

COMMENTARY

Neither Ethical Nor Effective: The False Promise of Involuntary Commitment to Address the Overdose Crisis

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The continuing polysubstance overdose crisis in the United States is the result of a series of policy failures. This includes stigma, misinformation, underfunding and inaccessibility of treatment, and counterproductive measures masquerading as public health. One example of such measures is the increasing popularity of involuntary civil commitment for substance use disorder. A painful illustration of the limitations of the civil commitment system was recently on display when Jesse Harvey, a prominent harm reduction practitioner and activist, passed away from an apparent overdose. His death followed involuntary treatment at Stonybrook Stabilization and Treatment Center under Massachusetts' Section 35 earlier in the year.¹ Unfortunately, Jesse's fate is not an uncommon one; an analysis of opioid related deaths in Massachusetts in 2013-2014 found that people released from civil commitment treatment had more than double the risk of overdose after their release than those receiving voluntary care.²

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In 2018, Massachusetts Governor Charlie Baker introduced the CARE Act, which included a proposed expansion of the use of involuntary commitment for substance use disorder.³ We (MSS and LB) co-authored a resolution at the Massachusetts Medical Society (the Society) in opposition to involuntary civil commitment for individuals with substance use disorder. Our resolution asked the Society to oppose "involuntary civil commitment of persons for reasons solely related to substance-use disorder without judicial involvement" and to advocate for increased access to voluntary substance use treatment services across the state.⁴ Upon passage in April 2018, our proposals became the official position of the Society. With the help of strong advocacy efforts by the Society's Opioid Task Force, the provision expanding involuntary commitment was removed from the final iteration of the CARE Act.⁵ Additionally, one of us (LB) has worked as a part of Governor Baker's Section 35 Commission, which released a series of proposals seeking to reform civil commitment programs by enhancing quality of care during treatment, instituting mandatory reporting and monitoring, and decriminalizing the commitment process.⁶ A year after the release of this report, it is still unclear which — if any — of these changes have been successfully adopted. Tragically, some Section 35 facilities that the Commission recommended closing have since become COVID-19 hotspots.

Two important studies in this issue of *JLME* shed light onto the role of involuntary civil commitment in addressing the overdose crisis. In the first, Evans et al. organized focus groups of patients, clinicians, and patient allies in Massachusetts that have experience with Section 35, the state's process for involuntary civil commitment.⁷ The inclusion of patients and

patient allies is critical, as input from these groups is often ignored by even the most well-intentioned of policymakers.

Perceived benefits of involuntary civil commitment centered around a lack of available alternatives, the risk of harm in the absence of such a protocol, and for some patients, experiences of anger that evolved into gratitude. Much of the focus was on what the facilities do provide (food, shelter) than what they do not provide (services like behavioral counseling and treatment). Though facilities vary widely, some in Massachusetts are actually operated in correctional

transmission in overcrowded shelters, a bed in a treatment facility may seem preferable. Any congregate setting — especially securitized institutions, such as those used for civil commitment — poses an elevated risk for the spread of infectious disease. In acknowledgment of this risk, Massachusetts judges are now required to consider the dangers of COVID-19 when deciding to commit an individual to treatment for substance misuse.¹³ Despite this limitation, the number of civil commitments in Massachusetts has now largely reverted to pre-pandemic levels. Outpatient treatment has become more limited during the pandemic

In sum, we contend that involuntary commitment for substance use disorder is neither ethical nor effective. Offering treatment and addressing people's structural needs in lieu of incarceration and other punitive measures is not only appropriate clinically; it values the dignity of persons with substance use disorders. If a patient with diabetes came to the emergency department in crisis, we would treat them with insulin, not involuntarily commit them for poor diet and glucose control. Substance use disorder has known, proven treatments; it is time to start using them, in order to ensure that evidence-based medicine takes the place of approaches like involuntary civil commitment, which are rooted in stigma.

institutions, which house most of the state's men civilly committed for substance use.⁸ Some respondents acknowledged that they were able to access treatment, but a recent national survey of outpatient treatment programs for opioid use disorder found that only 29% of such programs offered opioid-agonist therapy, the standard of care for treating opioid use disorder.⁹ An overarching concern expressed by respondents was the disruption of relationships between the individual and the one filing the paperwork (often family or clinicians). Involuntary civil commitment can foster mistrust of healthcare systems, meaning that individuals will be less willing to seek treatment in the future;¹⁰ further, they have a higher risk of overdose after being released.¹¹

A second article in this issue by Udwardia and Illes summarizes involuntary commitment in Massachusetts as “fraught with ethical shortcomings.”¹² These issues are compounded by the COVID-19 pandemic. In emergency settings that may be overwhelmed by the COVID-19 response, it may seem easier to commit persons with substance use disorder than to expend resources on their care. Given the risk of COVID-19

as well. We agree with the authors that medication for opioid use disorder should be available to all patients, ideally at the point of care. This means that emergency departments should be able to prescribe medications like buprenorphine to patients, while ensuring follow-up and continuity of care.

A common refrain from proponents of involuntary civil commitment is that it becomes an easily-navigated and free option in an environment of choice scarcity. Instead of expanding the number and scope of involuntary programs, a far better strategy is to decrease barriers to accessing treatment for opioid and polysubstance use disorders. This means eliminating treatment deserts and repealing the X-waiver that restricts access to buprenorphine by requiring eight hours of training before clinicians can prescribe. This also means expanding treatment venues to include primary care and emergency settings. The “bridge clinic” at Brigham and Women's Hospital in Boston is one such option; clinicians there are able to initiate buprenorphine in the emergency department and connect patients to follow-up for long-term care at the clinic.¹⁴ For similar models to achieve broader

adoption, it is vital to increase access, improve insurance coverage, and decrease stigma associated with pharmacologic treatment for substance use.¹⁵ Broader drug policy reforms are vital to improve access and reduce counterproductive punitive approaches.¹⁶

In sum, we contend that involuntary commitment for substance use disorder is neither ethical nor effective. Offering treatment and addressing people's structural needs in lieu of incarceration and other punitive measures is not only appropriate clinically; it values the dignity of persons with substance use disorders. If a patient with diabetes came to the emergency department in crisis, we would treat them with insulin, not involuntarily commit them for poor diet and glucose control. Substance use disorder has known, proven treatments;¹⁷ it is time to start using them as first-line treatments, such that evidence-based medicine takes the place of approaches like involuntary civil commitment, which are rooted in stigma.

Note

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