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Involuntary treatment for substance use disorder: A misguided response to the opioid crisis

Posted By Leo Beletsky, JD, MPH On January 24, 2018 @ 10:30 am In Addiction,Health | Comments Disabled

Recently, Massachusetts Governor Charlie Baker introduced "An Act Relative to Combatting Addiction, Accessing Treatment, Reducing Prescriptions, and Enhancing Prevention" (CARE Act) as part of a larger legislative package to tackle the state's opioid crisis. The proposal would expand on the state's existing involuntary commitment law, building on an already deeply-troubled system. Baker's proposal is part of a misguided national trend to use involuntary commitment or other coercive treatment mechanisms to address the country's opioid crisis.

The CARE Act and involuntary hold

Right now, Section 35 of Massachusetts General Law chapter 123 authorizes the state to involuntarily commit someone with an alcohol or substance use disorder for up to 90 days. The legal standards and procedures for commitment are broad; a police officer, physician, or family member of an individual whose substance use presents the "likelihood of serious harm" can petition the court.

Upon reviewing a petition, the court can issue a warrant for the arrest of the person with substance use disorder. The individual — who is not charged with a crime — is held pending an examination by a court-appointed clinician. The statute mandates that the determination proceed at a rapid pace, making it difficult to mount a meaningful defense.

The CARE Act proposes to further accelerate this process. The proposal would allow clinical professionals — including physicians, psychiatric nurses, psychologists, and social workers (or police officers when clinicians are not available) — to transport a person to a substance use treatment facility when the patient presents a likelihood of serious harm due to addiction and the patient will not agree to "voluntary treatment." Upon determination by a physician that the failure to treat the person would create "a likelihood of serious harm," the treatment facility has 72 hours to get the person to agree to voluntary treatment. If the person refuses, but the facility superintendent determines that discontinuing treatment would again cause "a likelihood of serious harm," the facility must petition the court for involuntary treatment under the process outlined in Section 35.

The expanded use of these laws

Laws that allow the state to commit people for substance use disorder are not new. The number of states with such laws went from 18 in 1991 to 38 jurisdictions, and counting. Existing laws vary significantly in the specific criteria for commitment, length, and type of treatment, if any is provided. The use of this mechanism has rapidly expanded as the opioid crisis has worsened; Massachusetts, with a population of under 7 million, committed a shockingly high number — more than 6,500 individuals — in 2016. Ironically, this expansion has occurred in conjunction with calls to move away from a criminal justice and toward a public health approach to the crisis, including a more concerted emphasis on treatment for people with addiction. But this well-intentioned shift carries little meaning when coercion and institutionalization are involved. In fact, 70% of the beds for men in Massachusetts are at a prison facility, where patients wear prison uniforms and answer to correctional officers. In recent months, these facilities have been rocked by a series of high-profile scandals, including escapes, suicides, and alleged sexual assault.

Do these laws help or hurt?

Existing data on both the short- and long-term outcomes following involuntary commitment for substance use is "surprisingly limited, outdated, and conflicting." Recent research suggests that coerced and involuntary treatment is actually less effective in terms of long-term substance use outcomes, and more dangerous in terms of overdose risk. The prospects for positive outcomes from the CARE Act are especially bleak, given the standard of care currently available to Massachusetts residents committed under Section 35. The facilities housing Section 35 patients commonly offer counseling sessions and classes to "learn more about addiction;" shockingly few offer appropriate medication. In fact, the treatment provided is often not rooted in science at all. The state's own mandated evaluation of

overdose data has found that people who were involuntarily committed were more than twice as likely to experience a fatal overdose as those who completed voluntary treatment.

Though further research is needed to confirm these findings, there are several possible reasons for this. One is that recovery is much more likely when it is driven by internal motivation, not by coercion or force (i.e., the person must "want to change"). Second, the state may actually route individuals to less evidence-driven programs on average (e.g., "detox") than the kind of treatment accessed voluntarily (i.e., outpatient methadone or buprenorphine treatment). Finally, those receiving care in outpatient settings may be more likely to receive services that help address underlying physical or mental health needs, which are often at the root of problematic substance use.

Involuntary commitment for people with substance use disorder deprives them of liberty, fails to offer evidence-based treatment, and may leave patients worse off by making them vulnerable to overdose risk. But for the families or medical providers of individuals with substance use disorder, court-ordered involuntary commitment for their loved ones or patients may seem like an attractive option, or indeed the only viable one, to get them into treatment. Understanding the procedures, ramifications, and consequences of involuntary commitment is vital before initiating a process that deprives a person of liberty just as much as prison would.

What is the alternative?

There is far too little on offer in Massachusetts — or elsewhere — that would trigger the timely assistance and intensive case management necessary to support people in crisis. In the absence of such supports, involuntary commitment promises to help families that are desperate to find treatment for their loved ones. Unfortunately, the promise offered by involuntary treatment is a false one. Instead, we need to develop new approaches to support families and patients in non-coercive, evidence-driven ways.

Related Information: Understanding Opioids: From addiction to recovery

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