

Testimony of Professor Keith Humphreys, Stanford University, to the Joint Committee on Mental Health, Substance Use, and Recovery, Massachusetts Legislature, October 6, 2025

Chair Velis, Chair Domb, and distinguished committee members thank you for the opportunity to speak with you today about mandated addiction treatment initiatives. Over the past 35 years I have seen both the potential and the limits of programs that require addicted people to enter treatment either through the criminal justice system, civil commitment proceedings, or other mechanisms. To keep within time, I am just going to make two points about such initiatives.

First, many people wonder why we need to pressure anyone to seek addiction treatment at all. Don't people need to "become ready" on their own and shouldn't that happen quickly given the devastation wrought by addiction? It's a fair question, and the answer to it lies in how addiction is different from many other disorders, namely that it is experienced with ambivalence.

People with conditions like chronic pain or psoriasis suffer consistently and therefore will move mountains if needed to become free of their illness. But addicted people are mostly not like that because even as it burns your life down around you, alcohol and drug use is rewarding in the short term. And when someone repeatedly uses powerful addictive drugs year after year, it alters their ability to set priorities and weigh future consequences in their life accurately.

As a result, almost every person who enters addiction treatment is under some type of external pressure to change. There is no law requiring people to stop drinking alcohol, yet a study of almost 500 people seeking alcohol treatment found that over 9 in 10 were there under pressure anyway, for example from their spouse, family, employer or combinations thereof.¹

Given how much pressure it typically takes for someone to enter addiction treatment, the ethical case for using legal power to push people in that direction is more compelling. And we don't have the time we did 50 years ago to wait until an addicted person spontaneously overcomes their

ambivalence about change, because with the high potency of stimulants and opioids on the street today, a lack of action can easily translate into another fatal overdose.

The other point I wanted to make today may seem obvious, but I have worked on some mandatory treatment initiatives that forgot it. It is this: We can't mandate people to treatment services that don't exist. I advised the province of Alberta, Canada on their mandatory treatment program and supported it because they spent years building up a strong network of high-quality services *before* they began changing civil commitment laws to cover addiction. In contrast, I opposed the effort of former San Francisco Mayor Breed to mandate to addiction treatment everyone applying for welfare who had a positive drug test, because at the time the city had waiting lists at all its addiction treatment programs. Mandating people to care that doesn't exist isn't compassionate, it's punishment. So when I see for example in Senate Bill 1402 the observation that some parts of Massachusetts don't have sufficient accessible services, I think of that lesson, namely we should build high-quality, accessible services first and worry about whether there needs to be a mandatory program second.

I'll stop there. Thank you for your time and attention.

This testimony does not necessarily reflect official positions of Dr. Humphreys' employers or any elected official or agency that he advises.

Reference

1 Polcin, D. et al.(2012). Available on line at <https://pmc.ncbi.nlm.nih.gov/articles/PMC3888964/>