HHS Public Access

Author manuscript

Addiction. Author manuscript; available in PMC 2025 February 01.

Published in final edited form as:

Addiction. 2025 February ; 120(2): 327–334. doi:10.1111/add.16690.

Use and perceptions of involuntary civil commitment among post-overdose outreach staff in Massachusetts, United States: A mixed-methods study

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DECLARATION OF INTEREST

None.

SUPPORTING INFORMATION

Additional supporting information can be found online in the Supporting Information section at the end of this article.

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Abstract

Background and aims: Involuntary civil commitment (ICC) is a legal process by which people are compulsorily admitted to substance use treatment. This study explored views about and promotion of ICC procedures for substance use disorders among public health-public safety post-overdose outreach programs and their outreach team members in Massachusetts, USA.

Design: In this mixed-methods study, survey data were collected from post-overdose outreach programs in 2019, and semi-structured interviews were conducted with outreach team members in 2019 and 2020.

Setting: Massachusetts, USA.

Participants: We received 138 survey responses and conducted 38 interviews with post-overdose outreach team members (law enforcement officers, recovery coaches, social workers and harm reductionists) who were majority male (57%) and white (66%).

Measurements: We used the survey instrument to categorize programs as more (discussed ICC at 50% or more of outreach encounters) or less ICC focused (discussed ICC at less than 50% of outreach encounters) and to identify program characteristics that corresponded with each categorization. Semi-structured interviews explored staff perceptions of ICC effectiveness.

Findings: Among 138 programs, 36% ($n = 50$) discussed ICC at 50% or more of outreach encounters. Discussing ICC at a majority of visits was positively associated with abstinence-only program philosophies (36% v. 6%, $P < 0.001$) and collaborating with drug courts (60% v. 30%, $P < 0.001$), but negatively associated with naloxone distribution (48% v. 75%, $P < 0.001$) and referring to syringe service programs (26% v. 65%, $P < 0.001$). Qualitative interviews identified three themes: 1) some programs viewed ICC as a first line tool to engage overdose survivors in treatment; 2) other programs considered ICC a last resort, skeptical of its benefits and concerned about potential harms; 3) families commonly initiated discussions about ICC, reportedly out of desperation.

Conclusions: Promotion of involuntary civil commitment (ICC) appears to vary widely across post-overdose outreach programs in Massachusetts, USA, with approaches ranging from seeing it as a first step to treatment to being a tool of last resort. Demand for ICC among family members may relate to inadequate access to voluntary treatment. Family interest in ICC appears to be driven by inadequate availability of treatment and other services. ICC at post-overdose outreach visits should be limited, if used at all.

Keywords

drug policy; involuntary civil commitment; mixed-methods; opioids; overdose; policing; qualitative research

INTRODUCTION

Opioid overdose deaths have increased each year in the United States (US) since 2001, surpassing deaths caused by both gun violence and car accidents [1–3] In the Commonwealth of Massachusetts, opioid overdose deaths increased from 671 (10.5 per 100 000 residents) in 2010 to 2310 in 2022 (33.5 per 100 000 residents) [4].

In response to rising overdose rates, novel public health-public safety partnerships for post-overdose outreach have spread rapidly across the United States [5–8]. In Massachusetts, post-overdose outreach is typically carried out by a first responder (most often police), and a public health representative such as a recovery coach or harm reductionist. These teams conduct home-based visits to suspected overdose survivors 1 day to 1 week after an overdose event. Overdose survivors are typically identified by emergency call records and contacted by a team of public safety and public health workers, typically by phone or a visit to a place of residence [6, 7]. Services provided vary, but may include naloxone distribution, referral to treatment for substance use disorders (SUD) including medication for opioid use disorder, and referral to recovery supports, family supports and social services. Many Massachusetts programs provide families with information regarding or assistance filing involuntary civil commitment (ICC) court petitions [7].

In Massachusetts, ICC for SUD is colloquially known as ‘Section 35,’ a reference to the statute that establishes this intervention [9]. Per statute, petitions for ICC under Section 35 may be filed by family members, guardians, physicians, police officers or court officials on behalf of a person alleged to be at imminent danger to themselves or others because of their substance use. Although ICC hearings are not criminal proceedings in Massachusetts, the person subject to the petition is processed like a criminal defendant and arrested by police on a court-issued warrant, handcuffed or restrained, transported to court, held in custody with others arrested for crimes and handcuffed during court proceedings. If the court grants the petition, the individual is then transported to a commitment facility; such facilities for men are commonly located within a prison or jail [10].

Compulsory and involuntary substance use treatment is pervasive throughout the world. These coercive modalities have garnered media support and political traction in North America in response to the spiraling overdose crisis [11]. There is little evidence that ICC improves substance use outcomes, and numerous studies suggest ICC aggravates health risks including overdose on discharge [12–16]. In a 2018 Massachusetts study, over one-third of people subjected to ICC for opioid use returned to use the day they were released from commitment [17]. In Puerto Rico, ICC procedures are often uninformed by clinical expertise, resulting in long periods of commitment in restrictive facilities for individuals who have not formally been diagnosed with substance use disorder [18]. This had led many to question whether ICC is an ethical response to problematic substance use, including whether it is a violation of one’s free will and/or civil rights [16, 19–22].

Although 38 US states and Washington, District of Columbia have ICC systems in place, little guidance exists to inform post-overdose outreach program staff about clinical and ethical concerns associated with this practice. Our group has released best practice guidance

for post overdose outreach programs based on expert opinion collected through a modified Delphi process that was informed, in part, by the findings in this study [23]. Factors shaping the use of ICC, including how staff of post-overdose outreach programs perceive, promote or use ICC following a non-fatal overdose, have not been rigorously evaluated.

Following an explanatory-sequential approach [24], the aim of this study was to explore views about and promotion of ICC for SUD within public health-public safety post-overdose outreach programs in Massachusetts.

METHODS

Study design and population

This mixed methods study analyzed data from a state-wide survey distributed to all known post-overdose outreach programs in Massachusetts between February and November of 2019 as well as qualitative interview data collected with outreach staff from a subset of those programs between December 2019 and September 2020. Outreach staff interviewed included law enforcement officers, recovery coaches, harm reduction specialists and other public health representatives.

Quantitative measures and analysis

Full details of the survey design and methods are published elsewhere [7]. In brief, a representative from each identified post-overdose outreach program in Massachusetts was asked to complete the survey to the best of their abilities on behalf of their organization. To assess the extent to which ICC is part of post-overdose outreach, the primary outcome of interest in this analysis was how frequently ICC was brought up by a team member while on outreach, based on the following survey item: ‘Please indicate on the scale how frequently Section 35 is brought up by a member of the team during post-overdose outreach (both initial and follow-up)’ (sliding scale from ‘never-0’ to ‘every time-100’). To describe how program characteristics differ, we defined ‘more ICC-focused programs’ as those that reported discussing ICC at 50% or more of their outreach encounters and ‘less ICC-focused programs’ as those that reported discussing ICC less than 50% of the time. We chose to dichotomize programs at a threshold of discussing ICC at 50% of visits, so that we could ensure that there were enough programs in each group to compare and because this 50% threshold seemed reasonable from a practical programmatic perspective.

Other ICC-related descriptive variables captured in the survey included: with whom the team will discuss ICC (overdose survivor, family of the survivor, friends of the survivor and other/blank); how ICC is presented during outreach (as a first step to treatment, as a last resort and depends on the situation); whether outreach staff will assist families in filing a petition for ICC (yes/no); and whether outreach staff will serve as a primary petitioner for ICC (yes/no). Programs were also asked whether they collaborate with drug courts and/or SUD treatment providers; refer participants to syringe services programs; distribute naloxone; or promote abstinence-based recovery (all yes/no).

Survey data were analyzed using Pearson χ^2 for assessing the correlation of binary measures or Fisher’s exact test for assessing the correlation of binary measures for rare events ($n <$

5), as appropriate to compare differences in these contextual variables across more and less ICC-focused programs. Analyses were conducted in R (R Core Team 2020).

Qualitative interviews

Participants were recruited for qualitative interviews (by E.C.) using purposive sampling strategies, which sought to capture the greatest range of professional roles, guided by data from the survey [25]. Eligible interview participants met the following criteria: at least 18 years of age, currently working in a post-overdose outreach program that responded to the state-wide survey and had conducted post-overdose outreach home visits or made phone calls to survivors and/or to survivors' friends and family in the past 12 months. Interviews followed a semi-structured guide and lasted ~45 to 60 minutes and were conducted (by E.C.) in-person before March 2020 or via telephone or video call thereafter in accordance with coronavirus disease 2019 (COVID-19) protocols. All interviews were recorded and transcribed for analysis.

Transcripts were free coded to identify an initial set of themes related to ICC (by E.C.). Following a constant comparison grounded theory approach [25], several members of the research team (E.C., J.C. and S.S.) independently reviewed interview transcripts and met to further refine initial themes and meet to achieve consensus on the final code book, which was then applied to all transcripts (by E.C.). Findings presented here emerged in this stage of analysis [26]. (See Appendix S1 for further details). This study was not pre-registered before data collection and all results should be considered exploratory.

Human subjects approval

This research protocol and all amendments to that protocol in response to COVID-19 were approved by the institutional review board at Boston Medical Center.

RESULTS

Survey findings

Of the 157 outreach programs identified and invited to participate in the survey, 138 returned a completed survey for a response rate of 88%. The mean percentage of visits during which outreach teams discussed ICC was 35% (SD = 32.65). Based on these responses, we assigned programs that reported discussing ICC during less than 50% of visits to the 'less ICC-focused' group (n = 88, 64%) and we assigned programs that reported discussing ICC at 50% or more visits to the 'more ICC-focused' group (n = 50, 36%) (Table 1).

Half of the more ICC-focused programs (25/50) reported discussing ICC as either a first step to treatment or when overdose survivors and their social networks show awareness of ICC as an option. By contrast, only 23% (20/88) of less ICC-focused programs reported discussing ICC in this way ($P < 0.01$). More ICC-focused programs were more likely to collaborate with drug courts versus less ICC-focused programs (60% vs. 30%, $P < 0.01$). More ICC-focused programs were less likely to distribute naloxone 48% (24/50) and less likely to refer survivors to syringe services programs 26% (13/50) compared to less ICC-focused programs 75% (66/88, $P < 0.01$) and 65% (57/88, $P < 0.01$). See Table 2 for more detail.

Qualitative findings

A total of 38 persons working within post-overdose outreach programs in Massachusetts participated in interviews. All interviewees were members of outreach teams that include at least one law-enforcement partner at each outreach visit, although exact team composition varied from program to program. Of these 38 participants, 15 were law enforcement, nine identified as recovery coaches, five as outreach specialists and two identified as harm reductionists. Three participants represented other professions, including social work and fire. Of those remaining, two were program managers and two were members of the clergy. More than half (57%) of participants were male, and two-thirds (66%) were White.

Analysis of the interviews identified three overarching themes. The first two themes consist of the general perspective on ICC of programs that largely approached ICC as a first line tool in their overdose survivor outreach activities and programs that largely approached ICC as a tool to be used only as a last resort. The programs that viewed ICC as a first line tool, more frequently discussed, recommended and pursued ICC petitions, believing it was an effective, useful approach. The programs that viewed ICC as a last resort were skeptical of its benefits and effectiveness and concerned about a high risk of harm. In the third theme, the topic of ICC was most often raised by family members seeking assistance in pursuing ICC on behalf of the overdose survivor. We discuss these themes in order below.

Framing ICC as a first step

Outreach team members working with programs that viewed ICC as a first line tool were, in general, comfortable suggesting ICC and likely to view it as useful in their outreach efforts. Andrew,* a detective, shared that his team was willing to Section 35 overdose survivors when there was a perceived risk of death: ‘I do Section 35 [ICC] people, if I do find somebody that I think could die. Or at high risk. I will Section 35 them.’ Public health partners working within the same program as Andrew agreed. Sheila, a recovery coach, stressed that she has had ‘people that have been Section 35’d [by us] come out and hate us,’ yet she justified ICC as an important intervention with the assertion that ‘ultimately they [the people subject to ICC] were grateful [for being Sectioned].’ Several staff persons similarly described scenarios where they felt ICC was crucial to keeping outreach recipients alive despite acknowledging it might be a negative experience.

Staff in programs that used ICC as a first line tool often justified the use of ICC through assertions that overdose survivors were incapable of making decisions about their own health. Bryan, a fire fighter working closely with law enforcement, stated, ‘Oh, I think it’s [ICC] a very powerful tool, absolutely’, explaining that ‘they [the overdose survivor] may not be of the sound mind to make that decision [to seek help] for themselves. You know, they may not recognize that they’re a harm to themselves.’ In this way, some outreach staff may have appealed to the culturally informed idea that addiction implies an individual is incapable of making sound decisions related to their own health to assert that participants displayed ‘likelihood of serious harm,’ a necessary precondition for ICC in Massachusetts [27, 28].

*All names are pseudonyms.

Many of the programs that described ICC as a first step tool were law enforcement-led, meaning law enforcement officers were responsible for developing the intervention and hiring or partnering with public health representatives and acted as a leader during an initial post-overdose outreach visit. Although ICC petitions can be and are most often filed by family members, some officers noted that they, too, are explicitly empowered to file ICC petitions by the Massachusetts statute. One officer recalled a family in which someone was 'using heroin and fentanyl incredibly heavily,' noting that '[the family] had no means to get to court to do Section 35 or anything. I ended up doing a Section 35 for the individual.' Another officer gave a similar explanation for his use of ICC, comparing the process to 'tough love'. He described ICC as appropriate if 'they're [the outreach recipient] not going to get help from us and [not from] family and friends … then you know what, honestly a little tough love. You're going to get a 35 and force them to get that help.' Program staff across roles described similar scenarios, agreeing that ICC represents a tough, but ultimately useful and appropriate legal mechanism, from their perspective, to support outreach recipients.

Framing ICC as a last resort

Staff in several programs were skeptical of ICC as an intervention for overdose survivors, questioning the benefits and effectiveness, although concerned about the harms of coerced treatment. These programs were often public health-led programs: those in which a public health representative led the outreach visits and law enforcement partners generally followed the lead of the public health representative during outreach. Jackie, an outreach specialist in one such program, explained that she was '[n]ot a huge fan of Sectioning 90% of the time, since it doesn't seem to work for a large chunk of people and can increase overdose risk after they get out.' Similarly, Rob, a recovery coach working for a different program, cautioned, 'there's a high risk that person can fatally overdose [after ICC]. For me, that is the last resort to everything.' In this way, these team members considered ICC as a last resort, if they considered it at all.

Outreach staff from public health-led programs often sought to convince public safety partners that ICC is not the only approach available and that it could be harmful when used. Jackie, the outreach specialist mentioned above, elaborated that, '[w]e've actually come a really long way, and we've educated them [law enforcement] a lot about Section 35-ing someone and, like, the ways that there are other treatment pathways for people.' Ben, a harm reductionist, forcefully stated his experience working with law enforcement partners around ICC, 'It's [ICC] been super-abused … and I battled it with law enforcement people, they are all for it … You know, welcome to recovery, put on your shackles and handcuffs, get in the back of the transport, locked in your cage. That's not recovery.'

Robert, a police sergeant working with an outreach program that grew out of a harm reduction-based behavioral health intervention, described ICC as 'our nuclear option'. Craig, also a police sergeant, worked closely with his public health-led program and credited his public health partners with shifting his perspective. Craig described ICC as 'something I'm very reluctant to use, just because … learning from [my harm reduction partners] about how vulnerable people are after they get out of those facilities.' Kathy, a recovery

coach, similarly worked to redirect law enforcement partners away from ICC on outreach visits. Kathy described her experience conducting 'hundreds' of outreach visits with law enforcement partners during which ICC was rarely mentioned. She stated that '… I think, historically, if you took me out of the equation, then a Section 35 probably would have been … the [team's] solution.' She contended that her own recovery experience provided an important counterbalance to the positive view that prevailed among law enforcement.

Even in programs that considered ICC as a last resort, staff across roles could still imagine scenarios in which ICC might be appropriate. Tim, a recovery coach working with a public health-led program, viewed ICC as a last resort, but supported its use when indicated, saying 'we still have to recognize that there are times where people's use can be a real danger to themselves … and so, it's necessary.' Most interview respondents, regardless of their professional background, endorsed the idea that ICC is a feasible approach to take when person's life is genuinely understood to be in imminent danger, although what might constitute imminent danger was not something that interviewees clearly defined.

Families commonly request assistance with ICC

Interviewees across professions and programs reported that discussions about ICC were most often initiated by family members of overdose survivors, not outreach staff. Many further reported that family members frequently requested assistance filing ICC petitions, motivated in large part by frustration or fear. Natalie, a recovery coach from a law enforcement-led program, shared that families treat ICC as 'their go-to thing'. Jake, a social worker in a public health-led program explained that most of his conversations about ICC were with parents who would not discuss ICC during the visit, but would reach out to him 'very often on the phone, afterwards' following a visit to inquire about ICC. Likewise, Trey, a recovery coach working in a law enforcement-led program, suggested that family requests for help filing ICC petitions is rooted in emotions of anger, fear and desperation. 'There are a couple of different ways that Section 35 [ICC] comes up. One is the knee jerk reaction. "I'm going to Section you. I'm at my wits' end and I'm angry." And the other is, "We've tried everything we can possibly think." So, one comes from a place of anger and hurt and the other is one of desperation and care.'

Nearly every interviewee who discussed family members' interest in ICC shared similar narratives, noting that family members deeply fear for their loved one's safety and view ICC as a necessary intervention in times of dire concern.

Some differences did emerge in how team members answered families' queries about ICC, although these were more pronounced across professional lines than across program types. Public health staff was more likely to counsel family members about the risk of overdose following ICC. Those who self-identified as harm reductionists typically presented the risks of ICC to families in more blunt terms than their peers from other professions. Daniel, a harm reductionist, recounted how he describes the realities of ICC to families, 'And I tell families, if you are just doing this because you feel like you have to keep someone safe … You're gonna destroy that rapport with that person. If you cannot understand … that you are putting them in a situation of high risk … And you are setting them up for failure in that sense.'

Public health staff was also more likely to suggest families first pursue alternatives to ICC. John, a harm reductionist, stated he shares with families, '… the process, the risks, other options … what can be done prior to going that route' to dissuade the use of ICC.

In contrast, no law enforcement staff described cautioning families against risks associated with ICC. One officer even declared, 'I can tell you, if I was a parent, I would probably Section 35 the crap out of my kid if they were having those issues …' Therefore, although both public health staff and law enforcement staff confirmed that families were most likely to bring up ICC, seeking help in petitioning to commit loved ones, only public health staff—harm reductionists in particular— prioritized explanations of the risks that ICC may pose to family members interested in pursuing this option.

DISCUSSION

This mixed-methods study explored perceptions and use of ICC for SUD among public health-public safety post-overdose outreach program staff across Massachusetts. Direct collaboration with drug court programs and the adoption of an abstinence-only program philosophy were associated with teams discussing ICC on a majority of outreach visits. Conversely, distributing naloxone during outreach and referring survivors to syringe service programs were associated with teams not discussing ICC on a majority of outreach visits.

Staff perceptions of ICC

In interviews, program staff reported varying views on ICC following a non-fatal overdose. Perceptions tended to bifurcate along philosophical lines. Staff from programs that viewed ICC as a last resort were more outspoken about the potential harms of involuntary commitment than programs that considered ICC an important first line part of their outreach toolkit. In some cases, there were clear distinctions between programs that were more directly guided by law enforcement partners and those more directly guided by public health partners. Nearly all interviewed staff members across programs agreed that ICC is a viable course of action if an overdose survivor is perceived to be in imminent danger, but no clear consensus about what situations or characteristics constitute 'imminent danger' emerged. Future studies should explore and better define imminent danger.

ICC and guidance on best practices

How information about ICC is communicated and received in the context of these deeply emotional interactions is a key question for post-overdose outreach programs. Our interviews indicate that family members, not outreach staff, were most likely to bring up ICC during outreach visits and often seek the assistance of law enforcement personnel on post-overdose outreach teams in filing petitions on behalf of loved ones. Recent research finds, similarly, that family members seek ICC out of fear and frustration, but also because they believe it will prevent subsequent overdose [22]. Our study also supports findings from existing research that suggests a belief that ICC can 'save lives in the moment' by acting as a stopgap [29]—one that should ordinarily be covered by evidence-based treatment and recovery services, but may appear necessary where such essential services are unavailable or inaccessible. Outreach staff generally described family members seeking ICC as angry,

frustrated or afraid. Some outreach staff were personally familiar with possible harms of ICC, such as increased risk of overdose or damage to interpersonal relationships, which they conveyed to families. Others built their views of ICC on their experiences at outreach visits and the requests they received from families seeking an accessible pathway to treatment.

Best practice guidance released in 2023, informed in part by this study, recommends that use of ICC by post-overdose outreach programs should be limited, if used at all; that outreach teams should not serve as the primary petitioner; that outreach teams should not proactively raise ICC as an option for survivors or families; and that outreach teams should be knowledgeable about ICC local laws and systems, and when asked, should be able to explain how these system function and how overdose survivors will be treated [21]. The creation and promotion of meaningful guidelines for the use of ICC, ideally informed and jointly created by people who use drugs and those experiencing SUD, should inform its use by outreach teams and other community support and recovery professionals.

Evidence-based options as a first line approach

Given the extent and scope of fatal overdose in Massachusetts and beyond, it is likely that post-overdose outreach staff who endorse ICC are responding to a very real problem with the tools (solution) they genuinely believe are lifesaving. Despite many experts voicing alarm at the harms associated with involuntary treatment, the belief that forcing people into treatment against their will is lifesaving or transformative is pervasive and often bolstered in the popular press [10, 19, 20, 30–33]. Although there is scant scientific evidence to suggest that involuntary treatment may accelerate someone's fall into a metaphorical 'rock-bottom' that subsequently kickstarts a recovery journey, this belief maintains cultural significance and may inform staff decisions to pursue ICC [34, 35]. For many families, the appeal of ICC emerges in the absence of accessible, evidence-based treatment options for their loved ones. Unlike ICC, opioid agonist medications (methadone and buprenorphine) are proven to save lives [36]. Sufficient access to compassionate, low-barrier, evidence-based treatment and harm reduction services would give Massachusetts residents real options for positive change in lieu of ICC, allowing this extreme intervention to be a true last resort.

Limitations

These results should be interpreted with certain limitations in mind. First, this project was undertaken in the US Commonwealth of Massachusetts. Findings may not be fully generalizable in regions (within or beyond the United States) with different cultural, socio-economic or infrastructural contexts. Outreach team members who participated in this study were majority White and male. The views, preferences and experiences of racialized and minoritized communities are not sufficiently represented here and should be assessed by future studies. Given the use of coercive and punitive drug laws to criminalize and incarcerate Black, Hispanic and Native persons, purposeful research and policies are needed to address and protect these groups from historical and current harms stemming from punitive and carceral systems. Additionally, this study does not capture the perspectives and experiences of people who have experienced ICC as the result of discussions initiated during post-overdose outreach visits. Further, validity of survey findings may be limited by the fact that one representative answered the survey on behalf of each program. Future work

should more specifically examine the various and complex aspects of mandatory treatment, including how and why family members decide to file ICC petitions.

CONCLUSION

Views about and promotion of ICC among the staff of public health-public safety post-overdose outreach programs in Massachusetts varied across (and sometimes within) programs, with some programs more likely to leverage ICC as a first step to treatment, whereas other programs considered it potentially harmful and only to be considered as a last resort. Families of overdose survivors regularly expressed interest in pursuing ICC. Low-barrier evidence-based treatment options need to be expanded to provide accessible, appealing and evidence-based alternatives to ICC.

Supplementary Material

Refer to Web version on PubMed Central for supplementary material.

ACKNOWLEDGEMENTS

We thank Katherine Waye for her assistance in interview recruitment. Moriah Wiggins for her editing assistance. We are grateful to all study participants for sharing their time and expertise with us. We thank the Centers for Disease Control and Prevention for providing funding for this study.

Funding information

Funding for this project was received from the Centers for Disease Control and Prevention (R01CE003052).

DATA AVAILABILITY STATEMENT

Data available on request from the authors.

REFERENCES

1. O'Donnell J Trends in and characteristics of drug overdose deaths involving illicitly manufactured Fentanyls — United States, 2019–2020. MMWR Morb Mortal Wkly Rep 2021;70: 1740–6. PMID: Available from: https://www.cdc.gov/mmwr/volumes/70/wr/mm7050e3.htm [PubMed: 34914673]
2. Spencer MR, Miniño AM, Warner M. Drug overdose deaths in the United States, 2001–2021 [internet]; 2022 Report No.: 457. Available from: https://www.cdc.gov/nchs/products/databriefs/db457.htm
3. Centers for Disease Control and Prevention. FastStats - injuries [internet]; 2024 Available from: https://www.cdc.gov/nchs/fastats/injury.htm
4. Massachusetts Department of Public Health. Data brief: opioid-related overdose deaths among Massachusetts residents [internet]; 2023 Available from: https://www.mass.gov/doc/opioid-related-overdose-deaths-among-ma-residents-december-2023
5. Formica SW, Apsler R, Wilkins L, Ruiz S, Reilly B, Walley AY. Post opioid overdose outreach by public health and public safety agencies: exploration of emerging programs in Massachusetts. Int J Drug Policy. 2018;54:43–50. 10.1016/j.drugpo.2018.01.001 [PubMed: 29414484]
6. Bagley SM, Hadland SE, Levy S, Schoenberger SF, Roy T, Yule AM. Opioid use among Adolescents & Young Adults: toolkit for Pediatric & Primary Care Providers [internet]; 2019 Available from: https://files.hria.org/files/SA5829.pdf

7. Formica SW, Waye KM, Benintendi AO, Yan S, Bagley SM, Beletsky L, et al. Characteristics of post-overdose public health-public safety outreach in Massachusetts. Drug Alcohol Depend. 2021;219: 108499. 10.1016/j.drugalcdep.2020.108499 [PubMed: 33421800]
8. Bailey A, Harrington C, Evans EA. A scoping review of community-based post-opioid overdose intervention programs: implications of program structure and outcomes. Health Justice. 2023;11(1):3. 10.1186/s40352-022-00201-w [PubMed: 36707446]
9. The General Court of the Commonwealth of Massachusetts. General law - part I, title XVII, chapter 123, section 35 [internet]; 2024 Available from: https://malegislature.gov/Laws/GeneralLaws/PartI/TitleXVII/Chapter123/Section35
10. Christopher PP, Appelbaum PS, Stein MD. Criminalization of opioid civil commitment. JAMA Psychiatry. 2020;77(2):111–2. 10.1001/jamapsychiatry.2019.2845 [PubMed: 31577343]
11. Kang S, McCreedy K, Messinger J, Bhargava R, Beletsky L. The other infodemic: media misinformation about involuntary commitment for substance use. J Addict Med 2023;17(6):e396–8. 10.1097/ADM.0000000000001194 [PubMed: 37934540]
12. Ledberg A, Reitan T. Increased risk of death immediately after discharge from compulsory care for substance abuse. Drug Alcohol Depend. 2022;236:109492. 10.1016/j.drugalcdep.2022.109492 [PubMed: 35617775]
13. Vo AT, Magana C, Hickman M, Borquez A, Beletsky L, Martin NK, et al. Assessing HIV and overdose risks for people who use drugs exposed to compulsory drug abstinence programs (CDAP): a systematic review and meta-analysis. Int J Drug Policy. 2021;96:103401. 10.1016/j.drugpo.2021.103401 [PubMed: 34389218]
14. Lunze K, Idrisov B, Golichenko M, Kamarulzaman A. Mandatory addiction treatment for people who use drugs: global health and human rights analysis. BMJ 2016;353:i2943. 10.1136/bmj.i2943 [PubMed: 27284009]
15. Pilarinos A, Barker B, Nosova E, Milloy MJ, Hayashi K, Wood E, et al. Coercion into addiction treatment and subsequent substance use patterns among people who use illicit drugs in Vancouver. Canada Addict Abingdon Engl 2020;115(1):97–106. 10.1111/add.14769
16. Werb D, Kamarulzaman A, Meacham MC, Rafful C, Fischer B, Strathdee SA, et al. The effectiveness of compulsory drug treatment: a systematic review. Int J Drug Policy. 2016;28:1–9. 10.1016/j.drugpo.2015.12.005 [PubMed: 26790691]
17. Christopher PP, Anderson B, Stein MD. Civil commitment experiences among opioid users. Drug Alcohol Depend. 2018;193:137–41. 10.1016/j.drugalcdep.2018.10.001 [PubMed: 30384320]
18. Parker CM, Miranda-Miller OE, Albizu-García C. Involuntary civil commitment for substance use disorders in Puerto Rico: neglected rights violations and implications for legal reform. Health Hum Rights. 2022;24(2):59–70.
19. Wahbi R, Beletsky L. Involuntary commitment as “carceral-health service”: from healthcare-to-prison pipeline to a public health abolition praxis. J Law Med Ethics J Am Soc Law Med Ethics. 2022;50(1): 23–30. 10.1017/jme.2022.5
20. Sinha MS, Messinger JC, Beletsky L. Neither ethical nor effective: the false promise of involuntary commitment to address the overdose crisis. J Law Med Ethics J Am Soc Law Med Ethics. 2020;48(4): 741–3. 10.1177/1073110520979384
21. Udwadia FR, Illes J. An Ethicolegal analysis of involuntary treatment for opioid use disorders. J Law Med Ethics J Am Soc Law Med Ethics. 2020;48(4):735–40. 10.1177/1073110520979383
22. Evans EA, Harrington C, Roose R, Lemere S, Buchanan D. Perceived benefits and harms of involuntary civil commitment for opioid use disorder. J Law Med Ethics J Am Soc Law Med Ethics. 2020;48(4): 718–34. 10.1177/1073110520979382
23. Best practice guidance for post overdose outreach [internet] Boston, MA: Grayken Center for Addiction, Boston Medical Center; 2023 Available from: www.prontopostoverdose.org
24. Fetters MD, Curry LA, Creswell JW. Achieving integration in mixed methods designs-principles and practices. Health Serv Res 2013; 48(6 Pt 2):2134–56. 10.1111/1475-6773.12117 [PubMed: 24279835]
25. Glaser BG. The constant comparative method of qualitative analysis*. Soc Probl 1965;12(4):436–45. 10.2307/798843

26. Valverde M Diseases of the will: alcohol and the dilemmas of freedom Cambridge University Press; 1998.
27. Massachusetts Bureau of Substance Addiction Services. Section 35: the processjMass.gov [internet]; 2024 Available from: https://www.mass.gov/info-details/section-35-the-process
28. Slocum S, Paquette CE, Walley AY, Pollini RA. Civil commitment perspectives and experiences among friends and family of people who use illicit opioids in Massachusetts, USA. Int J Drug Policy. 2023; 117:104074. 10.1016/j.drugpo.2023.104074 [PubMed: 37244144]
29. Rafful C, Orozco R, Rangel G, Davidson P, Werb D, Beletsky L, et al. Increased non-fatal overdose risk associated with involuntary drug treatment in a longitudinal study with people who inject drugs. Addiction. 2018;113(6):1056–63. 10.1111/add.14159 [PubMed: 29333664]
30. Wild TC. Social control and coercion in addiction treatment: towards evidence-based policy and practice. Addiction. 2006;101(1):40–9. 10.1111/j.1360-0443.2005.01268.x
31. Section 35: saving the lives of addicts that don't want to be saved – Boston 25 news [internet]; 2024 Available from: https://www.boston25news.com/news/section-35-saving-the-lives-of-addicts-that-dont-want-to-be-saved/496578709/
32. Mass BD. Lawmakers to wade into fierce debate over court-mandated mental health care [internet] WBUR; 2023 Available from: https://www.wbur.org/news/2023/03/13/massachusetts-courts-assisted-outpatient-forced-treatment
33. Addiction Policy Forum. The myth of waiting for rock bottom [internet]. In: Addiction foreign policy; 2020 Available from: https://www.addictionpolicy.org/post/myth-of-waiting-for-rock-bottom
34. Shinebourne P, Smith JA. The communicative power of metaphors: an analysis and interpretation of metaphors in accounts of the experience of addiction. Psychol Psychother. 2010;83(Pt 1):59–73. 10.1348/147608309X468077 [PubMed: 19712543]
35. Wakeman SE, Larochelle MR, Ameli O, Chaisson CE, McPheeters JT, Crown WH, et al. Comparative effectiveness of different treatment pathways for opioid use disorder. JAMA Netw Open. 2020;3(2): e1920622. 10.1001/jamanetworkopen.2019.20622 [PubMed: 32022884]
36. Larochelle MR, Bernson D, Land T, Stopka TJ, Wang N, Xuan Z, et al. Medication for opioid use disorder after nonfatal opioid overdose and association with mortality: a cohort study. Ann Intern Med 2018;169(3):137–45. 10.7326/M17-3107 [PubMed: 29913516]

TABLE 1

Frequency of discussion of ICC at post-overdose outreach visits, Massachusetts, 2019 (n = 138).

Frequency of ICC discussion	No. of programs
Never discuss ICC at outreach visits	5% (7)
Discussion of ICC at 1%–24% of outreach visits	47% (65)
Discussion of ICC at 25%–49% of outreach visits	12% (16)
Discussion of ICC at 50%–74% of outreach visits	14% (19)
Discussion of ICC at 75%–99% of outreach visits	14% (20)
Discussion of ICC at every outreach visit	8% (11)

Abbreviation: ICC, involuntary civil commitment.

TABLE 2

Characteristics of ICC among post-overdose outreach programs and associations with discussing ICC during more or less than half of visits, Massachusetts, 2019 (n = 138).

Characteristics				
ICC-related characteristics	**More ICC-focused (≥50%) programs *n* = 50**	**Less ICC-focused (<50%) programs *n* = 88**	**Overall *n* = 138**	***P*-value**
ICC is promoted in these discussions:				
As a first step/depends on the situation (when survivor and social networks show awareness of this option)	50% (25)	23% (20)	33% (45)	<0.01 *
As the last resort	50% (25)	69% (61)	62% (86)	
Not answered	0% (0)	8% (7)	5% (7)	
The outreach team typically discuss ICC				
With overdose survivor involved	44% (22)	11% (10)	23% (32)	<0.01 *
With family members, friends and other social networks alone	56% (28)	81% (71)	72% (99)	
Not answered	0% (0)	8% (7)	5% (7)	
The outreach team ever				
Assist with ICC	90% (45)	76.1% (67)	81% (112)	0.05 *
When assisting, ever serves as primary petitioner	32% (16)	42% (37)	38% (53)	0.06
Other relevant characteristics				
Refer overdose survivor to syringe service programs	26% (13)	65% (57)	51% (70)	<0.01
Distribute naloxone during outreach visits	48% (24)	75% (66)	65% (90)	<0.01
Collaborate with drug courts	60% (30)	30% (26)	41% (56)	<0.01
Train staff on harm reduction	66% (33)	83% (73)	77% (106)	<0.01
Abstinence as team philosophy	36% (18)	6% (5)	17% (23)	<0.01 *

Abbreviation: ICC, involuntary civil commitment.

* Due to small cell size, Fisher's exact tests were conducted instead of Pearson χ^2 tests.