Perceived Benefits and Harms of Involuntary Civil Commitment for Opioid Use Disorder

Elizabeth A. Evans, Calla Harrington, Robert Roose, Susan Lemere, and David Buchanan

Introduction

A national public health emergency,[1] the opioid epidemic has resulted in extraordinary numbers of accidental injuries, infectious diseases, and premature deaths,[2] contributing to a historically unprecedented shortening of American life expectancy.[3] Given this epidemic, there is increased public and policymaker support for statutes that provide for the involuntary civil commitment (ICC) to treatment for opioid use disorder (OUD).[4]

ICC is intended to use judicial authority to place people with OUD, or other substance use disorders, who pose an imminent danger to themselves or others in supervised residential settings where they cannot obtain opioids. ICC for substance use disorders may also apply to outpatient commitments in certain jurisdictions. ICC is commonly invoked by family, but it can also be initiated by friends, physicians, and others depending on the rules of the applicable statute or jurisdiction. There is significant variation in ICC programming nationally, including the processes for determining dangerousness or incapacitation, the burden of proof required for issuing a ruling, where individuals are placed in care, the type of treatment provided, and the duration of confinement (from 24 hours to 12 months).[5] Also, the criteria for invoking *parens patriae* — state commitment of an individual due to inability to meet basic needs, care for self, or make decisions in their own best interests — is controversial given that police, emergency department physicians, or judges may be insufficiently trained and knowledgeable about OUD to determine whether ICC is appropriate. Nevertheless, 37 states have legislation that allows for ICC for adults with OUD or other types of substance use disorders, alone or in combination with mental health disorders.[6] Massachusetts is a top ICC user, committing 5,700-6,500 people annually.[7]

From an ethical standpoint, ICC is commonly justified because it prevents opioid overdose, saving lives in the moment.[8] Problematic, however, is that ICC abrogates individual liberty. Moreover, the few studies of ICC outcomes have limited generalizability

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and mixed results.[9] Thus, it is unknown whether ICC improves or worsens future opioid overdose risks or has other harms.[10] Effectively, ICC imposes problematic infringements on autonomy and represents significant threats to the principle of non-maleficence, thereby raising important, yet largely unexamined, ethical questions. In the present study, we explore this knowledge gap by assessing the perceived benefits and harms of ICC for OUD. We use qualitative methods, a study design which is suitable for establishing meaning by soliciting individuals' perspectives and experiences.[11] Furthermore, in contrast to existing qualitative research on ICC, which has featured insights from one type of stakeholder group [12] we present views from patients, patients' friends and family, and treatment provider staff, which enables us to provide in-depth understanding of ICC and salient ethical issues.

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Methods

Conceptual Framework

We draw on standards from the Kass Public Health Ethics Framework[13] which specifies that the extent to which ICC restricts or infringes on individual liberty should be proportionate to the harm it will prevent. This framework suggests that (1a) if ICC is likely to achieve its stated goals, and (1b) if its potential burdens are recognized and minimized, and (1c) if ICC is expected to be implemented in a nondiscriminatory way, then (2) proponents must decide if the expected benefits of ICC outweigh the identified harms. Also, the framework states that public health officials have an obligation to communicate with and involve constituent communities, along with experts, to understand the benefits and risks of strategies to address public health threats. In this context, we solicited perspectives on the benefits and harms of ICC as perceived by three key stakeholder groups in Massachusetts, a top user of ICC: patients being treated for OUD; nurses, physicians, counselors, and other clinical staff who treat this population; and family and friends (i.e., allies) of patients with OUD. An overarching goal was to generate findings on how to use ICC to address OUD in ways that adequately balance beneficence, autonomy, and non-maleficence.

Participants

A total of 70 individuals were recruited from two outpatient Opioid Treatment Programs (OTP) located in Holyoke and Springfield, Massachusetts and operated by one of the largest behavioral health services providers in Western Massachusetts. These facilities are licensed to administer the three FDA-approved medications for opioid use disorder (MOUD): methadone, buprenorphine, and naltrexone. The services provided by participating OTPs include both withdrawal management and MOUD maintenance therapy.

Inclusion criteria comprised: (1) patients currently receiving MOUD in participating OTPs, the ally of a MOUD patient, or clinical staff who serve MOUD patients and (2) no cognitive impairment that would disallow informed consent. Individuals were recruited via flyers distributed in the OTPs. As part of the recruitment and consent processes, research staff verbally checked participants' understanding of the research and the risks and benefits by asking open-ended questions that enabled assessment of whether prospective participants adequately understood the study. Participants included 31 MOUD patients, 15 clinicians (e.g., physicians, nurses, counselors, social workers, therapists, peer coaches), and 24 patient allies.

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Data Collection and Analysis

Utilizing a mixed methods design, a semi-structured focus group (6-12 participants per group) was conducted in-person, after which participants completed a demographic questionnaire and other assessments. Groups were held separately with patients, allies, and staff. Staff focus groups were supplanted with individual interviews when needed. Interviews explored when and how it is appropriate to use ICC to treat OUD patients. The discussion guide included questions on ICC benefits and risks; scenarios in which ICC is appropriate; and how ICC should be adapted to increase both immediate and long-term benefits, for both patients and society. The Principal Investigator (EE) led each discussion using a standardized discussion guide.

Data were collected from July 2018 to March 2019. Each discussion lasted 1.5 to 2.0 hours and was held in a private room at participating OTPs. Using budgeted study funds, research staff paid each participant $100 or, at the participants' request, assisted with having the payment donated to a charitable organization. To maintain confidentiality, participants were assured that findings would be anonymized. Interviews were digitally recorded, professionally transcribed, and transcripts were reviewed for accuracy. All procedures were approved by the OTP's affiliated Institutional Review Board.

Using grounded theory methods,[14] two research staff coded each transcript independently, and then met to compare codes and resolve discrepancies through discussion. We analyzed patterns within and across the interview transcripts and identified major themes inductively, allowing the data to dictate analytical categories. We grouped common responses, and chose quotations that best illustrated salient ideas. The resulting summary of themes was reviewed by the entire research team. To check for accuracy and resonance with experiences, we solicited feedback on

Table 1

Sample characteristics (n=70)

	Patients (n=31)	Allies (n=24)	Staff (n=15)
Sex			
Female	67.7	62.5	93.3
Male	32.2	37.5	6.7
Race and Ethnicity			
White	54.8	45.8	93.3
Hispanic	32.2	25.0	0
African American	3.2	4.2	0
Other	9.7	8.3	6.7
Education			
Less than HS	19.4	37.5	0
HS diploma/ GED	19.4	37.5	0
Trade/ vocation/ tech after HS	12.9	4.2	0
Associate's / College	48.4	20.8	13.4
Graduate/Master's/Doctoral	0	0	86.7
Employment			
Full-time	16.1	8.3	80.0
Part-time	16.1	20.8	20.0
Unemployed	6.5	8.3	0
Not in the Workforce	58.1	62.5	0
How Impacted by Opioid Epidemic			
Parent to person with opioid problem	10.0	25.0	13.3
Partner has opioid problem	38.7	29.2	6.7
Family member has opioid problem	29.0	41.7	33.3
Friend has opioid problem	38.7	37.5	53.3
Provide services to people with opioid problems	3.2	8.3	100
Participant has own opioid problems	100	54.1	0

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preliminary results from a patient advisory council made up of OUD patients and allies, clinicians, and other community stakeholders.

Results

This study examines data from a non-random convenience sample consisting of 70 individuals: 31 patients, 24 allies, and 15 clinicians (Table 1). The patient sample was 67.7% female; 25-59 years old (mean 40.5 years, standard deviation +/-10.0); and 54.8% White, 32.2% Hispanic, 3.2% African American, and 9.7% more than one race. Many patients had attained some college (48.4%); 58.1% were unemployed and not looking for work. The ally sample was 62.5% female; 21-74 years old (mean 36.6 years +/-12.8); and 45.8% White, 20.8% African American, 25.0% Hispanic, and 8.3% multi-racial. Most allies were currently unemployed and not looking for work (62.5%). The staff sample was 93.3% female; 27-67 years old (mean 43.2 years +/-15.3); and White (93.3%). All had attained some college or an advanced degree and many worked as therapists, followed by nurses, administrators, and physicians. Half or more of participants in each group had a family member, partner, friend, or co-worker with an opioid problem.

Among staff, few reported having been directly involved in ICC proceedings, but many had treated patients with ICC experiences. In contrast, more patients and allies had direct ICC experiences. All three groups (staff, patients, allies) expressed a desire for more information about ICC processes, such as who is authorized to initiate ICC, the type, location, and length of treatment that ICC provides, and whether its intended outcomes are supported by empirical evidence.

Hereafter, we provide illustrative examples of the perceived benefits and harms of ICC (alternatively called "Section 35" or "sectioning" by participants due to the Section of MA general law where the provision for ICC is contained therein). We also highlight participants' ideas for when and how ICC is appropriate and how it should be adapted going forward. For each section, we present themes in order of greater salience and frequency and for narrative flow. We conclude by discussing areas for making improvements to ICC to ensure it is used in ways that assure a satisfactory balance across the principles of beneficence, non-maleficence, and autonomy.

Perceived Benefits

Saves Lives in the Moment

Participants overwhelmingly indicated the primary benefit of ICC is its ability to save lives in the short-term. ICC was described as a tool for handling urgent and immediate life-threatening situations.

Table 2

Major themes regarding the perceived benefits of involuntary civil commitment for opioid use disorder

- Saves lives in the moment
- Protects vulnerable patients who are out of control, pose a danger to self or others
  - Active opioid and other substance use
  - Co-occurring mental health disorders
  - Unable to make "good" or competent decisions
  - Living in conditions of desperation, hopelessness, and despair
- Provides families with options
  - Safety for patient and family
  - It's an expression of love
  - Patients are angry at first, but grateful later
  - Best when used "for the right reasons"
- "Better than overdose or jail"
- Provides treatment access
  - Provides for immediate treatment access and for a longer period of time
  - Offers monitoring and other supports that enable treatment engagement
- Can be a turning point event
- Promotes public health and increases public safety
  - Detect and treat infectious disease and co-occurring mental health conditions
  - Prevent crime

For example, a clinician explained that ICC is appropriate "...Because it's [OUD is] an immediate threat, [thus] immediate action has to be taken to save their life."

An ally said, "It [ICC] could save your life at that particular moment ... And get you out of a bad situation ... it's best if you get sectioned at that time because that could be your last day."

A patient stated "Saving somebody's life, period, [that's] the main thing."

Protects Vulnerable Patients Who Are Out of Control and Pose a Danger to Self or Others

Participants emphasized that ICC is most appropriate for patients who are "out of control" or have "lost

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touch with reality". This state was typically indicated by repeated non-fatal opioid overdoses within a short time-period.

> A patient described events preceding her ICC, "I was at [hospital emergency department for heroin overdose] at 6:30 in the morning. I woke up severely dope sick, threw my clothes on, ran out the door. At 10:15 I was back at [emergency department], overdosed again....I get there [to court later that day] and the judge was like, '...I'm only releasing you to a Section 35.' And that's how I got into treatment."

> An ally said, "...if you section yourself, you probably need to be [sectioned] because that's basically when you know that you're a danger to yourself and when you know that things are really bad...and it's because you're out of control and you're a danger to yourself or to [others]"

Others clarified that patients reach an out-of-control state due to active opioid and poly-substance use or because of co-occurring depression or other mental health disorders.

> A clinician said "...in some cases, it [ICC] is necessary. If somebody is so messed up on a drug or a mixture of drugs that they don't even know where they are, or they're being violent or aggressive, or self-harming, yeah, it's a definite need."

> Another clinician said "...if [because of] their psychosis...they're going to harm themselves or others, I think it's good to section them, and then get them regulated with medication where they're not going to be harmful to themselves or others."

> A patient reported "...I was very depressed...and I tried to commit suicide. So my husband sectioned me."

Staff participants perceived patients in this state to be "illogical" and unable to make "good" or competent decisions, and thus in need of ICC protections to avoid endangering themselves and loved ones, and also people in the community.

> A clinician stated "...I've seen people in the middle of an addiction shooting up, and snorting, and rolling on the floor, and completely out of it... [they] come out of it a little while later, only to do it again...at that point, it's totally obvious that they cannot make a good, informed decision."

> Another clinician stated "...the changes in the brain, and the memory loss and the impulsivity and the attention deficit and the depression, all of these things that are the end result [of addiction]...I think a lot of folks really live moment to moment and can only really think about what they have to do today...[addiction] erodes your forward thinking, your ability to perceive things, manage problems..."

> A third clinician said "I think it [ICC] can be useful...if you have a family member, and they're really engaging in high-risk behavior, and they're in danger of killing themselves, or even somebody else — if they're driving around like that, then yeah. The family should have that [ICC] option."

Other participants described situations in which OUD had caused individuals to be homeless or otherwise living in harmful conditions. These conditions often led to feelings of desperation, hopelessness, and despair that individuals with OUD were unable to change without the help offered by ICC. In this context, ICC was perceived to be the only option to help individuals who were unable to help themselves.

> A patient reported about a friend, "The last time we sectioned somebody it was my friend's mom and she'd been living behind a grocery store and sucking dick to survive...she's got mental health issues and that's one of her problems is she's never going to make that next right decision. She needs that help. And there's a lot of people that are like that. They just get so drug down from living on the street, they're doing things they're ashamed of that they don't even have the want to not be high. They're just so hopeless."

> A clinician recalled about a patient, "I felt like [ICC was appropriate because] she was just really lost and would wander the streets all the time, and wouldn't really stop doing that...she was super lost...I just felt like other things [alternatives to ICC] had been exhausted."

> Another clinician said, "...I had an individual who had some kids, and...just kept using, and using, and using PCP and mixing other stuff, and...I didn't really feel that bad about it [ICC].

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> I was like, 'yeah, let's try that'…It didn't bother me that that person was being sectioned at that time."

PROVIDES FAMILIES WITH OPTIONS

Another perceived benefit of ICC was its ability to empower family and friends to keep their loved ones safe. Participants talked about how ICC was "leverage" or an option that family could use to remove a loved one with OUD from the family and thus create safety for siblings or others.

> One staff member said, "I am a big proponent for Section 35…it's the only thing that family members can use to save the life of somebody…it empowers families…to get people help."

> Another staff member said, "…the patients I've had who have been sectioned…[were] so severely intoxicated that their family was scared and didn't know what to do with them other than call the police and have them taken away…I think for the most part it's [the family's motivation] safety."

> An ally speaking about his own ICC experience reported "…my mom and my stepdad had to play tough love…because I had a little brother and…he already had seen a lot of stuff that he shouldn't have seen as a kid. He was like traumatized…And there's a lot of different parties that are involved when we use…there's a lot of people that get affected by it [addiction]…"

AN EXPRESSION OF LOVE

Some patients and allies talked about ICC as an expression of concern and love. For these participants, ICC signified that there was someone in the patient's life who loved them enough to get help.

> An ally recalled when he sectioned his sister, "…she looked like she was on her last will. So I called my brothers up and I said, 'Hey, we could section her.' …she was mad at the beginning but then she didn't want to leave after being there like 90 days. So it's got benefits, especially when you love someone. That's what sectioning is for, actually. Some people say it's wrong, some people say if you love the person you're going to do it."

> A patient said "…I wish someone would have done it [ICC] for me. And it really says a lot that if someone is sectioned … there's somebody that loves and cares about you and that you actually have someone that actually gives a shit."
> Another patient, who spoke of her role as an ally, shared, "…she's like been my best friend since we were in high school and her family doesn't give two shits about her…I can go to court and say, 'This is my best friend…she needs some help.' And they'll let me do it [civilly commit friend]… Joe Schmo over here could probably have like no family that could give a shit about him. 'Like, oh my God, you're an addict?!' Not 'take him to court to section him,' but 'get him to court to put a restraining order on him.' Some of us are lucky and some of us aren't…"

ANGRY AT FIRST, GRATEFUL LATER

Participants shared that at the time of an ICC, patients commonly became angry and confused, but developed feelings of gratitude and thanks over time as patients came to understand that ICC helped them to come out from being under the influence of substances and engage with treatment.

> A patient reported "…I was pissed when I got sectioned… but by the time I left, I was so grateful that I was there because…you need to come out of that cloud of using [drugs]."

> Another patient said "I was so mad [after ICC], I was so angry, I hated everybody, but it saved my life…After like about 30 to 35 days…and the more the drugs started leaving my body and my psychiatric meds…started working, then I started feeling better and thinking clearly…And I called my mother and…I was like, 'Thank you for saving my life and I'm so sorry.'"

> An ally talking about his own prior ICC said "…for a long time I never understood why my mom did what she did. And she even went to the DA and told the DA to please not let me go when I had court. She like begged them, she said, 'I just want to be able to sleep one night where I know he's safe.' …I thank her to this day now because I think it's the only reason I'm alive today. Most of my friends, their parents didn't do that. They let them just come home and get high in their bathroom and their parents ended up finding them [dead]. And I thank God that my parents did that."

BEST WHEN USED "FOR THE RIGHT REASONS"

Clinicians observed that patients were thankful for ICC, and that there were likely to be better outcomes,

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when there was an understanding that family and friends had acted "for the right reasons," i.e., out of concern and love, and not from anger, fear, or desires to exact punishment.

> One clinician said "…I've seen patients who have been thankful that somebody in the family stepped in and did that. Not at first…they're not appreciative right off. They're very angry…So it takes a while to subside, and for them to realize that people are doing it for the right reason."

> Another clinician said "…I think in the end, they [patients who were sectioned] probably realize that 'yes, I was mad that that was happening at that time.' But understanding that that…family member was doing that out of concern. It's not meant to be a punishment."

> A third clinician explained that ICC is more likely to have better outcomes when the intent of the ICC is "not malicious" or "derogatory" but instead is "coming from a loving place, a protective place." This participant explained that if ICC is "…coming from a derogatory place, I think the chances of overdose are really high…when they come from a loving place they know that they're out of control, that has a different thing to it. And so referrals, and the chances of follow-up are much, much better in that population than someone who is treated like 'you dirty whatever'…that's obviously not coming from a loving place. That's going to heavily more likely lead to suicidal ideations, suicidal gestures, maybe even overdose…"

"Better than Overdose or Jail"

Besides preventing overdoses, another perceived benefit of ICC is that it enables people with OUD who accept ICC to avoid jail. Participants indicated that ICC reduces future incarceration risks because it provides access to treatment or can function as a turning point event (detailed below). Participants also shared that ICC was "better than overdose or jail," primarily because most jails do not provide medications to treat OUD.

> An ally shared "…you can also use the sectioning to keep you from going to jail…I would rather be at the Section 35 than in jail because then at least I still can receive my medications…I would still get my Suboxone every day and whatever rather than be sitting in jail completely withdrawing cold turkey with nothing…."

> A patient reported that ICC is "…recovery-based…it's like rehab, just forced rehab but it's so much different [from jail]. It's way better."

Provides Treatment Access

Participants reported that ICC is a way to receive immediate access to needed OUD treatment, and for a longer period of time. Participants shared how community-based OUD treatment was not readily available, for example due to long waiting lists, overly strict treatment policies, or lack of long-term care. In these communities, ICC was viewed as filling critical gaps in the OUD treatment system of care.

> One patient explained "…sometimes it's hard to even get into a place [treatment], so if someone goes and sections you, you go right in."

> Another patient said "That's why sectioning is good…you have a bed no matter what…if you want to go to further treatment, like you always have a bed there. Like they don't kick you out."

> A clinician explained, "…whoever did the sectioning felt like there was no other option. Because detox…you could end up waiting a week or more. So, with a section, it just seems like there's more urgency to it…after being sectioned, they're in that facility for a longer amount of time. So in detox, it's only a few days, maybe a week or two at most. But when somebody is sectioned, they might be there up to a month."

Some patients explained that they had voluntarily arranged for themselves to be "sectioned" by family or others because they wanted monitoring and other supports that would help them to remain engaged in treatment.

> A patient said, "I just wanted somewhere long term because I had went to detox and then I left. I knew I would just leave again, I knew myself. I keep leaving. I can't do this myself."

> A clinician recalled, "I had someone who wanted to be sectioned [because] she didn't trust herself to not bounce [to not leave treatment]…a lot of patients will say, 'I know I'll leave.' …And so when they get to a place of feeling helpless enough, sometimes it's they'd rather just have someone force them. Because they can't do it themselves."

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> Another clinician said, "…it can be beneficial in those patients that are kind of teetering like, 'Yes, I wanna get the help but I can't stop and I don't know how,' and it could be that extra push for a longer term care that they might need."

CAN BE A TURNING POINT EVENT

Participants noted that ICC could be a turning point that changed the course of their OUD. In these cases, ICC was described as an event that enabled patients to think clearly, make a fresh start, gain hope for the future, recover the ability to make decisions, commit to "staying clean," or engage in ongoing treatment. Despite these perceived benefits, participants also described how ICC was "the worst best thing," that is, an experience that many patients did not want to repeat (discussed further under harms).

> A patient explained "At least if you're able to come out [of ICC] and be clean, like then you have a sober mind to make that decision you wouldn't want to go back to all that bullshit or am I going to walk a different path this time… Because of my sectioning, I ended up in [facility] and …it was the worst experience of my life…But it was the best thing that ever happened to me. It got me clean and then when I got out…I chose to stay clean because I'd got a little bit of hope there."

> An ally said, "…I know a lot of people that got out of there, stayed clean, and that have been clean for years because…that's a really eye-opening experience to say, 'You know what? I don't want to go through that again, I'm gonna really give it a shot this time.'"

> Another ally said "…from that section, you get the chance to come out with a fresh start, not only being clean, but for housing or programs or just starting fresh with everything: your living circumstances, being clean, like the way your relationships are with your family and everything else…you're getting a complete fresh start when you are sectioned."

Participants indicated that the primary harm of ICC is that it places people with OUD in settings that are run like jail. Participants further explained that, in fact, ICC is sometimes located inside an actual jail. These comments reflect, in part, that many male commitments in Massachusetts are to a facility that previously served as an all-male minimum security prison and, only until recently, women were civilly committed to state prison. Participants described the perceived and actual jail-like settings of ICC, along with the ways in which patients are brought to them, as being "punitive," "degrading," "humiliating," "terrible," "harrowing," "isolating," and "stigmatizing." Participants explained that these aspects of ICC caused patients to experience "fear" and "shock" which thus functioned as a deterrent to recovery and ultimately made a patient's reality worse.

Clinicians described how they hoped that ICC would be a "wake-up call" or life-changing event, primarily because it could help people to engage with ongoing treatment. Clinicians were skeptical, however, as to whether ICC actually improved patient lives.

> A clinician said "I think overall the benefit, or the hope, would be that somebody gets sectioned, and either they're ready for treatment then, or they get ready for treatment when they're in the section. And they come out and their head is sort of clearer. They can really commit to some kind of ongoing treatment and get to the point where they're ready to live their life."

> A second clinician said "…if they are sectioned for a long enough period of time, where their brain has the ability to heal and make a clear decision at some point, then yes, it [ICC] can be really beneficial. Because at that point, then 'okay yes, now I'm open to hearing your resources…I'm

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open to hearing what you have to say.' And then maybe at that point they'd be willing to go and get treatment. I think that's a really big positive, like A-plus yes, that would be fantastic. Does it work out that way most of the time? No."

PROMOTES PUBLIC HEALTH AND INCREASES PUBLIC SAFETY

Clinical staff noted that two other benefits of ICC is that it can promote public health and increase public safety. Clinicians noted that ICC provides health services (e.g., assessments, diagnosis, education, medications) and thus helps to prevent Hepatitis C and other infectious diseases or connect people to treatment. Clinicians also believed that ICC prevents crime by removing from the community individuals whose substance use might increase their risk for dangerousness towards others. Clinicians cited these as reasons why ICC was worthwhile, even if patients later returned to opioid use.

Perceived Harms

FEELS LIKE JAIL, AND OFTEN IS A JAIL

Participants indicated that the primary harm of ICC is that it places people with OUD in settings that are run like jail. Participants further explained that, in fact, ICC is sometimes located inside an actual jail. These comments reflect, in part, that many male commitments in Massachusetts are to a facility that previously served as an all-male minimum security prison and, only until recently, women were civilly committed to state prison.[15] Participants described the perceived and actual jail-like settings of ICC, along with the ways in which patients are brought to them, as being "punitive," "degrading," "humiliating," "terrible," "harrowing," "isolating," and "stigmatizing." Participants explained that these aspects of ICC caused patients to experience "fear" and "shock" which thus functioned as a deterrent to recovery and ultimately made a patient's reality worse.

> A patient said "I've been sectioned — I hated it. I didn't like it. I didn't want to go at the time… they came and got me out of my house, like I tried to run, and it didn't work, and then I got shackled and cuffed, and, stupid, — locked up all day at the court, and then you're dope sick that whole time, and then I didn't get to somewhere until like 10:00 that night…And yeah, I was aggravated."

> Another patient said "I've been sectioned against my will and…it's virtually a jail…"

> A clinician said, "…it [ICC] has the feel of a jail setting…this is terrible…a huge downside… because it's [ICC] smaller quarters and it's not clean there, it's overcrowded, there's a lot of fighting. So it's just a culture shock…I think that's a big deterrent, people just feel that they've been put in jail."

> Another clinician explained that people "…are sometimes sent to places that are jails. And what is that telling people who are in that situation? It's stigmatizing, and they have enough stigma to deal with. So I think that can be a con."

> A third clinician said "I think for those that feel afraid, that spend a portion of their time just environmental scanning, they are unable to take anything else in, other than the shock of where they are and how it happened."

When asked to identify ICC harms, two allies responded:

> P1: "The way they arrest you…they should pick you up in like an ambulance, maybe, but just putting you in handcuffs, taking you to [jail] all weekend — and bring you to the courthouse…I didn't commit a crime. They should take you to the hospital and let the hospital transport you to [court].
> P2: in the backseat of a car, not cuffed and shackled in the back of a paddy wagon.
> P1: Yeah, it's not a very nice — it could be a very bad experience. Even though you're saving that person's life —
> P2: It is a very bad experience, the way you get there.
> P1: — the way they go about it, it is horrible. Cops come, pick you up, handcuff and just throw you in the back of the car."

> A patient suggested that ICC processes be altered to treat patients with respect and dignity, saying "Instead of a cop pulling up to you and locking you up, have the recovery officers, have an ex-addict, in that cruiser to guide you and show you what's going on in your life…get to know that population, and don't treat them like scumbags and forgotten souls. Talk to them. We're people. We're not criminals. We don't start out robbing then go to dope. We go to dope and then have no choice. So, if…there was a clean addict in the [police] car to point out [my situation], that would actually make me click. 'Wow.' Instead of just, 'all right, I got locked up, I'm

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> sick, I've got to cop tomorrow.' Get involved in a positive way, not just a handcuff."

For some participants, that ICC felt more like incarceration than treatment, and that people seeking help under ICC were treated as if they had committed a crime, constituted a violation of human rights.

> A clinician said ICC is "…this weird place that's between a legal consequence and a treatment. And because of so many negative experiences with the legal system and already feeling they're not worth anything, or feeling their human rights have been violated, I think that the experience of being thrown in a jail cell is…a violation of human rights."

> A clinician said "I don't feel it's right for folks to be held on a civil commitment in a jail cell prior to going to treatment. In our society, we generally have an agreement that we don't just grab people off the street and put them in jail cells because they have certain diagnoses…they're human beings. They don't deserve to be treated that way."

Table 3

Major themes regarding the perceived harms of involuntary civil commitment for opioid use disorder

- Feels like jail, and often is a jail
- Divides families
- Provides limited or no medications to treat OUD or other evidence-based care
- Coercive
  - Undermines patient autonomy and empowerment
  - Angers patients, causes patients to "rebel," increases patient resistance to behavioral change
  - Leads to a return to opioid use
  - Infringement of human rights
- May worsen risks over the long-term
  - Could cause patients to view OUD treatment negatively
  - Worsens OUD-related social stigma
  - Isolates and dehumanizes patients
  - Decreases opioid tolerance without providing supports for continued community-based treatment with medications for OUD
- Lacks empirical support and unsustainable

DIVIDES FAMILIES

Participants expressed concern that, in some cases, family used ICC with a harmful intent. Participants described situations in which ICC was "abused" by angry or "spiteful" family members to control or punish loved ones.

> An ally said "…there's people that abuse [ICC] and they just want to control their kids or their husband."

> A clinician shared "I could see a family member abusing [ICC]…and using it as a reason to just get rid of somebody even if they're not at risk of hurting themselves or others. I've seen that happen before where a…patient might have burned their bridges…and they [the family] want them [the patient] out of the house. They [the family] might call the cops and lie and say that they're [the patient] being unsafe when they weren't."

In other instances, participants described how it was harmful when ICC was used unnecessarily or "prematurely," for example either to remove the person from the family or because the family did not know about the actual nature of ICC or lacked knowledge about ICC alternatives.

> A clinician said "I think some people [patients] are going to be stable and because the mother, the father or whomever, doesn't know the situation, they're [the family] going to section them [patient], because they [the family] think that's what's best, whether it's actually best or not."

> A patient said, "I resent my family so much because I got sectioned to a place with no medication, with my family not even knowing all the options…they just thought that was their only choice…Had my family known other options… it would have been so much better…if you go section someone, make sure the family knows all the options…because it could really screw the family up. I know you're doing it out of quote-unquote 'love' [but]…love and suffering is a fine line."

Participants described how ICC caused some patients to feel betrayed or fearful of asking for help. In these situations, ICC was perceived to "divide families" and to exacerbate opioid use.

> An ally said "A lot of times it's your friends or your family, so they [patients] may have a per-

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> spective of betrayal, of them going to court and sectioning against you."

> A woman patient shared "...one of the bad things I was thinking about [is] if you have children — and even if they're not getting harmed physically, emotionally, whatever — they have to call DCF [Department of Children and Families]...It's [ICC] ripping apart families and instead of giving...families help...I just don't think it's fair because...as a woman...my biggest fear was my children and me being honest about my addiction or wanting to get help held me back because I knew somebody was going to call [DCF]. I couldn't release my feelings or my emotions the way I needed to or I wanted to..."

> A patient said "It [ICC] did nothing for me but piss me off from the people that I wanted to get help from....if I'm getting sectioned, and my family hasn't exhausted their options, 'why are you treating me like I should be locked up when I'm not even doing the things to be locked up? I might as well go out and do them because that's how you think of me. Shit, now I'll just go out and do them. What's to hold back?'"

Participants emphasized the need to use several methods to ensure that ICC is not misused. These included thorough assessments by knowledgeable professionals, urine testing to verify reports of opioid use, multiple written statements from people who know the patient in different capacities (family, psychologist), and to not "serial section" patients who have had poor outcomes from prior ICC events. Participants also made it clear that ICC should be used only as the "last resort" or "absolute last tool," after other treatment options have been exhausted.

Provides Limited or No Medications to Treat OUD or Other Evidence-Based Care

Participants shared several ways in which ICC fell short of patient's specific health needs and desired outcomes. Most notably, participants stated that ICC generally provides limited or no medications to treat OUD. This situation was described as "cruel and unusual punishment" and "torture."

> A patient said "...when I got sectioned, there was no medicine. No methadone... I've been through the worst...it just showed me what way don't go. I learned to never do that [ICC] to somebody."

> Another patient said "You get methadone for a few days [under ICC] and then you're off. If you're on methadone, they keep you on the methadone but you can't go up or down or anything like that. But you do get methadone for seven days and then you go over to the other side [of the ICC facility] and stay there for the rest of your time."

> A clinician said "And up until recently, if you were on methadone, you didn't know if you were going to be sent to...[jail facility] for the criminally insane...And that place didn't really have much [methadone] treatment...really no treatment; [it] was not a very good facility. So you didn't know if you were going to go there, or if you would go to [different facility that provided methadone]...[it's] a roll of the dice if you're going to try to section somebody who was on methadone...not knowing if there would be a bed available [that provided methadone]."

> Another clinician said that ICC without medications for OUD is "...cruel and unusual punishment, 100%...that's a really, really cruel thing to do to somebody. I think that for a long time, medication-assisted treatment was the end of the road...and it really should be a front-line resource. Because it's the same as any other disease...you're going to take medications to treat something while you get everything else together...if you don't know what it [withdrawal] feels like, it sucks. So I would not...wish it on anybody and I think it's a really cruel thing to do to somebody."

In addition to withholding OUD medications, participants noted several other shortcomings of ICC processes and settings. For example, ICC was described as a lengthy process that is "difficult" to navigate, in part because it requires that family members or physicians interact with the courts. Also, participants noted that ICC facilities are located 45-120 minutes away by car from where patients reside, which makes it hard for family to visit, thus further isolating patients. Participants felt ICC would not meaningfully change patients' OUD because the duration of ICC treatment (generally <30 days) was too short, but also because ICC did not provide counseling or therapy, and it was not equipped to appropriately treat co-occurring psychiatric conditions. Participants shared how for these and other reasons, some patients who had experienced ICC never wanted to be sectioned again.

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COERCIVE

Other perceived ICC harms stem from the fact that it forces patients into getting help against their will. Participants explained how the coerciveness of ICC may have negative consequences, i.e., it may undermine patient autonomy and empowerment, anger patients, cause patients to "rebel," increase patient resistance to behavioral change, and lead to a return to opioid use.

Two patients explained:

> P1: "If you don't want to get the help, and then they're making you get the help, that would piss me off.
> P2: I don't think it would work.
> P1: You got no choice.
> P2: Yeah, it wouldn't work until that person's ready.
> P1: You can't force someone.
> P2: ... I would shoot up and say 'God, take me today, Lord.'
> P1: Well, they're not ready. If they get sectioned, they're not ready...They'll get out and just use.
> P2: It would just be a waste of resources.
> P1: They'll just hide it [opioid use] better next time."

Two allies said:

> P1: "A lot of times people get so angry that as soon as they get out [of ICC], they use and they die.
> P2: Yes, they want to like rebel against [who sectioned them].
> P1: Yep, yep."

> A clinician said "Section 35 is useful only if the person is ready for treatment, otherwise if you push them, they're just going to push back... some of them would start using more, and some of them would just resist any kind of treatment... if it takes people's choices completely out of their hands...I think people will rebel against it."

> Another clinician shared that a patient with OUD "...probably already feels very out-of-control, like they don't make very good decisions. And I don't think that taking further control away from them is always a good idea... [because] it kind of destroys...any ability they would have to empower themselves in recovery."

Some clinicians shared how they involved patients and their family in decision-making processes such that patients were more likely to agree to ICC. Participants shared these experiences to show how clinicians could try to circumvent the coercive nature of ICC.

One clinician explained to another:

> "P1: "But I wasn't the one doing the sectioning. I was recommending [to the patient] 'you know what your father's going to do...let him section you, please!'
> P2: And that's letting her make the choice to be sectioned.
> P1: Exactly, exactly...she wasn't willing to go to detox. She knew she would bounce...She had bounced from several programs before, and had used up her last straws...she knew what her family was going to do. And she was like, 'This [ICC] is the best thing for me, I guess.'"

> Another clinician said "We will sometimes recommend [ICC] and call a family member and say, 'You need to do this' [because the patient's] mental health condition has deteriorated to the point where they really need to go inpatient, and they will not go. We can't make them go."

Participants suggested that ICC could be improved if there were processes in place to offer options for help such that patients could voluntarily "choose ICC or another fate." Clinicians talked about being uncomfortable with the coerciveness of ICC, expressing uncertainty and uneasiness with the idea that ICC may be an infringement of human rights.

> One clinician said "I hate that it's coercive, but you have to do what you have to do. And when you're saving somebody's life, and they can't help themselves, you have to take the tough love approach."

> Another clinician observed that "...with Section 35, self-determination [is] just completely taken away," wondering "is it our right to make decisions for other people when we're taking away their rights by doing that?" This clinician shared she was "uncomfortable" with ICC being an example of how the medical field is "violating" or "controlling" people's rights. She observed that ICC "...definitely, straight-up seems like one [violation of rights], hands-down, and I think people should be able to make their own decisions. Even if it's causing them harm, it's their choice...[ICC] is going against what I feel like are my values."

MAY WORSEN RISKS OVER THE LONG-TERM

Participants described ICC as "a short-term solution that's going to lead to long-term problems." For example, participants worried that ICC places patients in criminal justice contexts where they are more likely to

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accrue additional legal trouble or could cause patients to view OUD treatment negatively. Participants also worried that ICC does not help patients find reasons to remain in recovery, but instead worsens OUD-related social stigma and ultimately isolates and dehumanizes patients.

To explain what was most upsetting about ICC, two clinicians described how ICC can jeopardize their special therapeutic role in helping patients to understand that they are humans with value despite their OUD:

> P1: "They [patients] don't have the connections anymore, which is part of why [it is important for clinicians to]…humanize everybody and just treat them like a human being… Because we would be the first people in someone's life to treat them like a human being, [that] they are a good and worthy person no matter what kind of behaviors we see…[starts to cry]
> P2: And showing compassion and concern for their overall well-being…
> P1: …that, just, they have a value."

Also, of great concern among clinicians was that ICC decreases opioid tolerance without providing supports for continued treatment in the community after ICC exit.

> A clinician explained, "We know that anytime there is abstinence, there's a decrease in tolerance, so there will be some [ICC] folks that…will be at a higher risk of overdose."

> Another clinician explained that after ICC exit, "…their tolerance is going to drop so quickly and so fast that if they aren't getting the assistance and [instead] they're just re-sectioned, held, and then released back to exactly where they came out of, they're probably going to use, and they're probably going to die. So is it really saving somebody's life? I don't know. It might be, for a few days, but it could be putting them at greater risk, also."

> A third clinician said, "A lot of people tell me it [ICC] stops that runaway train, they're so out of control, it just stops it. Gives them an opportunity to…stop a runaway train, [but] by putting a brick wall in front of it."

To address these problems, clinicians called for better integration of ICC with existing healthcare systems. Specifically, clinicians suggested that at ICC exit, patients be provided with immediate access to methadone and other OUD medications, aftercare planning, and regular check-ins regarding treatment progress after community re-entry.

Lacks Empirical Support and Unsustainable

Participants questioned whether ICC is an empirically-supported program. Some doubted whether ICC is a sustainable solution. Participants suggested that instead of ICC, the community should increase long-term treatment capacity or invest in other alternatives that would eliminate the need for ICC altogether.

> A patient suggested that before deciding to continue or expand ICC, we need "Better information first. See how many people are having success stories from being sectioned, and how many people are just going back out and using. Take that information and use that to make the decision to get rid of it [ICC] or [keep it]"

> Another patient said, "…expanding Section 35 is probably not the best of ideas, or spending the money for it, because…we don't want it doing… what bad it's doing. We don't want to exacerbate the situation. I'm sure the money can best go to other methods…."

> A clinician said, "When I heard of Section 35, the first thing that I thought of was how many Section 35s can we possibly have, 100, 1000, 10,000? Every time somebody uses, you're going to Section 35 them? You'll run out of space very quickly."

> A clinician explained, "We're sending people on the street because we can't get them a bed at long-term treatment. Then the cycle starts all over again and maybe they'll crash into a car with a kid in it, or a mother, your uncle. If there was more treatment out there, that was voluntary, maybe we wouldn't have to Section 35 people."

Discussion

Primary Results and Implications

Our results suggest that, despite some perceived benefits among clinicians and persons with OUD, the extent to which ICC for OUD restricts individual liberty may not be proportionate to the harm it will prevent. Specifically, while ICC is likely to achieve its stated goals of saving lives from fatal opioid overdoses

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Table 4
Recommendations for balancing the potential benefits and harms of ICC

Acknowledge that ICC serves a vulnerable patient population
- Context of urgency: ICC is enacted in settings of immediate and life-threatening crises.
- Patients have impaired decisional capacity and lack what is needed to understand healthcare choices, make informed decisions, or advocate for their own health interests.
- Programmatic challenges can act as broad forces that jeopardize the ability of the program to yield beneficial outcomes.
- Individuals who are eligible for ICC should be seen as a population of vulnerable patients whose status warrants added protections to guard against potential harms.

Ensure ICC provides medications for OUD and other evidence-based care
- All three FDA-approved medications for OUD (e.g., methadone, buprenorphine, naltrexone) should be offered to patients within ICC settings.
- ICC should be integrated with the community-based OUD treatment system of care to support patient utilization of medications and other evidence-based care.

Treat ICC patients with dignity, especially given the context of being denied liberty
- Recognize preferences for healthcare settings over jail-like settings.
- Design ICC processes and contexts that are safe but also consensual and humanizing.
- Use ICC only as the last resort.
- Expand the OUD system of care and create alternatives to ICC.

Educate patients, allies, and clinicians about the practice and ethics of ICC
- Provide education about ICC policies and procedures.
- Create forums to consider ICC ethical conflicts and potential solutions.

Establish ICC outcomes
- Conduct studies to provide empirical evidence on a range of issues related to ICC programming and outcomes.
- Recognize that in the absence of evidence, broad diffusion of ICC risks being an unethical and inappropriate use of public resources.

while the patient is confined, this benefit is likely to be at the expense of potentially worsening long-term opioid overdose risks. The Kass framework suggests that health department officials have a responsibility to remove from policy debate those programs that are unethical, whether because of insufficient data, clearly discriminatory procedures, or unjustified limitations on personal liberties. Since we initiated the present study, concerned professionals have increasingly called for actions to minimize the potential harms of ICC, or eliminate it altogether.[16] Our results point to several areas where remedial efforts could potentially minimize current harms, provide minimal criteria to justify suspending the right to informed consent, and increase the potential for benefits over the long-term.

Acknowledge that ICC serves a vulnerable patient population

A key finding is that patients with OUD and those around them turn to ICC as a last resort, that is, in the context of immediate and life-threatening crises. This is a context of urgency in which ICC patients are perceived to have impaired decisional capacity, for example due to opioid and poly-substance use and co-occurring mental illness. Therefore, it should be common practice that validated and objective measures are used to make such determinations. Also, ICC patients are perceived to lack the resources (e.g., legal advocate) and skills that are needed to understand their healthcare choices and make informed decisions or advocate for their own health interests. Well-known potential remedies, such as requirements for third party verification, are warranted. Moreover, like mental health and imprisoned populations, many consider that OUD patients constitute a vulnerable population who should be afforded a higher standard of protection. Overcrowding, insufficient staffing,[17] staff stress,[18] compassion fatigue ("burn-out"), [19] and high staff turnover[20] further undermine treatment quality and prospects for successfully maintaining

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recovery. These factors jeopardize the ability of the ICC program to yield beneficial outcomes. Thus, ICC-eligible individuals should be seen as a population of vulnerable patients whose status warrants added protections to guard against potential harms.

Ensure ICC Provides Medications for OUD and Other Evidence-Based Care

Our results reveal how few patients receive any of the three FDA-approved medications to treat OUD, either within ICC settings or after ICC exit. These experiences contradict recommendations by most health experts who view OUD as a chronic health condition best managed with medications.[21] Patients with OUD who are treated with medications have lower mortality,[22] less opioid use,[23] less infectious disease risk, and other positive outcomes.[24] For these reasons, all three FDA-approved medications for OUD should be offered to patients within ICC settings. Also, ICC should be integrated with the community-based OUD treatment system of care such that at ICC exit, patients may readily continue to utilize medications and other evidence-based care.

Treat ICC Patients with Dignity, Especially Given the Context of Being Denied Liberty

Many ICC programs have historically treated patients in criminal justice settings, and in discriminatory ways in which the circumstances and type of services offered differ by gender and other sociodemographic factors.[25] The results presented here support the need for administering ICC in healthcare settings, instead of jail, a point of virtually unanimous consensus across patients their allies and providers. Specifically, participants shared their preferences for ICC processes and contexts that are safe, humanely enacted and negotiable within reasonable limits. In this context, the concepts and practices of shared decision-making[26] may offer strategies to better incorporate patients' healthcare needs and preferences into ICC programming. At the same time, participants made it clear that ICC should only be used as the last resort when all other options have been exhausted. They also shared why patients sometimes arranged to have themselves committed, i.e., because of limited or no community-based treatment options, which raises further important questions about justice and the lack of sufficient treatment beds. Additionally, while the state pays for ICC in Massachusetts, ICC may not be a mechanism to receive state-provided services in other jurisdictions, i.e., states where the petitioner has to sign a guaranty of payment for treatment under ICC. These findings underscore participants' identification of the need for communities to expand the OUD system of care and create other alternatives to ICC.

Educate Patients, Allies, and Clinicians About the Practice and Ethics of ICC

Results revealed that patients, their allies, and treatment practitioners are not knowledgeable about ICC, are uncertain of the relevant ethical issues, and are unsure how to act ethically when working with ICC-eligible patients. These knowledge gaps mean that the actual and potential burdens of ICC have mostly gone unrecognized. Findings point to the need for more education about ICC policies and procedures. Examples of ethical and other educational topics worth considering include: principles of autonomy and non-maleficence in relation to treating individuals with OUD, where individuals are placed in care, the type of treatment provided, the duration of confinement, processes for community re-entry, expected outcomes and impacts, safeguards to minimize potential harms, potential alternatives to ICC, and other information that would enable individuals to weigh the potential harms and benefits of ICC. Also needed are forums such as ethics consultations to consider ICC ethical conflicts and potential solutions.

Establish ICC Outcomes

Participants expressed reservations about the fact that there is now insufficient evidence to make an informed decision about whether the short-term benefits of ICC are outweighed by its potential long-term harms. In particular, little research has been conducted to understand intermediate and long-term ICC outcomes and variation in outcomes by program characteristics. It is critical that studies are conducted to provide empirical evidence on a range of such issues. These include, for example, studies on the variability of ICC programs, including their provision of health and social services (e.g., type, amount, frequency), types of patients for whom ICC is most effective, whether ICC has better outcomes than alternative policies, and the cumulative effect of ICC events over the short- and long-term. In the absence of such evidence, broad diffusion of ICC as a potential solution to the opioid epidemic risks being an unethical and inappropriate use of public resources.

Limitations and Strengths

Findings are based on a non-random convenience sample of 70 individuals receiving or providing MOUD in OTP settings in Western Massachusetts. Small sample sizes are the norm in qualitative research[27] and are not intended to support generalizations, but rather provide depth of information.[28] Also, findings may not reflect the experiences and perspectives of individuals who have not provided or received MOUD. A significant limitation is that this study is based in Massachu-

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setts, with unique ICC-related laws and procedures, and so findings might not generalize to other states. Some participants shared experiences that Massachusetts is actively working to address (e.g., provision of ICC outside of jail settings, especially for women), and therefore these issues may not be as salient for current ICC programming.[29] Also, some individuals shared experiences that had occurred many years previously, and therefore reports may be subject to retrospective recall biases. Finally, despite facilitator instructions and probes, some participants may have conflated ICC with drug court experiences or experiences with other criminal justice diversion options. A strength is that we solicited perspectives regarding ICC from individuals receiving OUD treatment, a population that previously has been little studied. Also, the study is set in Massachusetts, which has a large and growing ICC program. Finally, in contrast to most ICC research, which has mostly utilized an observational design,[30] we employed qualitative methods to explore the experiences of patients with OUD, their allies, and their healthcare providers. We thereby gain insight into the complex set of factors that shape views regarding ICC.

Conclusion

Involuntary civil commitment to treatment for opioid use disorder carries significant potential harms that, if unaddressed, may outweigh its benefits. Findings can inform policies and practices for ensuring that involuntary civil commitment is used in an ethically responsible way that achieves a sound balance across beneficence, autonomy, and non-maleficence.

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Note

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