment in Vietnam. *Journal of Substance Abuse Treatment*, *87*, 9–15. https://doi.org/10.1016/j.jsat.2018.01.011

Vuong, T., Shanahan, M., Nguyen, N., Le, G., Ali, R., Pham, K., Vuong, T. T. A., Dinh, T., & Ritter, A. (2016). Cost-effectiveness of center-based compulsory rehabilitation compared to community-based voluntary methadone maintenance treatment in Hai Phong city. *Vietnam Drug and Alcohol Dependence*, *168*, 147–155. https://doi.org/10.1016/j.drugalcdep.2016.09.008.

Wegman, M. P., Altice, F. L., Kaur, S., Rajandaran, V., Osornprasop, S., Wilson, D., Wilson, D. P., & Kamarulzaman, A. (2016). Relapse to opioid use in opioid-dependent individuals released from compulsory drug detention centres compared with those from voluntary methadone treatment centres in Malaysia: A two-arm, prospective observational study. *The Lancet Global Health*, *5*(2), e198–e207. https://doi.org/10.1016/S2214-109X(16)30303-5.

Yifrah Kaminer
Department of Psychiatry, University of Connecticut
Farmington, Connecticut, USA
kaminer@uchc.edu

Simon Zhornitsky
Department of Behavioral Sciences, Medical University of the Americas Nevis, West Indies