An Ethicolegal Analysis of Involuntary Treatment for Opioid Use Disorders

Farhad R. Udwadia and Judy Illes

Background

In the USA, approximately 67,071 people lost their lives to drug overdoses in a 12 month period ending in July 2019.[1] According to a 2018 US national survey, an estimated 10.3 million people misused opioids in that year, and approximately 2 million people suffered from opioid use disorders.[2] In 2017, the Center for Disease Control (CDC) estimated the total economic burden of prescription opioid misuse in the United States to be approximately $78.5 billion per year.[3] In Canada, the best comparators suggest that over 13,900 opioid related deaths occurred between January 2016 and June 2019, with over 17,050 opioid related hospitalizations.[4]

Many supply-side interventions have been tried to curb the ongoing opioid crisis, with strategies that range from prescription drug monitoring programs and "pill mill" laws to dispensing limits. Involuntary commitment laws are an increasingly used demand-side intervention, with the number of states with such laws increasing from 18 in 1991 to 38 jurisdictions and counting.[5] In general, there is a great degree of variability amongst regions of the USA, at least, with regard to these laws. States such as Massachusetts have been particularly hard hit by the crisis, and have been increasingly reliant on this mechanism. The number of people involuntarily committed in the state increased by 76% from 2011-2018, with 6,048 people being committed in 2018 (Table 1).[6] A 2015 review found that Florida commit 9,000 people on average annually, whereas states such as Hawaii (83 in 2009), Texas (22 in 2010), and Wisconsin (260 in 2011) do so less frequently.[7] The study also found that some states such as Illinois and Utah had, at that time, never used their statutes.

In Canada, involuntary commitment for youth under 18 years old is known as secure care legislation.[8] Secure care legislation for this age group exists in 7 out of Canada's 11 provinces (Alberta, Saskatchewan, Manitoba, Ontario, Quebec, New Brunswick, and Nova Scotia). British Columbia is considering following suit in response to the ongoing opioid crisis, with families and community members petitioning for legislative change.[9] Secure care laws vary by province with regards to treatment type and duration, but stabilization and detoxification remain the primary goals of all programs in Canada.

The experience of Massachusetts as a case study tempers enthusiasm about this intervention. In 2019, civilly committed men at the minimum security Massachusetts Alcohol and Substance Abuse Center (MASAC) in Plymouth sued the state on the grounds that the prison is a "perversely oppressive environment that is punitive, humiliating and detrimental to treatment."[10] Complaints like this that tell of breaches in liberty and dignity have been consistent since the application of the law. Moreover, as of 2019, involuntary commitment centers such as the MASAC have substandard treatment programs with no medication assisted treatment, and it is unknown whether other centers offer medication to all the patients committed.[11]

In Massachusetts, involuntary commitment takes the form of the statute Section 35, which allows for

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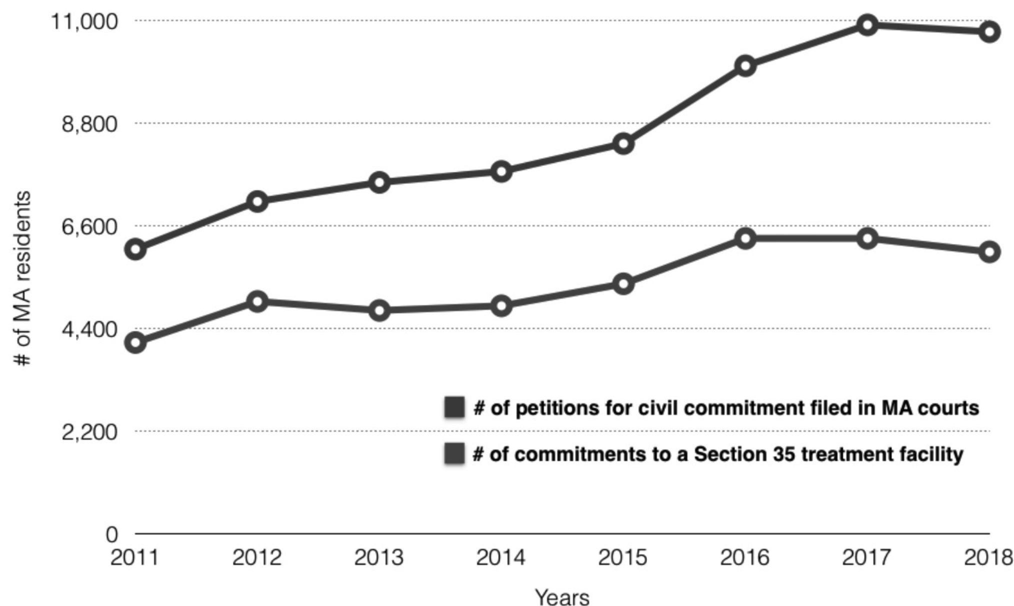
Figure 1
Rise in Section 35 commitment requests (Filed and Accepted). (Source: Section 35 Commission Report, 2019)[41]



the involuntary commitment and treatment of a person with an alcohol or substance use disorder, who is at a likelihood of serious harm to themselves or others.[12] A person is classified as such if they consume substances to the extent that it compromises their health, interferes with their social or economic functioning or causes loss of self-control over its use.[13] A spouse, blood relative, guardian, police officer, physician or court official can petition the court to take action in these circumstances.[14] If the court shows that use of such substances poses a likelihood of serious harm, they may commit the user for a period not exceeding 90 days.[15]

Ethical Analysis

The ethical quandaries regarding the practice of Section 35 in Massachusetts and elsewhere consist of ethicolegal issues with the statute itself, breaches of privacy, liberty, and dignity to the patient, a poor benefit/risk ratio and a failure to meet the medical standard of care in treatment.

Ethicolegal Issues

From an ethicolegal standpoint, it is uncertain whether the standard of a likelihood of serious harm is high enough to justify the degree of invasiveness of the intervention. The standard "likelihood of" represents a relatively low bar of proof, as opposed to the "clear and convincing" or "beyond a reasonable doubt" standard, which are the standards typically employed in legal considerations regarding civil liberties. The statute is intended to serve as a last resort measure for people with severe and debilitating addictions. Empirical data show that requests for Section 35 have increased by 85% from 2010-2017, with nearly 58% approved between 2016-2017.[16] These statistics raise the question of whether the low standard of proof contributes to rising rates of involuntary commitment and whether the option is not being exercised as a last resort pathway as intended.[17]

The statute cap on period of commitment of up to 90 days raises further consideration. There is no documented medical evidence to date that suggests that this particular length of time is effective with regards to the treatment of addiction disorders. The mandate thus seems to be arbitrary, depriving individuals of their liberty for a period of time that is scientifically unfounded.

Privacy, Liberty, and Dignity

While the very nature of the intervention involves a significant breach of privacy and liberty, the majority of the ethical issues raised by Section 35 lies in the implementation of the law itself. For example, patients have historically been handcuffed at several stages of the treatment process and then placed in holding cells.[18] Approximately 40% of all patients are commit-

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ted and treated at the large MASAC facility, where they are under the watch of armed correctional officers and are required to wear prison-like jumpsuits for identification. According to press reports, since the MASAC opened in 2017 there has been at least one serious assault, one rape, three suicide attempts and one suicide amongst the patient population.[19] The superintendent reported that approximately 15 patients had been physically attacked in at least two dozen fights in the facility.[20] A 2017 lawsuit alleged that patients were housed close to violent sex offenders, and were routinely strip searched and segregated.[21] The latest lawsuit in 2019 laid similar claims, with additional allegations that the patients were placed in solitary confinement subject to abusive treatment from correctional officers and made to follow prison-like rules and regulations.[22] The lawsuit claims that *"many, if not most, emerge from prison traumatized by the experience and even more vulnerable to relapse and overdose".*[23] Other reporters who interviewed former patients described unhygienic conditions, including descriptions of bathrooms soiled with feces and lacking soap.[24]

The Massachusetts government faced similar challenges previously, with involuntary commitment for female patients suffering from opioid use disorders. Women who were housed at the Massachusetts Correctional Institute at Framingham lodged similar complaints regarding treatment in a correctional facility. Recognizing this, the Massachusetts government passed legislation in 2016 that ended involuntary commitment for women at the Framingham facility. The legislation specifically acknowledged that the women deserved to be treated like patients in hospitals, and not in prison facilities.[25]

Risk-Benefit Trade-Offs

Proponents of involuntary commitment and treatment maintain that the privacy breached is justified due to the favorable benefit to risk ratio that the intervention poses. A systematic review evaluating the effectiveness of compulsory drug treatment, however, concluded that evidence does not suggest improved outcomes related to compulsory treatment, with some studies even suggesting potential harms.[26] They concluded with a recommendation for the prioritization of non-compulsory treatment modalities to reduce drug-related harms.

Another large study compared relapses in opioid use in opioid-dependent individuals released from compulsory drug detention centers with those from voluntary medication treatment centers in Malaysia.[27] The study concluded that opioid dependent individuals in compulsory treatment are *"significantly more likely to relapse to opioid use after release, and sooner, than those treated with evidence-based treatment,"* suggesting that compulsory treatment has no role in the treatment of opioid use disorder.

Data regarding the effectiveness of involuntary commitment in specific states are limited, but there has been a call for rigorous study of existing statutes.[28] However, a few studies have examined provider receptiveness to involuntary treatment. For example, a 2007 study surveyed members of the American Psychiatric Association, of whom the majority had direct experience with involuntary commitment.[29] The study found only 22% supported civil commitment for alcohol addiction, and 22.9% for drug addiction. Another study from Minnesota examined provider reception to involuntary treatment also found that providers were generally opposed to it.[30]

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Outcomes data released by the Massachusetts government seem to reflect the literature as well. According to the Massachusetts Section 35 outcomes report, people who are involuntarily committed under the Section 35 pathway are at a 2.2 times greater risk of overdosing post release relative to those who are voluntarily treated.[31] Notwithstanding the possibility of confounding variables, this statistic is startling, and raises significant doubt as to the overall impact and cost effectiveness of the intervention.

Standard of Care During and Post Commitment

Several Massachusetts treatment facilities fail to provide the standard of care treatment to all patients

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committed.[32] In July 2019, the Section 35 Commission (established in Section 104 of Chapter 208 of the Acts of 2018) released a report detailing the active treatment facilities in Massachusetts, along with the number of beds they possess and the treatment they offer. Although every facility in the report is listed as offering various options for medication assisted treatment (MAT), evidence suggests that those who are committed rarely, if ever, receive such treatment. The report goes on to mention that, *"Practice varies by facility, medication-assisted treatment (MAT) may be offered as a complement to addiction counseling and other supports."*[33] Based on the report data and existing press coverage, this statement portrays the reality of the situation slightly better, which is that although MAT may be offered, it is rarely so. In fact, according to the discharge data in the same report, only 12% of patients across three facilities (High Point Women's Addiction Treatment Center, High Point Treatment Center at Shattuck Hospital and High Point Men's Addiction Treatment Center) received MAT.[34] It is also well known and often cited that the MASAC, which houses 40% of all patients involuntarily committed, does not provides MAT to any of their patients.[35] There are no data on whether or not the other facilities provide MAT to their patients, and this uncertainty highlights an urgent need for their collection and dissemination. This is a national concern for both the USA and Canada, with other regions also lacking outcomes-oriented, granular data.[36]

Evidence shows MAT is effective at reducing overdose mortality in people dependent on opioids and involuntary commitment alone is substantially less effective in reducing negative outcomes.[37] A substantial number of patients are not treated with MAT, however. It is unacceptable for any state to take away patient autonomy, under the guise of treatment, and to then subject patients to inferior and outdated methods of treatment, all the while denying them the standard of care. Furthermore, the facility to which a patient is sent, and by extension the treatment received, depends on morally arbitrary factors such as gender, a judge's expert but subjective consideration, space at a facility, insurance status and other related factors. This also raises ethical concerns regarding the fairness of the process.

The failure of the government to commit to the long-term care and management of patients is a further ethically problematic issue. Massachusetts law does not mention the need for any coordinated or long-term care for patients who are involuntarily committed. Like most addiction disorders, opioid use disorders are chronic in nature, requiring long-term care and management for the long-term difficulties associated with mental health disorders and societal stigma.[38] This is reflected in the Section 35 data, which shows that a significant number of patients who are discharged enter into medical facilities, shelters, and nursing homes directly.[39] The post release overdose risk data released by the Massachusetts Section 35 report further underscores the concern for long-term management.[40]

Conclusions

Thirty-eight US jurisdictions and 7 Canadian provinces already have involuntary commitment laws on the books and many are considering expansion. The experiences of Massachusetts tell a cautionary tale. The empirical evidence available, coupled with the manner in which these laws have been translated into practice does not support an expansion of such laws. More so, they raise a warning to families and patients considering such a route. However, it is understandable that involuntary commitment and treatment will continue to be practiced, at least in the foreseeable future as effective options are scarce, especially as an option for families who have tried unsuccessfully to find for their loved ones the medical care that they need.

Still, the current implementation of Section 35 legislature in Massachusetts is fraught with ethical shortcomings. Here we suggest four guiding principles to achieve an updated, ethically sound, and goal-concordant practice:

1. **Ensure that patients are housed in a safe and dignified environment during their stay**. If dignified treatment cannot be provided in a correctional facility, alternative housing possibilities should be pursued.
2. **Work with physicians to provide all necessary treatment to patients who are involuntarily committed**. Rehabilitation can be best achieved when coupled with appropriate medication assisted treatment. Principles of access and distributive justice implore access to MAT by all patients.
3. **Collaborate with regional social services to co-ordinate the long-term care of patients post release, including assistance to transition them out of the facility**. Addiction disorders require longitudinal care.
4. **Commit to document and release relevant data**. Specific data on overdose rates post-release, availability of MAT, other treatments offered, treatment center resources and patient health outcomes are of critical importance to test and implement fiscally-realistic, sustainable solutions to the identified ethicolegal challenges.

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The implementation of these recommendations will require additional investment in time and resources from already burdened criminal justice and healthcare systems. Nonetheless, they represent positive steps to achieve morally justifiable trade-offs for the autonomy and beneficence of incarcerated patients with opioid addictions, and just and equitable access to healthcare for this patient population that encounters multiple barriers to care.

Note

The authors have no conflicts of interest to disclose.

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