Perceived benefits and harms of involuntary civil commitment for opioid use disorder

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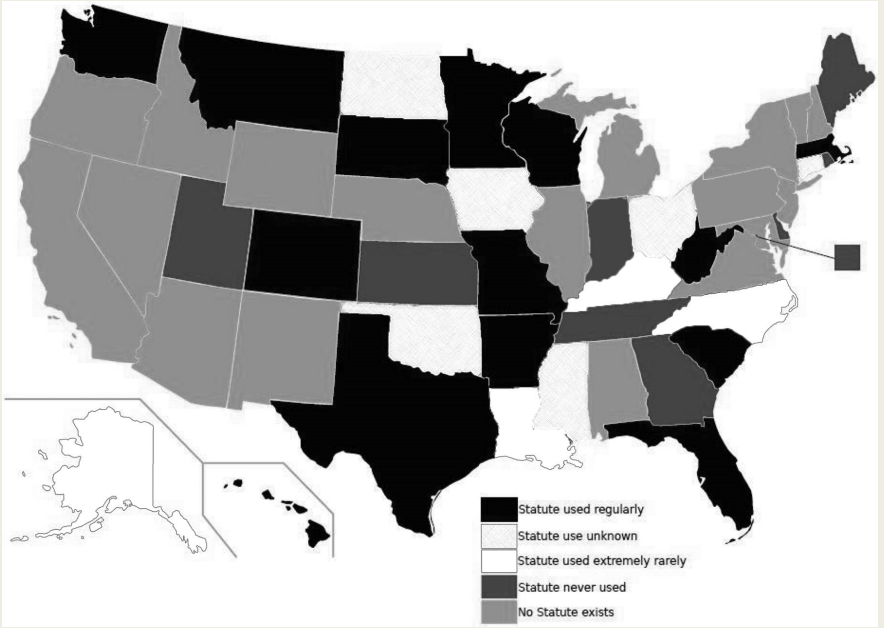
Context

- Opioid epidemic is a national public health emergency.
- Growing support for involuntary civil commitment (ICC) to treatment for opioid use disorder (OUD).
  - Initiated by family or physicians.
  - Places people with OUD who pose an imminent danger to themselves or others in supervised residential settings where they cannot obtain opioids.
- Massachusetts is a top user of ICC ("Section 35").

Has civil commitment statute for substance abuse



Cavaiola et al., 2016

A public health ethics conceptual framework

(Kass, 2001)

- The extent to which ICC restricts or infringes on individual liberty should be proportionate to the harm it will prevent.
- Core principles
  - if ICC is likely to achieve its stated goals, and
  - if its potential burdens are recognized and minimized, and
  - if ICC is expected to be implemented in a nondiscriminatory way, then
  - proponents must decide if the expected benefits of ICC outweigh the identified harms.
- Public health officials have an obligation to work with constituent communities and experts to understand benefits and risks.

Methods

- Semi-structured in-person focus groups and 1:1 interviews with n=70 adults in 2018-2019
  - Recruited via flyer from 2 opioid treatment programs in Western Massachusetts.
  - IRB approved, 1.5-2.0 hours, $100 payment, digitally recorded, professionally transcribed.

- Using grounded theory methods, two research staff coded each transcript independently, compared codes, and resolved discrepancies.
  - Analyzed patterns within and across transcripts, identified major themes. Grouped common responses with illustrative quotations.
  - Research team reviewed summary of themes.
  - Solicited feedback on preliminary results from patient advisory council.

Participant demographics

		Patients (n=31)	Allies (n=24)	Staff (n=15)
Gender	Female	67.7	62.5	93.3
Race & 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/vocational	32.3	41.7	0
	College or higher	48.4	20.8	100
Employment	Employed	32.2	29.1	100
	Not working	54.6	70.8	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

PERCEIVED BENEFITS

1. Saves lives in the moment
2. Protects vulnerable patients who are danger to self or others
3. Provides families with leverage
4. “Better than overdose or jail”
5. Provides treatment access
6. Can be a turning point event
7. Promotes public health, increases public safety

1. Saves lives in the moment

“Saving somebody's life, period, the main thing.”

“…Because it’s an immediate threat, [thus] immediate action has to be taken to save their life.”

2. Protects vulnerable patients who are danger to self or others

- Active opioid and other substance use
- Co-occurring mental health disorders
- Unable to make “good” decisions
- Living in conditions of desperation, hopelessness, and despair

3. Provides families with leverage

- Safety for patient and family
- ICC is an expression of love
- Patients are angry at first, but grateful later
- Best when used “for the right reasons”

ICC is more likely to have better outcomes when the intent is “not malicious” or “derogatory” but instead is “coming from a loving place, a protective place.”

4. “Better than overdose or jail”

“…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….”

civil commitment is “…recovery-based…it's like rehab, just forced rehab but it's so much different [from jail]. It's way better.”

5. Provides treatment access

- Immediate treatment access, for a longer period of time

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

"…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 voluntarily "ICC" self

"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."

"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."

6. Can be a turning point

- Patients can think clearly, get fresh start. But also “the worst best thing.”

“…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.”

- Clinicians skeptical re whether ICC actually improves patient lives.

“…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…And then maybe at that point they’d be willing to go and get treatment. I think that’s a really big positive…Does it work out that way most of the time? No.

7. Promotes public health, increases public safety

- Provides health services.
  - Assessments, diagnoses, education, medications.
- Helps to prevent Hepatitis C and other infectious diseases.
- Prevents unintentional injury to others.
- Prevents crime.

PERCEIVED HARMS

1. Feels like jail, often is a jail
2. Divides families
3. Provides limited or no medications to treat opioid use disorder
4. Coercive
5. Short-term solution that may lead to long-term problems
6. Lacks empirical support and is unsustainable

1. Feels like jail, often is a jail

- Places patients in settings that resemble jail, or are a jail
- Settings and procedures described as “punitive,” “degrading,” “humiliating,” “terrible,” “harrowing,” “isolating,” and “stigmatizing.”
- Causes patients to experience “fear” and “shock”-- deterrent to recovery and makes patient’s reality worse.
- For some, these aspects of ICC constitute a violation of human rights.

2. Divides families

- Family uses ICC with a harmful intent, to control or punish loved ones
- Family uses ICC unnecessarily - not knowledgeable
- Divides families, triggers opioid use

“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?’”

3. Provides limited or no medications to treat opioid use disorder

ICC without medications for OUD is “…cruel and unusual punishment, 100%…that’s a really, really cruel thing to do to somebody…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.”

4. Coercive

- Undermines patient autonomy and empowerment
- Makes patients angry, “rebellious,” resistant to change
- Leads to a return to opioid use
- Infringement of human rights

5. Short-term solution that may lead to long-term problems

- 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

6. Lacks empirical support & is unsustainable

“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.”

“When I heard of Section 35, the first thing 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.”

DISCUSSION

Implications

- The extent to which ICC for OUD restricts individual liberty may not be proportionate to the harm it will prevent.
  - While ICC is likely to achieve its stated goals of saving lives from fatal opioid overdoses in the moment, this benefit is at the expense of potentially worsening long-term opioid overdose risks.
- Health department officials have a responsibility to remove from policy debate those programs that are unethical
  - insufficient data, clearly discriminatory procedures, unjustified limitations on personal liberties.
- Recently, advocates have called for actions to minimize the potential harms of ICC, or eliminate it altogether.
- Our results point to several next steps.

Recommendations

1. **Recognize ICC serves a concentrated population of vulnerable patients**
   - 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.
   - Status warrants added protections to guard against potential harms.

2. **Ensure ICC provides medications and other evidence-based care**
   - Should offer all three FDA-approved medications for OUD (e.g., methadone, buprenorphine, naltrexone) within ICC settings.
   - Should integrate ICC with the community-based OUD treatment system of care.

Recommendations

3. **Treat ICC patients with dignity, especially in 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.
4. **Educate about ICC practices and ethics**
   - Provide education about ICC policies and procedures.
   - Create forums to consider ICC ethical conflicts and potential solutions.
5. **Establish ICC outcomes**
   - Conduct studies to provide empirical evidence on 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.

Limitations

- Non-random convenience sample; n=70
- Recruited from two settings; vulnerable patients
- Recall bias
- Some harms being addressed now

Strengths

- Understudied population
- Qualitative methods
- Provide insight into factors that shape views of 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 adequately balances beneficence and non-maleficence and is used in an ethically responsible way.